DATA LABEL: Public

West Lothian Council

West Lothian Integration Joint Board

West Lothian Civic Centre
Howden South Road
LIVINGSTON
EH54 6FF

17 August 2016

A meeting of the **West Lothian Integration Joint Board** of West Lothian Council will be held within the **Strathbrock Partnership Centre, 189 (a) West Main Street, Broxburn EH52 5LH** on **Tuesday 23 August 2016** at **2:00pm**.

BUSINESS

Public Session

1. Apologies for Absence

2. Order of Business, including notice of urgent business

3. Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.

4. Confirm Draft Minute of Meeting of West Lothian Integration Joint Board held on Tuesday 31 May 2016 (herewith)

5. Note Minute of Meeting of West Lothian Integration Strategic Planning Group held on Thursday 07 April 2016 (herewith)

6. Running Action Note (herewith)

7. IJB 2016/217 Budget Update - Report by Chief Finance Officer (herewith)

8. Physical Disability Commissioning Plan - Report by Director (herewith)

9. Needs Assessment for Older People - Report by Director (herewith)

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10. Schedule for Mental Health Commissioning Plan - Report by Diretor (herewith)

11. Alcohol and Drugs Partnership Funding 2016/17 - Report by Director (herewith)

12. Technology Enabled Care Programme - Report by Director (herewith)

13. Draft Unaudited Accounts/Draft Governance Statement - Report by Finance Officer (herewith)

14. IJB Member Induction - Report by Director (herewith)

15. Workplan (herewith)

NOTE **For further information contact Anne Higgins, Tel: 01506 281601 or email: anne.higgins@westlothian.gov.uk**

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 31 MAY 2016.

Present

Voting Members – Councillors Frank Toner (Chair), Martin Hill, Alex Joyce, Danny Logue, Julie McDowell (Vice-Chair), John McGinty, Anne McMillan.

Non-Voting Members – Elaine Duncan (Professional Advisor), Jim Forrest (Director), Jane Houston (Staff Representative), Mairead Hughes (Professional Advisor), Jane Kellock (Chief Social Work Officer), Mary-Denise McKernan (Stakeholder Representative), Martin Murray (Staff Representative), Patrick Welsh (Finance Officer).

Apologies – David Farquharson.

In Attendance – Marion Barton (Head of Health Services), Alan Bell (Senior Manager, Communities and Information, WLC), Donald Forrest (Finance and Property Services, WLC) James Millar (Standards Officer), Kenneth Ribbons (Audit, Risk and Counter Fraud Manager, WLC), Carol Mitchell (NHS Lothian).

1. ORDER OF BUSINESS, INCLUDING NOTICE OF URGENT BUSINESS

The Chair informed the Board that Susan Goldsmith (Director Finance, NHS Lothian) would join the meeting later and that the order of business would be changed to allow the presentations on the Budget Setting Process (Agenda Item 9) to be heard at an appropriate time after Susan's arrival.

2. DECLARATIONS OF INTEREST

Councillor Logue declared an interest as an employee, NHS Lothian.

Councillor Toner declared an interest as a former Non-Executive Director, NHS Lothian.

3. MINUTES

(a) The Board approved the minute of meeting of the West Lothian Integration Joint Board held on 23 March 2016.

(b) The Board approved the minute of meeting of the West Lothian Integration Joint Board held on 31 March 2016.

(c) The Board approved the minute of meeting of the West Lothian Integration Joint Board held on 5 April 2016.

4. RUNNING ACTION NOTE

A copy of the Running Action Note had been circulated for information.

Decision

To note the content of the Running Action Note.

5. PROPOSED MEETING DATES 2016/2017

A report had been circulated by the Director outlining a proposed schedule of meetings until June 2017.

The report recalled that the Board had previously agreed that a meeting should take place on 23 August 2016, but that further discussions should take place about potential dates before further decisions were made.

As part of those discussions, the requirements of the legislation about approval of the Board's annual accounts had been considered and Audit Scotland had provided information about their timescales for completing and reporting on their audit work.

To ensure compliance with the Board's Standing Orders and provide Board members with as much notice of meeting arrangements as possible, it was proposed that the following dates, in addition to the meeting already set for 23 August, were agreed for Board meetings after August 2016 until June 2017:-

2016
18 October – 2.00 pm
29 November – 2.00 pm

2017
31 January – 2.00 pm
14 March – 2.00 pm
20 April – 10.00 am
27 June – 2.00 pm

It was also proposed that the IJB meetings continued to be held in Strathbrock Partnership Centre, Broxburn, as this building met requirements for accessibility, parking and meeting space.

It was noted that dates had been drafted after taking into account legislative requirements and available date and time opportunities within NHS Lothian and West Lothian Council meeting calendars.

It was recommended that the Board agree the proposed schedule of meetings.

Martin Hill thanked the Director for his efforts in trying to accommodate Board members' diaries. However, Martin advised that he had a clash of meetings on the proposed date of 29 November 2016.

Decision

To agree the proposed schedule of meetings.

6. CODE OF CONDUCT - REPORT BY STANDARDS OFFICER

The Board considered a report (copies which had been circulated) by the Standards Officer informing Board members of the revised Model Code of Conduct for Members of Integration Joint Boards and seeking its adoption for submission to the Scottish Ministers for approval.

The Standards Officers recalled that on 20 October 2015, the Board had adopted a Code of Conduct on an interim basis, pending the conclusion of work being undertaken by the Scottish Government and the Standards Commission for Scotland to produce a Model Code specifically designed for IJBs as a specific type of public body. The Standards Officer went on to advise that, on 1 April 2016, a new Model Code had been issued and IJBs had been requested to consider it and adopt it for future use by their IJB members. There was scope for each IJB to make changes to it "in exceptional circumstances" but any such changes would require approval when adoption of the Code was reported back to Ministers.

Although the Model Code was almost identical to the Interim Code adopted by the Board in 2015, there were some changes in relation to wording and layout, but very few of any significance for Board members. A copy of the Model Code of Conduct for Members of Integration Joint Boards (April 2016) was attached as Appendix 1 to the report.

The more significant change which members were asked to consider was the inclusion of the statement that Board members who were concerned about their position in relation to the Code of Conduct should first of all seek advice from the Chair. Representations had been made in relation to the draft Model Code to change that to a seeking advice from the IJB's Standards Officer. These representations had not been taken on board.

It was now recommended that the references in the Model Code be changed to direct Board members to the Standards Officer in the first instance, rather than the Chair.

The report went on to explain the procedure for approval (or otherwise) of the adopted Code. The report also provided details of additional statutory guidance issued by the Standards Commission.

The Standards Officer recommended that the Board:-

1. note that the Scottish Ministers had issued a Model Code of Conduct for Members of Integration Joint Boards.

2. adopt the Model Code for submission to the Ministers for approval, but with amendments to Paragraphs 1.8, 5.4, 5.15 and 6.8 to direct Board members to the Standards Officer for advice, rather than to the Chair.

3. Note the recent issue by the Standards Commission of further guidance to members of devolved public bodies on relationships with employees, and the use of social media.

Decision

To approve the recommendations by the Standards Officer.

7. STRATEGIC PLAN IMPACT ASSESSMENT

A report had been circulated by the Consultant in Public Health presenting the Integrated Impact Assessment carried out on the Strategic Plan.

The report recalled that members of the Strategic Planning Group had met on 18 January 2016 to carry out an impact assessment of the draft Strategic Plan. The assessment met the requirements for Equality Impact Assessment and therefore included explicit consideration of the needs of people with protected characteristics as defined in the Equality Act (2010). It also considered the potential for wider impacts on other vulnerable population groups and determinants of health. The completed impact assessment report was attached as Appendix 1 to the report.

The recommendations made in the impact assessment were as follows:-

- The Plan should make clear that operational responsibilities for children's and adult services remain combined under the same Director, as now.

- There should be clear strategic links made with corresponding plans and governance structures for children's services.

- The Engagement Plan should include actions to engage with the voluntary sector, and with vulnerable groups including, but not only, people with protected characteristics. It should identify ways to engage with people with communication needs.

- The needs assessments for client group and locality plans should include local intelligence to ensure services are best directed to people with the greatest needs.

- There should be training in the use of 'teachback' for health and social care staff.

- The relevant needs assessment should consider differing needs of men and women as they age.

- There should be consideration of the needs of refugees.
- The strategic plan and commissioning plans should continue to focus on prevention and addressing health inequalities.

The Integration Joint Board was recommended to:-

1. approve the recommendations of the Impact Assessment on the Strategic Plan.

2. approve the use of the Integrated Impact Assessment process for subsequent commissioning and other plans.

During discussion, Martin Hill queried the review date in relation to 'Maintain focus on prevention and early intervention in the Plan' (Appendix 1, page 11) which was showing as May 2016. In response, officer undertook to update the review date.

Decision

To approve the recommendations set out in the report.

8. IJB ANNUAL ACCOUNTS COMPLIANCE

A report had been circulated by the Chief Finance Officer setting out final accounts requirements and timescales for the IJB and proposed reporting arrangements to meet compliance with the Local Authority Accounts (Scotland) Regulations 2014.

The report explained that the Chief Finance Officer of the IJB was responsible for preparing the financial statements in accordance with relevant legislation and the Code of Practice on Local Authority Accounting. This required the maintenance of proper accounting records and the preparation of financial statements giving a true and fair view of the state of affairs of the IJB at 31 March 2016.

The Board noted that the Annual Governance Statement required to be approved and submitted as part of unaudited annual accounts provided to Audit Scotland by 30 June 2016. Taking account of this, a draft Annual Governance Statement was appended to the report for approval by the Board.

The report went on to explain the provisions in relation to the unaudited accounts including the requirement for the accounts to be considered by the Board, or a committee whose remit included audit or governance, prior to submission to the external auditor. It was therefore considered appropriate for the unaudited annual accounts to be considered by the IJB Audit Risk and Governance Committee at the committee meeting scheduled on Friday 24 June 2016.

The Board was asked to note that IJBs must give public notice of the right to inspect the annual accounts and this should be done in advance of

submission of the accounts to external audit. In addition, there was a requirement to publish the unaudited accounts on the IJB website following submission to Audit Scotland and until the publication of the audited accounts.

Under the 2014 regulations, the audited accounts were required to be approved by 30 September. Following approval, and by 31 October at the latest, the audited annual accounts required to be signed and dated by the IJB Chair, Director and Chief Finance officer, and then provided to the auditor. The Controller of Audit then required audit completion and issue of an independent auditor's report.

Audit Scotland had confirmed they would be unable to complete their audit of the IJB and associated audit report to meet the timescales of the Board meeting arranged for 23 August 2016 and the next meeting of the Board was not proposed until 18 October 2016. Taking account of this, it was proposed that the annual audited accounts along with Audit Scotland's audit report be presented to the Audit Risk and Governance Committee for consideration and approval at its scheduled meeting on 23 September 2016.

It was recommended that the Board:-

1. note the requirements set out in the report.

2. approve the draft governance statement for inclusion in the unaudited annual accounts.

3. note that the unaudited annual accounts would be considered by the Audit Risk and Governance Committee on 24 June 2016.

4. agree to give authority to the Audit Risk and Governance Committee to consider and approve the audited annual accounts at its meeting on 23 September 2016, allowing Audit Scotland's deadline of 30 September to be met.

Decisions

To approve the recommendations by the Chief Finance Officer.

9. RISK MANAGEMENT - REPORT BY DIRECTOR

A report had been circulated by the Director advising the Board on the approach being taken to the management of risk and of the risk identified.

The Board was informed that the object of risk management was to ensure that risks were properly identified, assessed and managed. Under the terms of the Integration Scheme, the IJB was required to operate a risk management strategy. The risk management strategy would comprise relevant policies and procedures for the management of risk. These were currently in the process of being developed and it was expected that the IJB Risk Management Policy would be submitted to the IJB's August meeting for approval.

The Integration Scheme also required that the IJB maintain a risk register The Director was required to produce and agree a list of the risks to be report and monitored. A risk register had been set up using West Lothian Council's Covalent system and the risks to be reported and monitored were attached as Appendix 1 to the report. The methodology used was outlined in Appendix 2 to the report.

The Board was asked to note that the risks identified represented high level, or strategic, risks to the IJB's objectives. Operational risks were separately recorded in the risk registers of both West Lothian Council and NHS Lothian.

It was recommended that the Board:-

1. note progress on risk management as set out in the report.

2. consider the risks identified, and the control measures in place to mitigate their impact

A number of questions were raised by Board members and these were dealt with by West Lothian Council's Audit, Risk and Counter Fraud Manager.

It was also noted that those members using iPads had found the format of the appendices useful, but those members with black and white paper copies had found the copies to be inadequate.

Decision

1. To note progress on risk management as set out in the report; and

2. To note the risks identified and the control measures in place to mitigate their impact.

10. BUDGET SETTING PROCESS - PRESENTATION BY DONALD FORREST, HEAD OF FINANCE & PROPERTY SERVICES, WEST LOTHIAN COUNCIL AND SUSAN GOLDSMITH, FINANCE DIRECTOR, NHS LOTHIAN

Presentation by Donald Forrest

The Board heard a presentation by Donald Forrest, Head of Finance and Property Services (WLC) providing details of the five year financial strategy approved by West Lothian in January 2013.

It was noted that, in February 2016, the Council had approved updated budgets for 2016/17 and 2017/18.

The approach to corporate and financial planning comprised a consultation process, identification of priorities, the development of workstreams to deliver priorities and the development of a medium term financial strategy to ensure sustainability.

The Head of Finance and Property Services highlighted a number of risks and uncertainties. These were:-

- The council only had a funding settlement for 2016/17
- The level of future grant from 2017/18 onwards had not been indicated
- Possible conditions attached to the funding settlement
- Economy
- Demographics
- Inflation

The Head of Finance and Property Services considered that the council had robust medium term financial planning in place and this would continue in future. Detailed annual budgets would continue to be presented to council each year in compliance with legal requirements.

Presentation by Susan Goldsmith

A detailed presentation was given by Susan Goldsmith. The presentation slides illustrated the income funding sources to NHS Lothian and details of the various expenditure blocks.

The Board was informed that the financial planning process for NHS Lothian comprised:-

- Preparation of a consolidated financial plan based on individual business unit plans
- The development of individual forecasts and specific action plans at a Business Unit level to help strengthen the delivery of financial balance
- Ensuring that the financial impact of IJB strategic plans were reflected in the overall NHS Lothian Financial Plan

Susan then went on to explain the key elements of the 2016/17 financial plan and provided a summary showing the projected 16/17 costs and projected net position.

It was noted that measures to fund the gap had been identified, and these were:-

- Further Recovery Actions
- National Savings Initiatives
- NRAC Acceleration
- Quality Management System – Waste/Variation/Unnecessary

Interventions

Finally, Susan outlined the West Lothian IJB budget position.

The Chair reminded the Board that a report would be prepared for the IJB following confirmation of the final resources allocation by NHS Lothian.

A number of questions raised by the Board were then dealt with by Donald Forrest and Susan Goldsmith.

Decision

To note the terms of the presentations.

11. PLANNING CYCLE - REPORT BY DIRECTOR

A report had been circulated by the Director advising the Board of a proposed planning cycle which would allow detailed scrutiny of the Strategic Plan and associated Care Group Commissioning Plans.

The report recalled that the IJB had previously approved its strategic plan which included details of how high level outcomes were to be achieved through a process of strategic commissioning. The Strategic Plan also included a commitment to develop a series of care group based commissioning plans.

It was proposed that the IJB meeting schedule be structured to allow the IJB an appropriate level of scrutiny for each stage of the commissioning cycle. In addition the Strategic Plan had a specific commitment to report overall progress on an annual basis. Appendix 1 to the report provided the detail of the proposed planning cycle.

The Board was recommended to agree the planning cycle as detailed in Appendix 1 to the report.

Decision

To approve the terms of the report.

12. SCHEDULE FOR PHYSICAL DISABILITY COMMISSIONING

A report had been circulated by the Director advising the Board of the schedule for the development of the strategic commissioning plan for Adults with a Physical Disability.

Appendix 1 to the report provided a schedule for the development of the plan for Adults with a Physical Disability. The first phase of this had already been completed in respect of the analytical phase – the needs assessment.

Appendix 2 to the report provided a summary of the key themes and recommendations from the needs assessment.

Appendix 3 provided the Terms of Reference for a short life Working Group that had been established to develop the three year commissioning plan. The intention was to prepare the plan in conjunction with the Strategic Planning Group, including relevant stakeholder engagement, thereafter to present a final draft of the strategic commissioning plan for Adults with a Physical Disability to the IJB meeting on 23 August 2016 for approval.

It was recommended that the Board note the planning schedule as detailed in Appendix 1, in particular to note the commitment to present a final draft of the strategic commissioning plan for Adults with a Physical Disability to the IJB meeting on 23 August 2016 for approval.

Decision

To note the terms of the report.

13. WORKPLAN

A copy of the Workplan had been circulated for information.

Referring to Julie McDowell's departure from the Board, the Chair conveyed his appreciation of the work carried out by Julie in her role as Vice-Chair of the IJB. On behalf of the IJB, the Chair thanked Julie for her contribution to the Board.

Decision

To note the Workplan.

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION STRATEGIC PLANNING GROUP of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189(A) WEST MAIN STREET, BROXBURN EH52 5LH, on 7 APRIL 2016.

Present – Jim Forrest (Chair, Health Professional), Marion Barton (Health Professional), Alan Bell (Social Care Professional), Ian Buchanan (User of Social Care), Steve Field (Professional) Diane Hayley (Health Professional), Jane Houston (Unison Health), Mairead Hughes (Health Professional), Pamela Main (Social Care Professional), Mary-Denise McKernan (carer of users of health care), Siobhan Mullen (non-commercial provider of social housing), Charles Swan (Social Care Professional), Robert Telfer (commercial provider of Social Care) and Patrick Welsh (Chief Finance Officer)

1. DECLARATIONS OF INTEREST

No declarations of interest were made.

2. MINUTE

The Group confirmed the Minute of its meeting held on 23 February 2016. The Minute was thereafter signed by the Chair.

3. PRESENTATION BY CHIEF FINANCE OFFICER ON IJB BUDGETS

The Group were provided with a presentation of the budget arrangements that had been put in place for the Integration Joint Board and would cover a number of aspects including budget responsibilities, resource allocation to and from the IJB and how the budget had been derived.

The Finance Officer explained that the components that made up the IJB budget came from Adult Social Care (West Lothian Council) and delegated core health services, share of delegated pan-Lothian hosted services and share of delegated acute services (NHS Lothian).

The Finance Officer continued to explain the how the IJB budget differed from the budget for the Health and Social Care Partnership and how resources would be allocated to and from the IJB.

Budget responsibilities were also outlined noting how resources would be used and directions would be issued to parties accordingly. Monitoring on financial performance would also be undertaken and financial recovery plans would be developed in conjunction with the IJB if an overspend was forecast.

The presentation concluded that the Strategic Plan would drive what services were to be delivered and the resources for this noting that Directions from the IJB were being finalised and which would in turn be issued to West Lothian Council and NHS Lothian. Likewise budget information has recently been issued to both the Chief Executive of West

Lothian Council and NHS Lothian.

Decision

1. To note the contents of the presentation on IJB budgets;

2. To note that budget information had recently been distributed to the Chief Executives of both West Lothian Council and NHS Lothian Health Board; and

3. To note the concerns expressed with regards to lack of stability within the prescribing budget and that these concerns had been raised on a Scotland-wide basis with the Scottish Government.

4. IJB FINANCIAL ARRANGEMENTS

A report had been circulated by the Director setting out the outcome of the financial assurance process on the proposed resources to be delegated to the IJB for 2016-17.

A key aspect of the ability of the IJB to deliver its Strategic Plan and improve health and social care outcomes was the level and adequacy of resources available. The report before the group therefore considered assumptions, risks and budget saving plans incorporated within the 2016-17 resources set out for the IJB delegated functions.

The report then provided a summary of the position with regards to the financial resources being provided by West Lothian Council and NHS Lothian; this included details on financial assurance, key risks and uncertainties.

The report concluded that a further report on financial assurance would be provided to the IJB following NHS Lothian having finalised their 2016-17 budget plans. Any amendments required to the NHS Lothian budget contribution to the IJB would be taken into account as part of the report and reflected in revised Directions as necessary.

In addition financial assurance would be ongoing during the year as part of the regular financial reporting on the 2016-17 resources associated with IJB functions.

Decision

1. To note the contents of the report;

2. To note the gap in funding being report by NHS Lothian which could in turn effect the IJB budget; and

3. To note the additional £7.130m that had been allocated to West Lothian specifically for social care and which would go some way to assist with discharges and was also to be used to introduce the Living Wage for all social care workers.

5. JOINT COMMISSIONING PLANS UPDATE

A report had been circulated by the Director providing an update on the development of the Joint Commissioning Plans, now to be known as Strategic Commissioning.

Attached to the report were the Needs Assessments that had been carried out in respect of Adults with Physical Disabilities and Adults with Learning Disabilities and were provided for the information of the group.

It was further reported that the IJB had recently agreed Terms of Reference and membership of the planning groups who would progress the development of the relevant care group commissioning plans

The strategic commissioning process was circular and in four main stages. These being :-

1. Analyse
2. Plan
3. Do
4. Review

The process started with a comprehensive assessment of needs, preferences and intended outcomes and included the mapping and reviewing of existing service provision to inform future commissioning.

It was noted that there was an Executive Summary for each of the Needs Assessments already completed and that these would be circulated to members of the group.

Decision

1. To note the contents of the Needs Assessments already completed in respect of Adults with Physical Disabilities and Adults with Learning Disabilities;
2. To agree that the Executive Summaries for each of these Needs Assessments would be circulated to the members of the group; and
3. To note that the IJB had recently agreed the composition of the Strategic Commissioning Groups and work would soon begin on the remaining Strategic Commissioning Plans.

6. LOCALITIES GROUPS - TERMS OF REFERENCE

A report had been circulated by the Director providing proposed terms of reference including membership of the two Locality Groups as required within the West Lothian IJB Integration Scheme and Strategic Plan.

The IJB approved its Strategic Plan on 31 March 2016. The plan defined two localities across the health and care services that were planned for delivery across West Lothian. Locality Groups would be formed with direct involvement and leadership from the following groups :-

- Health and social care professionals involved in the care of people who used the services
- Representatives of the housing sector
- Representatives of the third sector and independent sectors
- Carers and patients representatives
- People managing services

Attached to the report at Appendix 1 were the draft terms of reference for the Locality Groups with the intention being to present a report to the IJB seeking approval for the establishment of the Locality Groups within the approved terms of reference.

It was also being recommended that a development event be hosted in June 2016 for identified members of both locality groups for the purpose of providing background context for the work of the locality groups and the developing of workplan priorities for each group for 2016-17.

It was recommended :-

1. To agree the terms of reference including membership of the two locality groups as required within the West Lothian IJB Integration Scheme and Strategic Plan and were submitted for approval to the IJB; and
2. To agree to deliver a development event for locality group members in June 2016.

Decision

1. To approve the terms of the report; and
2. To agree to seek involvement in the Locality Groups from the council's Community Regeneration Service.

7. PARTICIPATION AND ENGAGEMENT STRATEGY

A report had been circulated by the Director providing an update on progress in preparing the West Lothian Health and Social Care Participation and Engagement Strategy, a copy of which was attached to the report.

The group were advised that the approved Integration Scheme committed both the council and NHS Lothian to the development of a Participation

and Engagement Strategy which would ensure significant engagement with and participation by members of the public, representation organisations and other organisation in relation to the decisions about the carrying out of delegated functions. This would include using existing forums, networks and stakeholder groups with an interest in health and social care.

Therefore taking into account the Integration Scheme and the requirements of the Strategic Plan a Participation and Engagement Strategy had been prepared and which comprised of three sections :-

- Overview
- Community Participation and Engagement; and
- Communication

The report also provided a narrative on the three sections of the engagement strategy.

The report concluded that officers would finalise the draft strategy over the next month in consultation with key stakeholders with a view to presenting a finalised strategy to the IJB for approval at its meeting on 31 May 2016. It was specifically noted that officers would be meeting with a series of stakeholders including Ian Buchanan in the coming days at which a number of issues raised concerning communication with the wider public would be discussed.

It was also noted that reference to Acute Services had been omitted from the document and therefore this would be addressed over the next few weeks.

Once approved it was proposed to develop an action plan which would identify specific activities to be undertaken in the coming year.

Decision

1. To note the content of the report and engagement strategy which it was hoped would be approved by the IJB by 31 May 2016;

2. To agree that Steve Field would contact Jacqui Campbell with regards to the inclusion of Acute Services; and

3. To note that Steve Field would be meeting with Ian Buchanan to discuss further options to ensure that engagement was undertaken with the wider public promoting the work of the IJB.

8. TIMETABLE OF MEETINGS 2016-17

A timetable of meetings for 2016-17 had been circulated for the information of the Strategic Planning Group.

Decision

To approve the timetable of meetings for 2016-17

9. WORKPLAN

A workplan had been circulated which provided details of the work of the Strategic Planning Group over the coming months.

It was agreed that an additional item be included in the workplan and which concerned an update on Lothian's Hospital Plan which could be reported towards the end of the year.

Decision

1. To note the contents of the workplan; and

2. To agree to include an additional item concerning an update on Lothian's Hospital Plan.

Date: 23 August 2016

Agenda Item: **6**

Running Action Note for West Lothian Integration Joint Board 2016

Number	Action Note reference	Matter arising and responsible officer	Action taken	Outcome
1	**Action Note 16/2/16 005**	Draft Minute of WLSPG held on 3 December 2015 Following advice from the Standards Officer, the Board agreed that the membership of the Strategic Planning Group be reviewed after 6 months of operation and that a paper be brought to the Board at the appropriate time for consideration. **Action: James Millar**	Noted.	Report will be produced in due course.
2	**Action Note 23/3/16**	IJB Financial Assurance Agreed that as part of the ongoing need for financial assurance a report was to be brought to a subsequent meeting outlining the final resource allocation by NHS Lothian and assessing the impact of the revised figures.	Report will be prepared for IJB following confirmation of the final resource allocation by NHS Lothian.	Report will be produced for August meeting.
3	**Action Note 05/04/16**	IJB Member Induction Agreed that plans be developed for two visits, and that a paper would come back to the Board in due course.	Noted	Report will be produced in due course.
4	**Action Note 31/05/16**	Code of Conduct Agreed to adopt the Model Code for submission to the Ministers for approval, but with one change. **Action: Jim Forrest**	Letter to Scottish Government with the Board's reasons for the change.	Action completed –Code approved by Ministers

17 August 2016

West Lothian Integration Joint Board

Date: 23/08/2016

Agenda Item: 7

IJB 2016/17 BUDGET UPDATE

REPORT BY CHIEF FINANCE OFFICER

A PURPOSE OF REPORT

The purpose of this report is to provide an update on the IJB's 2016/17 delegated resources taking account of NHS Lothian's submission of the 2016/17 Local Delivery Plan and resulting updated level of delegated resources to the IJB.

B RECOMMENDATION

It is recommended the IJB:

1. Notes the updated financial assurance position on resources delegated to the IJB

2. Agrees that Directions are updated and re-issued to NHS Lothian based on the updated resources allocated to the IJB taking account of the NHS Lothian budget plans submitted to the Scottish Government

3. Notes that financial assurance and monitoring of financial performance will be ongoing during the year and reported on a regular basis to the IJB

C TERMS OF REPORT

C.1 Background

The previous report on 2016/17 financial assurance presented to the IJB on 31 May 2016 reflected the approved council contribution to the IJB and an indicative NHS Lothian contribution. It was agreed that a further update on financial assurance would be brought to the Board upon NHS Lothian updating their 2016/17 budget and submitting their Local Delivery Plan to the Scottish Government.

This report updates the financial resources position based on the budget assumptions contained in the submitted Plan. This report also provides an update on the West Lothian Council contribution and an initial indication of key financial risks emerging in 2016/17.

C.2 NHS Lothian Resources

Overall Position

NHS Lothian's Local Delivery Plan, containing 2016/17 budget plans, was submitted to the Scottish Government on 31 May 2016. The Local Delivery Plan set out a funding gap of over £20 million.

However, since then the Scottish Government have agreed to provide NHS Lothian with an additional £6 million of recurring funding to recognise NHS Lothian's unfavourable position in relation to NRAC funding. This will reduce the overall NHS Lothian gap to approximately £14 million, against an overall budget of almost £1.5 billion. The use and distribution of this funding has still to be agreed and will take account of NHS Lothian Quarter 1 forecasts for 2016/17 which will be reported to Finance and Resources Committee on 14 September 2016.

West Lothian Position

Based on the 2016/17 budget plans submitted to the Scottish Government, an updated allocation of resources to the IJB for delegated functions was provided in writing by the NHS Lothian Director of Finance, on 14 June 2016. This letter is shown in Appendix 1 and notes an updated allocation of £140.586 million and a funding gap of £2.935 million, of which £1.249 million relates to the payment to the IJB. The split of the funding and gap between the three elements of the NHS Lothian contribution is set out in the table below.

NHS 2016/17 Contribution to WL IJB		
	2016/17	**2016/17**
	Funding £'000	**Gap £'000**
Core West Lothian Health Services	92,070	627
Share of Pan Lothian Hosted Services	17,577	622
Payment to IJB - Total	**109,647**	**1,249**
Notional Share of Acute Set Aside	30,939	1,686
Total Contribution	**140,586**	**2,935**

The revised allocation of £140.586 million reflects further significant work on refining allocations to IJBs and updating overall NHS Lothian funding and spend assumptions with the objective of managing 2016/17 spend within budget resources available. This represents an increase of £7.015 million for West Lothian IJB compared to the indicative contribution reported to the Board on 31 March of £133.571 million. Appendix 2 sets out a reconciliation of the movement in the contribution over the period. It is important to note that the level of budget funding will continue to move throughout the year as a result of normal accounting adjustments across budget lines and, for example, additional funding awarded during the year.

In respect of the NHS Lothian payment (excluding the notional share of acute set aside) the revised allocation assumes that £2.292 million of low to medium risk savings will be achieved. In addition, further measures of £1.249 million are also anticipated to be required to manage within current funding assumptions of £109.647 million. This gap of £1.249 million reflects an improvement compared to the equivalent gap of £2.519 million previously reported to the Board on 31 March 2016.

In terms of acute services, the amount set aside for strategic planning purposes as notionally representing the share of resources for West Lothian acute delegated functions is £30.939 million. Acute services do not form part of the payment to the IJB and responsibility for operational management and delivery are part of NHS Lothian's Acute Business Unit arrangements.

Based on the methodology agreed by NHS Lothian for allocating resources, it is considered that the revised contribution represents a fair share of resources to the IJB, albeit that there remains a gap to be addressed.

In terms of this, a number of areas are being considered by NHS Lothian to identify options to manage within both the overall NHS Lothian budget and the West Lothian IJB budget resources. A key element of this is the additional £6 million NRAC funding confirmed by the Scottish Government which is still to be allocated and will potentially reduce the current budget gap.

In addition, in year flexibility funds and ongoing review of existing financial recovery plan assumptions, in conjunction with robust budget management are anticipated by NHS Lothian to help in achieving a balanced position.

Key Risks

There are a number of risks around the NHS Lothian contribution to the West Lothian IJB, the key risk being that NHS Lothian as yet does not have a balanced budget position, although the extent of the budget gap has reduced significantly over recent months. In addition, the following specific risks will require to be closely monitored.

- Prescribing. A key change to the budget setting arrangements for this year relates to the move to a 'PBSG' based budget setting approach. The result of this change means that additional resources of just under £3.2 million is transferred to Edinburgh's prescribing budget from East, Mid and West Lothian Business Units. In order to support transition to PBSG, and giving due recognition to concerns expressed by IJBs on this issue, it was agreed that a principle of nil detriment will be applied from 2016/17 and on a recurring basis. As previously reported, this will be achieved through the use of £3.163 million of recurrent NRAC funding of which West Lothian IJB received £1.771 million. In addition, a further £1.6 million has been provided in the revised contribution from NHS Lothian to help meet prescribing cost pressures. However, even allowing for this, prescribing will remain a key risk as inflation and demands continue to indicate pressures in this area
- Delayed Discharge. Pressures in this area continue to be a budget risk and will require continued joint working to reduce bed days lost
- Delivery of savings required to ensure spend is managed within available 2016/17 resources. Meetings are taking place across all NHS Business Units to discuss the saving proposals and seek reassurance that work is progressing with the objective of achieving a balanced budget position

C.3 Alcohol Drug Partnership Funding

The Scottish Government wrote to NHS, Local Authority and IJB senior officers on 4 July to confirm the funding allocation for the Lothian Alcohol and Drug Partnership (ADP). The Lothian wide funding for 2016/17 of £8.887 million represents a 23% reduction compared to 2015/16.

Given the late confirmation of funding for 2016/17 and the contractual agreements in place, it is anticipated that existing funding commitments on West Lothian IJB delegated ADP services will require to be met for the current year within overall resources available. This will require close monitoring during 2016/17 to ensure the one off pressure is managed.

It is proposed a separate strategic commissioning approach will be used to prioritise investment to revised funding available from 1 April 2017. A separate report to the Board sets out further detail on ADP plans for this year and future years.

C.4 West Lothian Council

As previously reported to the Board, the council's budget contribution to the IJB was approved by Council on 23 February 2016. While the council's budget contribution represented a balanced budget position, there remain a number of risks as noted below.

Key Risks

- Increasing demands in social care capacity. West Lothian has the fastest growing elderly population in Scotland and while the budget resources assume £2.275 million to meet growth in demand and help meet delayed discharge targets, there is a risk that demand will outstrip the assumptions and resources available.
- The introduction of the Living Wage for all independent and third sector providers. This will require significant discussion and negotiation with a range of care providers. A sum of £2.240 million has been estimated but there remains uncertainty over the actual cost of introduction which will not be known until contractual uplifts have been agreed
- Delivery of 2016/17 Savings. Substantial saving totalling £1.604 million will be required to be achieved. Ongoing monitoring of progress towards delivery will be required on a regular basis.

C.5 Additional Funding

West Lothian IJB will benefit from successful bids for Scottish Government funding that has recently been confirmed and as a result has not yet been taken account of in IJB resources included in this report.

This relates to £515,000 for Technology Enabled Care (TEC) and £351,000 for Primary Care and Mental Health, awarded in line with the investment plans submitted within the successful bids. More details on the TEC funding award is contained in separate report to the Board which contains proposed Directions on use of the funding.

Discussions with the Scottish Government have now been finalised around the use of Primary Care and Mental Health funding and a further report will be submitted to the next meeting of the Board.

C.6 Financial Assurance – Key points

The purpose of the financial assurance process is to set out the assumptions and risks associated with the contributions agreed by NHS Lothian and the council. The council and NHS Lothian are, in accordance with legislation, responsible for agreeing the functions delegated to the IJB and setting their respective budgets including the level of payments and set aside resources to the IJB.

The IJB is then responsible for allocating the resources it has been provided back to partners to operationally deliver services. This is achieved through Directions issued to the council and NHS Lothian who, in line with the approved West Lothian Integration Scheme, remain operationally responsible for delivering services within the resources available.

Given NHS Lothian have now agreed a revised 2016/17 contribution to the West Lothian representing their financial plan submitted to the Scottish Government, it is recommended that updated Directions are issued to NHS Lothian reflecting the updated financial resources. These are attached in Appendix 3.

Taking account of the updated budget resources noted in this report, the table below shows the level of 2016/17 resources associated with IJB functions.

West Lothian IJB – Updated 2016/17 Delegated Resources	
	£'000
Adult Social Care	66,666
Core Health Services	92,070
Share of Hosted Services	17,577
IJB Payment	**176,313**
Acute Set Aside	30,939
Total IJB Resources	**207,252**

As noted, based on the financial assurance undertaken to date, NHS Lothian have further action to take to agree a balanced budget for 2016/17 although progress has been made over recent months to reduce the extent of the budget gap.

An important part of ongoing financial assurance will be regular updates to the Board on monitoring of spend against budget and the forecast outturn for the year. While NHS Lothian and West Lothian Council are operationally responsible for the delivery of functions within resources, it will clearly be important for the Board to have oversight of the in year budget position as this influences the strategic planning role of the Board.

C.7 2016/17 Budget Monitoring

Work on updating the forecast 2016/17 outturn position against IJB budget resources is currently being undertaken on an operational basis by NHS Lothian and West Lothian Council.

Initial monitoring undertaken has highlighted the following key points in relation to the 2016/17 budget position:

- The key pressure areas within Health services based on the initial mth 3 position relate to prescribing, mental health and the acute set aside areas.
- In overall terms the NHS IJB position at month 3 shows an adverse variance of £321,000 against budget
- Adult social care pressures at month 3 have been identified in elderly care homes and within care for both learning disability and physical disability clients.
- In overall terms, adult social care is forecasting a break even position at month 3

The overall position will continue to be closely monitored over the coming months and a full budget monitoring forecast for 2016/17 IJB functions will be reported to the Board at its next meeting on 18 October 2016

D CONSULTATION

Relevant officers in NHS Lothian and West Lothian Council.

E REFERENCES/BACKGROUND

West Lothian Integration Scheme

2016/17 Financial Assurance Report to IJB on 31 March 2016

F APPENDICES

Appendix 1 – NHS Lothian 2016/17 Resource Allocation Letter 14 June 2016

Appendix 2 – NHS Lothian 2016/17 Movement in Contribution

Appendix 3 – NHS Lothian Updated Directions

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted. The relevance assessment can be viewed via the background references to this report.
National Health and Wellbeing Outcomes	The 2016/17 budget resources delegated to the IJB will be used to support the delivery of outcomes.
Strategic Plan Outcomes	The 2016/17 budget resources delegated to the IJB will be used to support the delivery of the Strategic Plan.
Single Outcome Agreement	The 2016/17 budget resources delegated to the IJB will be used to support the delivery of the Single Outcome Agreement.
Impact on other Lothian IJBs	None.
Resource/Finance	The 2016/17 budget resources relevant to functions that will be delegated to the IJB from 1 April 2016 have been quantified at over £207 million.
Policy/Legal	None.
Risk	There are a number of risks associated with health and social care budgets, which will require to be closely managed.

H CONTACT

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23 August 2016

Lothian NHS Board

By Email Only

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Waverley Gate
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Telephone 0131 536 9000
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www.nhslothian.scot.nhs.uk

To: Chair of West Lothian Integration Joint Board

cc: Chief Officer and Chief Financial Officer of West Lothian Integration Joint Board

Date 14 June 2016
Your Ref
Our Ref SG/AWW
Enquiries to Susan Goldsmith
Extension 35810
Direct Line 0131 465 5810
Email: - Susan.Goldsmith@nhslothian.scot.nhs.uk

Dear Colleague

RESOURCE ALLOCATION TO THE INTEGRATION JOINT BOARD (IJB) IN RELATION TO FUNCTIONS DELEGATED BY NHS LOTHIAN

Further to my letter of 15 January 2016 and the submission of NHS Lothian's Local Development Plan to the Scottish Government on 31st May 2016, I am now in a position to provide you with an updated financial proposal for your IJB.

This year NHS Lothian financial plans were developed at business unit level, in part to support the financial assurance process for the IJB. However, NHS Lothian remains out of financial balance by over £20m and has submitted a plan which includes this gap to the Scottish Government as part of the LDP submission on the 31st May. The schedule presented for your IJB (see appendix 1) shows your delegated budget for 16/17. For the West Lothian IJB, the estimated gap is £2,935k based on the NHS Lothian Financial Plan.

NHS Lothian recognises that a number of outstanding issues require resolution, such as final confirmation of reduced values for the ADP and a number of bundles. Budgets have been prepared based on the latest available information, recognising that confirmation of some values may impact on the total budget identified in your IJB. As part of an ongoing reporting process, we will provide you with reconciled updates to your budgetary position.

By way of reminder the methodology for apportioning budgets and allocating uplift is summarised in sections 1 to 4 below:

1. Core Services (Specific IJB services and GMS budgets)

The budgets that are held for the services that represent functions delegated to the IJBs by NHS Lothian are held at cost centre level and a detailed model has been developed to allocate these budgets by cost centre to the IJBs. These cost centres will be allocated to IJBs based on the historic core budgets held by the CHPs.

2. GP Prescribing budgets

It is proposed to allocate the current prescribing budget for NHS Lothian across the 4 IJBs using the Prescribing Budget Setting (PBSG) model. The PBSG model is specifically designed for GP Prescribing and is based at GP Practice level. However, in recognition of the distortion to a number of IJB prescribing budgets arising from the move to a PBSG based approach, additional funding has been allocated on the principle of nil detriment from the PBSG adjustment. Further, uplift has been provided to budgets based on anticipated growth estimates from Lothian's Medicines Management Team. This is shown in Table 1 below

Table 1: Prescribing Budget

	East Lothian £'000	Edinburgh £'000	Mid Lothian £'000	West Lothian £'000	Total £'000
Opening Budget	17,857	74,365	15,250	30,154	137,626
NRAC	554	-	838	1,771	3,163
MMT Growth	900	3,600	800	1,600	6,900
Total Budget	19,311	77,965	16,888	33,525	147,689

Any risk sharing arrangements relating to the management of the financial gap within Prescribing across Lothian will be a matter for IJBs.

3. Share of pan-Lothian Services (Hosted and Set Aside)

Generally, budgets for services that represent functions delegated to the IJBs by NHS Lothian currently managed on a pan-Lothian basis have been split on a PCNRAC basis with certain exceptions as appropriate.

This model has been agreed by the Chief Finance Officers on behalf of the IJB. The full mapping table containing all cost centre allocations will be sent under separate cover.

4. 2016/17 Additional Funding

NHS Lothian has received 3 elements of additional uplift resource in 2016/17, including pay and price uplift, NRAC parity funding and Social Care funding.

1. Pay and Prices - The general uplift of 1.7% available to NHS Lothian in 2016/17 is calculated on NHS Lothian's baseline funding of £1.2bn and therefore equates to circa 1.4% when shared across all budget. This is distributed on a pro rata basis with the exception of GMS which receives a separate nationally determined uplift.

2. NRAC - NHS Lothian has agreed to distribute NRAC resources totalling £14m on the following basis:

   - In order to ensure all pay awards can be funded across NHS Lothian; NRAC resources have been prioritised within this area. In total, to ensure the affordability of all pay awards, a total of £5.4m has been allocated from the NRAC resource;

   - GP prescribing has received an additional £3.1m based on the principle of nil detriment from the move to a PBSG based budget (as noted under section 2 earlier);

   - Additional funding of £5.4m has been allocated to cover the cost pressures from Acute Medicines, principally arising from anticipated SMC decisions. This additional resource is likely to feature in part within set aside budgets and will be highlighted to the IJB as part of ongoing budgetary updates.

3. Social Care Fund - This Fund has been distributed as directed by the Scottish Government and does not form part of this budget proposal.

5. Efficiency

Partnerships have been provided with a summary financial plan for 16/17 which identifies the forecast cost pressures within their services for 16/17and we've included the uplifts as referred to above. Chief Officers in their capacity as managers of NHS Lothian services have developed financial recovery plans to demonstrate how financial balance can be achieved for these services. IJBs will need to be assured that those recovery actions identified do not impact on their ability to deliver strategic direction. As plans are agreed this may result in the reallocation of budgets to reflect the consequent service change. This will be agreed with IJBs.

Although the budget offer does not demonstrate balance at this stage, I expect that Partnerships and acute services will work with IJBs to reduce estimated expenditure to deliver a balanced position this year.

Yours sincerely

Susan Goldsmith
Director of Finance

Enc

Appendix 1		16/17 West Lothian IJB Budget (£'000)	
Status	Allocation	Service	
Delegated	Core	Community AHPS	3,326
		Community Hospitals	3,114
		District Nursing	2,869
		GMS	22,975
		Health Visiting	0
		Long Term Conditions	0
		Mental Health	11,484
		Prescribing	33,525
		Resource Transfer	6,885
		Other	7,891
		Total	92,070
	Corporate	Public Health	271
		Strategic Programmes	930
		Other	0
		Total	1,201
	Hosted	AHP Dietetics	564
		AHP Other	142
		AHP Podiatry	662
		AHP Rehabilitation	850
		Complex Care	0
		GMS	1,838
		Learning Disabilities	3,779
		Lothian Unsched. Care Serv.	1,935
		Mental Health	681
		Oral Health Services	2,061
		Psychology Service	1,088
		Rehabilitation Medicine	1,110
		Sexual Health	924
		Substance Misuse	1,074
		Other	(331)
		Total	16,377
	Total		109,647
Set Aside	Acute	A & E (outpatients)	4,104
		Cardiology	5,856
		Diabetes	462
		Endocrinology	407
		Gastroenterology	1,872
		General Medicine	7,758
		Geriatric Medicine	5,570
		Infectious Disease	3,187
		Management	140
		Rehabilitation Medicine	732
		Respiratory Medicine	177
		Therapies	565
		Wgh Surgery	108
		Total	30,939
	Total		30,939
Grand Total			140,586

WEST LOTHIAN INTEGRATION JOINT BOARD

RECONCILIATION OF REVISED NHS LOTHIAN CONTRIBUTION TO INDICATIVE CONTRIBUTION REPORTED TO BOARD ON 31 MARCH 2016

	£'000
NHS Indicative 2016/17 Contribution (31 March 2016)	**133,571**
NHS Revised 2016/17 Contribution (23 August 2016)	**140,586**
Movement	**7,015**

Movement Made Up as Follows		**Notes**
1.NHS Financial Planning - Budget Savings Realignment	3,213	Increase to reflect non achievement of prior year efficiency savings that were previously shown in 2016/17 as a decrease in budget rather than an increase in spend. Neutral impact.
2. Bathgate Primary Care Centre	257	Additional Bathgate Primary Care Centre budget and spend now included - neutral impact
3. Primary Care Contractors Organisation (PCCO) Budget Allocation	365	West Lothian share of PCCO budget resources. Equivalent share of spend will also be included therefore neutral impact overall.
4. General Medical Services - Updated 2016/17 Funding	802	Reflects updated Scottish Government allocation for 16/17 - neutral overall as additional budget reflects equivalent additional expenditure anticipated.
5. Overall Realignment of Budgets / Financial ledger structure changes	350	Realignment of budgets / ledger structure to reflect expenditure associated with West Lothian. Neutral impact.
6. PCNRAC Adjustment across budgets	187	Reflects West Lothian share of PCNRAC increasing from 21.88% to 22%. Equivalent expenditure assumptions, therefore neutral impact.
7. Revised Allocation of Base Funding Uplift	205	Impact of additional share of funding across all West Lothian service areas
8. Revised allocation of NRAC funding	-77	Impact of revised allocation of funding across West Lothian functions.
9. Adjustment for recurrency of 2015/16 Financial Plan Savings	-321	Various budgets reduced to reflect efficiency savings relating to West Lothian budget that were previously not taken account of.
10. Reduction in Scottish Government Bundle Funding	-20	Revised reduction in Scottish Government funding relating to share of West Lothian functions
11. Additional Budget Provision - Prescribing	1,600	Additional budget agreed for West Lothian prescribing costs.
12. Pharmaceutical Price Regulation Scheme	94	Additional share of funding for West Lothian
13. Additional Budget Provision - Acute Set Aside	360	Share of West Lothian additional funding for Acute set aside functions
TOTAL MOVEMENT	**7,015**	

Appendix 3

West Lothian Integration Joint Board

1	Implementation date	1st April 2016
2	Reference number	WLIJB/WLC/D01-2016
3	Integration Joint Board (IJB) authorisation date	23rd August 2016
4	Direction to	NHS Lothian Health Board
5	Purpose and strategic intent	In accordance with the IJB Strategic Plan, to provide effective services to all service users and carers within West Lothian Council area, promoting the highest standards of practice in accordance with statutory obligations, policies and procedures. To provide services to all service users and carers within the geographical boundaries of West Lothian which promote health, wellbeing and quality of life. To provide services to all service users and carers within the geographical boundaries of West Lothian which: – Maximise independent living – Provide specific interventions according to the needs of the service user – Provide an ongoing service that is regularly reviewed and modified according to need – Provide a clear care pathway – Contribute to preventing unnecessary hospital admission – Support timely hospital discharge – Prevent unnecessary admission to residential or institutional care

Appendix 3

		– Are personalised and self-directed, putting control in the hands of the service user and their carers
6	Does this direction supersede or amend or cancel a previous Direction?	N/A
7	Type of function	Integrated function
8	Function(s) concerned	All services planned and delivered by West Lothian IJB which are delivered within the geographical boundaries of the West Lothian Health and Social Care Partnership as they relate to primary and community health services and defined as health care services as required by the Public Bodies (Joint Working) (Scotland) Act 2014. This includes additional functions exercisable in relation to health services as they relate to provision for people under the age of 18 as defined in West Lothian Integration Joint Board's Integration Scheme. – District nursing – Allied Health Professional services: physiotherapy, occupational therapy – Mental health services – General Medical Services – General Dental Services – General Ophthalmic Services – General Pharmaceutical Services – Primary Care Prescribing – Inpatient services provided at St Michael's Hospital, Tippethill Hospital, Maple Villa – Community Learning Disability services

		– Community Palliative Care services – Continence services provided outwith a hospital – Kidney dialysis services provided outwith a hospital – Services provided by health professionals that aim to promote public health The Chief Officer in West Lothian will be the lead operational director for these services.
9.	Required Actions / Directions	West Lothian IJB directs NHS Lothian Health Board to provide health services as outlined in Section 5 and Section 9, and ancillary support as required for effective functioning of those services for the population of West Lothian. Over the course of the financial year 2016-2017, West Lothian IJB directs NHS Lothian Health Board to work with the Chief Officer and officers of the IJB to develop the following care group commissioning plans and bring them to the IJB for consideration and approval in accordance with a schedule to be agreed by the IJB at its meeting on 5 April 2016 : – Older People – Adults with Learning Disabilities – Adults with Physical Disabilities – Adults with Mental Health problems – Adults with Alcohol and Drug problems These commissioning plans will provide details of: – Specific needs of the relevant client group based on a detailed needs assessment, including stakeholder engagement – Specific outcomes to be addressed consistent with the IJB Strategic Plan – How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)

		– How specific needs of localities will be addressed Consideration by the IJB of those care group commissioning plans may lead to further Directions being issued which may amend or supersede this one.
10.	2016/17 Resources	2016/17 Payment to IJB (£'000) Community Hospitals 3,114 Mental Health 11,484 District Nursing 2,869 Community AHPS 3,326 GMS 22,975 Prescribing 33,525 Resource Transfer 6,885 Other Core 7,891 Total Core Health Services 92,070
11.	Principles	The IJB has examined a number of factors to estimate anticipated growth including population and non-demographic growth, estimated looking at historical trends and extrapolated. Our plans acknowledge rising year-on-year activity and growth demand. In monitoring directions, the IJB will continue to undertake further analysis of the assumptions applied as they develop including: – whether the total budget and activity aligned to each programme is realistic and achievable – whether the split of budget and activity assumed for individual programmes is sensible

		– further examination of thresholds and any assumed increases or reductions As a fundamental principle there should be neither disinvestment nor further investment in delegated services without being subject to full discussion and agreement with West Lothian IJB. West Lothian IJB expects that the principles of Best Value (to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost, maintaining regard to economy, efficiency, effectiveness) are adhered to in carrying out this direction.
12.	Aligned National Health and Wellbeing Outcomes	To support the following national outcome measures: 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 to reduce any negative impact of their caring role on their own health and well-being 7. People using 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

14.	Aligned priorities, strategies, outcomes	This direction relates to and will be monitored against the detailed performance framework within West Lothian IJB's Strategic Plan.
15.	Compliance and performance monitoring	1. In order to ensure West Lothian IJB fulfils its key strategic planning and scrutiny functions, and further develops and coordinates the implementation of its Strategic Plan, monitoring our own and our partners' performance is imperative. The primary responsibility for performance management in respect of delivery of the delegated functions will rest with the IJB and NHS Lothian Health Board will provide performance information so that the IJB can develop a comprehensive performance management system. 2. In addition to the specific commitments set out in West Lothian IJB's Integration Scheme and the obligations regarding provision of information under the Act, NHS Lothian Health Board will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability. 3. Details of how compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) will be provided in the appropriate care group commissioning plan. 4. The IJB directs NHS Lothian Health Board, through its officers, to provide a quarterly update and an annual report in the final quarter of financial year 2016-17 on delivery of directions. 5. The IJB directs NHS Lothian Health Board, through its officers, to provide an annual report in the final quarter of financial year 2016-17 on how it: – assesses the quality of services it provides on behalf of the IJB – ensures the regular evaluation of those services as part of an integrated cycle of service improvement 6. The IJB directs NHS Lothian Health Board, through its officers, to provide financial analysis, budgetary control and monitoring reports as and when requested by the IJB. The reports will set out the financial position and outturn forecast against the payments by the IJB to NHS Lothian Health Board in

		respect of the carrying out of integration functions. These reports will present the actual and forecast positions of expenditure compared to Operational Budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.
16.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	N/A

Appendix 3

West Lothian Integration Joint Board

1	Implementation date	1st April 2016
2	Reference number	WLIJB/WLC/D04-2016
3	Integration Joint Board (IJB) authorisation date	23rd August 2016
4	Direction to	NHS Lothian Health Board
5	Purpose and strategic intent	In accordance with the IJB Strategic Plan, to provide effective services to all service users and carers within West Lothian Council area, promoting the highest standards of practice in accordance with statutory obligations, policies and procedures. To provide services to all service users and carers within the geographical boundaries of West Lothian which promote health, wellbeing and quality of life. To provide services to all service users and carers within the geographical boundaries of West Lothian which: – Maximise independent living – Provide specific interventions according to the needs of the service user – Provide an ongoing service that is regularly reviewed and modified according to need – Provide a clear care pathway – Contribute to preventing unnecessary hospital admission – Support timely hospital discharge – Prevent unnecessary admission to residential or institutional care

		– Are personalised and self-directed, putting control in the hands of the service user and their carers
6	Does this direction supersede or amend or cancel a previous Direction?	N/A
7	Type of function	Integrated (hosted)
8	Function(s) concerned	A range of delegated functions defined as health care services as required by the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 and including additional functions as they relate to provision for people under the age of 18 as defined in West Lothian Integration Joint Board's Integration Scheme, require them to be provided as part of a single Lothian-wide service, commonly referred to as "hosted services". **These services will be managed at a pan-Lothian level by one of the Chief Officers of the Lothian IJBs in their role as a Joint Director of NHS Lothian (the IJB area in brackets confirms the Chief Officer who will manage this service)** The services are: – Dietetics (Midlothian) – Art Therapy (Midlothian) – Lothian Unscheduled Care Service (East Lothian) – Integrated Sexual and Reproductive Health service (Edinburgh) – Clinical Psychology Services (West Lothian) – Continence Services (Edinburgh) – Public Dental Service (including Edinburgh Dental Institute (West Lothian) – Podiatry (West Lothian)

		– Orthoptics (West Lothian) – Independent Practitioners (East Lothian via the Primary Care Contracting Organisation) – SMART Centre (Edinburgh) – Royal Edinburgh and Associated Services (Director of Mental Health accountable to the Chief Officer of Edinburgh and the NHS Lothian's Chief Executive) – Substance Misuse (Ritson Inpatient Unit, LEAP and Harm Reduction (Director of Mental Health accountable to the Chief Officer of Edinburgh and NHS Lothian's Chief Executive)
9.	Required Actions / Directions	West Lothian IJB directs NHS Lothian Health Board to provide health services as outlined in Section 5 and Section 9, and ancillary support as required for effective functioning of those services for the population of West Lothian. Over the course of the financial year 2016-2017, West Lothian IJB directs NHS Lothian Health Board to work with the Chief Officer and officers of the IJB to develop the following care group commissioning plans and bring them to the IJB for consideration and approval in accordance with a schedule to be agreed by the IJB at its meeting on 5 April 2016 : – Older People – Adults with Learning Disabilities – Adults with Physical Disabilities – Adults with Mental Health problems – Adults with Alcohol and Drug problems These commissioning plans will provide details of: – Specific needs of the relevant client group based on a detailed needs assessment, including stakeholder engagement

		– Specific outcomes to be addressed consistent with the IJB Strategic Plan – How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) – How specific needs of localities will be addressed Consideration by the IJB of those care group commissioning plans may lead to further Directions being issued which may amend or supersede this one.
10.	2016/17 Resources	2016/17 Payment to IJB — (£'000) Sexual Health — 924 Hosted AHP Services — 2,218 Hosted Rehabilitation Medicine — 1,110 Learning Disabilities — 3,779 Mental Health — 681 Substance Misuse — 1,074 Oral Health Services — 2,061 Hosted Psychology Service — 1,088 Hosted GMS — 1,838 Public Health — 271 Lothian Unscheduled Care Service — 1,935 Strategic Programmes — 930 Other Hosted Services — -331 Total Hosted Health Services — 17,577

11.	Principles	The IJB has reviewed the budget proposals from NHS Lothian referred to in Section 10 as part of a due diligence process and the core baseline budget been jointly agreed. In doing so the IJB has examined a number of factors to estimate anticipated growth including population and non-demographic growth, estimated looking at historical trends and extrapolated. Our plans acknowledge rising year-on-year activity and growth demand. In monitoring directions, the IJB will continue to undertake further analysis of the assumptions applied as they develop including: – whether the total budget and activity aligned to each programme is realistic and achievable – whether the split of budget and activity assumed for individual programmes is sensible – further examination of thresholds and any assumed increases or reductions As a fundamental principle there should be neither disinvestment nor further investment in delegated services without being subject to full discussion and agreement with West Lothian IJB. West Lothian IJB expects that the principles of Best Value (to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost, maintaining regard to economy, efficiency, effectiveness) are adhered to in carrying out this direction.
12.	Aligned National Health and Wellbeing Outcomes	To support the following national outcome measures: 10. People are able to look after and improve their own health and wellbeing and live in good health for longer 11. 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 12. People who use health and social care services have positive experiences of those services, and have their dignity respected 13. Health and social care services are centred on helping to maintain or improve

		the quality of life of people who use those services 14. Health and social care services contribute to reducing health inequalities 15. 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 well-being 16. People using health and social care services are safe from harm 17. 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 18. Resources are used effectively and efficiently in the provision of health and social care services
14.	Aligned priorities, strategies, outcomes	This direction relates to and will be monitored against the detailed performance framework within West Lothian IJB's Strategic Plan.
15.	Compliance and performance monitoring	7. In order to ensure West Lothian IJB fulfils its key strategic planning and scrutiny functions, and further develops and coordinates the implementation of its Strategic Plan, monitoring our own and our partners' performance is imperative. The primary responsibility for performance management in respect of delivery of the delegated functions will rest with the IJB and NHS Lothian Health Board will provide performance information so that the IJB can develop a comprehensive performance management system. 8. In addition to the specific commitments set out in West Lothian IJB's Integration Scheme and the obligations regarding provision of information under the Act, NHS Lothian Health Board will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability. 9. Details of how compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) will be provided in the appropriate care group commissioning plan. 10. The IJB directs NHS Lothian Health Board, through its officers, to provide a

		quarterly update and an annual report in the final quarter of financial year 2016-17 on delivery of directions. 11. The IJB directs NHS Lothian Health Board, through its officers, to provide an annual report in the final quarter of financial year 2016-17 on how it: – assesses the quality of services it provides on behalf of the IJB – ensures the regular evaluation of those services as part of an integrated cycle of service improvement 12. The IJB directs NHS Lothian Health Board, through its officers, to provide financial analysis, budgetary control and monitoring reports as and when requested by the IJB. The reports will set out the financial position and outturn forecast against the payments by the IJB to NHS Lothian Health Board in respect of the carrying out of integration functions. These reports will present the actual and forecast positions of expenditure compared to Operational Budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.
16.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	NHS Lothian Health Board carries out functions across four local authority areas. Some of the functions that will be delegated to the Lothian IJBs are currently provided as part of a single Lothian-wide service, commonly referred to as “hosted services” and identified in Section 8 of this Direction. As such there is not currently a separately identifiable budget for those services by local authority area. NHS Lothian Health Board has identified a budget for “hosted services” integrated functions based on an apportionment of the relevant NHS Lothian budgets.

Appendix 3

West Lothian Integration Joint Board

1	Implementation date	1st April 2016
2	Reference number	WLIJB/WLC/D03-2016
3	Integration Joint Board (IJB) authorisation date	23rd August 2016
4	Direction to	NHS Lothian Health Board
5	Purpose and strategic intent	In accordance with the IJB Strategic Plan, to provide effective services to all service users and carers within West Lothian Council area, promoting the highest standards of practice in accordance with statutory obligations, policies and procedures. To provide services to all service users and carers within the geographical boundaries of West Lothian which promote health, wellbeing and quality of life. To provide services to all service users and carers within the geographical boundaries of West Lothian which: – Maximise independent living – Provide specific interventions according to the needs of the service user – Provide an ongoing service that is regularly reviewed and modified according to need – Provide a clear care pathway – Contribute to preventing unnecessary hospital admission – Support timely hospital discharge – Prevent unnecessary admission to residential or institutional care

Appendix 3

		– Are personalised and self-directed, putting control in the hands of the service user and their carers
6	Does this direction supersede or amend or cancel a previous Direction?	N/A
7	Type of function	Set aside
8	Function(s) concerned	All adult acute hospital health services planned by West Lothian IJB and defined as hospital services as required by the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Act 2014 and as defined in West Lothian Integration Joint Board's Integration Scheme. 1. Accident and Emergency services provided in a hospital 2. Inpatient hospital services relating to the following branches of medicine: – General medicine – Geriatric medicine – Rehabilitation medicine – Respiratory medicine – Psychiatry of learning disability 3. Palliative care services provided in a hospital 4. Services provided in a hospital in relation to an addiction or dependence on any substance 5. Mental health services provided in a hospital except secure forensic mental health services Services provided on the three acute hospital sites within NHS Lothian (Royal Infirmary of Edinburgh, Western General Hospital and St. John's Hospital) will be operationally managed by the relevant site director.

Appendix 3

9.	Required Actions / Directions	West Lothian IJB directs NHS Lothian Health Board to provide health services as outlined in Section 5 and Section 9, and ancillary support as required for effective functioning of those services for the population of West Lothian. Over the course of the financial year 2016-2017, West Lothian IJB directs NHS Lothian Health Board to work with the Chief Officer and officers of the IJB to develop the following care group commissioning plans: – Older People – Adults with Learning Disabilities – Adults with Physical Disabilities – Adults with Mental Health problems – Adults with Alcohol and Drug problems These commissioning plans will provide details of: – Specific needs of the relevant client group based on a detailed needs assessment, including stakeholder engagement – Specific outcomes to be addressed consistent with the IJB Strategic Plan – How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)
10.	2016/17 Resources	2016/17 IJB Set Aside — (£'000) A & E (outpatients) — 4,104 Cardiology — 5,856 Diabetes — 462 Endocrinology — 407 Gastroenterology — 1,872

		General Medicine	7,758
		Geriatric Medicine	5,570
		Infectious Disease	3,187
		Rehabilitation Medicine	732
		Respiratory Medicine	177
		Therapies/Management	813
		Total Set Aside	30,939
11.	Principles	The IJB has examined a number of factors to estimate anticipated growth including population and non-demographic growth, estimated looking at historical trends and extrapolated. Our plans acknowledge rising year-on-year activity and growth demand. In monitoring directions, the IJB will continue to undertake further analysis of the assumptions applied as they develop including: – whether the total budget and activity aligned to each programme is realistic and achievable – whether the split of budget and activity assumed for individual programmes is sensible – further examination of thresholds and any assumed increases or reductions As a fundamental principle there should be neither disinvestment nor further investment in delegated services without being subject to full discussion and agreement with West Lothian IJB. West Lothian IJB expects that the principles of Best Value (to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost, maintaining regard to economy, efficiency, effectiveness) are adhered to in carrying out this direction.	
12.	Aligned National Health and Wellbeing Outcomes	To support the following national outcome measures: 19. People are able to look after and improve their own health and wellbeing and live in good health for longer	

		20. 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 21. People who use health and social care services have positive experiences of those services, and have their dignity respected 22. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services 23. Health and social care services contribute to reducing health inequalities 24. 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 well-being 25. People using health and social care services are safe from harm 26. 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 27. Resources are used effectively and efficiently in the provision of health and social care services
14.	Aligned priorities, strategies, outcomes	This direction relates to and will be monitored against the detailed performance framework within West Lothian IJB's Strategic Plan.
15.	Compliance and performance monitoring	13. In order to ensure West Lothian IJB fulfils its key strategic planning and scrutiny functions, and further develops and coordinates the implementation of its Strategic Plan, monitoring our own and our partners' performance is imperative. The primary responsibility for performance management in respect of delivery of the delegated functions will rest with the IJB and NHS Lothian Health Board will provide performance information so that the IJB can develop a comprehensive performance management system. 14. In addition to the specific commitments set out in West Lothian IJB's Integration Scheme and the obligations regarding provision of information under the Act, NHS Lothian Health Board will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability. 15. Details of how compliance and performance will be measured and reported on (performance

		indicators, delivery outcomes, targets etc.) will be provided in the appropriate care group commissioning plan. 16. The IJB directs NHS Lothian Health Board, through its officers, to provide a quarterly update and an annual report in the final quarter of financial year 2016-17 on delivery of directions. 17. The IJB directs NHS Lothian Health Board, through its officers, to provide an annual report in the final quarter of financial year 2016-17 on how it: – assesses the quality of services it provides on behalf of the IJB – ensures the regular evaluation of those services as part of an integrated cycle of service improvement 18. The IJB directs NHS Lothian Health Board, through its officers, to provide financial analysis, budgetary control and monitoring reports as and when requested by the IJB. The reports will set out the financial position and outturn forecast against the payments by the IJB to NHS Lothian Health Board in respect of the carrying out of integration functions. These reports will present the actual and forecast positions of expenditure compared to Operational Budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.
16.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	N/A

West Lothian Council

NHS Lothian

Integration Joint Board

Date: 23/08/2016

Agenda Item: 8

PHYSICAL DISABILITY COMMISSIONING PLAN

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the IJB of the development of a strategic commissioning plan for Adults with a Physical Disability and to seek approval for this plan.

B RECOMMENDATION

To approve the strategic commissioning plan for Adults with a Physical Disability plan (Appendix 1).

C TERMS OF REPORT

At the meeting of 24 March 2016 the Integration Joint Board (IJB) approved its strategic plan which includes details of how high level outcomes are to be achieved through a process of strategic commissioning. The Strategic Plan also includes a commitment to develop a series of care group based commissioning plans.

These plans are based on an ANALYSE, PLAN, DO and REVIEW approach:

- Analyse: the process of needs assessment intended to identify the priority needs associated with the relevant care group
- Plan: the planning process that is informed by the needs assessment and identifies how priority needs are to be addressed including the deployment of resources and the performance management approach to be used to monitor progress
- Do: the implementation phase of the plan
- Review: the review of progress based on the agreed performance measures of the plan in conjunction with any significant changes in the environment

Recommendations from the needs assessment are derived from evidence gathered and analysed from the review of literature, surveys and fieldwork including study informants.

A short life Working Group was established to develop the three year commissioning plan. This group included representatives of key stakeholders, including service users and providers. A draft plan was prepared and considered by the Strategic Planning Group on 8 August 2016.

Following comments by the Strategic Planning Group the draft of the strategic commissioning plan for Adults with a Physical has now been finalised (Appendix 1) and is presented to the IJB for approval.

D CONSULTATION

- Strategic Planning Group

E REFERENCES/BACKGROUND

- West Lothian Integration Joint Board meeting - 05 April 2016
- Scottish Government Guidance and Advice - http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance

F APPENDICES

1. Draft of Physical Disability Commissioning Plan

G SUMMARY OF IMPLICATIONS

Equality/Health	The commissioning plan will be subject to an equality impact assessment.
National Health and Wellbeing Outcomes	The commissioning plan addresses the relevant National Health and Well-Being Outcomes in accordance with the IJB Strategic Plan
Strategic Plan Outcomes	The commissioning plan is aligned to relevant Strategic Plan outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The Strategic Plan outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care
Impact on other Lothian IJBs	None
Resource/finance	None
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014 and statutory regulations and guidance
Risk	None

H CONTACT

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Tel 01506 281937

23 August 2016

West Lothian Health & Social Care Partnership | NHS Lothian | West Lothian Council

Physical Disability Commissioning Plan

2016/17-2018/19

The West Lothian Strategic Commissioning Plans for Adults with a Physical Disability sets out our strategic ambitions, priorities and next steps required to deliver integrated health and social care support and services for people with a physical disability, their families and carers in West Lothian for the next three years.

Data label: Public

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

FOREWORD

The West Lothian Strategic Commissioning Plan for Adults with a Physical Disability (the **PD Plan**) sets out our strategic ambitions, priorities and next steps required to deliver integrated health and social care support and services for people with a physical disability, their families and carers in West Lothian for the three year period to 2018/19.

The Disability Discrimination Acts (1995/2005) and the Equality Act (2010) define physical disability as: **'a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities'.** Long term in this context means a year or longer.

The PD Plan has been developed within the context of national and local policy direction taking into account the key principles and values which underpin the planning, commissioning and provision of services and support for people with a disability, and has been informed through consultation with key partners, service users and carers.

The PD Plan should be read in conjunction with:-

- West Lothian Integration Joint Board Strategic Plan 2016-26 (**Strategic Plan**)
- West Lothian Physical Disability, Sensory Loss and Acquired Brain Injury Needs Assessment (**PD Needs Assessment**)

It is acknowledged that it is difficult to view services and commissioning for care groups as distinct or isolated from one another. Consequently the PD Plan acknowledges the crossover with other health and social care groups:

- Adults with learning disabilities
- Adults' Mental health
- Older people
- People affected by substance misuse issues

Ensuring our services are well positioned to meet the needs of residents in West Lothian is key to achieving the outcomes we have identified, and I will be reviewing progress against this PD plan on an annual basis refining where necessary as the Integration Board matures in our local ownership of the resources we have to spend on health and social care services.

COUNCILLOR FRANK TONER
CHAIR OF THE WEST LOTIAN INTEGRATION JOINT BOARD

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

CONTENTS

SECTION 1: OVERVIEW

Who we are

The Public Bodies (Joint Working) (Scotland) Act 2014 requires arrangements to be put in place for the delivery of integrated health and social care. Local and joint commissioning of health and social care services will be built around the needs of patients and service users and managed through the West Lothian Integration Joint Board (IJB) who will in turn direct West Lothian Council and NHS Lothian to deliver services on its behalf.

Vision, values, aims and outcomes

The vision of the IJB Strategic Plan 2016-26 for West Lothian (Strategic Plan) is "to increase wellbeing and reduce health inequalities across all communities in West Lothian". The plan describes the values and aims and commits the IJB to deliver the nine national and wellbeing outcomes for health and social care as required by the Scottish Government (See Appendix 1).

The strategic plan covers the geographical area of West Lothian and in accordance with the legislation defines two localities across which health and social care services will be planned and delivered, the East and the West. The localities will provide a key mechanism for strong local, clinical, professional and community leadership, ensuring that services and support are planned and led locally in a way that is engaged with the community and contributing to effective strategic commissioning.

The case for change

- It is recognised both nationally and locally that whilst the health and care needs of individuals are closely intertwined, the services put in place to meet these needs can be disjointed and not as co-ordinated as they could be.

- West Lothian has a faster than average population growth, an aging population and growing numbers of people living longer with disabilities, long term conditions and complex needs, all of which require us to ensure we have commissioned our health and social care services to meet our duty of Best Value but also to ensure our resources are targeted to achieve the greatest impact on those most in need.

- Combining the resources of both agencies within the integrated partnership will allow for greater exploration of efficiencies to ensure we can meet the main health and wellbeing challenges at a time when we also need to reduce costs.

OUR APPROACH

The IJB has committed to develop strategic commissioning plans for all adult care groups. These plans will aim over time to 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. Each commissioning plan will confirm the total resources available across health and social care and relate this information to the needs of the care group population as determined by a local needs assessment and other relevant local or national strategies.

The PD Plan aims to address the current and potential needs of people from 18 to 65 years of age living in West Lothian who have physical and complex disability and includes sensory loss and/or acquired brain injury

As a first stage in the development of this commissioning plan, independent specialists in research and evaluation of the health and social care sector were commissioned to carry out a comprehensive local needs assessment. The needs assessment process involved:

- analysis of data based on the population, including demographic trends, health status and risk
- a wide consultation with service users, carers and their families which included surveys and focus groups
- consideration of the views of professionals or experts
- benchmarking with other areas in Scotland

The resultant commissioning plan for adults with physical disability will:

- reflect needs and plans as articulated at a local level for West Lothian
- confirm the desired outcomes and link investment to them
- detail what services will be delivered against outcomes and the associated performance indicators
- prioritise investment and disinvestment in line with assessed needs
- ensure that resource deployment and performance is consistent with the duty of best value
- ensure that sound clinical and care governance is fully considered

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STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

SECTION 2: NEEDS ASSESSMENT RECOMMENDATIONS

The Needs Assessment made nineteen recommendations with a key message for local commissioners and service planners are to learn from latest national surveys and research based on the social model of disability.

The recommendations have been mapped against the National Health and Wellbeing Outcomes (See Appendix 1) and then referenced against existing strategies and policies in order to evaluate whether the recommendation will be delivered through other routes or included for delivery as part of our commissioning cycle in this PD plan.

Ref	Recommendation	National Health and Wellbeing Outcomes									In scope of the PD plan	Out of scope of the PD plan	Existing strategies / policies						
		1	2	3	4	5	6	7	8	9			IJB Strategic Plan	WL TEC[1] Project	WL Transport Strategy	WL Engagement Strategy	IJB Performance Framework	Data sharing protocols	IJB Workforce Plan
1	An integrated Health & Social Care Physical Disability Strategy for West Lothian should be developed with a broad range of stakeholders, considering and agreeing a set of joint principles for action to be addressed through the lifetime of the strategy				✔							✔	✔			✔			
2	In order to involve all relevant stakeholders as equal partners in developing an overarching strategy, it is recommended that commissioners consider resourcing a disability "change agent". A primary function of the "change agent" would be to ensure a full					✔				✔		✔	✔						

[1] Technology Enabled Care

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Ref	Recommendation	National Health and Wellbeing Outcomes									In scope of the PD plan	Out of scope of the PD plan	Existing strategies / policies						
		1	2	3	4	5	6	7	8	9			IJB Strategic Plan	WL TEC[1] Project	WL Transport Strategy	WL Engagement Strategy	IJB Performance Framework	Data sharing protocols	IJB Workforce Plan
	communication strategy is developed and engaged with across all services and stakeholders																		
3	Commissioners need to work with providers, service users, carers and other stakeholders to consider how innovation and creativity can be encouraged within the physical disability sector					✔						✔							✔
4	The development of an inclusive strategy which needs to address accessibility of services within West Lothian; must include a conversation around transport provision to and from services, as well as access to community activity and work					✔						✔			✔				

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Ref	Recommendation	National Health and Wellbeing Outcomes									In scope of the PD plan	Out of scope of the PD plan	Existing strategies / policies						
		1	2	3	4	5	6	7	8	9			IJB Strategic Plan	WL TEC[1] Project	WL Transport Strategy	WL Engagement Strategy	IJB Performance Framework	Data sharing protocols	IJB Workforce Plan
5	Create a West Lothian commissioning strategy for physical disability services; and commission and manage transparent, needs led, good quality and integrated services to maximise opportunities in respect of service user outcomes.				✔	✔				✔	✔								
6	Encourage, identify, affirm and recognise good practice through commissioner engagement.				✔	✔				✔		✔	✔				✔		
7	Consideration needs to be given to conducting ongoing, consistent and equitable evaluation of all physical disability services across West Lothian.				✔	✔				✔		✔	✔						
8	Undertake regular needs assessment and specific, targeted research to address areas of unmet need and inequality				✔	✔				✔		✔	✔						

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Ref	Recommendation	National Health and Wellbeing Outcomes									In scope of the PD plan	Out of scope of the PD plan	Existing strategies / policies						
		1	2	3	4	5	6	7	8	9			IJB Strategic Plan	WL TEC[1] Project	WL Transport Strategy	WL Engagement Strategy	IJB Performance Framework	Data sharing protocols	IJB Workforce Plan
9	Produce, maintain and coordinate West Lothian wide disability information from a single, central source, in order to ensure ready availability and accuracy.				✔	✔				✔	✔								
10	Implementation of an information sharing protocol								✔			✔						✔	
11	Construct an integrated working guide involving physical disability specialist services, learning disability services, housing, employability, GPs, other relevant services (e.g. criminal justice and alcohol/drug) and peer led networks.								✔	✔	✔								
12	Develop clear strategic approaches to reducing; and where possible, preventing dependency or deterioration of physical disabilities.				✔				✔	✔		✔	✔						

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Ref	Recommendation	National Health and Wellbeing Outcomes									In scope of the PD plan	Out of scope of the PD plan	Existing strategies / policies						
		1	2	3	4	5	6	7	8	9			IJB Strategic Plan	WL TEC[1] Project	WL Transport Strategy	WL Engagement Strategy	IJB Performance Framework	Data sharing protocols	IJB Workforce Plan
13	Services need to be developed to be more responsive ensuring that: waiting time targets are consistently met, have clear access criteria, and are available for longer hours and that staff understand what services are available and how to appropriately refer.				✔	✔			✔	✔		✔	✔						
14	Commissioners need to work with providers to look at how IT can be more effectively used to enhance appropriate support.									✔		✔		✔					
15	Enhance the role and availability of the third sector and peer support services and networks to support integrated care and outcomes for people.				✔	✔				✔		✔	✔			✔			
16	Consideration should be given to developing a clear framework for how service users and their families/carers could and should be involved in the commissioning, delivery, development, and commissioning of specialist physical				✔	✔				✔		✔	✔			✔			

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Ref	Recommendation	National Health and Wellbeing Outcomes									In scope of the PD plan	Out of scope of the PD plan	Existing strategies / policies						
		1	2	3	4	5	6	7	8	9			IJB Strategic Plan	WL TEC[1] Project	WL Transport Strategy	WL Engagement Strategy	IJB Performance Framework	Data sharing protocols	IJB Workforce Plan
	disability services, and the wider system.																		
17	Devise a long-term programme of workforce development opportunities								✔			✔							✔
18	Promote empowerment and personal independence; and celebrate achievement.	✔	✔		✔		✔					✔				✔			
19	Learn from experience and emerging evidence; and forge alliances to support networks and communities.				✔		✔		✔	✔		✔					✔		

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

SECTION 3: COMMISSIONING PRIORITY ACTIVITIES

This section details the specific recommendations captured by the needs assessment relevant to this commissioning plan and provides information on the planned spend to meet these priorities. In addition to these recommendations, all other existing services and resources currently providing health and care for people with a physical disability will continue to be delivered. Universal health services available to residents of West Lothian are also provided to show the full picture of the resources available.

Ref	**Needs Assessment Recommendation / Commissioning Priority(CP)**	**Integration Outcomes** (Appendix 1)	**Activity Name**	**Description**	**Indicators** (Appendix 2)	**Planned 2016 /17 Spend (£)**	**Provider**
West Lothian Physical Disabilities Needs Assessment (2015)							
Rec 5	Create a West Lothian commissioning strategy for physical disability services; and commission and manage transparent, needs led, good quality and integrated services to maximise opportunities in respect of service user outcomes.	1,2,3, & 4	PD Commissioning Plan	Included in the IJB Strategic Plan - each care group to produce a Commissioning Plan	3 & 4		Within internal resources
Rec 9	Produce, maintain and coordinate West Lothian wide disability information from a single, central source, in order to ensure ready availability and accuracy.	4	West Lothian Disability information and advice service	Dedicated WL service providing disability information and advice service and a Peer Counselling Service.	2, 3 & 5	103,113	Capability Scotland contract in place until 31 March 2018

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Ref	**Needs Assessment Recommendation / Commissioning Priority(CP)**	**Integration Outcomes** (Appendix 1)	**Activity Name**	**Description**	**Indicators** (Appendix 2)	**Planned 2016 /17 Spend (£)**	**Provider**
Rec 11	Construct an integrated working guide involving physical disability specialist services, learning disability services, housing, employability, GPs, other relevant services (e.g. criminal justice and alcohol/drug) and peer led networks.	4	West Lothian Disability information and advice service	Prepare a joint H &SC Information Plan to coordinate activity •Map local PD landscape •Coordinate with other "information dissemination activities" e.g. Web page/publications •Align with WL Digital Inclusion Plan	2, 3 & 5	0	Within Capability Scotland contract in place until 31 March 2018 as above
West Lothian IJB Strategic Plan - Physical Disability Commissioning Priorities (CP)							
CP 1	Increase delivery of 'B4 and On2 Work' employability advocacy and support.	2 & 4	Employability	B4 and On2 Work service is one of the services delivered as part of the provision at the Ability Centre, Carmondean.	2 & 7	556,386	Included in planned spend for Ability Centre
CP 2 & CP 3	Short Breaks from Caring (respite) and Day Support	3 & 4	Registered Care Home	Forrest Walk in Uphall is a registered care resource specifically designated for people with physical and complex disability it also provides residential placements, short breaks from caring and day support	2 & 7	397,724	Included in planned spend for Cornerstone Community Care. Contract in place until 31 March 2018
CP 4a	Information & Advice Service Peer Counselling Service	3 & 4	Information, advice and peer counselling service	See Recommendations 9 & 11 above			Capability Scotland contract in place until 31 March 2018

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Ref	**Needs Assessment Recommendation / Commissioning Priority(CP)**	**Integration Outcomes** (Appendix 1)	**Activity Name**	**Description**	**Indicators** (Appendix 2)	**Planned 2016 /17 Spend (£)**	**Provider**
CP 4b	Independent Living support service	1 & 4	Maximise independence and promote independent living	A support service for people who have chosen to manage their own care and support via SDS Option 1 - this includes support to recruit Personal Assistant's, administration, employment support and payroll service	2 & 7	52,000	Lothian Centre for Inclusive Living (LCiL) – due to be reviewed 2016
CP 5	Commission the Community Rehabilitation and Brain Injury Service`	1 & 4	Community Rehabilitation and Brain Injury Service	CRABIS provides multi-disciplinary assessment and rehabilitation within the home or community setting to individuals who have a physical disability and/or acquired brain injury.	2, 4, 5 & 7	121,846	Integrated WLC and NHS team based within West Lothian
CP 6 and 7	Commission Services for the Deaf, Deafened and Hard of Hearing and for the Blind and People with Sight Loss	1 & 4	Sensory Support	Social care assessment and care management service for people with sensory loss	2, 4, 5 & 7	86,702	WLC internal resource
	Commission Services for the Deaf, Deafened and Hard of Hearing	1 & 4	Services for the Deaf, Deafened and Hard of Hearing	• Assessment and care management • Specialist assessment, installation and maintenance of environmental equipment • Communication support	2, 4, 5 & 7	60,402	Deaf Action contract in place until 31 March 2018
	Commission Services for the Blind and People with Sight Loss	1 & 4	Services for the Blind and people with sight loss	• Rehabilitation and mobility service •A range of core environmental and support equipment	2, 4, 5 & 7	31,678	Royal National Institute for the Blind (RNIB) contract in place until 31 March 2017

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Activity Name	Activity Description	Indicators (Appendix 2)	Planned 2016/ 17 spend £	Provider
Assessment and Care Management Services allocated to people with physical disability				
Social care assessment and care management	The Social Policy Physical Disability Assessment and Care Management Team is responsible for conducting needs-led outcomes based assessments for adults with physical disability and for developing appropriate care and support plans in response to identified eligible need. This includes assessment and care management in relation to palliative care.	2,3,4,5,7,& 8	281,634	WLC Social Work teams
Support for carers	Carers of West Lothian (CoWL) provides support, information, advice, training, consultation, representation to the HSCP for carers and young carers	8	118,000	Carers of West Lothian (COWL) Contract in place until 31 March 2018
	Minority Ethnic Carers of Older People (MECOPP) provides support, advice, information and training services for BME adults aged 25 plus	8	4,870	MECOPP contract in place until 31 March 2018
Residential and nursing care	If an individual's assessed care and support needs cannot be safely and appropriately met within their own home, then a long-term residential placement with 24 hour care services and support may be appropriate. Residential and Nursing Care Home placements are provided by the independent sector.	4,5,7 & 9	1,347,718	Various providers - mainly residential or nursing homes commissioned as individual placements following assessment
Direct payments	For people assessed as eligible for social care services and support and who have chosen SDS Option 1 (Cash payment as an alternative to direct service) provision	1,2,3,4,5,& 7	758,000	Individual service users received payment
Specialist care and support in the community	The aim of our specialist framework is for care and support to be delivered to adults with a disability in a way that promotes and maximises independence. The providers will provide specialist support to assist with personal care and support, with daily living, domestic tasks and activities to support social inclusion.	2,3,5 & 7	512,000	Various specialist providers as per the Specialist Care Framework. The contract is in place until 31 December 2018
Physical disability transport	Payment of transport costs enabling people to access services and support	2,4,5,7 & 9	120,000	Contribution towards WLC fleet and transport costs
External transport	Payment of transport costs enabling people to access services and support	2,4,5,7 & 9	142,844	Payment to taxi and bus hire companies

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

Activity Name	Activity Description	Indicators (Appendix 2)	Planned 2016/ 17 spend £	Provider
Care at home framework	The Care at Home service is provided by independent sector agencies under a framework agreement which covers all aspects of care and support such as personal care, medication management and personal assistance	1,4, & 5	1,537,000	Various providers as per the Care at Home Framework. The contract is in place until 31 December 2018
		DEDICATED BUDGET FOR PHYSICAL DISABILITIES	**6,231,917**	
Universal Health Services available (Total budget)				
Core Health Services	People with a physical disability have access to Core Health Services including Community Hospitals, District Nursing, Community AHP's and Prescribing	1,5,6,7,9	69,271,000	West Lothian GPs, District and Community nurses and Allied Health Professionals and Prescribing
Hosted Health Services	People with a physical disability have access to Hosted Health Services e.g. Sexual Health, Oral Health Services, and Public Health services	1,5	11,737,000	NHS Lothian on behalf of West Lothian IJB
Acute Services	People with a physical disability have access to Acute Services e.g. A & E, Cardiology, General Medicine, Rehabilitation and Respiratory Medicine		29,191,000	St John's Hospital

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

SECTION 4: NEXT STEPS

The PD Commissioning Plan is designed to run for 3 years from 2016 /17 to 2018/19, at a time of considerable change in the commissioning environment within health and within social care.

The PD Commissioning Plan will be reviewed annually, and commissioning intentions developed each year in the form of an annual report which will summarise activity, progress and performance for the year.

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

APPENDIX 1: NATIONAL HEALTH & WELLBEING OUTCOMES AND INTEGRATION OUTCOMES

Ref	Outcome
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

Integration Outcomes

Ref	Outcome
1	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
2	Resources are used effectively and efficiently in the provision of health and social care Services
3	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
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

STRATEGIC COMMISSIONING PLAN – ADULTS WITH PHYSICAL DISABILITY

APPENDIX 2: PERFORMANCE INDICATORS

1	% of adults able to look after their health very well or quite well.
2	% of adults supported at home who agree that they are supported to live as independently as possible.
3	% of adults supported at home who agree that they had a say in how their help, care or support was provided.
4	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5	% of adults receiving any care or support who rate it as excellent or good
6	% of people with positive experience of care at their GP practice.
7	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
8	% of carers who feel supported to continue in their caring role.
9	% of adults supported at home who agree they felt safe
10	% of staff who say they would recommend their workplace as a good place to work.

West Lothian Council

NHS Lothian

Integration Joint Board

Date: 23/08/2016

Agenda Item: 9

SCHEDULE FOR OLDER PEOPLES COMMISSIONING PLAN

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the Integration Joint Board of the schedule for the development of the strategic commissioning plan for Older People.

B RECOMMENDATION

To note the planning schedule as detailed in Appendix 1, in particular to note the commitment to present a final draft of the strategic commissioning plan for Older People to the IJB meeting on 18 October 2016 for approval.

C TERMS OF REPORT

At the meeting of 24 March 2016 the Integration Joint Board (IJB) approved its strategic plan which includes details of how high level outcomes are to be achieved through a process of strategic commissioning. The Strategic Plan also includes a commitment to develop a series of care group based commissioning plans.

These plans are based on an ANALYSE, PLAN, DO and REVIEW approach:

- Analyse: the process of needs assessment intended to identify the priority needs associated with the relevant care group
- Plan: the planning process that is informed by the needs assessment and identifies how priority needs are to be addressed including the deployment of resources and the performance management approach to be used to monitor progress
- Do: the implementation phase of the plan
- Review: the review of progress based on the agreed performance measures of the plan in conjunction with any significant changes in the environment

Appendix 1 provides the schedule for the development of the plan for Older People. The first phase of this has now been completed in respect of the analytical phase – the needs assessment.

Recommendations from the needs assessment are derived from evidence gathered and analysed from the review of literature, surveys and fieldwork including study informants; these have been grouped under six key themes. Appendix 2 gives a summary of the key themes and recommendations from the needs assessment.

The recommendations have been developed to match the level of resource availability. A focus on the recommendations will lead to a comprehensive programme of change and improvement with improved outcomes for older people and the communities in which they live.

A short life Working Group has been established to develop the three year commissioning plan. Appendix 3 provides the Terms of Reference for this group as previously approved by the IJB.

The intention is to prepare the plan in conjunction with the Strategic Planning Group, including relevant stakeholder engagement, thereafter to present a final draft of the strategic commissioning plan for Older People to the IJB meeting on 18 October 2016 for approval.

D CONSULTATION

- Strategic Planning Group

E REFERENCES/BACKGROUND

- West Lothian Integration Joint Board meeting - 05 April 2016
- Scottish Government Guidance and Advice - http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance

F APPENDICES

1. Schedule and current progress summary
2. Needs Assessment Executive Summary
3. Terms of Reference of the Working Group

G SUMMARY OF IMPLICATIONS

Equality/Health	The commissioning plan will be subject to an equality impact assessment.
National Health and Wellbeing Outcomes	The commissioning plan will address the relevant National Health and Well-Being Outcomes in accordance with the IJB Strategic Plan

Strategic Plan Outcomes	The commissioning plan will be aligned to relevant Strategic Plan outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The Strategic Plan outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care
Impact on other Lothian IJBs	None
Resource/finance	None
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014 and statutory regulations and guidance
Risk	None

H CONTACT

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Tel 01506 281937

23 August 2016

Appendix 1 **Older People Strategic Commissioning Plan - schedule**

		2016 Week Ending																				
	Activity	April	May	June	01-Jul	08-Jul	15-Jul	22-Jul	29-Jul	05-Aug	12-Aug	19-Aug	26-Aug	02-Sep	09-Sep	16-Sep	23-Sep	30-Sep	07-Oct	14-Oct	21-Oct	Comment
	Analyse																					
1	Needs assessment undertaken																					Ongoing
2	Terms of ref approved for Commissioning Group	23-Apr																				Completed
3	Outline Commissioning Plan template agreed		6th May																			Completed
4	Commissioning Group membership agreed		13-May																			Completed
5	Invitations issued to proposed members		25-May																			
7	Preparation of planning material																					Commenced
8	Initial planning docs circulated to group			21-Jun																		
9	Meeting of Commissioning Group			21-Jun																		
	Plan																					
10	Agree scope of Commissioning Plan			21-Jun																		
11	Identify current resources available			21-Jun																		
12	Prioritise Needs Assessment recommendations			21-Jun																		
13	Discuss action plan and activities			21-Jun																		
14	Prepare action plan and agree activities																					
15	Prepare draft plan for review																					
16	Meeting of Commissioning Group			21-Jun			15-Jul			03-Aug				30-Aug								
17	Investment/Disinvestment plans agreed													30-Aug								
	Review																					
18	Review and update draft plan																					
19	Equality Impact Assessment																					
20	Meeting of Commissioning Group			21-Jun			15-Jul			03-Aug				30-Aug								
22	Amendments to draft plan																					
23	Submit draft plan to IJB Strategic Planning Group																22-Sep					
24	IJB Strategic Planning Group Meeting																		6th Oct			
	Do																					
25	Submit plan for IJB for agenda																		06-Oct			
26	IJB Meeting																				18-Oct	

FIGURE 8
CONSULTANCY SERVICES LTD

2016

WEST LOTHIAN OLDER PEOPLE'S NEEDS ASSESSMENT

PART ONE – THE REPORT

Report prepared for West Lothian Health and Social Care Partnership

EVIDENCE INTO PRACTICE

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RESEARCH TEAM

Andy Perkins (Managing Director)	Elisabeth Hill OBE (Associate Consultant)
Dr Donna Nicholas (Senior Researcher)	Allan Johnston (Associate Consultant)
Kevin Gardiner (Research Assistant)	Simon Little (Associate Consultant)
Jennifer Turnbull (Administrator)	Trevor McCarthy (Associate Consultant)

PROJECT ADVISORY GROUP

The research team was assisted by an Advisory Group (below), which provided accountability, guidance and support. This group met physically on four occasions. The research team are grateful for the advice and facilitation provided by this group throughout the duration of the study.

Carol Bebbington (Senior Manager, Primary Care)	Pamela Main (Senior Manager - Community Care, Assessment and Prevention)
Alan Bell (Senior Manager - Community Care, Support and Service)	John McLean (Outreach and Day Services Manager)
Nick Clater (Service Manager – Mental Health)	Dr David Murray (Service Development Officer)
Jillian Dougall (Service Development Officer)	Charles Swan (Group Manager)

ACKNOWLEDGEMENTS

The research was financed by the West Lothian Health and Social Care Partnership.

The research team offers its sincere thanks to all the individuals who have participated in the interviews, focus groups, working group and stakeholder event. Particular thanks go to the members of the focus groups and working group who have been an immense help to the research team in developing their findings.

REPORT FORMAT

This report has been written primarily with the practice community in mind. Supplementary appendices are also available containing further data, and detail about the research methodology **(see Part 2 – Appendices Report)**. Each strand of data collection and synthesis – dataset reviews, interviews, stakeholder events, working groups, focus groups, and surveys – contains a box with key findings. **To preview this report, the researchers would recommend reading the key findings from each section followed by the final recommendations (Chapter 7 of this report).**

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TABLES AND FIGURES

CHAPTER 1: INTRODUCTION

1.1 Introduction and background

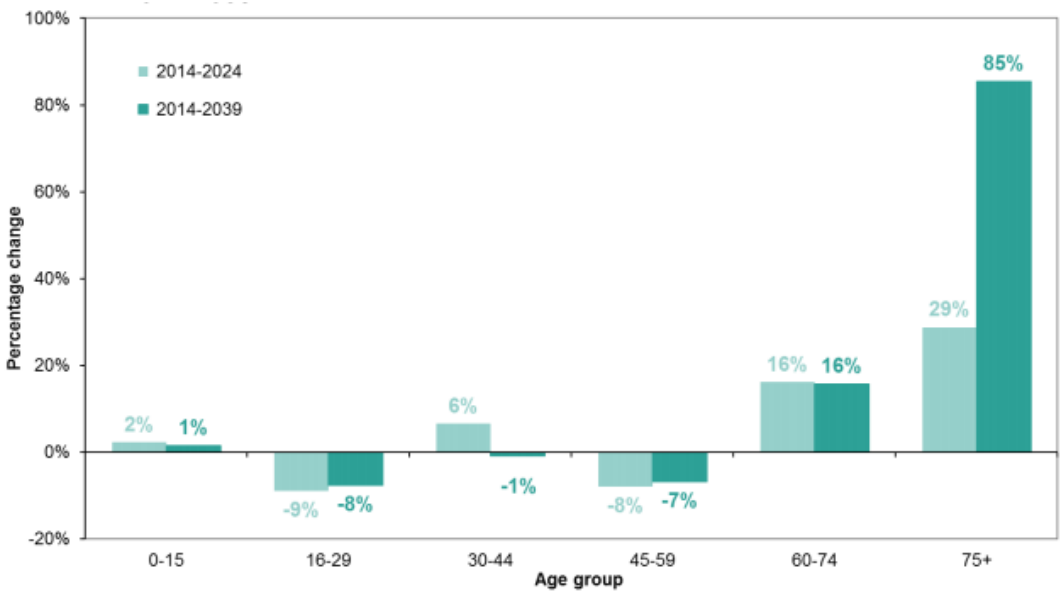
Figure 8 Consultancy Services Ltd. was commissioned by West Lothian Health and Social Care Partnership in March 2016 to carry out a comprehensive older people's needs assessment project; and fieldwork took place between April and June 2016.

This needs assessment is a report that presents an overview and analysis of the needs of older people; those aged 65 plus who reside in West Lothian (inclusive of those with dementia). The report will be used as the basis for the development of an action plan to address the identified gaps in current provision and the development and updating of an outcome focused commissioning plan.

The WL Partnership's Reshaping Care for Older People Joint Commissioning Plan outlines our local vision and commissioning intentions for the period 2013-2023, as does the Integrated Joint Boards Strategic Plan for 2016-2026. These plans were developed in response to national and local policy directions taking into account key principles and values.

We know that the number of older people in Scotland has increased (see Figure 1.1) and that people's expectations about the lives they will lead in older age have changed. Older people are living healthy lives for longer, are economically active for longer, and both expect and are expected to participate in social and political life.

Figure 1.1: The projected percentage change in Scotland's population by age group, 2014-2039[1]



Older people, including those with dementia, are living longer and are increasingly remaining in the community rather than more formal care settings. As the demographic profile shows the number of

[1] National Records for Scotland. *Projected Population of Scotland (2014-based): National population projections by sex and age, with UK comparisons*. Published on 29 October 2015. Figure 5.

older people who reside in West Lothian is projected to increase significantly, this as well as taking cognisance of the fact that the probability of having one or more long term condition increases with age confirms there are significant challenges to be met.

Telecare and telemedicine has been used to a degree to support people living in the community. It is recognised however there remains substantial scope to develop this provision further, including but not exclusively in supporting those with dementia as well as carers.

Upstream investment that allows for a focus on prevention and early intervention have been seen as key to bringing about the required shift in the balance of care which has enabled older people to remain at home to date.

1.2 Defining 'older people'

For the purposes of this analysis, 'older people' are defined as those aged 65 and over. However, where data are not available for this specific age group, the nearest alternative age group is used (often those over state pension age).

1.3 Strategic and local drivers impinging on services

1.3.1 National policy and strategic context

Policymakers have come to understand that defining a group of individuals by their age - and therefore requiring a standard level of care and support - fails to take into account the range of different needs that exist. National care and housing policy for older people has therefore shifted in recent years, from an emphasis on providing care within a 'one size fits all' system, towards promoting independence, choice, and well- being.

At the same time, the increase in life expectancy and the number of people living into advanced old age has placed greater pressure on public resources, for example, through greater demand for certain medicines. In response to this rising demand, successive governments have tried to improve outcomes and efficiency in services for older people. Developing policy and services that are designed to prevent problems occurring, rather than addressing problems once they occur, is seen as an effective way of doing this. For example, providing an affordable home adaptations service for older people can reduce accidents and falls in the home, potentially reducing health and care costs.

This policy shift towards independence, choice and well-being for older people has been set out in a range of government documents, such as the Scottish Government's *Reshaping Care for Older People* (2011) document; an initiative aimed at improving services for this demographic by shifting care towards anticipatory provision and prevention. Its vision is that 'Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home

or in a homely setting.'[2] It identifies greater choice and control, better access to public services and information, and empowerment of service users and their carers as priorities for the reform of the adult social care system. To achieve this local health and social care partnerships are asked to demonstrate optimum use of all existing resources that fund care for older people and promote a philosophy of care centred on supporting independence through helping older people to remain safe and well and outside the formal care system for as long as possible.

This framework complements the ambitions of the NHS Quality Strategy and is a key driver to achieve the 'effective' ambition within this Strategy. It sits above, and supports the delivery of, other relevant strategies (some of which will be mentioned in brief below) and together these build a cohesive and comprehensive approach to meeting the care and support needs of older people.

Other relevant strategies include:

The Dementia Strategy[3]

Dementia is considered to be one of the foremost public health challenges worldwide and in Scotland that the number of people with dementia is expected to double between 2011 and 2031. The Chief Medical Officer's Report (CMO) published in 2014 also notes as a key area of concern deafness and blindness and dementia. A recent GP patient survey shows a greater prevalence of dementia, including Alzheimer's disease, in those with severe vision loss or severe hearing impairment. The CMO highlights the lack of robust data which hampers our understanding of this possible association. The CMO says that investigating this potential link could tell us more about the causes of dementia.[4]

According to Alzheimer's Scotland, approximately 90,000 people have dementia in Scotland in 2016,[5] only around 3,200 of these people are under the age of 65 (3.56%). More specifically, the prevalence of dementia by locality is estimated thus:

Table 1.2: The number of people with dementia in Scotland in 2016 by local authority area[6]

Area	Males	Females	Totals
SCOTLAND	31,282	59,402	90,684
West Lothian	847	1,469	2,316

[2] Scottish Government (2012). Reshaping Care for Older People 2011-2021. Scottish Government: Edinburgh.

[3] Scottish Government (2010), Scotland's National Dementia Strategy. Scottish Government: Edinburgh.

[4] Davies. S. (2014) Chief Medical Officer annual report: surveillance volume 2012. Department of Health. Available at: https://www.gov.uk/government/publications/chief-medical-officer-annual-report-surveillance-volume-2012

[5] Source: Alzheimer's Scotland website, http://www.alzscot.org/campaigning/statistics Accessed 30th July 2016.

[6] Source: Alzheimer's Scotland, http://www.alzscot.org/assets/0002/0373/2016_Webpage_Stats.pdf Accessed 18th March 2016.

The current *National Dementia Strategy (2013-2016)* has piloted the 8 Pillar Model of Community Support, developed by Alzheimer Scotland, which sets out the responses that are essential to support people with dementia, their families and carers. This strategy highlights three key challenges over the lifespan of the strategy and sets out how the Scottish Government, and consequently local authorities and HSCPs will seek to address these:

- Ensuring that all care and support to people living with dementia, their families and carers promotes wellbeing and quality of life, protects their rights and respects their humanity.
- Services and support from diagnosis, and throughout the course of the illness, including supporting the needs of carers, must continue to improve. This support must be person centred, and should understand care and support from their perspective, not the perspective of service managers or clinicians.
- The redesign and transformation of services to ensure that they are adequately supported to deliver service effectively and efficiently.

2020 Vision for Health and Care in Scotland

In 2011, the Scottish Government set out its strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland, in the face of the significant challenges of Scotland's public health record, the changing demography and the economic environment.

The 2020 Vision provides the strategic narrative and context for taking forward the implementation of the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability.

The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that Scotland will have a healthcare system where:

- Health and social care is integrated
- There is a focus on prevention, anticipation and supported self-management
- Hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

This vision is supported by the following legislation/strategic drivers:

The Self-Directed Support Strategy

In order to foster the Scottish Government belief that everyone should be in control of their life, The Social Care (Self-directed Support) (Scotland) Act 2013 was enacted. The Act came into force on 01

April 2014 and places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their social care and support.

Self-directed Support includes a range of four options to which aim to maximise choice and control for all eligible:

- Option One: Direct Payment (a cash payment);
- Option Two: funding allocated to a provider of your choice (sometimes called an individual service fund, where the council holds the budget but the person is in charge of how it is spent);
- Option Three: the council can arrange a service for you; or
- Option Four: you can choose a mix of these options for different types of support.

The idea underpinning the act is that service users (or their carers where capacity is an issue) can use their allocated budget in any way they see fit to meet their personal outcomes. This has inevitably had an impact on the provision of health and social care services across Scotland.

Integration of health and social care

The Public Bodies (Joint Working) (Scotland) Act came into force in 2014 and legislates for health boards and local authorities to integrate budgets and services and to ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities and their carers.

The legislation and the regulations and guidance that accompany it support the arrangements for integrating health and social care, in order to improve outcomes for patients, service users, carers and their families.[7] The overarching idea being, this will enable health boards and local authorities to work together effectively to deliver quality, sustainable care services.

The Act highlights the importance of Joint Strategic Commissioning (referred to as strategic planning) in achieving the right outcomes for people. As recognised in the invitation to tender documentation, strategic commissioning involves a wide range of strategic activities such as: agreeing strategic outcomes and priorities, understanding and forecasting needs and considering prevention and early intervention. The approach is also informed by guidance issued by the Joint Improvement Team on strategic joint commissioning.

Other pertinent strategic drivers include:

The Carers Strategy

The Scottish Household Survey, 2007 – 2008, suggested there were approximately 657,300 carers in Scotland (that's one in eight of the population in Scotland).[8]

[7] And the relevant frameworks which acted as precursors such as *Better Outcomes for Older People: Framework for Joint Services (2005).* Available at http://www.gov.scot/Publications/2005/05/13101338/13397

[8] A National Statistics Publication for Scotland (2008) Scottish Household Survey: Annual Report - Results from 2007. Available at http://www.gov.scot/Publications/2008/08/07100738/0

Underpinning Scotland's Carers Strategy[9] is the recognition that carers are equal partners in the planning and delivery of care and support and that there is a strong case based on human rights, economic, efficiency and quality of care grounds for supporting carers. The Carers Strategy is a framework for policy and legislation development in Scotland and has driven the development of a range of projects and initiatives that aim to improve the lives of Scotland's carers, ensure that organisations and services are able to support carers and recognise them as equal partners in care, and support carers to have a life outside of caring and to care with confidence.

In February 2016 The Carers (Scotland) Bill was passed.[10] This make provision about carers, including the identification of carers' needs for support through adult carer support plans and young carer statements; the provision of support to carers; the enabling of carer involvement in certain services; the preparation of local carer strategies; the establishment of information and advice services for carers; and for connected purposes.

In combination, the strands of this strategy will have an impact on all HSCPs in Scotland.

End of Life / Palliative Care

The World Health Organization (WHO) defined palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[11] In 2004, the WHO recommended that planning for care at the end of life should be responsive to patient choice regarding place of care and place of death,[12] the Scottish Government's response was *Living and Dying Well: a national action plan for palliative and end of life care in Scotland (2008)*.

Living and Dying Well was intended to be a plan to ensure that good palliative and end of life care is available for all patients and families who need it in a consistent, comprehensive, appropriate and equitable manner across all care settings in Scotland. It was intended for all health and social care policy makers, planners and practitioners, and was designed to produce achievable and measurable changes which will ensure quality improvement and enhance patient and carer experience.

More recently, supported by the Scottish Partnership for Palliative Care and Healthcare Improvement Scotland, new NHS Scotland Scottish Palliative Care Guidelines have been published in November 2015.[13] They replace the previous pain & symptom control section of the "Lothian Palliative Care Guidelines (2010)" and reflect a consensus of opinion about good practice in the management of adult patients with life limiting illness. They are designed for healthcare professionals from any care setting who are involved in supporting people with a palliative life-limiting condition.

[9] Scottish Government (2010). *Caring Together: The Carers Strategy for Scotland 2010-2015*. Scottish Government. Edinburgh.

[10] See more at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/86987.aspx#sthash.SILflfHm.dpuf

[11] World Health Organization definition of Palliative Care, 2004. http://www.who.int/cancer/palliative/definition/en/

[12] World Health Organization. Palliative Care: the solid facts. World Health Organization, Geneva: 2004; World Health Organization. Palliative care for older people. World Health Organization, Geneva: 2004

[13] http://www.palliativecareguidelines.scot.nhs.uk/

Such good practice guidelines, policies and plans impact on health and social care service provision across all areas of Scotland.

Housing Strategy

The Wider Planning for an Ageing Population working group which created Scotland's housing strategy for older people (2012-21)[14] identified five key outcomes for housing and related support for older people, covering: clear strategic leadership; information and advice; better use of existing housing; preventative support; and new housing provision. These five outcomes form the framework for this strategy and underlying the outcomes are four key principles: older people as an asset; choice; planning ahead; and preventative support.

The strategy presents a ten-year vision and programme of action which directs local service provision across Scotland and embraces the recurring themes of choice and early intervention/prevention.

Service provision is also driven and affected by other legislation such as:

1. National Telecare Development Programme 2006 – 11
2. An evaluation of the TDP programme[15] noted the following:
3. Overall, the gross value of TDP funded efficiencies over the period 2006-11 was approximately £78.6 million at 2011 prices. It should be noted however that, unless actual care home bed reductions, hospital ward closures and other service adjustments were subsequently made, these efficiency gains will not have resulted in cash releasing savings.
4. In overall terms, the Telecare Development Programme has also shown that telecare can have a transformational effect on service user and carer quality of life and that it has the potential to play an important role in continuing efforts to shift the balance of care.
5. The Mental Health (Care & Treatment) Scotland Act 2003
6. The Adults with Incapacity (Scotland) Act 2000
7. The Adult Support and Protection (Scotland) Act 2007

1.3.2 Local drivers

Ageing Population

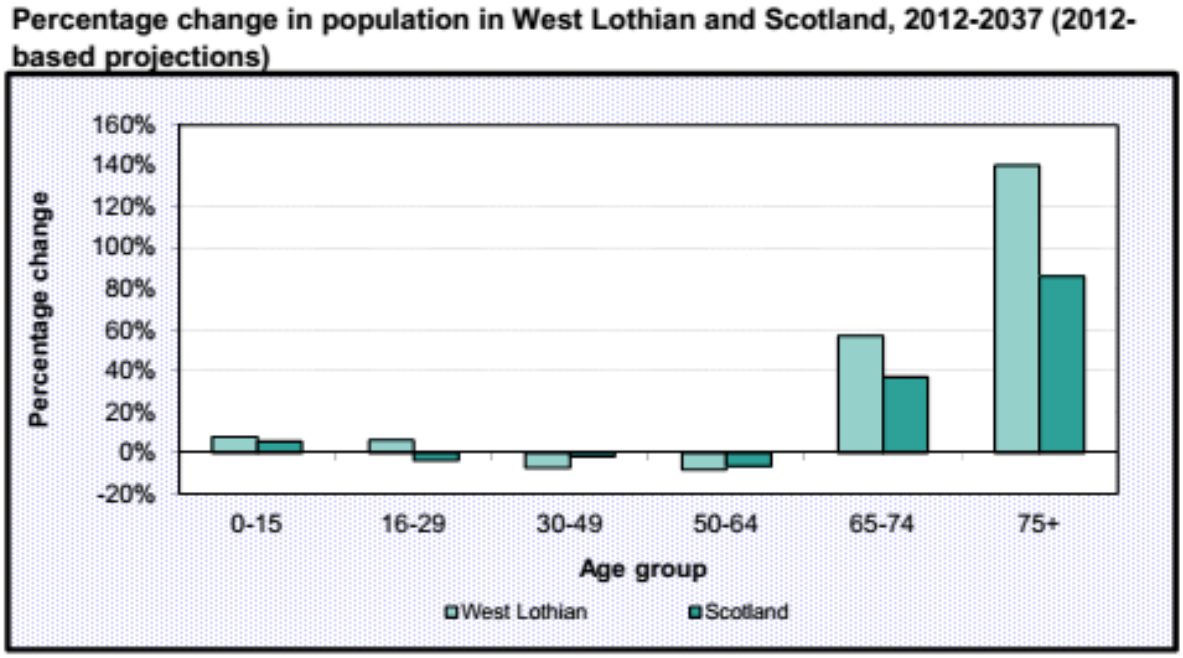
West Lothian is facing an ageing population profile that presents a significant challenge. Compared to other local authorities West Lothian will see a significantly higher level of growth in the number of over 75s and over 85s, who will typically have increasing social care needs. Over the period 2012 to 2017, West Lothian's population of over 75s will have increased by 20% compared to the national average of 7%. In addition, over the period 2017 to 2027, West Lothian's population of over 85s is

[14] Scottish Government. (2011) *Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012 – 2021*. Scottish Government: Edinburgh.

[15] O'Sullivan. T. (2011) *The Telecare Development Programme in Scotland 2006-11*. Newhaven Research. Available at http://www.jitscotland.org.uk/resource/telecare-development-programme-final-report/ Accessed 30th July 2016.

forecast to increase by 74% compared to the national average of 43%. Moreover, West Lothian also has an increasing younger population meaning that demand for services is increasing at both ends of the spectrum. [16]

Figure 1.3: Percentage change in population in West Lothian and Scotland 2012-2037 (2012-based projections)[17]



Long Term Conditions

According to the West Lothian Partnership, in West Lothian approximately 27,000 – 31,000 of the adult population live with one or more long term condition which potentially limits their ability to cope with day to day activities.[18] Indeed it is estimated that 35% of households in West Lothian have someone with a longstanding illness, health problem or disability.[19]

[16] Source: West Lothian Council Website: http://www.westlothian.gov.uk/article/9639/Pressure-on-West-Lothian-to-meet-demands-of-population-increase

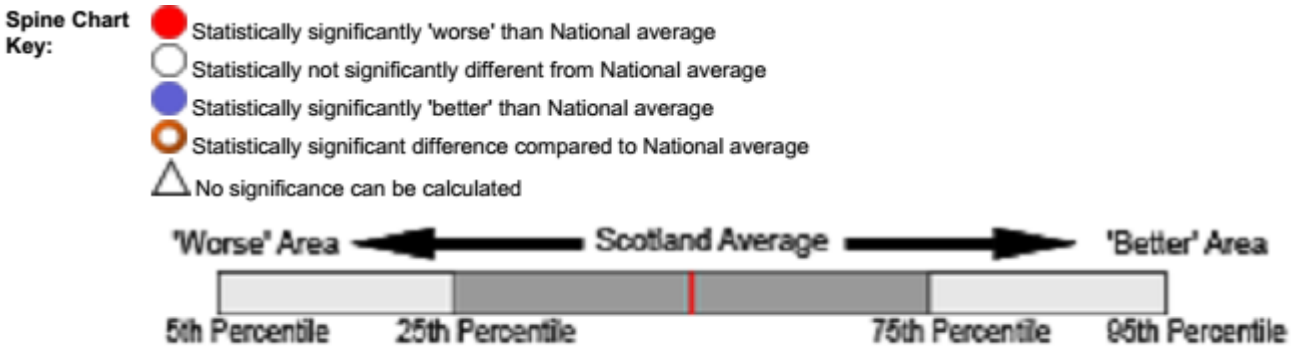
[17] Source: National Records of Scotland (17/12/2015) *West Lothian Council Area - Demographic Factsheet*. p.6. Available at http://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/west-lothian-factsheet.pdf

[18] West Lothian Partnership. *West Lothian Partnership's Reshaping Care for Older People Joint Commissioning Plan (2013-2023).* 15th February 2013. Available at: http://www.westlothian.gov.uk/media/4214/Reshaping-Care-for-Older-People-2013-2023/pdf/reshapingcareforolderpeople2013-2023.pdf p.9

[19] Scotland's People: Annual Report Results from the 2012 Scottish Household Survey: Local Authority Tables West Lothian, August 2013

Figure 1.4: Health & Wellbeing Profiles (West Lothian): Ill Health & Injury (2014)[20]

	Indicator	Period	Number	Measure	Type	National Average
13	Patients registered with cancer [12]	2012	914	646.0	sr4	634.1
14	Patients hospitalised with chronic obstructive pulmonary disease (COPD) [12,15]	2012	947	709.9	sr4	659.9
15	Patients hospitalised with coronary heart disease [12]	2012	599	419.7	sr4	440.3
16	Patients hospitalised with asthma [12]	2012	164	86.4	sr4	91.2
17	Patients with emergency hospitalisations [12]	2012	13,046	8,189.7	sr4	7,500.2
18	Patients (65+) with multiple emergency hospitalisations [12]	2012	1,364	5,944.9	sr4	5,159.5

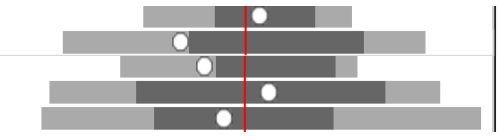


The Figure above indicates that West Lothian has an average number of patients registered with cancer and an average number of patients hospitalised with coronary heart disease, and asthma; but more patients hospitalised with COPD than the Scottish average.

The Figure below illustrates that in 2011 West Lothian had an average number of patients over 65 registered with cancer and that hospital admissions in the over 65s for chronic diseases was also in line with the Scottish average:

Figure 1.5: Older People Profiles 65+ (West Lothian) (2014)[21]

Domain		Indicator	Period	Number	Measure	Type	National Average
Health-Status	7	Patients registered with cancer - Males [2,11]	2011	799	2,493.8	sr5	2,528.5
	8	Patients registered with cancer - Females [2,11]	2011	730	1,831.4	sr5	1,765.9
Use of Health Services - Secondary Care	13	Patients hospitalised with COPD [2,11]	2011	791	1,110.4	sr6	979.9
	14	Coronary Heart disease patients [2,11]	2011	1,029	1,467.8	sr6	1,502.7
	15	Cerebrovascular disease patients [2,11]	2011	739	1,113.9	sr6	1,098.9



Health Inequalities

There is a recognised correlation between deprivation and poor health. That withstanding, according to the West Lothian Partnership, although there is improved life expectancy across the county an inequality gap of 8-9 years persists from East to West.[22]

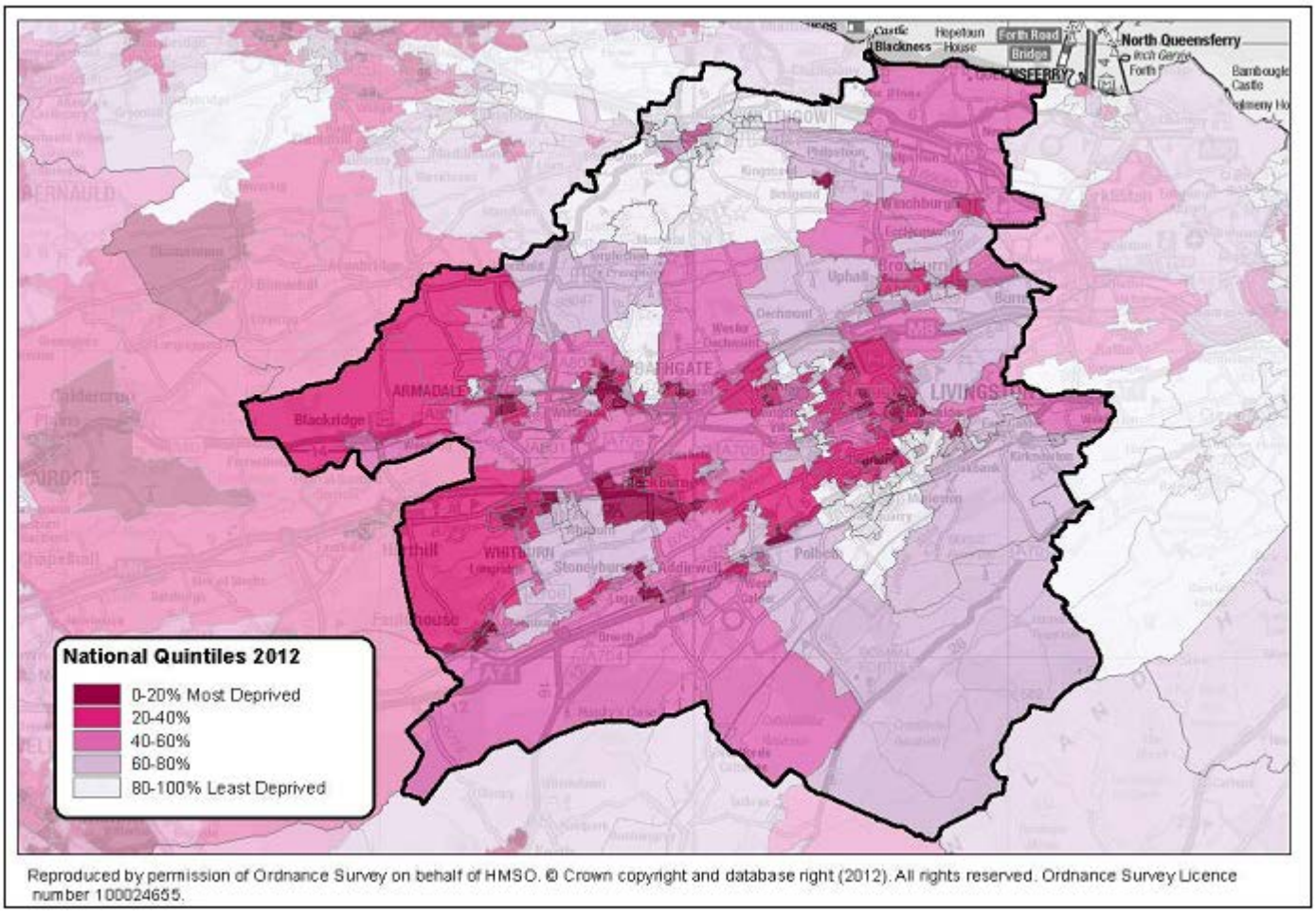
[20] ScotPHO (2014) Health & Wellbeing Profiles (West Lothian) Available at: https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do

[21] ScotPHO (2014) Older People Profiles 65+ (West Lothian) Available at: https://scotpho.nhsnss.scot.nhs.uk/scotpho/profileSelectAction.do

[22] West Lothian Partnership. *West Lothian Partnership's Reshaping Care for Older People Joint Commissioning Plan (2013-2023).* 15th February 2013. Available at: http://www.westlothian.gov.uk/media/4214/Reshaping-Care-for-Older-People-2013-2023/pdf/reshapingcareforolderpeople2013-2023.pdf p.10

For almost every health indicator there is a clear gradient showing progressively poorer health with decreasing affluence and influence. People who are disadvantaged by race, disability, gender and other factors also have poorer health. Although West Lothian has very few datazones in the most deprived decile, most of this local authority's datazones are found in the second, third, and fourth deciles (towards the more deprived end of the distribution) in SIMD 2012., and so tends to have poorer health than the Lothian average. There are also inequalities within West Lothian. Life expectancy for women ranges from 87 years in Linlithgow to only 76.6 years in Dedridge; life expectancy for men ranges from 82.6 years in Linlithgow to 74.9 years in Breich. These figures reflect wider socio-economic differences.[23]

Figure 1.6: Areas of deprivation in West Lothian (2012)[24]



[23] West Lothian Integration Joint Board Strategic Plan 2016-26 Available at http://www.westlothianchcp.org.uk/media/10225/West-Lothian-IJB-Draft-Strategic-Plan-2016-26/pdf/West-Lothian-IJB-Strategic-Plan-2016-26-Draft-Consultation.pdf p.7

[24] Wilson. L. (2015) *Livingston South Ward Profile* Available at http://www.westlothian.gov.uk/media/3505/Livingston-South-Ward-Profile/pdf/2015_(08)_Livingston_South_Ward_Profile_April_2015.pdf p.5

Income Generation for Non-Residential Care[25]

West Lothian Council currently has the lowest level of income generated via charging for non-residential care in Scotland with 42 pence generated as income per head of population. This is in contrast to many other councils. In Dundee, for example, income generated from non-residential care is equivalent to £15.25 per head, with Angus at £18.44 per head. Closer to home, Falkirk Council income is equivalent to £10.80 per head and Midlothian Council £15.74 per head.

West Lothian Partnership's Reshaping Care for Older People Joint Commissioning Plan (2013-2023)

This plan responds to national policy and attempts to demonstrate clear, joined-up commissioning priorities across health and social care to respond to local challenges and to improve service delivery to an aging population. It identifies and details actions to address gaps to ensure fair access to services across West Lothian and was developed by the four main partners of the West Lothian Reshaping Care for Older People Programme (West Lothian Council, NHS Lothian, Scottish Care as representative of the independent sector, and Voluntary Sector Gateway as representative of the voluntary sector), in conjunction with a range of stakeholders including older people and their carers.

The principle outcome of the joint commissioning plan for older people is:

"To enable older people live longer healthier and more independent and fulfilling lives within a safe and supportive community and continue to learn and develop."

In order to achieve this the plan notes that the partnership will focus on **giving older people / carers control and choice**. It will direct resources towards **prevention** and **early intervention** which enables older people to maximise their independence and remain within their own home where they chose to do so, whilst applying the principles of personalisation, in order to meet the needs and aspirations of individuals and their local communities.[26]

West Lothian Integration Joint Board (IJB) from 2016-2026

This strategy aims to increase wellbeing and reduce health inequalities across all communities in West Lothian. It too is 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.

[25] Source: West Lothian Council Website: http://www.westlothian.gov.uk/article/9639/Pressure-on-West-Lothian-to-meet-demands-of-population-increase

[26] West Lothian Partnership. *West Lothian Partnership's Reshaping Care for Older People Joint Commissioning Plan (2013-2023).* 15th February 2013. Available at: http://www.westlothian.gov.uk/media/4214/Reshaping-Care-for-Older-People-2013-2023/pdf/reshapingcareforolderpeople2013-2023.pdf p.4

Carers Strategy

According to the Scottish Household Survey there were 18,000 carers in West Lothian in 2007-8 - that's one in nine of the local population. According to the local Carers Strategy (2013-2015),[27] West Lothian's vision is that the contribution carers make to the community is recognised and that they are valued as equal partners in care and supported and empowered to manage their caring responsibilities with confidence and in good health and to have a life of their own outside of the caring role. This strategy is linked to the national strategy *Caring Together* and consequently the thematic areas reflect the national priorities. Fundamentally the focus is on:

1. Improved identification of carers
2. Outcome based assessment of carers needs,
3. Information and advice
4. Carer support
5. Participation and partnership

Technology

The development and provision of innovative telecare solutions for people in their own homes and housing with care is both in line with national practice and has been an area in which the West Lothian Partnership has invested to date. Telecare also supports housing with care where people with complex needs live within their own tenancy in a supported housing complex with dedicated call service and support team. The demographic trends imply there will be an increasing demand for services such as this in the future to maximise independence and care support via telehealth technology.

Other local strategies / drivers include:

1. A Sense of Belonging – Joint Strategy for Improving Mental Health & Well-being of Lothian's Population 2011
2. Older People and Dementia Joint Commissioning Plan
3. West Lothian Joint Health and Social Care Commissioning Strategy 2011 - 21
4. Older Peoples Strategic Service Statement 2009 – 2012
5. Dementia Strategic Service Statement 2009-2012
6. West Lothian Council Housing Strategy 2011
7. Social Care & Social Work Improvement Scotland Scrutiny Report 2011

[27] Carers Strategy Implementation Group (2013) *West Lothian Carers Strategy* Available at http://www.westlothianchcp.org.uk/media/3355/West-Lothian-Carers-Strategy/pdf/WL_Carers_Strategy_2013.pdf

8. Social Policy Management Plan 2011
9. West Lothian Local Transformation Plan – Reshaping Care for Older People 2011
10. West Lothian Single Outcome Agreement
11. Adult Support & Protection: Ensuring Rights Preventing Harm 2010
12. West Lothian Community Planning Partnership Strategic Assessment 2012
13. Health & Well Being Profile 2012

1.4 Wellbeing and Quality of Life

The report examines not just health and social care needs, but also considers what promotes and supports mental and emotional wellbeing for older people.

The concept of wellbeing, called 'quality of life' by older people, is not yet sufficiently understood and reflected in the planning, development and everyday delivery of public services. A common definition or understanding of the term remains lacking. Older people have defined quality of life as a life that has value, meaning and purpose when they:

14. Feel safe and are listened to, valued and respected;
15. Are able to get the help they need, when they need it, in the way they want it;
16. Live in a place which suits them and their lives; and
17. Are able to do the things that matter to them.

However, these four points depend to a large degree on both the ability to make choices and on fluctuations and changes in personal and life circumstances. The dynamic nature of wellbeing is reflected in remarks made by Nic Marks, of the New Economics Foundation:

> *"Wellbeing is not a beach you go and lie on. It's a sort of dynamic dance and there's movement in that all the time and actually it's the functionality of that movement which actually is true levels of wellbeing"* (Nic Marks, Radio 4, 7 January 2012)

The concept of 'wellbeing' has gained a wider public airing following the decision to embark on a national measurement programme developed by the Office for National Statistics (ONS), introduced in 2011. At a personal level wellbeing is "a positive physical, social and mental state" at a population, or national level, a range of indicators are being included, individual wellbeing but also the quality of the environment, equality, sustainability and the economy. Research indicates that 'wellbeing' comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity, and engagement are characteristic of someone who has a positive experience of their life. Equally important for wellbeing is our functioning in the world.

Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.[28]

In a review of the evidence on how individuals can improve wellbeing, the New Economics Foundation (nef)[29] identified five actions to improve wellbeing that individuals could be encouraged to build into their lives:

1. Connect ... With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. Be active ... Go for a walk or run. Step outside, cycle, play a game, garden, or dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. Take notice ... Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. Keep learning ... Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.
5. Give ... Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Aked et al (2009) contend that it is vital to combine consideration of the structural factors affecting the circumstances of individual's lives, together with the psychological and social aspects of their wellbeing. Only by taking this 'twin track' approach is it possible to account for the dynamic nature of wellbeing, where positive experiences ('feeling good') and outcomes ('doing well') arise through the interplay between external circumstances, inner resources, and capabilities and interactions with the surrounding world.[30]

[28] Huppert F (2008) *Psychological well-being: evidence regarding its causes and its consequences* (London: Foresight Mental Capital and Wellbeing Project 2008).

[29] Aked, J. and Thompson, S. (2011). *Five ways to wellbeing – new applications, new ways of thinking*. New Economics Foundation: London.

[30] Aked, J., Steuer, N., Lawlor, E. and Spratt, S., (2009), *Backing the Future*. See also Foresight Mental Capital and Wellbeing Project (2008), *Final Project report – Executive summary*, London: The Government Office for Science; and Thompson S, & Marks N (2008) *Measuring well-being in policy: Issues and applications,* New Economics Foundation: London.

1.5 Purpose

The purpose of this study is to assist the West Lothian Health and Social Care Partnership to:

- Identify and describe the profiles and distribution of older people in West Lothian.
- Identify the prevalence of older people with dementia in West Lothian.
- Confirm existence and accessibility of current provision inclusive of formal service provision plus community support available as a consequence of community capacity building.
- The current strengths, gaps and inequalities in provision.
- Recommendations with regards to future provision, prioritised and cross referenced with outcomes identified and deemed desirable for older people inclusive of those with dementia.

1.6 Objectives

The specific objectives of this project are as follows:

- To provide a comprehensive assessment and mapping of specialist and non-specialist services and support provisions for older people (aged 65+);
- To conduct an assessment of local need for such services;
- To identify gaps and areas of unmet need in current provision;
- To examine the current use of services, both community and inpatient;
- To examine the accessibility, appropriateness and location of current services;
- To identify any areas with over-provision;
- To provide evidence based recommendations as to how services could be extended or adapted to meet need including relationship and any overlap between agencies; and
- To suggest locality pathways for intervention and support for older people.

1.7 Scope

This document presents the findings of the needs assessment and reports on the future requirements for older people's services/supports across West Lothian. Evidence from the Needs Assessment will assist:

- In providing evidence on the extent to which current services are meeting demand;
- In the commissioning of new services;
- In identifying gaps in existing service provision;
- In identifying areas of over provision;
- In providing evidence on the extent to which services are accessible and in the right location; and

- In suggesting ways as to how West Lothian Health and Social Care Partnership and its partner agencies could extend / adapt services to meet need; and

Conducting needs assessments in such a complex environment requires a great deal of understanding and flexibility on the part of the project team, and it is essential to engage as broad a range of interests as possible in the assessment process. To this end, the research team sought the views of a wide range of different older people and mainstream services, people who use services, families and carers; advocates and other stakeholders. The qualitative element of the study in particular aimed to consult with staff from specialist older people services, together with a sample of the following groups which support older people:

- Service users across the whole spectrum of older people's services;
- Carers and families;
- Advocates;
- Treatment and care providers (statutory, third, private);
- Strategic Planners – West Lothian HSCP;
- GP's and Public Health Consultants;
- Health and Social Care Practice Teams;
- Police Scotland; and
- Housing services.

Discussions with the project steering group and key strategic planners took place at several points during the fieldwork, and this acted as a helpful 'sounding board' for the emerging findings of the study.

1.8 The Needs Assessment Process

This needs assessment project uses a tried and tested model for health needs assessment (which is detailed below) and applies it to both the health and social care needs of older people across West Lothian.

In broad terms, health needs assessment is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way. It involves methods to describe the health problems of a population, identify inequalities in health and access to services, and determine the priorities for the most effective use of resources.

Health needs assessment has become important as the costs of health care are rising and resources for health care are, at the same time, limited. In addition, there is a large variation in availability and use of health care by geographical area and point of provision (Andersen and Mooney, 1990).[31]

[31] Andersen, T.F. & Mooney, G. (Eds) (1990) *The challenges of medical practice variations.* MacMillan Press: London.

Another force of change is consumerism. The expectations of members of the public have led to greater concerns about the quality of the services they receive, from access and equity to appropriateness and effectiveness.

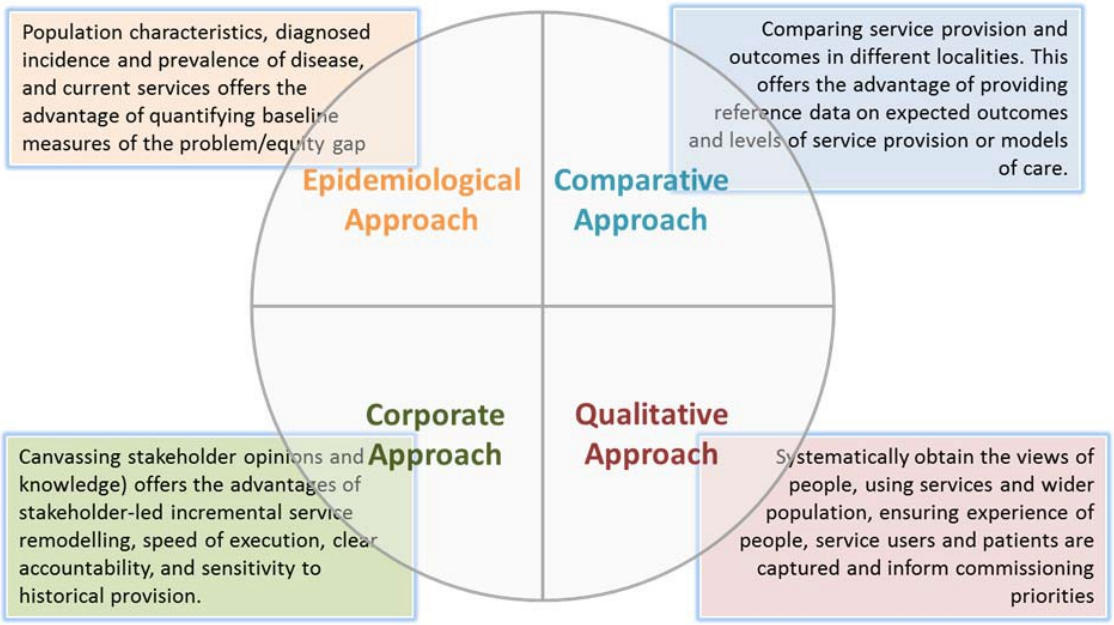
The health needs assessment process has been defined, in guidance from the National Institute of Clinical Excellence (NICE), as:

> *"A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities."*[32]

The assessment process involves identifying need from four different perspectives (see Figure 1.7):

- **Epidemiological needs** – the use of health information based on the population, including demographic trends, health status and risk, as well as evidence of clinical effectiveness of services and interventions.
- **Felt and expressed needs (Qualitative)** – the views of the public, from surveys, focus groups and the like, often using participatory appraisal methods.
- **Normative or expert needs (Corporate)** – as identified by professionals or experts.
- **Comparative needs** – the scope and nature of services available to the population and how these compare with services elsewhere.

Figure 1.7 Diagram of the needs assessment process



The study methods used in this needs assessment (outlined in section 1.9 below) were designed to capture each of these four different approaches/perspectives and are identified in Table 1.8 below.

[32] Cavanagh S and Chadwick K (2005), "Health needs assessment: A practical guide". London: NICE. Available at: http://www.nice.org.uk/

1.9 Summary of Study Methods

The study was conducted in four stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods and sample populations. These are set out in the table below. All questionnaires and interview schedules were approved by commissioners prior to use.

Table 1.8: Summary of Data Collection Methods

Stage 1	**Method**		**Link to approaches / perspectives on need**
Review of Existing Datasets	Desk-based review of national and local datasets and any local specialist service data available.		• Epidemiological • Comparative
Stage 2	**Method**	**Sample**	
Quantitative Survey	Online Surveys	• Managers of all specialist older people services • Staff in all specialist older people services.	• Normative/Expert (Corporate) • Comparative
Stage 3	**Method**	**Sample**	
Quantitative Surveys	Online and paper-based surveys	• Service users • Non (potential) service users • Carers, family members, advocates	• Felt and Expressed (Qualitative)
Stage 4	**Method**	**Sample**	
Stakeholder Event / Working Group / Qualitative Interviews / Focus Groups	Stakeholder Event	• All key stakeholders invited to a half-day event in relation to older people.	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Working Group	• Sample of key stakeholders recruited via approaches from the Research Steering Group, and via the stakeholder event above. The working group to meet twice to explore issues for older people.	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Semi-structured interviews	• All specialist services • A range of non-specialist services • Other relevant stakeholders	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Focus Groups	• Service users • Non (potential) service users • Carers, family members, advocates	• Felt and Expressed (Qualitative)

1.10 Terminology

When quoting individual respondents or citing literature sources we will use the terms they have chosen for accuracy of representation.

1.11 Considerations and limitations

There are a number of factors which should be taken into account when reading this report. These are:

- The views of those interviewed and surveyed were taken and reported in good faith and are their own, not necessarily those of Figure 8 Consultancy Services Ltd. or the organisations they represent. It cannot be assumed that the views of the participants in interviews, focus groups, stakeholder events or working groups are representative of all similar stakeholders.
- Making comparisons with other areas of similar population and/or geography, as well as prevalence of health and social care conditions, allows for a degree of 'benchmarking' to observe the relative position of West Lothian. It should be noted that there may be variations between areas in the way in which this data is collected.
- In health care, need is commonly defined as 'the capacity to benefit'. If health needs are to be identified then an effective intervention should be available to meet these needs and improve health. There will be no benefit from an intervention that is not effective or if there are no resources available (Wright, Williams & Wilkinson, 1998).[33] The definition of need used in this study is 'the number of individuals in the general population with health problems who could benefit from intervention'. There are several challenges in estimating the prevalence of health and social care conditions in the older population involving the definition of 'problems' and the methods used to obtain the estimate.

[33] Wright, J., Williams, R., & Wilkinson, J.R. (1998). Development and Importance of Health Needs Assessment. *British Medical Journal,* 316; 1310-1313.

CHAPTER 2: EPIDEMIOLOGY

2.1 Introduction and Aims

After considering first the overall demographic make-up of West Lothian, this section is broken into a number of sub-sections. Under each of these, it examines the general research on what makes older people more or less vulnerable in terms of their mental wellbeing, then at the national statistics, and then the local figures where they are available.

2.2 Method of Data Collection

Information was identified and drawn together from a range of local and national sources on prevalence and trends in the patterns of health and social care issues for older people in Scotland over the past ten years. In order to provide comparative analysis on a range of health and social indicators three local authority areas were identified from similar socioeconomic deprivation backgrounds as West Lothian[34], as well as using information from the Local Government Benchmark Framework (LGBF)[35]. The LGBF considers the many differences between local authorities that contribute to variations in performance, including: population; geography; social and economic factors; and the needs and priorities of local communities.

Falkirk, Renfrewshire and South Lanarkshire were agreed with the study commissioners and chosen as comparators as they have similar characteristics and populations as West Lothian.

2.3 Data Issues

Data relating specifically to older people can be difficult to find and often there are problems with the data which mean that it does not give a completely accurate picture. This said, the data which is available is still useful in providing information regarding the needs of this population as long as it is interpreted with certain caveats in mind.

2.4 Demography of West Lothian

Present and future need for services and assets to address the health and social care needs of older people in West Lothian depends in part on the demography of the county. In this section basic population data is therefore briefly assessed.

[34] http://www.scotland.gov.uk/Topics/Statistics/Browse/Social-Welfare/TrendSIMD

[35] http://www.scotborders.gov.uk/info/691/council_performance/1352/local_government_benchmarking_framework

2.4.1 Area Profile

West Lothian is an area of 165 square miles (428 square km) situated in the east of Scotland, positioned between Glasgow and Edinburgh, and surrounded by the council areas of Edinburgh, Falkirk, North Lanarkshire and the Scottish Borders. Livingston, Bathgate and Linlithgow are the main centres of population in this local authority.

Figure 2.1: Map of West Lothian[36]

According to National Records of Scotland, the 2015 mid-year population estimate for West Lothian was 178,550[37], an increase of 0.8% from 177,200 in 2014. This represents a 2% increase of the whole population figures reported in 2011 Census (175,118). In relation to the comparison areas, the table below shows West Lothian has a higher population than Falkirk (157,640) and Renfrewshire (174,230), and lower than South Lanarkshire (315,360). Scotland's overall population is also shown (5,347,600).

Table 2.2: Whole Population Figures for West Lothian, Scotland and Comparison Areas.[38]

	West Lothian	South Lanarkshire	Renfrewshire	Falkirk	Scotland
2015 Mid-Yr Estimate	**178,550**	316,230	174,560	158,460	5,373,000

*NRS = National Records of Scotland

[36] West Lothian Map, Google Map 2015. Available at: https://www.google.co.uk/maps/place/West+Lothian/@55.8546737,-3.7929644,10z/data=!4m2!3m1!1s0x4887c514c305f6ff:0x9f54bb6a8afceff3. [Accessed on: 22nd July 2016].

[37] National Records of Scotland.2016. *West Lothian Council Area - Demographic Factsheet. Available at:* http://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/west-lothian-factsheet.pdf. [Accessed on: 22nd July 2016].

[38] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

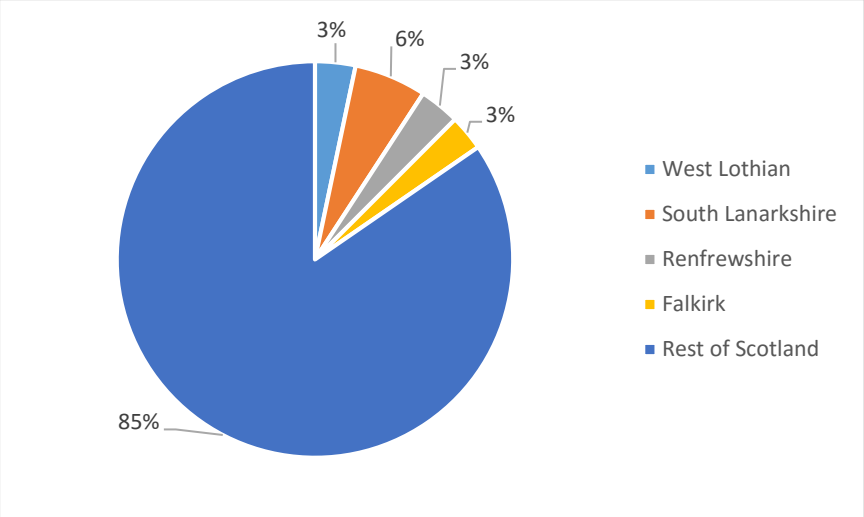
A full breakdown by age group and gender is shown in the table below:

Table 2.3 Estimated population of West Lothian, by age group and gender, 2015[39]

Age Group	Male Population	Female Population	Total	%
0-15	17,962	17,140	35,102	19.7
16-29	15,168	14,705	29,873	16.7
30-44	17,572	18,417	35,989	20.2
45-59	19,546	20,453	39,999	22.4
60-74	**12,557**	**13,806**	**26,363**	**14.8**
75+	**4,746**	**6,478**	**11,224**	**6.3**

Further analysis of the available population figures is demonstrated below which shows population percentages of West Lothian, South Lanarkshire, Renfrewshire and Falkirk compared with the rest of Scotland. The figure reveals that West Lothian, Renfrewshire and Falkirk have a similar population percentage (3%), with South Lanarkshire double this (6%). The rest of Scotland accounts for 85% of the population.

Figure 2.4: Population Breakdown of West Lothian, Comparison Areas and Rest of Scotland.[40]



[39] National Records of Scotland. 2016. Statistics and data. *Available at:* http://www.nrscotland.gov.uk/statistics-and-data. [Accessed 19 May 2016].

[40] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

2.4.2 Population: Sex

There are more females than males in West Lothian (90,999 compared to 87,551). As can be seen in the table below, there are similarities between West Lothian figures, Scottish figures and comparison areas when male and female statistics are put in percentages.

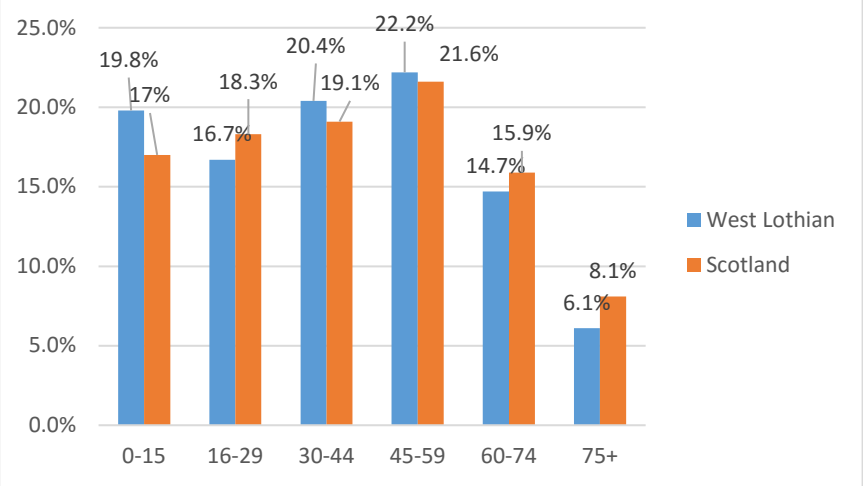
Table 2.5: Breakdown of population by Gender (for West Lothian, Scotland and Comparison Areas)[41]

	West Lothian	South Lanarkshire	Renfrewshire	Falkirk	Scotland
Male	**48.9%**	48.1%	48.1%	48.8%	48.5%
Female	**51.1%**	51.9%	51.9%	51.2%	51.5%

2.4.3 Population: Age

The population of the West Lothian is largely aged between the age brackets of 30-44 and 45-59 years of age, with 20.4% and 22.2% of people in West Lothian belonging to these age categories. This is more than the Scottish averages for these age categories (19.1% and 21.6% respectively). The graph below shows comparisons of age categories in West Lothian compared to the Scottish average.

Figure 2.6: West Lothian Population Breakdown by Age, Compared to the Scottish Average.[42]



[41] National Records of Scotland, 2011 *Census*. Available at: http://www.scotlandscensus.gov.uk/ods-web/area.html. [Accessed 22nd July 2016].

[42] National Records of Scotland. 2016. *West Lothian Council Area- Demographic Factsheet.* Available at: http://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/west-lothian-factsheet.pdf [Accessed 22nd July 2016].

2.4.4 Population: Projected Population

Current projections for West Lothian are estimating an overall population increase of 10.1 % between 2015 (n=178,550) and 2037 (n=196,664). From the table below it can be seen that the projected population of West Lothian until 2037.

Table 2.7: Projected Population in West Lothian - 2015, 2017, 2022, 2027, 2032, 2037.[43]

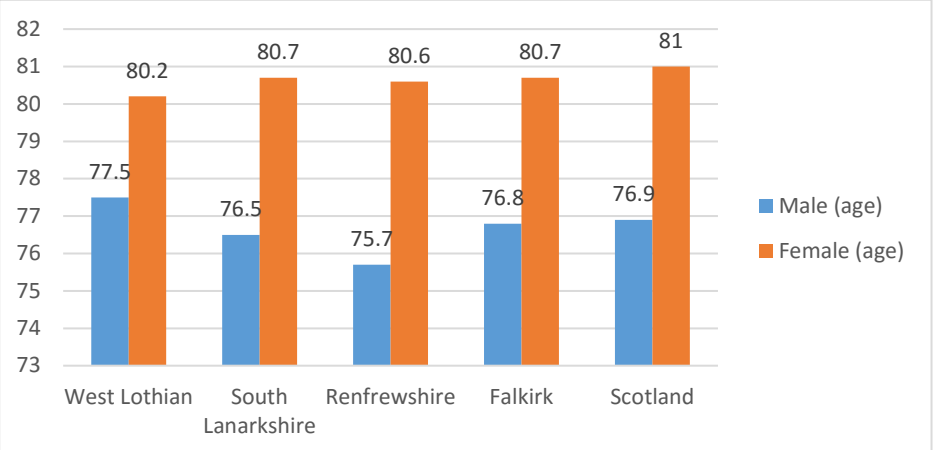
Projected years	2015	2017	2022	2027	2032	2037
Projected population	178,550	180, 252	184,774	189, 208	193,254	196,664

2.4.5 Population: Life expectancy

Female life expectancy at birth (80.5 years) is greater than male life expectancy (77.9 years) in West Lothian, with male life expectancy higher than the Scottish average (77.9 years compared to 77.1 years) and female life expectancy lower (80.5 years compared to 81.1 years). Male life expectancy at birth in West Lothian is improving more rapidly than female life expectancy.

Further analysis is revealed in the graph below and it can be seen that life expectancy at birth for males in West Lothian is higher than all other areas (South Lanarkshire 76.6 years, Renfrewshire 75.9 years and Falkirk 77.3 years). Life expectance at birth for females is slightly lower than all other areas (South Lanarkshire 80.9 years, Renfrewshire 80.6 years and Falkirk 81.0 years).

Figure 2.8: West Lothian Life Expectancy at Birth by Sex, Comparison Areas and Scotland, 2012-2014.[44]



[43] Ibid.

[44] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

2.4.6 Population: Ethnicity

The 2011 Census reveals 97.5% of the people in West Lothian consider their ethnic group to be 'white' which is higher than national figures (96.1%). Further analysis of these figures demonstrates that 87.8% of people within West Lothian consider their ethnic group to be 'White Scottish', which, again, is higher than the national average (84%), but lower than all comparison areas (South Lanarkshire 91.6%, Renfrewshire and Falkirk both 91.3%). The table below demonstrates further analysis of 2011 census data on ethnicity.

Table 2.9: Ethnicity Breakdown for West Lothian, Comparison Areas and Scotland.[45]

	West Lothian	S. Lanarkshire	Renfrewshire	Falkirk	Scotland
White- Scottish	87.8%	91.6%	91.3%	91.3%	84%
White- Other British	5.8%	3.8%	3.3%	4.5%	7.9%
White- Irish	0.7%	1%	0.9%	0.6%	1%
White-Gypsy/Traveller	-	0.1%	-	0.1%	0.1%
White-Polish	1.9%	0.4%	0.7%	0.7%	1.2%
White- Other	1.3%	0.8%	0.9%	0.9%	1.9%
Asian, Asian Scottish or Asian British	1.7%	1.6%	1.8%	1.3%	2.7%
Mixed or multiple ethnic groups	0.3%	0.2%	0.2%	0.2%	0.4%
African	0.3%	0.2%	0.5%	0.1%	0.6%
Caribbean or Black	0.1%	0.1%	0.1%	0.1%	0.1%
Other Ethnic group	0.1%	0.1%	0.2%	0.1%	0.3%

2.5 Deprivation

It is documented that individuals from deprived areas have lower overall mental well-being compared to those from more affluent areas, with national and international research demonstrating that those in deprived areas are more likely to have higher rates of hospital admissions, increased risk of premature death[46], are twice as likely to have anxiety problems than those in the least deprived areas, and also have higher rates of suicide.[47]

[45] National Records for Scotland. 2013. *2011 Census: Key Results on Population, Ethnicity, Identity, Language, Religion, Health, Housing and Accommodation in Scotland - Release 2A. Available at:* http://www.scotlandscensus.gov.uk/documents/censusresults/release2a/StatsBulletin2A.pdf [Accessed 22 July 2016].

[46] Office of the Deputy Prime Minister. 2004. *Mental health and social exclusion: Social Exclusion Unit report.* Available at: http://www.socialfirmsuk.co.uk/resources/library/mental-health-and-social-exclusion-social-exclusion-unit-report[Accessed 22 July 2016].

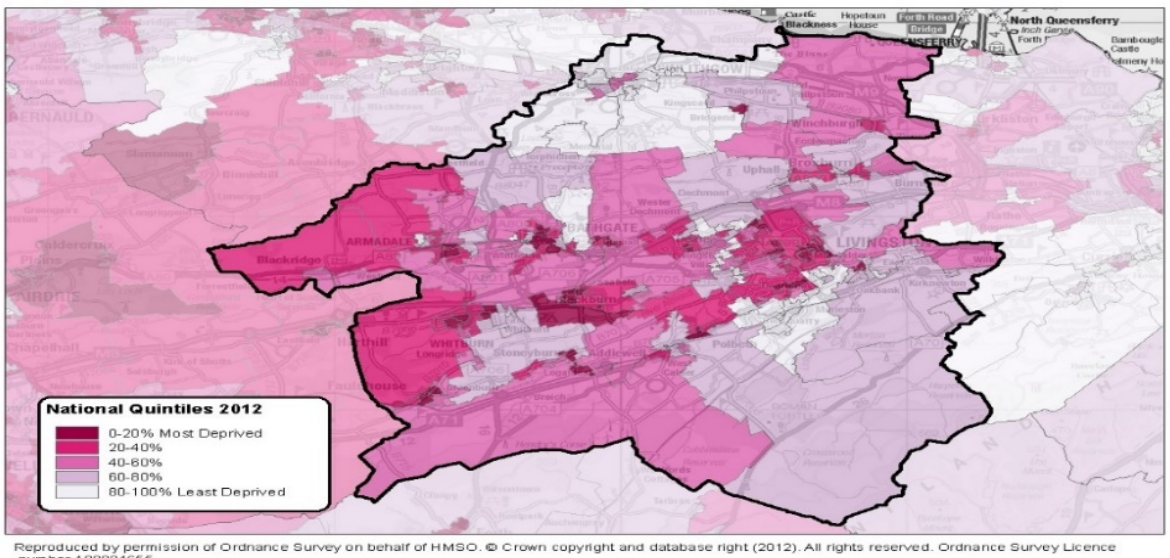
[47] Audit Scotland. 2012. *Health inequalities in Scotland.* Available at: http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf [Accessed 22 July 2016].

The Scottish Index of Multiple Deprivation (SIMD herein) is a Scottish Government tool which includes different aspects of deprivation to combine them into a single index. Specifically, the index incorporates seven domains to measure the multiple aspects of deprivation and the overall index is a weighted sum of the seven domain scores as follows: income (28%), employment (28%), health (14%), education (14%), geographic access (9%), crime (5%) and housing (2%). There are a total of 6,506 datazones (small areas) within Scotland to which the SIMD offers a relative ranking for each datazone from 1 (most deprived) to 6,506 (least deprived). The datazones contain approximately 350 households/ 800 people. Current SIMD (2012) figures for Scotland show that 742,200 people live in the 15% most deprived areas of Scotland. Figures also shows that multiple deprivation has become less clustered over time with 2004 figures highlighting approximately half of all datasets in the most deprived 10% across Scotland were in Glasgow City, whereas 2012 figures highlights that this has fallen to 35.8%. Currently Ferguslie Park, Paisley, is the most deprived area in Scotland, whereas the least deprived datazone is the Craiglockhart area of Edinburgh.[48]

2.5.1 Deprivation within West Lothian

Within West Lothian there are 211 datazones. The SIMD 2012 reveals that 13 (6.2%) of West Lothian's 211 datazones were found in the 15% most deprived datazones in Scotland, compared to 19 (9%) in 2009, 14 (6.6%) in 2006 and 9 (4.3%) in 2004. The most deprived datazone in West Lothian in the overall SIMD 2012 is S01006416, which is found in Bathgate East. It has a rank of 440, meaning that it is amongst the 10% most deprived areas in Scotland. The figure below shows the national quintiles for West Lothian.

Figure 2.10: Levels of Deprivation in West Lothian in SIMD 2012 by quintile.[49]

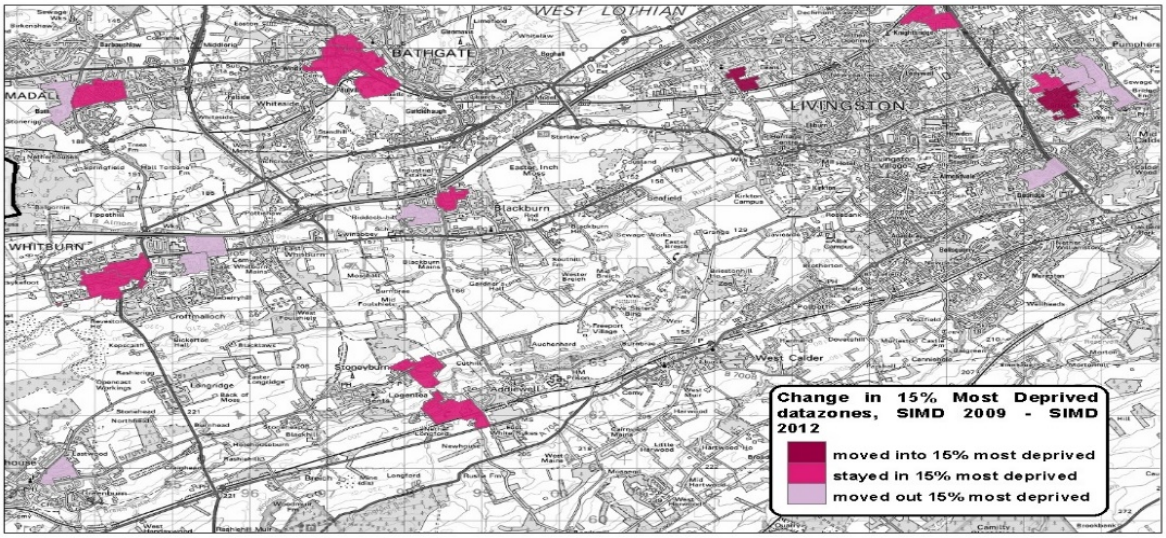


[48] Scottish Government. 2012. *SIMD 2012 Results.* Available at: http://simd.scotland.gov.uk/publication-2012/simd-2012-results/ [Accessed 22 July 2016].

[49] Ibid.

The figure below shows changes in deprivation within West Lothian with areas which have moved into the 15% most deprived, areas which have stayed in the 15% most deprived and areas which have moved out the 15% most deprived areas between SIMD 2009 and SIMD 2012.

Figure 2.11: Datazones in West Lothian Which Have Stayed in or Moved Out of the 15% Most Deprived in Scotland.[50]



SIMD mages courtesy of the Scottish Government

Further analysis of the SIMD (2012) figures is presented in the table below which shows West Lothian as having 6.2% of the 211 datazones in the 15% most deprived datazones in Scotland. This figure is lower than South Lanarkshire (13.3%), Renfrewshire (22.4) and also Falkirk (9.1%).

Table 2.12: Percentage of Most Deprived Zones in West Lothian and Comparison Areas According to SIMD 2012.[51]

West Lothian	South Lanarkshire	Renfrewshire	Falkirk
6.2% (13 out of 211)	13.3% (53 out of 398)	22.4% (48 out of 214)	9.1% (18 out of 197)

2.6 Wellbeing

Mental wellbeing is an essential part of a person's capacity to lead a satisfying life which includes the capacity to make informed choices, study, pursue leisure interests, as well the ability to form relationships with others.[52] The nation's mental health is a key priority for Scottish government policy. In Scotland, mental health is measured within the Scottish Health Survey which adopts the

[50] Scottish Government. 2012. *SIMD 2012 Results.* Available at: http://simd.scotland.gov.uk/publication-2012/simd-2012-results/ [Accessed 22 July 2015].

[51] Ibid.

[52] Scottish Government. 2012. *The Scottish Health Survey*. Available at: http://www.scotland.gov.uk/resource/0043/00434590.pdf [Accessed 16 May 2016].

Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). This scale is made up of 14 separate statements regarding mental health and wellbeing to which respondents answer. A score is then created to determine the person's state of mental wellbeing. The maximum score is 70 and the minimum score is 14, with the higher the score the better level of mental wellbeing.[53] WEMWBS mean scores for both men and women have been relatively static since 2008, with only minor, non - significant fluctuations observed. In 2014, the average mean WEMWBS score for adults (aged 16 and over) was 50. The scores for men (50.1) and women (49.9) were not significantly different. As seen in previous years, levels of wellbeing varied across age groups. Men's wellbeing was lowest for those aged 45-54 (49.1), and highest for those aged 65-74 (51.2). Women's wellbeing showed less variation for those aged 25 and over (49.3-50.5), with lower levels seen for those aged 16-24 (48.7).

Figure 2.13: Warwick Edinburgh Mental Wellbeing Scale Mean Scores (2014) by age group and sex[54]

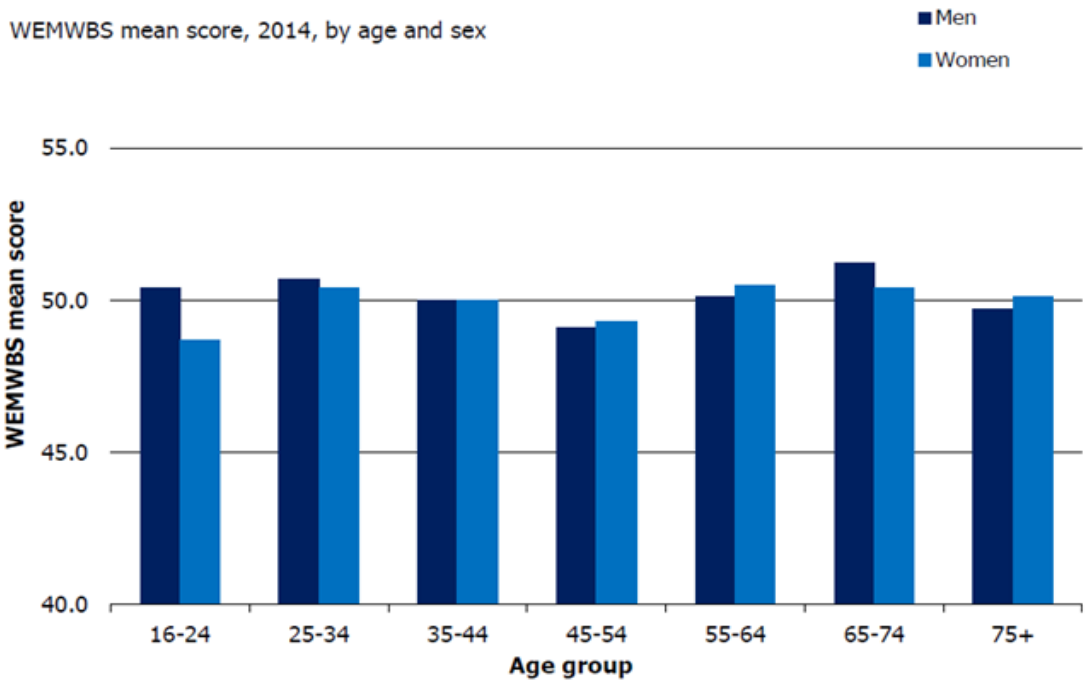


Image courtesy of the Scottish Government

Wellbeing results for each local authority are available from data in the UK Annual Population Survey.[55] To asses personal well-being in the UK the survey uses responses from approximately 165,000 people across the UK, and the publication includes the four following key questions to measure well-being which are answered on a scale from 0 to 10 with 0 the lowest and 10 highest.

The questions are as follows:

[53] Scottish Government. 2015. *Health of Scotland's population-mental health.* Available at: http://www.gov.scot/Topics/Statistics/Browse/Health/TrendMentalHealth [Accessed 16 May 2016].

[54] Scottish Government. 2012, op. cit.

[55] Office for National Statistics. 2015. *Personal well-being in the UK, 2014/15.* Available at: http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23/pdf [Accessed 22 July 2016].

- *Overall, how satisfied are you with your life nowadays?*
- *Overall, to what extent do you feel the things you do in your life are worthwhile?*
- *Overall, how happy did you feel yesterday?*
- *Overall, how anxious did you feel yesterday?*

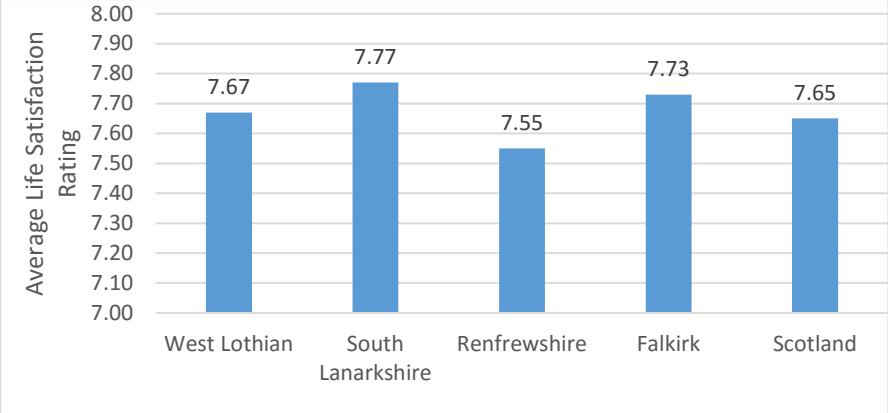
An overview of the well-being estimates is that there has been year on year improvements in reported average personal well-being ratings in the UK across each of the four measures of well-being, with the greatest gain being in the reduced anxiety levels. It should be noted that the survey should be interpreted as giving an estimate of well-being in the UK, rather than an exact measure.

There are mixed results for personal well-being in West Lothian with estimated average figures showing an increase in the reportings of 'life satisfaction' measures (2013/14=7.57; 2014/15=7.67) and 'worthwhile' measures (2013/14=7.81; 2014/15=7.9). Reporting on 'happiness' measures have slightly decreased (2013/14=7.49; 2014/15=7.44), as have ratings of 'anxiety' measures (2013/14=2.71; 2014/15=2.63). Further analyses of personal well-being ratings are presented below.

2.9.1 Life satisfaction

How satisfied a person is with their life is an important aspect of their overall well-being and from the figure below it can be seen that estimates of life satisfaction in West Lothian (7.67) are greater than Renfrewshire (7.55) and Scotland (7.65), but lower than South Lanarkshire (7.77) and Falkirk (7.73).

Figure 2.14: Estimates of Life Satisfaction From the Annual Population Survey (APS) Personal Well-being, 2014/15[56]

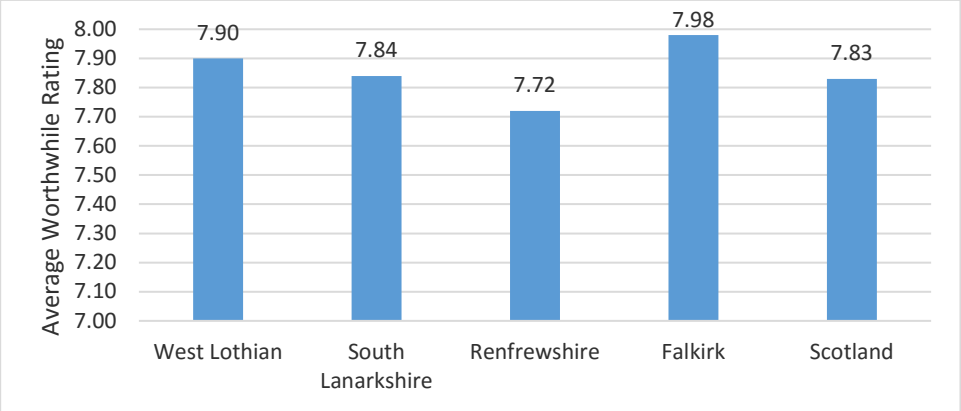


[56] Office for National Statistics. 2015. *Measuring National Well-being, Personal Well-being Across the UK, 2012/13.* Available at: http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23 [Accessed 18 April 2016].

2.9.2 Worthwhile

It can be seen from the figure below that worthwhile ratings in West Lothian are greater than South Lanarkshire (7.84), Renfrewshire (7.72) and Scotland (7.83), but lower than Falkirk (7.98).

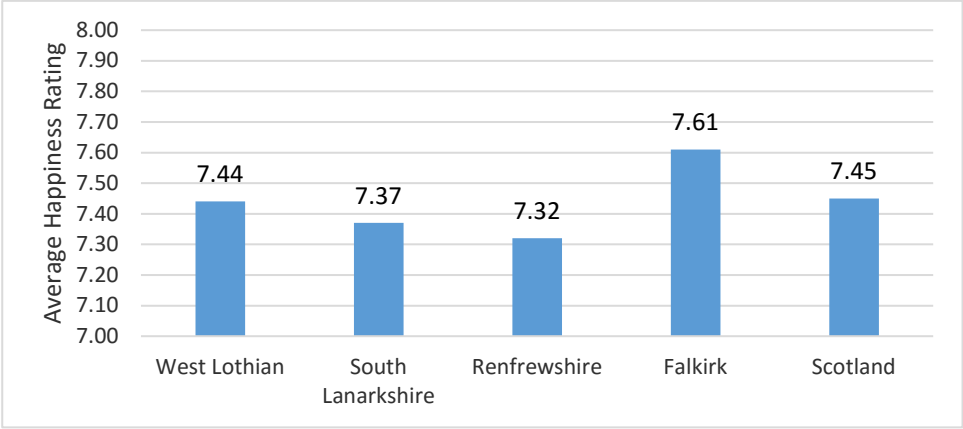
Figure 2.15: Estimates of Worthwhile From the Annual Population Survey (APS) Personal Well-being, 2014/15[57]



2.9.3 Happiness

In regards to happiness ratings it can be seen below that West Lothian (7.44) has greater happiness ratings compared with South Lanarkshire (7.37) and Renfrewshire (7.32). When compared to Falkirk (7.61) and Scotland (7.45) West Lothian's ratings are lower.

Figure 2.16: Estimates of Happiness From the Annual Population Survey (APS) Personal Well-being, 2014/15[58]



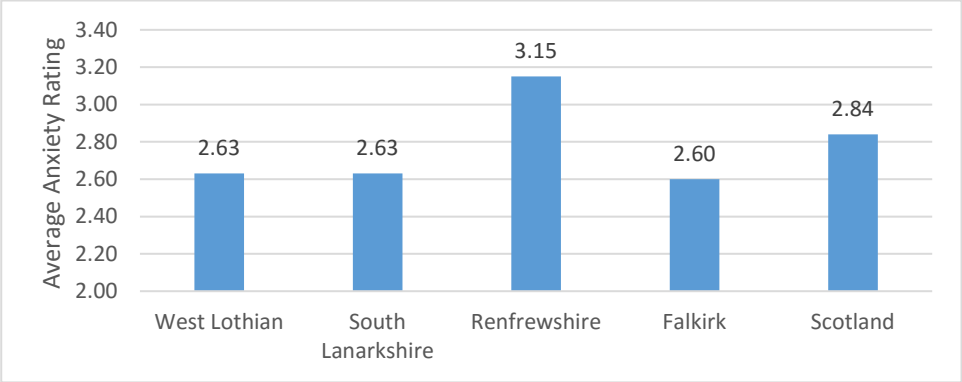
2.9.4 Anxiety

In regards to anxiety ratings, West Lothian echoes ratings from South Lanarkshire (both 2.63). This is slightly higher that Falkirk (2.6), but lower than Renfrewshire (3.15) and Scotland (2.84).

[57] Ibid.

[58] Ibid.

Figure 2.17: Estimates of Anxiety From the Annual Population Survey (APS) Personal Well-being, 2014/15[59]



[59] Ibid.

CHAPTER 3: KEY FINDINGS – PROFESSIONAL VIEWS

3.1 Introduction

This chapter presents an overview of the key findings of each of the mixed methods of the study that focused on the views of professionals:

- Semi-structured interviews;
- Stakeholder Events and Working Groups; and
- Professional Surveys (Service Staff, Dentists, Optometrists and Pharmacists).

For maximum insight, it should be read in conjunction with the full detail of the transcribed groups and interviews, and surveys, which are presented in the accompanying **Part 2 Appendix Report (Appendices II, III and IV)**. These key findings have then been analysed by the research team against the original objectives of the study (see **Chapter 7** below).

To give structure, our analysis of views and what they tell us will be loosely presented under each of the project areas of interest/objectives, and will be divided where possible into Strengths, Weaknesses, Opportunities and Threats (SWOT) to reflect sometimes differing evidence provided by different stakeholders. It should therefore be remembered that not all stakeholders were in agreement, and hence drawing hard and fast conclusions may be inappropriate and disguise the complexity of the position.

Finally, this strand of analysis is based on subjective views and therefore must be combined with the evidence from other sources (such as service users and carers) to provide a more comprehensive perspective.

3.2 Project Objectives

1. Views on the 2012-2015 strategic priorities
2. Views on current services and any community supports that are available as a result of community capacity building
3. Views on accessibility, integration and pathways
4. Views on service user / carer involvement
5. Views on transition
6. Views on resourcing
7. Views on localities
8. Views on what services should look like in the future

3.3 Views on 2012-15 Strategic Priorities

3.3.1 Strengths

In general, the majority of professionals and stakeholders agreed with the thrust and direction of travel indicated in the overall priorities, as far they went, and saw the pursuit of them as being a strength.

3.3.2 Weaknesses

It was noted that, as it stands, the strategic priorities noted do not take account of the fact that the IJB has commissioning responsibility over areas which come under the line management of NHS Lothian – there are therefore significant gaps in this area.

Other general weaknesses noted by professionals and stakeholders, in the form of material omissions within the list of strategic priorities, included the following:

- Dementia care generally (and care for those with co-morbidities);
- Early intervention and emphasis on preventative measures such as those focussing on minimising isolation;
- Tackling access to services – dealing with the challenge of public transport;
- Provision of suitable, flexible and fit for purpose respite care (for older people and carers together and older people on their own), including for those with dementia;
- Support for carers;
- Training and education – upskilling both care staff and family carers to deal with more complex presentations, palliative care and behavioural issues.

3.3.3 Opportunities

In their reflection on the strategic priorities, professionals and stakeholders identified a range of opportunities to make them more fit for purpose:

- Several noted the opportunity to increase community capacity. This was seen to work both ways in that Rosemount Gardens was mentioned as a statutory provision that could be used effectively as a community facility;
- Others also reflected on the opportunity to use the third sector more;
- The opportunity to develop peer support was reflected upon by some;
- Others considered there were opportunities to develop the provision of self-management – particularly in end of life care;
- Finally, many saw the development of the IJB as being an area of potential opportunity in the form of better integration of services and streamlining of provision.

3.3.4 Threats

The current wording of the strategic priorities was noted as being a potential threat. It was noted that there appears to be competition between needs led and service driven priorities resulting in no clear vision.

Furthermore, whilst many did identify the development of the IJB as being an area of potential opportunity, others highlighted what they perceived to be threats implied by this development. Chief among these noted were the potential threat to some jobs and questions pertaining to accountability and reporting lines.

More generally, professionals and stakeholders made several comments pertaining to threats implicit in the setting of any strategic priorities. These included:

- The fact that there is an ageing/retiring workforce which need to be addressed;
- Funding concerns/short-term funding cycles for voluntary organisations which makes long-term planning very difficult;
- The impact of patients controlling their own budgets on SDS which makes the commissioning of services difficult.

3.4 Views on Current Services and Community Supports

3.4.1 Strengths

The professionals and key stakeholders polled generally agreed older people were well served in terms of services and community supports and suggested that West Lothian has strong foundations in care for older people. Specifically mentioned were:

- Acute medical services – the REACT (hospital at home) team and OPACT were singled out for praise and there was also positive comment regarding inpatient acute care and contributions made by the specialist services based at St John's;
- Acute social care services – the Reablement service and District Nursing were also repeatedly mentioned as being areas of strength, particularly in relation to keeping older people in their own home/in a homely setting for longer;
- Technology (Tele-Care / Tele-Health / 'Jointly App' for carers) – was also praised for its role in keeping older people at home for longer;
- Third sector provisions – a range of different third sector organisations were commended such as the Food Train, MOOD, Carers of West Lothian, Alzheimer's Scotland, Macmillan, Marie Curie, Cyrenians and the Red Cross etc. Also seen as a strength was the relationship between the commissioners and the third sector.

- Wellbeing services – the Aging Well Co-ordinator, Xcite provisions, community provisions such as lunch groups and Health Improvement Team interventions were celebrated as areas of strength in terms of early intervention and prevention.

More generally, a range of specialist staff and key stakeholders reported that a strength of older people's services/supports in West Lothian was that they provided person-centred care.

3.4.2 Weaknesses

In reflecting on current services and provisions the professionals and key stakeholders implied there were a range of weaknesses in terms of groups inadequately served. For instance:

- Older people who do not have access to a car / who live in outlying areas were seen to be poorly provided for;
- Stakeholders reported a definite gap in services for older people with severe and enduring mental health problems;
- Relatedly, psychological interventions for older people were seen to be weak;
- Older people with other pre-existing conditions such as learning disabilities and substance misuse issues were also seen by some to be poorly served;
- Support for carers was seen by some to be lacking – for instance there is no independent advocacy for carers in West Lothian since VOCAL lost its funding and bereavement support is also seen to be insufficient;
- A paucity of provision for minority ethnic groups was also noted by various professionals and stakeholders;
- Support for those with dementia was also seen by some to be an area of weakness. In particular, those that mentioned this believed one-year post-diagnostic support was not currently fit for purpose.

Another area of weakness identified by some key stakeholders was that although in their opinion there is a wide range of services and supports available for older people, they questioned how much people actually know about what is available.

Other areas of weakness noted included:

- Staff recruitment and retention – the unwillingness of people today to apply to work in the care industries; the high level of retirement amongst GPs etc.;
- Funding concerns;
- Duplication / overprovision – whilst stakeholders found it difficult to identify many areas of potential duplication/overprovision, one mentioned by some was the overlap in practice in roles within between community mental health nurses; the REACT team and district nurses.

3.4.3 Opportunities

Professionals and stakeholders identified a number of opportunities pertaining to service/support provision for older people, either directly or by inference. For instance:

- Several stakeholders mentioned the opportunity to build on the use of tele-care / tele-health e.g. to deal with social isolation etc.;
- Some professionals noted the opportunity for older people's acute services to work more closely together and with community provisions e.g. OPACT, CPNE and REACT with care homes etc.;
- The opportunity to develop creative solutions to staffing concerns were mentioned by some stakeholders e.g. building on the 'Wise Doc' scheme for using retired GP's to act as locums etc.;
- The opportunity to develop creative solutions to the public transport problem was mentioned by several stakeholders e.g. using a Public Social Partnership / daycare centre transport / extending the Edinburgh community bus scheme etc.
- Several professionals and stakeholders highlighted the opportunity to move away from the commissioning of services/provisions on the basis of age to the basis of need;
- Several stakeholders in both the statutory and third sectors drew attention to the opportunity to develop service monitoring, evaluation and impact assessment;
- Finally, the opportunity to manage discharge from St John's in a more effective/planned manner was mentioned by some stakeholders.

3.4.4 Threats

Stakeholders and professionals noted a range of threats to current service and support provision for older people in West Lothian – some of which have been mentioned under the strengths and weaknesses heading above.

- Staff recruitment and retention – the unwillingness of people today to apply to work in the care industries; and in particular the high level of retirement amongst GPs threatens older people service provision;
- Subsidising public transport – several stakeholders noted the threat to commercial companies inherent in subsidising public transport;
- The need to redesign models of care – many professionals and stakeholders recognised the need to redesign the current model of care, but highlighted several threats inherent in this:
    - this needs political buy-in and will which may not necessarily be forthcoming;
    - with the health and social care integration exercise you may get one governance framework, but that does not mean all the challenges are solved e.g. staff need to know their roles;
    - there is a great deal invested in bricks and mortar – this is a significant challenge in the era of personalisation.

3.5 Views on Accessibility, Integration and Pathways

3.5.1 Strengths

In general, accessibility of older people's services and integration as joint working between older people's services and supports was seen to be an area of strength by many stakeholders. In particular:

- Many third sector services are 'open access' – older people can self-refer to groups such as Carers of West Lothian; MOOD; EARS; the Food Train etc.;
- The way in which social work interact with third and independent sectors is seen to be a strength in West Lothian;
- Numerous examples of good joint working practice were mentioned including the fact that much training/work force development is inter-agency;
- Single Shared Assessments – several stakeholders mentioned the use and sharing of SSA as being a strength in West Lothian e.g. between Community Occupational Therapy and Older People's Social Work;
- Frailty Pathway – the frailty pathway was seen by some to be a good example of an Integrated Care Pathway.

3.5.2 Weaknesses

In reflecting on accessibility, integration and pathways within older people's services in West Lothian, professionals and stakeholders identified a range of weaknesses inherent in current systems and operations:

- Lack of awareness of services available – many stakeholders noted that the major barrier to accessing services is that older people, their carers and professionals in the field are not fully aware of all the services and provisions actually available. Linked to this is the fact, repeatedly highlighted, that most service information is only available online, which is not accessible to all e.g. those with dementia;
- Waiting Lists / Capacity Issues – another significant barrier to access noted by stakeholders was that many services/supports are at capacity (e.g. Carer's of West Lothian/MOOD) and that others, such as older people's psychology, psychiatry, one-year post diagnostic support for dementia, physio and podiatry have long waiting lists. Access to GPs was noted as being a particular problem;
- Dementia pathway – several professionals and stakeholders noted that at the moment the dementia pathway is not fit for purpose; that it is so poorly organised as to be effectively non-existent;
- People still have to tell their stories to many professionals – there was a feeling among several stakeholders that information is still not shared between all the involved organisations (health; social care; third sector; independent providers) as effectively as it could be;

- Pathways and information sharing is ad hoc rather than formalised – some professionals and stakeholders noted that the third sector are not involved in pathway planning / information sharing in any formalised way; that their involvement is more ad hoc and therefore does not happen as a matter of course which was seen to be a weakness of the current system;
- The Single Shared Assessment for SDS cannot be shared as yet – several stakeholders noted IT systems were currently a barrier for the sharing of SDS SSAs;
- The process of assessment for SDS and Carer's was seen be several stakeholders as being too onerous and a barrier to uptake and promotion.

3.5.3 Opportunities

Professionals and stakeholders identified a range of opportunities, either explicitly or by inference, under this heading. Chief among them included:

- Third sector involvement – several stakeholders noted the opportunity to involve the third sector more formally in both sharing information and pathway planning e.g. within the frailty pathway;
- Role of the IJB – several stakeholders noted that joined-up care pathways need to be multidisciplinary and that there is still room for improvement in this area in West Lothian – the opportunity in particular for health and social care to share information more effectively. The IJB was seen by some to be in a position to drive this;
- Involving the community more – some stakeholders highlighted the opportunity to involve the wider community in pathway planning and information sharing e.g. the CPP; the library for video-conferencing for consultant appointments etc.;
- Opportunity to streamline assessment processes – some stakeholders identified the opportunity to streamline SDS and Carer assessment processes to increase uptake;
- Opportunity to unite acute services for older people – some stakeholders noted the significant overlap between mental and physical health in older people and identified an opportunity to link services such as REACT/OPACT/CPNE involvement etc. Another saw advantage in uniting all mental health services for older people.

3.5.4 Threats

A range of threats were also identified quite clearly under this heading:

- Service / organisation culture and ethos – several stakeholders noted that different organisations / services still have different cultures and ethos' (e.g. NHS and social work) which may be a threat to integration;
- Silo working – several professionals and stakeholders highlighted that a number of silo / bespoke services have been created which could be considered a threat to integration;

- Confusion over issues of confidentiality / data protection – some stakeholders noted that information sharing was sometimes threatened by fears over the legislative requirements pertaining to patient confidentiality and data protection;
- Referral criteria – many geriatric services only accept referrals from medical professionals, some stakeholders noted that in order to work effectively, shared assessment etc. requires that geriatric teams accept referrals from suitably qualified social work professionals etc. too.

3.6 Views on Service User (i.e. Older People) / Carer Involvement

3.6.1 Strengths

Many professional and stakeholders agreed that as users of specific services, older people and carers are given the opportunity to give their opinion. It was noted that services send out evaluations, capture informal feedback via case notes etc., and many ask for feedback on a random basis. More specifically:

- Dementia Cafes – several stakeholders saw these as being a strength in West Lothian in terms of offering a forum for consultation;
- Rosemount Gardens – this development was offered by many stakeholders as an example of good practice in engaging with and involving older people/carers;
- Carers Representation – it was noted that there is carers representation at strategic levels e.g. on the CHCP which is seen to be a strength;
- General will – many professionals and stakeholders referred to the fact that there is a general will within older people's services/support provisions to seek and incorporate the views of older people/their carers within service design and implementation.

3.6.2 Weaknesses

Many stakeholders agreed that service user/carer involvement was a goal to aim for, but acknowledged that it is sometimes very difficult. Particular weaknesses noted in this area included:

- Lack of feedback – several stakeholders noted that whilst older people/carers may be asked for their views/opinions, sometimes organisations fail to feedback the results of engagement exercises which can demotivate / discourage future involvement and is therefore a weakness;
- Older People's Forum – the Older People's Forum was not seen to be representative of the demographic it purports to speak for;
- Health – several professionals and stakeholders commented that health are not very good at involving service users/carers at the planning and service design level;

- Monitoring and Evaluation – several stakeholders commented that services are not very good at monitoring and evaluating impact and by implication gathering service user/carer views in any systematic or meaningful way.

3.6.3 Opportunities

Stakeholders appeared to be committed to the concept of involving older people and carers more routinely and identified a range of opportunities which could be exploited in the future:

- 'Catch-All' Feedback mechanism – several stakeholders noted that many older people – particularly the frailest – may be in receipt of numerous services, which means they are likely to be asked for feedback on more than one provision on a regular basis. This can lead to survey-fatigue. The opportunity therefore exists to create some sort of generic / 'catch-all' feedback mechanism;
- Use of staff who have daily interaction with older people – it was noted that carers and staff go in to see people every day and that there is therefore the potential to use these daily interactions to ask for opinions;
- Older person / carer representation on Care Home Forum – several stakeholders noted professional staff populate the Care Home Forum and suggested the potential for resident (older person) / carer representation on this group too;
- Community Engagement Worker – several stakeholders acknowledged that if service user/carer involvement was to be fully embedded in service practice, new posts may need to be created which focus on this.

3.6.4 Threats

In terms of threats to increasing service user/carer involvement in service design and implementation, stakeholders were quite clear in identifying the following:

- Time / workload – the major threats to developing service user involvement noted by professionals and key stakeholders were "lack of time" and "staff workload";
- Tokenism – several stakeholders suggested that there is service user/carer involvement, but warned that often it is at very late stages, when projects are a fait accompli, so can be seen as 'tick box' exercises. Furthermore, others noted that there are insufficient places for service users/carers on fora such as the JIB and CPP;
- Many Fora have ceased to exist – some stakeholders noted that many fora (patient, service user, mental health) have ceased to function which is seen to threaten the interface between the medical profession and the public and thus service user involvement;
- Engaging the most vulnerable – several professionals and stakeholders noted that it is a challenge to engage older people with severe needs and their carers who have very limited time. Linked to this was the point made that the loudest voice is not necessarily the neediest voice and that

caution therefore needs to be exercised when making decisions based on service user/carer opinion;

- Fear – finally, some stakeholders acknowledged that to fully involve service users/carers requires a level of bravery – that very often we do not ask the difficult questions, because we may not know the answers.

3.7 Views on Transition – the move from inpatient services back home / to a homely setting and to community based services

It was noted that the new 'Care at Home' contract has only recently been introduced (January 2016) and is still 'bedding in', but that it seems to be an improvement on what went before in terms of being more responsive to facilitating timely discharge. Other points of note pertaining to this transition included:

3.7.1 Strengths

- Acute community based services – services such as the Reablement Service were praised by a range of professionals and stakeholders as promoting timely discharge;
- REACT service – some professionals saw the REACT service as excelling at facilitating rapid discharge for frail patients.
- Joint working – the REACT and the Reablement Service were said to work closely together to facilitate discharge with REACT dealing with the health needs and the Reablement service providing the social care provision.

3.7.2 Weaknesses

A range of weaknesses were also clearly identified:

- Delayed discharge – despite the aforementioned, some stakeholders did note that there was sometimes still a delay in discharge whilst waiting for a care package to be put in place;
- Lack of awareness of community services – some stakeholders noted that consultants were not always aware of what is possible / available in the community which may delay discharge;
- Closure of Red Cross Home from Hospital service – numerous professionals and stakeholders saw the closure of the Home from Hospital service as being a weakness. This service was seen to facilitate the transition back into the community and prevent readmission.

3.7.3 Opportunities

Stakeholders appeared to believe things were improving in terms of transition, but did identify a range of opportunities for future development in this area:

- Discharge to assess – the opportunity to alter the pathway and discharge patients to a safe, non-clinical setting for comprehensive assessment once medical conditions have been stabilised was mentioned by some. This was seen to free beds for those with medical need and allow for assessment in a more comfortable, empowering setting;
- Plan in advance – some stakeholders suggested there was an opportunity to get better at planning in advance for discharge – to more proactively manage patients. For example, if it takes seven days to get a care package in place, it needs to be organised seven days before the patient is ready for discharge;
- Self-Directed Support - although not mentioned explicitly in this context, it can be inferred from comments made by stakeholders that an increased uptake of SDS should mitigate some of the most significant challenges posed by inpatient/community transitions since competition should encourage services to be more responsive.

3.7.4 Threats

One key threat was however identified – limited resources. Some stakeholders noted the effective operation of services such as REACT and Reablement were threatened in a climate of limited budgets.

3.8 Views on Transition – the transition from adult services to older people's services

In terms of the transition from adult to older people services, stakeholders generally felt (physical) health services were better in their handling of the transition than either mental health or social care. In particular:

3.8.1 Strengths

- The REACT team – this team was praised by stakeholders because access is based on need rather than age;
- Occupational Therapy / Adaptations – similarly, these services were commended as being based on assessed need rather than age.

3.8.2 Weaknesses

The weaknesses identified mainly pertained to mental health and social care provision:

- Frailty Pathway – several stakeholders noted that the frailty pathway should be based on need/condition rather than age. It was also noted that development of the frailty pathway has stalled recently which was seen to be a weakness;
- Gaps – it was noted by several stakeholders that some people aged under 65 who need a support worker may struggle to get one; but that after 65, they may have more options through social

inclusion budgets. Therefore, there is a gap in provision between adult and older people's services with no real bridge between them;

- Mental health services for the over 65s – the fact that adult mental health services e.g. depo clinics etc. stop at 65 is seen by many professionals and stakeholders as being a significant weakness. And putting those in their mid/late 60s into Old Age Psychiatry Wards was also seen by many to be inappropriate.
- Social care provisions for the over 65s – the fact that adult day services e.g. the Ability Centre stops at 65 is seen by many professionals and stakeholders as being a significant weakness – particularly in terms of the risk to isolation, because attendees often lose contact with their friends.

3.8.3 Opportunities

The opportunities stakeholders identified did, in the main, address current areas of weakness:

- Social care provisions – the opportunity to integrate adult day services such as the Ability Centre with older people's day services was mooted by some;
- Mental health service provision – similarly, the opportunity of making mental health services ageless was also raised, although it was acknowledged that this might be difficult since many mental health services are provided pan-Lothian by NHS Lothian and there would therefore be wider implications.
- Frailty Pathway – the opportunity for the Frailty Pathway to ease transitions was noted by some;
- Self-Directed Support – although not mentioned explicitly in this context, it can be inferred from comments made by stakeholders that an increased uptake of SDS should mitigate some of the most significant challenges posed by age-related transitions since services should be personalised rather than block-purchased.

3.8.4 Threats

The main threat to this transition noted was the structure of NHS Lothian. It was acknowledged that West Lothian is only one of four CHCPs which commission services and therefore there will be limits/constraints to the changes which can be made in health service design and implementation.

3.9 Views on Resourcing

Professionals and stakeholders agreed, in the main, on two things when asked about resourcing – that there is a vast array of assets for older people in the community, which was seen to be a strength; and that growing demand / those living longer in poor health, including with dementia, is the biggest threat. More specifically:

3.9.1 Strengths

- Many community resources;
- Good staff teams – many professionals and stakeholders noted that, generally, across the board, staff in health, social care and the third sector are all very committed and willing to work together in the best interest of the service user.

3.9.2 Weaknesses

Weaknesses and threats overlapped quite significantly under this heading, and classification was quite difficult. These two sections should therefore perhaps be read as one:

- Short funding cycles – several stakeholders noted that good innovative services come and go due to lack of continued funding which is not good for people using the services;
- Monitoring and Evaluation – as noted elsewhere, several stakeholders commented that services are not very good at monitoring and evaluating impact which suggests decisions on resource allocation may not always be based on service/provision efficacy.

3.9.3 Opportunities

Two major opportunities pertaining to using resources more creatively were identified by different groups of professionals and stakeholders:

- To work in a more joined up manner – several professionals and stakeholders suggested that in a time of limited resources there is the opportunity to work better together – 'you don't have to reinvent the wheel';
- To develop community assets more – although many commended the quality and range of community assets available for older people, several stakeholders also noted the opportunity to develop this further – to ensure the whole of West Lothian is well served.

3.9.4 Threats

As aforementioned, some of the weaknesses noted above could also be considered threats, and should perhaps therefore augment the following factors which stakeholders identified:

- Growing demand / those living longer in poor health including with dementia;
- Reduced number of people willing to work in the care industry – stakeholders noted that fewer people wish to work in the care industry which is a threat to future social care service provision;
- Staff recruitment and retention issues in health services – many professionals and stakeholders also mentioned the difficulty in finding and retaining well qualified and experience medical personnel. In particular the paucity of GPs, psychiatrists and psychologists was noted;
- Funding:

- Many noted that in the current economic climate budgets for all areas was tight and there was a fear that this would threaten service delivery;
- Focusing on early intervention and prevention is a challenge with restricted budgets. Several stakeholders noted a growing dichotomy – the desire to move resources upstream but because monies are limited there is a tendency to deploy resources at the more acute end – in part this may be due to a better evidence base, but it is also because West Lothian prioritise those at the critical level rather than those at the low or moderate end.

- Political environment – several stakeholders noted many residents in West Lothian are very politically engaged and that there are many pressure groups etc. This makes it very difficult to 'sell' any changes if it means 'stopping' any service provision.

3.10 Views on Localities

Professionals and stakeholders were asked for their opinions on the new localities model. In general, the majority did not believe that the new model was either particularly appropriate for West Lothian or would have any great impact on service delivery. That said, strengths, weaknesses, opportunities and threats can be extrapolated from what was said:

3.10.1 Strengths

- Already working in some service areas – some professionals highlighted the fact that services such as AHPs already do cluster-working after a fashion, and that this is successful;
- Greater flexibility – several stakeholders noted that dealing with smaller geographical areas can provide greater flexibility.

3.10.2 Weaknesses

The major potential weakness, concern (or threat?) highlighted pertained to commissioning priorities. Several stakeholders noted that commissioning should be based on need and gaps rather than geographic split or localities.

3.10.3 Opportunities

A range of opportunities can be inferred from the views expressed by the professionals and stakeholders sampled:

- To align specific services along localities lines – several stakeholders noted the opportunity for mental health services to cluster work in line with the localities model; others noted the potential to make localised REACT / community-type based teams along localities lines;

- Awareness raising – some stakeholders suggested they saw the opportunity to advertise / raise awareness of their service in a more focussed way with the localities model i.e. use different routes/networks in each locality;
- To address inequalities – the opportunity to contribute to addressing inequalities via the localities model was mentioned by some stakeholders. They noted the potential to link in with community regeneration areas and local communities/groups within each locality.

3.10.4 Threats

One major potential threat which may be associated with the localities model can be inferred from expressed stakeholder opinion – the pressure for differentiation. Some stakeholders noted a concern that the localities model may potentially create pressure to have different services in the different localities which may not necessarily be appropriate.

3.11 Views on what services should look like in the future

Finally, professionals and stakeholders were asked for their views on future service delivery. A range of opportunities were identified and one or two strengths pertaining to current direction of travel were identified:

3.11.1 Strengths

- Commissioning plans encourage community capacity building – several stakeholders noted that contracted providers are now expected to have cognisance of personalisation – this means they need to build/access community resources, which is seen as a significant strength, and something to be continued and encouraged in the future;
- New models of care – several professionals and stakeholders explicitly mentioned Rosemount Gardens as example of a new model (Assisted Living Model) which is seen to be an area of strength as it focusses on reablement.

3.11.2 Weaknesses

When reflecting on where to go from here, several professionals and stakeholders noted that many current services are at capacity, and that this is a weakness which needs to be address.

3.11.3 Opportunities

Reflecting the weakness noted above, one of the opportunities for future service development several stakeholders noted was to extend the range and capacity of existing services.

Other opportunities noted included:

- Self-Directed Support – the opportunity to design and deliver services and provisions differently in response to an increased uptake of SDS was also noted by some. Suggestions included:
    - To use SDS budgets creatively for dementia respite etc.;
    - The "Need to develop a 'market'; the need to develop 'real choices'";
- More service user / carer involvement – as noted elsewhere, several professionals and stakeholders identified an opportunity to incorporate service user / carer involvement more comprehensively in future service delivery and implementation.

3.11.4 Threats

Underpinning all conversations on future service design was the realisation that 'more has to be done with less', and that creative solutions must therefore be adopted to deal with increasing demand and static or decreasing resource availability.

CHAPTER 4: KEY FINDINGS – SERVICE USER AND CARER/FAMILY VIEWS

4.1 Introduction

This chapter presents an overview of the key findings of each of the mixed methods of the study that focused on the views of service users, families and carers:

- Focus Groups;
- Service User Survey; and
- Family/Carer Survey.

The full detail of the transcribed focus groups and surveys are presented in the accompanying **Part 2 Appendix Report (Appendix V and VI)**. These key findings have then been analysed by the research team against the original objectives of the study (see **Chapter 5** below).

To give structure, our analysis of views and what they tell us will be loosely presented under each of the project areas of interest/objectives, and will be divided where possible into Strengths, Weaknesses, Opportunities and Threats (SWOT) to reflect sometimes differing evidence provided by different stakeholders. It should therefore be remembered that not all stakeholders were in agreement, and hence drawing hard and fast conclusions may be inappropriate and disguise the complexity of the position.

A SWOT analysis is an examination of a system's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival.

Figure 4.1: SWOT Analysis structure

Some areas figure under more than one theme; for example, where there is evidence of both strengths and weaknesses. Similarly, it should be remembered that not all stakeholders were in

agreement, and therefore drawing hard and fast conclusions may be inappropriate and disguise the complexity of the position.

Finally, this strand of analysis is based on subjective views and therefore must be combined with the evidence from other sources (such as professional views – see Chapter 3) to provide a more comprehensive perspective.

4.2 Project Objectives

1. Views on current services and any community supports that are available as a result of community capacity building
2. Views on accessibility, integration and pathways
3. Views on service user / carer involvement
4. Views on transition
5. Views on resourcing
6. Views on what services should look like in the future

4.3 Views on Current Services and Community Supports

In general, the older people and carers whose views we were able to capture were very complimentary about the range and quality of services and community supports available for older people in West Lothian; they did however identify areas of weakness in current provision and opportunities for future development. Specifically:

4.3.1 Strengths

Older people and carers provided many examples of services and supports they thought work well in West Lothian. For instance:

- Third sector organisations such as: MOOD; Cyrenians Befriending Service; Alzheimer's Scotland (in particular the Dementia Cafes; and Football Memories Club); Food Train and Food Train Extra Service; Macmillan; Carers of West Lothian;
- Specific Health Services such as: REACT; OPACT; The Templar Day Hospital/Ward; the fact specialist consultants from Edinburgh go to St John's; the Community Nursing Service; Diabetic Clinic; Ward 21; the 'balance ward';
- Social Care Provisions such as: Careline; Day Care Services (Braid House, the Ability Centre); Community Occupational Therapy / Adaptions; the falls assessor;
- Services which promote wellbeing/independence such as: Xcite; Dial-A-Bus / Dial-A-Taxi; the Advice Shop (Bathgate);

- Residential provisions such as: Trust Housing Association provision; Bield Housing & Care; and Medicare care home provision.

Both older people and carers also thought that there were examples of good communication between organisations and sectors (health, social care and voluntary sector), but they also noted that this was not universal across the board.

Finally, many older people and carers reported that, generally, service staff were friendly, helpful and treated them with respect.

4.3.2 Weaknesses

Older people and carers implicitly referred to weaknesses in current service/support provision in their reflection on gaps in what is available. Of particular note:

- Several noted there was a lack of services and supports for those with dementia, specifically:
    - one-year post diagnostic support – long waiting lists were reported;
    - early-intervention – i.e. before it gets to crisis point;
    - services for those with early-onset dementia;
    - dementia awareness – particularly amongst professionals e.g. GPs and A&E staff.
- Older people who do not have access to a car / who live in outlying areas were seen to be poorly provided for;
- Services and provisions for those who are experiencing loneliness/isolation are seen to be deficient e.g. befrienders (including for those with dementia);
- Some noted there was a paucity of services and community provision for the frailest;
- Others noted services for those with physical disabilities / sensory loss were limited;
- Services for BME communities were also noted by some as being lacking;
- Others noted services for those with co-morbidities or pre-existing conditions e.g. mental health; Parkinson's etc. could be significantly improved.

Another area of weakness identified by some was that although in their opinion there is a wide range of services and supports available for older people, they questioned how much people actually know about what is available.

Other areas of weakness noted included:

- Care at home provision was seen by some to be unreliable; could be of a poor quality; and was often seen to be unresponsive i.e. not available quickly enough to enable timely discharge from hospital;
- The assessment process e.g. for adaptations etc. and then the subsequent wait for implementation can take a very long time according to some older people/carers;

- Current respite options were seen by some – particularly carers – as not being flexible or responsive enough.

4.4.3 Opportunities

The major opportunities identified under this heading by older people and their carers pertained to awareness raising and physically accessing the services available i.e. transport options:

- Community Navigator / Helpline / Welfare Nurses / Annual Leaflet – many expressed the view that there exists the potential to more effectively raise awareness of services and community supports currently available;
- To improve transport options – suggestions included planning the public transport system to better meet the needs of older people; and introducing a network of volunteer drivers like they have for those who need cancer treatment.

4.3.4 Threats

- The most significant threat to current services and support provisions identified by older people and carers was reduced funding in the current economic climate.

4.4 Views on Accessibility, Integration and Pathways

Older people and carers gave their opinions on how easy it is to actually access services and appropriate supports they need in West Lothian, and on how well services work together. Overall, the picture was positive:

4.4.1 Strengths

Older people and carers generally reported that they could get / access services they wanted, when they needed them. There were however some notable exceptions to this generalisation as detailed in the section below.

Furthermore, it was noted by several that some services can and do work well together e.g. the third sector and hospitals.

4.4.2 Weaknesses

Older people and carers identified a range of weaknesses, either explicitly or by inference, under this heading. Some of these have been mentioned in the section above as there is an overlap between these areas:

- Transport – as noted above, transport to and from services was a major issue highlighted;

- Getting information – as noted above, another significant barrier to accessing appropriate services was that older people and carers did not always know about them. Linked with this is the fact that the reliance on the Internet for communication and information on services is a weakness given that not everyone has or can access it – particularly those with dementia;
- Referral criteria – some services were seen to be very good, but not open to all. For instance, Braid House was seen to be an excellent service, but it is only available to those who live in their own homes – it is not open if you live in residential accommodation, which was seen to be a limitation;
- Getting an appointment with a GP – many advised that it is very difficult to get an appointment with a GP, and that to get an appointment with a particular GP is a real problem;
- Accessing the memory clinic was also seen by some to be problematic and therefore a weakness of the current system.

4.4.3 Opportunities

Whilst many older people and carers noted that some services work well together, others identified an opportunity for more effective communication between services and support organisations.

Other pertinent opportunities mentioned under this heading have been alluded to above e.g.:

- More effective information dissemination – suggestions made included having an annual leaflet on services and community support provisions like you have with bin collections etc. and developing a Community Navigator.

4.4.4 Threats

- Whilst many disliked the fact that service information is mainly available online, it was acknowledged by some that services and community organisations come and go frequently and that keeping service directories up to date is therefore difficult. This fluid picture of support is therefore potentially a threat to ensuring people have relevant and easily accessible information available to them.

4.5 Views on Service User (i.e. Older People) / Carer Involvement

Some older people and carers had strong views on the degree to which they are involved in service design and implementation.

4.5.1 Strengths

Generally, older people and carers reported that they are asked for their opinions on any services they are specifically in receipt of. This was seen to be a strength, although some noted that not every

older person is able to express their views, and some do not have family/friends to speak on their behalf.

Several also noted there is an Older People's Forum (although it's efficacy was questioned by some).

4.5.2 Weaknesses

There was a general impression that older people and carers did not feel that they have many appropriate opportunities to influence service development and improvement at a strategic level in West Lothian. Specifically:

- Many Fora have ceased to exist – some noted that many fora (patient, service user, mental health) have ceased to function which is seen to threaten the interface between the medical profession and the public and thus service user and carer involvement;
- Service User / Carer representation at strategic level – some said that there should be more lay people on the Care Commission etc. / and on the IJB.

4.5.3 Opportunities

The opportunities highlighted by older people and carers mainly dealt with the weaknesses highlighted above:

- There is an opportunity to increase the validity of the IJB by increasing the numbers of lay people on it;
- There is an opportunity to increase the validity of the Older People's Forum by altering its composition;
- Patient advocacy – another suggestion made by some was that there is an opportunity for a patient advocacy service for older people who may not have anyone to put their views across.

4.5.4 Threats

Some expressed the view that fora had been disbanded because professionals – particularly medical professionals – really do not like lay people 'stirring the pot'. It was opined by some that this ethos / dislike of being questioned by non-medical personnel threatened service user / carer involvement and limited influence on service delivery and implementation.

4.6 Views on Transition

Two main transitions were discussed by older people and carers – the move from inpatient services back home / to a homely setting and to community based services; and the transition from adult services to older people's services.

In terms of the former, several services which help smooth the return from hospital to home were praised:

4.6.1 Strengths

- REACT and Reablement service – these services were particularly mentioned as facilitating the transition from hospital to home.

4.6.2 Weaknesses

A range of weaknesses were also clearly identified:

- Delayed discharge – despite the aforementioned, some did note that there was sometimes still a delay in discharge whilst waiting for a care package to be put in place;
- Poor communication – related to the above, some noted that communication between health and social care does not always work very well;
- Closure of Red Cross Home from Hospital service – several older people and carers saw the closure of the Home from Hospital service as being a weakness. This service was seen to facilitate the transition back into the community and prevent readmission.

4.6.3 Opportunities

The aforementioned services which aid the transition from hospital to home were seen to be very effective, thus the major opportunity identified was to further develop these services to reduce delayed discharge.

4.6.4 Threats

The most significant threat to a smooth transition process identified was reduced funding in the current economic climate.

4.7 Views on Transition – the transition from adult services to older people's services

Whilst the transition from adult to older people's services was not dealt with in any great detail, a weakness identified by several carers was that The Ability Centre is a great service, but that it stops at 65. Service users then have to move to a day centre. In an ideal world, these carers noted, this service would go beyond 65 for those capable of still enjoying the provisions and activities provided.

4.8 Views on Resourcing

One of the major concerns older people and carers repeatedly raised was over future funding for services and community support provisions. There were however some strengths and opportunities also noted:

4.8.1 Strengths

Several older people and carers indicated that there are some good services which are well funded at the moment e.g. Carers of West Lothian, the Food Train etc.

4.8.2 Weaknesses

Some suggested the one-year funding cycle does not allow for any development of services which is seen to be a weakness.

4.8.3 Opportunities

Addressing the major weakness noted above, several older people and carers proposed that there should be sustainable funding for commissioned services such as three or five year packages. This should allow services to develop better and meet the needs of older people/carers more effectively.

4.8.4 Threats

A major threat to resources identified implicitly by older people and carers in general discussion was that there is increased need for services and support provisions to deal with this demographic since there is a rapidly aging population in West Lothian. This is a significant threat in the current economic climate.

4.9 Views on what services should look like in the future

Finally, older people and carers were asked for their views on future service delivery. A range of opportunities were identified and one or two strengths pertaining to current direction of travel were identified:

4.9.1 Strengths

Many older people and carers repeated that there are many good services and support provisions currently available so several noted that a future priority should be to protect, maintain and expand the services that already exist to cope with increasing demand.

4.9.2 Weaknesses

As can be inferred from above, older people and carers see short-term funding cycles as being a weakness of the current system which should be avoided in the future.

4.9.3 Opportunities

Reflecting the strength noted above, one of the opportunities for future service development several stakeholders noted was to extend the range and capacity of existing services. This might include for instance, as noted by several carers, providing more flexible respite services, not just for longer periods but for shorter time slots such as a couple of hours to allow a carer to attend a funeral or a GP or hospital appointment.

Other opportunities noted included:

- Improve quality of care – several older people and carers noted an opportunity exists to develop a National Standard of Care for Older People, delivered through a national qualification or assessment;
- More service user / carer involvement – as noted elsewhere, several identified an opportunity to incorporate service user / carer involvement more comprehensively in future service delivery and implementation – particularly at the strategic level.

4.9.4 Threats

Underpinning all conversations on future service design was the realisation that 'more has to be done with less'.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Older people must be viewed as a valuable asset to society and their contribution recognised and valued. Their skills, knowledge and experience are invaluable resources that can be used for positive change for future generations, whilst providing older people themselves with the immediate means to play a full and active part in society. This will in turn encourage older people's independence and enhance wellbeing.

This chapter sets out a series of recommendations for deliberation by the West Lothian Health and Social Care Partnership. Recommendations are derived from evidence gathered and analysed from the review of data, surveys and fieldwork, including study informants.

5.2 Recommendations

The following series of recommendations have been structured around a series of key themes.

5.2.1 Joint Strategic Priorities

- **Recommendation 1:** In future development of Joint Strategic Priorities should be needs-led and not service-led, with a key focus on prevention and early intervention (e.g. minimising isolation).
- **Recommendation 2:** Dementia care in general requires higher prioritising in the future (including respite, training, SDS uptake, etc.). Particular attention needs to be given to improving post-diagnostic support.
- **Recommendation 3:** Given the important role of the Third Sector in helping with the integration of health and social care, consideration should be given to strengthening the current Third Sector Interface arrangements in West Lothian. This review of Third Sector involvement should involve consideration of pathway planning, which has been highlighted as currently being ad-hoc in nature.
- **Recommendation 4:** Given the important role of carers, consideration needs to be given to including 'support for carers' in future priorities (as this was not included in the 2012-15 priorities).

5.2.2 Short-Term Funding Cycles

- **Recommendation 5:** In order to provide the best conditions for sector sustainability and growth, commissioning practices need to avoid short-term funding cycles (e.g. year on year funding arrangements).

5.2.3 Performance Monitoring Framework

- **Recommendation 6:** An urgent review to be undertaken of current performance monitoring arrangements. This should include consideration of mandatory core datasets and the adoption of standard collection tools on a 'comply or explain' basis. Divergence from agreed methods by individual services to require endorsement from the H&SCP Board. The key aim of the review should be to develop and agree an appropriate and proportionate (long-term) monitoring framework to audit performance against both outputs and outcomes, as well as to provide equity of compliance across all statutory and commissioned provision.

5.2.4 Single Point of Information

- **Recommendation 7:** Regular references were made throughout the course of the study (from a variety of stakeholders) to a general lack of awareness of services and supports available for older people across West Lothian. In addition, it is noted that at no point during the fieldwork did any stakeholder indicate their knowledge of the 'New Horizon' document, which is regularly updated (although appears to only be available online). It is therefore recommended that consideration be given to establishing a single point of information for Older People's services and supports, which provides written information in addition to online availability. For example, this is especially important for those with dementia who tend not to use the internet.

5.2.5 Silo Working

- **Recommendation 8:** The challenges created by a culture of 'silo working' by services was consistently highlighted as a problem in West Lothian. A review of opportunities to move away from the practice of 'silo working', alongside the current integration of health and social care agenda, should be undertaken.

5.2.6 Community Capacity Building

- **Recommendation 9:** Consideration needs to be given to realising the significant opportunities for community capacity building.
- **Recommendation 10:** Where future emphasis is placed on community capacity building there will be a need to provide training and learning opportunities for a much wider 'workforce' (including family carers, volunteers, community activists, etc.).

5.2.7 Staffing

- **Recommendation 11:** If future strategic planning for older people's services is to be effective then significant attention needs to be paid to the challenges created by the issues of (1) recruitment (i.e. the difficulty in recruiting new staff into the sector), (2) retention (i.e. the

challenge of retaining staff once in the sector), and (3) retirement (i.e. an ageing workforce is leading to higher numbers of staff approaching retirement age).

5.2.8 Service User Fora

- **Recommendation 12:** The current West Lothian Older People's Forum is viewed by many as not being representative of the demographic it serves and should be reviewed as an urgent priority. Other Fora (e.g. the Mental Health Forum) no longer operate and the gaps exposed by the lack of Service User Fora should be included as part of a review (e.g. places made available to service users and carers on the IJB).

5.2.9 Older People with Severe and Enduring Mental Health Problems

- **Recommendation 13:** The study has highlighted a significant gap in relation to specialist service provision (e.g. Depo Clinics) for older people (65+) who have severe and enduring mental health problems, since Mental Health service provision stops at the age of 65. This requires urgent attention, and due to the ever increasing life expectancy of this particular demographic, as it will inevitably become an increasing demand on resources in the coming years.

  [Note: The above also applies to older people with Learning Disabilities, although the strength of evidence provided in the study was not as strong as that for those with severe and enduring mental health problems.]

5.2.10 Telecare

- **Recommendation 14:** Views were expressed that suggested current priorities to increase Telecare opportunities could be having an adverse effect on the social isolation of Older People. However, it was also suggested that Telecare could provide significant opportunities for helping to connect Older People with a wider range of help and support (e.g. peer support, connection through social media and online 'virtual' activities).

FIGURE 8
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2016

WEST LOTHIAN OLDER PEOPLE'S NEEDS ASSESSMENT

PART TWO – APPENDICES – THE SUPPORTING DOCUMENTS

Report prepared for West Lothian Health and Social Care Partnership

EVIDENCE INTO PRACTICE

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PROJECT ADVISORY GROUP

The research team was assisted by a Project Advisory Group, which provided accountability, guidance and support. This group met physically on four occasions. The research team are grateful for the advice and facilitation provided by this group throughout the duration of the study. This group comprised:

Carol Bebbington (Senior Manager, Primary Care)	Pamela Main (Senior Manager - Community Care, Assessment and Prevention)
Alan Bell (Senior Manager - Community Care, Support and Service)	John McLean (Outreach and Day Services Manager)
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REPORT FORMAT

The report has been written primarily with the practice community in mind. Each strand of data collection and synthesis – dataset reviews, interviews, stakeholder events, working groups, focus groups, and surveys – contains a box with key findings. **To preview this report, the researchers would recommend reading the key findings from each section followed by the final recommendations (Chapter 7 of the Part 1 report).**

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APPENDIX I: DATASETS REVIEW

It is not possible to include this section at this time, as Caldicott Guardian approval has not been received, in order to access NHS data. Once approval is received, this section will be completed and included within the report.

APPENDIX II: STAKEHOLDER EVENT AND WORKING GROUP SESSIONS

Introduction

A Key Stakeholders Event was held at the front end of the research (6th May 2016) to gather views and themes for consideration during the main fieldwork phase of the project. From this Event the recruitment of a small working group took place (see **Appendix VII** for the full list of Working Group members). The Working Group met twice to consider the key messages that arose from the initial Stakeholder Event.

The purpose of thes qualitative elements of the project was to find out:

- Your views on current provision of older people's services and support;
- Any gaps in current provision;
- Your views in relation to the nature and extent of future requirements; and
- Assets (groups, networks, individuals, etc.) across West Lothian.

Key Stakeholders Event (6th May 2016)

The first section of the Stakeholders Event involved small group discussions focused around the following six key areas of investigation:

1. WHAT WORKS WELL - What support and services currently work well for older people across West Lothian?
2. GAPS - What are the main gaps and areas for improvement in support and service provision for older people across West Lothian?
3. DUPLICATION - Are there any areas of duplication in support and service provision for older people across West Lothian?
4. CAPACITY AND INEQUALITIES - Which groups/geographic areas are currently well served across West Lothian and which are not well served?
5. ACCESSIBILITY - What are the current facilitators of and barriers to support/service accessibility for older people across West Lothian?

<u>What works well?</u>

- Carers are being treated as equals
- There is effective joint working between the statutory services and the 3rd sector organisations
- Mood is going really well and there are growing links with the community. The organisation is utilising a social prescribing model about mental health. People are referred who are experiencing MH problems, and there are effective links in to the community

- Mood are effectively working with crossroads, and also good at linking people back into their local community
- Very good partnership working across the independent and voluntary sector
- Living it up service
- In regards to dementia, the HEAT target, one-year post diagnostic is a valuable resource!
- Housing with care – onsite care – flexible to meet needs of tenants on daily basis (sleeping nights only). Able to keep people at home longer because of service. ACCESS NEEDS – link in with Carers WL / Foodtrain → good partnership working
- OT – do housing assessment for allocation based on physical needs – access to council house. New policy for MH too. Close links with housing.
- SW – look to allocate within 2 days. Look to deal within 2-3 days (well within 2wks guidelines)
- Provide good nursing and MH care (Tippit) – too many beds in unit – better in a smaller unit – need the number of beds; but in smaller units
- Palliative service think
- they see the right people at the right time
- good at co-production – joined up thinking →
- more people die at home in WL
- people remaining at home longer
- community palliative care – partnership working → community hospitals
- Integration of services = very good
- very responsive council – very good at planning packages of care for discharge (much better than Edinburgh Council)
- Foodtrain think – WL = very integrated / joined up approach
- Ageing Well Co-ordinators – e.g. Carolympics.
- Food Train working very successful. Accessible and most valued
- Day centres addressing and socialisation
- The REACT team are very good at keeping people in their home; people are treated with dignity and respect
- The Social Work team within St Johns in very integrated with other services
- Very few people are waiting for assessment and care at home
- Dementia carers across West Lothian
- Health in later life (HILL) group – multi-disciplinary strategy group for older people support in West Lothian. Feeds into Health Improvement Alliance / health inequalities groups

- Community care services- providing services which enable people to remain living at home rather than in institutional care (e.g. Carewatch)
- Carers of West Lothian – support for carers at a strategic level / sitter service/ carer support/ carer training
- Respite/ short breaks-Limecroft has good feedback (waiting lists), but different types of respite. Different ideas of what respite is and what works for people
- Have flexi-flats/ sitter service/ Self-directed support
- Ability to build capacity / support to people in the way they would want it
- REACT service-focussed on maintaining people at home
- Reablement service
- Good communication between providers and West Lothian Council

Gaps?

- There are gaps in the provision for older people who have anxiety; because of their age they do not communicate this very well and there is not a straight forward gateway, especially men. This leaves them more isolated
- A significant gap is that there is no gateway through to other wider services for older people. It has to become a crisis before something is done. In each area there should be an elderly person/ gateway person/ connector so other elderly people can speak to her and they can slot people into wider services
- The length of time in systems or referrals-how do we get to the person before the crisis? Easy access should be priority
- There are gaps in the care package some people are receiving. Sometimes people who are in their home all day are waiting hours between seeing people and when they do this is not reliable and there is no continuity in regards to the people who are caring for them I their own home. Also there are times when they are getting their breakfast, dinner and tea at wholly unsuitable hours. Other times all the person can do is make them a quick cup of tea and then they have to move on to the next person in need
- The challenge is there is so much on offer in WL – people often get bombarded upon discharge – too much info all at once → people overwhelmed. The timing issue.
- Not good at co-ordinating what there is – need a key worker to navigate everything (not necessarily a H&SC Worker) – doesn't matter who it is. 'COMMUNITY NAVIGATORS'. Needs to be the right person at the right time. Would help carers too because this is the point where carers get lost.
- All individual systems
- Too many communication routes

- OT might refer to 4 different agencies – not always appropriate
- As society we need to be educated – NHS / SW can't do everything. Needs to manage expectations.
- Housing with care – aging workers 60-70. How do you manage this.
- Some GP's work well and others do not there is not a regular review done for GP's.
- There are gaps when it comes to access definitely, especially when it comes to contact with social workers etc. This is a minefield. It's that initial getting through. It takes far too long; it could be two days before the duty worker gets back to you.
- Another gap lies in the systems we use, we are having to ask people their story over and over again. Someone shouldn't have to tell their story ten times! Can we no introduce a system… some live document that could be added to?
- There are major gaps in funding
- Online resources can be very difficult for older people to use.
- The social work referral document is too long- need to simplify this
- Answer House project, extra care missed
- Preventative services generally
- A service which takes people out in the community (e.g. shopping, coffee, day trips
- Services to address social isolation
- Training and education gap with carers (e.g. dental care)
- Befriending service
- Communication is a key issue between staff/services – access to information on people across different providers (e.g. residential care & dentistry)
- Access to information - no central HUB (different services provide information to people)
- Day Care- barrier to access can be the need to be referred by social work
- There can sometimes be concerns about involving social workers (e.g. in times of crisis), however social workers are also seen as a positive- preventative, maintaining in community, etc.
- Day Care- need social work transport therefore people cannot access directly
- Need to build community capacity
- Need prevention and early intervention
- Increased understandings of opportunities around Self-directed support
- Dementia gaps- single point of entry, interface between health and social care
- Transition from health to social care
- Older people's mental health issue- day hospital at St Johns, but has no other resources

- Support for older people's mental health issues
- Understanding of post-diagnostic support- who is going to manage this
- Nursing support to care homes and liaison between post-diagnostic support and care homes
- Information-sharing between health and social care- - access to shared information would support all service
- Dementia sits within both health and social care – let's look at this collectively
- Communication- people can fall between services, especially as they become more frail. This should be embedded as can be a way of identifying issues early on and referring.

Areas of duplication?

- Sharing information, there are so many areas of duplication. If we shared information things would be easier. All care plans should come with a referral; we should all know who was involved. Sometimes there are workers from other services working with a client but then all the services/ agencies involved are not aware of this. Then we are duplicating work and resources
- More of an issue with accessing provision rather than duplication
- REACT/ OPAT (prevent admissions to ward 3). Both receive referrals because both might have been involved
- Need to consider education/ training for all staff
- CPD training e.g. in dementia, can help to avoid duplication of provision but gap- no significant therapist overnight available
- Multi-agency involvement with one person
- Need a one stop shop
- Need early intervention and prevention
- Shared agreement and ability to arrange services
- Sometimes services bombard upon discharge – lots of people go in all at once.
- Resourcing issue – lots of services can offer small pieces of equipment (e.g. SW/OT) etc. some staff don't know how to do this; others maybe don't have the time; others perhaps don't know they are able to do that. Can then end up with a bit of duplication or a wait whilst unnecessary referral.
- Red Cross Home to Home service – really good. 1:1 point of contact was really good service. Lost its funding.

Capacity and inequalities?

- Many people do not have online access

- Turnover of staff, it's sad but the care sector now is a profit making service
- Linlithgow- you can't get a provider to administer care in Linlithgow- they go on the unmet needs list, they end up taking an NHS bed. Community care nursing staff has reduced
- There are no resources during the night to assist people
- Sometime people are not doing basic needs such as brushing the hair of the client because, 'it's not in the care plan'. There is a total lack of appreciation- people are proud and do not want to ask for help, but the social care worker does not appreciate this
- There are not enough care homes
- Carers are well served
- Services stretched whilst demand is increasing generally
- Independent voting member on the IJB-inequality
- 15-minute care at home service an issue
- People in the independent and voluntary sector staff paid the same
- Access in rural areas (e.g. getting to day care)
- Access to public transport in more remote areas-can impact more on older people if they have no independent transport
- Outreach groups have proved successful in rural areas but have not been able to become fully self-sustaining and so have stopped when funding ran out
- Access to dentistry for frail older people- need to come to a service-not all can be done at home
- Access to a range of services can be more difficult for some older people than others (e.g. those in remote areas)
- Areas of deprivation – great variation across West Lothian
- Dentistry, clinics in remote areas have been closed due to both resource and demand issues
- SW addressed geographic issues re packages of care – bedding in just now
- Areas on periphery of borders – sometimes not well served → confusion → time lag in getting services
- More towards west (Hartheld GPs) - cross borders
- Postcodes vs who empties your bins!
- Free personal care for all; attendance allowance for some
- Sometimes people with money don't get as much → inequality
- MH – inequality of uptake of services
- Some who make difficult/certain choices – don't fit into the boxes → inequalities

- SDS – how well educated are people about it? Do they get the best service for them, or the one that appears to be the easiest for them?
- Those starting to get frail, but not ill-health, but on anyone's radar – don't know where to get the information
- Frailty one of the bigger issues
- Confidence – big issue after falls etc.
- Frail carers – co-dependent
- Need to identify the ones under the radar → understand community routines. Community Assets.
- OVER-SERVED? – package of care on discharge might be too much for the whole 12m (get 6wk review then 12m afterwards). Step-up/step-down model
- Early prevention for those diagnosed with condition age 40-60, but not eligible for older people services. May be able to live quite healthily for years, but problem suddenly at 65ish.
- Services for those not 65! May need a service but may not be old enough to receive one!

Accessibility?

- The bus service has been heavily reduced and it is affecting everything
- There is an issue regarding information sharing – what's available?
- Transport across West Lothian is an issue
- Use of technology- there is a potential barrier if people are not IT literate or do not wish to use technology
- Lack of information of what is available
- There is a need to use plain English so the public understand the information available
- Sensory impairment and hearing loss
- Resources have eligibility criteria which can impact on access
- BME community/ other nationalities
- Need to look at individual need in all areas
- There can be cultural issues, not all barriers are from services/ can be more familiar
- Need to involve social work can be a barrier to people accessing services
- How do we deliver individual care and support to people in West Lothian? Need to explore and address any issues
- How do we ensure people have information so they can look at support that isn't just about health and social care?

- Facilitators – all those around table
- Housing with care – Rosemount – extend throughout WL? More integrate into community Mid-Caulder.

During the second part of the stakeholders event, each of the four small groups discussed five key priority areas they believed should be taken forward for consideration by the proposed working group. The five key priority areas were discussed in depth. Once the five key areas were identified at each table, all stakeholders were then allowed to vote for their top four from all key priority areas identified from all table (20 key priority areas in total). The top five key areas/themes are shown below, with the number of votes received in parenthesis:

- Sustainable funding (14)
- Prevention and early intervention (13)
- Streamlining access to services and support (10)
- Leadership and accountability (9)
- Training and Education (8)

Other priorities are as follows:

- Social Isolation (6)
- Integration and Partnership (6)
- Carers support (5)
- Needs led not age led (5)
- End of life care (4)
- Funding (4)
- Transport (3)
- Age and condition appropriate day services (3)
- Identification of a community navigator (one person to coordinate support) (2)
- Development of a compassionate community (2)
- Support for unpaid carers (2)
- Preparing for older age (1)

Working Group Session 1 (18th May 2016)

Are the key messages highlighted at the stakeholder event a fair reflection of the current position in West Lothian (as headline themes)?

- General agreement they are fair
- Sustainable funding
    - EARS get 3 years funding from West Lothian and commissioners are thinking about extending this to 5 years because they understand how important consistency is especially for older people and they recognise there is a transition period.
- Accountability – there was a general feeling this is very important with the IJB. Who is responsible is a key question.

Are there any missing 'key' messages?

- "Should be needs led not age led"
- Knowing what's out there is key – perhaps a community navigator / hub?
- Social isolation
- Befriending services – for older people AND carers
- Home from Hospital Support – Red Cross used to do this – lost their funding
    - Carers of West Lothian (COWL) part of Public Social Partnership (PSP) looking into this
- Reablement service – waiting list whilst care providers getting ongoing care in place
    - Care provision has now been zoned – seems to be an improving picture, but older people may not want to change provider if they trust whoever if doing personal care etc.
- Peer-groups
- "CPN Care-Home Liaison service was great but it's not operating any longer. It Is a gap though, as you now have to refer back to GP who refers back to psychiatry – it takes time and may exacerbate situation."

Currently, is there sufficient provision of services and support to meet presenting needs? Are the needs and expectations of older people currently being met in West Lothian?

- There is a step missing – "People are thrust into group support – we're missing the 1:1 support first to enable engagement in group work."
- MOOD work a lot with housing support.
- Transitions for adult to older people services – "why change at 65?"

- "NHS are doing not too bad; for once it's in social care its where there is an issue for instance the Ability Centre is only for those between 16 and 64."
- "The social side is failing, there is a lack of choice once you reach 65."
- "MOOD trying to link with community 'stuff' going on, but it's difficult"

Is there a genuine choice of services and support available in relation to range, consistency and quality of provision?

- "There is a choice, the barriers are being supported to engage:
  - Mobility
  - Transport
  - Unawareness of what is available"
- Duplication: around dementia
  - There are around 2,300 with dementia in West Lothian. There is a link worker from Alzheimer's Scotland, there is a problem re workload and waiting list though. COWL have a full time support worker for dementia – she does lots of the same work, but the council can only report what the link worker does, this suggests West Lothian is doing better than is reported.
- "NHS Choices / Inform etc. provides lots of information / databases, but it's all online!"

Are there any particular groups (including 'hidden' populations) of people with mental health problems that you feel are NOT well-catered for in West Lothian?

- Independent advocacy for carers – VOCAL lost its funding
- Services for men – "MOOD do have a men's group; it is under-staffed though"
- BME – are difficulty to engage:
  - Language can be a barrier
  - Getting a translator can be an issue
  - Accessing MECOP difficult

What works particularly well for services and support for older people in West Lothian?

Participants were asked to comment on what works well in older people's service provision across West Lothian by noting their thoughts on Post-It notes. These were the remarks made:

- Third sector provisions such as:
  - MOOD

    - EARS
    - Carers of West Lothian
- Certain health services:
    - React
    - District Nursing
- Certain social care provisions:
    - Home Safety Service
    - Crisis Care
    - Reablement

<u>How effective are the identification, assessment and care management processes for older people?</u>

- "Assessment should belong to the client – they should then decide who to share their information with."
- "It is an improving picture though with the Inter-Agency Information Exchange"
    - Council get referrals through this portal
- "Single Shared Assessment for SDS is not shared as yet; there are IT systems issues":
    - Acute can't speak to primary care within NHS
    - NHS can't speak to Social Work
    - GP practices use different IT systems - NHS Inform / NHS Choices
- Sharing Information – this is a big issue for third sector too e.g., MOOD / COWL
    - Some OTs share assessment with MOOD – "this is really useful as we don't have to ask the same questions all over again. Other times we get no information."
- Carer's Assessment (Carers Support Plan under Carer's Act) – the number of carers assessments which take place is very low because:
    - 17-page form
    - Many carers don't want to be 'assessed'
    - "Flexible respite can only be accessed via a carer's assessment; this is often the only time they are done."
- Formal Information sharing protocol?
    - The council has one – "can share information with health or other service providers as necessary. The inference being, in discussion with the person involved."
    - Horizon Housing have one with the council

- COWL are creating one – it is not in place as yet
- Caldecott Guardian underpins NHS data sharing

How accessible are services and support for older people?

- "People really don't know all that's available"
- Many services are open access:
  - MOOD – because there are so few services MOOD get people coming with whole range of issues including severe and enduring
  - COWL
  - EARS
- Waiting times:
  - Physio and podiatry there are waiting lists
  - Community nursing – no waiting lists
- "If Ward 17 is full, people aged 67-8 are being put in Ward 3 [Older People Psychiatry– mainly dementia], but if you've not got dementia you really need a key worker to talk through your problems this is only available in Ward 17."
- "The biggest issue regarding access is getting a GPs appointment." This is especially problematic if they the gatekeeper for required services. "From a GPs point of view, an ongoing referral may not be a priority."

How well do services and support integrate and work together?

- "Lines of communication between health and social care are there and being worked on."
- "The way West Lothian social work interact with the third and independent sectors is far better than other area's social workers."

How good is accessibility to and integration with mainstream health and social care services?

- Peacock Nursing Home – residents use NHS dentists in community
  - They have to arrange times / escorts carefully to account for staffing/rotas etc.
- The NHS only want to provide podiatry for those with diabetes
  - Peacock have to facilitate / provide private podiatry, but residents have to pay for it and some residents either can't afford to use the service, or don't feel they should have to as they have paid into the NHS all their lives.

Working Group Session 2 (3rd June 2016)

Service User Engagement

- "Some service users / carers are involved; the overwhelming majority are not, however groups and organisations can point older people / carers in right direction."
- Many older people's mental health organisations were unaware of levels of involvement.
- "The Older People's Forum is not a representative sample."
    - Meetings are cancelled
    - The Agenda is what officers put forward and it is chaired by a Councillor
- "Carers are represented at the strategic level and Carers of West Lothian (COWL) are a conduit to consultation with carers in the community."
    - COWL are in contact with 4,500 carers – they have been involved in thematic consultations e.g. SDS, Figure 8
- Peacock Nursing Home:
    - Residents attend consultations
    - There is a Care Home Forum facilitated by the Council. It meets every 4 months. Of 18 care homes, 5 are represented. BUT, it is attended by professional staff rather than by residents or carers. *"We would welcome the involvement of residents in this forum, but many have dementia, so this is difficult."* Care in the Community clients are not represented.
    - Many [family] carers do not engage with the care home.
- District Nursing Team:
    - Work closely with Social Policy Agencies (Reable and Crisis Care)
    - Unit 65+ work with the elderly
    - "On a local level, service users have day to day involvement in shaping services."
    - "In a broader sense there is a variable level of partial integration."
- "There was carer representation on a recent physical disability working group (facilitated by Lesley Broadly). It was noticeable that health was missing."
- Good example of service user/carer involvement – COWL identified carers to attend a Post-Diagnostic Support Event
- Occupational Therapy:
    - Conduct pilots – OT and housing equipment etc.
    - Helped write a dementia leaflet

    - Listen to user's comments as part of the complaints process. The individual complainant is written to and advised of the result of their complaint; practice may be changed if necessary or appropriate (the wider public is not advised). Complaints are not seen as a bad thing because consistency is important.

- Peacock Nursing Home – "the newsletter publicises the number of complaints we've had per month and whether anything has changed."
- Health:
    - On complaints – "it's about lessons learnt. At the local level it may lead to a significant event analysis."
        - in District Nurse teams – "we share best practice / complaints at team meetings"
    - "NHS Lothian has the worse level of complaints in Scotland. They are trying to change this by moving to a more devolved model, but it is a major problem."
    - "One thing about anonymous feedback – you don't know who to feedback to."
- QIF – COWL helped with surveying carers in Ward 17
- Rosemount Gardens:
    - There was service user engagement involved with that.

<u>What does/doesn't work particularly well in West Lothian, in relation to the transition of adults into older people's services?</u>

Community to Acute:

- "The Care at Home contract was revised in January. The aim was to work on the 'bed blocking' issue."
    - "It is a geographic contract. It is very clear who is expected to do what. It is still bedding in – early days, but contractually organisations will be held to this so it is expected to be more efficient eventually." There are now shorter timescales – "we get the impression that this is an improving picture."
        - There are recruitment issues for some companies
        - From a District Nursing perspective, some people receiving care have been told their care provider is changing – there is an option to remain with your current provider through Option 2 SDS.
        - Care at Home provider packages may cease if you are in hospital for any length of time – this is an issue for some older people
            - "West Lothian Council sent out a letter last year to inform people about the change of care providers, but communication was poor – the contact name on the letter didn't know about it. They had to call us back!"

- "The letter didn't say you could use Option 2 to remain with your current provider."

- There are only 12 care of the elderly beds – there can be a shortage
  - "West Lothian does have interim care facility – it is limited, but we are lucky to have them."

Adults to Older People Services/Supports:

- "Some people under 65 who need a support worker may struggle to get one, but after 65, may have more options through social inclusion budgets. Cross Roads for instance provide a service for those with conditions like Parkinson's etc. It can work the other way too though."
- Community OT – there is no age limit; but the focus is environmental.
- Frailty Pathway – West Lothian are working on this. It was generally felt that this *"should be based on condition not age."*
- On the Mental Health side:
  - Clients turning 65 – move to older people's services on next admission
  - "There are lots of younger people with dementia and very few appropriate services for them…it can be a long process for them – diagnosis/appropriate support."

<u>Are there any defined and agreed 'Integrated Care Pathways' within the MH sector in West Lothian?</u>

- There was a general feeling that health and social care works together – that you *"get to see the right person at the right time."*
  - e.g. District Nurses and Community OT work together – streamlining where appropriate
- It is often more informal
- Peacock Nursing Home – *"all residents coming from West Lothian come into the nursing home with good ICPs – this is not the same with every authority."*
  - There is a good rapport with CPNs / REACT etc. – *"We used to be able to refer directly, but now we have to go through GPs"*
  - *"West Lothian is a really good place to work for with the elderly."*
- Re the third sector – MOOD work well with all services, but not formally. *"If you keep yourself open it works well. We always appreciate full information, but obviously we don't have to get it as a charity."*
  - REACT / REABLE carry COWL leaflets with them in their packs
- *"Health and Social Care have done quite well working together in West Lothian."*
  - *"I worry more about the hospital and primary care working together – hopefully the IJB model should work quite well to return better communication."*

- Frailty Pathway – lots of work going on mapping this now. The focus will be on communicating this to the public.
    - COWL are not as involved in this as they would have liked.

What are the key gaps or issues that need to be addressed pertaining to service provision for older people in West Lothian?

- The Third Sector as formal members involved in pathway planning
- For MOOD it is about the networks they have built – but there are lots that have yet to be built e.g. with District Nurses
- "There is guidance in the Single Shared Assessment to let carers know about COWL – but there is a gap about formal involvement in the pathway."
    - There is an issue/concern around sharing information – a fear of data protection
    - "Information sharing is informal. It works where there are good relationships, but it is a bit of a hit or a miss."
- Re post-diagnostic support for dementia – those involved don't know about the other professionals involved.

Where would you like to see future investment go? (Ranked in order of priority)

1. IMPROVING THE INTEGRATION of older people's services and other services
    - Should be based on need/frailty rather than age
2. EXPANDING THE RANGE of existing older people's services
    - MOOD would like to be able to offer a service to adults with mental health issues aged under 55. "It is more about how people use SDS – there is scope through SDS."
    - Staff need to explain SDS and be confident in its application
3. INCREASING THE CAPACITY of existing older people's services
    - "MOOD has a capacity issue – if we advertise we wouldn't cope with demand. We appear to be about the only service offering peer support / social prescribing, yet this is a government priority."
    - COWL - "We are hitting capacity. There is a year on year increase in capacity. We have secured a 3-year Big Lottery grant to support with this and with the introduction of the Carer's Act."
    - On day services – "because more people are staying at home longer with additional supports, day services need additional supports/staffing to engage these people e.g. moving and handling etc."

- Rosemount Gardens – assisted living model. "Staff's only support role is to get people engaged with the community. This should hopefully reduce reliance on specialist services."

4. ENHANCING THE QUALITY of existing older people's services
    - All feedback from District Nursing surveys suggests the service is either excellent or very good
    - Inpatient wards have various different inspections – Mental Health Community Team has not been inspected for a while.
    - Dementia strategies – Commitment 10 – hitting the inpatient wards, not the community as yet
    - Peacock Nursing Home – inspected by the Care Inspectorate
    - Sheltered / Housing with care is all inspected
    - Managers go through the inspection reports for their services
    - On staffing
    - Council – managers have policies in place re absence management. Increasingly there is a demand for all to perform to the required standard to meet the demand
    - NHS has a better training / WFD policy/plan than the council. The council is now tapping in to this.
    - Health & Social Care integration may allow opportunities to develop / learn best practice.
    - "Generally, carers who receive a service are happy with it – it's getting the service in the first place/navigating their way around the system that is often the problem."
    - Focus group for Mental Health Commission
    - It was generally felt that they could do with a report on the community services as well as the statutory ones
    - "When people loose capacity some service users just rail against the system - most respect the social workers, they just don't like what's being done to them."

APPENDIX III: KEY STAKEHOLDER INTERVIEWS

Introduction

In order to ascertain the views of a range of key professional stakeholders, and to explore in greater detail the information and suggestions coming out of the working groups, a series of **XX** one to one interviews were conducted by staff at Figure 8 (see **Appendix VII** for complete list). The majority were conducted face-to-face, but where this was not possible, telephone interviews were used instead.

Topics addressed during interview included reflection on current (now expired) older people strategic priorities; wellbeing and tackling inequality; the locality model; current acute and community services for older people in West Lothian; joint working; and the quality and extent of older people and carer involvement in shaping the priorities and practice of relevant services and supports. These discussions have been combined with information garnered from the stakeholder event and working groups and data from the staff and manager surveys, and are summarised in SWOT analysis form in **Chapter V** of the Main Report.

Current Strategic Priorities

Interviewees were asked to reflect on the current (now expired) strategic priorities as a 'jump off point' (see Figure below) and to provide their views on them. In general, the majority of respondents agreed with the overall priorities, and a summary of key themes is provided below. One interviewee did however note that *"there is quite a mix of needs-led and service-driven priorities. We need to look at our overall vision."* And others pointed out that previous CHCP commissioning priorities had no direct responsibility for the acute/hospital sector whereas; *"now the IJB has commissioning responsibility including over areas which might come under the line management of NHS Lothian."*

Figure x.x: Older People's Commission Plan 2012-2015[i]

Table 6: Older People's Commissioning Plan 2012-2015
Live at Home or in a Homely Setting for Longer 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.
Joined Up Care Pathways Develop integrated assessment and rehabilitation service to support provision of specialist multidisciplinary assessment for older people and timely access to rehabilitation.
End of Life Care Review specialist service agreements. Monitor access to palliative care services for those with non malignant conditions.
Frail Elderly Development Priorities
Comprehensive geriatric assessment and frailty pathway in hospital 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.
Frailty capacity modelling Create analytical model of current systems to assess costs and benefits of proposed changes and prioritise investment.
Mental Health 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.
Supporting health and care in the community 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 *REACT* hospital at home and rehabilitation care pathways to prevent admission and facilitate early supported discharge.

Living at Home or in a Homely Setting for Longer

There was unanimous agreement that this was both the right approach and the direction of travel within West Lothian. Several services and provisions were seen to support this overarching aim such as:

- Technology (Tele-Care / Tele-Health / 'Jointly App' for carers) – e.g. the core package of pendant and button box (tele-care) and 'FLOW' (tele-health) – "keeping people at home longer – all technology is aiming at that." It was however remarked that "the medical profession is still very much focussed on face to face interventions", but that since "GPs are becoming more willing to embrace telephone consultations; video conferencing/photo diagnosis", there is an opportunity to expand the tele-health aspects – "it is essentially a diminution of care, but necessary with reduction in resources."

- REACT Service – "the REACT team are working very well"; "from hospital perspective – has prevented admissions"; "REACT doesn't prevent hospital admissions because they are still hospital based; where they excel is at rapid discharge." The React team also undertake an element of anticipatory care planning – their staff speak to people when they are not in crisis to work out what they want longer term – "The GP model doesn't have the time to have this conversation."
- Reablement Service – "the reablement service is working well [to keep people at home longer] now that staff understand you assist rather than 'do to'."
- Care at Home provision – a new service framework was introduced in January 2016, it is therefore still bedding-in, but interviewees who commented suggest "So far signs are good" that the new system is an improvement on what went before.
- Day Care provision – "a strength"; "day service for those with dementia is important respite for carers."
- Adaptations and building alterations etc. – "confident this has had a significant effect on the flat-lining of the care-home population."
- Third sector provisions – "the Food Train is very successful at linking with local groups to link people in with their communities – keeping them in their homes."
- CPNE support to care homes to help with challenging behaviour exhibited by residents with dementia / Parkinson's etc. helps to keep these older people in a homely setting for longer.
- Falls Prevention Work / Postural Stability – has been "very successful – fewer A&E admissions."

Several concerns and areas for future further development were however also mentioned:

- Isolation:
    - "Living at home is good, but there is the fear of isolation. Some older people like to live in residential living."
    - "Technology won't stop isolation"; however, another interviewee suggested tele-care represents a huge opportunity – "there is the potential to use things like Skype / Facetime to join up lonely people – with their consent – to enable virtual networking. Things like virtual cooking classes could be hosted on Skype etc."
    - "Isolation is as damaging as smoking 20 cigarettes a day [sic]".ii
    - "It's great that we are keeping people at home, but the more we keep people at home the more isolated they get, and that is a worry…"
- Increasing community capacity:
    - "What do you do at 2am?... There's the opportunity to learn from children and families work…lots of work has been done in the regeneration areas to bring the communities together. Adults and older people are attached to these children and families too."

- "We've relied too much on providing rather than supporting the development of community assets. [We] need to get back to some of the community work principles and develop capacity in the community. If we don't, the burden of cost will be unsustainable."
- "Contracted providers are now expected to have cognisance of personalisation. This means they need to build/access community resources."

- Opportunity to use the third sector more:
  - "We need to look at what we wrap around people. There's the opportunity to use the third sector, community supports, neighbourhoods…"
  - The closure of the Red Cross Home from Hospital Service was mentioned as being a significant loss. The service "integrat[ed] people back into community, ensuring they had food; medication and start[ed] to see what they need. By the time the Red Cross left, the person had a care package in place. [The service] helped social work - kept people out of the hospital."
- It was noted that keeping people at home / in a homely setting longer means that carers (professional and family) will have to deal with increasingly complex presentations. A need for workforce development and the upskilling of family carers was therefore also mentioned:
  - "staff / family need really good training…you have to maximise what people do for themselves – it does take longer, and if you only have 15 minutes to get someone dressed you may not have the time to do this."
  - "it's important staff understand the basics of everything around the person they are caring for."
  - "there's an opportunity for nursing homes to do initial medical 'stuff' [sputum, blood tests, urine etc.] before they call in specialist health/mental health services."
- On Day Care Services:
  - "SDS is becoming a challenge for day-care, people are using their budgets for other things. There are signs people are voting with their feet."
  - "There's lots invested in bricks and mortar – a challenge in the era of personalisation."
  - "Feedback from carers – reduction in days hasn't been helpful for them."
  - "There is an opportunity to make some of it therapeutic to teach carers [especially of dementia patients] behavioural support techniques as they are doing the vast bulk of caring."
- On Step-Up Step-Down Care Provision, a variety of comments were made:
  - Housing with care was seen to be a good form of step-up step-down provision "as people can get a little more support at times when it is necessary – it's responsive, but it must be 'stepped-down' when it is no longer needed."

- "There's the opportunity to develop step-up step-down, thinking about how we use community beds (in hospital and care home settings) and how we link with REACT. We need to work out what we think we need and test it."
- "Step-up step-down – this needs looked at…it doesn't exist in West Lothian"
- "Step-up step-down is very important – a couple of community hospitals could work there – potential to use care homes in a planned or elective way too."
- The opportunity to use technology to facilitate / support step-up step-down was also mentioned.

Joined Up Care Pathways

Where it was explicitly mentioned, interviewees believed integrated multidisciplinary assessment to be an important strategic priority – often linked with the comprehensive geriatric assessment mentioned under the Frailty Pathway. Specific comments made included:

- "Joined up care pathways need to be multidisciplinary. West Lothian is not far enough along here – the IJB will drive this. There is a bit of work to do on this."
- "Perhaps REACT and OPACT should be linked together; there is a big overlap between physical and mental health in older people so division is artificial."
- "Joined up care pathways are a really progressive move – with post diagnostic dementia support this is what is being attempted, but there is an opportunity to do this better." However, also noted was that "Joined up care pathways from a dementia point of view are not as well developed."; and that currently "case allocation / triage very consultant-led; other areas are much smarter, using Senior Nurses."
- "Who's patient is it? Primary Care's usually because most are registered with a GP/district nurse. The patient should be 'owned' by primary care; go into hospital for an acute episode; have their personal care plan updated; be discharged to primary care."
- "Medics should trust their social work colleagues…geri-teams should accept referrals from social work."
- "If a SSA is completed by an OT we share it with older people's social work. Likewise, we ask them to share if one has been done in the last 12 months."
- "Housing with Care Managers can now access simple OT equipment like Mowbrays. Before it had to be via a referral to OT…[aim] to reduce the number of assessments required."
- "We need to be clear what we mean to service users. [We're] not very good at engaging service users where it goes wrong – asking them what they want where it goes wrong."
- "We still need to get better at reducing the number of times people have to tell their stories."

- One interviewee also mentioned that third sector (such as COWL) should be formally involved in multidisciplinary assessment, meetings and decision making. "We really need integrated pathways so organisations know where they fit in each process – it's ad hoc at the moment."

End of Life Care

This was also seen to be key, and some interviewees noted a difference in current provision for EOL care for cancer patients compared with non-cancer patients. Generally, EOL palliative care for cancer patients was seen to be good:

- "Macmillan and Marie Curie do excellent work"
- "Less and less people are dying in institutions"
- COWL are beginning a joint piece of work with Marie Curie to help support carers of those with terminal/life limiting conditions longer term.

Although it was noted that Allied Health Professionals were not involved in the previous review of Service Level Agreements with Marie-Curie which they saw to be a limitation.

Conversely, EOL palliative care for non-cancer patients was labelled by one interviewee as "dysfunctional". In part this was seen to be because "there is no societal uptake for EOL acknowledgement. People with non-cancer conditions don't see themselves as terminally ill because of the course of their illness."

The above withstanding, also noted was that there is no hospice in West Lothian – they "tend to use hospital beds as EOL facilities."; and that "Inpatient palliative care may be lacking."

Also mentioned under this heading was EOL in care/nursing homes:

- They are "not particularly well equipped to deal with this difficult time. There's the opportunity to develop this aspect of care a lot more – I envisage doing this with the third sector too."

Frail Elderly Development Priorities - General

Several interviewees noted that "the frail elderly programme has stalled a bit to date". A couple of general comments were made under this heading (noted below) – there were, however, no recurring themes:

- Prevalence modelling: "We need to know exact levels of frailties. We have ages, but not necessarily frailties. It is a quiet population until they reach crisis."
- "There is a huge opportunity for psychology to work really effectively with other services to improve the quality of health care for the frail older person."
- "There is a growing population of older people with increased complexity. Recent legislative changes (AWI Assessments) are putting additional demands on services [MHO]. Guardianship Assessments are growing."

- "It would be good if community OT could be part of this."
- "I would like to explore / get to a position where we discharge to assess because I am not convinced the hospital environment is conducive to reablement – it's very clinical with people doing to you. Where long term care in a care home is being considered there should be an alternative pathway and this should be done outwith the hospital setting – where they have the information and feel more comfortable i.e. being discharged to a care home setting on an intermediary basis. Social work staff could then work from there, with physios/OTs etc… Having options depending on the level of frailty."

Frail Elderly Development Priorities – Mental Health

Several interviewees mentioned behavioural support as being a key priority:

- "Dementia behaviour support service is vital in the community…care home staff are not trained up sufficiently to deal with this"
- "Need to extend challenging behaviour support for carers – dementia / MS etc."

And one interviewee thought "Mental health and daycare should perhaps work in a more integrated way," going on to note, "joint daycare services work."

There were also several comments made pertaining to one-year post diagnostic support for dementia patients. Generally, interviewees thought "Post diagnostic support is an area of concern" which could be developed and made more effective:

- "Senior leadership between the Council and the Health Service is needed to understand /implement a coherent approach to the delivery of Post Diagnostic Support across West Lothian."
- PDS "is a bespoke model at the moment – it's not sustainable…[we] need to expand the scope to deliver this support."
- "Development of the IJB means Post Diagnostic Support is very locally driven. This can lead to local services. This could lead to some Post Diagnostic Support being less effective."
- "One year post diagnostic support for dementia is happening, but staffing/resources means it's a challenge to meet targets."
- "One year post diagnostic support discourages diagnosis because it kicks in as soon as you have a diagnosis."
- "CPNE may already be on-board – isn't that post-diagnostic support? Memory treatment may already be on-board – isn't that post diagnostic support? OT may already be on-board – isn't that post diagnostic support? There may be duplication."
- "Post diagnostic support is poor. Joined up support is very difficult. [There is a] waiting list for the service – up to a year."

- "Post diagnostic support for dementia feels so poorly organised, it feels like there is no pathway at the moment."
- "Post diagnostic support only lasts for 12 months, but it's often much later that carers need help/support – at the aggressive stage; at the wandering stage."

What is Missing?

Interviewees were also asked whether they thought there were any significant omissions to the strategic priority list. Several were noted:

- Dementia Generally (and comorbidities)
    - "Dementia needs to be higher up the agenda. Diagnosis is still poor; post diagnostic support poor"
    - "Those with dementia [are] not getting a good medical service"
    - "Those with dementia and physical conditions [are] not getting a good medical service"
    - "Dementia – huge numbers involved"
    - "Dementia – a challenge"
    - "Levels of dementia are expected to grow. There are gaps here."
    - "Early intervention is an issue. Probably don't do as much as we should."
    - "We need a refreshed, jointly agreed approach regarding how to commission dementia services. We need to understand commissioning means personalisation."
- Preventative Measures such as befriending services etc. to minimise isolation
    - "Reducing isolation / loneliness would be my number one priority"
    - "Groups are needed to tackle social isolation…"
    - "Isolation is paramount."
    - "Emotional wellbeing needs to be a priority"
    - There are high levels of isolation in the deaf community – "lip readers are an understated equalities group."
    - "There is a will to invest in prevention, but the practicalities can be difficult. Many of the challenges are the same across all client groups."
- Access / Transport
    - "Transport is a real barrier"
    - "Transport is a real issue in West Lothian."

    - One interviewee suggested using the daycare buses to ferry people to Xcite classes; another suggested extending the community bus service currently operating in Edinburgh to West Lothian.
    - One interviewee did however note that "you can't do 'stuff' that'll put the commercial companies out of business."
- Respite (including for those with dementia)
    - "Respite is missing [from list] – it's key to maintaining people in their home"
    - "The respite needs to be meaningful and of a good quality."
- Support for carers
    - "Support for carers should be given higher priority – elevated a bit – if you want to keep older people at home for longer."
    - Local authority duties under the new Carer's Act
- Several interviewees noted that West Lothian should adopt a holistic GIRFEC-type model for adults/older people which addresses wider health and wellbeing including poverty etc. – that commissioning should be based on need not age.

Wellbeing

Since the IJB Strategy also emphasises the promotion of wellbeing, interviewees were asked for their views on this. Generally, it was opined that the notion of wellbeing is "embedded in policies"; that "West Lothian provide good resources for wellbeing"; and that the commissioners "do look at upstream investment to try to prevent crisis, and that the Aging Well Coordinator does a lot in this regard." One interviewee also remarked that "Wellbeing is the ultimate driver for everything."

Specifically mentioned were services/provisions such Xcite; the Aging Well Coordinator; the Care Activity Network in Care Homes (comprised of Care Home Activity Coordinators); the Health Improvement Team; and the See Hear Strategy. It was also noted that "everything which comes out of the CPP is underpinned by wellbeing"; that "interface with all partners in the CPP is crucial", and that there is "an understanding the strength of your local community enhances wellbeing."

A couple of interviewees did however sound notes of caution:

- "We do need to target this though [wellbeing services/provisions] with limited resources."
- "Wellbeing has the expectation of moving funding upstream with all the aforementioned challenges i.e. because we have limited resources there is a tendency to deploy resources at the more acute end – in part this may be due to better evidence base, but also because we prioritise those at the critical level rather than those at the low or moderate end."

Tackling Health Inequalities

Similarly, the IJB Strategy also emphasises the tackling of health inequalities so interviewees were asked for their comments on this too. It was generally acknowledged that there are significant health inequalities within West Lothian (10 years' life expectancy difference across the area), but that that there is a clear commitment to address this. One interviewee noted "The strapline for the Health and Social Care Partnership and IJB and CPP is tackling inequalities. We know we have a big gap; we also know that it's very difficult to make a difference and that it takes a long time."

In terms of what can and is being done in this regard, one noted that it was all about "clinical engagement, community engagement and what we can do to promote community capacity building." That it is "about driving things from the bottom up", but that there is "no magic solution" and "some real political minefields about what people can have a say about (i.e. some things are universal; some things are needs led)."

Interviewees noted that the localities model is one way commissioners will attempt to reduce the inequalities gap (see below) – but only one way. The feeling was expressed that intuitively – there is no benchmarking – West Lothian "do a bit better at being accessible to all because services have a good reputation (especially social care services) …because West Lothian have invested in low cost interventions (including with third sector partners – there are 1,000+ community resources that can be mapped just now) that are not intrusive but are effective."

Groups Well Served / Not Well Served

Interviewees were then asked whether there were any groups (either geographic or presenting with specific illnesses/frailties) that are either particularly well or poorly served by existing arrangements.

Groups Well Served

- It was suggested that crisis support for older people is good in West Lothian (OPACT / REACT).
- Other groups which were mentioned as being well served were terminal cancer patients (EOL palliative cancer care).

Other comments made were:

- "There are lots of community groups going on out there; 50+; lunch clubs; church clubs etc."
- "Dementia is well supported in the community; Memory Clinic and Alzheimer's Scotland. The same is true of Chest, Heart and Stroke."

Overall it was suggested that "Those getting support [are] given holistic support, from all services. Once they are on the radar, there's a whole range of services for them and these are well joined up."

Groups Not Well Served

A range of groups were seen to be not so well served currently. These included:

- Older people who do not have access to a car / who live in outlying areas. Comments were made such as:
    - "Transport is a real issue in West Lothian…our venues are great [leisure facilities], but they are not easy to get to – you need a car."
    - "Few people can make a 9am appointment at St John's if they don't drive."
    - "Some small villages on the outskirts e.g. Breich have no services."
    - "It's more challenging in outlying villages – there's not a lot going on there."
    - "There is a barrier to access[ing] services and that's transport."
- It was however also noted that the council has subsidised some of the small, rural lines to help prevent isolation, and that this remains an aspiration, but a challenge in times of limited budgets. One interviewee said, "we need to be creative – look at community transport…we are currently looking to find solutions to transport for third sector day-care provision – a Public Social Partnership."
- Older people who are "not on anyone's radar."
- Older people with severe and enduring mental health problems:
    - "Mental health services shouldn't stop at 65; people should get a service based on their needs – we need to ditch this age barrier to services and make decisions on a person's care based on the issues and their illness."
    - "There's a depo clinic for the under 65s, not the over 65s – why not? This will become an increasing problem. They are just picked up as an afterthought at the moment."
- Older people requiring psychological interventions:
    - "The provision of psychology for older adults in West Lothian is less than required, and less than the rest of Lothian; particularly given the levels of deprivation."
    - "Nobody in West Lothian is trained in psychological treatment for older adults; how to adapt their approaches. Some trained in psychology in Adult Mental Health, but don't understand the impact of cognitive impairment."
- That withstanding, it was also noted that "In older adult services no one waits over 18 weeks [for psychology]. Psychologists have prioritised that."
- Those with dementia who also present with challenging behaviour:
    - "There are those with dementia who are engaging; others that are more challenging and they don't get a day service – they are referred back to mental health."
    - "West Lothian is not able to participate in the Behavioural Support Service (in Edinburgh and East Lothian). This works with organisations to take people with advanced dementia; such as care homes. It houses organisations to manage difficult / challenging behaviour; for example, sexually disinhibited behaviour as a result of dementia. It has

been a very successful team, showing an exponential reduction in distressed behaviour in patients and carers."

- Those with non-cancer terminal / life limiting conditions.
- Carers for those with dementia:
    - "With dementia the numbers involved are huge. COWL support 100 carers – we could double this if we had the resources."
- One interviewee also noted that if people are admitted to hospital with a social care rather than a medical need they may not always get a good service because "nurses don't have those skills."

Localities Model

In line with national legislation, West Lothian has been split into two localities – East and West (along data zone lines). Interviewees were asked for their opinions on this development and what it might mean for older people's services and provisions going forwards.

Generally, interviewees did not believe that the localities model was either particularly appropriate for West Lothian or would have any great impact on service delivery because "geographically West Lothian isn't a big place", and only has 160,000 residents.

More specifically, some services such as AHPs already do cluster-working after a fashion so did not see the localities applying particularly.

Some opportunities were however noted:

- The potential for mental health services to cluster work in line with the localities model was mooted by one interviewee.
- Another suggested that "with localities and GP clusters there is the opportunity to make localised REACT / community-type based teams."
- To deal with inequalities: "We need to link with community regeneration areas and there is the opportunity to link with local groups / CPPs [in each locality]." / "There will be opportunities for communities."
- "Might find particular routes [in each locality] through which we can raise awareness of our service [COWL]"
- "Dealing with smaller geographical areas may lead to greater flexibility…"

Some fears were also noted though:

- "I fear it will create pressure to have different services in different areas that don't have different health concerns."
- "…we should commission services on the basis of need and gaps; may or may not be locality."

Acute Services

Interviewees were asked to comment on the strengths and weaknesses of acute services for older people in West Lothian. As many of the comments above have reflected, it was generally agreed that acute/impatient services are, on the whole, good. Some challenges were however noted:

- "St John's works well, but there are challenges depending on the time of year (peaks in terms of pressures) and challenges regarding discharges. The frailty pathway should improve this."
- "On discharge planning – bed management is a challenge. [It gets to] crisis point on a regular basis, which leads to a lot of stress on medical staff. This places demands on others…we need a discharge to assess model."
- "Need to plan in advance - more pro-actively managing patients. For example, if it takes seven days to get a care package in place, it needs to be organised seven days before the patient is ready for discharge."
- "Sometimes acute services don't understand what can be managed in the community."

Community Services

Similarly, interviewees were asked to comment on the strengths and weaknesses of community services for older people in West Lothian. Again, as noted above, interviewees were largely complimentary of the community supports available – those provided by heath (such as REACT, Xcite, the Memory Clinic), social care (such as the Reablement service, OT) and the third sector (such as MOOD, COWL, Alzheimer's Scotland, the Food Train).

The opportunity to "use libraries intelligently" was also mentioned – "potentially using libraries for video-conferencing for consultant appointments etc."

The comment, "services are good – there just needs to be more of them" was made. Conversely, another interviewee remarked that "one of the issues is, there is such a wide range of services out there – how much do people know about what's available."

However, another interviewee noted, "there is a fair amount of duplication in community services…[we] need to invest more in an outcomes focussed approach."

Links and Joint Working

Interviewees were asked to describe the effectiveness of links and joint working with other relevant disciplines. Generally joint working was seen to be very good, and numerous examples of good practice were mentioned, some of which are noted below:

- Occupational Therapy work with a range of organisations such as district nursing, REACT, and refer to the third sector (such as the Food Train and COWL) as appropriate. "The OT assessment is holistic and we ask if all benefits are being accessed and provide lists of council approved cleaning services etc. if required. We work with Education and offer placements / work

experience with schools like Pinewood…[also] have volunteers in a few of the units – some individuals with disabilities clear tables etc."

- "All networks work inter-agency. Most training is inter-agency. Reflective practice is inter-agency. Care Plans are never reliant on one group or person – everything is designed to be integrated."
- "Links with housing work very well."
- "Services/provisions have a 'can do' attitude. Nurses, doctors, social care – everyone rallies…There are good workforce teams – people know each other. We're very good at picking up the phone to each other and working together. But we don't necessarily underpin this structurally."
- REACT and the Reablement Service work closely together – both in hospital and in the community. "REACT do the health bit; we [Reablement] do the care bit to prevent admission into hospital…or to enable discharge from hospital. It works well – rarely have delayed discharge, but in times of limited resources this is becoming increasingly difficult."
- The Advice Shop works in partnership with Alzheimer's Scotland and Macmillan Cancer Support – "We have a referral system with Alzheimer's Scotland and The Memory Clinic…also do outreach at Carers of West Lothian; this has been so successful there we are changing from monthly to once a fortnight…think we should still be working better in partnership across all services for older people."

But some interviewees sounded notes of caution:

- "Services are not as integrated as we think they are – social policy, education, mental health services, older people's services – there's the opportunity to much better join up services."
- "Sharing of information could be more streamlined."
- "People want to work together, but come from different perspectives."
- "Communication needs improving between health and social care – they operate at different rates; have a different approach – health more reactive; council slower but more methodical."
- "People are great at working with their own particular area of expertise; we need to join it all up."
- "We need to join all the bits of the jigsaw together."
- "We need to involve the community more in the future…there are real opportunities with the wider CPP (West Lothian College; Fire Service; Police etc.)"

Quality and Extent of Service User and Carer Involvement

Interviewees were asked to describe the quality and extent of service user and carer involvement in shaping the priorities and practice of services for older people in West Lothian. A range of views was expressed covering both the strategic and specific service level.

Some felt that "service user / carer involvement is slightly better than average, but there is still room for improvement." Another comment made was that "West Lothian Council is getting better at involving service users/carers in consultations e.g. with Rosemount Gardens, but that it can be very difficult."

Many interviewees agreed that as users of specific services, older people and carers are given the opportunity to give their opinion. It was noted that services send out evaluations, capture informal feedback via case notes etc., and many (such as REACT) ask for feedback on a random basis. More specifically:

- One interviewee advised that Health have signed up the Commitment for Excellence Award / Quality Improvement Framework (QIF) and that part of this is engaging with the public. Another said "the council are much further forward."
- Other interviewees remarked that service complaints and compliments processes are a good way of gathering service user/carer views.
- AHPs are piloting 'patient shadowing' as a method of involving service users and carers.
- OT pilot new items e.g. a new bath hoist was recent trialled.
- Each residence has a Tennent's Committee
- "We are proud of the dementia cafes we have in each ward – they are a useful way of engaging for consultation."

Some interviewees actually stated they thought "People are surveyed out"; that "There are many – maybe too many requests for people to complete questionnaires…there is a high proportion of older people who just want to access services; many don't want to be involved in user forums etc. – they may comment on their experiences, but there are too many requests." This led to a suggestion that perhaps a 'catch all' service user / carer feedback mechanism could be devised.

Other interviewees raised a concern that "we never feedback to people and ignore what they say if it's not born out by fact. For instance, if they say they are frightened of going out, we just ignore it because the crime rate is actually low." Another mused, "In my experience I think views are listened to, but I don't know whether that would be the views of the people in West Lothian."

At the strategic level a variety of observations were made:

- "We have a strong carer organisation which is represented on the CHCP"
- "West Lothian should perhaps have a service user and carer representative on the CPP as well as the Gateway."
- "Older people do have representation, but it could be better – there is a danger of tokenism."
- "I don't think there are enough spaces in each of the groups"
- "At the health level, there isn't particularly good engagement at the planning and service design level… We're not very good at setting up focus groups / fora. It's an area for improvement."

- "We are probably weakest in this area…have a good sense from a small number of people, but don't have participation in the design of services. We don't have a designated expert around communication and engagement; reliant on staff who do other things."
- And another was explicit that "we do no co-production – we ignore the Christie Report."

There is an Older People's Forum, however the model may not be meeting the needs of the demographic it ostensibly represents according to the feedback received from various interviewees:

- "These are not the people we provide services for"
- "It's a challenge to engage older people with severe needs"
- "The Senior People's Forum is very political because it has councillors on it"

Many acknowledged that there is the opportunity to engage with service users and carers more effectively going forwards:

- "We should go to people (service users / carers) at early stages, not when it's a fait accompli."
- "We have carers and staff going in to see people every day – there's the potential to ask people's opinion…but this might not be possible with such time constraints for care providers."
- "We need to empower people – this includes asking people how they want to spend the money."
- "We need to be more confident in our engagement with service users and others. Really listen to what people need; could reshape services. This might bring efficiencies. This is where social capital is important."
- "Need a community engagement worker – could feed in better the views of older people."

Notes of caution were raised by several interviewees however:

- "It's difficult to get opinions out of people, and the loudest voice isn't necessarily the neediest voice. Decisions should be made on need, not reported need. Service user opinions should be sought, but decisions should be taken one step away from this."
- "Officers would like to have more time to engage with these individuals / groups, but there's a lack of time."
- "To get real carers to engage with consultation processes is a real challenge because they are so busy."
- "Very often we don't ask the difficult questions, because we may not know the answers. We may be unwilling to ask, as [it] may be a challenge."

Other Points of Note

Interviewees were then asked whether there were any other Strengths, Weakness, Opportunities or Threats pertaining to older people's service provision that had yet to be commented on. Responses to this have been thematised below:

Structural Management

A range of observations were made which, broadly, fall under the heading 'structural management'. These include:

- Discharge to assess – assessing people outwith a hospital setting.
- "Old Age Mental Health should be one team – this would cover staff sickness too. Splitting into psychology, psychiatry, CPN…isn't helpful – maybe include social work in this team too."
- Reduce silo working:
    - CPNE as a generic – perhaps HUB service: "keen to talk of HUB to cover sickness and 22% annual leave / training etc.";
    - CRABIS OTs reintegrated as members of the general community OT team – "opportunity to share learning across wider OT team."
- Concern over 'bespoke' services – "Really what you want is a generalisation in higher medical functions – encourage geriatricians to remain generalists and to encourage input from mental health."
- "Perhaps REACT and OPACT should be linked together; there is a big overlap between physical and mental health in older people so division is artificial."
- Rosemount Gardens – new Assisted Living Model – "focussed on reablement…more of a community facility."

Self-Directed Support

A range of observations were made which, broadly, fall under the heading 'SDS'. These include:

- "SDS implementation is middle of the road in West Lothian. We made the decision to progress SDS across the board. We invested a lot in infrastructure / the assessment process."
- Challenges:
    - "It has always been difficult in older people's services because at this time of life it is mainly about personal care and they may not want the added stress of controlling their own budgets etc." / "It's quite daunting for individuals."
    - Housing with care – "SDS with this model is more of a challenge – if you don't want the care element it would require a different staffing complement. This would be a threat to the model. My view is HWC is an assessed need; if you don't want this, it's about mainstream housing with an SDS care package commissioned."
    - Day care centres – "SDS is becoming challenging for day care…signs people are 'voting with their feet'"

- Care at home under the new framework – "if the client wanted a different provider, it might become more difficult to offer this if one provider operates solely in one area i.e. other companies might not have staff in the area – may not be able to offer a service there. The long term viability of this model may not work, but SDS was never meant to be just about using budgets for providing care – meant to be used much more creatively. There's the opportunity to advertise this more."
- "Lot of Option Two choices are just around choosing a different provider – there's no real choice"
- "I don't think our staff has bought into SDS as much as they could be."
- "Individual purchase makes it harder to plan."
- "The Assessment documentation is too complicated…. It needs to be proportionate – if they want Option 3, why do they have to go through the whole process? Couldn't we target resources?"

- Opportunities:
  - To use SDS budgets creatively for dementia respite etc.
  - "Need to develop a 'market' – need to develop 'real choices'"

Monitoring and Evaluation

A range of observations were made which, broadly, fall under the heading 'monitoring and evaluation'. These include:

- "West Lothian is not great in its impact assessment. It depends on the service."
- "It's very difficult to get Managers / people involved in Impact Assessments; there's 50 pages of guidance."
- Health - "We're very good at what we think we're going to do; not so good at the monitoring/evaluating part of the audit cycle."
- "Historically no local authority is good at encouraging commissioned services to measure impact – we need to get better at that as a local authority."
- "We're looking to do touchpoints (NHS Tool) – incorporating an assessment tool, [with residents in the new Rosemount Gardens]. This should enable us to do a cost-benefit analysis of sorts re the model."
- "We need a better knowledge of cost and performance in older people's services."
- "REACT has looked at data since day one and it is part of a Randomised Controlled Trial (including economic analysis)."

Staffing / Workforce

A range of observations were made which, broadly, fall under the heading 'staffing / workforce'. These include:

- "Care home work force is aging – this needs consideration."
- "There is a reduced number of people willing to provide the care – people don't want to work in the care industries."
- "There is a very high turnover of catering staff in care homes."
- "GP workforce is getting old / retiring. This is a significant issue. There have been some new initiatives such as 'Wise Doc' using retired GPs as locums and supporting them with the CPD etc…[But] we need to identify new initiatives to deal with this significant problem…Need to re-educate the public about the roles of GPs, community pharmacies, dentists and optometrists."
- "Under this Curriculum of Excellence should there be a generic pool of suitably trained staff that can be used for both Maple Villa (NHS) and Craigmaire (Council)? Can health care workers cross into social care and vice-versa?"
- "Not sure care at home providers are skilled enough to manage the needs of some clients. We need to value this group of staff. Need to recognise career progression; need to create a Senior Carer / Carer structure."
- "Gold standard training is necessary for [paid] carers."
- "Work force development is very important."
- "Need to ensure we employ staff who understand the ethos of Rosemount Gardens." / "Unless you get staff who understand the ethos of their role as an enabler, system change won't work."

Politics and Finance

Finally, a range of observations were made which, broadly, fall under the heading 'politics and finance'. These include:

- "AHPs are in more premises in West Lothian than we are in Edinburgh. We've been successful at reducing premises numbers elsewhere, but not here because of all the political activism."
- "Politics always comes into things in West Lothian – people are very quick to go to their local MSP / councillor. There are lots of pressure groups."
- "Politically difficult to sell anything if it means stopping something."
- "Need to look at contributions policy. Most things are free in West Lothian. Should this be? If you look at other authorities – this is not the case."
- Focusing on early intervention and prevention is a challenge with restricted budgets.
- "People that [sic] would have been in Inpatient care are now in community / care homes, but the resources/infrastructure haven't shifted accordingly."

- The current budget is approximately £200 million for 2016/17. There has been a growth in demand from previous years; elderly population. As part of the budget settlement, West Lothian received an additional £7.13 million. This is for supporting and growing social care. It's addressing such requirements as the 'Living Wage' and growth.
- The biggest risk in budgetary terms is Older People; the growth in demand is very significant. There has been a 15% growth in social care spend each year on Older People. Since 2012/13 the budget has grown from £5.4 million to £8 million in 2015/16. These demands are only going to increase with introduction of the 'Living Wage'. West Lothian faces the highest growth in those over 75 in Scotland.
- West Lothian will be looking for efficiency savings across all areas. NHS Lothian are unable to balance the budget; at time of writing £19 million deficit. This year part of that deficit will be allocated to West Lothian.

APPENDIX IV: SURVEY RESULTS (STAFF, DENTISTS, OPTOMETRISTS AND PHARMACISTS)

Staff Survey

In order to capture the views of staff working in older people's services across West Lothian, an online survey was created using the Survey Monkey tool and the link disseminated to all local services. The distribution list was agreed in advance with commissioners. Staff were asked for their opinions on current service provision and to identify any gaps or areas which could be developed going forwards.

In total, 66 individuals began the survey, but some questions attracted fewer than twenty responses. Key themes and issues are presented in the appendix below.

The vast majority of respondents were female (86%; n=57) and around 41% (n=27) were aged between 46 and 55.

Staff who responded (n=61) came from a variety of health, social care and third sector agencies – the full breakdown is shown in the table below:

Organisation	Frequency of Response	As a % of Total Responses (n=109)
Third Sector	15	25%
NHS Lothian	10	16%
Dental Services	8	13%
West Lothian Council – Various Depts.	7	11%
Allied Health Professionals	4	7%
Housing	3	5%
Community Palliative Care	2	3%
Community OT	2	3%
Day Services	2	3%
Housing Association	2	3%
Very Sheltered Housing	2	3%
Reablement Team	1	2%
Old Age Psychiatry	1	2%
Health Improvement Team	1	2%
Care & Repair Team	1	2%

Respondents were asked which areas their services cover; Livingston was most comprehensively served (n=45; 74%); Linlithgow was least comprehensively served (n=17; 28%).

In order to further contextualise the subsequent answers given, it is important to note the roles respondents carry out on a daily basis. The full list of roles is shown in the table below, but it is clear the majority have at least some direct operational experience:

Job Role	Frequency of Response	As a % of Total Responses (n=109)
Senior / Service Manager	15	25%
Case Worker	10	16%
Nurse / Clinician	9	15%
Team Leader	7	11%
Occupational Therapist	5	8%
Allied Health Professional	5	8%
Housing Officer	4	7%
Dental Nurse	2	3%
Development Officer	2	3%
Assessor	1	2%
Dentist	1	2%

Service Evaluation

Staff were asked to evaluate their service against a variety of criteria. Their responses are shown in the Figure below:

Statement	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	Nil Responses
Our service works effectively with older people.	**33.3% (n=22)**	30.3% (n=20)	1.5% (n=1)	3.0% (n=2)	1.5% (n=1)	30.3% (n=20)
Our staff are knowledgeable about how to respond appropriately to age-related health issues.	**36.4% (n=24)**	30.3% (n=20)	0	1.5% (n=1)	1.5% (n=1)	30.3% (n=20)
Our service undertakes comprehensive assessments.	**36.4% (n=24)**	21.2% (n=14)	4.5% (n=3)	3.0% (n=2)	1.5% (n=1)	33.3% (n=22)

Our service uses a validated or common assessment tool to identify individual risks and needs.	19.7% (n=13)	**25.8% (n=17)**	7.6% (n=5)	12.1% (n=8)	1.5% (n=1)	33.3% (n=22)
Our service has established referral routes with other older people services.	25.8% (n=17)	**30.3% (n=20)**	6.0% (n=4)	1.5% (n=1)	3.0% (n=2)	33.3% (n=22)
Our service is easily accessible to service users from across the whole of West Lothian.	**30.3% (n=20)**	22.7% (n=15)	9.1% (n=6)	6.0% (n=4)	1.5% (n=1)	30.3% (n=20)
There are effective pathways into older people services that promote joint working.	9.1% (n=6)	**27.3% (n=18)**	22.7% (n=15)	9.1% (n=6)	1.5% (n=1)	30.3% (n=20)
Our service communicates effectively with other older people services.	15.2% (n=10)	**39.4% (n=26)**	7.6% (n=5)	4.5% (n=3)	0	33.3% (n=22)
Our service has effective working relationships with other older people services.	13.6% (n=9)	**45.5% (n=30)**	6.0% (n=4)	4.5% (n=3)	0	30.3% (n=20)
Our service communicates effectively with a wide range of other non-specialist older people services.	7.6% (n=5)	**40.9% (n=27)**	10.6% (n=7)	7.6% (n=5)	0	33.3% (n=22)
Our service has effective working relationships with a wide range of other non- specialist older people services.	9.1% (n=6)	**37.9% (n=25)**	10.6% (n=7)	7.6% (n=5)	0	34.8% (n=23)
Our service provides good information about age-related health problems, including other sources of help available.	13.6% (n=9)	**33.3% (n=22)**	7.6% (n=5)	12.1% (n=8)	1.5% (n=1)	31.8% (n=21)
I am confident working with people with older people, including those in crisis.	28.8% (n=19)	**36.4% (n=24)**	1.5% (n=1)	1.5% (n=1)	1.5% (n=1)	30.3% (n=20)
I am competent working with older people, including those in crisis.	30.3% (n=20)	**33.3% (n=22)**	4.5% (n=3)	0	1.5% (n=1)	30.3% (n=20)
						Total responses: 66

Over 60% of respondents appear to believe their service works effectively with older people and that staff are knowledgeable and know how to respond effectively to age-related health issues. As individuals, over 60% of respondents reported feeling both confident and competent working with older people, including those in crisis.

Respondents were then asked what they think their service does particularly well. Thirty-two responses were received and a range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=69)	Example comments
Person Centred Care	9	28%	"Accommodating patient requirements." "Provides personalised support to older people with dementia meeting the outcomes that are important to them." "We provide a holistic approach to older people's services." "I think my service responds in a very person centred way to the needs of the person diagnosed with dementia and to their family / supporters."
Financial / Benefits Advice	4	12.5%	"Gives clear concise and updated information on benefits, debt, housing and energy advice." "Our service delivers advice to older people in benefits, energy, money and housing and debt. The specialised advisers work with older people to ensure they are receiving everything they are entitled to. The advisers are excellent at this…"
Keeps People at Home / Maintain Independence	4	12.5%	"Enabling older and disabled people to remain in their own homes." "Support people to remain at home and be as independent as possible." "We engage with lonely and isolated older people, encourage them to get out and about and engaging in social activities and making new friends. Helping them to feel much more positive, connect with their local community and to remain at home for longer."
Signposting	4	12.5%	"Provides emotional and psychological support as well as signposting to other services." "… We then look to see what other help the person might need and refer to other council departments or partners."
Prevents Isolation / Facilitates Social Interaction	3	9.4%	"Supporting older people to reduce loneliness and social isolation." "We engage with lonely and isolated older people, encourage them to get out and about and engaging in social activities and making new friends."
Advice	3	9.4%	"Good range of services - support, health and wellbeing, advice." "It also provides practical advice and information."
Assessment	3	9.4%	"Holistic assessment of patient's needs and support for families." "We provide a comprehensive, client centred assessment for the patients who are referred to our service."
Listen	3	9.4%	"Listens and understands needs."

			"Listens to the needs of individual carers and those they support."
Work Well with Families	3	9.4%	"We work well with families and carers." "Promotes client and carer engagement."
Promotes Wellbeing / Health Promotion	2	6.3%	"Delivers high quality activities that impact on older people's mental and physical wellbeing."
Partnership Working	2	6.3%	"[Good at] Partnership working."
Acute Care	2	6.3%	"Acute care to a certain degree." "Responding to crises in the community." "Treating high risk patients."
Misc.	6	18.8%	"Excellent Nursing Team Leaders who use leadership skills, clinical knowledge as well as managing change with excellent professional skills." "Teamwork, communication." "Falls education."

They were then asked how they thought their service could be improved. Thirty-one responses were received and a range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=65)	Example comments
Better Joint Working / Better Information Sharing	12	38.7%	"Closer links to other services outwith the hospital." "Work closer with other older person services for things like referrals." "It would be helpful to have access to hospital information about clients." "Building relationships within West Lothian for future referrals to ensure all carers are aware of services to support them." "We need to have better partnership working within the council teams." "Need for closer integration with health. Co-location needs to be developed in order to address the two operational area system."
Extension of Service	9	29.0%	"I would like our service to incorporate the provision of the Care-at-Home service to provide continuity to residents as well as a more flexible service provision." "Offering falls education sessions in community based venues."

			"… expand our service to identify and support carers in rural West Lothian."
Additional Funding	5	16.1%	"Additional funding would enable us to provide a wider service. As demand for our service has increased, we are less able to meet the needs of everyone who contacts us." "Increased funding to maintain our existing service and also to expand our service." "Increased funding to expand our dementia support service and associated strategies for offering practical support at the earliest possible opportunity for those in need."
Improved Knowledge / Definition of Pathways	3	9.7%	"Better definition of pathways in areas such as OPACT, CPNE, Post Diagnostic Support. Better understanding of criteria for continuing care wards. Better understanding of implications of Health and Social Care integration." "The Health and Social Care Partnership need to realise the importance that finance has on older people's lives."
Better Leadership	2	6.5%	"Leadership with a clear vision." "…All these problems are something we are trying to fix but it needs to come from the top down and the bottom up."
Public Transport for Older People	2	6.5%	"More affordable and accessible transport for older people."
Misc.	8	25.8%	"By constantly re-evaluating and looking at how we can do better." "Greater recognition of the substantial and preventative impacts that participation in creative activity has on older people." "Develop self-directed support policy and documentation." "Ease of access i.e. automatic doors, streamlines ambulance service, working lifts."

Next, respondents were asked what forms of support their service provides post-discharge. Thirty people answered and a range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=68)	Example comments
Signposting / Relevant Referrals	9	30%	"We provide information on other services in the community." "Referrals onto other agencies to continue support after discharge."

			"We sign post and refer on to a range of services including Carers of West Lothian, Leisure Xcite, local activity groups, Day Centres." "Information and advice on other local services." "Consultant or Nurse follow-up where assessed as appropriate."
Can be Re-Referred / Rapid Re-Referral	6	20%	"Residents are able to return to Tollgate House after a hospital stay sooner than they would if they were living in a house in the community." "The patient can return with a problem in the future, or will be invited to a health education session." "Can be re referred at any time. If within 6 months, then patient themselves can re refer."
Watching Brief / Telephone Follow-Up	5	16.7%	"We keep in touch with clients after their befriending stops to ensure that they are remaining linked in with the community." "Telephone follow up, sometimes post discharge visits." "Follow up and review."
Misc.	3	10%	"Volunteers to alleviate isolation." "Carers support and peer support groups are also invaluable." "Support in establishing a person centred carer package."
Nil Response / Don't Know / Answer Not Relevant	10	33.3%	

As a follow-up question, respondents were then asked what more could be done to support service users post-discharge. Twenty-six responses were received and a range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=63)	Example comments
Better Joint Working / Better Info Sharing	6	23.1%	"Better links perhaps between Health and Social Work as well as other professions (e.g. OT, Psychologist)." "We record very detailed information regarding service users through their individual care plan, this information would be useful to new care providers." "Better joint working and communication between health & social work and with the care provider."

More Info for Older People / Carers	4	15.4%	"More information leaflets etc..." "Great information need by clients and families." "Better understanding of who we are and the services available to older people with a leaflet to every patient discharged regardless of what Ward they have been in."
'Named Person' / Info Navigator	3	11.5%	"Provide a 'named person' to help individuals and their carers navigate the overwhelming amount of information that they are given on discharge." "Information worker who is the navigator for the patient/carer to access services that may be required."
Misc.	10	38.5%	"Further improvements in support and education for care workers providing oral care." "There is no one who will currently provide one to one individual continuing regular support to someone with dementia like the support they received during PDS." "Providing good transport links to promote inclusion in the resources we have sign posted to." "A more flexible care-at-home service would help." "A holistic needs assessment to look at the bigger picture. A person centred approach." "Social prescribing our activities as part of care packages."
Nil or N/A	3	11.5%	"I think as a service we do as much as we can." "Nil at present."

Respondents were then asked to rate the level of service user and carer engagement and involvement in their service and the community (Rating scale: 1=Very Poor, 2=Poor, 3=Adequate, 4=Good, 5=Very Good, 6=Excellent).

Between 29 and 31 responses were received to these questions, and the average ratings were thus:

- The level of service user engagement in your service: 4.45 (i.e. between Good and Very Good)
- The level of service user involvement in your service: 3.80 (i.e. between Adequate and Good)
- The level of involvement/ integration service users have in their community: 3.38 (i.e. between Adequate and Good)
- The level of carer/family involvement in your service: 4.00 (i.e. Good)

Respondents were also asked to use the same scale to rate the overall quality of their service. Thirty responses were received, and the average rating was 4.77 (i.e. between Good and Very Good).

Gaps in Current Service Provision

Respondents were asked whether they thought there are any gaps in older people's services in West Lothian. Thirty people answered this question and over 80% (n=25) thought there were gaps. A range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=70)	Example comments
Dementia Support / Befriending	6	20%	"Yes I think for older people with dementia they are offered very little in way of continuing services. Most are offered day care but this does not suit everyone…" "Support for people/carers with dementia and other mental health issues." "Dementia Befriending." "One-year diagnostic support for those newly diagnosed with Dementia."
Better Joint Working	5	16.7%	"All services should work closer together." "Welfare advice being integrated into all aspects of delivery."
Preventative Measures	4	13.3%	"High quality preventative activities should be mandatory in all care services. We must better look after people's mental health and not only focus on the medical." "I think more could be done to combat loneliness and isolation." "Social opportunities, identifying those who are vulnerable before crisis situation occurs." "Befriending to address social isolation, which can exacerbate loneliness, depression and dementia if not addressed."
Befriending Services	4	13.3%	"More befriending services required." "Gaps regarding befriending services for older people."
Support for Carers	3	10%	"Support for people/carers with dementia and other mental health issues." "Children of older people are being asked to work longer before reaching pensionable age so struggle to support their parents as well as work."
Transport	3	10%	"Transport for rural areas." "Accessing information can be difficult due to infrequent bus services in some areas."

Mental Health Support	3	10%	"Access to psychological therapies could perhaps be improved?" "Mental health support."
Misc.	9	6.3%	"More people want individualised personalised support tailored to their situation. SDS takes too long to access." "Housebound people are unable to access services, so more home bound services would fill that gap." "Complex MH and dementia care in Care Home facilities." "The need for increased access to crisis care when care packages are taking so long to implement would perhaps reduce the amount of crisis admissions to acute settings." "More respite services being available and being easier to access at short notice."

Areas of Duplication and Overprovision

Respondents were then asked whether they thought there were any areas of duplication or overprovision in older people services in West Lothian.

Twenty-six people answered these questions. Nearly 75% (n=19) did not think there were any areas of duplication. Of the seven who did, the following pertinent comments were made:

- "Role of MH nurses in community are often duplication REACT and DN which could easily be prevented with clear guidance on what to do when before you consider a referral to MH."
- "Sometimes people are going to day care and have a care package that provides tea -why can't day cares provide tea?"
- "Mental Health services"
- "Often information given twice to professionals from health & social care."
- "Where do I start!!!???"

Similarly, nearly 90% of respondents (n=23) were unable to identify any areas of overprovision. The three respondents who believed there were areas of overprovision, made the following comments:

- "There is an over emphasis on day provision for those without MH diagnosis and Dementia care required for those who need MH training to understand and support their symptom management."
- "Services specifically delivering assistance that can be found free and easily in the 'real world'. i.e. Supermarket online shopping and delivery, specialist websites etc. These and much more are already available in the community there is no need to specially fund things like that. Give people technology and the support to access existing services."
- "Unsure."

On Resourcing

Respondents were asked for their comments about the resourcing of services for older people. Fourteen individuals answered this question and a range of comments were provided. The key theme which came through was that many services were not adequately funded:

- "As with most local authority areas, more funding is needed for many services."
- "Yes I think most services are not adequately prioritised. Many very good innovative services come and go due to lack of continued funding and this is not good for people using the services."
- "…funding cuts place an inevitable and untenable stress on the provision being offered."
- "Dental services, including Oral Health Improvement, are struggling to recruit and replace members of staff due to budget cuts."
- "Mental Health services across the board would benefit from increased funding. We have a rapidly ageing population in West Lothian."

Another theme which recurred was that joint working could be better:

- "Be more joined up. Contract experts / those already doing the work and support them to make small changes to their services rather than inventing the wheel with crappy expertise"
- "NHS and WLC need to get better at working together and sharing information. There should be a list made available to older people's services of people diagnosed with long term health condition, this list should be used to contact the older person to advise of all the help available to them."

One other comment was made on the level of care packages in place and the role of Self Directed Support (SDS):

- "I think care packages are inadequate and provide minimal social interactions. They are often unreliable regarding times, staff and put older people at risk as a result. Social workers etc. try very hard but the resources they can access to support older people are limited. Self-Directed Support has made no difference to older people as the services offered are the same as they were before and very few carers will try to take a budget as they are exhausted."

Groups Not Well Served

Respondents were asked whether, in their opinion, there any particular groups with age-related issues that are not well-catered for in West Lothian. Sixteen individuals answered this question, and the following key groups were mentioned as being poorly served:

- Those with dementia (n=4) – particularly noted were subgroups – 'younger old people' with dementia (i.e. those aged just over 65) and those with early-onset dementia;
- Those with mental health issues (n=3);
- Those with learning disabilities (n=2);

- Those with substance misuse issues (n=2);
- Individual respondents also mentioned the following groups:
    - Carers
    - Women with experience of Domestic Abuse
    - Older Men
    - The very elderly
    - Those with mobility issues

Asset Mapping

Respondents were asked what other assets, resources, groups, individuals, and/or opportunities are available across West Lothian to support mainstream services in meeting the needs of older people. Eighteen individuals provided an answer to this question and a range of comments were provided. Key assets mentioned included:

- Third sector provisions e.g. The Food Train; The Food Train Extra; MOOD; Befriending Services; Red Cross Volunteer Transport; Aging Well; Dementia Cafes; Advocacy
- Community provisions e.g. Lunch Groups; Xcite / Aging Well
- Specific Health Services e.g. CBT Dentists; the Health Improvement Team
- Specific Social Care Services e.g. Day Care; Supported Accommodation
- West Lothian Council Initiatives e.g. The Advice Shop

Future Priorities

Integration, capacity and quality have emerged as common issues from similar research studies conducted by Figure 8. Accordingly, respondents were asked to rate the following four statements in order of importance: (Rating Scale = 1= Most Important, 4= Least Important). Between 27 and 30 staff responded, and the average ratings and relative ranking of the statements is shown below:

- Expanding the range of older people services – Average Rating: 2.03
- Increasing the capacity of older people services – Average Rating: 2.59
- Enhancing the quality of older people services – Average Rating: 2.85
- Improving integration of older people services and other services – Average Rating: 2.86

Staff therefore ranked expanding the range of older people's services most highly as a future priority.

Any Other Points

Finally, respondents were asked whether they had any additional comments to make. There were few common themes so all points made are noted below:

- "Working for WLC I am amazed that all the older people's services don't work closely together. There are some good working relations with other teams in social policy but not all. The NHS and WLC need to share information in order to give the older person the best outcomes for them."
- "I can't overstate the importance of benefit / money advice been taken seriously for the sake of older people's health and well-being."
- "People with dementia need speedier access to SDS. Long delays not just for a social worker but for getting decisions. Support need to be more personalised to the individual. Care at home services not always able to do this. some people accepting this as there is nothing else but do not find it particularly helpful."
- "More effort to enable older people to get on-line. More opportunities for older people to participate in cross-generational activities."
- "Having worked in Edinburgh in the past, it strikes me that we do appear to have as developed third sector involvement in West Lothian."
- "I think it is easier to fund projects if older people are treated as one homogenous group. Day care caters for a larger number of people but the age ranges within day care can be vast and yet the services tend not to cater for the younger age group because they still run on very traditional lines."
- "Because Community Care provision is unlike many other councils split into silos for those under 65. An integrated service for community care and a joined up Occupational Therapy service with Health would improve things, give continuity and remove artificial barriers and transfer issues. In addition, would render the two area system for joint working more easily."

Pharmacy Survey

Since Community Pharmacists are increasingly important front-line healthcare providers in the modern NHS and are taking on more of the clinical roles that have traditionally been undertaken by doctors, it was decided to survey this demographic for their views on service provision for older people across West Lothian.

The survey was devised by Figure 8 and signed off by key members of the Steering Group. The link was then disseminated to all community pharmacists across West Lothian (n=**x**) by Carol Bebbington (Senior Manager Primary Care and Business Support).

Unfortunately, only three pharmacists started the survey and one did not complete all of the questions posed. As such, few generalisations can be made, therefore instead of a systematic review of the whole survey, a few key points are instead noted.

Role of Pharmacists

Respondents were asked what they, as pharmacists, are currently doing to support older people. Answers suggest respondents both provide services directly to this demographic and signpost older people to other relevant organisations:

- Services provided:
    - "Provide dossette trays including delivery/ordering to elderly patients after discussion with GPs. Identify patients struggling with tablets as candidates for a tray then discuss with GP."
    - "Report any concerns to district nurse/GP and feedback on deliveries to the housebound elderly where problems often surface."
- Agencies signposted to: Carers of West Lothian; GP's; and meal services.

When asked whether they were happy with the level of information they have received about services in West Lothian for older people, the following comments were made:

- "Think there should be an up to date directory which is relevant to each area of West Lothian."
- "Leaflets to hand out and more info on what is available would help."

Barriers Preventing Older People Accessing Services

Pharmacists were then asked whether they believed there were any barriers preventing older people from accessing services/provisions from which they might benefit. Both of the respondents who answered this question believed 'Distance to Service' and 'Availability of Public Transport' were barriers.

Services Which Work Well / Not So Well for Older People

Respondents made the following comments when asked which services work well for older people in West Lothian:

- "Area's like meals on wheels and local groups for older people can work well if volunteers are prepared to assist. The service at SJH older people very much enjoy and engage with and are often sad when their 12 weeks are up as it gives them social contact, Braid House is excellent but again not everyone wants to engage."
- "Memory clinic and REACT"

And they made the following comments when asked what the main gaps and areas for improvement are in support and service provision for older people:

- "Keeping support and services local, having a directory for all health care professionals to access, directory for families of older people or mental health problems to access."
- "Better signposting and self-referral process maybe."

Dentistry and Optometry Survey

Since both dentists and optometrists also have a key role to play in keeping people healthy and in the community they too were surveyed for their opinions on service provision for older people across West Lothian.

The survey was devised by Figure 8 and signed off by key members of the Steering Group. The link was then disseminated to all community dentists and optometrists across West Lothian (n=**x**) by Carol Bebbington (Senior Manager Primary Care and Business Support).

Unfortunately, only one dentist and five optometrists started the survey and two of the latter did not complete all of the questions posed. As such, few generalisations can be made, therefore instead of a systematic review of the whole survey, a few key points are instead noted.

Dentistry

The one dentist who responded indicated that they were *"totally unaware of support services"* available for older people in West Lothian, and concluded by noting, *"As we are not NHS employees we receive virtually no information regarding support services and are consistently forgotten in local health planning."*

Role of Optometrists

Respondents were asked what they, as optometrists, are currently doing to support older people. Answers suggest respondents both provide services directly to this demographic and signpost older people to other relevant organisations:

- Services provided:
    - "Home visit appointments; Delivering glasses."
- Agencies/services signposted to:
    - "Referral to hospital eye service or local low vision clinics as required. Referral to GP regarding any concerns not covered under the hospital eye service/low vision clinics."

The only other service for older people the responding optometrists were aware of was RNIB.

None of the respondents were happy with the amount of information they have received about services in West Lothian for older people. One made the following comment:

- "Would appreciate further advice and support to give to patients."

Barriers to Accessing Local Optometrist Services

When asked whether there were any barriers preventing older people accessing local optometrist services, one respondent made the following comment pertaining to accessibility:

- "There is no disabled parking on the main street on our side of the road. None of the disabled parking is enforced."

Another noted:

- "Patients concerned with being judged, stressed or anxious about giving the "wrong answers" or being told they have severe eye or general health problems. Some patients are also worried that we cannot help them, i.e. if they are non-verbal."

Services Which Work Well / Not So Well for Older People

Respondents made the following comments when asked which services work well for older people in West Lothian:

- "I am unsure of this as we have not received much information on support and services available but would be keen to have this information to pass on to patients."
- "Unable to comment."
- "No knowledge of any provision."

None of the respondents felt able to comment on what the main gaps and areas for improvement are in support and service provision for older people.

One optometrist concluded by noting:

- "Would appreciate more information to be able to pass patients on to the correct services if needed."

APPENDIX V: FOCUS GROUPS

Introduction

In order to capture the views and opinions of older people and carers themselves, as part of the fieldwork staff at Figure 8 facilitated a series of seven qualitative focus groups.

Groups were hosted in a variety of venues across West Lothian and representatives of the following groups were spoken to:

- Residents of Very Sheltered Housing / Housing with Care (n=8)
- Residents of Sheltered Housing / Retirement Housing (n=5)
- Older People who use Day Activities (n = 12)
- Residents of Care Homes (n=8)
- Older People with Mental Health Issues (n=11)
- Active Older People (to include those approaching old age) (n=2)
- Family Carers of Older People (n=7)

Discussion encompassed a range of topics including what services and community supports work well and not so well locally for older people; whether there are any areas of duplication; whether there are any particular inequalities in service and support provision; and whether these supports and services can be easily accessed by those who would benefit from them. These discussions have been combined with data from the older people's and carer's surveys and are summarised in SWOT analysis form in **Chapter V** of the Main Report.

What Works Well

Participants were asked what services and community supports currently work well for older people across West Lothian. Older people and carers provided many examples of services and supports they thought work well. Common themes included:

- Third sector organisations such as: MOOD; Cyrenians Befriending Service; Alzheimer's Scotland (in particular the Dementia Cafes; and Football Memories Club); Food Train and Food Train Extra Service; Macmillan; Carers of West Lothian;
    - "MOOD is a vital service for us that use it – not just a good service"
    - "Macmillan palliative care is excellent, but very stretched – they have to prioritise, which is very hard"
    - "The Dementia Café is very good with information too. They offer company and the opportunity to talk to people with the same problems. They offer games and puzzles for those with dementia too."

    - "The Food Train in particular the extra service which turns mattress and changes light bulbs [works wells] – it's almost like the old home help service."

- Specific Health Services such as: REACT; OPACT; The Templar Day Hospital/Ward; the fact specialist consultants from Edinburgh go to St John's; the Community Nursing Service; Diabetic Clinic; Ward 21; the 'balance ward';
    - "Staff at Ward 21 treated my mother-in-law [patient with severe dementia] with dignity and respect."
    - "The Reablement Team was absolutely excellent when I went into hospital."
    - "The REACT team is great – the links, the communication with carers was absolutely marvellous – [mother-in-law] didn't have to go into hospital; [and] the whole team seemed to know about the patient."
- Social Care Provisions such as: Careline; Day Care Services (Braid House, the Ability Centre); Community Occupational Therapy / Adaptions;
    - "Braid House gives carers respite – they are very flexible and will change day if necessary; if you call up in the morning in an emergency they try to accommodate you." However, a comment was made that you can only access Braid House if you live at home; "it's not open if you live [in] residential [accommodation]", which was seen to be a limitation.
    - "The Ability Centre is a great service, but this stops at 65. They then have to move to a day centre."
- Services which promote wellbeing/independence such as: Xcite; Dial-A-Bus / Dial-A-Taxi; the Advice Shop (Bathgate)
- Residential provisions such as:
    - Trust Housing Association provision where many services 'come in' e.g. hairdressers, - *"I tell everyone it's a happy place"*; *"I feel safe here."*
    - Bield Housing & Care
    - Medicare care home provision where many services 'come in' e.g. hairdressers, chiropodist, podiatrist, optometrist, doctors etc.

Both older people and carers also thought that there were examples of good communication between organisations and sectors (health, social care and voluntary sector), but they also noted that this was not universal across the board – that it often depends: *"If you get the right person in the beginning who knows about the services, you are alright and it works well."*

Gaps

Participants were then asked whether there were any gaps, or services/provisions which were not working well for older people in West Lothian. Older people and carers provided various examples

of services and supports they thought were missing or not working as well as they might. Common themes included:

- Services and supports for those with dementia, in particular:
    - One-year post diagnostic support
        - "It's good, but it's too early."
    - Services – general
        - "There are no services until crisis point. People are vulnerable at this point – they go out any buy things that aren't necessarily the best things."
    - Services for those with early-onset dementia
    - Dementia Awareness
        - "GPs know nothing [about dementia]";
        - "YouTube Video [Alzheimer's Scotland] – would be good for staff / nurses to see something like this"
        - "There is a lack of communication with me as a carer of someone with dementia."
        - "A&E and some of the wards treat people with dementia very poorly – staff have very limited capacity and can't cope with dementia patients who need significant care. They won't let carers through without a fuss; they keep changing wards for them which leads to disorientation."
        - Lack of dementia awareness
- Care at home provision:
    - Quality / Reliability:
        - "The reliability and standard of carers isn't good – we had 11 different carers in a week coming in from 7:30am to 11am.";
        - "Some [carers] are far too young for what they need to do."
        - "Hear talk that they are very prescriptive."
        - "Should be a National Care Standard in terms of education and expectations/support provided."
    - On discharge from hospital:
        - "You're not able to be discharged from hospital because your care package is not in place. I've been transferred to St Michaels or Tippit Ward."
        - "The communication between health and social care doesn't always work very well."
- Service and community provision for the frailest:

- "There's lots available for the more-able – the over 50's/60's; not the less able";
- "Would like more wheelchair/seated Zumba; singing jamboree thing"
- "The Howden Park Centre only has four wheelchair spaces so we can't go on group outings there."
- "There's nothing very much in the community I don't think."

- The Assessment Process:
  - Community Occupational Therapy / Adaptations
    - "It can take 12 weeks to have an assessment, and sometimes the assessor doesn't believe you – e.g. that you can manage the stairs up, not down. Then there is a long wait for implementation and you have to go through a process e.g. bath seat before wet room when you know you'll eventually need a wet room."
- Knowledge / Awareness about what is available:
  - "People don't necessarily know about things e.g. taxi cards"
  - "[Gap] Information about what is going on in the community"
  - "GPs don't know about all the services. "
  - "Not everyone in Health and Social Care will advise carers about COWL. Some do, but many carers only get to COWL when they are in crisis… [There is a] gap in both knowledge and referral - staff [are] constantly changing, especially in hospital."
  - "Welfare Nurses are a good idea – they'd know about the services available."
  - "Silverline have a phoneline; West Lothian Council could have someone you could call similarly [to ask for information]."
- Public Transport:
  - "Buses are atrocious for this area"; "Transport / buses are poor; you have to rely on friends with a car."
  - "Transport is an issue from more rural areas e.g. Armadale, Whitburn, Stoneyburn…"
  - "We usually have to use taxis; it costs £7.80 to get into the town."
  - "Subsidised routes have reduced as well."
  - "Bathgate has a poor bus service (not before 9am or after 5pm) – old people who live at home are getting isolated because buses don't run outwith these times – you are reliant on a car."
  - "Getting from A to B can be difficult with the transport situation."
  - "Could do with a volunteer driving service like for cancer treatments."
- The opportunity for service user involvement:

- "Lots of forums[sic] have ceased to operate – Patient, Service User, Mental Health etc. – there's a feeling they didn't want people to question what's going on…Now you lose the interface with the medical profession. They don't really like people who are not professionals 'stirring the pot'."
- "There should be more lay people on the Care Commission etc. / and on the IJB (more than Ian Buchanan – perhaps 4 or 5)."

- Other gaps identified:
  - Respite / Short-breaks:
    - "Crossroads exists and is a fabulous service – if you can afford to pay. If it is council funded, you can be on a long waiting list."
  - "A service that no longer exists – the Red Cross Home from Hospital Service was very good."
  - Befriending service for both the elderly and for their carers.
  - Patient advocacy for older people who may not have anyone to put their views across.

Areas of Duplication

Participants were asked to identify any areas of duplication in service or support provision for older people in West Lothian. Neither older people nor carers could identify any significant issues in this area, but one pertinent comment was made thus:

- "There are lots of care [at home] providers"

Inequalities

Participants were then asked whether there are any groups of older people (men/women/those with certain conditions/frailties) which are currently not well served in West Lothian. A range of comments were made under this point:

- Economic Inequalities:
  - "Owner-occupiers may not be entitled to the same stuff – we didn't get two rails; we would have if it was a council property."
  - "There are limitations if you're not a pensioner - it comes down to benefits / the savings you have."
- Those with limited mobility:
  - "Livingston is pedestrian-friendly, but it's not designed for those who can't walk."
- Those with mental health issues:

    - "The GP doesn't always understand your mental health situation – he doesn't have the time."

- Those with physical disabilities / sensory-loss:
    - "Sign language – those who need it, have to pay for it"
    - "People pay lip-service to Disability Legislation; not in practice – there's a lack of ramps."
    - "All council people should have deaf-awareness training."
- BME populations:
    - "There are few BME carers; MECOP exists in Edinburgh and COWL would take advice; but it may be a cultural thing – this demographic tend to live multi-generational homes."
- Those with co-morbidities:
    - "If you have co-existing conditions (dementia/Parkinson's) it can be difficult – especially as dementia straddles mental health and older people's services – who do you ask?"

Subsequently addressed were the geographic areas currently well served across West Lothian and those which are not so well served. Many comments made following this question referred back to the limitations of public transport. It was repeatedly noted that if you live in outlying areas / remote villages, access to services via public transport is problematic – that you really need a car.

Accessibility

Older people and carers were then asked whether they can get to the supports/services they want, when they want them. Comments made pertaining to this question encompassed a range of themes, but overall it was felt that, *"You get services when you want them"* (with the possible exception of a GP appointment); and that *"West Lothian care about their older people"*. Specific issues were however highlighted:

<u>Availability of Information:</u>

- "Lots of information is just available on the internet – not everyone has access or is capable of using it (those with dementia can't access it)"; "West Lothian Council did have a booklet for older people's services – now everything is online. What about an annual leaflet like you have with bin collections etc.?"
- "The library has information – but you also need to be able to access it."

<u>Capacity – Medical Services</u>

- General Practitioners
    - "It's difficult to get a GP's appointment sometimes…if you want a particular doctor, it's a real problem."; "The nurses are quite good, pharmacists help for small things – give out prescriptions etc. which is a good thing."

    - "If you can't access the GP – how can you access other services? The GP is the gatekeeper to the memory clinic; neurologist; oncologist. We need to resolve that or the health service is going to get more and more fragmented. "
- "Access to the memory clinic can be difficult."

Priorities

Finally, older people and carers were asked for their list of future commissioning priorities. In order to get a comprehensive picture, all those mentioned are noted below in no particular order:

- Effective information dissemination (all those groups answering this question mentioned this as a top priority)
- Improved communication (two groups mentioned this as a key priority)
- Care at home providers and care home providers must provide good quality care
- Transport to community groups
- Cut red-tape – shorten timescales for assessment and implementation of care package / adaptation
- A drop-in centre for older people (Monday to Friday all day) with space for carers too
- Sustainable funding for commissioned services – 5-year planning
- More CPNs for West Lothian
- More dementia nurses
- A better planned transport system
- A network of volunteer drivers like they have for those who need cancer treatment
- Access for wheelchairs
- Increased respite services – more readily available at short notice and for short periods of time
- To protect, maintain and expand the services that already exist to cope with increased need

APPENDIX VI: SURVEY RESULTS (SERVICE USERS AND FAMILIES/CARERS)

Introduction

The purpose of this element of the research was to seek the views from a broad audience of service users and carers on the current provision of specialist older people services across West Lothian. Specifically, service users and carers were asked to provide their views on the quality of services, key issues, gaps and areas for improvements.

Service user survey - response rates

There were only **16** responses received to the service user survey, of which **13** were completed sufficiently to enable use within the research.

No quantitative analysis was possible due to lack of returns; however, a number of qualitative responses were made which are detailed below.

Carer survey - response rates

There were only **4** responses received to the carer/family survey, of which **2** were completed sufficiently to enable use within the research.

No quantitative analysis was possible due to lack of returns; however, a number of qualitative responses were made which have been incorporated into the following section of the report.

Limitation

Although, the survey was an important element of the study, the lasck of responses means that the strength of the evidence gained through the survey is highly restricted. In light of this, the evidence gathered from service users and carers through the other varied qualitative elements of the study is deemed to be stronger and has been given greater consideration when forming the conclusions and recommendations of the study.

Survey Qualitative Responses from Service Users and Carers

<u>What Works Well</u>

- Falls Assessor/Assessment (WLC):
    - "I receive an excellent caring service which I find most impressive and faultless."
    - "Very helpful."

    - "They have been so great in helping us with everything the information they have given us has been of immense help with everything."
    - "Lorna [Falls Assessor] has been amazing in helping us with everything and answering all our questions in a manner which we could understand for which we are very grateful."
- The Food Train:
    - "It is dependable and timely and the people who bring the food orders are extremely friendly and very helpful."
    - "the service is very reliable and efficient, it is also punctual."
- The Food Train Extra:
    - "Makes me able to stay in my own home."
- Care at Home:
    - "Carers and nurses are always kind caring considerate, cheerful as are the nurses. I am most grateful for their help, I look forward to them coming in."
- District Nurses:
    - "Carers and nurses are always kind caring considerate, cheerful as are the nurses. I am most grateful for their help, I look forward to them coming in."
- Carers of West Lothian:
    - "Without Carers of West Lothian I don't know what I would do." (Carer)
    - "I think we are very lucky having West Lothian carers." (Carer)

<u>What Doesn't Work So Well</u>

- Care at Home:
    - "Different care workers"
- Post-diagnosis:
    - "When you are first told what is wrong there is a gap, you feel left on your own. It is up to the carer to find out what help is out there" (Carer)

<u>Future Improvements / Priorities</u>

- "I would like a named carer [with Care at Home Provider]"
- "Respite in our own home…" (Carer)
- "…male befriends to take him [man with Parkinson's and Dementia] out" (Carer)

APPENDIX VII: STAKEHOLDER LIST

In total, through the variety of methods used in this study, **XX** individuals were consulted as part of this needs assessment project. Names, titles and organisations for those professionals involved in the research are noted in the tables below. All service users and carers are anonymised.

List of Interviewed Stakeholders

	Name	Designation	Organisation
1	**Carole Bebbington**	Primary Care Manager	
2	**Alan Bell**	Snr Mgr Community Care & Support Services also Care Homes (temp)	
3	**Fiona Bonnar**	Mental Health Manager	
4	**Lesley Broadley**	Service Development Officer	Technology Enabled Care
5	**Nick Clater**	Mental Health Service Manager	
6	**Avril Clerkson**	Ageing Well Co-ordinator	
7	**Patricia Donald**	Manager	Allied Health Professionals & Rapid Elderly Assessment & Care Team
8	**Jillian Dougall**	Service Devleopment Officer	
9	**Elaine Duncan**	Clinical Director	
10	**Aileen Eland**		Alzheimer's Scotland
11	**Patricia Graham**	Head of Adult Psychology	NHS Lothian
12	**Belinda Hacking**	Head of Applied Psychology for Older Adults	NHS Lothian
13	**Helen Hay**		Alzheimer's Scotland
14	**Mairead Hughes**	Chief Nurse	
15	**Aileen Maguire**	Group Manager	Support at Home Services
16	**Pamela Main**	Snr Mgr	Commuity Care Assessment & Prevention
17	**Katy McBride**	Housing Development Officer	
18	**Len McCaffer**	Arts Officer	Wellbeing
19	**Dr Douglas McGowan**	Lead GP	Health & Social Care Partnership

20	**Alan McIver**		Alzheimer's Scotland
21	**Mary-Denise McKernan**	Manager	Carers of West Lothian
22	**Linda Middlemist**	Health Improvement Team Manager	
23	**Dr Scott Ramsay**	REACT Consultant	
24	**Margaret Robertson**	Advisor, Dementia & Older Persons Team	Advice Shop
25	**Ailsa Sutherland**	Group Manager	Housing with Care & Occupational Services
26	**Charles Swan**	Group Manager	Assessement & Care, Management Older People
27	**Patrick Welsh**	IJB Fianance Offier	
28	**Jenny White**	Regional Manager	Food Train + Food Train Extra

List of Participants at Key Stakeholder Event (6th May 2016)

	Name	Designation	Organisation
1	**Gail Allan**	Palliative Care Manager	Marie Curie
2	**Fiona Bonner**	Clinical Nurse Manager	NHS Lothian
3	**Jim Brown**		Carers of West Lothian
4	**Gill Burns**		Carers of West Lothian
5	**Jill Derby**	Self-Directed Support Lead	West Lothian Council
6	**Caroline Donaldson**	Project Leader	Mood
7	**Aileen Eland**	Service Manager	Alzheimer Scotland
8	**Lyndsey Fleming**		Braidhouse Day Centre
9	**Karen Gordon**	Special Care Consultant Dentistry	NHS Lothian
10	**Michelle Halloran**	Branch Manager	Carewatch
11	**Dianne Hayley**		NHS Lothian
12	**Marilyn Higham**	Deputy Charge Nurse	Tippethill Hospital
13	**Lynn McAvoy**		Carewatch

14	**Len McCaffer**	Arts Officer-wellbeing	West Lothian Council
15	**Anne McGougan**	Care Coordinator	Crossroads
16	**Paul McGuiness**	Social Worker	West Lothian Council
17	**Elaine McLernan**	Charge Nurse	NHS Lothian
18	**Wilma Pincott**	Resident, GCC	
19	**Fiona Rodger**		NHS Lothian
20	**Sharon Sansome**		NHS Lothian
21	**Jennifer Smith**		Braidhouse Day Centre
22	**Vera Soosay**		West Lothian Pensioner
23	**Ailsa Sutherland**		West Lothian Council
24	**Liz Torrance**	Manager	Crossroads
25	**Christine Watt**	Development Worker	Foodtrain
26	**White Jenny**	Regional Manager	Foodtrain

List of Participants at 1st Working Group Session (18th May 2016)

	Name	Designation	Organisation
1	**Ian Buchanan**	Chairman	West Lothian Public Partnership
2	**Wilma Campbell**		Peacock Nursing Home
3	**Caroline Donaldson**		Mood Project
4	**Anne Forest**		
5	**Mary-Densie McKernan**	Manager	Carers of West Lothian
6	**Elaine McKernon**		
7	**Colin Small**		
8	**Barry Steven**		

List of Participants at 2nd Working Group Session (3rd June 2016)

1	**Ian Buchanan**	Chairman	West Lothian Public Partnership
2	**Wilma Campbell**		Peacock Nursing Home

3	**Caroline Donaldson**		Mood Project
4	**Anne Forest**		
5	**Mary-Densie McKernan**	Manager	Carers of West Lothian
6	**Elaine McKernon**		
7	**Colin Small**		
8	**Barry Steven**		
9	**Ailsa Sutherland**		

Focus Group Participants

In order to capture the views and opinions of older people and carers themselves, as part of the fieldwork staff at Figure 8 facilitated a series of seven qualitative focus groups.

Groups were hosted in a variety of venues across West Lothian and representatives of the following groups were spoken to:

- Residents of Very Sheltered Housing / Housing with Care (n=8) – Sunday 15th May 2-4pm
- Residents of Sheltered Housing / Retirement Housing (n=5) – Monday 9th May 10:30-12pm
- Older People who use Day Activities (n=12) – Monday 16th May 1-3pm
- Residents of Care Homes (n=8) – Monday 9th May 2-4pm
- Older People with Mental Health Issues (n=11) – Friday 13th May 10:30-12:30pm
- Active Older People (to include those approaching old age) (n=2) – Friday 27th 10-12pm
- Family Carers of Older People (n=7) – Monday 16th May 10-12pm

[i] West Lothian Integration Joint Board Strategic Plan 2016-2026 (Final Draft), p.33

[ii] Research actually shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2010).

West Lothian Health & Social Care Partnership | NHS Lothian | West Lothian Council

Older People Commissioning Plan Working Group

Terms of Reference and Membership

A. Remit of Working Group

The Scottish Government requires Integration Joint Boards (IJB) in collaboration with their partners to develop strategic commissioning plans for all adult care groups. Strategic commissioning plans should 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.

The purpose of this Working Group is to develop a three year commissioning plan for Older People in accordance with the Scottish Government guidance on Strategic Commissioning Plans[1]. The plan will be informed by a detailed needs assessment which will have been prepared in conjunction with the IJB Strategic Planning Group.

The commissioning plan 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.

The Older People commissioning plan will confirm the total resources available across health and social care in respect of service users and carers and relate this information to the needs of Older People population set out in the needs assessment; such resources should be consistent with the relevant Directions issued by the IJB. The plan 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

[1] http://www.gov.scot/Resource/0046/00466819.pdf

B. Frequency
The group will meet on a regular basis in accordance with the overall schedule for the delivery of the commissioning plan (attached).

C1. Lead Officer
The group will be chaired by Marion Barton, Head of Health.

C2. Contact
The Lead Officer will be supported by

- support officer/s from Commissioning and Programme Management
- support officer from Financial Management

D. Reporting
The group will report to the Strategic Planning Group in accordance with the overall schedule for the delivery of the commissioning plan.

E1. Membership Profile
Participants are chosen to provide the relevant knowledge and expertise to fulfil the remit of the group.

E2. Membership

Member	Role
Marion Barton	Lead Officer
Jillian Dougall	Commissioning Officer
Patrick Welsh	Financial Management Officer
	Health professionals
Dr Douglas McGown	
Mairead Hughes	
Carol Bebbington	
	Social care professionals
Alan Bell	
Pamela Main	
Charles Swan	
Katy McBride	Housing representative
Helen Hay, Anne Forrester	Third sector provider representative/s
Robert Telfer	Scottish Care (Commercial providers)
tbc	Service Users representative
tbc	Carers representative

F. Review
As a short life group it is not anticipated that the remit and membership will need to be reviewed.

Integration Joint Board

Date: 23/08/2016
Agenda Item: 10

SCHEDULE FOR MENTAL HEALTH COMMISSIONING PLAN

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the Integration Joint Board of the schedule for the development of the strategic commissioning plan for Adults with Mental Health problems.

B RECOMMENDATION

To note the planning schedule as detailed in Appendix 1, in particular to note the commitment to present a final draft of the strategic commissioning plan for Adults with Mental Health problems to the IJB meeting on 18 October 2016 for approval.

C TERMS OF REPORT

At the meeting of 24 March 2016 the Integration Joint Board (IJB) approved its strategic plan which includes details of how high level outcomes are to be achieved through a process of strategic commissioning. The Strategic Plan also includes a commitment to develop a series of care group based commissioning plans.

These plans are based on an ANALYSE, PLAN, DO and REVIEW approach:

- Analyse: the process of needs assessment intended to identify the priority needs associated with the relevant care group
- Plan: the planning process that is informed by the needs assessment and identifies how priority needs are to be addressed including the deployment of resources and the performance management approach to be used to monitor progress
- Do: the implementation phase of the plan
- Review: the review of progress based on the agreed performance measures of the plan in conjunction with any significant changes in the environment

Appendix 1 provides the schedule for the development of the plan for Adults with Mental Health problems. The first phase of this has now been completed in respect of the analytical phase – the needs assessment.

Recommendations from the needs assessment are derived from evidence gathered and analysed from the review of literature, surveys and fieldwork including study informants; these have been grouped under six key themes. Appendix 2 gives a summary of the key themes and recommendations from the needs assessment.

The recommendations have been developed to match the level of resource availability. A focus on the recommendations will lead to a comprehensive programme of change and improvement with improved outcomes for Adults with Mental Health problems and the communities in which they live.

A short life Working Group has been established to develop the three year commissioning plan. Appendix 3 provides the Terms of Reference for this group as previously approved by the IJB.

The intention is to prepare the plan in conjunction with the Strategic Planning Group, including relevant stakeholder engagement, thereafter to present a final draft of the strategic commissioning plan for Adults with Mental Health problems to the IJB meeting on 18 October 2016 for approval.

D CONSULTATION

- Strategic Planning Group

E REFERENCES/BACKGROUND

- West Lothian Integration Joint Board meeting - 05 April 2016
- Scottish Government Guidance and Advice - http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance

F APPENDICES

1. Schedule and current progress summary
2. Needs Assessment Executive Summary
3. Terms of Reference of the Working Group

G SUMMARY OF IMPLICATIONS

Equality/Health	The commissioning plan will be subject to an equality impact assessment.
National Health and Wellbeing Outcomes	The commissioning plan will address the relevant National Health and Well-Being Outcomes in accordance with the IJB Strategic Plan

Strategic Plan Outcomes	The commissioning plan will be aligned to relevant Strategic Plan outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The Strategic Plan outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care
Impact on other Lothian IJBs	None
Resource/finance	None
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014 and statutory regulations and guidance
Risk	None

H CONTACT

Contact Person:
Alan Bell, Senior Manager Community Care Support & Services
mailto:Alan.bell@westlothian.gov.uk

Tel 01506 281937

23 August 2016

		2016 Week Ending																		
	Activity	April	May	June	01-Jul	08-Jul	15-Jul	22-Jul	29-Jul	05-Aug	12-Aug	19-Aug	26-Aug	02-Sep	09-Sep	16-Sep	23-Sep	30-Sep	Oct	Comment
	Analyse																			
1	Needs assessment undertaken																			On-going
2	Terms of ref approved for Commissioning Group	05-Apr																		Completed
3	Outline Commissioning Plan template agreed		06-May																	Completed
4	Commissioning Group membership agreed		13-May																	Completed
5	Invitations issued to proposed members		23-May																	Completed
7	Preparation of planning material																			Commenced
8	Initial planning docs circulated to group																			
9	Meeting of Commissioning Group						12-Jul													
	Plan																			
10	Agree scope of Commissioning Plan						12-Jul													
11	Identify current resources available						12-Jul													
12	Prioritise Needs Assessment recommendations						12-Jul													
13	Discuss action plan and activities						12-Jul													
14	Prepare action plan and agree activities																			
15	Prepare draft plan for review																			
16	Meeting of Commissioning Group									05-Aug										
17	Investment/Disinvestment plans agreed									05-Aug										
	Review																			
18	Review and update draft plan																			
19	Equality Impact Assessment																			
20	Meeting of Commissioning Group												25-Aug		09-Sep					
22	Amendments to draft plan																			
23	Submit draft plan to IJB Strategic Planning Group																	22-Sep		
24	IJB Strategic Planning Group Meeting																		06-Oct	
	Do																			
25	Submit plan for IJB for agenda																		06-Oct	
26	IJB Meeting																		18-Oct	

FIGURE 8
CONSULTANCY SERVICES LTD

2016

WEST LOTHIAN MENTAL HEALTH NEEDS ASSESSMENT

PART ONE – THE REPORT

Report prepared for West Lothian Health and Social Care Partnership

EVIDENCE INTO PRACTICE

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Allan Johnston (Associate Consultant)

Simon Little (Associate Consultant)

Trevor McCarthy (Associate Consultant)

David McCue (Associate Consultant)

PROJECT ADVISORY GROUP

The research team was assisted by an Advisory Group (below), which provided accountability, guidance and support. This group met physically on four occasions. The research team are grateful for the advice and facilitation provided by this group throughout the duration of the study.

Carol Bebbington (Senior Manager, Primary Care)

Alan Bell (Senior Manager - Community Care, Support and Service)

Nick Clater (Service Manager – Mental Health)

Jillian Dougall (Service Development Officer)

Pamela Main (Senior Manager - Community Care, Assessment and Prevention)

John McLean (Outreach and Day Services Manager)

Dr David Murray (Service Development Officer)

Charles Swan (Group Manager)

ACKNOWLEDGEMENTS

The research was financed by the West Lothian Health and Social Care Partnership.

The research team offers its sincere thanks to all the individuals who have participated in the interviews, focus groups, working group and stakeholder event. Particular thanks go to the members of the focus groups and working group who have been an immense help to the research team in developing their findings.

REPORT FORMAT

This report has been written primarily with the practice community in mind. Supplementary appendices are also available containing further data, and detail about the research methodology **(see Part 2 – Appendices Report)**. Each strand of data collection and synthesis – dataset reviews, interviews, stakeholder events, working groups, focus groups, and surveys – contains a box with key findings. **To preview this report, the researchers would recommend reading the key findings from each section followed by the final recommendations (Chapter 7 of this report).**

TABLE OF CONTENTS

TABLES AND FIGURES

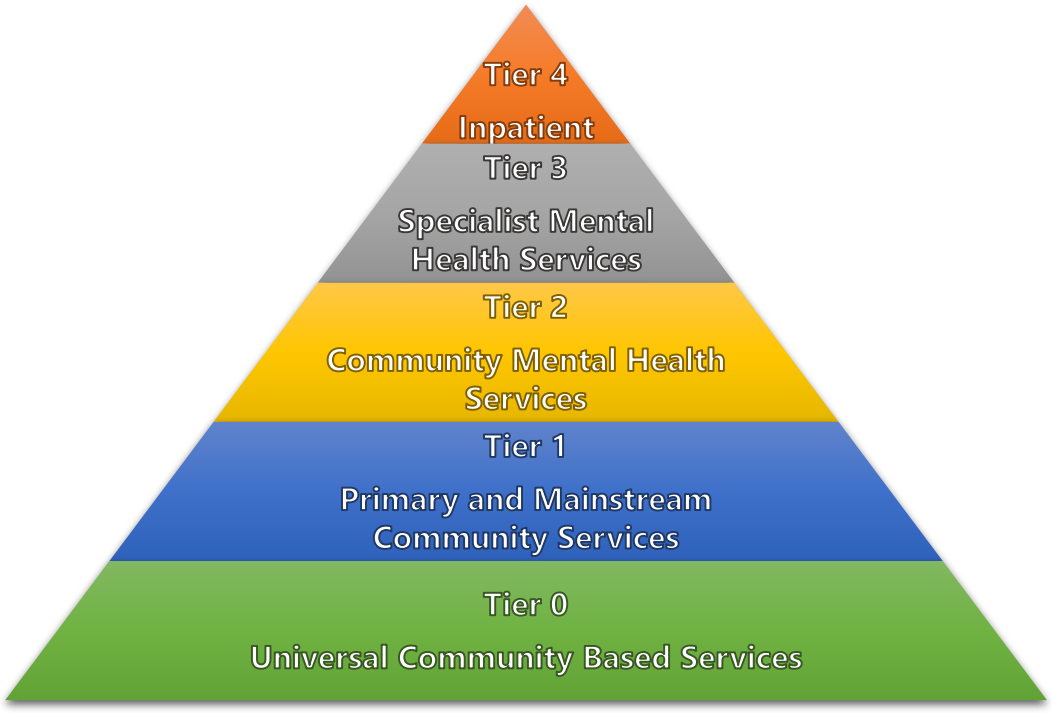
CHAPTER 1: INTRODUCTION

1.1 Introduction and background

Figure 8 Consultancy Services Ltd. was commissioned by West Lothian Health and Social Care Partnership in March 2016 to carry out a comprehensive mental health needs assessment project; and fieldwork took place between April and June 2016.

This needs assessment is a report that presents an overview and analysis of the mental health needs for adults with mental health problems (inclusive of those with early onset dementia), to mental health stakeholders across West Lothian; and will form an important and independent component to inform future mental health planning and service/support provision across Tiers 0-4:

Figure 1.1: Definition of mental health service tiers



Tier 0 Universal Community Based Services - generic services within the community to promote or improve a person's mental health and wellbeing.

Tier 1 Primary and Mainstream Community Services - comprise of GP practices as well as general medical settings and mainstream community support services available to all.

Tier 2 Community Mental Health Services - currently comprise of a range of commissioned community mental health services aimed at people living in the community.

Tier 3 Specialist Mental Health Services - currently comprise of the community mental health teams, the mental health social work team (including the mental health officer service), the community rehabilitation team and statutory day services.

Tier 4 Inpatient Services - currently include an acute psychiatric unit and mental health rehabilitation wards.

The document takes cognisance of the *Mental Health Strategy for Scotland (2012-2015)*[1] which is the successor document to *Delivering for Mental Health*[2] and *Towards a Mentally Flourishing Scotland*[3]and sets out the Scottish Government's objectives for improving mental health and treating mental illness for the period to 2015. It also takes account of the more recent *What Research Matters for Mental Health Policy in Scotland*[4] document which seeks to improve both the impact of research and the evidence base for mental health strategy in Scotland.

1.2 Defining 'mental health' and 'wellbeing'

The World Health Organisation (WHO) defines mental health as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'[5]

Alongside the WHO's definition of overall health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'; this means it is not just important to consider how to support people with mental health problems or disorders, but also how to promote and sustain good mental health in a population. This also highlights the intertwining of physical and mental wellbeing.

Aligned to WHO descriptions, the national *Mental Health Strategy*[6] identifies the importance of terminology but recognises the challenges and difficulties of clear definitions. It states: 'We use the term 'mental illness' where there is or may be a diagnosis of a particular and defined condition within a document such as *The ICD-10 Classification of Mental and Behavioural Disorders* published by the WHO; 'mental disorder' to refer to the broader category of mental illness, personality disorder or learning disability (which follows the definition in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as well as substance misuse disorders); and 'mental health problems' to refer to the more ambiguous territory which includes those with illness, but also people who may be experiencing challenges to their psychological wellbeing, but who do not have a persisting mental illness or disorder.'

For the purposes of this report we use the following terms:

---

[1] Scottish Government (2012). *Mental Health Strategy for Scotland: 2012-2015*. Accessed at: http://www.scotland.gov.uk/resource/0039/00398762.pdf [20th July 2016].

[2] Scottish Executive (2006). *Delivering for Mental Health*. Accessed at: http://www.scotland.gov.uk/resource/doc/157157/0042281.pdf [20th July 2016].

[3] Scottish Government (2009). *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*. Accessed at: http://www.scotland.gov.uk/resource/doc/271822/0081031.pdf [20th July 2016].

[4] Scottish Government (2015). *What Research Matters for Mental Health Policy in Scotland.* Accessed at: http://www.gov.scot/Resource/0049/00494776.pdf [20th July 2016].

[5] http://www.who.int/features/factfiles/mental_health/en/

[6] Scottish Government (2012) op. cit.

1.2.1 Mental health problem

This is an overarching term used to refer to a wide range of diagnosable mental illnesses and disorders, including common mental health problems of low severity and long lasting severe problems.

1.2.2 Mental illness

This is generally used to describe more serious mental health problems which may require specialist services, ranging from depression and anxiety (often referred to as common mental problems) to less common problems such as schizophrenia and bipolar disorder (sometimes referred to as severe mental illness).

1.2.3 Mental Disorder

This is often used to cover a broad range of illnesses, learning disability, personality disorder and substance misuse problems. Under the 2003 Mental Health Act mental disorder was defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind' and was divided into a number of classifications. The 2007 Mental Health Act amended to a more general statement and removed specific classifications.

1.2.4 Wellbeing

The report examines not just mental illness or conditions, but also considers what promotes and supports mental and emotional wellbeing. The concept of 'wellbeing' has gained a wider public airing following the decision to embark on a national measurement programme developed by the Office for National Statistics (ONS), introduced in 2011. At a personal level wellbeing is "a positive physical, social and mental state" at a population, or national level, a range of indicators are being included, individual wellbeing but also the quality of the environment, equality, sustainability and the economy. Research indicates that 'wellbeing' comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity, and engagement are characteristic of someone who has a positive experience of their life. Equally important for wellbeing is our functioning in the world. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.[7]

In a review of the evidence on how individuals can improve wellbeing, the New Economics Foundation (nef)[8] identified five actions to improve wellbeing that individuals could be encouraged to build into their lives:

[7] Huppert F (2008) *Psychological well-being: evidence regarding its causes and its consequences* (London: Foresight Mental Capital and Wellbeing Project 2008).

[8] Aked, J. and Thompson, S. (2011). *Five ways to wellbeing – new applications, new ways of thinking*. New Economics Foundation: London.

1. Connect ... With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. Be active ... Go for a walk or run. Step outside, cycle, play a game, garden, or dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. Take notice ... Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. Keep learning ... Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.
5. Give ... Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Aked et al (2009) contend that it is vital to combine consideration of the structural factors affecting the circumstances of individual's lives, together with the psychological and social aspects of their wellbeing. Only by taking this 'twin track' approach is it possible to account for the dynamic nature of wellbeing, where positive experiences ('feeling good') and outcomes ('doing well') arise through the interplay between external circumstances, inner resources, and capabilities and interactions with the surrounding world.[9]

1.3 Risks and resilience - factors impacting mental health and well being

Mental health is not just a function of an individual's characteristics or attributes, it is also affected by a wide range of social, economic and environmental factors. These have been summarised in Table 1.2 below.

- At an individual level people may be affected by biological or genetic factors or may have specific difficulties, for example communication difficulties, increasing vulnerability to mental health problems, by affecting their ability to engage, participate or understand aspects of daily living.

[9] Aked, J., Steuer, N., Lawlor, E. and Spratt, S., (2009), *Backing the Future*. See also Foresight Mental Capital and Wellbeing Project (2008), *Final Project report – Executive summary*, London: The Government Office for Science; and Thompson S, & Marks N (2008) *Measuring well-being in policy: Issues and applications,* New Economics Foundation: London.

- There are numerous socio-economic circumstances which impact mental health and wellbeing; The Marmot Review[10] highlighted the issue of employment and education; but specific events can also affect mental wellbeing including bereavement, family or relationship breakdown and exposure to violence or abuse. When considering a life course, people may be more exposed to risks at different ages; for example older people are more likely to experience bereavement of partners/friends and may become more socially isolated whereas younger adults may be more at risk of homelessness and unemployment.
- Although this needs assessment is focussed on adults, it is recognised that experience in childhood is important and resilience in adulthood may relate to the experiences and skills developed in childhood.
- At a higher level wider factors such as basic access to services, economic recession or exposure to widespread violence or insecurity also impact mental health; these factors can be considered as the prevailing environment or conditions in which people live.

Table 1.2: Risk factors and resilience

LEVEL	ADVERSE FACTORS		PROTECTIVE FACTORS
Individual attributes	Low self-esteem	⇔	Self-esteem, confidence
	Cognitive/emotional immaturity	⇔	Ability to solve problems & manage stress or adversity
	Difficulties in communicating	⇔	Communication skills
	Medical illness, substance use	⇔	Physical health, fitness
Social Circumstances	Loneliness, bereavement	⇔	Social support of family & friends
	Neglect, family conflict	⇔	Good parenting / family interaction
	Exposure to violence/abuse	⇔	Physical security and safety
	Low income and poverty	⇔	Economic security
	Difficulties or failure at school	⇔	Scholastic achievement
	Work stress, unemployment	⇔	Satisfaction and success at work
Environmental Factors	Poor access to basic services	⇔	Equality of access to basic services
	Injustice and discrimination	⇔	Social justice, tolerance, integration
	Social and gender inequalities	⇔	Social and gender equality
	Exposure to war or disaster	⇔	Physical security and safety

(Taken from Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors WHO 2012)

[10] The Marmot Review (2010). *Fair Society, Healthy Lives.* Available at: http://www.ucl.ac.uk/whitehallIII/pdf/FairSocietyHealthyLives.pdf [Accessed on 20th July 2016].

1.4 Vulnerable groups

Risks to mental health manifest themselves at all stages in life and potentially leave us all vulnerable to experiencing mental health problems. Having said this, by understanding the range of factors outlined in Table 1.2, it is possible to identify specific groups of people who have a greater risk or vulnerability to poor mental health; groups where we might expect to find greater levels of mental health need, including:

- People with long term physical illness, conditions or disabilities;
- People with substance misuse problems;
- Deprived communities, people on low incomes;
- Unemployed and people on out of work illness and disability benefits;
- People with poor education outcomes, no qualifications and low skill;
- Military veterans and people affected by conflict and war;
- People affected by violence and/or abuse, including domestic violence;
- Homeless people and people at risk of homelessness;
- Offenders, young offenders, prisoners and detainees;
- People who have suffered bereavement, and/or family breakdown including "care leavers";
- People who are socially excluded;
- People who experience barriers to accessing services and support; and
- People from black and minority ethnic groups.

Of course the relationship is complex, and risk factors may work both ways; so that people who are homeless may be at greater risk of poor mental health, and people who have mental health problems may be more at risk of being homeless. Some people fall into numerous groups; for example many people rough sleeping on the streets have "tri-morbidity", mental health problems and substance misuse problems and multiple long term health conditions or disabilities.

1.5 Purpose

The purpose of this study is to assist the West Lothian Joint Mental Health Service and its partner agencies to:

- Identify the 'bigger picture' in terms of the health and wellbeing needs and inequalities of those with mental health problems;
- Establish a process that will identify the existing and future needs of those with mental health problems;
- Map services and the way they are used; and

- Analyse and enable the prioritisation of services; and therefore inform commissioning requirements.

1.6 Objectives

The specific objectives of this project are as follows:

- To provide a comprehensive assessment and mapping of specialist and non-specialist services for those with mental health problems;
- To conduct an assessment of local need for such services;
- To identify gaps and areas of unmet need in current provision;
- To examine the current use of services, both community and inpatient;
- To examine the accessibility, appropriateness and location of current services;
- To identify any areas with over-provision;
- To provide evidence based recommendations as to how services could be extended or adapted to meet need including relationship and any overlap between agencies; and
- To suggest locality pathways for intervention and support for those with mental health problems.

1.7 Scope

This document presents the findings of the needs assessment and reports on the future requirements for mental health services/supports across West Lothian. Evidence from the Needs Assessment will assist:

- In providing evidence on the extent to which current services are meeting demand;
- In the commissioning of new services;
- In identifying gaps in existing service provision;
- In identifying areas of over provision;
- In providing evidence on the extent to which services are accessible and in the right location;
- In suggesting ways as to how West Lothian Health and Social Care Partnership and its partner agencies could extend / adapt services to meet need; and
- In providing objective comment on the re-structuring of relationships between specialist mental health services, wider health and social care services, communities, families and individuals to promote and maintain a recovery-oriented system of care across the area.

Conducting needs assessments in such a complex environment requires a great deal of understanding and flexibility on the part of the project team, and it is essential to engage as broad a range of interests as possible in the assessment process. To this end, the research team sought the

views of a wide range of different mental health and mainstream services, people who use services, families and carers; advocates and other stakeholders. The qualitative element of the study in particular aimed to consult with staff from specialist mental health services, together with a sample of the following groups which support people with mental health problems:

- Service users across the whole spectrum of mental health services;
- Carers and families;
- Advocates;
- Treatment and care providers (statutory, third, private);
- Addiction services;
- Criminal Justice services;
- Police; and
- Housing and homelessness services.

Discussions with the project steering group and key strategic planners took place at several points during the fieldwork, and this acted as a helpful 'sounding board' for the emerging findings of the study.

1.8 Data Sources

The needs assessment incorporates data from a wide variety of sources and includes evidence collated from an extensive consultation process with services users, local organisations and professionals.

The various data sources utilised in this report include:

- Audit Scotland – Overview of Mental Health Services 2009 (http://www.audit-scotland.gov.uk/docs/health/2009/nr_090514_mental_health.pdf);
- Information Services Division, part of NHS National Services Scotland (http://www.isdscotland.org/);
- National Records of Scotland – Statistics and Data[11] (http://www.nrscotland.gov.uk/statistics-and-data);
- NHS Health Scotland – Mental Health Indicators (http://www.healthscotland.com/scotlands-health/population/mental-health-indicators.aspx);
- Office for National Statistics – NOMIS Official Labour Market Statistics (https://www.nomisweb.co.uk/reports/lmp/gor/2013265931/report.aspx);

[11] The National Records of Scotland now holds the information contained on the former General Register Office for Scotland website, which is no longer being updated, as of 30/09/14 (http://www.gro-scotland.gov.uk/).

- Office for National Statistics – Personal Wellbeing in the UK 2014-15 (http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2013-14/sb-personal-well-being-in-the-uk--2014-15.html);
- Scotland's Census 2011 (http://www.scotlandscensus.gov.uk/);
- Scottish Government Statistics (http://www.scotland.gov.uk/Topics/Statistics);
- Scottish Health Survey (SHeS) 2014 (http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/scottish-health-survey/Publications);
- Scottish Index of Multiple Deprivation 2012 (http://simd.scotland.gov.uk/publication-2012/);
- Scottish Parliament Information Centre (SPICe) – Mental Health in Scotland 2014 (http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_14-36.pdf);
- Scottish Public Health Observatory (ScotPHO) – Health and Wellbeing Profiles 2015 (http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool);
- Scottish Public Health Observatory (ScotPHO) – Public Health Information for Scotland (http://www.scotpho.org.uk/);
- West Lothian Intergration Joint Board – Strategic Plan 2016-2026 (http://www.westlothianchcp.org.uk/media/10225/West-Lothian-IJB-Draft-Strategic-Plan-2016-26/pdf/West-Lothian-IJB-Strategic-Plan-2016-26-Draft-Consultation.pdf);
- local data gathered from commissioned mental health services; and
- other locally gathered information and lifestyle surveys etc.

1.9 The Needs Assessment Process

This needs assessment project uses a tried and tested model for health needs assessment (which is detailed below) and is applied to both the health and social care needs of people with mental health problems across West Lothian.

In broad terms, health and social care needs assessment is the systematic approach to ensuring that the Health and Social Care Partnership uses its resources to improve the health and wellbeing of the population in the most efficient way. It involves methods to describe the health and wellbeing problems of a population, identify inequalities in health and social care (and access to services and support provisions), and determine the priorities for the most effective use of resources.

Health and social care needs assessment has become important as the costs of health and social care are rising and resources are, at the same time, limited. In addition, there is a large variation in availability and use of health and social care services and support provisions by geographical area and point of provision.

Another force of change is consumerism. The expectations of members of the public have led to greater concerns about the quality of the services they receive, from access and equity to appropriateness and effectiveness.

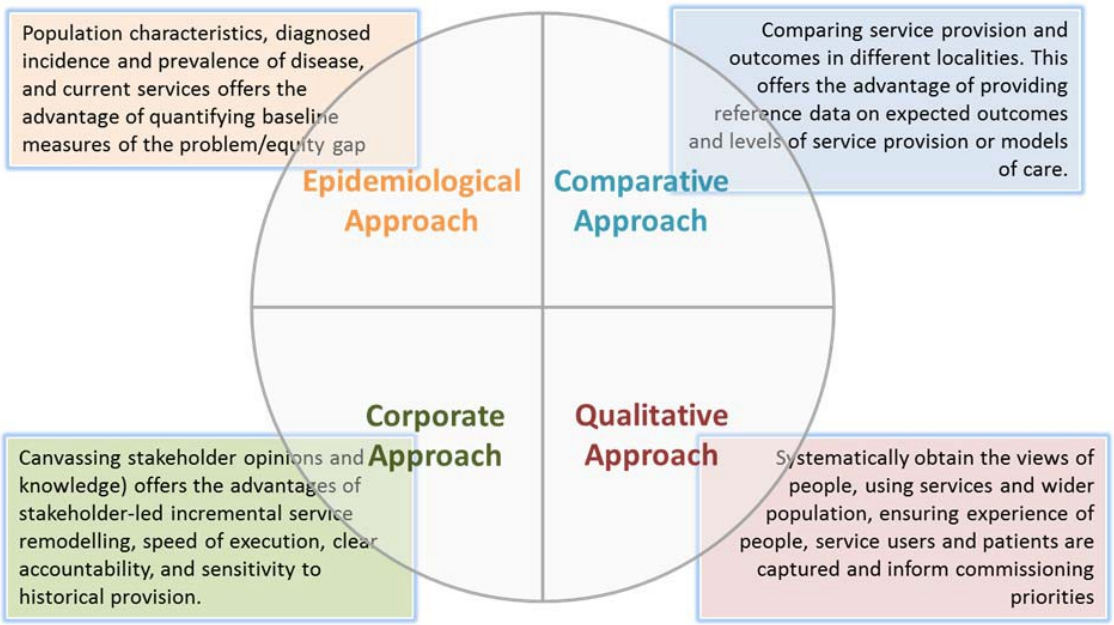
The needs assessment process has been defined, in guidance from the National Institute of Clinical Excellence (NICE), as:

> *"A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities."*[12]

The assessment process involves identifying need from four different perspectives (see Figure 1.3):

- **Epidemiological needs** – the use of health and social care information based on the population, including demographic trends, health status and risk, as well as evidence of clinical effectiveness of services and interventions.
- **Felt and expressed needs (Qualitative)** – the views of the public, from surveys, focus groups and the like, often using participatory appraisal methods.
- **Normative or expert needs (Corporate)** – as identified by professionals or experts.
- **Comparative needs** – the scope and nature of services available to the population and how these compare with services elsewhere.

Figure 1.3 Diagram of the needs assessment process



The study methods used in this needs assessment (outlined in section 1.10 below) were designed to capture each of these four different approaches/perspectives and are identified in Table 1.4 below.

[12] Cavanagh S and Chadwick K (2005), "Health needs assessment: A practical guide". London: NICE. Available at: http://www.nice.org.uk/

1.10 Summary of Study Methods

The study was conducted in four stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods and sample populations. These are set out in Table 1.4 below. All questionnaires and interview schedules were approved by commissioners prior to use.

Table 1.4: Summary of Data Collection Methods

Stage 1	**Method**		**Link to approaches / perspectives on need**
Review of Existing Datasets	Desk-based review of national and local datasets and any local specialist service data available.		• Epidemiological • Comparative
Stage 2	**Method**	**Sample**	
Quantitative Survey	Online Surveys	• Managers of all specialist mental health services • Staff in all specialist mental health services.	• Normative/Expert (Corporate) • Comparative
Stage 3	**Method**	**Sample**	
Quantitative Surveys	Online and paper-based surveys	• Service users • Non (potential) service users • Carers, family members, advocates	• Felt and Expressed (Qualitative)
Stage 4	**Method**	**Sample**	
Stakeholder Event / Working Group / Qualitative Interviews / Focus Groups	Stakeholder Event	• All key stakeholders invited to a half-day event in relation to mental health.	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Working Group	• Sample of key stakeholders recruited via approaches from the Research Steering Group, and via the stakeholder event above. The working group to meet twice to explore mental health issues.	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Semi-structured interviews	• All specialist services • A range of non-specialist services • Other relevant stakeholders	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Focus Groups	• Service users • Non (potential) service users • Carers, family members, advocates	• Felt and Expressed (Qualitative)

1.11 Terminology

When quoting individual respondents or citing literature sources we will use the terms they have chosen for accuracy of representation.

1.12 Considerations and limitations

There are a number of factors which should be taken into account when reading this report. These are:

- The views of those interviewed and surveyed were taken and reported in good faith and are their own, not necessarily those of Figure 8 Consultancy Services Ltd. or the organisations they represent. It cannot be assumed that the views of the participants in interviews, focus groups, stakeholder events or working groups are representative of all similar stakeholders.
- Making comparisons with other areas of similar population and/or geography, as well as prevalence of mental health problems, allows for a degree of 'benchmarking' to observe the relative position of West Lothian. It should be noted that there may be variations between areas in the way in which this data is collected.
- In health care, need is commonly defined as 'the capacity to benefit'. If health needs are to be identified then an effective intervention should be available to meet these needs and improve health. There will be no benefit from an intervention that is not effective or if there are no resources available (Wright, Williams & Wilkinson, 1998).[13] The definition of need used in this study is 'the number of individuals in the general population with mental health problems who could benefit from intervention'. There are several challenges in estimating the prevalence of mental health problems in the general population involving the definition of 'problems' and the methods used to obtain the estimate.

[13] Wright, J., Williams, R., & Wilkinson, J.R. (1998). Development and Importance of Health Needs Assessment. *British Medical Journal,* 316; 1310-1313.

CHAPTER 2: EPIDEMIOLOGY

2.1 Introduction and Aims

After considering first the overall demographic make-up of West Lothian, this section is broken into a number of sub-sections. Under each of these, it examines the general research on what makes people more or less vulnerable in terms of their mental wellbeing, then at the national statistics, and then the local figures where they are available.

2.2 Method of Data Collection

Information was identified and drawn together from a range of local and national sources on prevalence and trends in the patterns of mental health problems in Scotland over the past ten years. In order to provide comparative analysis on a range of health and social indicators three local authority areas were identified from similar socioeconomic deprivation backgrounds as West Lothian[14], as well as using information from the Local Government Benchmark Framework (LGBF)[15]. The LGBF considers the many differences between local authorities that contribute to variations in performance, including: population; geography; social and economic factors; and the needs and priorities of local communities.

Falkirk, Renfrewshire and South Lanarkshire were agreed with the study commissioners and chosen as comparators as they have similar characteristics and populations as West Lothian.

2.3 Data Issues

Data relating specifically to people with mental health problems can be difficult to find and often there are problems with the data which mean that it does not give a completely accurate picture. This said, the data which is available is still useful in providing information regarding the needs of this population as long as it is interpreted with certain caveats in mind.

2.4 Demography of West Lothian

Present and future need for services and assets to address mental health needs in West Lothian depends in part on the demography of the county. In this section basic population data is therefore briefly assessed.

[14] http://www.scotland.gov.uk/Topics/Statistics/Browse/Social-Welfare/TrendSIMD

[15] http://www.scotborders.gov.uk/info/691/council_performance/1352/local_government_benchmarking_framework

2.4.1 Area Profile

West Lothian is an area of 165 square miles (428 square km) situated in the east of Scotland, positioned between Glasgow and Edinburgh, and surrounded by the council areas of Edinburgh, Falkirk, North Lanarkshire and the Scottish Borders. Livingston, Bathgate and Linlithgow are the main centres of population in this local authority.

Figure 2.1: Map of West Lothian[16]

According to National Records of Scotland, the 2015 mid-year population estimate for West Lothian was 178,550[17], an increase of 0.8% from 177,200 in 2014. This represents a 2% increase of the whole population figures reported in 2011 Census (175,118). In relation to the comparison areas, the table below shows West Lothian has a higher population than Falkirk (157,640) and Renfrewshire (174,230), and lower than South Lanarkshire (315,360). Scotland's overall population is also shown (5,347,600).

Table 2.2: Whole Population Figures for West Lothian, Scotland and Comparison Areas.[18]

	West Lothian	South Lanarkshire	Renfrewshire	Falkirk	Scotland
2015 Mid-Yr Estimate	**178,550**	316,230	174,560	158,460	5,373,000

*NRS = National Records of Scotland

[16] West Lothian Map, Google Map 2015. Available at: https://www.google.co.uk/maps/place/West+Lothian/@55.8546737,-3.7929644,10z/data=!4m2!3m1!1s0x4887c514c305f6ff:0x9f54bb6a8afceff3. [Accessed on: 22nd July 2016].

[17] National Records of Scotland.2016. *West Lothian Council Area - Demographic Factsheet. Available at:* http://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/west-lothian-factsheet.pdf. [Accessed on: 22nd July 2016].

[18] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

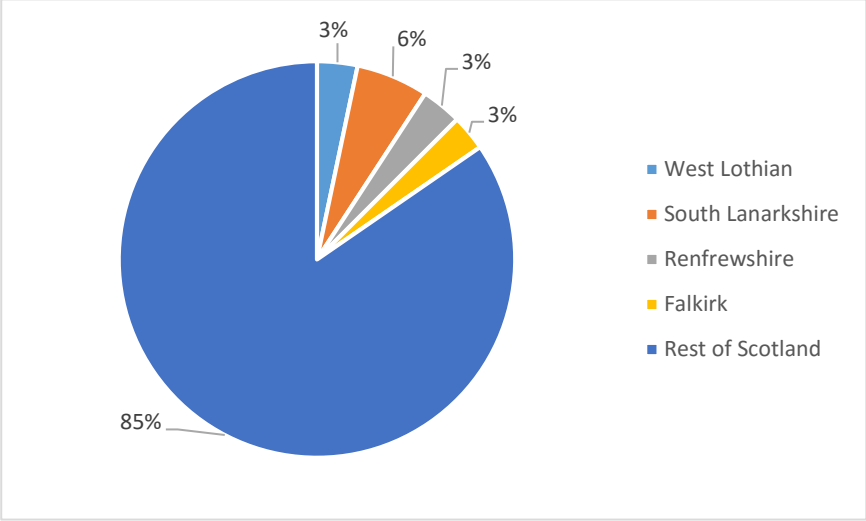
A full breakdown by age group and gender is shown in the table below:

Table 2.3 Estimated population of West Lothian, by age group and gender, 2015[19]

Age Group	Male Population	Female Population	Total	%
0-15	17,962	17,140	35,102	19.7
16-29	15,168	14,705	29,873	16.7
30-44	17,572	18,417	35,989	20.2
45-59	19,546	20,453	39,999	22.4
60-74	**12,557**	**13,806**	**26,363**	**14.8**
75+	**4,746**	**6,478**	**11,224**	**6.3**

Further analysis of the available population figures is demonstrated below which shows population percentages of West Lothian, South Lanarkshire, Renfrewshire and Falkirk compared with the rest of Scotland. The figure reveals that West Lothian, Renfrewshire and Falkirk have a similar population percentage (3%), with South Lanarkshire double this (6%). The rest of Scotland accounts for 85% of the population.

Figure 2.4: Population Breakdown of West Lothian, Comparison Areas and Rest of Scotland.[20]



[19] National Records of Scotland. 2016. Statistics and data. *Available at:* http://www.nrscotland.gov.uk/statistics-and-data. [Accessed 19 May 2016].

[20] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

2.4.2 Population: Sex

There are more females than males in West Lothian (90,999 compared to 87,551). As can be seen in the table below, there are similarities between West Lothian figures, Scottish figures and comparison areas when male and female statistics are put in percentages.

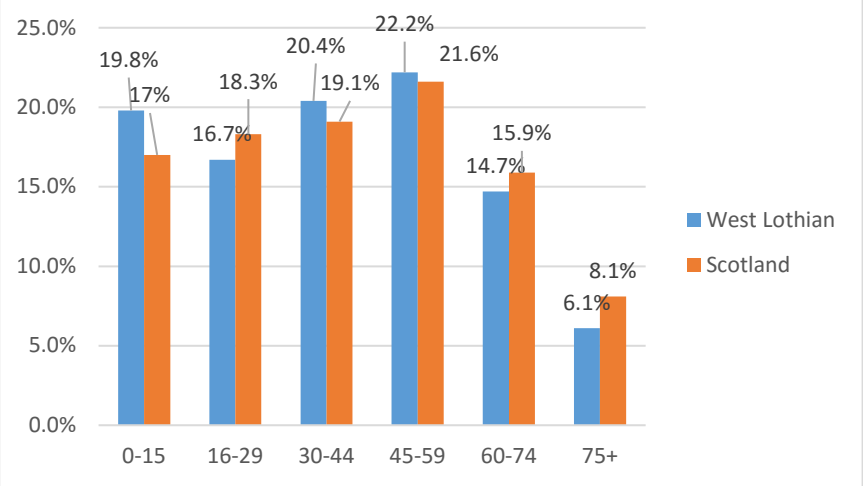
Table 2.5: Breakdown of population by Gender (for West Lothian, Scotland and Comparison Areas)[21]

	West Lothian	South Lanarkshire	Renfrewshire	Falkirk	Scotland
Male	**48.9%**	48.1%	48.1%	48.8%	48.5%
Female	**51.1%**	51.9%	51.9%	51.2%	51.5%

2.4.3 Population: Age

The population of the West Lothian is largely aged between the age brackets of 30-44 and 45-59 years of age, with 20.4% and 22.2% of people in West Lothian belonging to these age categories. This is more than the Scottish averages for these age categories (19.1% and 21.6% respectively). The graph below shows comparisons of age categories in West Lothian compared to the Scottish average.

Figure 2.6: West Lothian Population Breakdown by Age, Compared to the Scottish Average.[22]



[21] National Records of Scotland, 2011 *Census*. Available at: http://www.scotlandscensus.gov.uk/ods-web/area.html. [Accessed 22nd July 2016].

[22] National Records of Scotland. 2016. *West Lothian Council Area- Demographic Factsheet.* Available at: http://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/west-lothian-factsheet.pdf [Accessed 22nd July 2016].

2.4.4 Population: Projected Population

Current projections for West Lothian are estimating an overall population increase of 10.1 % between 2015 (n=178,550) and 2037 (n=196,664). From the table below it can be seen that the projected population of West Lothian until 2037.

Table 2.7: Projected Population in West Lothian - 2015, 2017, 2022, 2027, 2032, 2037.[23]

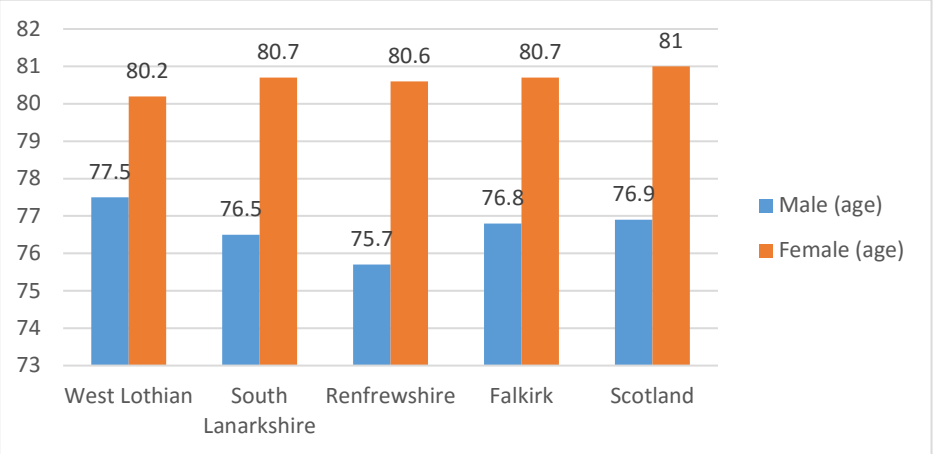
Projected years	2015	2017	2022	2027	2032	2037
Projected population	178,550	180, 252	184,774	189, 208	193,254	196,664

2.4.5 Population: Life expectancy

Female life expectancy at birth (80.5 years) is greater than male life expectancy (77.9 years) in West Lothian, with male life expectancy higher than the Scottish average (77.9 years compared to 77.1 years) and female life expectancy lower (80.5 years compared to 81.1 years). Male life expectancy at birth in West Lothian is improving more rapidly than female life expectancy.

Further analysis is revealed in the graph below and it can be seen that life expectancy at birth for males in West Lothian is higher than all other areas (South Lanarkshire 76.6 years, Renfrewshire 75.9 years and Falkirk 77.3 years). Life expectance at birth for females is slightly lower than all other areas (South Lanarkshire 80.9 years, Renfrewshire 80.6 years and Falkirk 81.0 years).

Figure 2.8: West Lothian Life Expectancy at Birth by Sex, Comparison Areas and Scotland, 2012-2014.[24]



[23] Ibid.

[24] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

2.4.6 Population: Ethnicity

The 2011 Census reveals 97.5% of the people in West Lothian consider their ethnic group to be 'white' which is higher than national figures (96.1%). Further analysis of these figures demonstrates that 87.8% of people within West Lothian consider their ethnic group to be 'White Scottish', which, again, is higher than the national average (84%), but lower than all comparison areas (South Lanarkshire 91.6%, Renfrewshire and Falkirk both 91.3%). The table below demonstrates further analysis of 2011 census data on ethnicity.

Table 2.9: Ethnicity Breakdown for West Lothian, Comparison Areas and Scotland.[25]

	West Lothian	S. Lanarkshire	Renfrewshire	Falkirk	Scotland
White- Scottish	87.8%	91.6%	91.3%	91.3%	84%
White- Other British	5.8%	3.8%	3.3%	4.5%	7.9%
White- Irish	0.7%	1%	0.9%	0.6%	1%
White-Gypsy/Traveller	-	0.1%	-	0.1%	0.1%
White-Polish	1.9%	0.4%	0.7%	0.7%	1.2%
White- Other	1.3%	0.8%	0.9%	0.9%	1.9%
Asian, Asian Scottish or Asian British	1.7%	1.6%	1.8%	1.3%	2.7%
Mixed or multiple ethnic groups	0.3%	0.2%	0.2%	0.2%	0.4%
African	0.3%	0.2%	0.5%	0.1%	0.6%
Caribbean or Black	0.1%	0.1%	0.1%	0.1%	0.1%
Other Ethnic group	0.1%	0.1%	0.2%	0.1%	0.3%

2.5 Deprivation

It is documented that individuals from deprived areas have lower overall mental well-being compared to those from more affluent areas, with national and international research demonstrating that those in deprived areas are more likely to have higher rates of hospital admissions, increased risk of premature death[26], are twice as likely to have anxiety problems than those in the least deprived areas, and also have higher rates of suicide.[27]

[25] National Records for Scotland. 2013. *2011 Census: Key Results on Population, Ethnicity, Identity, Language, Religion, Health, Housing and Accommodation in Scotland - Release 2A. Available at:* http://www.scotlandscensus.gov.uk/documents/censusresults/release2a/StatsBulletin2A.pdf [Accessed 22 July 2016].

[26] Office of the Deputy Prime Minister. 2004. *Mental health and social exclusion: Social Exclusion Unit report.* Available at: http://www.socialfirmsuk.co.uk/resources/library/mental-health-and-social-exclusion-social-exclusion-unit-report[Accessed 22 July 2016].

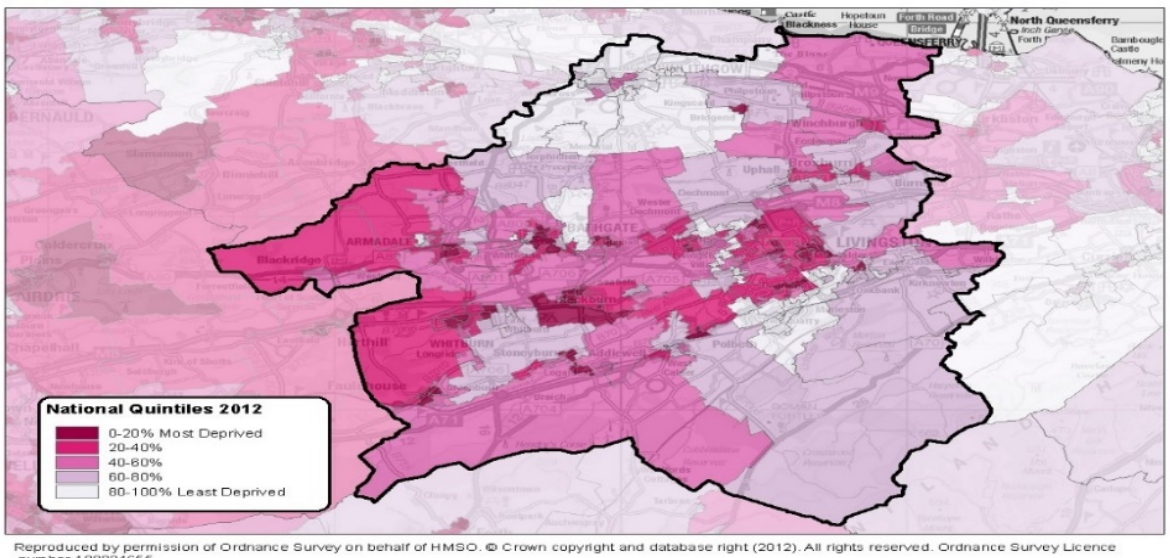
[27] Audit Scotland. 2012. *Health inequalities in Scotland.* Available at: http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf [Accessed 22 July 2016].

The Scottish Index of Multiple Deprivation (SIMD herein) is a Scottish Government tool which includes different aspects of deprivation to combine them into a single index. Specifically, the index incorporates seven domains to measure the multiple aspects of deprivation and the overall index is a weighted sum of the seven domain scores as follows: income (28%), employment (28%), health (14%), education (14%), geographic access (9%), crime (5%) and housing (2%). There are a total of 6,506 datazones (small areas) within Scotland to which the SIMD offers a relative ranking for each datazone from 1 (most deprived) to 6,506 (least deprived). The datazones contain approximately 350 households/ 800 people. Current SIMD (2012) figures for Scotland show that 742,200 people live in the 15% most deprived areas of Scotland. Figures also shows that multiple deprivation has become less clustered over time with 2004 figures highlighting approximately half of all datasets in the most deprived 10% across Scotland were in Glasgow City, whereas 2012 figures highlights that this has fallen to 35.8%. Currently Ferguslie Park, Paisley, is the most deprived area in Scotland, whereas the least deprived datazone is the Craiglockhart area of Edinburgh.[28]

2.5.1 Deprivation within West Lothian

Within West Lothian there are 211 datazones. The SIMD 2012 reveals that 13 (6.2%) of West Lothian's 211 datazones were found in the 15% most deprived datazones in Scotland, compared to 19 (9%) in 2009, 14 (6.6%) in 2006 and 9 (4.3%) in 2004. The most deprived datazone in West Lothian in the overall SIMD 2012 is S01006416, which is found in Bathgate East. It has a rank of 440, meaning that it is amongst the 10% most deprived areas in Scotland. The figure below shows the national quintiles for West Lothian.

Figure 2.10: Levels of Deprivation in West Lothian in SIMD 2012 by quintile.[29]

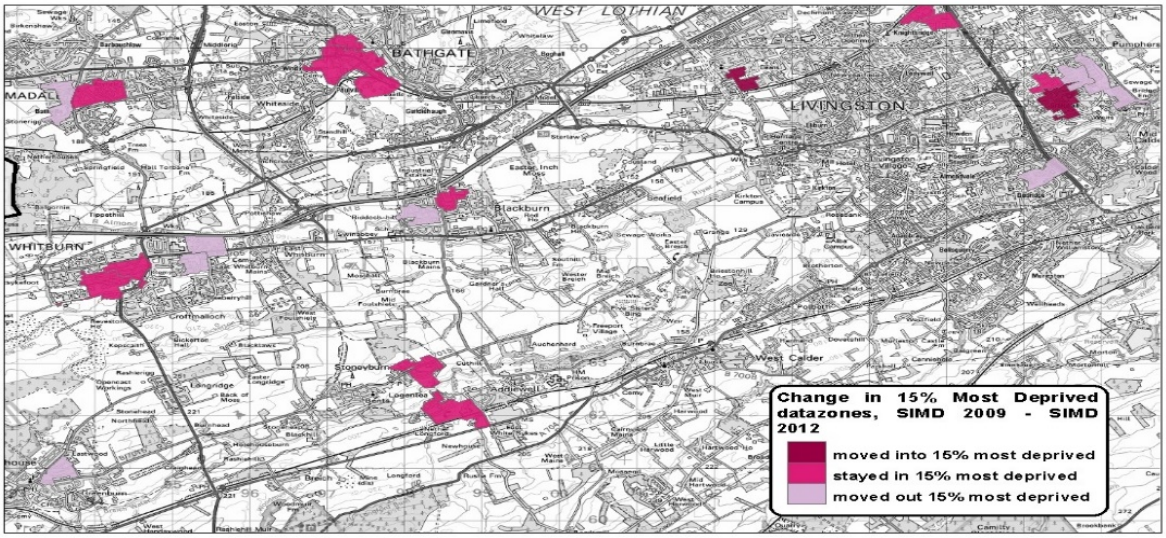


[28] Scottish Government. 2012. *SIMD 2012 Results.* Available at: http://simd.scotland.gov.uk/publication-2012/simd-2012-results/ [Accessed 22 July 2016].

[29] Ibid.

The figure below shows changes in deprivation within West Lothian with areas which have moved into the 15% most deprived, areas which have stayed in the 15% most deprived and areas which have moved out the 15% most deprived areas between SIMD 2009 and SIMD 2012.

Figure 2.11: Datazones in West Lothian Which Have Stayed in or Moved Out of the 15% Most Deprived in Scotland.[30]



SIMD mages courtesy of the Scottish Government

Further analysis of the SIMD (2012) figures is presented in the table below which shows West Lothian as having 6.2% of the 211 datazones in the 15% most deprived datazones in Scotland. This figure is lower than South Lanarkshire (13.3%), Renfrewshire (22.4) and also Falkirk (9.1%).

Table 2.12: Percentage of Most Deprived Zones in West Lothian and Comparison Areas According to SIMD 2012.[31]

West Lothian	South Lanarkshire	Renfrewshire	Falkirk
6.2% (13 out of 211)	13.3% (53 out of 398)	22.4% (48 out of 214)	9.1% (18 out of 197)

2.6 Employment (Working age)

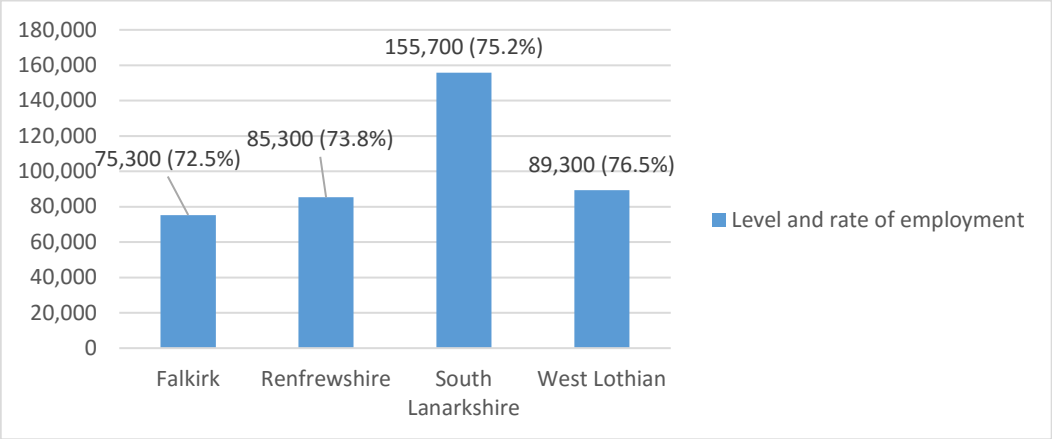
Current figures show that there are approximately 85,900 (73.3%) people employed within West Lothian. The figure below shows employment rates and levels in West Lothian and comparison areas from April 2015 - March 2016. Between 2014-15 and 2015-16 there has been a 3.2% drop (76.5% to 73.3%) in percentage rate of people employed in West Lothian, compared to a stable rate across Scotland (72.9%). In this period, West Lothian has gone from having a higher percentage rate

[30] Scottish Government. 2012. *SIMD 2012 Results.* Available at: http://simd.scotland.gov.uk/publication-2012/simd-2012-results/ [Accessed 22 July 2015].

[31] Ibid.

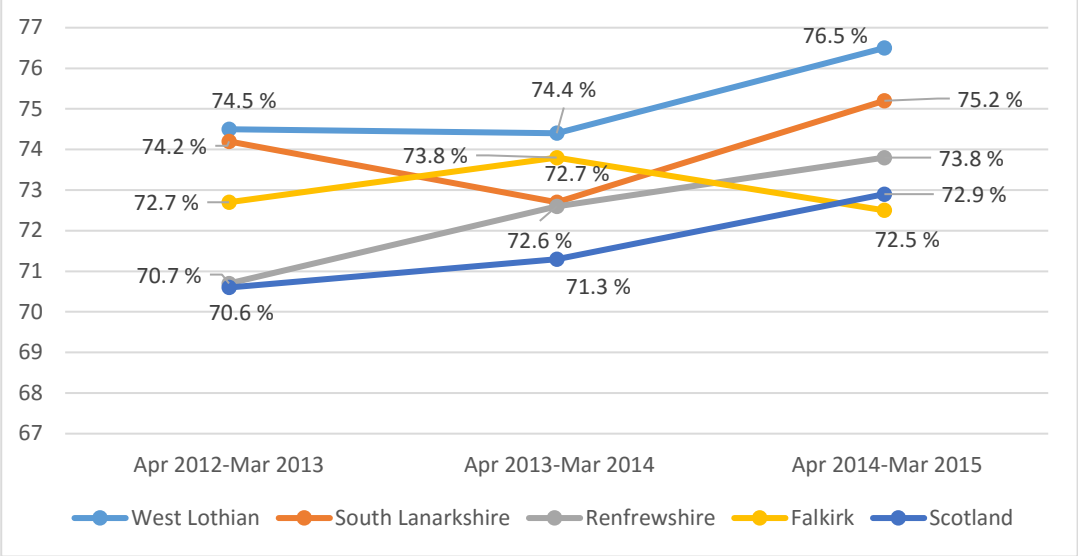
employed than all three comparison areas, to now having a lower percentage rate employed than all three comparison areas areas (Falkirk 75.3%; Renfrewshire 74.0%; South Lanarkshire 75.5%).

Table 2.13: Employment Rates and Levels in West Lothian and Comparison Areas, April 2014 - March 2015.[32]



In further detail, the figure below shows employment rates and levels in West Lothian, comparison areas and Scotland in years 2012-2013, 2013-2014, 2014-2015 and 2015-2016. The figure reveals that West Lothian is the only area to have experienced a decrease in its employment rate in the most recent period.

Figure 2.14: Percentages of Employment Rates in West Lothian, Comparison Areas and Scotland, 2012-2013, 2013-2014, 2014-2015 and 2015-2016[33]



[32] Scottish Government. 2016. *Annual population survey, results for year to March 2016 - summary tables.* Available at: http://www.gov.scot/Topics/Statistics/Browse/Labour-Market/Publications/APSAMTables [Accessed 22 July 2016].

[33] Scottish Government. 2016, op. cit.

2.7 Unemployment

Overall unemployment figures include people who are out of work and not only those claiming unemployment benefits. From the table below it can be seen that the unemployment figures in West Lothian are lower than the Scottish average (5.2% compared to 5.7%). Furthermore, West Lothian has lower unemployment figures than South Lanarkshire (5.5%), Renfrewshire (5.8%), but an equivalent rate to Falkirk (5.2%).

Table 2.15: Unemployment Figures for West Lothian, South Lanarkshire, Renfrewshire and Falkirk Compared to Scotland, April 2015-March 2016[34]

West Lothian numbers	%	Scotland
4,700	5.2%	5.7%
South Lanarkshire numbers	**%**	
9,100	5.5%	5.7%
Renfrewshire numbers	**%**	
5,2000	5.8%	5.7%
Falkirk numbers	**%**	
4,300	5.2%	5.7%

Recent labour market profile figures show the breakdown of key benefit claimants who are of working age within West Lothian and from the table it can be seen that there were a total of 15,440 working age clients claiming key benefits from April 2015-March 2016.

Table 2.16: Working-age Client Group - Key Benefit Claimants in West Lothian, April 2015-March 2016.[35]

	West Lothian numbers	(%)	Scotland %
Total claimants	15,440	13.4	13.6
Job seekers	1,670	1.5	1.7
ESA and incapacity benefits	8,970	7.8	7.9
Lone parents	1,190	1.0	1.0
Carers	1,890	1.6	1.6
Others on income related benefits	270	0.2	0.2
Disabled	1,200	1.0	1.1

[34] Office for National Statistics. 2016. *Local authority profile.* Available at: http://www.nomisweb.co.uk/reports/lmp/la/contents.aspx [Accessed 22nd July 2016].

[35] Office for National Statistics. 2016. *Local authority profile.* Available at: http://www.nomisweb.co.uk/reports/lmp/la/contents.aspx [Accessed 22nd July 2016].

Bereaved	260	0.2	0.2
Main Out-of-Work Benefits	12,090	10.5	10.7

*Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. These groups have been chosen to best represent a count of all those benefit recipients who cannot be in full-time employment as part of their condition of entitlement. Those claiming solely Bereavement Benefits or Disability Living Allowance (DLA) are not included as these are not out-of-work or income based benefits.

2.8 Welfare Sanctions

With the introduction of the new Welfare Reform Act in 2012, a new system of sanctions was implemented which has resulted in the number of unfavourable sanctions increasing for jobseekers. However, such sanctions can have negative outcomes for claimants.[36] The graph below highlights sanctions under the old regime and the higher level of sanctions since the new regime was implemented in 2012.

Figure 2.17: Annual Number of Adverse JSA Sanction Decisions in Scotland, 2001-2013[37]

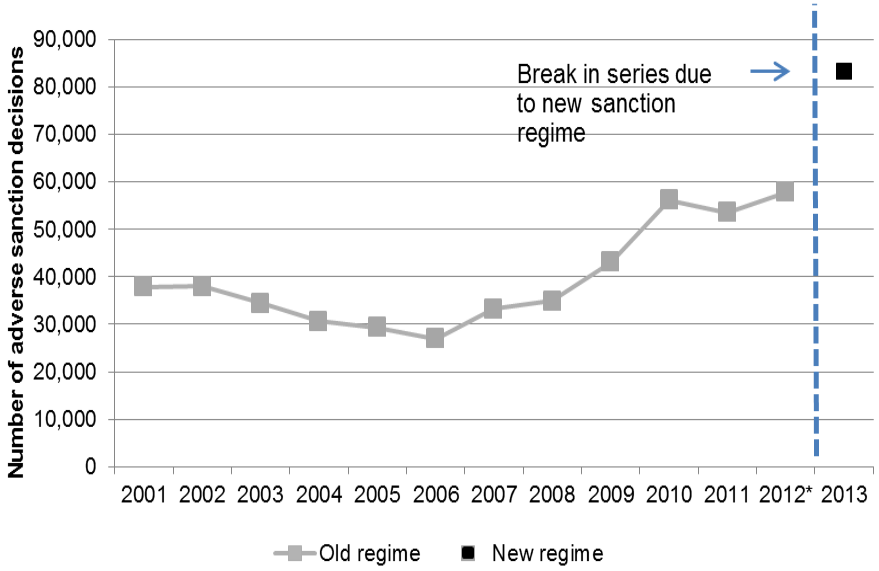


Image courtesy of the Scottish Government. 2014. Welfare Reform (Further Provision) (Scotland) Act 2012 Annual Report – 2014.

2.9 Wellbeing

Mental wellbeing is an essential part of a person's capacity to lead a satisfying life which includes the capacity to make informed choices, study, pursue leisure interests, as well the ability to form relationships with others.[38] The nation's mental health is a key priority for Scottish government

[36] Scottish Government. 2014. *Welfare Reform (Further Provision) (Scotland) Act 2012 Annual Report – 2014.* Available at: http://www.scotland.gov.uk/Resource/0045/00454504.pdf [Accessed 29 July 2015].

[37] Scottish Government. 2014, op. cit.

[38] Scottish Government. 2012. *The Scottish Health Survey*. Available at: http://www.scotland.gov.uk/resource/0043/00434590.pdf [Accessed 16 May 2016].

policy. In Scotland, mental health is measured within the Scottish Health Survey which adopts the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). This scale is made up of 14 separate statements regarding mental health and wellbeing to which respondents answer. A score is then created to determine the person's state of mental wellbeing. The maximum score is 70 and the minimum score is 14, with the higher the score the better level of mental wellbeing.[39] WEMWBS mean scores for both men and women have been relatively static since 2008, with only minor, non - significant fluctuations observed. In 2014, the average mean WEMWBS score for adults (aged 16 and over) was 50. The scores for men (50.1) and women (49.9) were not significantly different. As seen in previous years, levels of wellbeing varied across age groups. Men's wellbeing was lowest for those aged 45-54 (49.1), and highest for those aged 65-74 (51.2). Women's wellbeing showed less variation for those aged 25 and over (49.3-50.5), with lower levels seen for those aged 16-24 (48.7).

Figure 2.18: Warwick Edinburgh Mental Wellbeing Scale Mean Scores (2014) by age group and sex[40]

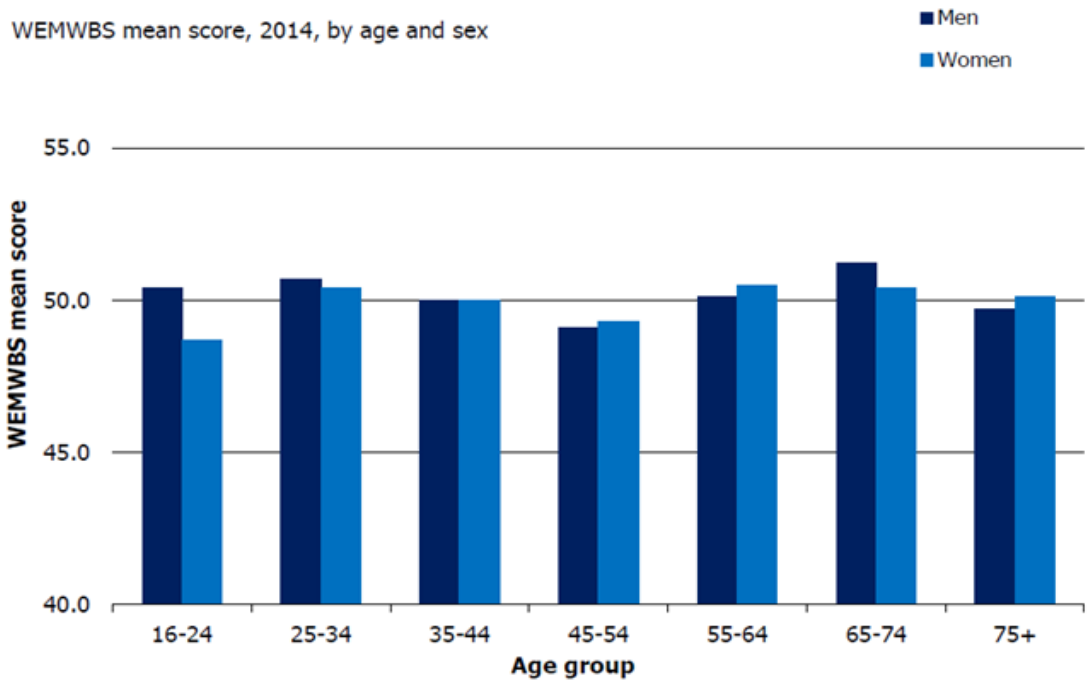


Image courtesy of the Scottish Government

Wellbeing results for each local authority are available from data in the UK Annual Population Survey.[41] To asses personal well-being in the UK the survey uses responses from approximately 165,000 people across the UK, and the publication includes the four following key questions to measure well-being which are answered on a scale from 0 to 10 with 0 the lowest and 10 highest.

[39] Scottish Government. 2015. *Health of Scotland's population-mental health.* Available at: http://www.gov.scot/Topics/Statistics/Browse/Health/TrendMentalHealth [Accessed 16 May 2016].

[40] Scottish Government. 2012, op. cit.

[41] Office for National Statistics. 2015. *Personal well-being in the UK, 2014/15.* Available at: http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23/pdf [Accessed 22 July 2016].

The questions are as follows:

- *Overall, how satisfied are you with your life nowadays?*
- *Overall, to what extent do you feel the things you do in your life are worthwhile?*
- *Overall, how happy did you feel yesterday?*
- *Overall, how anxious did you feel yesterday?*

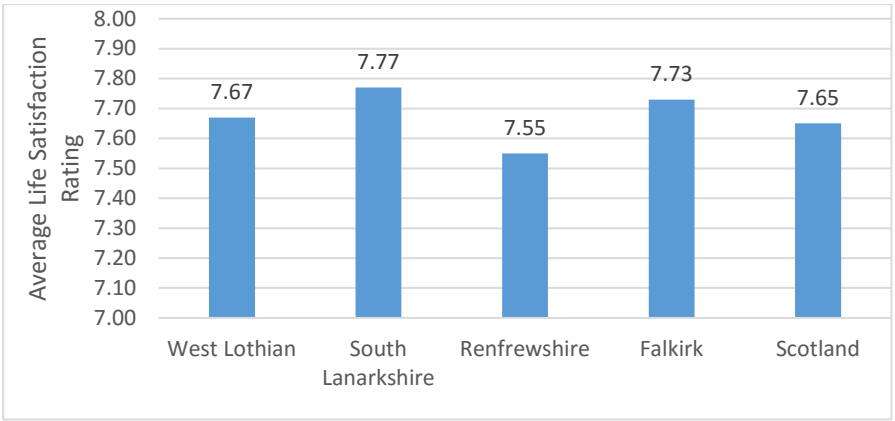
An overview of the well-being estimates is that there has been year on year improvements in reported average personal well-being ratings in the UK across each of the four measures of well-being, with the greatest gain being in the reduced anxiety levels. It should be noted that the survey should be interpreted as giving an estimate of well-being in the UK, rather than an exact measure.

There are mixed results for personal well-being in West Lothian with estimated average figures showing an increase in the reportings of 'life satisfaction' measures (2013/14=7.57; 2014/15=7.67) and 'worthwhile' measures (2013/14=7.81; 2014/15=7.9). Reporting on 'happiness' measures have slightly decreased (2013/14=7.49; 2014/15=7.44), as have ratings of 'anxiety' measures (2013/14=2.71; 2014/15=2.63). Further analyses of personal well-being ratings are presented below.

2.9.1 Life satisfaction

How satisfied a person is with their life is an important aspect of their overall well-being and from the figure below it can be seen that estimates of life satisfaction in West Lothian (7.67) are greater than Renfrewshire (7.55) and Scotland (7.65), but lower than South Lanarkshire (7.77) and Falkirk (7.73).

Figure 2.19: Estimates of Life Satisfaction From the Annual Population Survey (APS) Personal Well-being, 2014/15[42]

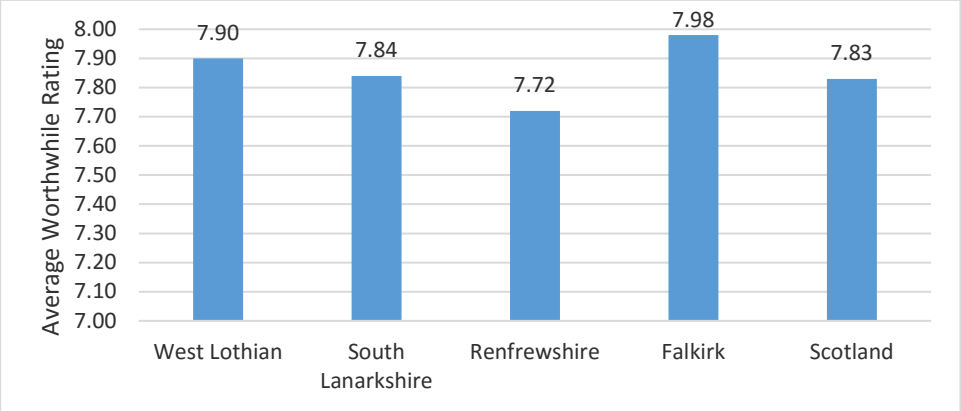


[42] Office for National Statistics. 2015. *Measuring National Well-being, Personal Well-being Across the UK, 2012/13.* Available at: http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23 [Accessed 18 April 2016].

2.9.2 Worthwhile

It can be seen from the figure below that worthwhile ratings in West Lothian are greater than South Lanarkshire (7.84), Renfrewshire (7.72) and Scotland (7.83), but lower than Falkirk (7.98).

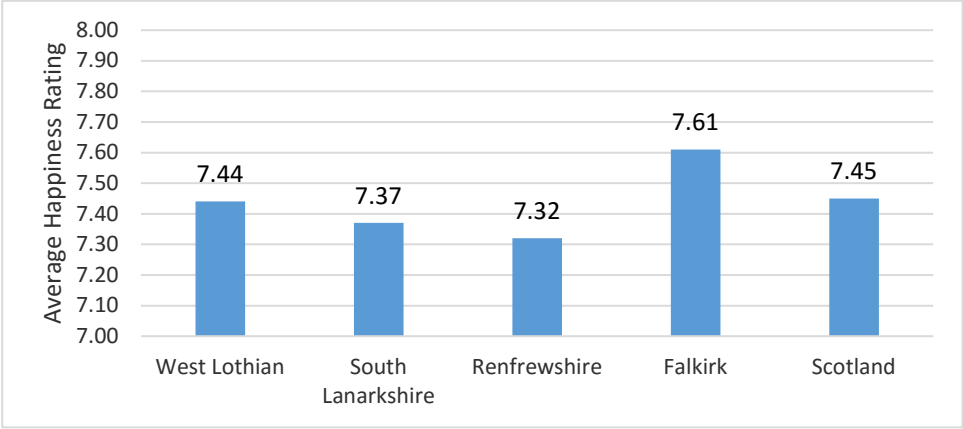
Figure 2.20: Estimates of Worthwhile From the Annual Population Survey (APS) Personal Well-being, 2014/15[43]



2.9.3 Happiness

In regards to happiness ratings it can be seen below that West Lothian (7.44) has greater happiness ratings compared with South Lanarkshire (7.37) and Renfrewshire (7.32). When compared to Falkirk (7.61) and Scotland (7.45) West Lothian's ratings are lower.

Figure 2.21: Estimates of Happiness From the Annual Population Survey (APS) Personal Well-being, 2014/15[44]



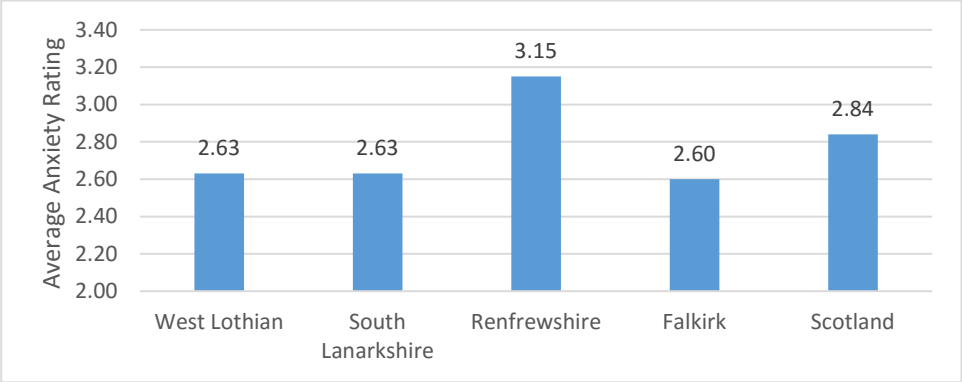
2.9.4 Anxiety

In regards to anxiety ratings, West Lothian echoes ratings from South Lanarkshire (both 2.63). This is slightly higher that Falkirk (2.6), but lower than Renfrewshire (3.15) and Scotland (2.84).

[43] Ibid.

[44] Ibid.

Figure 2.22: Estimates of Anxiety From the Annual Population Survey (APS) Personal Well-being, 2014/15[45]



[45] Ibid.

CHAPTER 3: PREVALENCE

3.1 Introduction

The issue of mental health is a primary concern for the Scottish government with statistics currently suggesting that 1 in 4 Scottish people will experience at least one diagnosable mental health problem every year.[46] Depression and anxiety are the most common; however others include eating disorders, personality disorders and schizophrenia. Further afield, estimates imply that 83 million people in Europe experience a mental health condition each year, and it is suggested that mental ill health is the primary source of chronic illness.[47] It should be noted that these figures are estimates due to the exact prevalence of mental health issues being problematic to approximate as many do not seek assistance.

A mental illness can be defined as any diagnosable illness which considerably interferes with a person's emotional, cognitive and social abilities, however the term is used interchangeably with mental health problem/ metal health issue/ mental health disorder and all terms cover various conditions and illnesses which can have different origins and symptoms and manifestations.[48]

3.2 Common Mental Health Issues

3.2.1 Depression

Depression can be described as feelings of sadness and worthlessness, a lack of energy and concentration, and/ or a loss in pleasure in activities that were previously enjoyed. In the UK, the overall prevalence in adults is 10%, and this is higher in females than males with females twice more likely to suffer from depression than males.[49] Figure 3.1 below shows the estimated number of patients in Scotland consulted for depression in the financial year 2012/13. Overall, it can be seen that females in every age group had a higher number of consultations. For both males and females the rates peaked in the 35-44 years age group.

[46] http://www.mentalhealth.org.uk/help-information/mental-health-statistics/uk-worldwide/

[47] Nowell, R. 2014. *Mental health in Scotland*. Available at: http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_14-36.pdf [Accessed 26th July 2016].

[48] Ibid.

[49] Ibid.

Figure 3.1: Estimated number of patients in Scotland consulting a GP or Practice Nurse at least once in the financial year 2012/13 per 1,000 patients registered[50]

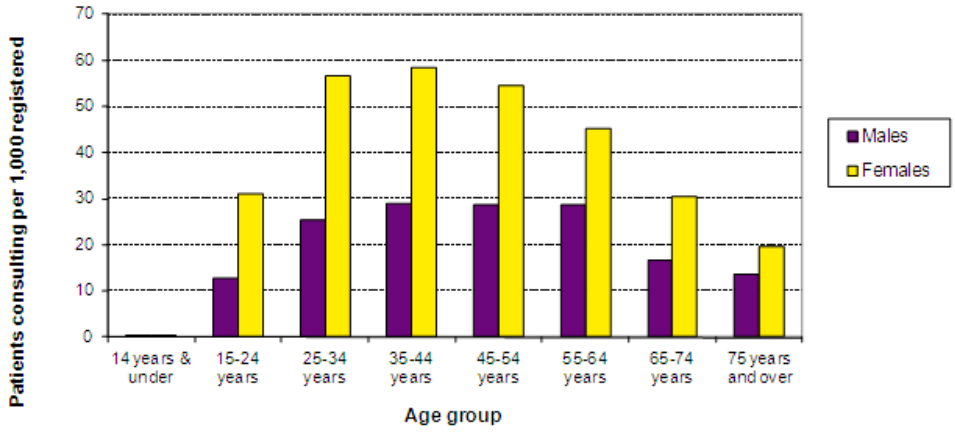
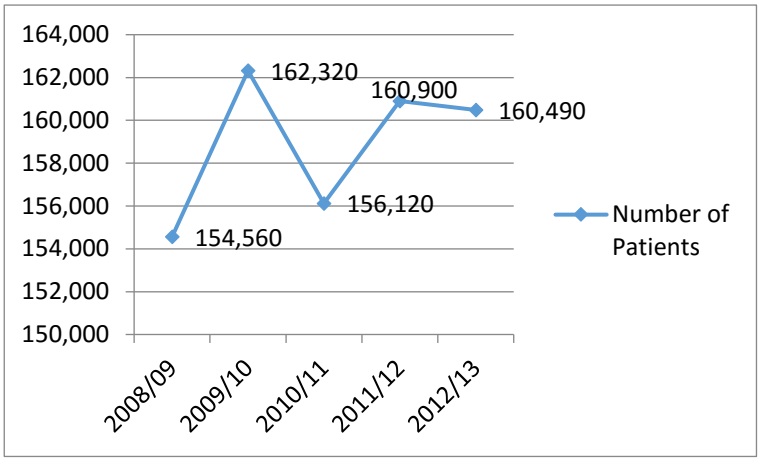


Image courtesy of ISD Scotland

Overall estimated prevalence rates in Scotland can be seen in the figure below and it can be seen that nearly 161,000 patients were seen in the year 2012/13 which is an increase from 2008/09 figures.

Figure 3.2: Estimated Number of Patients in Scotland Consulting a GP or Practice Nurse for Depression 2008/09-2012/13[51]



3.2.2 Anxiety

Anxiety can be described as an acute fear of something happening and in the UK the overall prevalence in the UK population is 9.2%.[52] Figure 3.3 below shows the estimated number of patients in Scotland consulted for anxiety and related conditions in the financial year 2012/13. Overall, it can

[50] Information Services Division Scotland. 2013a. *Health conditions-Depression.* Available at: http://www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/Health-Conditions/Depression/ [Accessed 26th July 2016].

[51] Ibid.

[52] Op.cit., Nowell, 2014

be seen that, similar to depression, females in every age group had a higher number of consultations. For both males and females the rates, again, peaked in the 35-44 years age group.

Figure 3.3: Estimated number of patients in Scotland consulting a GP or Practice Nurse at least once in the financial year 2012/132 for anxiety and related conditions per 1,000 Patients[53]

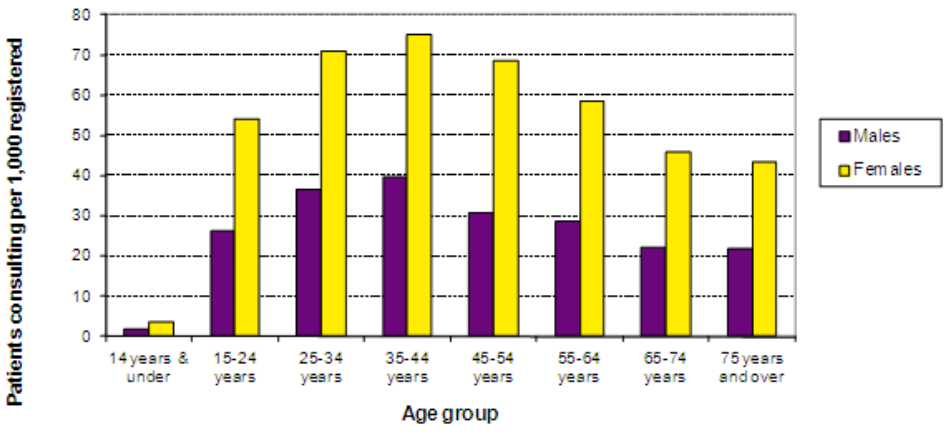
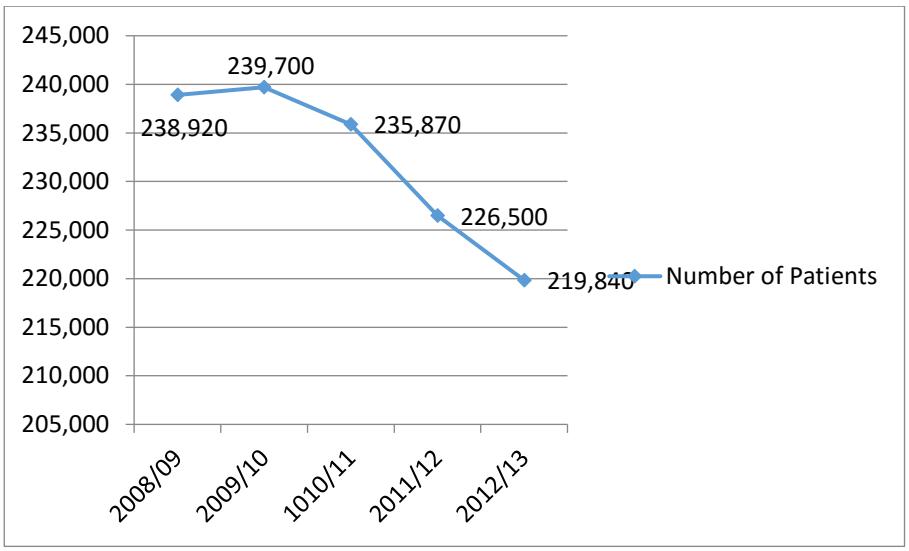


Image courtesy of ISD Scotland

Overall estimated prevalence rates in Scotland can be seen in the figure below which shows that nearly 220,000 patients were seen in the year 2012/13 which is a decrease from 2008/09 figures. The figure also shows that there has been a steady reduction from 2009/10 figures (239,700) to 2012/13 figures (219,840).

Figure 3.4: Estimated number of patients in Scotland consulting a GP or Practice Nurse for anxiety and related conditions 2008/09-2012/13[54]



[53] Information Services Division Scotland. 2013b. *Health conditions-Anxiety.* Available at: http://www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/Health-Conditions/Anxiety/ [Accessed 26th July 2016].

[54] Ibid.

3.2.3 Eating Disorders

Eating disorders primarily involve eating too much or too little and can involve the development of extreme associations with food resulting, at times, to anxiety and depression. Two common forms of eating disorders are Anorexia Nervosa and Bulimia Nervosa.[55] The overall prevalence of eating disorders in the UK is estimated at 2.5% of the population, of which 86% are female. Figure 3.5 below shows the estimated number of patients in Scotland consulted for eating disorders in the financial year 2012/13. It can be seen that, in contrast to depression and anxiety, there is no clear pattern in the number of consultations, however most consultations were for females in the age group of 15-24.

Figure 3.5: Estimated number of patients in Scotland consulting a GP or Practice Nurse at least once in the financial year 2012/132 for Eating Disorders per 1,000 Patients[56]

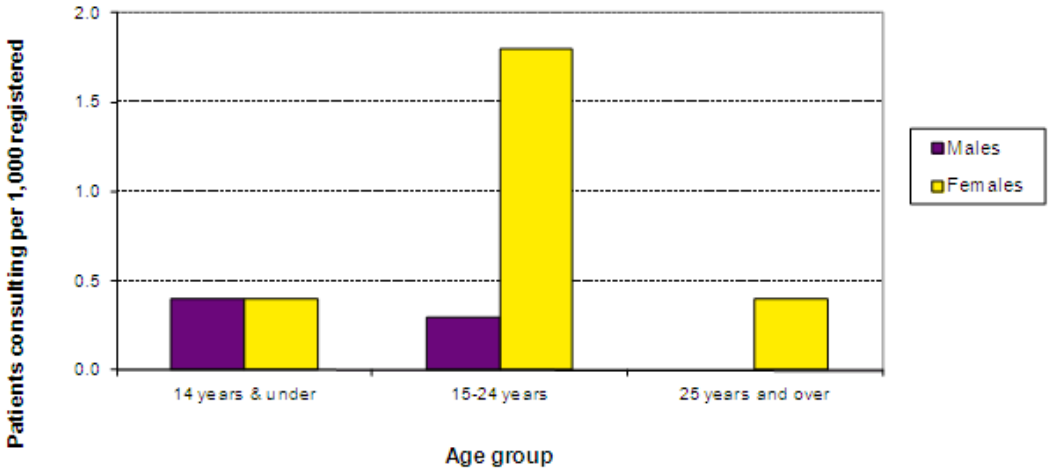


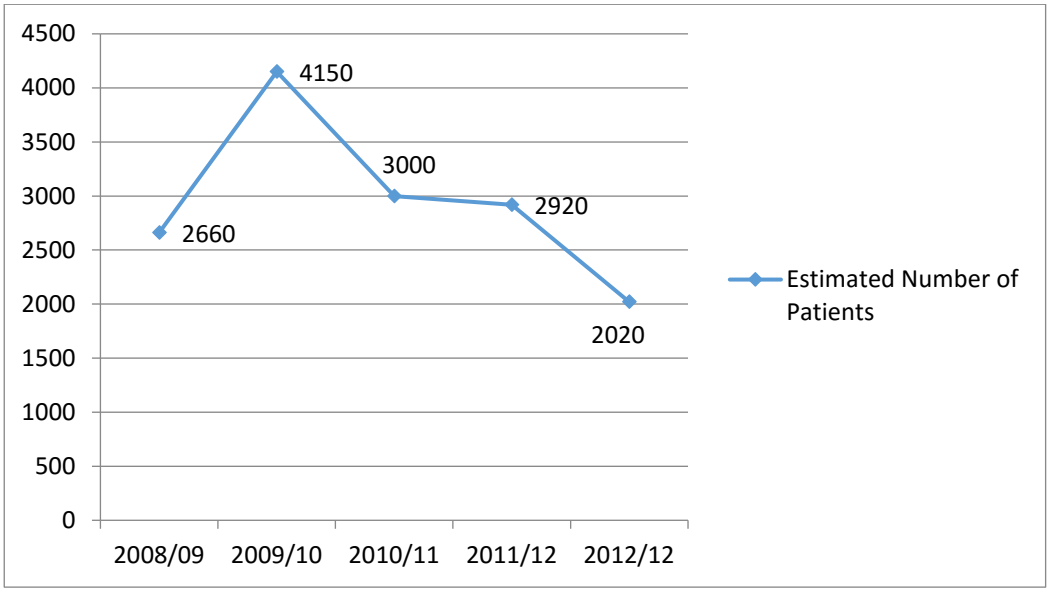
Image courtesy of ISD Scotland

Overall prevalence rates in Scotland can be seen in the figure below and it can be seen that approximately 2000 patients were seen at least once in the year 2012/13 which is a decrease from 2008/09 figures. The figure also shows that the estimated number of patients figures were highest in 2009/10 (N=4150) and since then there has been a steady reduction.

[55] Op.cit., Nowell, 2014

[56] Information Services Division Scotland. 2013c. *Health conditions-Eating Disorders.* Available at: http://www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/Health-Conditions/Eating-Disorders/ [Accessed 26th July 2016].

Figure 3.6: Estimated number of patients in Scotland consulting a GP or Practice Nurse for Eating Disorder conditions 2008/09-2012/13[57]



3.3 Medicines Prescribed to Treat Mental Health Issues

Medicines used for treating mental health problems are broken down into five general categories:

- Hypnotics and anxiolytics;
- Antipsychotics and related drugs;
- Antidepressants;
- Drugs used for Attention Deficit Hyperactivity Disorder (ADHD); and
- Drugs for dementia.

From the table below is can be seen that the most common drug used is antidepressants, both in the number of patients and the number of dispensed items.[58],[59]

[57] Ibid.

[58] Op.cit., Nowell, 2014

[59] Please note: antidepressants are also prescribed for a range of other conditions, such as migraine, chronic pain and myalgic encephalomyelitis (ME) – thus, the usage of antidepressants is unlikely to directly correspond to the number of patients with prescriptions for depression (see ISD, 2013e p 6).

Table 3.7: Prescription and usage information for drugs used in mental health treatments in Scotland, 2012/13[60]

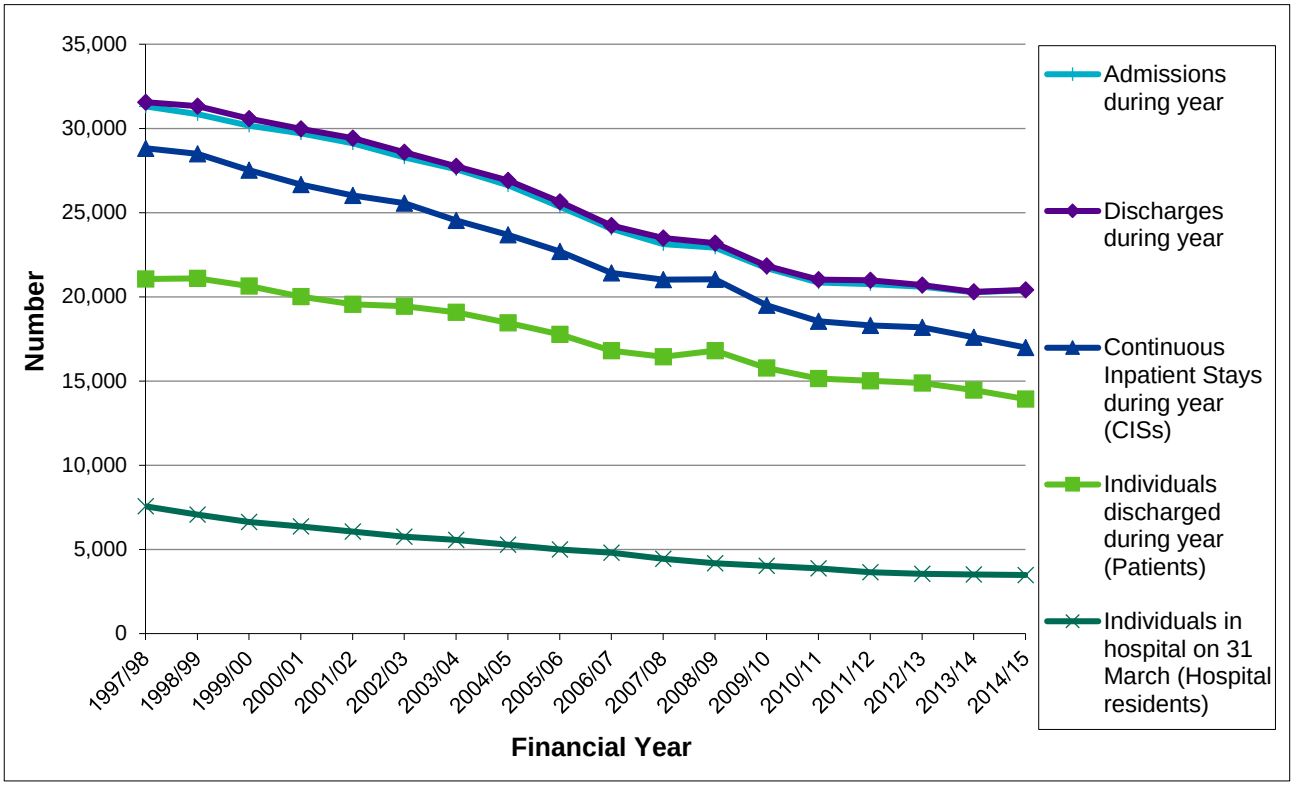
No. of dispensed items		Number of patients	Gross ingredient cost (£m)	% Change since 2003/04
Antidepressants	**5.2 million**	747,158 (67% female)	£29.5	52%
Hypnotics and anxiolytics	**2.08 million**	358,273 (64% female)	£8.8	–22%
Antipsychotics	**836,756**	80,479 (54% female)	£19.8	23%
Drugs for dementia	**183,176**	19,763 (65% female)	£10.2	229%
Drugs for ADHD and ADD	**90,885**	7,918 (19% female)	£4.3	103%

Please note: these figures are lower than figures in the graphs below; however, these figures may be an underestimate as not all prescriptions have a valid Community Health Index (CHI) attached that allows for the identification of which prescriptions have been dispensed to which patient.

3.4 Mental Health Inpatients

Information relating to mental health inpatient admissions in Scottish hospitals shows that there were a total of 20,384 inpatient admissions for the year ending 31st March 2015.

Figure 3.8: Mental health inpatient admissions in Scottish hospitals: Year ending March 2015[61]

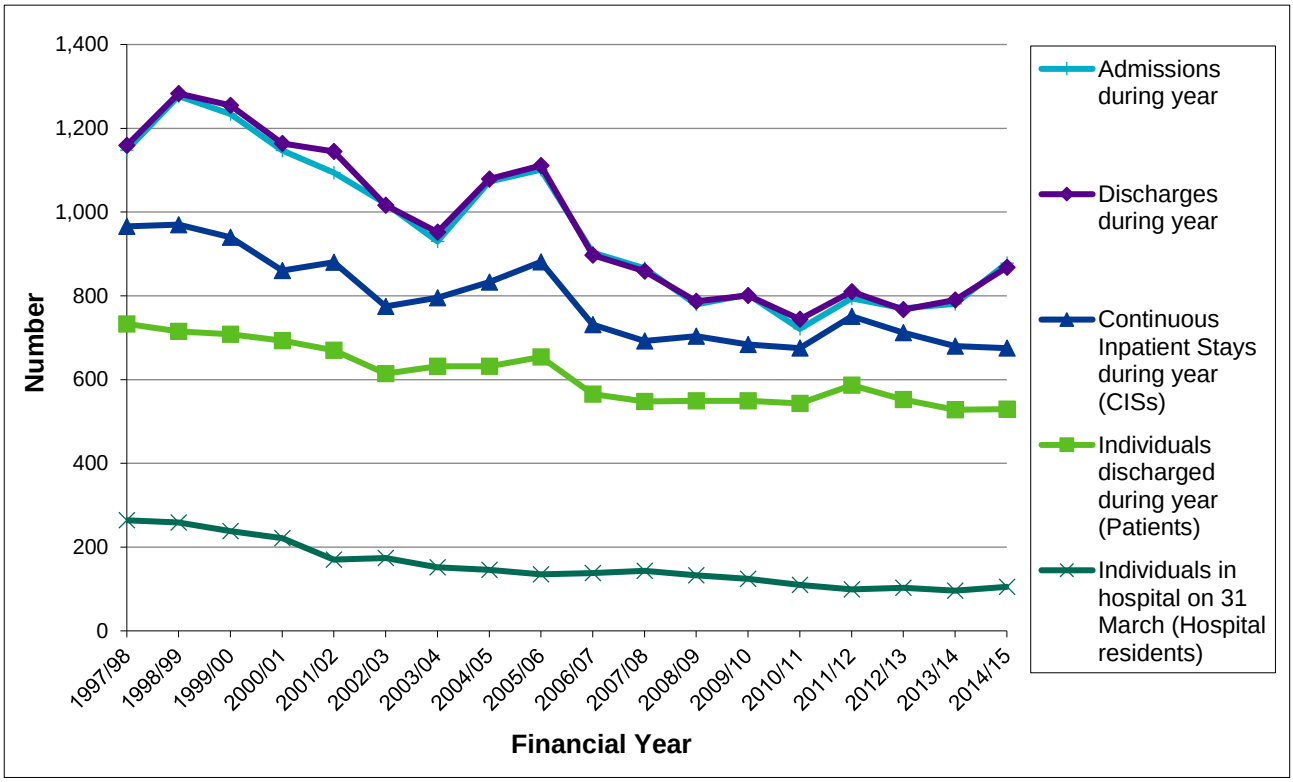


[60] Op.cit., Nowell, 2014

[61] Information Services Division Scotland. 2016. *Hospital inpatient care of people with mental health problems in Scotland: Trends up to 31 March 2015.* Available at: http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/data-tables.asp?id=1275#1275 [Accessed 26th July 2016].

Within West Lothian, there were 878 mental health inpatient admissions during 2014/15. This represents a significant increase (12.4%) from 2013/14 and the highest number since 2006-2007. The figure below shows admissions from 1997/98 to 2014/15.

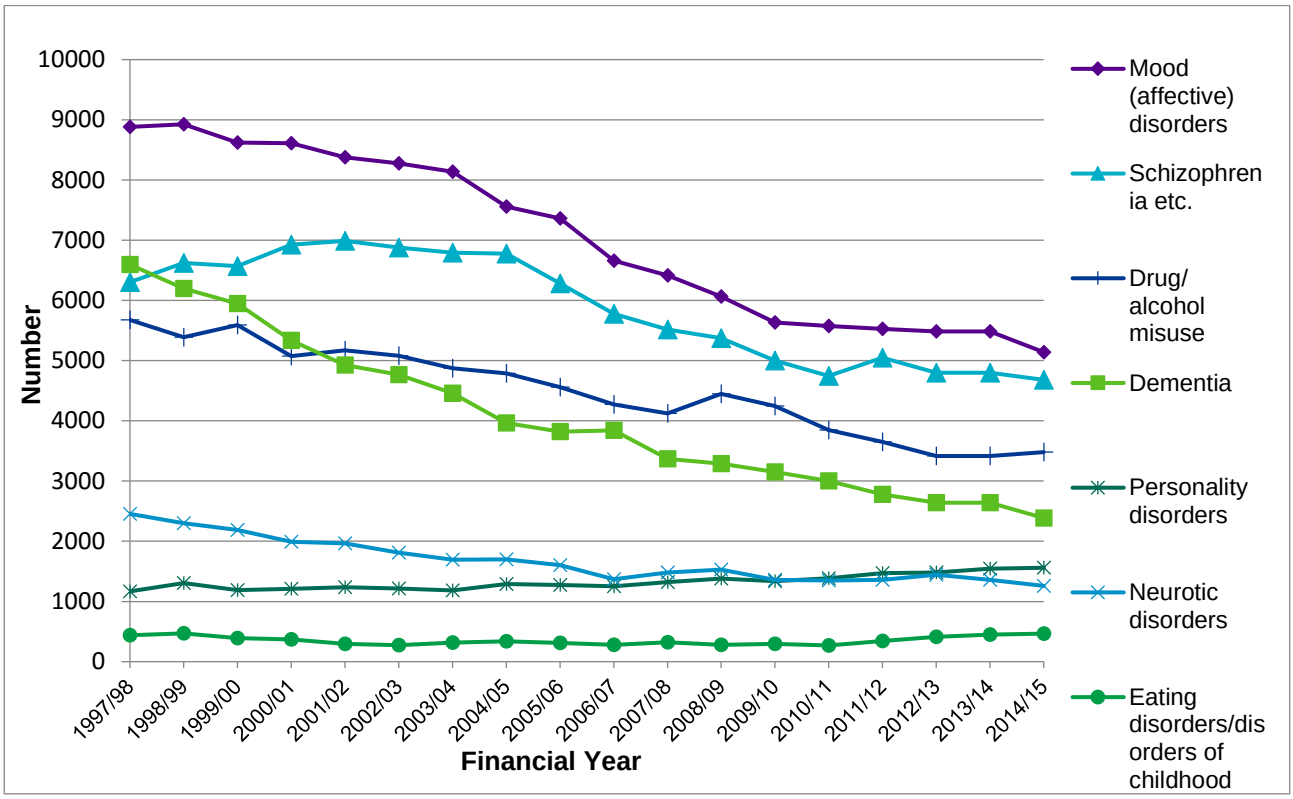
Figure 3.9: Mental health inpatients in West Lothian 1997/98-2014/15[62]



The number of mental health inpatient discharges (by principle diagnosis) from hospitals in Scotland for the year ending 31st March 2015 is shown in the figure below and it can be seen that most discharges relate to mood (affective) disorders.

[62] Ibid.

Figure 3.10: Mental health inpatient discharges by principle diagnosis: Year ending March 2015[63]



3.5 Suicide

The leading cause of death for people aged 15-34 years in Scotland is suicide[64], and preventing suicides is a major public health challenge for the Scottish Government. Since the Scottish Government rolled out the 'Choose Life' strategy in 2002, which aimed to reduce suicides by 20% by the year 2013, there has been a range of prevention methods undertaken in statutory, non-statutory and the voluntary sector which appear to have contributed towards positive results, although it is impossible to prove direct cause and effect. Since 2002 there has been an overall downward national trend in suicide rates with a reduction of 19.5% as seen in the graph below[65]; although this reducing trend has not been replicated in West Lothian over the same period.[66]

[63] Information Services Division Scotland. 2016. *Psychiatric hospital discharges by diagnosis, type of admission and gender - years ending 31 March 2010 – 2015.* Available at: http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/data-tables.asp?id=1275#1275 [Accessed 26th July 2016].

[64] Information Services Division. 2014. *The Scottish Suicide Information Database Report July 2014 Revision.* Available at: http://www.isdscotland.org/Health-Topics/Public-Health/Publications/data-tables.asp?id=1272#1272 [Accessed 04 November 2014].

[65] The Scottish Government. 2014. *Suicide reduction.* Available at: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/SuicideReduction [Accessed 27 November 2014].

[66] http://www.scotpho.org.uk/downloads/suicide/Suicide_LA_overview_2016.xlsx

Figure 3.11: Scotland level suicide rates form 2000-2013[67]

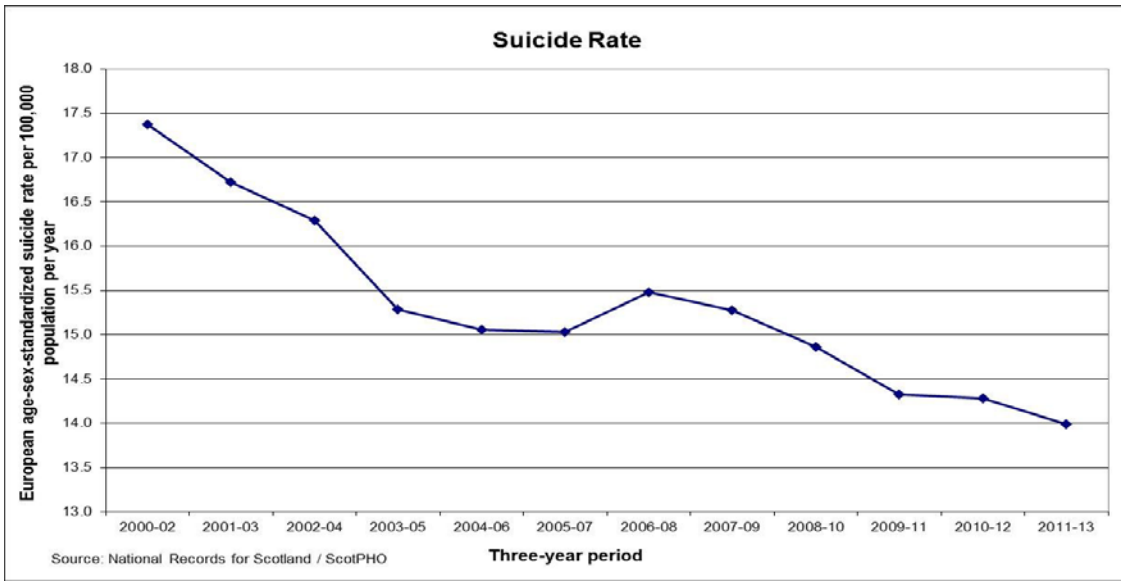


Image courtesy of the Scottish Government

More recently, figures show that between 2011 and 2015 there were a total of 3,882 deaths from 'probable suicide' (intentional self-harm and undetermined intent [UI]) in Scotland. A total of 1,847 deaths (n=47.6%) involved people aged 35-54 years old, whereas 2,831 deaths (n=72.9%) were males which suggests that men are three times more likely to die from suicide than women. As seen from the table below there were 137 deaths by probable suicide within West Lothian in this date range which amounts to 15.3 deaths per 100,000 population. A breakdown of these figures indicates that men of working age are a key risk group in West Lothian.

Table 3.12: Deaths Caused by Probable Suicide in Scotland 20011-2015[68]

Local authority	Suicide Death Self Harm		Undetermined intent [UI]		Total	
	Number	%	Number	%	Number	%
Scotland	2,802	72.2	1,080	27.8	**3,882**	100.0
Falkirk					**117**	100.0
Renfrewshire					**137**	100.0
South Lanarkshire					**203**	100.0
West Lothian					**137**	100.0

[67] Op.cit., The Scottish Government, 2014

[68] http://www.nrscotland.gov.uk/files//statistics/probable-suicides/15/suicides-table5-2015.pdf [Accessed 26th July 2016].

3.6 Psychological Therapies Waiting Times

Psychological therapies combine a variety of psychological interventions which help individuals to understand and make changes to their thinking, behaviour and relationships in order to relieve distress, and improve wellbeing.[69] In Scotland, there is a set HEAT target which requires at least 90% of Psychological Therapies patients to wait no longer than 18 weeks from the referral stage to the treatment of a psychological therapy from December 2014 onwards.[70]

The table below shows the national figures for the number of patients seen for psychological therapies within the last two quarters, and from the table it can be seen that in the quarter ending June 2014, 81.9% (n=8,090) of patients were seen within 18 weeks, whereas 81.3% (n=8,218) of patients were seen within 18 weeks in the quarter ending September 2014.

Table 3.13: Psychological Therapies Waiting Times - Number of Patients Seen in Scotland in Quarters Ending June and September 2014[71]

Quarter Ending	Type of Adjustment	Total Patients Seen	Number of Patients		% of Patients		Median Weeks
			0-18 Weeks	Over 18 Weeks	0-18 Weeks	Over 18 Weeks	
Mar-16	-	13,451	11,133	2,318	82.8	17.2	7
Dec-15	-	13,126	10,963	2,163	83.5	16.6	7
Sept-15	-	13,077	10,609	2,468	81.1	18.9	7
June-15	-	12,599	10,288	2,311	81.7	18.3	8
Mar-15	-	11,659	9,649	2,010	82.8	17.2	8
Totals	-	**63,912**	**52,642**	**11,270**	**81.6**	**18.4**	**7.4**

3.7 Dual Diagnoses

The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance misuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder.[72] This client group are very vulnerable and have complex needs relating to health, social, economic, and emotional stressors or circumstances which can often be exacerbated by their substance misuse.[73] People with a dual diagnosis are more likely to have experienced

[69] Information Services Division. 2014. *Psychological Therapies Waiting Times in Scotland*. Available at: https://isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/Publications/2014-11-25/2014-11-25-WT-PsychTherapies-Report.pdf?76824587584 [Accessed 26th July 2016].

[70] The Scottish Government. 2014. *Psychological Therapies.* Available at: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/PsychologicalTherapies [Accessed 26th July 2016].

[71] Op.cit., ISD, 2014

[72] Lehman (1996), cited Evans, K., & Sullivan, J. M., *Dual Diagnosis: Counselling the Mentally Ill Substance Abuser,* Guilford Press, 2001 p.1.

[73] Afuwape S. A., 'Where are we with dual diagnosis (substance misuse and mental illness)? A review of the literature', November, 2003.

difficulties with education, employment, housing, personal relationships and their physical health. They are also more likely to have suffered trauma or abuse.[74]

Research has shown that service users with a dual diagnosis typically use NHS services more and cost more. A study of services in South London found a greater proportion of the patients with dual diagnosis used the support of community psychiatric nurses, inpatient care and emergency clinics. Their analysis found that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than patients without a dual diagnosis.[75] Moreover, service users with a dual diagnosis are more likely to be non-compliant and fail to respond to treatment than either people with substance misuse issues or a mental illness, and in their National audit of violence, the Healthcare Commission and the Royal College of Psychiatrists identified drug and alcohol use as a major trigger for violence in mental health services.[76]

In his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health, Professor Louis Appleby stated that "services for people with dual diagnosis - mental illness and substance misuse - are the most challenging clinical problem that we face."[77]

The term Dual Diagnoses is used interchangeable at times with co-morbidity, and there is no one single definition of the term. The World Health Organisation (2010)[78] defines the term as the '*co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder*', whereas another term refers to '*the co-occurrence of two psychiatric disorders not involving psychoactive substance use*'.[79]

Dual diagnosis or co-morbidity is often underestimated and under-diagnosed. Between 30 and 50% of psychiatric patients in Europe today have a mental illness as well as a substance use disorder, mainly with alcohol, sedatives or cannabis. In clinical prevalence samples of drug dependent patients, personality disorders (50–90%) are the most prevalent form of co-morbidity, followed by affective disorders (20–60%) and psychotic disorders (15–20%), although these syndromes interact and overlap which means a person might have more than one of these disorders in addition to drug-

[74] Banerjee, S., Clancy, C., Crome, I., *Co-existing problems of mental health and substance misuse (dual diagnosis): An Information Manual*, Royal College of Psychiatrists, 2002. Available at http://www.rcpsych.ac.uk/pdf/ddipPracManual.pdf. Accessed 04/12/2013.

[75] National Mental Health Development Unit, Briefing 189, *Meeting the challenge of dual diagnosis*, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf. Accessed 09/12/2013.

[76] Ibid.

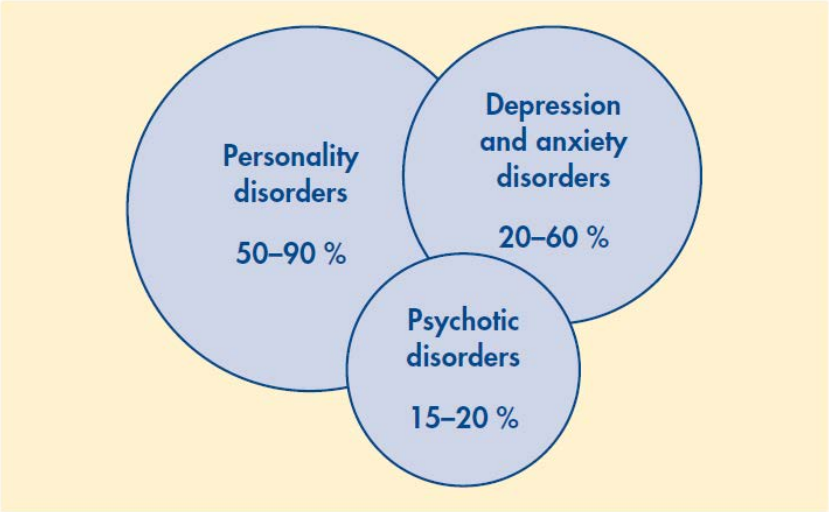
[77] The National Service Framework for Mental Health - Five Years On, Appleby L., Dept. of Health, Dec 2004.

[78] World Health Organisation. 2010. *Lexicon of alcohol and drug terms published by the World Health Organization. Available at:* www.who.int/substance_abuse/terminology/who_lexicon/en/ [Accessed 27 November 2014].

[79] European Monitoring Centre for Drugs and Drug Addiction. 2013. *Co-morbid substance use and mental disorders in Europe: a review of the data*, EMCDDA Papers, Publications Office of the European Union, Luxembourg. Available at: http://www.emcdda.europa.eu/attachements.cfm/att_220660_EN_TDAU13002ENN.pdf [Accessed 26 November 2014].

related disorders.[80]

Figure 3.14: Overlap of the three dominating diagnostic syndromes in patients with co-morbid drug-use disorders[81]



Furthermore, estimates of substance use of more than 50% are not uncommon in mental health services embedded in urban psychiatric facilities, although estimates in ruralities have been shown to be three to four times lower.[82]

The prevalence of co-occurring disorders has also been studied in community/general population samples[83] and particular links have been found between high alcohol consumption and depression

The nature of the relationship between mental health and substance misuse problems is complex, but possible mechanisms recognised by Crome et al (2009)[84] include:

- A primary psychiatric illness may precipitate or lead to substance use, misuse, harmful use, and dependent use, which may also be associated with physical illness and affect social ability.

[80] Fridell, M. And Nilson, M., *Drugs in Focus: Briefing of the European Monitoring Centre for Drugs and Drug Addiction*, 2004. Office for Official Publications of the European Communities. Available at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/dual.pdf Accessed 04/12/2013.

[81] Op. cit. Fridell & Nilson (2004).

[82] Rush, B, and Koegl, C., 'Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders within a Comprehensive Mental Health System', *La Revue Canadienne de Psychiatrie*, 2008; 53(12):810-22.

[83] For example: Reiger DA, Farmer ME, Rae DS. 'Co-morbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiological Catchment Area (ECA) study,' *JAMA*, 1990;264;2511–2518; Kessler, R., Nelson, C., McGonagle, K., Swartz, M., Blazer, D., 'Co-morbidity of DSM-III-R major depressive disorder in the general population: results from the US National Co-morbidity Survey', *British Journal of Psychiatry Supplement*, 1996; (30):17-30; Kessler R., Chiu W., Demler O, et al., 'Prevalence, severity, and co-morbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey Replication.,' *Archive of General Psychiatry,* 2005;62(6):617–627; Grant B., Stinson F., Dawson D., et al. 'Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States,' *Archive of General Psychiatry,* 2004;61:361–368.

[84] Crome, I., Chambers, P., Frisher, M., Bloor, R. & Roberts, D., *The relationship between dual diagnosis: substance misuse and dealing with mental health issues*, Research Briefing 30, January 2009. Available at http://www.scie.org.uk/publications/briefings/files/briefing30.pdf. Accessed 02/12/2013. p. 4.

- Substance use, misuse, harmful use and dependent use may exacerbate a mental health problem and physical health problem, e.g. painful conditions, and any associated social functioning.
- Substance use e.g. intoxication, misuse, harmful use and dependent use may lead to psychological symptomatology not amounting to a diagnosis, and to social problems.
- Substance use, misuse, harmful use and dependent use may lead to psychiatric illnesses, physical illness, and social dysfunction.

Establishing which problem came first is often complicated and some authors warn that focussing on this issue can result in vulnerable individuals with co-morbidity being excluded from services whilst a decision about ultimate attribution is made.[85]

Co-morbidity can occur at any level of severity, and it is important to note that whilst in the UK there has been both an increased prevalence of substance misuse (particularly alcohol)[86] and an increased prevalence of dual diagnosis,[87] there is not necessarily a causal relationship between substance misuse and mental illness. Frisher et al (2005) concluded that, based on their sample of 3,969 patients with both substance misuse and psychiatric diagnosis, only a comparatively small proportion of psychiatric illness could be attributed to substance use (0.2%), whereas a more substantial proportion of substance use seems possibly attributable to psychiatric illness (14.2%).[88]

There are no routinely available national or local data on the prevalence of dual diagnosis, and because the definition of the term varies widely, so do prevalence estimates. This difficulty is further compounded by an inconsistency in definition. Moreover, most studies are based on data collected from those already known to specialist services (mental health or substance misuse) and do not therefore tell us about the prevalence of dual diagnosis amongst the general population.

In line with European estimates, the charity 'Rethink Mental Illness' estimate that in the UK, a third of patients in mental health services have a substance misuse problem, and around half of patients in drug and alcohol services have a mental health problem.[89] Studies have however shown widespread social and regional variation in the prevalence of dual diagnosis, with higher rates recorded in deprived areas than in affluent areas. That withstanding, it has been suggested that the rate is increasing more rapidly in affluent areas.[90]

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[85] Op cit. Crome et al (2009), p.3.

[86] British Medical Association Science and Education Department and BMA Board of Science (2008) Alcohol Misuse: Tackling the UK Epidemic. London, British Medical Association; NHS Information Centre (2008) Statistics on Alcohol: England 2008, London, NHS Information Centre; Murphy, R. and Roe, S. (2007) Drug Misuse Declared: Findings from the 2006/07 British Crime Survey – England and Wales, London, Home Office.

[87] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *J Epidemiology and Community Health* 2005;59:847–850; Frisher, M., Collins, J., Millson, D., Crome, I., and Croft, P. (2004) 'Prevalence of co-morbid psychiatric illness and substance misuse in primary care in England and Wales', *Journal of Epidemiology and Community Health* 2004;58:1034–1041.

[88] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *Journal of Epidemiological Community Health* 2005; 59:847–850.

[89] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.32.

[90] Op. cit., Frischer et al (2005).

Another aspect of co-morbidity relates to individuals with mental health problems having higher rates of health inequalities than the average population. Examples of higher rates of health inequalities for those with mental health issues are as follows. People with mental health problems are:[91]

- More likely to die sooner than the general population.
- Twice as likely as the general population to die from heart disease.
- More susceptible to drug and alcohol addiction.
- People with schizophrenia and psychosis die on average 15-20 years younger than the general population.
- Schizophrenics are 2-3 times more likely to develop type 2 diabetes than the general population.
- Women with schizophrenia are 42% more likely to get breast cancer than other women.
- People with schizophrenia who develop cancer are three times more likely to die than those in the general population with cancer. 61% of people with schizophrenia smoke, compared with 33% of the general population.

There are many determinants of these health inequalities and below is a brief summary of the various contributing factors to these health inequalities:[92]

- Effects of some psychiatric medications: antipsychotic medications, mood stabilisers and some antidepressants increase appetite and therefore can cause weight gain and obesity, and this can result in cardiovascular disease. (For example, it is common to have weight gain of 5-6kg within two months of first taking an antipsychotic medication and this gets worse over 12 months (Foley & Morley, 2011).
- Lifestyle factors adversely affect the physical health of people with mental health problems: poorer diets, low rates of exercise and higher prevalence of smoking than among the general population (RETHINK 2013).
- Higher rates of suicide, accidental or violent death.
- Poor monitoring of physical health.
- Misattribution of physical symptoms: seen as side effects of medication or secondary symptoms of mental health problem.
- Poorer access to physical healthcare: lack of clarity about professional roles and responsibilities can mean that when mental health service users develop physical disorders they are less likely to gain access to appropriate physical health interventions.
- Lower engagement with universal health screening and health promotion programmes.

[91] McCollam, A., and Allison, G. Mental health and health inequalities.

[92] ibid

3.7.1 The 'COSMIC' Study

In 2002, the Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC) estimated the prevalence of dual diagnosis in four inner-city areas in England (two in London, Sheffield and Nottingham). They reported that 74.5% of drug service users and 85.5% of alcohol service users experienced co-occurring mental health problems.[93] The prevalence of particular mental health problems amongst the subject group are shown in the table below:

Table 3.15: COSMIC study: Estimated prevalence of mental health problems among substance misuse patients[94]

Condition	% of drug treatment population	% alcohol treatment population
Psychiatric disorder	75	85
Non-substance induced psychosis disorders	8	19
Personality disorder	37	53
Depression &/or anxiety disorder	68	81
Severe depression	27	34
Mild depression	40	47
Severe anxiety	19	32

Similar rates of dual diagnosis were also reported in a study undertaken at the same time in the London borough of Bromley. Strathdee et al (2002) estimated that 83% of substance misuse clients had a dual diagnosis.[95]

The COSMIC study also found that 44% of the community mental health team (CMHT) patients reported problem drug use and harmful alcohol use in the preceding twelve months – the most commonly used substances being alcohol and cannabis:

Table 3.16: COSMIC study: Use of substances by CMHT patients[96]

Substance	Use in the past 12m by CMHT patients (%)
Harmful alcohol or drug use	44
Any drug use	31
Harmful alcohol use (AUDIT ≥8)	26

[93] Weaver, T., Charles, V., Madden, P., & Renton, A., 'A study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse & Mental Health Treatment Populations', Drug Misuse Research Initiative/Dept. of Health, 2002. Available at http://dmri.lshtm.ac.uk/docs/weaver_es.pdf. Accessed 06/12/2013.

[94] Source: Table 2 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.33.

[95] Strathdee et al (2002), 'Dual diagnosis in a primary care group (PCG) – a step by step epidemiological needs assessment and design of a training and service response model', Department of Health/National Treatment Agency.

[96] Source: Table 3 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.34.

Cannabis	25
Dependent cannabis use	12.8
Sedatives/tranquilisers	7
Crack cocaine	6
Heroin	4
Ecstasy	4
Amphetamines	3
Cocaine	3
Opiate substitutes	1.4

The study in Bromley suggested lower levels of dual diagnosis within community mental health clients (20%), but recorded a prevalence rate of 43% for psychiatric in-patients and 56% in forensic patients.[97]

Other key findings of the COSMIC report were that around 30% of drug service users and 50% of alcohol service users had 'multiple morbidity' (i.e. complex needs); and some 38.5% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem. Also important is the conclusion drawn that the treatment population is heterogeneous, and that responding to the range and level of need is challenging.

[97] Op. cit. Strathdee et al (2002).

CHAPTER 4: KEY FINDINGS – PROFESSIONAL VIEWS

4.1 Introduction

This chapter presents a thematic analysis of the key findings of each of the mixed methods of the study that focused on the views of professionals:

- Semi-structured interviews;
- Stakeholder Events and Working Groups; and
- Professional Surveys (Service Staff, Dentists, Optometrists and Pharmacists).

The full detail of the transcribed groups and interviews, and surveys are presented in the accompanying **Part 2 Appendix Report (Appendices II, III and IV)**. These key findings have then been analysed by the research team against the original objectives of the study in order to inform the study recommendations (see **Chapter 6** below).

For maximum insight, it should be read in conjunction with Appendix III, which sets out the range of viewpoints articulated in the interviews.

To give structure, our analysis of views and what they tell us will be presented under the headings of Strengths, Weaknesses, Opportunities and Threats (SWOT).

A SWOT analysis is an examination of a system's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival.

Figure 4.1: SWOT Analysis structure

Some areas figure under more than one theme; for example, where there is evidence of both strengths and weaknesses. Similarly, it should be remembered that not all stakeholders were in

agreement, and therefore drawing hard and fast conclusions may be inappropriate and disguise the complexity of the position.

Finally, this strand of analysis is based on subjective views and therefore must be combined with other evidence from other sources (such as service users and carers) for a fully rounded perspective.

4.2 Strengths

Traditional SWOT analysis views strengths as current factors that have prompted outstanding performance. Some examples could include: sufficient capacity across services, highly competent personnel or a focus on quality improvement. The aim here is to identify current strengths across the Mental Health sector in West Lothian as well as to identify the building blocks for developing new strengths across the sector.

What are the perceived strengths of Mental Health services in West Lothian; either directly stated or inferred from wider comments?

4.2.1 The quality and commitment of staff

Many stakeholders gave examples of where the quality and commitment of staff was a positive asset to the delivery of mental health services; such comments were made both about the staff within the stakeholder's own service but also with reference to external services. For example, individual interviewees remarked upon the personal commitment to work with patients, flexibility and willingness to do things differently.

Positive remarks were made about both statutory services (inpatient and community mental health services) as well as those working in third sector organisations.

Of course, it cannot be deduced from this that all services are universally comprised of high-quality staff and there was also evidence of staffing weaknesses in, for example, recruitment and staff absence.

4.2.2 Services for those with severe and enduring mental health problem

Services for those with severe and enduring mental health problem were identified as an area of strength by several interviewees. The Community Outreach Team were singled out for praise and there was also positive comment regarding inpatient acute care and contributions made by the specialist services based at St John's.

4.2.3 Joint Working

Interviewees cited a number of areas of good joint working, but this was not universal and others identified weaknesses.

In some areas positive joint working appeared born out of formal structural arrangements, but in others it seemed more reliant on individual relationships. In illustration, the Mental Health Well-Being Screening Group (which acts as a clearing-house for young people with mental health issues) was cited as effective at regularly bringing together a range of services to systematically triage and allocate cases. But in other cases the strength of joint working appeared more reliant on the quality of relationships between people; 'I get on well with X, we work well together'. Ultimately, a reliance on individual relationships creates vulnerability; as the quality of joint working may be diminished by staff turnover.

Some put the quality and strength of joint working down to an overarching culture; occasionally referred to as 'The West Lothian Way'. Thus some remarked upon a strong ethos of corporate working, whilst others commented on the benefits of tranches of staff working together in the same area, with shared values, over a long period of time.

There was positive comment about good working relationships between the statutory and third sectors, as well as between Council departments, e.g. in addressing wider issues of health and social inequality.

4.2.4 Service User and Carer engagement

As with joint working, this was identified as an area of both strengths and weaknesses. However, where service user or carer engagement was identified as a strength, this appeared reliant on the commitment and ethos of individual services and their staff; rather than as an embedded strength of all provision.

Examples were given of positive engagement with service users in in-patient and community mental health services; for example, in-patient wards holding weekly meetings with service users and a high level of engagement in day services run by The Community Outreach Team. There was positive comment about The Mental Health Advocacy Project and evidence that it is engaged with -a sizeable number of people with mental health issues, albeit primarily those with severe and enduring mental illness.

We heard examples of positive engagement with and support to carers, but again this appeared confined to individual services and staff members.

4.2.5 Services for people with Dementia and their carers

Strengths were identified in some aspects of services for people with Dementia and their carers. In particular, a number of interviewees commented on the positive contribution and reach into communities offered by the area's nine Dementia Cafes.

4.3 Weaknesses

Weaknesses are either system or organisational factors that will increase costs or reduce quality. Examples could include ageing facilities and a lack of continuity in care and support processes, which could lead to duplication of efforts. Weaknesses can be broken down further to identify underlying causes. For example, disruption in the continuity of care often results from poor communication. Weaknesses also breed other weaknesses. For example, poor communication disrupts the continuity of care, and then this fragmentation leads to inefficiencies across the entire system. Inefficiencies in turn, deplete financial and other resources.

The aim here is to successfully identify, explore, resolve and reduce weaknesses.

What are the perceived weaknesses of Mental Health services in West Lothian; either directly stated or inferred from wider comments?

4.3.1 The current configuration of services is not fully fit for purpose

Taking an overview of comments made, it was clear that many felt overall the current service configuration was deficient and, ultimately, not fully fit for purpose. Whilst many would have agreed that most of the necessary service elements were in place, interviewees identified issues with the scale and scope of those elements and how they were managed.

Key concerns were:

- Issues with capacity and patient flow
- Inappropriate presentations and referrals
- Inadequate or poorly functioning patient pathways
- The contribution made by psychological therapies
- Structural arrangements for management of services.

These are big issues, and we will tease out more fully areas of weakness over coming sections.

Although there were differences of emphasis and interpretation, a significant number of interviewees identified issues of capacity, capability and flow across in-patient and community mental health services. Causes suggested were: that an historic reduction in in-patient beds had gone too far; that the pace of progress into and through Rehab could be too slow; and inadequate levels of community support causing delayed discharges. We are not in a position to fully assess the validity of these individual views, but overall a sufficient number of interviewees spoke of: difficulties accessing acute inpatient beds: patients delayed in acute wards when they should be progressing into Rehab: patients delayed in Rehab because appropriate supported accommodation was not available: and of some service users requiring to be placed in out of area community services, to conclude that the current systems are not functioning optimally. A whole system view is required when it comes to capacity, capability and flow and suboptimal performance by individual elements can impact negatively on the functioning of all.

Interviewees often remarked upon inappropriate presentations and referrals and we interpret this as symptomatic of problems with service configuration. We will illustrate this more fully later, but inappropriate presentations at A&E, to CAMHS and referrals back to the GPs were a common concern.

Inappropriate presentations and referrals may well confirm claims that patient pathways can be inadequate or malfunction. We heard both positive and negative comments about patient pathways, and it is likely the quality of these will be open to variation across services and disciplines. However, the fact that we regularly heard that primary access services such as A&E, GPs and the Mental Health Assessment Team could be overloaded and unable to find appropriate, or sufficiently responsive, services onto which they could refer as confirmation of a lack efficacy in current pathways.

The role and input of psychological therapies was often a contentious topic. At a basic level there was universal agreement that waiting times for adult psychology services were far far too long; of the order of a year. The capacity of the service was recognised as an issue, but some also felt the service was not always run efficiently. Whilst there was not always agreement on the causes and extent of problems with the current service, there appeared more consensus on what the potential solutions were. Consequently, we believe there would be widespread support for an enhanced psychological therapies service, including implementation of a robust and well-resourced Stepped Model of Care; where a broader range of non-specialist staff and organisations (including the third sector) delivered psychological therapies.[98]

Finally, interviewees made a number of observations which when taken together suggest a lack of coherence to the existing management arrangements for Mental Health services. For example, some interviewees complained of disjointed or dysfunctional lines of accountability. We also heard examples of individuals appearing to wilfully not engage with fellow professionals, or who pursued their own narrow self-interest and "hobbies", to the detriment of contributing to general services. There were advocates of Mental Health services having a single manager.

4.3.2 Services for The Distressed

A common theme was the adequacy and configuration of services for those that might loosely be categorised as 'Distressed'. Whilst lumping a wide range of presenting issues - Anxiety, Depression, Substance Misuse etc. - together under the banner of 'Distress' is crude, we see merit on this occasion because progress might best be achieved through psychological interventions, Recovery based models and changes to the service users wider social circumstances (addressing homelessness, relationships, poverty and unemployment).

In contrast to perceptions of services for those with Severe and Enduring Mental Health problems, we were struck by how many interviewees thought services for people 'In Distress' were inadequate. Evidence indicated these inadequacies stem from both a lack of capacity and inappropriate service

[98] Such as advocated in 'The Matrix - A Guide to Delivering Evidence Based Psychological Therapies in Scotland', NHS Education for Scotland, 2014.

models. We heard of excessive presentations of people 'in crisis' at A&E, GPs and the Mental Health Assessment Team but for whom there was no appropriate and timely therapeutic response. Interviewees often complained of a lack of low-level, rapidly accessible services. Some went so far as to assert a lack of options was fostering a culture of risk aversion and over treatment; for example, where passing reference to suicide could trigger an automatic referral to Adult psychology, even though in practice it could be a year before such therapy was available.

Some interviewees implied that GPs were often left to carry the burden of assisting those In Distress; unsure of who to refer to or having to make do while specialist services either did not prioritise their patient or were slow to respond. Whilst this may well be true, there are surely far wider consequences if people In Distress are being let down by current arrangements. There will be negative consequences for relationships, children and families, employers, other service providers and communities.

There were mixed views about the Distress Tolerance Group, which has been discontinued relatively recently. There were positive advocates who saw it as an appropriate and cost-effective option, but others questioned its value; some went as far as suggesting the group had been dysfunctional and had amplified behaviours and distress. Whilst we cannot comment on the merits, or otherwise, of this group and approach, we would note that this is one option no longer available and some interviewees commented negatively that they now had nowhere to refer. The Distress Tolerance Group may not have been the answer, but a service remains. Going forward, it is likely that a range of options will be necessary, both from a clinical perspective and to fit with individual service user preferences.

Having already touched upon the current inadequacy of psychological services, an expanded range of services for people In Distress, based on a stepped model of care, appears appropriate.

Comments from interviewees would suggest the scale of unmet need could be significant. It is likely that further investment would be required although effective interventions may lead to savings / resources released in other areas.

4.3.3 Joint working / interdisciplinary relationships

There was evidence of poor joint working; between agencies, disciplines and individuals. Unfortunately, whilst we heard of good collaboration between individual services, this was offset by examples of unwillingness to collaborate, shallow and transient relationships and, on occasion, behaviours that appeared positively disrespectful.

It was alleged by more than one source that, historically, some psychiatrists had undermined efforts to work together; failing to attend and engage with interdisciplinary initiatives. For example, there were advocates of a single point of referral in adult services but, they observed previous efforts to establish this had faltered because of non-attendance by psychiatrists.

The presence of Locum psychiatrists was highlighted by some as detrimental to joint working; the transitory tenure meaning working relationships were not fully developed and sustained.

We heard of behaviours that appear disrespectful and high-handed; for example, regularly not replying to phone calls and emails from important partner organisations.

Whilst a more coherent management structure will not of itself be a panacea for dysfunctional personal and interdisciplinary relationships, future leadership could set clear expectations regarding the necessity for collaboration and mutual respect.

4.3.4 Patchy engagement with service users and carers

Taking the sweep of interviews as a whole, the evidence was that engagement with, and empowerment of, service users and carers was at best variable.

Some aspired to a thorough-going empowerment of service users and carers and an honesty and openness to co-production. However, it was evident that they did not expect such ambitions to be realised in the near future. More generally, there was an acceptance that more could be done to have meaningful engagement.

Finally, some implied that there was an institutional resistance to increasing service user and carer influence; noting that some vehicles for engagement, had been removed or diminished.

4.3.5 Health Inequalities

Generally, there was acceptance that health inequalities were a continuing issue. Some interviewees were of the view that there was a tokenistic up approach to tackling health inequalities, and that the NHS did not always recognise or value the contribution of partner organisations.

Some identified specific drivers of Health Inequalities - poverty and deprivation, poor public transport and out of area services. Several remarked that small rural communities were not well served by bus links and this could impact on access. One interviewee noted it was unreasonable to expect some people afflicted by anxiety to travel significant distances, including out of area to Edinburgh-based services.

4.3.6 SDS and assessment processes

Whilst often the principles of Self Directed Support were supported, there was significant concern regarding how it is currently delivered and its impact on availability of support services.

Particular weaknesses identified with SDS were: a 'failure to grow the market', its potential impact on the viability of some services and inequity between client groups. Some were also concerned about the length of time taken to conclude assessments and finalise care packages.

Some interviewees observed that whilst in theory the market should be responsive to the individual demands arising from personalisation, in reality this was not always occurring. Service users had difficulty finding providers willing to offer bespoke care packages. Providers on the other hand could struggle to deliver viable services; challenged by flexible demands from small numbers and uncertain levels of return.

Some interviewees claimed that SDS was not allocating resources equitably; for example, comment was made that whilst very significant care packages could be available for those with Learning Difficulties, other client groups might struggle to secure relatively small packages of care. One interviewee argued that current SDS arrangements actively worked against those with Severe and Enduring mental health problems; because their illness prevented them from fully understanding, or having the organisational capacity, to take full advantage of the system, consequently they were losing out to other groups.

4.3.7 Staffing - recruitment, retention and staff absence

Evidence from interviews confirmed that local NHS mental health services face challenges with recruitment and retention of staff and also high-levels of staff absence in some inpatient facilities; these issues also afflict the NHS nationally. Interviewees identified a range of damaging consequences affecting the quality of care, joint working and staff morale.

4.3.8 Well-Being

The concept and approach to Well-Being divided interviewees. Some argued its pursuit ran through everything the Community Planning Partnership did, but one derided the whole concept as meaningless and a waste of money. Whilst the latter view was rare, it was more common for people to remark that there was a lack of clarity regarding Well Being objectives and that a greater practical focus was required.

4.3.9 Support to Carers

A number of interviewees felt there was a lack of support for Carers. For example, there were positive reports regarding Post-Diagnostic Support for some people and carers with Dementia, but pressure on the service meant not all carers had benefited from this and for other carers, the support ended too early; before the most gruelling stages of the illness.

We understand that Carers of West Lothian have relatively recently increased their support to people caring for someone with a mental health problem. Time will tell if this initiative allays the concerns of those who felt the organisation was more focused on supporting carers of older people and those with physical disabilities.

4.3.10 Transitions and age-based services

Service transitions precipitated by age - from CAMHS and other Young Persons services into Adult and Adult into Older Person's services - were identified as a weakness by many interviewees.

The transition from CAMHS into Adult services was identified by some as an area of weakness because of a marked difference in the ways the two services operated; young people and families

could find the transition something of a culture shock it was also noted that planned service handovers commonly didn't happen.

It was also suggested that insufficient attention was paid to the needs of Looked After Young People; should be a strategic priority because of a higher prevalence of issues leading to poor mental health.

More than one interviewee questioned whether age boundaries remained relevant, particularly between Adult and Older Persons services. Such boundaries, it was argued, could place an artificial and inefficient barrier to delivery of some services, for example, psychology.

4.3.11 Access to specialist services

The local presence of specialist services for Eating Disorders and the Mother and Baby Parental were generally remarked upon as positives, however some also saw weaknesses in provision for other conditions; such as Autistic Spectrum Disorder and Brain Injury. In the former case, access was perceived as limited because the service for those with ASD was consultant led and based in Edinburgh.

With small numbers commenting the extent, or actuality, of such gaps in service would require further evidencing.

4.3.12 Other miscellaneous weaknesses

A number of other weaknesses were identified or inferred by interviewees, often in the passing. Often, given limited time available for interviews and focus of the study, there was insufficient time to pursue these in any detail. Thus, whilst the following may be relevant, we cannot expand on them to any extent.

- Lack of consistent approach to localities boundaries: - It was observed that there is not a consistent approach to localities boundaries in West Lothian. The Health and Social Care Partnership has two localities, but The Council may use three localities. This could cause problems for planning and data analysis.
- West Lothian's rural areas could present challenges when commissioning services. This could show itself in labour force shortages and an unwillingness from contractors to provide services.
- Some interviewees felt there was a lack of critical self-analysis amongst the primary players. These concerns appeared linked to other concerns about lack of engagement with service users and carers. There was a need to listen more and be more open to lessons from criticism.
- Although progress was credited, some clinicians made passing reference to concerns that the physical health needs of people with mental health problems were not always fully addressed.
- Some were of the view that are Medical model still held undue sway in the design and delivery of services.
- As well as noting a high prevalence of drug and alcohol issues as those In Distress, some perceived wider weakness services for these client groups.

4.4 Opportunities

Traditional SWOT analysis views opportunities as significant new initiatives available to a system. Examples could include collaboration among health and social care organisations through the development of delivery networks, community partnering to develop new care and support programmes and the introduction of protocols to improve quality and efficiency. Integrated delivery networks have an opportunity to influence health and social care policy at both local and national levels. They also have an opportunity to improve client satisfaction by increasing public involvement and ensuring client representation on boards and committees. For example, systems that are successful at using data to improve processes have lower costs and higher quality client care. The aim here is to enhance current opportunities as well as to exploit new opportunities.

This section summarises the 'opportunities' identified; either directly stated by interviewees or which can be inferred.

4.4.1 Service redesign

Whilst the appetite and ambition of interviewees varied, many saw opportunities for service redesign.

In particular, several saw a need and an opportunity to redesign services for those In Distress. There were advocates for a radical rethink, with the goals of: speeding access; enhancing the diversity and scale of psychological therapies; and making best use of existing staff resources. Some argued this could be achieved by Stepped Models of Care drawing more fully on the third sector and legitimising psychological interventions by a wider range of clinical and support staff.

Some spoke of how service redesign could bring opportunities to strengthen collaborative working; for example, through multidisciplinary teams and GP clusters.

Service redesign could also revisit the merits of age-based services, potentially sweeping away troublesome transitions and realising efficiencies.

4.4.2 Co-production

Several coupled service redesign with opportunities to build strengthened relationships with service users and carers, through co-production. Implicit in this view was that providers could learn from the experience of users and carers and that, consequently, future services models would have greater legitimacy and support.

4.4.3 A revised management structure

There's an opportunity to address perceived weaknesses in the existing management structure for mental health services. Some argued that services should be brought together under a single Mental Health Manager. Such a post could: promote a more coherent approach to service delivery and redesign; further enhance a culture of joint working and address any tensions between disciplines and individuals.

4.4.4 Recovery

Some saw opportunities to further embrace Recovery as an ethos; through the promotion of self-management, enhancing social capital and the recognition that Recovery is a journey not a destination.

4.4.5 Enablement

It was observed that Recovery was not relevant to those with a degenerative condition such as Alzheimer's. Nonetheless, there were opportunities to enhance Enablement; facilitating the fullest living of life.

4.4.6 Personalisation / SDS

In spite of perceived difficulties with the current operation SDS, generally there was support for the concept of personalisation and the opportunities it presented individual service users and carers to shape the services received.

4.4.7 Early intervention / prevention

There were those that argued for an increased focus on prevention and early intervention; or at the very least, protection of existing levels of resource allocation. There was little opportunity to discuss the precise form of future preventative activities, but we're comment was made, work with Children and Families figured most strongly.

4.4.8 Health and Social Care integration

Interviewees saw opportunities in the integration of Health and Social Care; securing sustainable services through shifting the balance of resources, clarity in priorities, efficiencies and enhanced joint working. However, it was evident that many believed there were obstacles to the achievement of these ambitions. We will touch upon these in the following Threats section.

4.5 Threats

Threats are factors that could negatively affect system performance. Examples could include: political or economic instability; and increasing pressure to reduce care and support costs.

The aim here is to avoid and thwart direct and indirect threats to the Mental Health system across West Lothian.

This section summarises Threats identified; either directly stated by interviewees or which can be inferred.

4.5.1 Unsustainable service arrangements

Many perceived current service arrangements as unsustainable in the medium to long term. Causes identified were a combination of: growing demand, unrealistic expectations and resource constraint. Some asserted these threats made the case for change, including changing models of care, reviewing priorities and potentially scaling back activities.

4.5.2 Current inefficiencies

Participants identified areas of current inefficiency that were ongoing threats; examples being: unnecessary escalation into specialist services; over treatment; inappropriate presentations and referrals; and issues with staff recruitment, retention and sickness absence.

4.5.3 Ill-informed commissioning

For a range of reasons, there was concern that inappropriate services may be commissioned. Reasons given included: failure to listen to service users and carers; unilateral action by commissioners without regard to professional advice and the evidence base; and a failure to gather and utilise performance and impact measures.

4.5.4 Personalisation and SDS

Two threats were articulated or implied. Firstly, that a drive toward bespoke delivery could undermine the viability of existing services and organisations; demand, and consequently, income could be volatile and this might result in service closures or a lack of innovation and risk aversion on the part of providers.

Secondly, individually tailored services could be more expensive because of a lack of the economies of scale achieved through group based commissioning.

4.5.5 Failure to invest in prevention and early intervention

There was concern that resource constraint would lead to further de-prioritisation of preventative activities, which would over time prove costlier.

4.5.6 Diminution of workforce, ratios and competence

Some argued that with most of service costs being staff related, continuing resource constraint would have the inevitable consequence of reducing staffing ratios, changing skill mix and reducing overall competence.

4.5.7 Lack of political support

There was concern that politicians, both locally and nationally, could not be relied upon to be consistent to take difficult decisions.

4.5.8 Vested interests

Efforts to significantly redesign services or shift the balance of resources could be opposed by supporters of the status quo.

4.5.9 Worsening Health Inequalities

Some suggested that welfare reform and increasing in work poverty would lead to an exacerbation of health inequalities. Those with mental health problems were particularly vulnerable in this regard.

4.5.10 Further centralisation of services

Concern was expressed that some local services - including in-patient beds - might be centralised in Edinburgh, with a negative impact for service users and carers.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Ensuring good mental health within the population throughout the life course is about more than just the absence of mental disorder, and is a major contributor to wellbeing within the population. Mental health impacts on all aspects of people's lives and it is therefore the responsibility of not only the individual, but also families, friends, employers and the wider community to enable people to develop and importantly maintain good mental health.

This needs assessment has been produced to support the appropriate and efficient commissioning of mental health and wellbeing services and support provisions across West Lothian.

This chapter sets out a series of recommendations for deliberation by the West Lothian Health and Social Care Partnership. Recommendations are derived from evidence gathered and analysed from the review of data, surveys and fieldwork, including study informants.

5.2 Recommendations

The following series of recommendations have been structured around a series of key themes.

5.2.1 Joint Strategic Priorities

- **Recommendation 1:** In future, these priorities should be needs-led and not service-led.
- **Recommendation 2:** Consideration should be given to strengthening the contribution of the Third Sector; particularly in areas of lower speciality community based supports.
- **Recommendation 3:** Inclusion of 'support for carers' in future priorities.
- **Recommendation 4:** Taking cognisance of the recent NHS National Clinical Strategy and accepting issues of resource constraint and growing demand, the Integrated Joint Board to reassess the current balance of regionally and locally delivered mental health services to ensure the most beneficial and sustainable arrangements are put in place to deliver quality care as close as practicable for service users and carers; such a review to include consideration of opportunities arising from GP clusters.

5.2.2 Current Configuration of Services

- **Recommendation 5:** A comprehensive review is required, to address issues of capacity, capability and flow across the Acute, Rehab and Community Support services.
- **Recommendation 6:** A review of management arrangements for Mental Health services in light of the evidence provided in this study.

- **Recommendation 7:** A review of services for the 'Distressed' with the aim of delivering an expanded range of services and enhanced early intervention. It would seem appropriate that future services are based on a Stepped Model of Care.

5.2.3 Ethos

- **Recommendation 8:** The Integrated Joint Board to develop a statement of Vision and Values to which all Mental Health services should subscribe; this to emphasise the centrality of Recovery and the benefits of engagement and co-production with service users and carers.

5.2.4 Adult Psychology Services

- **Recommendation 9:** We would recommend consideration of developing an enhanced psychological therapies service, including implementation of a robust and well-resourced Stepped Model of Care; where a broader range of non-specialist staff and organisations (including the third sector) deliver psychological therapies (such as advocated in 'The Matrix - A Guide to Delivering Evidence Based Psychological Therapies in Scotland' NHS Education for Scotland, 2014).

5.2.5 Joint Working Arrangements

- **Recommendation 10:** Given the evidence of variable joint working between agencies and disciplines, we would recommend consideration of strengthened multidisciplinary teams across both in-patient and community settings.
- **Recommendation 11:** Consideration be given to a single point of referral for Adult services.

5.2.6 Service User and Carer Involvement

- **Recommendation 12:** Given this study has noted variable engagement with, and empowerment of, service users and carers, we would recommend consideration of developing a Service User and Carer Involvement Framework and Strategy.

5.2.7 Staffing

- **Recommendation 13:** Development of a workforce strategy for Mental Health services to address identified issues of recruitment, retention, sickness absence and an ageing workforce.

5.2.8 Transitions

- **Recommendation 14:** A review is required of transition arrangements between CAMHS and Adult Services given the evidence supplied in this study.

FIGURE 8
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WEST LOTHIAN MENTAL HEALTH NEEDS ASSESSMENT

PART TWO – APPENDICES – THE SUPPORTING DOCUMENTS

Report prepared for West Lothian Health and Social Care Partnership

EVIDENCE INTO PRACTICE

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PROJECT ADVISORY GROUP

The research team was assisted by a Project Advisory Group, which provided accountability, guidance and support. This group met physically on four occasions. The research team are grateful for the advice and facilitation provided by this group throughout the duration of the study. This group comprised:

Carol Bebbington (Senior Manager, Primary Care)	Pamela Main (Senior Manager - Community Care, Assessment and Prevention)
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REPORT FORMAT

The report has been written primarily with the practice community in mind. Each strand of data collection and synthesis – dataset reviews, interviews, stakeholder events, working groups, focus groups, and surveys – contains a box with key findings. **To preview this report, the researchers would recommend reading the key findings from each section followed by the final recommendations (Chapter 7 of the Part 1 report).**

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APPENDIX I: DATASETS REVIEW

It is not possible to include this section at this time, as Caldicott Guardian approval has not been received, in order to access NHS data. Once approval is received, this section will be completed and included within the report.

APPENDIX II: STAKEHOLDER EVENT AND WORKING GROUP SESSIONS

Introduction

A Key Stakeholders Event was held at the front end of the research (6th May 2016) to gather views and themes for consideration during the main fieldwork phase of the project. From this Event the recruitment of a small working group took place (see **Appendix VII** for the full list of Working Group members). The Working Group met twice to consider the key messages that arose from the initial Stakeholder Event.

The purpose of thes qualitative elements of the project was to find out:

- Views on current provision of adults' mental health services and support;
- Any gaps in current provision;
- Views in relation to the nature and extent of future requirements; and
- Assets (groups, networks, individuals, etc.) across West Lothian.

Key Stakeholders Event (6th May 2016)

The first section of the Stakeholders Event involved small group discussions focused around the following six key areas of investigation:

1. WHAT WORKS WELL - What support and services currently work well for people with mental health problems across West Lothian?
2. GAPS - What are the main gaps and areas for improvement in support and service provision for people with mental health problems across West Lothian?
3. DUPLICATION - Are there any areas of duplication in support and service provision for people with mental health problems across West Lothian?
4. CAPACITY AND INEQUALITIES - Which groups/geographic areas are currently well served across West Lothian and which are not well served?
5. ACCESSIBILITY - What are the current facilitators of and barriers to support/service accessibility for people with mental health problems across West Lothian?
6. TRANSITION - What are the current strengths, weaknesses, opportunities and threats of transition arrangements for young people moving to adult support / services?

<u>What works well?</u>

- Day services are really good, respite also
- Staff at Newell and SAMH are doing a great job
- West Lothian is a small enough area and due to this the statutory and 3rd sector organisations are well connected. There are good relationships

- Distressed tolerance is a very effective project. It is group work, a 12 week course- this worked. This involved Peer group work, where people were meeting even out with the group setting
- Multi-agency working. Communications between agencies. (we all know one another's mobile numbers). Good relationships at all levels from referral right through. 'The West Lothian Way'
- There are good relationships between the social work and the police, however the Adult Protection Officer post is being removed and this be a huge loss for social work
- Prioritising MH for housing – OT new involved in this. Early for assessing outcomes but looking at mental health not just physical health
- Blue badge – mental health – OT team involved in this in West Lothian. How does cognitive, impairment feed into disability and people's right to a blue badge. Criteria with this pilot might mean some fall through the gaps for the BB
- Perinatal mental health unit it St John's working well. Reactive attachment bonding helping to reduce neglect, not many beds though
- Wards in St John's are better than 10 years ago in staff attitudes and service provided
- Social prescribing works well. Structured psychologically informed service not as available for these who don't need psychology and psychiatry from NHS.
- Outreach mental health for tenancy support to ensure tenancy is not lost, works well but can do more
- Service flexibility
- Good at conducting health assessments
- Good relationships between health and social care
- Advocacy service response
- Peer volunteers
- Yes, there are good services, but not enough
- Think all good. Group Living a good service, always people to have people around them and support them
- Had been concerned about people being supported in own homes. Works well but doesn't suit all. Some need group support and come to services that provide group support. Something about being comfort of being in group situations where don't need to explain themselves
- Links with advocacy really strong
- Links with Social Work very good/ responsive, try to sort out things. Helped people move on through SDS particularly option 1. Seems more solid than in other areas
- Some services from past not sustained
- Want to see outcomes approach in West Lothian validated
- Dual diagnoses
- We are seeing people with learning disabilities with mental health issues
- Substance misuse is the background of people we are seeing

- Good working relationship with different clinical services → good outcomes for patients (systems/organisation not as sensible)
- Good communication with third sector – opportunity to make it better (systems makes it take a long time to get thing done)
    - Willingness to get things done
- People under 65 diagnosed with dementia – challenging for them. Deterioration can happen very quickly – services can struggle to keep up.
- Quality of care deteriorating because of recent changes
- Once we get patients into system actually assess/treat well (good skill base within team) - matching them up with right treatment works well.
    - Transition easier
    - Signposting works well
- MOOD doing really well – social prescribing
    - Low level intervention
    - work as conduit to other community-based activities
    - offer lot of peer support / buddying
    - signposting
    - issue is people becoming aware of MOOD – limited capacity)
- Is a flexibility re age in some community services

<u>Gaps?</u>

- There has to be more one to ones with a CPN.
- More education for GP's, as several do not understand mental health issues, also they are very time orientated.
- Distressed tolerance, a great initiative, but due to lack of funding there is a gap with this now as the service is not running. This was developed in West Lothian with lots of partners. The service kept people out of hospital and aided the recovery process.
- You have to be in the system to be referred.
- We found it hard to find free space where people could meet for a coffee and a blether.
- More supported accommodation, there is a gap there. There are many people in hops due to lack of supported accommodation. The accommodation available does not fit their needs. Young people with Early Onset Dementia, they lose out to older people with dementia.
- Housing is a really big issue, there used to be youth housing, but this has since disbanded.
- We should have a joint young person/mental health/substance use/ community based initiative. If we target young people we will not be working with them at 35.
- Supported accommodation model would be good so people are kept in the community.

- Eating Disorder Unit – few months away from national accredited. As these are hosted services for the region it shelves the budget line for folk in West Lothian. There is a significant loss in West Lothian for West Lothian residents. 156 adult mental health beds closed in West Lothian in last few years. Very little resource in community. Investment is currently short term with no exit strategies for clients in the community. Inpatient beds lost and no replacement to compensate in community services/outpatient
- Development in community has been around statutory not around general mental health. If you're subject to Mental Health Assessment you get a good service but not if you have a general mental health issue. Never meeting 18 week targets more like 18 months
- Caseloads for psychiatry is 2 to 3 times higher Edinburgh. Impact on clients is diagnosis deprivation which means other services are not available until patient has seen psychiatrists
- GP involved with self-management, every GP has access to CP. Current re-design as access to talking therapies not everything has to go through the GP but someone needs to direct the care. Employers helping support to those who work with ESA, counselling support
- Not enough to help those who can't self-manage "middle people not serviced" low level support can be offered under tenancy support and if the client has an alcohol drug problem, this feels/able driven.
- Services are not available until someone wants to engage, leads to crisis. Not turning up twice and discharged, then case helped by professional who isn't an expert and can't help. Not wanting people off as DNA's or sending letters, no opting in
- Not enough money in system, 3rd sector working at lower unit cost, can West Lothian meet capacity?
- Engagement model needs to change. Proactive approach, one to one intensive engagement could save money.
- Can ISB move money to early intervention? ISB has to be driven to do something differently.
- Needs of carers (e.g. respite/ provision generally)
- There are no information sharing systems between health and social work
- The police are only able to forwards information to social workers, people from health can't access information
- Incompatibility of IT systems is a big issue overall
- Don't have sufficient interim care
- Not enough accommodation available
- Not enough support available
- Limited resources – slows or blocks on discharges
- Unskilled workers working within the area
- Gatekeeping process delays things for people- more trust needs to be given to service and service delivery
- People are assessed to death

- Lack of GP services, people off for months have had to diagnosis
- There is a lack of young people services, we need to get one person to speak with young people once a month
- There are gaps in the workforce as well as some services, training/ awareness
- Limited rehab resources → difficult to move on from Ward 17
- Limited long-term care → bottle-neck in rehab services
- Housing / supported accommodation = big issue
    - Takes a long time / lots of red-tape
- Need to be more creative – not age-based service provision
    - community-based services getting better – Mindfulness services accept over 65s
- Timely post-diagnostic support (finance issue – not been confirmed)
- NHS doesn't necessarily know about third sector
- Very long waiting lists for things like psychology
- Not truly patient-centred – don't ask patients
    - Very quiet about some of the services for fear of over-subscription
    - People find it difficult to refer / services guard their resources very fiercely
- Stigma still there – doesn't help people access services they need
- Common information point / HUBS in local areas (people there to point them in the right direction – make referrals). People don't know about services that are available.
- Council / NHS and third sector all have different IT systems – if they could share info – save people time and effort. It's very disjointed.
- Managed Clinical Network should work better to sort out a directory
- Disconnect between management and staff on the floor – too much time spent away from 1:1 patient-care

<u>Areas of duplication?</u>

- During the referral process, there is a lot of paperwork duplication from a client's point of view. There is not one recording system where everyone could access.
- Given allocation of hours by commissioner. Sometimes deliver more than one service, need to be clear about who does what
- Framework agreement. Appears to be inequality about it as not getting same amount of hours
- Duplications and redesign need to be explored first before we decide there isn't enough resource
- Scatter gun approach
- Addiction services and mental health not sitting well together and often seeing the same client group
- Efficiencies can be achieved if merged together

Capacity and inequalities?

- There are no care homes for young people across West Lothian, the Young Person's Unit is in Edinburgh
- The Green gym is closed. This was a good resource, and it empowered people to take responsibility to go along
- Some 17 years olds are accessing services where there are lots of 35 year olds and this is not fair
- Social care workers are having to rush people in their own homes, as they run over the time allocated. Sometimes they cannot leave one person but then the next client loses out. But… there is not time frame for interaction with someone who has a mental health issue
- When someone presents at A&E it is very impersonal, however the Distressed Tolerance project involved working with NHS staff to overcome this
- Public transport is a big issue- buses starting later and finishing early. Affecting people using the variable community groups. People from Linlithgow cannot go to certain services due to buses. This is disabling rather than enabling.
- We compartmentalise things (physical health) but when people do move on… such as after rehab, then the chances of them sliding back increases, and then there are many of these services in Edinburgh and not in West Lothian.
- Delayed discharge is an issue due to lack of available housing
- Inequality of provision with acquired or traumatic head injuries
- People are unable to access all services- outlying areas- the public transport is a problem
- You have to have a formal diagnosis better service
- PTSD- people have difficulty in accessing services-capacity issue
- NO ex-offenders/ travelling community for years. Put in same category as veterans
- Refugees
- Prevention and early intervention
- There is a gap in crisis work
- For respite, awareness has to be raised- not sure if there is a gap
- Under 65s with dementia – don't fit into day care or lots of other activities because they just cannot do them
- some also limited what they can access by themselves also
- Multi-diagnosis – no services in WL for those with MH and
    - Dual-diagnosis (drug and alcohol)
    - Behavioural
    - LD
- Those without MH issues but:
    - those in distress
    - those with social crisis

- addiction

Accessibility?

- There are services which are Lothian health board but certain services cannot access these as they are based in West Lothian, however, this may change due to the integration agenda
- Several things happen in Glasgow or Edinburgh, and the smaller areas, such as West Lothian, are forgotten about. This is evident in SAMH
- There are lots of services based in Glasgow or Edinburgh and accessing them is difficult for clients
- HMP Addiewell are merging mental health and addiction together, this could happen in the community
- Performance monitoring framework in mental health – not here, should it be? Focused on heat targets and SW maybe in wider services
- Outcomes – are they properly assessed, specialised?
- Evidence base – how good is this? How closely are services following it?
- Edinburgh centric services easier for West Lothian residents living in the east of the country
- Vulnerable people are expected to travel
- Gap – Satellite – Services, professional networks.
- There is only access to health day care if a diagnosis of a severe and enduring mental is given
- People not being able to travel on their own- independent travel, fear of getting out the door
- Geographical barriers, time of travel and transport issues-lots of rural parts with small villages
- People with mental health problems do not know where to go for help
- People from years ago presenting to services most really not knowing what they need to say/ how to say they need help

Transition?

- There is a disconnect between education and social work. The introduction of a transition board who can look at the needs of young people earlier, may overcome this
- Limited knowledge of West Lothian position
- Difficult area- be a lot easier if money followed person
- Social work transition time have been really good
- Got to be 18 before most services (around the table) can engage with people
- In social work services a person becomes an adult at 16, but the foundations do not match up as referrals at social work is 16, but it is 18 for health
- The Child and Adolescent Mental Health Services waiting list is long
- Continuity in place for progressing-deemed to be a strength

- Younger adults team (17-25) – very small team – need diagnosis. Trying to join with social enterprise at Strathbrock. Still people with severe and enduring who can access.
    - Limitation – many YP don't have the required diagnosis but have significant needs that should be served. 'How can you provide so much for so few, but so little for so many?'
- Work better with third sector? Pilot Mid-Lothian in GP surgery for mapping services etc.

During the second part of the stakeholders event, each of the five small groups discussed five key priority areas they believed should be taken forward for consideration by the proposed working group. The five key priority areas were discussed in depth. Once the five key areas were identified at each table, all stakeholders were then allowed to vote for their top four from all key priority areas identified from all table (25 key priority areas in total). The top five key areas/themes are shown below, with the number of votes received in parenthesis:

- Accessibility (18)
- Unscheduled care (13)
- Keep well services (11)
- Early intervention (10)
- The 'West Lothian Way' (it's positive uniqueness) (9)

Other priorities are as follows:

- Communication (8)
- Service directory (information HUBS) (7)
- Suicide and self-harm (6)
- Training qualifications of non-specialised staff (5)
- Prevention and early intervention (4)
- Young people (4)
- Capacity building in community for those without severe and enduring diagnosis (4)
- Step down step up services (3)
- Duplication (3)
- Resources (3)
- Smarter use of resources (3)
- Reducing delayed / failed discharges (3)
- Work development and staff volunteers (2)
- Access (2)
- Person-centred (1)
- Mapping the way mental health services are offered (1)
- Inequalities (1)
- Post diagnostic support (no votes)

Working Group Session 1 (18th May 2016)

Are the key messages highlighted at the stakeholder event a fair reflection of the current position in West Lothian (as headline themes)?

- Attendees were not sure where or what the duplications are. One potential suggestion was WELDAS and the Drug and Alcohol Team.
- It was generally acknowledged that it is "necessary to define the terms; to be precise about what we mean e.g. accessibility is a problem in some areas; not in others."
- "Police can receive between 75-100 adult referrals a week in West Lothian and about 70-75% relate to Self-Harm/Attempted Suicide; it should have a higher priority. Early intervention is required."
- A worry was expressed about the so-called 'West Lothian way' – "sometimes the West Lothian officers don't cooperate with other areas (e.g. there is a feeling with NHS Lothian that there has been an over-centralising of funds to Edinburgh). It needs to be understood as a local responsiveness/connectiveness to client needs, but it shouldn't exclude working with and learning from other areas."

Are there any missing 'key' messages?

- "There is a lack of connectedness between drug and alcohol and mental health services – dual diagnosis."
- Transitions.
- Carers for those with mental health issues. There is no carers advocacy (VOCAL no longer do this).

Currently, is there sufficient provision of services and support to meet presenting needs? Are the needs and expectations of people with mental health problems currently being met in West Lothian?

- "There needs to be more."
- "The quality of provision is very good, there are just not enough of them."
- Generally, there is a good range and a good choice of service and support; although, "needs aren't always being met" and "medics and social work don't always necessarily know what is there".
- "There are lots of good services (e.g. the Garden centre), but sometimes there are long waiting lists."

Are there any gaps in service/support provision?

- "Service User / Carer Involvement is void – partly due to the new infrastructure with the IJB reorganisation." There used to be a Metal Health Forum and a Service User Forum.

- Residential support that is more than just housing support.
- There is no disposal point for those in distress / those under influence – this group is a problem for the police.
- For those in distress – medium term support; access to CPN / psychological therapies:
- "sometimes it's a question of having the appropriate disposal routes"
- "we are perhaps a missing bit for the shorter/medium term stuff"
- "things are changing though – there are things like telephone contact etc. like they do in Edinburgh."
- Something like the Crisis House in Edinburgh (Penumbra) – "This is a Lothian-wide support, but the practicalities of getting someone there who is in crisis may be insurmountable – maybe something like that in West Lothian would be good?"
- Supported accommodation:
- "SAMH – it's all shared which means we need to find suitable cohabitants."
- "There is no housing with care provision for those with dual diagnosis or for younger people with Early Onset Dementia (those under 55). We did have 21 beds; the 17 with Barony have been deregistered which means these people are not being appropriately cared for."
- "Templar Rise is not suitable for people with severe and enduring mental health problems which leads to the inappropriate use of Ward 17 and Pentland Court. This can lead to bed blocking."
- "There is a lack of housing with care for those with poly-substance misuse."
- *"The referral process / access into services may not be fit for purpose."* You either present to the GP or A&E – there is no middle option. Or you have to call the police.
- OPD5 do the assessment if the GP makes a referral

<u>Are there any particular groups (including 'hidden' populations) of people with mental health problems that you feel are NOT well-catered for in West Lothian?</u>

- Early Intervention – Crisis Prevention:
    - "There is no third sector intervention in this area like there is in North and South Valley; Lanarkshire; Forth Valley etc."
- Transition:
    - CAMHS to adult.
    - Adult to older people's service – 65 is no longer considered old; "Is the age that you are relevant at all? Should it be needs rather than age-led?" "Health are trying; social care are failing – e.g. the Ability Centre is age restricted 16-64."
- Carers.
- BME – especially women. There is Shakti in Edinburgh.
- The homeless – CPNs from the 'Moving into Health' service were however seen to be good.

- "There are problems on discharge from SPS Addiewell – often there is no support network in place. There is usually a substance misuse issue and often they are in need of a script over the weekend which hasn't been organised."
- Those with a Dual Diagnosis:
    - Substance Misuse;
    - Autistic Spectrum Disorder; and/or
    - Learning Disabilities.
- Those in need of Employment Support.

Service User Engagement

- "Service user engagement is falling apart in some ways in West Lothian. The integration agenda requires that you take the people with you – it's not done very well."
- "It should be about day to day activity. There should be the opportunity to do some collaboration – co-production."
- The Garden Centre is not accessed by SAMH, Barony etc. but could be – there needs to be better systems in place in order to do this.

What works particularly well for services and support for people with mental health problems in West Lothian?

Participants were asked to comment on what works well in mental health service provision across West Lothian by noting their thoughts on Post-It notes. These were the remarks made:

- Multi-agency working.
- Breakaway and Recovery.
- Addiction Services.
- Ward 17 is much better than before.
- Good relationships with SMU and CPNs (Joint Working).
- Interagency Working.
- Partnership working across different agencies/organisations.
- Joint working with police on ASP issues – good supportive links.
- Partnership working.

How effective are the identification, assessment and care management processes for people with mental health problems?

- "Self-Directed Support is not fully embedded – there is variation worker to worker about what is offered / what it is perceived to be able to do. The Council needs to audit that – it requires standardisation."
- "It is really down to your social worker."
- Mental Health is seen to have a smaller budget than Physical Disability - there is an inequality.
- "There are massive inequalities in levels of award"
- "Once a Service User gets an allocation there is a gap about what you do with it."
- "Carers don't know about SDS, but providers have come out to speak to carers / service users."

How well do services and support integrate and work together?

- "Confidentiality issues get in the way of allowing working together."
- The SDS Single Shared Assessment isn't accessible to the NHS.
- West Lothian has a good history of integrating Health and Social Care. "There are certain instances of good working practices, but there is room for improvement. There are good relationships with the college; Adult Support and Protection; advocacy; carers."
    - They are currently looking at two integrated community mental health teams; there may be opportunities for third sector?

Working Group Session 2 (3rd June 2016)

Is there a genuine choice of services and support available in relation to range, consistency and quality of provision?

- For Carers – Cares of West Lothian (COWL) is the only support for carers – they have a new service for carers of those with mental health problems
- Choice is given with initial assessment; in the goal setting
    - "There may be limitations if they don't have the right funding in place"
- Self-Directed Support (SDS):
    - "Choice from an SDS perspective depends on who is doing the assessment. It depends whether the person doing the assessment offers it."
    - "It might become confusing for the service user – some people just see a pot of money – they don't necessarily see the limitations (i.e. that they have to get a train to Oban not take a taxi)."
    - "We're trying to think outside the box a bit more – trying to drag people along with us – we're still trying to find our feet."

    - "Lots of people are still saying 'just get me whatever hen'"
- "Choice is a much wider thing – we need to think about: does a patient have a choice about their treatment/therapy? A Choice regarding coping strategy? Choice over whether they would be better in a ward or the community; choice regarding professional? Choice over physiatrist/CPN/anyone at all?"
- "Are the service users at the centre of their care?"
- (MHAP) "There is a common request to change psychiatrists– but there are limited psychiatrists, which leads to long waits for appointments."
- SAMH try to match clients with staff they 'gel' with
- ACAST – short term/crisis team – "it is a small team so we have to be clear with service users that the same member of staff can't always visit"
- Ward 17 – patients have more control/choice over key nurse/worker
- Community Outreach Team (COT) – assign a key worker too
- Psychological interventions – often have to be delivered by specific professionals. *"There are not many options."*
- For mild depression – Step out group / Nightingale groups / GPs refer to online support – *"lots of people are just looking for someone to speak to"*
    - GAP – counsellor to help through low mood / depression / anxiety – someone to help them through a low point. 'A listening ear'
    - Need this low level support
    - "Doesn't necessarily need to be delivered by highly trained mental health professionals – it doesn't require intensive mental health input."
    - "Lots fall into this category; but there is little support available out there"
    - ACAST can sometimes deliver something short term (assessment – needs mental health professional to do this; psycho-educational input/tools for anxiety / practical problem solving etc. – doesn't need a mental health professional for this), but there is nothing for them to refer to.
    - "The distress tolerance programme has gone now (many people attending this service attended no other service – this was preventative – it stopped them becoming service users)."

<u>How accessible are services and support for people with mental health problems?</u>

- "There doesn't seem to be any direct route for a person to self-refer to commissioned services [e.g. to LAMH]; people have to go through the assessment process because social work holds the purse strings. The problem could have deteriorated between referral and the assessment process."
    - No low threshold support in West Lothian whilst they are waiting for assessment (Bathgate House used to offer this)

    - Is a stress-control class
    - Cyrenians have a HUB
- Advocacy and COWL is self-refer
- Can self-refer to social work – all referrals are then screened
- NHS Mental Health Services are accessed via GP;
    - Out of hours - NHS 24 would make an out of hours GP appointment or set up an appointment with the duty psychiatrist for formal assessment. A&E in an emergency. ACAST is available up to midnight if you present at A&E. If you call the police with suicidal thoughts, they would also attend.
    - "Sometimes phoning out of hours or Breathing Space is the only way to get an out of hours' psychiatry appointment."
        - Sometimes it takes a long time to get an ambulance to take suicide attempts to hospital
- There is no crisis support for carers
- "Addictions services have a very good model – they have drop in centres which are self-referral / drop-ins"
- Transport – physical access to services is an issue:
    - If service users don't have a budget for staff to travel too – service users can't access these services
- In lots of ways things are better than 20 years ago – there wasn't an ACAST service then
    - "Stigma went away when it [inpatient provision] went to St Johns"
    - The hospital is much more open to working with the third sector

<u>How good is accessibility to and integration with mainstream health and social care services?</u>

- Lots of supported college places – Bathgate
- "The vast majority of those on mental health wards have other medical problems and perhaps their physical conditions aren't necessarily met. For example, if someone falls in Ward 17, they have to get medically trained staff from another ward to help lift as they don't have manual handling training."
    - It is getting better though
    - Addictions and mental health services work well together
- Xcite – good links with mental health services – offer gym memberships etc. to those with mental health problems
- Health Improvement Team – good links with mental health services; they help facilitate training/services etc.
- Criminal Justice – working in the Civic Centre makes a big difference; next to Police and Public Projection gives easy access

- Adult Protection
    - Having a point of contact does make a difference – but the post not being replaced upon retireal in September. *"This is a unique role in West Lothian – it will be missed."*

What does/doesn't work particularly well in West Lothian, in relation to the transition of young people into adult MH services?

CAMHS to Adult Services/Supports

- Carers find it very difficult – the level of support is much lower in adult services than CAMHs.
    - COWL do not offer transitions courses for mental health carers in same way as they do for parents of children with learning disabilities.
- High proportion of young people (14-17) presenting at A&E with self-harm/suicidal ideation; there are fewer young person inpatients.
    - Response for young people is good – they will always be seen; after initial assessment (doctor and assessing nurse); they always have access to on-call CAMHs specialist
    - Police get involved – they will contact social work and talk to young people and parents/education etc.
    - An alarming number of young carers self-harm (COWL) – COWL offer quite a lot of 1:1 support for this; they have a waiting list which is growing
    - "Young people need lifeskills and tools to deal with distress."
- There are link workers in schools – Guidance Teachers

Adults to Older People Services/Supports

- SAMH support people regardless of age
- MHAP could work with people over 65 – although contracted upto 65
- COWL work with those aged over 8
- Social work can work with people over 65 – *"it's about continuity of care"*
- In Health – "if they are receiving treatment they wouldn't automatically transfer at 65, we would wait for treatment to end."
    - CPNs – still work to 65 – "it's not prescriptive though"
    - "There is a fair amount of discretion"
- "There is an Issue with Ward 3 (Psychiatry of Old Age) – largely a dementia ward. It can be quite violent – not necessarily the right place for older people with other psychiatric issues or young people with early onset dementia."

Hospital to Community

- COWL work in St John's – often people are discharged at very short notice and rely on family carers
    - COWL sit on discharge planning meetings

    - Hospital discharge was an add-on with the Carers Act
- There is still an issue about whether the ward will talk to your care provider about getting a care package
- It can be inconsistent – "social work isn't always told when people are discharged"
- MHAP might get a referral but the patient may be discharged before they are seen and they leave with no forwarding address

Are there any defined and agreed 'Integrated Care Pathways' within the MH sector in West Lothian?

- Is a model the NHS tries to work to, but it is not consistent
- It does work with high tariff cases – referral to MAPPA (ICP merges into MAPPA)
- "It sounds like a big secret"
- "I think I've heard of it"

What are the key gaps or issues that need to be addressed pertaining to service provision for those with MH problems in West Lothian?

- "It is very difficult to deal with things in isolation – if you change something it has an effect on something else somewhere down the line."

Where would you like to see future investment go? (Ranked in order of priority)

1. INCREASING THE CAPACITY of existing mental health services
2. EXPANDING THE RANGE of existing mental health services
3. ENHANCING THE QUALITY of existing mental health services
4. IMPROVING THE INTEGRATION of mental services and other services

APPENDIX III: KEY STAKEHOLDER INTERVIEWS

Introduction

A total of 33 people representing public and 3rd sector services directly or indirectly engaged in the provision of Mental Health services participated in interviews. The majority were conducted as one-to-one, face-to-face interviews; a small number were joint interviews and another small number were conducted by telephone.

Interviews were semi-structured in nature, primarily focusing on the following topics:

- The role and responsibilities of the interviewee and a description of the service in which they operated.
- Strategic priorities.
- Which groups are well served / less well served by current arrangements.
- Localities.
- Service strengths and weaknesses.
- Service user / Carer involvement.
- Well-being.
- Any other relevant observations.

Strategic priorities

Commonly discussion of strategic priorities began with a review of the current Commissioning Priorities for Mental Health, as stated in West Lothian's IJB Strategic Plan 2016 / 26. However, this was not possible or appropriate in all cases; particularly where the interviewee was unlikely to have detailed knowledge of these priorities or how they had been arrived at.

Where interviewees were aware of the commissioning priorities stated in the strategic plan, there was often broad endorsement of these. But, importantly, thereafter interviewees would then offer a wide range of additional strategic priorities for consideration; sometimes these were explicitly stated as such, but more often they were inferred; by the weight of emphasis given by interviewees.

Where comments could be characterised as striking at the heart of how positive Mental Health and well-being could be delivered in the future, we have categorised these as a comment on strategic priorities.

The sheer range and diversity of priorities offered by interviewees was such that it is a challenge to represent them with clarity. Nonetheless, they can be broadly grouped under the following headings:

- Service configuration and service models.
- Management arrangements.
- Planning and resourcing.

- Prevention
- Health Inequalities and Access
- Assessment and SDS
- Service User and Carer involvement
- Well-being

Service configurations and service models

With regard to service configuration, a number of interviewees felt there was a need to address weaknesses in how services operated as a coherent whole.

Mental Health services and patient flow

Some suggested that whilst individual Mental Health services were working appropriately, linkages with complementary services were not always adequate to ensure effective treatment pathways and efficient patient flow through the system. Thus several people questioned whether the current configuration of Mental Health Acute in-patient, Rehab and support services in the community was fit for purpose.

More than one cause was suggested for issues with patient flow; slow progress through Rehab was cited as not only having negative consequences on the pace at which service users return to the community, but also on occupancy and availability of Acute in-patient beds; at worst preventing acute admissions and a reliance on treatment in the community through the Acute Care and Support Team. One said:

> *'The Rehab facility is consistently full. Recently, 25% of patients in Acute have been waiting for a move into Rehab. This is a whole system 'flow' issue.'*

Another:

> *'Some go straight home without appropriate access to Rehab.'*

Another said:

> *'156 in-patient beds have been removed, however they have not been well served by the community support models that have been put in place.'*

In a similar vein, another said:

> *'People are stuck in hospital because of a lack of appropriate supported accommodation…. The existing supported accommodation is appropriate for some, but not all. Some are being sent to supported accommodation out with the area.'*

Gaps in services

When discussing strategic priorities, many interviewees identified gaps in services. A common theme was the adequacy and configuration of services for those that might loosely be categorised as

'Distressed'. This was so commonly cited as an area of strategic concern that it's worth illustrating with a number of perspectives, each from a different interviewee. Thus one said:

> *'There are huge numbers of people with mental distress and related social problems. It shows in A&E and is probably impacting on community services'*

Another said:

> *'Those who need urgent unscheduled care are not well served; those with addictions, self-harm, in distress, with personality disorders, with dual diagnosis, and other conjoined medical and psychiatric problems. (Linked with this may be) social problems, homelessness, unemployment and loneliness'.*

Another:

> *'We have a lot of Young People presenting at A&E with signs of distress. This is a challenge because we don't have CAMHS in-patient beds on our doorstep'.*

And another:

> *'People in distress often present at the General Practitioner. But the GPs have nowhere to refer.'*

Discussion of those 'in distress' was often linked to discussion of the responsiveness and capacity of psychological therapies. Of those who commented, there was universal concern that the waiting list for Adult Psychology was approximately a year. One said:

> *'There used to be a full-time Adult clinical psychologist for West Lothian, but they now serve West Lothian, Midlothian and East Lothian.... The post is stretched to unbearable limits and West Lothian has less consultant time. ... It's appalling that it's a stand-alone service.'*

Another said:

> *'Psychology is struggling with access. There is a lot of room for improvement. It's letting a lot of people down.'*

Some argued the lengthy waiting lists were simply a function of inadequate capacity[1]; to which some ventured potential solutions.

> *'There was previously training for particular therapies, but now because we don't have a certificate, we are not able to deliver. I would like us to go back to that way of working. Staff have been de-skilled and dismissed, but we would be able to build this back into our working practice.'*

One commented that psychological capacity was a Lothian wide issue:

[1] At time of writing, we understand The Scottish Government has made additional finance available for psychology services in Lothian and that this will result in an additional 4.5 psychologists, five nurses and admin support available throughout the area. However, one estimate suggests Lothian would instead require an additional 13 psychological therapists, above the historic baseline, to provide a sustainable service.

'(Compared to other Health Boards) NHS Lothian has the lowest number of psychologists and the lowest banding. If there was more investment, we may be able to change the model of care. We should have more nurses delivering psychological therapies'.

For one, current arrangements were broken beyond repair:

'Our current approach to psychotherapies will never deliver. We must change the system. We can't reward people for being inefficient in a daft system'.

Referring to the lack of coherence, one observed that West Lothian lacked an adequate 'Matched Care model'; where psychological therapies could be delivered in a tiered manner, by a range of disciplines and including 3rd sector providers.

Other gaps / service weaknesses identified by more than one interview were 1/ for those with dual diagnosis (Substance Misuse and Mental Health problems) and 2/ those Young People who weren't sufficient priority to be treated by Children and Adolescent Mental Health Services (CAMHS).

Service models for Mental Health / Mental health problems

One interviewee questioned whether an adequate distinction was made between those with Mental Illness and those with a Mental Health problems; implicit in this view was the suggestion that current services were not adequately recognising the need for different approaches to the treatment of, on the one hand, Severe and Enduring Mental Illness (Schizophrenia, Bipolar Disorder etc.) and, on the other, Mental Health problems; such as Anxiety, Depression, Substance Misuse and Trauma.

Several interviewees saw a necessity or opportunity to redesign models of care. One said:

'Services are getting really quite stressed across all care groups; both by numbers and complexity. Local services have been designed for certain levels of need, but we need to revisit the service model and its relevance…. Our models of care are not going to be sustainable in the long term'.

Another said:

'We don't need more money, but the ability to transcend the models that cause us difficulty. We've mistaken guidance for tramways. We have become addicted to waiting lists to manage demand. But we should manage today's work today. We should look again at our pathways and co-produce with patients'.

Another:

'We want to stop working in silos. As a first step I would bring together psychologists and psychotherapists as part of a preferred model, leading in time to fuller a multidisciplinary team. There was a joint Mental Health team in the East which worked well. It comprised a Community Mental Health Team, an Intensive Home Treatment team and Psychological Therapies. Anything that involved Mental Health came through that team; the single referral point worked very well.'

Another:

'We must embed community-based care. Psychiatrists have historically worked to a sector role; i.e. assigned to 'random' GP practices. We need to ensure they are allocated more appropriately, perhaps along a localities model. We need to maximise GP capacity to deal with patients with Mental Health issues; approximately 1/3rd of appointments are Mental Health based.'

Several felt consideration should be given to 'ageless' models. For example:

'(In respect of transitions from Adult to Older Persons services) … Some areas, e.g. psychology, could be ageless. At the very least Adult Older People's Mental Health teams should treat patients the same. Older People's teams are still very consultant led, whereas Adult services use a triage system.'

Several commented favourably on a perceived increased emphasis on 'Recovery'. However, some felt the phrase was at times misapplied or misunderstood and also that the concept still had to gain traction in some areas.

'I like the Commissioning Plan's emphasis on building social capital, of doing for yourself. This is a recovery model'.

Another said:

'Recovery has to be a focus.'

Another said:

'As a result of current supportive approaches, clients are talking about what they are going to do to advance their Recovery; using the strategies they have been taught.'

But in contrast another said:

'The Recovery model is not as developed in West Lothian, still a very medical model.'

Another:

'Recovery does not mean 'get better'. Recovery is a journey. The outcome statement 'More people with mental health problems will recover' demonstrates a lack of understanding. The statement is irrelevant.'

And another:

'Recovery is not relevant in the case of Alzheimer's; Enablement is a better word… Enablement is about potentially releasing people to have a more fulfilled life.'

<u>Management / structural arrangements</u>

Several interviewees were of the view that current management / structural arrangements for Mental Health services in West Lothian are not fit for purpose; being fractured and disjointed.

'(On community services) The priority needs to be the integration of Mental Health services that are already in West Lothian. The structure holds us back. There are 2 Mental Health teams, an

MHO team, a Mental Health Assessment Team and the Community Outreach team. Services do not come together in a coherent form'.

Another said:

'I'm concerned that in West Lothian we have too many small teams; too many people fall between the stools. The structure is skewwhiff and does not make sense to me.'

Another:

'There is a lack of an appropriate governance structure'.

A view articulated by some was that all services should be pulled together under a single Mental Health Manager.

Resourcing and planning

Many interviewees considered that the combination of constrained resources and growing demand meant current approaches were unsustainable.

'There is a compelling case for change. We need to look at different models of care, whilst not underestimating the difficulty of choices. We need to look ahead to how we can provide good services; the way we are delivering just now won't be sustainable. That's a fact. There may not be cuts, there may be ways of doing things differently.'

Some suggested areas of current inefficiency:

'Some patients are being escalated unnecessarily and expensively … If we don't understand demand and capacity, it causes problems elsewhere. It can create more unscheduled care demand, which is very expensive'.

Another said:

(Arguing that inappropriate services had been commissioned) 'The contracts team are not equipped for the job. There is a dreadfully amateurish approach to commissioning because they don't look at the evidence base; they are driven by a contract culture. They don't listen to professional voices and alternative proposals are ignored'.

Another:

(Regarding workforce issues) 'We need got to get the models right. We have to keep using Bank and Agency staff. Sickness absence is high (7 – 8%).'

Others remarked on the impact of Locum consultant appointments, not only were they more expensive but the short periods of attachment meant that working relationships were undeveloped and joint working undermined.

One commented on the hidden costs of the Personalisation agenda.

'Delivering a person centred approach is challenging for us to purchase effectively and efficiently. Individual purchase makes it harder to plan. Personalised care may not be able to benefit from group provision.'

Some noted the current drive for savings could have adverse consequences for efficiency and quality in the long term, and impact on opportunities to redesign and develop services.

'We can demonstrate the case for preventative action, but I'm concerned there maybe cuts in this area. …Early intervention does stop things happening and is efficient'.

Another:

'Our budget is almost 100% staff; so any savings come from staffing. We have twice the number of referrals, but staffing levels have eroded'.

Another:

'I'm concerned at losing posts and trained staff being replaced by untrained. I'm not able to improve services and have to give up something to get something, but there's nothing to give. It feels like a vicious circle.'

Another:

'Funding uncertainty is stifling innovation…. We can't plan beyond next year'.

Another:

(Commenting on the impact of resource constraint on well-being initiatives) it's frustrating that there is no funding that gives a strategic approach to developing work such as this. There are fantastic bits of work going on, but sustaining interventions is a problem. All funding for projects is short-term.'

Interviewees had proposals for how resources might be better deployed.

'Sometimes we have too many silos. We need to look at the interface of the professions. We need more generic services and less duplication…. We need to think about how the whole system fits together; it may need radical redesign'.

Another said:

'Do less, but do it better'.

And, in a similar vein, others spoke of managing expectations:

'There is a big gap in expectations regarding Mental Health. Expectations are much larger than Mental Health see the role. This disjunction is a problem and sets up conflict and disappointment.'

There was often recognition that Health and Social Care integration offered opportunities but this was tempered by the knowledge that pursuit of change would be challenging.

'It is clear that the IJB will have to come up with different approaches. The organisations will need a bit of time to get used to the IJB. Progress is being made… There may need to be a shift

in resources between the NHS and the Council. There are vested interests, and these may be difficult to break'.

More than one commented on the political challenges, arising out of integration.

'We need to redesign models of care. This will need political buy in and the right national messages.'

Another:

'Setting up the IJB has been difficult; very political'.

And another:

'It's politically very close between the SNP and Labour; (leading to) paralysis for about a year before election.'

Some felt closer engagement with service users and carers offered opportunities in designing sustainable approaches.

'We need to be more confident in our engagement with service users and others. (When reshaping services) Really listen to what people need. This might bring efficiencies. This is where social capital is important. The SDS agenda is set up to do this; what are the outcomes for individuals? We need to grow this side of how we do business… Co-production needs to be at the heart of our thinking'.

Another saw opportunities for closer engagement leading to enhanced community capacity.

'What can we do to promote community capacity building? It's about driving things from the bottom up'.

Prevention

Many commented on the value of prevention and early intervention, but this was often qualified by the recognition that it can be hard to invest in this when struggling under the weight of current and pressing demand.

'Getting upstream is a good idea. For example, increasing the capacity of parents. Mental health services shouldn't be an island; they should have good links up and down, internally and externally; to education, social work, gyms etc., moving upstream to choke off demand.

Another said:

'Strategic upstream intervention is required and the impact would be quantifiable. Why does someone have a drug and alcohol issue? Because of the environment in which they exist. It needs a bolder approach.'

And another:

'Prevention is crucial in terms of early years, Children and Families. (This could) drive future reductions in inequalities.

But one noted:

> *'(Investment in) prevention and early intervention poses a challenge when there are restricted budgets. (Impact) is difficult to measure.'*

And another:

> *'We've had 10 years of focus around prevention and early intervention and it's a difficult and challenging place to go. Individuals will often not seek help until there is a crisis. People may be offered something early on, but may not take it up. In general, the prevention rhetoric is overstated and aspirational. Attribution becomes more difficult the more upstream you go.'*

Health Inequalities and Access

Whilst some commented on the importance of addressing health inequalities, others doubted whether significant change was being achieved.

> *'(Tackling) Health Inequalities has to be a major driver.'*

Practitioners spoke of the impact of health inequalities on their day-to-day work.

> *'Deprivation is a primary health inequality; we see it in our caseload… The impact of deprivation is a given; there's more unhappiness. I feel people from these communities feel like 'losers'… We are often fighting against wider issues.'*

As well as those in poverty, others identified homeless people, people with a dual diagnosis, and / or chaotic lives, as at particular risk of experiencing health inequalities. In this regard, some felt the contribution of wider services was not always recognised.

> *'Not all of the NHS see anti-poverty work as a key part of Recovery and tackling health inequalities'.*

Indeed, some voiced concern the current commitment to tackling health inequalities was tokenistic.

> *'Inequality will become an increasing problem. It's just picked up as an afterthought at the moment.'*

Access issues were identified by some as contributing to, or exacerbating, health inequalities. Interviewees identified more than one form of access issue; these could be broadly characterised as (1) practical impediments to access and (2) inappropriate or accidental restriction of service to those in need. In illustration of the former, several interviewees remarked that some people had to travel to access services using inadequate transport links. Thus one said:

> *'Bus and transport services are a weakness. Current arrangements undermine access.'*

Another:

> *'Semi-rural communities struggle to access services; for some villages the last bus back is 6 PM'.*

One combined a critique of geographic arrangements with comment on how those with Mental Health issues might be further affected by having to travel.

'What is lacking in West Lothian is equity. We are a poor relation because of our setting. Some services are based in Edinburgh, but call themselves Lothian wide. But for some, crippled by anxiety etc., it's a massive step to get on the bus to travel to the services. Consequently, those services are not equitable'.

Inadequate or poorly communicated pathways were seen as undermining access.

'Lack of a pathway affects how work is done on the ground. There is a lack of clarity about roles and responsibilities; how it fits together. If we can't understand it, we can't communicate it to service users.'

Another believed a lack of access to appropriate services could have profound consequences.

'Those with Distress are least able to access but most likely to complete suicide.'

But not everyone saw access as an issue in West Lothian:

'I am not aware that access is an issue.'

SDS and assessment

Whilst often the principles of Self Directed Support were broadly supported, there was significant concern regarding how it is currently delivered and its impact on availability of support services. Some felt SDS had not yet 'grown the market' and could in fact be detrimental to the provision of valued services.

'SDS is a serious problem for us. In principle fine, but could impact on the viability of services.'

Another:

'The reality is the market hasn't responded; it's not offering anything greater… The downside of SDS is not having firmed up budgets. It's difficult for small scale providers and undermines their viability.'

And another:

'It's hard to commission for small numbers. Even though SDS could theoretically address, it needs providers and (scarcity) is still reflected in the price'.

Two interviewees remarked upon what they saw as the inequitable impact of SDS resource allocation. Thus one said:

'There are inequalities in SDS; some with less need can access more than those with greater. Practice does not match the principles. Those people with the most severe illness are not getting the best out of it. People feel confused, including us.'

Similarly, another was of the view that some care groups received disproportionately large SDS packages compared to their client group.

But others were more positive about what SDS could offer. For example, it could offer greater flexibility in the purchasing respite care:

'SDS can be creative without you having to go to a (designated) 'place'; previously a Care Home was commissioned to provide respite, but having a building is inflexible and backward.'

To a lesser degree, practical issues were identified by a small number as hampering the assessment process: such as the time taken to complete assessments and deliver care packages; the sheer volume of workload arising from entitlements to assessment; and GP assessments not being able to passport people direct into services, such as the Acute Care and Support Team.

In Young People's services The Mental Health Well-Being Screening Group was identified as making a positive contribution to assessment and effective placement in services. Its multidisciplinary approach was seen as a strength.

'(The Screening Group) is a brilliant way of pulling sparse resources together into one meeting. It takes a lot of pressure off … Any disagreements happen in an open way.'

Service User and Carer involvement

There were mixed views regarding the quality and extent of service user and carer involvement, but the prevailing view was that both these areas require strengthening and that co-production could be beneficial to service design delivery. It was clear, that for some, enhancing service user and carer engagement should be a strategic priority.

A range of views is reflected here. One said:

'There isn't a way of doing service user and carer involvement; it's not an embedded way of working. If they improved that, it would be much more useful to them.'

Another:

'At a strategic level there is representation, but it could be better; there is a danger of tokenism. Health not particularly good at engagement at the planning service design level.... Historically service driven rather than person driven. This needs a cultural change.'

Another:

'The quality and extent of service user involvement varies. There is a high level of involvement in day services. Mental Health advocacy is accessible. There is a User's Forum and Collective Advocacy. I don't think primary health care is well served. General Adult Psychiatry is starting to look at getting feedback; driven by common complaints. It's a developing area of work and is a willingness and appetite to do it.'

And another:

'The quality and quantity of service user involvement is insufficient. We must be willing to hear even hear even if what we hear is unpleasant feedback we need to get a balanced view from everyone'

Well-being

The concept of Well-Being and the value of pursuing it divided some interviewees. One said:

> *'(Regarding the concept of Well-Being) Scrap it! This is promoted by well-meaning people, but it's a waste of money. I don't understand why it's there and the level resources that are going in. It's a taboo subject to criticise well-being, so management won't. If we are serious about the well-being agenda, we need more practical help. It can be tokenistic'.*

Another:

> *'Well-Being is such a broad term it is problematic. Need to be more focused about what we mean.'*

But another said:

> *'Everything which comes out of the CPP is underpinned by Well-Being. There's an understanding that the strength of your local community enhances Well-Being. Building community capacity (offers the opportunity of) low investment high-impact. Communities get a real buzz out of this.'*

Which groups are well served

Interviewees were asked to comment on which groups were well served and not well served by current arrangements. We would stress that comments were a matter of individual opinion and may not have been informed by systematic evaluation of service quality, therefore they should be treated with caution. Unless otherwise stated, this section only lists specific groups as well served if more than one interviewee commented to that effect. The same is also true of the following section, regarding less well served groups.

People with Severe and Enduring Mental Illness

Some identified those who suffered from a Severe and Enduring Mental Illness as being relatively well served, with community services being praised. Thus said:

> *'The Community Outreach Team is joined up and it works well. A lot of people are supported well by a good service with a good name.'*

People with Dementia

Some were positive about services for people with dementia. But this was not a universal view, with some believing those with early onset dementia were less well served.

The Affluent.

Two people remarked that the wealthy were well served.

Which groups are not well served?

People In Distress

As outlined earlier, many interviewees were of the view that those who suffered lower-level mental health problems and 'Distress' were not well served; due to a lack of services and clarity over referral pathways[2]. When discussing those 'In Distress interviewees often listed a wide range of subgroups; commonly this included: people with addictions, who self-harmed, who suffered anxiety or depression, who had personality disorders, or had additional social problems such as homelessness.

For example, one said:

> *'People with dual diagnosis are poorly served; they get shunted from pillar to post… (Also there should be more services) for those with low-grade anxiety / depression. GPs feel a lot is passed back to them; services are not persistent enough. If clients don't open the door they are referred back to the GP'.*

The duration of interviewees did not allow for detailed discussion of the reasons why all the individual subgroups listed above were not well served, or what opportunities there might be for improvement. However, we would note that, given the potential numbers associated with these groups, the volume of people poorly served by current arrangements could be sizeable indeed.

Carers, including those caring for people with dementia

Some concern was expressed that Carers, particularly those looking after people with dementia, were not always adequately supported.

Post Diagnostic Support was generally welcomed, but some commented on the timing and duration of this and also whether, given the high numbers diagnosed with dementia, support services to carers had sufficient capacity.

> *'Support for carers should be given higher priority… Post-Diagnostic Support only lasts 12 months, but it's often much later that carers need help and support; at the aggressive stage, the wandering stage.'*

Vulnerable Young People with a Mental Illness, particularly those transitioning into Adult services

More than one interviewee believed that Children and Young People, particularly vulnerable groups such as those who had been Looked After, were not always well served.

> *'Children and Young People should be a strategic priority. Traditionally they have separation and loss issues and may be traumatised. From 16 years upwards young people are less likely to*

[2] It is noteworthy that a Distress Tolerance Group has recently been discontinued. There was a clear difference of opinion between some interviewees as to whether this group had been effective value for money. One begged the question, 'where do we refer them to now?'

engage voluntarily. But the group are more likely to figure in Mental Health Services and have been less well served in the past.'

The same interviewee said:

'We don't have a Mental Health Team for Children and Young people, but by default have created a team through the Children and Young People team, but they are not trained in mental health. There are generic Support Workers morphed into servicing that group. This is not a strategic choice. It's a bit of a scary place for those workers; with people being referred in with self-harm / suicidal ideation… Some are sent back into (statutory) residential settings. Some young people have committed suicide over the years.'

It was commented that handovers of young people transitioning from CAMHS into Adult MH services often did not happen and that there was a significant difference in the working styles and arrangements of CAMHS and Adult services. This meant that:

'… Some families feel a bit out of it. It's a bit of a sharp jump off.'

Another said:

'The CAMHS is things GPs most complained about. There is a lack of clarity for GPs as to who is and isn't an appropriate referral. Transitions are also problematic. There is a sense that many are discharged at 17/18 without a plan because of their age; some should probably have been referred to Adult services.'

People with Autistic Spectrum Disorder (ASD).

Some interviewees commented on a lack of local services and a clear referral pathway for those diagnosed with ASD. Services for them were based in Edinburgh, and limited in capacity by being consultant led.

Others.

One interviewee thought people with brain injury were not well served. As a single voice, this view would require additional corroboration before being given weight.

Localities

Interviewees were asked their views on the current Localities arrangements of the Health and Social Care Partnership; the Partnership has two localities - East and West.

Many interviewees did not have strong views on the division into East and West. However, a few noted that this division ran counter to other divisional arrangements already operated by The Council and that a single standardised approach would be more helpful.

'Most work The Council does is in Ward areas; in some services we have three areas. We keep splitting West Lothian up into different areas, depending on service.... A commonality of areas would be good. Artificial lines are drawn'.

It was noted that one potential consequence of not being consistent in the way in which West Lothian is divided is that datasets may not be easily comparable.

As discussed already, transport arrangements were seen as a significant issue regarding access to local and Lothian wide services.

Some interviewees commented that differences in wealth across localities, coupled with the combination of rural and urban communities, could make commissioning and service delivery a challenge. For example, one said:

'It can be difficult to get support in the more outlying areas; there can be labour force issues'.

Some saw opportunities for closer links between Mental Health services and emergent GP clusters. But others were less optimistic, asserting that GP practices would not work together.

Strengths of current services and arrangements.

Interviewees were asked to identify the strengths and weaknesses of Mental Health services. Many diverse strengths were remarked upon but, to avoid overemphasising a single viewpoint, unless otherwise stated this section will focus on those strengths identified by more than source.

Some of the strengths are referred to in other sections and therefore will not be re-examined in depth.

Joint Working

Whilst some gave examples of where joint working was perceived as a weakness, many identified this as an area of strength and commented on the positive benefits this brought. For example, one said:

'A strength of local services is joint working across disciplines. It feels like an Open Door policy. You generally know someone who will help you; going the extra mile is really evident in West Lothian'.

Some remarked positively on what they described as 'The West Lothian Way'; although the nature of this was never fully articulated, by implication this was a unifying, locally derived, ethos and commitment.

The Community Planning Partnership was identified as a positive force by some; 'it's one of the better ones'.

The Mental Health Well-Being Screening Group was cited by more than one as a good example of joint working.

'(The group) is a multi-agency forum of Health, Local Authority and Voluntary organisations. It includes Child and Adolescent Mental Health services and Psychology. The purpose of the group is to offer a single referral route; matching services to people, rather than them sitting on a waiting-list… The single route stops multiple referrals and stronger joint working.'

Some commented on the positive relationships between statutory services and the third sector.

'There's some good work looking at where and when interventions can be made. They are prepared to work in partnership with ourselves and the third sector…. For example, with Ward X and also Addiwell Prison.'

Examples of positive joint working between community services were given.

'Having CPNs based in GP practices seems to be really good; allowing closer relationships'.

<u>The commitment and quality of staff.</u>

Several people identified staff across in-patient Mental Health, community Mental Health and supporting third sector services as positive assets. Thus one said:

'There is a definite will of staff to deliver the best services they can'.

Another:

'(Regarding community MH services) we have the basics of a fantastic service based on really good staff and relationships with each other. There is a willingness to work differently.'

Another:

'Staff are highly motivated to do the best they can for their clients. There is a high standard of work going on in the community.'

<u>Acute services</u>

Some made positive comment not only about staff in acute, but also service arrangements. For example:

'We have some fantastic specialist services; Mother and Baby, Eating Disorders etc. The wards are good; deeply therapeutic. Acute Psychiatry is full of fantastic caring nurses. The Crisis Team is good.'

Another said:

'There are very good reports about the work of the Acute Care and Support Team. They are vital in preventing emissions.'

Community services

Interviewees remarked upon positive and productive relationships between community teams, including third sector services. The relationship between The Community Outreach Team and the Mental Health Assessment team was described as good.

The Dementia cafes operated by Alzheimer's Scotland were recognised as making an important contribution. Some already use the dementia cafes to contact clients of mutual interest and others remarked that they might be a useful platform upon which other outreach activities could be built.

The Mental Health and Well-Being Screening Group was advocated as both educating referrers and connecting users to a broadened range of community services.

> *'Quite often refers don't know what is available, is needed or required…. The Group takes an increasing number of referrals from GPs; re self-harming / counselling…. More options are provided than previously; the range of services has strengthened and broadened…. CAMHS now divert a number of people through the Screening Group, so they get picked up and matched a lot quicker.'*

There was positive endorsement of the work of The Mental Health Advocacy Project, although there was a recognition that it may be most in contact with those suffering Severe and Enduring Mental Health issues.

> *'The Mental Health Advocacy service is very well-run and responsive.'*

Some interviewees were positive about the contribution of social housing providers, particularly at a strategic level, but this was not a universal. One said:

> *'There is a very well established approach to linking housing with people social care need.'*

Another:

> *'There is a strategic role across West Lothian Council and its partners to reduce health inequalities through Housing / Planning etc.; there's a strong focus on tackling poverty, using community development approaches.'*

Weaknesses of current services and arrangements

Previous and following sections, such as those on strategic priorities, refer to many of the key weaknesses identified by interviewees, therefore, we will largely avoid reiteration of these. Unless otherwise stated, to avoid overemphasis of a single individual's view, this section will concentrate on weaknesses identified by more than one interviewee.

Once again, we would stress that the following is based upon the opinions and experience of interviewees and their views are not necessarily founded on separate and substantial evidence.

Poor Joint working

Unfortunately, while some reported positive joint working, this was far from universal experience. For example, one said:

> *'Joint working is a big problem. There are not effective links regarding Dual Diagnosis.*

Another:

> *'(Our service has a problem with) Adult Psychiatry. There is a lack of willingness of Adult Psychiatry to work with us and communicate. (Staff) are not respected in the role..... don't return calls or emails.'*

Another spoke of their frustration at not engagement from psychiatry:

> *'It needs a simple point of referral plus a Panel to allocate appropriately into the right services. This was tried, but psychiatry didn't come.'*

Another identified the weakness weaknesses of joint working where it relied on relationships rather than systematic following procedures and process.

> *'West Lothian has had a well-developed integrated model. But this has made people quite tribal. It works on relationships, not systems.'*

Whilst some viewed 'The West Lothian Way' positively, not everyone agreed; implying that it undermined shared approaches..

> *'West Lothian constantly refers to the West Lothian culture, it needs to stop doing that. It sees itself out with Lothian'.*

Poor communication

Poor communication was a separate issue, but one that also appeared to be impacting on the effectiveness of joint working. Some interviewees spoke of a lack of awareness of referral pathways, tensions arising from misunderstandings of the role of particular services and unrealistic expectations fuelled by lack of knowledge. Thus one said:

> *'There can be communication problems between in-patient NHS staff and community services. A tension, and there can be over expectations of what can be provided in the community, including safely.*

Another said:

> *'(Regarding those with Dementia) Poor communication can lead to a breakdown between individuals and services. Information is not given in a clear way. People don't get a diagnosis in writing; therefore, may fail to retain.'*

Staffing issues

Several staffing issues were identified that were undermining current service delivery and the fostering of long-term productive relationships. As referred to earlier, there were concerns regarding vacancies / high turnover in psychiatry; not only were there high costs arising from locums but they're transient nature undermined joint working.

Sickness absence was reported as high (7-8%) in some in-patient wards and some interviewees also felt there was low staff morale.

> *'We have to keep using bank and agency staff. Sickness absence is high.'*

Evaluation of the impact

Some were of the view that there was insufficient effort made to evaluate impacts. One said:

> *'Historically (The Council) have not been good at encouraging our commissioned services to measure impact; we need to get better that.'*

Another:

> *'It's very difficult to get managers involved in impact assessment.'*

Inadequate physical health monitoring and interventions

Some voiced concerns, that whilst there might have been improvements, the physical health needs of people with mental health problems (particularly those with Learning Disability) were not always being systematically and adequately addressed.

> *'Physical health checks should be done and an evidential trail provided.'*

Lack of access to appropriate drug and alcohol services

As touched upon earlier, there was concern regarding the treatment of those with Dual Diagnosis and difficulties accessing appropriate services for this group. One said:

> *'There is a massive growth of substance misuse amongst those with Mental Health problems / Mental Illness. This is the biggest growth area. But we don't have enough internal access to specialist services. Better alignment is required.'*

Another believed that a failure to address the needs of those with drug and alcohol problems had wider consequences.

> *'Drug and alcohol is a massive problem. A growing area. The Police refer far more than before. Those with drug and alcohol problems clog up the system and put a huge strain on stretched resources.'*

Demand and capacity in CAMHS

Some expressed concern that there was a lack of capacity in the CAMHS. They argued this showed itself in waiting lists, referrals back into lower order services and only limited sessional work with some clients before discharge from CAMHS.

Ethos

Some interviewees felt the ethos of services was biased towards a medical model. Some advocated more social /empowerment based model.

> *'At the IJB level there is still the difference of thinking styles; the medical model, the social model and the empowerment model (which is more radical). There is still a dominance of the medical model, but we are dealing with people not an illness.'*

Risk aversion

Some suggested that risk aversion, especially with regard to threatened suicide, could lead to inappropriate service responses; such as overtreatment or referral into services that were unable to respond timeously. Thus one said:

> *'We are becoming very risk averse. Clinicians are worried about being sued. Using the S word (suicidal) opens many doors. Some patients may have already had similar presentations.'*

Lack of support for carers

Some felt there was a lack of support for carers of people with mental health problems. Some suggested that because the needs of such carers may be less obvious this resulted in a lack of prioritisation. Whilst it was noted that carers of West Lothian had a group for carers of people with mental health problems, some felt they were more focused on supporting carers of people with physical disabilities.

Service user engagement

Taking the sweep of interviews as a whole, the evidence was that engagement with, and empowerment of, service users was variable. There were examples offered of positive engagement with service users. One said:

> *'(Through weekly meetings etc.) I'm confident that where we can we seek patient and carer involvement. We are keen to get feedback. (But we're) not always good at showcasing and working through improvement.'*

Another:

'The quality and extent of service user involvement varies. There is a high level of involvement in day services. Advocacy is accessible. There is a User's Forum. There is collective advocacy.'

But others cited a lack of opportunity and commitment to co-production, limited efforts to build community capacity and lack of joint governance arrangements as indicative of an unwillingness to offer real influence. One said.

'There is very little opportunity for people to come together as a united voice. Feels like people are being kept apart deliberately… People don't hear back from consultation exercises.'

Another:

'We are probably weakest in this area. We do the basic stuff; survey people. We have a good sense from a small number of people, but don't have participation in the design of services.'

Another:

'We used to have a Reference Group, including members who were service users and carers. This gave major stakeholders a say in commissioning of services. It means there's nowhere to take complaints regarding the process of commissioning.'

Again, the evidence in respect of engagement with individual service users was also variable. One said:

'Everything we do is totally agreed with the service user.'

But another:

'I don't think staff are in a mind-set of empowerment. Empowerment would be more than just business as usual engagement…. When you look at what that (Empowerment) means you get more resistance.'

One articulated the benefits of service user involvement as:

'If we really listen to what people need, could reshape services. This might bring efficiencies. This is where Social Capital is important.'

Finally, a number felt insufficient effort was made to reach out to, listen and respond to the needs and wishes of minority groups. A number of reasons for this was suggested, including: the level of effort involved, cultural challenges, an unwillingness to look for problems, practical communication difficulties and the prejudices and biases of individual members of staff.

Carer engagement and support

Many saw benefits engaging with carers, but agreed that the quality and extent of this was variable. Thus one said:

'We need to work with carers. Every patient with a carer costs less. We shouldn't treat them as an unwanted extra.'

Another:

'There isn't a way of doing service user and carer involvement; it's not an embedded way of working. If they improved that, it would be much more useful to them.'

However, some were positive about their work in this area:

'We do this very well. Engage widely with carers and other (important parties). We provide a bit of a conduit; hospitals and psychiatry can be a bit of a mystery. We help to give people an understanding of what's going on.'

APPENDIX IV: SURVEY RESULTS (STAFF, DENTISTS, OPTOMETRISTS AND PHARMACISTS)

Staff Survey

In order to capture the views of staff working in adult mental health services across West Lothian, an online survey was created using the Survey Monkey tool and the link disseminated to all local services. The distribution list was agreed in advance with commissioners. Staff were asked for their opinions on current service provision and to identify any gaps or areas which could be developed going forwards.

In total, 115 individuals began the survey, but some questions attracted fewer than 40 responses. Key themes and issues are presented in the appendix below.

The vast majority of respondents were female (88%; n=97) and 40% (n=44) were aged between 46 and 55.

Staff who responded (n=109) came from a variety of health, social care and third sector agencies – the full breakdown is shown in the table below:

Organisation	Frequency of Response	As a % of Total Responses (n=109)
Commissioned Provider	31	28.4%
Adult Mental Health – General	13	11.9%
Social Policy	9	8.3%
Third Sector	9	8.3%
NHS	6	5.5%
Old Age Psychiatry - General	6	5.5%
Adult Mental Health - Community	5	4.6%
Allied Health Professionals (AHPs)	4	3.7%
Adult Mental Health – Inpatient	4	3.7%
Psychiatry	4	3.7%
Adult Mental Health – MH Nursing	3	2.8%
Old Age Psychiatry – Community	3	2.8%
Other (including H&SCP; Police; SPS; CAMHs)	12	11.0%

Respondents were asked which areas their services cover; Livingston was most comprehensively served (n=82; 75%); Linlithgow, West Calder and Whitburn were least comprehensively served (n=c22%).

In order to further contextualise the subsequent answers given, it is important to note the roles respondents carry out on a daily basis. The full list of roles is shown in the table below, but it is clear the majority have at least some direct operational experience:

Job Role	Frequency of Response	As a % of Total Responses (n=109)
Support Worker	29	26.6%
Nurse / Clinician	26	23.9%
Senior/Service Manager	19	17.4%
Team Leader	14	12.8%
Allied Health Professional (AHP)	6	5.5%
Occupational Therapist	5	4.6%
Counsellor	4	3.7%
Admin/Finance/HR	2	1.8%
Social Worker	2	1.8%
Other (Police/PO)	2	1.8%

Service Evaluation

Staff were asked to evaluate their service against a variety of criteria. Their responses are shown in the Figure below:

Statement	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	Nil Responses
Our service works effectively with people who have mental health problems.	**40.0% (n=46)**	29.6% (n=34)	3.5% (n=4)	5.2% (n=6)	0	21.7% (n=25)
Our staff are knowledgeable about how to respond appropriately to presenting mental health problems.	**40.9% (n=47)**	32.2% (n=37)	2.6% (n=3)	5.2% (n=6)	0	21.7% (n=25)
Our service undertakes comprehensive assessments.	**40.0% (n=46)**	27.0% (n=31)	5.2% (n=6)	2.6% (n=3)	1.7% (n=2)	24.3% (n=28)

Our service uses a validated or common assessment tool to identify individual risks and needs.	**36.5% (n=42)**	25.2% (n=29)	7.8% (n=9)	4.3% (n=5)	1.7% (n=2)	24.3% (n=28)
Our service has established referral routes with other mental health services.	**38.3% (n=44)**	29.6% (n=34)	7.0% (n=8)	1.7% (n=2)	0.9% (n=1)	22.6% (n=26)
There are defined criteria for classification of mental health risks (low, medium, and high); as well as referral to specific types of mental health services.	22.6% (n=26)	**34.8% (n=40)**	9.6% (n=11)	7.8% (n=9)	1.7% (n=2)	23.5% (n=27)
Our service is easily accessible to service users from across the whole of West Lothian.	**30.4% (n=35)**	29.6% (n=34)	7.0% (n=8)	10.4% (n=12)	0.9% (n=1)	21.7% (n=25)
There are effective pathways into older people services that promote joint working.	16.5% (n=19)	**35.7% (n=41)**	9.6% (n=11)	12.2% (n=14)	1.7% (n=2)	24.3% (n=28)
There is a defined written pathway(s) for people with co-occurring alcohol / drug and mental health problems.	8.7% (n=10)	**27.8% (n=32)**	25.2% (n=29)	13.0% (n=15)	1.7% (n=2)	23.5% (n=27)
Our service communicates effectively with other mental health services.	27.8% (n=32)	**37.4% (n=43)**	5.2% (n=6)	6.1% (n=7)	0.9% (n=1)	22.6% (n=26)
Our service has effective working relationships with other mental health services.	26.1% (n=30)	**39.1% (n=45)**	5.2% (n=6)	5.2% (n=6)	1.7% (n=2)	22.6% (n=26)
Our service communicates effectively with a wide range of other non-specialist mental health services.	21.7% (n=25)	**43.5% (n=50)**	7.8% (n=9)	5.2% (n=6)	0	21.7% (n=25)
Our service has effective working relationships with a wide range of other non- specialist mental health services.	20.9% (n=24)	**40.9% (n=47)**	7.8% (n=9)	6.1% (n=7)	0.9% (n=1)	23.5% (n=27)
Our service provides good information about mental health problems, including other sources of help available.	27.0% (n=31)	**42.6% (n=49)**	6.1% (n=7)	1.7% (n=2)	0.9% (n=1)	21.7% (n=25)
I am confident working with people with mental health problems, including those in crisis.	**44.3% (n=51)**	25.2% (n=29)	3.5% (n=4)	2.6% (n=3)	0.9% (n=1)	23.5% (n=27)
I am competent working with people with mental health problems, including those in crisis.	**47.8% (n=55)**	25.2% (n=29)	3.5% (n=4)	1.7% (n=2)	0	21.7% (n=25)
						Total responses: 115

Around 70% of respondents appear to believe their service works effectively with people with mental health problems and provides good information and that staff are knowledgeable and know how to respond appropriately to presenting mental health problems. As individuals, a similar number of respondents reported feeling both confident and competent working with people with mental health problems, including those in crisis.

Respondents were then asked what they think their service does particularly well. Sixty-nine responses were received and a range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=69)	Example comments
Person Centred Care	21	30.4%	"Supporting individual interests and skills, focussing on the person rather than their diagnosis or condition." "Respecting individual's differing needs." "I think we work with a person centred approach at all times and treat everyone as individuals regardless of their background and support them to achieve their goals." "We have been developing a person centred outcome approach and not service led."
Joint Working	17	24.6%	"We work effectively with other agencies in providing the best possible care for all our service users." "I believe that we have a very good relationship with other agencies. I would say this helps us to work very effectively and efficiently which ultimately is going to benefit the client." "Liaise well with other multi disciplinary teams."
Service User / Carer Involvement	16	23.2%	"Involves patients and carers in all aspects of the treatment." "Forming good working, therapeutic relationship with clients. Working in partnership with clients to meet their identified goals and needs. Working together with clients and any appropriate services to help the individual live as independently as possible within the community." "Works with younger people with dementia and their families and supports them to live their lives and achieve their outcomes. Supports carers to continue with their caring role."
Empowerment / Supporting Independence	11	15.9%	"Empowering people to make informed choices, responding quickly and effectively to changes in circumstances in people's lives and providing appropriate support."

			"We particularly help people we support to be more independent, and give them the skills to help them every day." "Listens to individuals needs and gives service users the tools to participate in their care plan, work well with other agencies."
Crisis Care / Inpatient Support	9	13.0%	"Working in acute inpatients I believe we respond well to those in crisis. The inpatient experience offers something creative and different from other acute inpatient units in that we offer a therapeutic programme that assists our clients to tackle their issues in many different settings..." "Flexible and very friendly service that helps to fill service gaps people need in a crisis." "Responds effectively to support individuals in crisis."
Keeping People at Home / Early Intervention	7	10.1%	"Maintaining people with mental disorders in the community." "Meeting the needs of the patients in an holistic approach within their own homes."
Promotes Recovery	6	8.7%	"We work in a recovery focused way, and we are person centred focused." "We use a Recovery based approach to our care and include all areas of Mental Health Services in statutory and voluntary in providing the best possible service to our service users."
Signposting / Sourcing Information	6	8.7%	"Provides a holistic assessment to identify needs & signposts to the appropriate service/resource." "Respecting individual's differing needs signposting to other services where appropriate." "We are good at finding out about support services for people in West Lothian."
Community Engagement / Reducing Isolation	5	7.2%	"Helps people to feel less lonely and allows them to get back out in the community. Participating in groups, doing things they once did before, making new friends." "We ensure all service users have access to all facilities within their community and provide one to one support in this area if need be."
Good staff team / Communication	5	7.2%	"Communication within the team and with other services." "Staff commitment and enthusiasm." "Work well as a team, communicate effectively."
Working with Dual Diagnosis	3	4.3%	"Treating clients with co-existing mental health and substance dependency." "Harm reduction and support for substance misuse."
Misc.	11	15.9%	"Being creative in approaches." "Supporting women fleeing domestic abuse."

	"Most of all caring." "Consistency of care."

They were then asked how they thought their service could be improved. Sixty-five responses were received and a range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=65)	Example comments
More Resources	21	32.3%	"Without wanting to sound simplistic, our greatest challenge is one of resourcing. I understand budgetary constraints affect all public and voluntary sector agencies, but resources are becoming ever scarcer and this has many effects on our ability to provide the high calibre of service we aim to." "More resources to cope with increasing referrals." "Improved therapeutic environments could be achieved with smaller units and higher nurse-patient ratios."
Staff Recruitment / Retention	17	26.2%	"Recruitment and retention of staff is affected by our inability to reward staff with the salary they merit. There are many jobs our staff could do which provide better wages and demand much less commitment, skill and are much less difficult in terms of the behaviour they are expected to tolerate in the performance of their role." "Staff recruitment difficult at the moment due to low rates of pay offered to care staff, paying staff higher wages will ensure adequately trained and experienced staff working in these important positions."
Better Joint Working	13	20.0%	"We view further collaboration and increased resourcing as essential in developing a better and more consistent service." "Better links with referrers and partner agencies." "More coordinated responses from joint working between NHS elements and WL Council so that there is no duplication of efforts and resources are streamlined to be more efficient."
Work Force Development	7	10.8%	"Staff training in mental health awareness." "More specific training in CBT, and other specific approaches." "I think all staff should have access to Assist (suicide intervention training) Also mental health first aid." "Better training for officers out on the street but this is resource intensive."

Better Communication	6	9.2%	"They could improve communications with in the team." "I feel there is always room to improve communication, no matter how conscientious we are there can always be something missed."
Reduced Waiting List	5	7.7%	"There is a increasing waiting list for post diagnostic services and it would helpful to have at least one more dedicated dementia link worker to help reduce this. People are currently having to wait up to 5-6 months for this service." "Better mental health services for adults and children with faster response times."
Better Advertising	4	6.2%	"Better communication/advertising." "Ensuring that professionals from statutory community mental health and addiction services are aware of the service we provide."
Less Paperwork	4	6.2%	"Keyworkers have more and more paperwork re: Service User participation that has to be completed and reviewed regularly, when asked, the people I am keyworker to will immediately refuse to look through these things, to offer any opinion or to sign them. Keyworkers then have to document every time this happens, all of which is very time consuming and keeping staff from being hands on and working one to one with the people we are there to support. I think Service Users should have the right to opt out of certain paper exercises that really have nothing to do with their support needs." "Less doubling up of paperwork/administration/computer work etc..." "Less paperwork."
Clearly Referral Pathways	4	6.2%	"More specialist awareness of mental health issues and referral options." "By further developing the pathways into the service and looking at a more robust joint working with our partners in social care to prevent lengthy waits for people into other services."
Clarity on Roles	3	4.6%	"Very little clarity on who does what for ex there is a lot of reluctance from CPN's to accept referrals as their roles have changed more recently and they feel they are forced to play second fiddle to psychologists..." "Joint working between the CPNs and Social Workers could be improved to better understand each other's roles within the team."
Misc.	10	15.4%	"More community based service." "More interaction with service users." "Prisoners complain regularly that they do not get the support they need from NHS in prison. Their opinion is that

			it takes too long to get any assistance from the point of referral. More mental health workers in the prison could help to reduce the delay." "Influence more about early prevention work rather than crisis management." "Rehab remains a problem - moving people on and stopping the "revolving door" culture." "Offering support in evenings / weekends not referrals as yet." "I think being able to provide alternative services within housing support such as employment and benefit advise, more a one stop shop."
Answer Not Relevant	4	6.2%	

Next, respondents were asked what forms of support their service provides post-discharge. Sixty-eight people answered and a range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=68)	Example comments
Onward Referral / Signposting / Information Provision / Advice	38	55.9%	"Looking into other agencies to continue working with the service user on their road to recovery." "Issued with helpline phone numbers and addresses if required." "When service is discharged the individual is given list of contact numbers i.e. suicidal prevention, if they feel they need further assistance to adjust." "We identify appropriate services to provide ongoing support."
Discharge to a Specialist	10	14.7%	"Discharge is usually to a Nursing Home or an NHS Palliative Care unit where all needs are met without our ward having to provide support." "The unique type of treatment we offer usually means that the person is followed up by their consultant." "Significant amounts of required via a nurse or Consultant. Medication management is provided as well as symptom management."
Peer Support	7	10.3%	"SMART recovery meetings/Specific support groups - e.g. anxiety/depression." "Peer support employment." "Groups - fellowships, recovery cafes, employability, aftercare."

Voluntary Placements	5	7.4%	"Voluntary Placements."
Isn't Any	5	7.4%	
Outpatient Support / Support at Home	5	7.4%	"Access to out patient treatment ie Anxiety Management; Confidence Building; Assertion Skills; working towards personal goals; structuring time and working towards employment." "Home visits, medication monitoring."
Misc.	11	16.2%	"With some clients we offer a provision whereby they can be placed on our passive caseloads for a period of three months, which means they can contact us within that 3 month period should they require further help or advice - if we do not hear from them in that period they are then discharged from our caseload." "Equipment & adaptations." "We make people aware that they can come back to our service if any issues arise in the future. We're also happy to speak to people on the phone until we can take them from the waiting list. We will also direct people to other services if they're having to wait for ours." "Up to 4 weeks telephone support."
Nil or N/A	13	19.1%	

As a follow-up question, respondents were then asked what more could be done to support service users post-discharge. Sixty-three responses were received, although many were not relevant and there was not any overwhelming agreement. Some of the key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=63)	Example comments
Growth of Supports in the Community	5	7.9%	"Increase amount of external support options, especially for younger people with cognitive impairment." "More access to recovery based services, more things for service users to engage in post discharge to support the work of the community team."
Peer Support	5	7.9%	"User lead peer support after discharge from outpatient service." "To be able to have a moving on group were there are people who have been through support and have manged without it so that it doesn't seem so daunting for the person."

Better Transition	4	6.3%	"I think the important issue for us is to advocate for an appropriate transition period prior to the ending of the service." "Introduce them to the perinatal CPN before discharge and perhaps an escorted home visit so its familiar to both patient, their families and the CPN."
Follow-Up Meetings/ Care	4	6.3%	"A follow up meeting possibly six months after leaving service." "Some kind of contact system that will engage clients at specific times." "Dedicated community service with definite date of follow up within 7-10 days of discharge from inpatient services."
More Support Workers	3	4.8%	"Increasing the number of Mental health workers in the prison." "Increase community nurses."
Wider Range of Resources	3	4.8%	"Wider range of resources." "More services to be moved onto."
Drop-Ins	3	4.8%	"More drop-in services so clients can receive immediate support when required." "Think some form of drop in / befriending service would be helpful."
Misc.	14	22.2%	"Transport to get to appointments." "Assure them they will receive the same level of support to help them on the road to recovery." "A point of contact should they require reassurance." "Possibly rehab treatment to support CPNs and Outreach Mental Health OT (SJH)." "Care in the community." "I think we should be asking the services users what they require." "Tenancy support or more increased general support services to help people deal with the issues listed above to promote sustained recovery." "Increased availability for day care to allow more than once weekly attendance in some cases."
Nil or N/A or Don't Know	26	41.3%	

Respondents were then asked to rate the level of service user and carer engagement and involvement in their service and the community (Rating scale: 1=Very Poor, 2=Poor, 3=Adequate, 4=Good, 5=Very Good, 6=Excellent).

Between 66 and 68 responses were received to these questions, and the average ratings were thus:

- The level of service user engagement in your service: 4.44 (i.e. between Good and Very Good)
- The level of service user involvement in your service: 4.28 (i.e. between Good and Very Good)
- The level of involvement/ integration service users have in their community: 3.45 (i.e. between Adequate and Good)
- The level of carer/family involvement in your service: 3.92 (i.e. between Adequate and Good)

Respondents were also asked to use the same scale to rate the overall quality of their service. Thirty responses were received, and the average rating was 4.79 (i.e. between Good and Very Good).

Gaps in Current Service Provision

Respondents were asked whether they thought there are any gaps in adult mental health services in West Lothian. Seventy people answered this question, and around 80% (n=57) thought there were. A range of comments were provided. Key themes are highlighted in the Figure below:

Key Theme	Frequency of Response	As % of Total Responses (n=70)	Example comments
Early Intervention / Prevention	8	11.4%	"Most people's mental health has deteriorated immensely before they get referred to mental health services, I believe if a service is available to them at the start of their mental health deteriorating, it would make it easier to help them on the road to recovery before it gets out of hand." "Crisis prevention/intervention to prevent hospital presentation/admission delivered by staff that are known to the people." "Early intervention - feedback from people we work with is it is difficult to get support early on and often you are dismissed if not seen to be in acute crisis."
Waiting Lists	6	8.6%	"Even when people become very acutely unwell there is a long wait to be seen by a psychiatrist." "Impression I have is that there are long waiting lists for out-patient appointments too." "Waiting lists too long and therefore gaps emerge."
Youth Services	5	7.1%	"There are also gaps for young people who are transitioning from adolescent to adult services." "Not enough services working directly with young people and families, some services now only offer consultation in schools." "More preventative services aimed at young people."

Appropriate Housing / Tenancy Support	5	7.1%	"Single supported accommodations funding." "Real issues regarding limited access to longer term beds/placements for people who can't live at home alone." "Types of housing support / supported accommodation." "Shortage of supported accommodation (with support 24/7) or cluster with 24/7 on call who could come out if need be."
Rehabilitation	5	7.1%	"…patients only receive a rehab type service if they are in the inpatient rehab unit (Pentland Court). There would be great benefits from having a service that would work with people in their own home." "Limited rehabilitation services." "Rehab need to be clarified/improved."
Crisis Support	4	5.7%	"A crisis help line for carers who are supporting someone who is in a crisis and is not able or willing to get to their doctor or A&E." "I feel there's a gap in mental health services when service users become unwell and their consultant is unable to see them for some time." "Individuals in crisis can be turned away from hospital. Leaving them nowhere to go."
Dementia Support (including EOD)	4	5.7%	"Need more support for people with dementia especially younger people with dementia." "People with Dementia require contact throughout their journey and this is not always possible which makes it harder to be re-referred and continuity for the PWD is fragmented."
Dual Diagnosis	3	4.3%	"No service for adolescents with mental health and substance misuse problems." "[No service] supporting individuals with dual diagnosis (such as drug and alcohol) or for those on the learning disability spectrum (adults who weren't diagnosed earlier with Asperger's)."
Mental Health Education	3	4.3%	"Educating people in mental health issues and early intervention." "Support for under 18's/ education about mental health."
Misc.	18	25.7%	"There is also a gap in providing exercise opportunities for people with severe and enduring illness who, as a side effect of their medications, are at greater risk of developing physical complications such as obesity and diabetes."

			"Very little for people with fatigue; anger management; vocational rehab; services for younger people; accessibility of services often Edinburgh based." "A more comprehensive and better resourced approach to day services appears to be essential." "There is a lack of provision for people whose behaviour has become very challenging but are not assessed as requiring hospital admission." "Particular gap for befriending for those with mental health issues." "No service for anxiety spectrum illness not reaching chronic and enduring status. Poor service for chronic and enduring affective disorders." "Whilst not specific to mental health, there are problems with the implementation of Self Directed Support." "Weekend and out of hours' services for people in crisis/distress." "Self Harm Counselling for mental health but not psychiatry- the likes of life coaching/mentoring/etc."
N/A / Nil Response	10	14.3%	

Areas of Duplication and Overprovision

Respondents were then asked whether they thought there were any areas of duplication or overprovision in mental health services in West Lothian.

Sixty-nine people answered these questions. Over 70% (n=50) did not think there were any areas of duplication. Of the 19 who did, the following pertinent comments were made:

- "People can be referred into various services and results in too many people trying to do the same thing."
- "Double work e.g. assessments on paper and on computer."
- "Within community mental health teams."
- "Quite often, we duplicate services if people are having to wait a while for various things to happen."
- "More than one service involved can duplicate work if not communicated effectively."
- One respondents did however note, "There is some overlap, but I think this is necessary."

Similarly, over 90% of respondents (n=63) were unable to identify any areas of overprovision. The six respondents who believed there were areas of overprovision, made the following pertinent comments:

- "COT as above."
- "Eating disorders and peri-natal care."
- "Lack of psychological therapies is an issue ACROSS Scotland. Biological psychiatry dominates."

On Resourcing

Respondents were asked for their comments about the resourcing of services for adults with mental health problems. Forty-two individuals answered this question and a range of comments were provided. The key theme which came through was that mental health services were not adequately funded (n=10; 23.8%):

- "In our view mental health services in West Lothian are under-resourced."
- "I think all public and voluntary sector services are under resourced at this time, but mental health services are not always viewed with the same sympathy, by the public, as some other areas, and this may impact on how resources are allocated."
- "Historically, funding has been thought to be poor for Mental Health services."
- "Mental ill health is one of the leading causes of sick leave from employment, therefore by providing better funding to mental health services this would not only help individuals but also help the economy as a whole. Young people's services are especially important to fund, as the better support and treatment children and young people receive with their mental health the less likely they are to require intense support from mental health services as adults."

One respondent did however note, "There is poor understanding of the demand and capacity that exists in WL which means no one has a clue about adequacy of resourcing."

A range of other comments were also provided as illustrated in the table below:

Key Theme	Frequency of Response	As % of Total Responses (n=42)	Example comments
Poor Referral Process / Difficult to Access Available Services	6	14.3%	"I feel that the services that are available are difficult to access without a social work or psychiatrist's referral." "We have to go through GP's before being referred to either A&E or psychiatrist, it feels like we are not recognised as being able to assess individual whom we work with on a daily basis and have a good awareness of them and any changes in their presentation." "It can be very difficult to access services to support people with mental health issues."

Long Waiting Lists	5	11.9%	"Usually people with mental health problems have to be placed on a waiting list before they are referred to mental health services." "Waiting times far too long for people to be seen." "Patients requiring rehabilitation services are often kept waiting due to the limited resources of rehab beds in West Lothian." "With self-directed support, there is generally a large waiting list and people require to wait a long time on the implementation of support."
Staffing Issues	5	11.9%	"Staffing levels are always a problem." "There is an increased demand for mental health services but staffing levels have not reflected this. If staffing levels were increased this would result in savings longer-term (currently money is wasted through delayed hospital discharges and guardianship assessments)." "For a number of years now we have been resourced by Locum Consultant Psychiatrists within the acute inpatient unit. clearly the cost of this is not sustainable. It also does not represent value for money... my view is that there is limited "buy in" from Locums to invest in making the service "fit for purpose" and again there can be a pretty narrow view as far as beds/flow is concerned."
Misc.	23	54.8%	"I think in some areas there is more of a focus on doing things for people rather than working with them to enable them to do things themselves." "Better partnership working with psychology/psychiatry - more communication from psychology/psychiatry." "Most of our prisoners suffer from metal health and addiction problems. I think there should be more interaction with prisoners and the NHS mental health providers within the prison to reduce the 'take a pill' attitude." "More specialist services required for children." "I have great concerns regarding the commissioning of services for provision of accommodation for individuals with mental health problems..." "Funding for the type of support some clients would benefit from i.e. befriending and social outlets/activities as they may not have the confidence or ability to manage to access mainstream outlets /activities such as these."

Groups Not Well Served

Respondents were asked whether, in their opinion, there any particular groups with mental health problems that are not well-catered for in West Lothian. Fifty-one individuals answered this question, and the following key groups were mentioned as being poorly served:

- Those aged over 65 who did not have dementia (n=9)
    - "Depression/other mental health issues in older people does not attract funding. Perception is that it is normal aging almost."
    - "Insufficient experienced/skilled staff."
- Younger adults (n=9)
    - "Services are aimed at the general adult population and there is poorer engagement with younger clients due to lack of knowledge/skills of this client group."
- Minority Ethnic Groups (n=7)
    - "Poor understanding of health care needs of this population."
- Carers (n=4)
    - "There is a range of support available for individuals who have a mental health condition, however those who support the person with the condition are often overlooked. The issues surrounding patient confidentiality, human rights etc can leave a carer feeling powerless, excluded and isolated."
- Those with a Dual Diagnosis – Substance Misuse (n=3)
    - "They are seen as being troublesome and addicts."
- Those with a Dual Diagnosis – Learning Difficulty/ASD (n=3)
    - "In my experience a service user with dual diagnosis can only access services for the most recognised diagnosis."
- Those aged between 50 and 65 (n=3)
- Those with Early Onset Dementia (n=3)
    - "Most of the traditional services are not appropriate and this group have very specific needs in terms of partner's potentially still working, financial implications, dependent children,
- Those with Dementia (n=2)
- Offenders (n=2)
- Those with a physical disability (n=2)
- The transgender community (n=2)
- Women (n=2)
- Individual respondents also mentioned the following groups:
    - Those with literacy issues
    - Those needed with a psychological intervention / counselling
    - Those living in outlying aread

- Those with personality disorders
- Men
- Children and Young People – especially LAAC
- Women experiencing domestic abuse
- Those with depression / anxiety
- Those exhibiting challenging behavious
- Those with ARBD

Asset Mapping

Respondents were asked what other assets, resources, groups, individuals, and/or opportunities are available across West Lothian to support mainstream services in meeting the needs of adults with mental health problems. Thirty-nine individuals provided an answer to this question and a range of comments were provided. Key assets mentioned included:

- **Third sector provisions (n=15)** e.g. West Lothian Family Support Group; CRUSE; One Parent Families Scotland; Sure Start; LBGT Youth Scotland; Penumbra; West Lothian Youth Project; Domestic Abuse Helpline; Edinburgh Women's Rape and Sexual Abuse Centre; Men Against Sexual Abuse (MASA); Men's Centre; Open Secret; Skylight; Survivor Support; Women's Aid West Lothian; Victim Support; Alzheimer's Scotland; Answer Project; Contact The Elderly; Older Men Under Stress (OMUS) Carers of West Lothian Carers Scotland; Depression Alliance Scotland; Mental Health Advocacy Project (MHAP); Postnatal Depression Project; Breathing Space; Samaritans; Food Train; MOOD; SHEDS; Cyrenians;
- **Mental Health Clinicians (n=11)** e.g. CPNs; GPs; Mental Health Workers; Psychiatrists; ACAST; St John's; COT; Pentland Court (Rehab); CAMHs
- Day Care Services (n=4) e.g. Bathgate House
- Peer Support / Self Help Groups (n=4) e.g. Step Out; AA
- Volunteer Gateway (n=4)
- Counselling / Helpline (n=4)
- Supported Education / Employment Support (n=4)
- Social Work (n=3)
- **Misc. (n=8)** e.g. Hospital chaplain at St John's; 50+ Groups; Moving into Health; Advice Shop; Libraries etc.

Recovery

Respondents were asked to what extent the principles and values of recovery are embedded in their personal practice, the service they work for, and more widely across provision in West Lothian. The following rating scale was provided: 1= Not at all, 2 = A little, 3= Partially, 4= Mainly, 5= Fully.

Between 65 and 68 individuals answered these questions, and the average ratings for each statement is shown below:

- Extent to which recovery is embedded in personal practice – Average Rating: 4.57 (i.e. between Mainly and Fully)
- Extent to which recovery is embedded within the practice of their service – Average Rating: 4.45 (i.e. between Mainly and Fully)
- Extent to which recovery is embedded within the practice of mental health services across West Lothian – Average Rating: 4.04 (i.e. between Mainly and Fully)
- Extent to which recovery is embedded within the local West Lothian mental health strategy – Average Rating: 4.11 (i.e. between Mainly and Fully)

Staff therefore believe recovery is more fully embedded within their personal practice than within services more generally and the wider mental health strategy.

Future Priorities

Integration, capacity and quality have emerged as common issues from similar research studies conducted by Figure 8. Accordingly, respondents were asked to rate the following four statements in order of importance: (Rating Scale = 1= Most Important, 4= Least Important). Between 64 and 67 staff responded, and the average ratings and relative ranking of the statements is shown below:

- Improving integration of mental health services and other services – Average Rating: 2.20
- Expanding the range of mental health services – Average Rating: 2.34
- Increasing the capacity of mental health services – Average Rating: 2.75
- Enhancing the quality of mental health services – Average Rating: 2.87

Staff therefore ranked improving the integration of mental health services and other services most highly as a future priority.

Any Other Points

Finally, respondents were asked whether they had any additional comments to make. There were few common themes so all points made are noted below:

- "Self-stigma and discrimination that is commonly associated with being a mental health carer or service user is a barrier to many who wish information, advice and support. Being able to support carers in overcoming self-stigma would hopefully help them in accessing support as soon as possible, both for them self and the person they support."
- "Due to poor motivation, the people I support have little interest in many of the paper exercises and Service User participation activities expected of them. But when staff are working one to one and hands on with them daily, they engage fully with support."

- "Just to reiterate need for services to be more than responding to crisis situations and to look at early intervention and prevention. Appreciate budget constraints however only ever mopping up if just respond to crisis situations."
- "I feel we have a fractured, disconnected service. communication, particularly between acute and Rehab services is poor and my view is that this is based on poor relationships with each other and a rather negative view of each other's role. this is historical and is not new... people are very quick to criticise without knowing the whole facts and due to a lack of understanding of the service that is provided."
- "Staff are demoralised because of staffing issues, top down changes, reliance on tick-boxes rather than trained professionalism. Lack of time to care. Bureaucracy. Revalidation, Appraisal. and endless HIS "improvements". Staff are fearful of speaking up. The CULTURE is wrong. We are also overmedicalising too much. (Realistic medicine) the net result is that we cannot meet the needs of those who most need it."
- "Our services provide stability for individuals with Psychotic illness. Investment in these areas need to be made to ensure that we can offer a continued and improving service to our service users, without causing further pressure and stress on the current workforce."
- "Waiting lists impact upon ability to deliver high quality services."
- "I think that there needs to be an acknowledgement of the range of difficulties that people can exist in terms of mental health - I have concerns when phrases including mental health needs / mental health difficulties are used as this covers people who may have anxiety such that it affects certain areas of their lives to a person with severe and enduring mental illness whose everyday life has been disrupted as a result of this."

Pharmacy Survey

Since Community Pharmacists are increasingly important front-line healthcare providers in the modern NHS and are taking on more of the clinical roles that have traditionally been undertaken by doctors, it was decided to survey this demographic for their views on service provision for adults with mental health problems across West Lothian.

The survey was devised by Figure 8 and signed off by key members of the Steering Group. The link was then disseminated to all community pharmacists across West Lothian (n=**x**) by Carol Bebbington (Senior Manager Primary Care and Business Support).

Unfortunately, only three pharmacists started the survey and one did not complete all of the questions posed. As such, few generalisations can be made, therefore instead of a systematic review of the whole survey, a few key points are instead noted.

Role of Pharmacists

Respondents were asked what they, as pharmacists, are currently doing to support adults with mental health problems. Answers suggest respondents both provide services directly to this demographic and signpost them on to other relevant organisations:

- Services provided:
    - "Provide trays for patients struggling with medication. Contact GPs where we feel there are compliance issues."
    - "We dispense instalment scripts as requested by GPs to help organise those needing this. Dosettes also provided for complicated regimes/where needed if confused easily by meds."
- Agencies signposted to: GPs; Support for Carers; and online resources on anxiety, depression.

When asked whether they were happy with the level of information they have received about services in West Lothian for adults with mental health problems, the following comments were made:

- "Aware can access services through GP's but not sure other than CAMHs what these are, also the chill out zone in Bathgate, these are just one's I know of for young people but again a directory for all age brackets would be very helpful."
- "More leaflets and info please."

Barriers Preventing Adults with Mental Health Problems Accessing Services

Pharmacists were then asked whether they believed there were any barriers preventing adults with mental health problems from accessing services/provisions from which they might benefit. Both of the respondents who answered this question believed 'Distance to Service', 'Availability of Public Transport' and 'Stigma' were barriers.

Services Which Work Well / Not So Well for Adults wth Mental Health Problems

Respondents made the following comments when asked which services work well for adults with mental health problems in West Lothian:

- "CAMHs appears to work well if individuals are agreeable to access. Chill out Zone works well for others but not everyone…"
- "Memory clinic and REACT."

And they made the following comments when asked what the main gaps and areas for improvement are in support and service provision for adults with mental health problems:

- "Keeping support and services local, having a directory for all health care professionals to access, directory for families of older people or mental health problems to access."
- "Better signposting and self-referral process maybe."

Dentistry and Optometry Survey

Since both dentists and optometrists also have a key role to play in keeping people healthy and in the community they too were surveyed for their opinions on service provision for adults with mental health problems across West Lothian.

The survey was devised by Figure 8 and signed off by key members of the Steering Group. The link was then disseminated to all community dentists and optometrists across West Lothian (n=**x**) by Carol Bebbington (Senior Manager Primary Care and Business Support).

Unfortunately, only one dentist and five optometrists started the survey and two of the latter did not complete all of the questions posed. As such, few generalisations can be made, therefore instead of a systematic review of the whole survey, a few key points are instead noted.

Dentistry

The one dentist who responded indicated that they were *"totally unaware of support services"* available for adults with mental health problems in West Lothian, and concluded by noting, *"As we are not NHS employees we receive virtually no information regarding support services and are consistently forgotten in local health planning."*

Role of Optometrists

Respondents were asked what they, as optometrists, are currently doing to support adults with mental health problems. Answers suggest respondents do not currently do as much as they would like to support this demographic:

- "GP referral or communicating with carers only."
- "We do not have much support to offer patients relating to their mental health issues and would be keen to have materials which could help."

None of the respondents were happy with the amount of information they have received about services in West Lothian for adults with mental health problems. One made the following comment:

- "Would appreciate further advice and support to give to patients."

Barriers to Accessing Local Optometrist Services

When asked whether there were any barriers preventing adults with mental health problems accessing local optometrist services, one respondent made the following comment:

- "Patients concerned with being judged, stressed or anxious about giving the "wrong answers" or being told they have severe eye or general health problems. Some patients are also worried that we cannot help them, i.e. if they are non-verbal."

None of the respondents were able to answer questions pertaining to good services for those with mental health problems or on any areas of over-provision / duplication.

APPENDIX V: FOCUS GROUPS

Introduction

In order to capture the views and opinions of adults with mental health problems and carers themselves, as part of the fieldwork staff at Figure 8 facilitated a series of four qualitative focus groups and a range of 1:1 semi-structured interviews.

Groups were hosted in a variety of venues across West Lothian and representatives of the following groups were spoken to:

- Adults with Severe and Enduring Mental Health Problems (n=12)
- Young People with Mental Health Problems (n=6)
- Family Carers of Adults with Mental Health Problems (n=10)
- Adults with Early-Onset Dementia and their Carers (via an Alzheimer's Scotland facilitated Dementia Café) (n=10)

Following discussion with Senior Charge Nurses it was agreed that the most effective way to capture the views of adults with mental health problems who were currently in-patients on Wards One, 17 and in Pentland Court, a series of one-to one interviews with this demographic were also conducted:

- In-patients on Ward One (IPCU) (n=3)
- In-patients on Ward 17 (n=2)
- Residents of Pentland Court (n=3)

Discussion encompassed a range of topics including what services and community supports work well and not so well locally for adults with mental health problems; whether there are any areas of duplication; whether there are any particular inequalities in service and support provision; and whether these supports and services can be easily accessed by those who would benefit from them. These discussions have been combined with data from the service user's and carer's surveys and are summarised in SWOT analysis form in **Chapter VI** of the Main Report.

What Works Well?

Participants were asked what services and community supports currently work well for adults with mental health problems across West Lothian. Those so affected and their carers provided several examples of services and supports they thought work well. Common themes included:

- Day-care Services such as Bathgate House; the '81 Club; Answer House
    - The activities that were facilitated in these services were mentioned by many who use them as being of particular value such as: history group, walking group, music group, art group etc. Similarly, the young people polled said they would appreciate supported learning (courses like photography and film studies) when they transition into adult

services. The opportunity for social drop-ins in day-care services were also appreciated by the adults.

  - "You can bring your official letters in to your key worker at Bathgate House"
  - "You can't quantify how much we get out of this group." [Early Onset Dementia Café]

- In-patient Services at St John's:
  - "The vast majority of staff are great" – (Carer)
  - On Ward 17:
    - "The staff are nice - they are very approachable; they smile"; "Staff are brilliant; really nice"
    - "It's not like a hospital – it's nice and relaxing"
    - "The food is great!"
    - "The activities are good, but they aren't on at the weekend"; "I like the gym, the meditation and the walking group."
  - On IPCU:
    - Staff - "the job they do is absolutely fantastic"; "they deal with really trying situations very well and still have time for me who's never been in a panic situation." "I have never been cared for as well; not even by my mother and father."
    - "It's better than the IPCU in Edinburgh because there you only get out once a day; here you can get out as many times as you want up to 10 or 11 o'clock at night."
    - "IPCU is good because it's more relaxed."
  - Links with other services:
    - "I'm getting my own house through the hospital."
    - "I've got three social workers and there is a good link up between substance misuse and mental health services."

All interviewees did however note that they did not like the smoking ban in place for in-patients in St John's. Comments made pertaining to this included:

- "I was in here three years ago when you could smoke and I never witnessed any restraints; this time, I've witnessed five and I think it's because people can't smoke to calm down."

One interviewee also noted activities did not always cater sufficiently for women:

> *"Some of the OT activities organised on the ward are too male orientated. There are only two women on the ward at the moment so they don't do many female activities."*

- Pentland Court:
  - "Pentland Court is a good service for my 20-year-old child" (Carer)
  - "Pentland Court is better than Ward 17 – have more freedom here."
  - "I like the trips."

There were also some negative comments made about this service. These included the feeling that physical health issues were not dealt with adequately and that the staff do not always give patients sufficient information:

> "*You don't get enough notice about reviews and meetings. I only found out on Sunday afternoon that I had a review meeting on the Monday."*
>
> *"No one tells you anything here* [PC] *– there are real communication problems."*

- Independent Advocacy – MHAP:
  - "Helps you to have a voice, like with the doctors"
  - "MHAP is an excellent intermediary; it helps to get opinions of service users heard with the Council / NHS etc."
- GPs:
  - "My GP surgery is fantastic [Practice in Armadale]"
  - "My GP was fantastic – she really listened to me"
- Other services mentioned:
  - Therapeutic Gardens
  - Strathbrock Centre – Woodwork; Gardens
  - "The Police are very good, but it is not their job to manage a mental health crisis" (Carer)
  - The young people polled valued the opportunity to manage their anger through sport and activities like karate / dancing: "It gives you something to channel your anger into – it helps you learn how to release your anger in an appropriate way and it also reduces anxiety."
  - One-Year Post Diagnostic Support for (Early-Onset) Dementia - *"PDS has worked well for me"; "I've got nothing but praise for her* [PDS worker]".

Some carers also mentioned the positive role of the wider community and the support they gained from friends: *"50% of the help I get [is from] my neighbour…"* (Carer for adult with early-onset dementia).

Gaps?

Participants were then asked whether there were any gaps, or services/provisions which were not working well for adults with mental health problems in West Lothian. Those so affected and their carers provided various examples of services and supports they thought were missing or not working as well as they might. Common themes included:

- Psychiatric Services:
  - "You see a different [psychiatric] consultant at hospital every time"
  - "There aren't enough ward rounds [inpatient] – you only see the psychiatrist one a week."
  - "It's really difficult to change psychiatrists because there aren't many of them."

- "I haven't seen a psychiatrist since I got here [3 months ago] …I feel like I've just been dumped here [Pentland Court]."
- "I had my Tribunal today [on STDO], but the hearing had to be postponed to next Tuesday because the doctor who attended wasn't Section 22 Approved."
- "ACAST operate until 12 midnight; but not after that"
- "Staff need to be appropriately trained and know how to talk to younger people / people with speech impediments – sometimes we feel patronised."

- Psychological Services:
  - "There's not enough psychology"
  - "There's a lack of trained practitioners for CBT"
  - "There's a really long waiting list for counselling – we had to access private counselling for our son." (Carer)
- In-patient Capacity:
  - "There aren't enough beds in Ward 17 – I've been waiting since last Thursday to be transferred [from IPCU; now Wednesday] and another lady was only transferred today and she was waiting since last Thursday too."
- Appropriate Housing Support / Options:
  - "Tenancy support doesn't always provide the right type of support – e.g. they don't always open the post if it's not in my care plan."
  - "I'm still here [Pentland Court] because the social worker said there's nowhere for me to go."
- Pathways into services:
  - "Access into services if your loved one deteriorates is really poor: the GP is the first point of call. Out of hours you have to either take them to A&E if they'll go or call the police – this isn't good though because they can end up with a criminal record. There is no crisis team; someone to call who would visit immediately." (Carer)
- Services for those with Depression / Anxiety:
  - "There're massive waiting lists for CPNs/counselling for those with depression – but we don't want services taken from psychiatry to psychological services."
- Low Level Preventative Services:
  - "There are few mental health services available if you work; things like the Ability Centre should be open in the evenings and offer wellbeing classes." (Carer)
  - "It has to get to crisis point before anything is done." (Carer)
  - "There's a lack of groups [in the community]. I would like to attend things like book clubs and writing clubs for people like me who suffer with lack of concentration."
- Support for Carers:
  - It was noted that there is no advocacy service for carers and this was seen, by carers, to be a gap in provisions. *"Carers are not being heard."* (Carer)

- It was also noted that families / carers are often unaware of legal procedures like appointeeship / guardianship etc. Carers of West Lothian are, apparently, trying to increase awareness about this.
- "Carers are not seen as of value until they want the carers involved – then they have to jump through hoops." (Carer)
- "There is no one for carers to phone when they are at their lowest point" (Carer)
- Loneliness can be an issue for carers (Carer of someone with early-onset dementia)

- Support for those with early-onset dementia/their carers:
  - Respite care:
    - One participant reported her frustration at having to wait months to be told whether she would be receiving respite for a holiday she had booked. She did not want to take on the role, through SDS, of organising respite and dealing with money.
    - Another spoke of using a local residential facility for respite but how it had been a bad experience and they hadn't used respite since.
  - Appropriate information / practical support:
    - Information and support regarding incontinence / female personal care/hygiene were important but not always available.
    - Training in managing difficult behaviour appears to be lacking.
- Self-Directed Support:
  - Many participants (including those with severe and enduring mental health problems) had not heard of SDS
    - "SDS is not explained"
    - "No one told us how to access the allocated budget"
- Knowledge/Awareness re what is available:
  - "You don't know what you don't know."
  - Websites are not always helpful - "*I wanted someone to talk to give me a simple yes or no.*" It was also noted that a reliance on online information could exclude some without Internet access.
  - People are unaware of services – "there's not the community spirit any more."
  - "You have to find out everything for yourself"
- Other gaps identified included:
  - Some reported that they had to wait in excess of 6 months for assessment and services.
  - A number of carers mentioned it was difficult to get an initial diagnosis – especially with young people/teenagers.
  - Carer's mentioned the potential for financial exploitation when loved ones are in Ward 17 etc. – unless the person is under guardianship / has an appointee, families/carers cannot stop them spending money when they are manic.

- "There are not many wellbeing services for men"
- Self-help / peer support groups

Areas of Duplication / Potential for Disinvestment?

Participants were asked to identify any areas of duplication in service or support provision or any areas from where funds could usefully be re-diverted for adults with mental health problems in West Lothian. Neither those with mental health issues nor carers could identify any significant issues in this area.

Inequalities?

Participants were then asked whether there are any groups of adults with mental health problems (men/women/those with certain conditions) which are currently not well served in West Lothian. A range of comments were made under this point, but there was little consensus. Individuals noted specific issues such as:

- "Support for younger adults isn't right"
- It appears that those with anxiety and depression do not get a good service.
- "Consultant services are no longer going to come out into communities – in the past they would have come out into health centres. Now they are just operating from St Johns, and lots of people [with mental health problems] can't do public transport which mean they miss appointments which means they will be discharged."
- "There are few mental health services available if you work."
- "There are a lack of options for those with sensory issues and mental health problems."

Subsequently addressed were the geographic areas currently well served across West Lothian and those which are not so well served. Many comments made following this question referred back to the limitations of public transport. It was repeatedly noted that if you live in outlying areas / remote villages, access to services via public transport is problematic – *"If you don't drive, it's difficult to get to services."*

Accessibility?

Adults with mental health problems and carers were then asked whether they can get to the supports/services they want, when they want them. Comments made pertaining to this question encompassed a range of themes:

- Out-of-hours provision
  - "There is no support after hours – ACAST stops at night"
  - "Bathgate House only opens one evening a week (Tues 4-6)"
- Waiting lists / Capacity

- "There are long waiting list for psychiatrist; psychology and CPNs"

Transitions?

Participants were asked for their views on the various transitions in mental health services in West Lothian. A range of comments were made for each transition, but it was evident there was less experience of the transition from CAMHs to Adult Services.

Child and Adolescent Services to Adult Services

- "It is often stable because they have a lot of support, but they often don't have a psychiatric referral to adult services. BUT sometimes COT does get a referral from CAMHs – it can work!"

From Acute / Inpatient Services back to the Community

- "Transitions from hospital to community [are] not terribly smooth."
- There is no support for loved ones to get the benefits those they care for are entitled to – "sorting out benefits was a nightmare – it was down to us [carer] to get it all sorted out and support x in the meantime." (Carer)
- "I'm worried about my transition back into the community – I don't want to come back [to Ward 17]. At my discharge meeting I want contact details for groups/services to access"
- "Transition support services from hospital to home 'does not exist' and there's no one to contact. I was given one hours' notice to prepare for my daughter's hospital discharge." (Carer)

From Adult Mental Health Services to Older People's Services

- "COT don't immediately transfer at 65 – it's a nice way of working – person-centred."

Priorities?

Finally, adults with mental health problems and carers were asked for their list of future commissioning priorities. In order to get a comprehensive picture, all those mentioned are noted below in no particular order:

- Publicise a simple pathway into services
- Awareness raising amongst communities / Dementia Friendly Communities
- Improve physical access for those less mobile; not just wheelchair access
- Mental health should be on a par with physical health – there should be parity
- Support on discharge from hospital
- "There shouldn't be so much of a stigma."

- "There should be drop-in centres for mental health manned by psychologists and psychiatrists where you could talk to people and take time out to get your head straight."
- SDS implementation for those who may not understand the implications
- Services like the Brock that encourages people to keep well – wellbeing / community engagement type activities
- We should be informed more
- Physical health should be dealt with better
- Key workers should be better
- Suitable housing solutions – "I'd like somewhere with my own bedroom, little kitchen and bathroom and a shared/communal living room, with help on hand if you need it. Somewhere with help on hand and privacy."
- Education to reduce the stigma around MH issues – *"kids still "laugh at the loonies"*
- "More support groups like bereavement counselling; and support for mums with mental health issues so that you don't always have to have your children taken away if you have a mental health condition."
- Change in the way people are diagnosed – "I've had multiple diagnoses over the last 25 years, but you're never told enough. If you don't understand what you've got, it's more difficult to recognise the symptoms for yourself."
- "Extend ACAST so more people can be treated at home."
- "There should be more people for us [people with MH issues] to talk to." / "More opportunities for 1:1 support – it's good to have someone to talk to you"
- "There should be more activities on the ward [Ward 17]"
- "More Ward 17-type things in the community across West Lothian."
- Support for carers and Carers Advocacy Service
- Community Outreach

APPENDIX VI: SURVEY RESULTS (SERVICE USERS AND FAMILIES/CARERS)

Introduction

The purpose of this element of the research was to seek the views from a broad audience of service users and carers on the current provision of specialist mental health services across West Lothian. Specifically, service users and carers were asked to provide their views on the quality of services, key issues, gaps and areas for improvements.

Service user survey - response rates

There were **73** responses received to the service user survey, of which **70** were completed sufficiently to enable use within the research.

Service user survey – key themes

Survey respondents - demographics

There was a fairly even gender split of respondents, with a slight majority (53%) being male; whilst the vast majority of respondents (81%) were aged between 36 and 65 and of Scottish descent (94%).

Respondents were asked what kind of mental health issue/condition they have. The full breakdown of results is shown in the table below:

Mental health issue/condition	Frequency of Response	As a % of Total Responses (n=132)
Anxiety	41	31.1%
Depression	32	24.2%
Schizophrenia	25	18.9%
Personality Disorder	7	5.3%
Bipolar Disorder	6	4.5%
Early Onset Dementia	6	4.5%
Obsessive Compulsive Disorder	4	3.0%
Post-Traumatic Stress Disorder	4	3.0%
Autistic Spectrum Disorder (including Asperger's)	3	2.3%
Korsakoff Syndrome	2	1.5%
Huntingdon's Disease	1	0.8%
Self-harm	1	0.8%

The vast majority of respondents (91%, n= 62) reported that they have received a formal diagnosis from a medical professional (e.g. GP, Community Psychiatric Nurse) in relation to their mental health condition.

Service and/or support provisions

Respondents were asked to note all services and/or support provisions that they are currently accessing or have recently accessed. The full range of services and/or support provisions noted are presented in the table below:

Service/support provision name	Frequency of Response	As a % of Total Responses (n=131)
Day Care Centre	20	15.3%
Advocacy MHAP	11	8.4%
SAMH	11	8.4%
GP	9	6.9%
Housing Support	9	6.9%
CPN	8	6.1%
Barony Housing	7	5.3%
Penumbra	7	5.3%
Psychiatry	6	4.6%
LAMH	5	3.8%
St John's	5	3.8%
Alzheimer's Scotland	3	2.3%
Autism Initiatives	3	2.3%
Carewatch	3	2.3%
Duty Social Work	3	2.3%
Social Inclusion	3	2.3%
Art Link	2	1.5%
COT	2	1.5%
Lifeskills Support	2	1.5%
Peer Support	2	1.5%
Addiction service	1	0.8%
Cyrenians	1	0.8%

DASAT	1	0.8%
DBT course	1	0.8%
Dementia advisor	1	0.8%
Distress tolerance	1	0.8%
Green gym	1	0.8%
Mental health outreach	1	0.8%
Reablement	1	0.8%
West Lothian Living Service	1	0.8%

Respondents were then asked to name the service/support provision that they are choosing to answer the survey questions about and the type of service/support they are/have been receiving. The breakdown of responses is provided in the two tables below:

Service/support provision name	Frequency of Response	As a % of Total Responses (n=68)
SAMH	18	26.5%
Bathgate House (DS)	12	17.6%
LAMH	10	14.7%
Penumbra	7	10.3%
Barony	6	8.8%
MHAP	5	7.4%
CPN	3	4.4%
Art Link	2	2.9%
Advice shop	1	1.5%
Carewatch	1	1.5%
COT	1	1.5%
Housing/tenancy support	1	1.5%
Social work	1	1.5%

Type of service/support received	Frequency of Response	As a % of Total Responses (n=107)
Lifeskills	43	40.2%
Emotional support	12	11.2%
Help with attending appointments	12	11.2%
Social inclusion	10	9.3%
Help with accessing services	9	8.4%
Help with housing/accommodation	6	5.6%
Talking therapy	5	4.7%
Benefits check	3	2.8%
Vocational classes	3	2.8%
DBT	2	1.9%
Company	1	0.9%
'Very little help'	1	0.9%

Service Evaluation

Respondents were asked to evaluate the service/support they were reporting on against a variety of criteria. Their responses are shown in the table below:

Statement	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	Nil Responses
The information I was given about this service/ support provision helped me decide whether to come along.	40.0% (n=28)	**47.1% (n=33)**	5.7% (n=4)	1.4% (n=1)	0	5.7% (n=4)
My referral to the service/support provision was straightforward and dealt with quickly.	**51.4% (n=36)**	38.6% (n=27)	0	4.3% (n=3)	2.9% (n=2)	2.9% (n=2)
I find it easy and convenient to get to the service/support provision.	**50.0% (n=35)**	40.0% (n=28)	2.9% (n=2)	2.9% (n=2)	0	4.3% (n=3)
I feel safe and comfortable when I attend the service/support provision.	**62.9% (n=44)**	34.3% (n=24)	1.4% (n=1)	0	0	1.4% (n=1)
The service/support provision is available at the times I need it.	**54.3% (n=38)**	35.7% (n=25)	1.4% (n=1)	2.9% (n=2)	2.9% (n=2)	2.9% (n=2)

The assessment/ initial discussion I was given helped me to work out my needs; and how they can best be met.	44.3% (n=31)	**48.6% (n=34)**	1.4% (n=1)	0	1.4% (n=1)	4.3% (n=3)
I have been actively involved in putting my care plan together and I am in agreement with it.	**51.4% (n=36)**	35.7% (n=25)	1.4% (n=1)	2.9% (n=2)	0	8.6% (n=6)
Other services/support provisions have been involved in my assessment and care plan.	**38.6% (n=27)**	31.4% (n=22)	12.9% (n=9)	5.7% (n=4)	2.9% (n=2)	8.6% (n=6)
My family/partner/carer are allowed to contribute to my assessment and care plan.	**37.1% (n=26)**	35.7% (n=25)	8.6% (n=6)	4.3% (n=3)	2.9% (n=2)	11.4% (n=8)
The service/support provision I attend encourages and supports me to talk honestly about my mental health needs.	**54.3% (n=38)**	41.4% (n=29)	1.4% (n=1)	1.4% (n=1)	0	1.4% (n=1)
The service/support provision I attend encourages and supports me to talk honestly about my general wellbeing.	**57.1% (n=40)**	37.1% (n=26)	2.9% (n=2)	1.4% (n=1)	0	1.4% (n=1)
The service/support provision I attend encourages and supports me to seek help from other services.	41.4% (n=29)	**50.0% (n=35)**	4.3% (n=3)	1.4% (n=1)	0	2.9% (n=2)
The service/support provision I attend has assisted me to get involved with my community.	38.6% (n=27)	**40.0% (n=28)**	11.4% (n=8)	4.3% (n=3)	0	5.7% (n=4)
I have a direct say in how the service/support provision is run and developed.	31.4% (n=22)	**42.9% (n=30)**	11.4% (n=8)	8.6% (n=6)	1.4% (n=1)	4.3% (n=3)
The service/support provision is good at working together with other services that I need and use.	35.7% (n=25)	**47.1% (n=33)**	10.0% (n=7)	1.4% (n=1)	1.4% (n=1)	4.3% (n=3)
The service/support provision focuses on my recovery.	**50.0% (n=35)**	34.3% (n=24)	8.6% (n=6)	4.3% (n=3)	0	2.9% (n=2)
The service/support provision meets my needs and helps me achieve my desired outcomes.	**47.1% (n=33)**	41.4% (n=29)	7.1% (n=5)	2.9% (n=2)	0	1.4% (n=1)
						Total responses: 70

At least 70% of respondents agreed with all the statements above. Levels of agreement with the given statements ranged from a minimum of 70% up to a maximum of 97.2% of respondents.

Respondents were then asked what they particularly liked about the service/support they are receiveing. Sixty-four responses were received, which ranged across the following eleven key themes:

Key Theme	Frequency of Response	As % of Total Responses (n=64)	Example comments
Good staff	34	53.1%	"Friendly professional staff. Knowledgeable as to update position re assistance available, very helpful." "The staff are good with confidentiality and helped make a good care plan for me." "Professional staff - flexible approach." "The friendliness of support staff, the assurance of being there when needed."
Enabling	11	17.2%	"It saved my life, it keeps me well, gives me the opportunity to develop new skills." "Allows me to live independently, help to complete household tasks." "My workers try to motivate me to go out in the community."
Easy to Access	8	12.5%	"Help is always available when I need it." "The assurance of being there when needed."
Peer Support	8	12.5%	"Mixing with others like myself." "Other service users help."
Person centred	6	9.4%	"Focuses on me. I am treated as an individual." "They are friendly and discuss my needs regularly, making changes as needed."
Good service ethos	4	6.2%	"Accepting, inclusive and non-judgmental." "Treating me with dignity and respect." "Feel as if i can speak to support workers without being judged, get plenty of encouragement."
Consistency of staff	2	3.1%	"Having the same worker so I don't have to explain what I need." The same worker all visits and someone else you know if your worker is on holiday."
Ensures wellbeing	2	3.1%	"The service looks after me well. The service ensures I am as well as I can be."
Feel secure	2	3.1%	"I feel secure." "I like the support, the support is structured."
Builds confidence	1	1.6%	"Helped my confidence and to gain valuable work experience which is really enjoyable. It allows me to put my skills from school to good use. Help is always available when I need it."
Nothing	1	1.6%	"There is nothing about …. that I like."
Supports individual decision-making	1	1.6%	"It helps me to carry out my decisions eg to make funeral plans, shopping."

Respondents were then asked whether there was anything they disliked about the service/support they are receiveing. Fifty-four responses were received, which ranged across the following ten key themes:

Key Theme	Frequency of Response	As % of Total Responses (n=54)	Example comments
Nothing	38	70.4%	"Nothing I dislike."
Lack of peer support	2	3.7%	"Would like more groups, chats, meet others like me."
Lack of time with staff	2	3.7%	"The time allocated to each session is limited." "Don't have enough time with staff."
Poor level of psychiatric support	2	3.7%	"Been too many cuts lately. Very disappointed at times, haven't seen a psychiatrist for years. I am on no medication and unless you are on medication, you are left to it."
Support times	2	3.7%	"I dislike my current support times." "When support worker appears at door with no notice."
Lack of night staff	1	1.9%	"Lack of staff during nights means not enough 1-1 time if staff are busy."
Paying for transport	1	1.9%	"Do not like paying for transport."
Poor service	1	1.9%	"Inconsistent, unreliable, incompetent, disorganised and not providing care needed."
Review system	1	1.9%	"Would like more people at the annual reviews ie perhaps a family member or advocacy."
Change of staff	1	1.9%	"Changing social workers."

Respondents were then asked what improvements they would like to see in service/support provision. Fifty responses were received, which ranged across the following ten twelve themes:

Key Theme	Frequency of Response	As % of Total Responses (n=50)	Example comments
None	24	48%	"No improvements needed."
Trips out	6	12%	"More staff, more groups outings for social interaction and well-being." "More social trips with service users."
More social support	5	10%	"More social support." "More social trips with service users, service user BBQ's."

More staff/resources	5	10%	"Additional staff and more resources."
More groups	4	8%	"More groups, more for me to do."
Better communication	3	6%	"Communications could be better."
Less paperwork	2	4%	" Less paperwork, I struggle with this."
Staff consistency	2	4%	"Try to maintain the key worker but I know I have to change with my worker is on holiday."
Alter support time	1	2%	"Adjustment to my support times."
Dementia testing	1	2%	"Testing for dementia."
Free transport	1	2%	"Allow some free transport if I need to pop out somewhere if the need arises, I can't really afford to pay."
Service reliability	1	2%	"Vast improvement in reliability is needed, and be more consistent. The company needs to improve in staff/time management and must provide care needed."

Finally, respondents were then asked to rate their overall level of satisfaction with the level of help and service they have received. (Rating scale: 1=not happy at all and 10=very happy). The sixty-nine responses received are presented in the table below:

Carer survey - response rates

There were only **23** responses received to the carer/family survey, of which **20** were completed sufficiently to enable use within the research.

Carer survey – key themes

Demographic information

Survey respondents (carers/family members) were asked to provide some demographic information about the person(s) that they care for.

There was a fairly even gender split of the persons cared for, with a slight majority (55%) being male; with a fairly even split across age groups from 16-66+.

Respondents were asked what kind of mental health issue(s)/condition(s) the person(s) they care for has/have. The full breakdown of results is shown in the table below:

Mental health issue/condition	Frequency of Response	As a % of Total Responses (n=41)
Depression	8	19.5%
Anxiety	7	17.1%
Autistic Spectrum Disorder (including Asperger's)	6	14.6%
Early Onset Dementia	4	9.8%
Bipolar Disorder	3	7.3%
Obsessive Compulsive Disorder	3	7.3%
Personality Disorder	3	7.3%
Schizophrenia	2	4.9%
Self-harm	2	4.9%
Acquired Brain Injury	1	2.4%
Learning Difficulties	1	2.4%
Post-Traumatic Stress Disorder	1	2.4%

* NOTE: The above categories are what respondents noted and not a prescribed set of mental health conditions (e.g. learning difficulties are not classed as a Mental Health condition).

The vast majority of respondents (95%, n= 19) reported that the person(s) they care for has/have received a formal diagnosis from a medical professional (e.g. GP, Community Psychiatric Nurse) in relation to their mental health condition.

Service and/or support provisions

Respondents were asked to note all services and/or support provisions that they have been in contact with in their role as a carer/family member over the last two years. The full range of services and/or support provisions noted are presented in the table below:

Service/support provision name	Frequency of Response	As a % of Total Responses (n=27)
CAMHS	4	14.8%
SAMH	4	14.8%
Autism Initiative	3	11.1%
CPN	2	7.4%
Maple Villa	2	7.4%
Art Link	1	3.7%
Bathgate (daycare)	1	3.7%
COT	1	3.7%
Craigs Hill	1	3.7%
GP	1	3.7%
Penumbra	1	3.7%
Places for People	1	3.7%
Psychology Specialist Care Facility	1	3.7%
St Johns	1	3.7%
Social Work	1	3.7%
Ward 3	1	3.7%
None	1	3.7%

Respondents were then asked to name the service/support provision that they are choosing to answer the survey questions about. The breakdown of responses is provided in the table below:

Service/support provision name	Frequency of Response	As a % of Total Responses (n=11)
SAMH	4	36.4%
Art Link	1	9.1%
Bathgate House	1	9.1%
Dementia Team	1	9.1%
Dialectic Behaviour Therapy	1	9.1%
Maple Villa	1	9.1%
Psychology Specialist Care Facility	1	9.1%
Social Work Assessment	1	9.1%

Service Evaluation

Respondents were asked whether the service/support they were reporting on as a carer/family member involves them directly in a number of different processes (Assessment; Care Delivery; Care Planning; Review of Care; Service Redesign/Development/Evaluation). The combined responses are shown in the table below:

Does the service/ support provision involve you directly as a carer/ family member in the following processes?	Yes	No
Assessment	**53.3% (n=8)**	46.7% (n=7)
Care Delivery	46.7% (n=7)	**53.3% (n=8)**
Care Planning	46.7% (n=7)	**53.3% (n=8)**
Review of Care	**64.7% (n=11)**	35.3% (n=6)
Service Redesign/Development/Evaluation	0.00% (n=0)	**100.0% (n=11)**

Respondents were asked whether they had had any contact with a family/carer support group/service within the past two years. A slight majority of those who responded (53%, n=10)

reported that they had. Those who had received support were then invited to describe the support they have received. The themed responses are presented below:

Description of support received as a Carer	Frequency of Response	As a % of Total Responses (n=11)
Peer Support	3	33.3%
Courses	2	22.2%
Guidance	1	11.1%
Professional Support	1	11.1%
Respite	1	11.1%
Sharing caring responsibilities	1	11.1%

Respondents were also asked to note any 'other' sources of information and/or support they had received as a family member/carer of someone with a mental health problem. The responses given are presented in the table below:

Description of 'other' sources of information and/or support received as a Carer	Frequency of Response	As a % of Total Responses (n=19)
COWL	5	26.3%
Social Work	3	15.8%
Autism Initiative	2	10.5%
Internet	2	10.5%
SAMH	2	10.5%
Ability Centre	1	5.3%
British Heart Foundation	1	5.3%
Diabetic Clinic	1	5.3%
GP	1	5.3%
Peer Support	1	5.3%

Respondents were asked if any of the following list of potential 'barriers' prevented them from seeking support in their role as a Carer:

Potential barriers to seeking support as a Carer	Frequency of Response	As a % of Total Responses (n=47)
I am unaware of support available.	7	14.9%
Lack of specialist facilities.	7	14.9%
Mental health-related support for carers is under-resourced.	6	12.8%
Stigma associated with a mental health problem.	5	10.6%
Mental health-related support for carers is not a priority.	5	10.6%
I am unaware of how to access support.	4	8.5%
My needs are not understood.	3	6.4%
Difficulty in getting to services.	3	6.4%
I do not need support.	2	4.3%
Confidentiality issues prevent me seeking personal support.	2	4.3%
My views are not listened to.	1	2.1%
The person I care for does not want me to seek support for myself.	1	2.1%
Delays or other difficulties in getting the help I need.	1	2.1%
A significant other does not want me to seek support for myself.	0	
Confidentiality issues prevent me getting involved in decisions about care or services.	0	

APPENDIX VII: STAKEHOLDER LIST

In total, through the variety of methods used in this study, **XX** individuals were consulted as part of this needs assessment project. Names, titles and organisations for those professionals involved in the research are noted in the tables below. All users of services, peer mentors and carers are anonymised.

List of Interviewed Stakeholders

	Name	Designation	Organisation
1	**Dr H Aditya**	Clinical Director, WL Mental Health Services	NHS Lothian
2	**Maggie Archibald**	HR Advisor, Equality and Diversity	West Lothian Council
3	**Marion Barton**	Head of Health	West Lothian HSCP
4	**Tommy Blue**	Team Co-ordinator, CAMHS	NHS Lothian
4	**Emma Boothroyd**	Team Manager, MH Assessment Team	West Lothian Council
5	**Morag Cameron**	Lead Occupational Therapist for MH	NHS Lothian
7	**Duncan Charles**	Manager, Adults With Incapacity & Mental Health Officer Team	West Lothian Council
8	**Aileen Eland, Alan Mciver and Helen Hay (Group intervew)**		Alzheimer's Scotland
9	**Patricia Graham**	Head of Adult Psychology	NHS Lothian
10	**Belinda Hacking**	Head of Applied Psychology for Older Adults	NHS Lothian
11	**Kathy Hamilton**	Project Co-ordinator	Mental Health, Advocacy Project (MHAP)
12	**Lynne Henderson**	Clinical Nurse Manager (Acute Services)	NHS Lothian
13	**Dr Deborah Innes**	Clinical Lead, Scottish MH Service for Deaf People	NHS Lothian
14	**Jane Kellock**	Head of Social Policy / Chief Social Worker	West Lothian Council

15	**Len McCaffer**	Arts Officer - Wellbeing	West Lothian Council
16	**John McLean**	Outreach and Day Services Manager	West Lothian Council
17	**Elaine Nisbet**	Welfare Advice and Adult Basic Education Manager (Acting)	West Lothian Council
18	**Margaret Robertson**	Advisor, Dementia and Older Persons Tea, WL Advice Shop	
19	**Sarah Summers**	Group Manager, Looked After Children Services	West Lothian Council
20	**Patrick Welsh**	IJB Finance Officer	West Lothian Council

List of Participants at Key Stakeholder Event (6th May 2016)

	Name	Designation	Organisation
1	**Dr H Aditya**	Mental Health Team	NHS Lothian
2	**Melanie Agnew**	Mental Health Nurse	NHS Lothian
3	**June Boothroyd**		West Lothian Council
4	**Ian Buchanan**	Chairman	West Lothian Public Partnership
5	**Gwen Burt**		Barony Housing
6	**Elizabeth Butters**	Alcohol and Drug Partnership	NHS Lothian
7	**Evelyn Cook**	Project Worker	Mental Health Advocacy Project
8	**Caroline Donaldson**	Project Leader	Mood
9	**Jillian Dougall**	Service Development Officer	West Lothian Council
10	**Aileen Eland**	Service Manager	Alzheimer Scotland
11	**Gillian Fairbairn**		Advice Shop
12	**Louise Finch**	Support Worker	Scottish Association for Mental Health
13	**Lesley Goldie**	Social Worker	West Lothian Council
14	**Lynn Gunn**		NHS Lothian
15	**Dianne Hayley**		NHS Lothian
16	**Gillian Henderson**	CPN Team Manager	NHS Lothian
17	**Ruth Kelly**	Regional Manager	Lanarkshire Association for Mental Health

18	**Wendy Kelly**		Richmond Fellowhship
19	**Sheena Lowrie**	Health Promotion Specialist	NHS Lothian
20	**Lesley Mains**	Community Psychiatric Nurse	NHS Lothian
21	**Jamie McDonald**		NHS Lothian
22	**Dyo McKay**		NHS Lothian
23	**John McLean**		West Lothian Health and Social Care Partnership
24	**Kathleen McWhir**	Support Manager	Penumbra
25	**Carole Middleton**	Team Leader	NHS Lothian
26	**Lynda Mitchell**	Team Leader	Scottish Association for Mental Health
27	**David Murray**	Service Development Officer	West Lothian Council
28	**Tracey Mutch**		NHS Lothian
29	**Louise Ramsay**	Service Manager	Places for People Scotland Care and Support
30	**Rosemary Rennie**	Pentland Court	NHS Lothian
31	**Karen Spence**	Community Psychiatric Nurse	NHS Lothian
32	**Shirley Stanley**		NHS Lothian
33	**Lorna Stevenson**	Team Leader	Bathgate House
34	**Ailsa Sutherland**		West Lothian Council
35	**Fiona Tall**	Area Manager	Penumbra

List of Participants at 1st Working Group Session (18th May 2016)

	Name	Designation	Organisation
1	**Jos Anderson**		Police
2	**Ian Buchanan**	Chairman	West Lothian Public Partnership
4	**Lynne Gunn**		NHS Lothian
5	**Kathy Hamilton**		Mental Health Advocacy Project
6	**Lesley Mains**	Community Psychiatric Nurse	NHS Lothian
7	**Mary-Denise McKernan**	Manager	Carers of West Lothian

8	**John McLean**		West Lothian Health and Social Care Partnership
9	**Lynda Mitchell**	Team Leader	Scottish Association for Mental Health
10	**Thomas Oswald**		West Lothian Drug & Alcohol Service

List of Participants at 2nd Working Group Session (3rd June 2016)

	Name	Designation	Organisation
1	**Jos Anderson**		Police
2	**Ian Buchanan**	Chairman	West Lothian Public Partnership
3	**Evelyn Cook**	Project Worker	Mental Health Advocacy Project
4	**Lynne Gunn**		NHS Lothian
6	**Lesley Mains**	Community Psychiatric Nurse	
7	**Mary-Denise McKernan**	Manager	Carers of West Lothian
8	**John McLean**		West Lothian Health and Social Care Partnership
9	**Lynda Mitchell**	Team Leader	Scottish Association for Mental Health

Focus Group Participants

Groups were hosted in a variety of venues across West Lothian and representatives of the following groups were spoken to:

- Adults with Severe and Enduring Mental Health Problems (n=12) – Friday 20th May 1pm-3pm
- Young People with Mental Health Problems (n=6) – Monday 30th May 1pm-3pm
- Family Carers of Adults with Mental Health Problems (n=10) – Monday 9th May 6-8pm
- Adults with Early-Onset Dementia and their Carers (via an Alzheimer's Scotland facilitated Dementia Café) (n=10) – Monday 20th June, 10am

Following discussion with Senior Charge Nurses it was agreed that the most effective way to capture the views of adults with mental health problems who were currently in-patients on Wards One, 17 and in Pentland Court, a series of one-to one interviews with this demographic were also conducted:

- In-patients on Ward One (IPCU) (n=3) – Weds 25th May 6-8pm
- In-patients on Ward 17 (n=2) – Monday 16th May 6-8pm
- Residents of Pentland Court (n=3) – Weds 8th June 2-4pm

West Lothian Health & Social Care Partnership | NHS Lothian | West Lothian Council

Mental Health Commissioning Plan Working Group

Terms of Reference and Membership

A. Remit of Working Group

The Scottish Government requires Integration Joint Boards (IJB) in collaboration with their partners to develop strategic commissioning plans for all adult care groups. Strategic commissioning plans should 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.

The purpose of this Working Group is to develop a three year commissioning plan for Adults with Mental Health problems in accordance with the Scottish Government guidance on Strategic Commissioning Plans[1]. The plan will be informed by a detailed needs assessment which will have been prepared in conjunction with the IJB Strategic Planning Group.

The commissioning plan 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.

The Adults with Mental Health commissioning plan will confirm the total resources available across health and social care in respect of service users and carers and relate this information to the needs of Adults with Mental Health problems population set out in the needs assessment; such resources should be consistent with the relevant Directions issued by the IJB. The plan 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

[1] http://www.gov.scot/Resource/0046/00466819.pdf

B. Frequency
The group will meet on a regular basis in accordance with the overall schedule for the delivery of the commissioning plan (attached).

C1. Lead Officer
The group will be chaired by Marion Barton, Head of Health.

C2. Contact
The Lead Officer will be supported by

- support officer/s from Commissioning and Programme Management
- support officer from Financial Management

D. Reporting
The group will report to the Strategic Planning Group in accordance with the overall schedule for the delivery of the commissioning plan.

E1. Membership Profile
Participants are chosen to provide the relevant knowledge and expertise to fulfil the remit of the group.

E2. Membership

Member	Role
Marion Barton	Lead Officer
David Murray	Commissioning Officer
Carol Mitchell/ Douglas Pirie	Financial Management Officer
	Health professionals
Nick Clater	
Dr Douglas McGown	
Dr Hosakere Aditya	
	Social care professionals
Alan Bell	
Duncan Charles	
Katy McBride	Housing representative
Susan Williamson	Third sector provider representative/s
Robert Telfer	Scottish Care (Commercial providers)
MHAP rep acting in this capacity	Service Users representative
Caroline Pacitti	Carers representative

F. Review
As a short life group it is not anticipated that the remit and membership will need to be reviewed.

West Lothian Integration Joint Board

Date: 23/08/2016
Agenda Item: 11

ALCOHOL AND DRUGS PARTNERSHIP SERVICES AND FUNDING

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the IJB of the reduction in direct grant funding for Alcohol and Drugs Partnerships in 2016/17 and the issues associated with this.

B RECOMMENDATION

- To note that all addictions services come within the scope of the IJB Scheme of Integration.
- To note that the budget contribution from NHS Lothian to the IJB incorporates the appropriate proportion of all NHS Lothian funding in respect of addictions services.
- To note the reduction in the Scottish Government's direct grant funding to for Alcohol and Drugs Partnerships in 2016/17.
- To agree that the ADP commissioning plan should be reviewed and revised to bring planned expenditure in line with the reduced resources for addictions services; this review to be based on the priorities established from the strategic needs assessment and carried out with the same level of stakeholder engagement as for the original development of the commissioning plan.
- To agree that the revised ADP commissioning plan should be presented to the IJB meeting of 29 November 2016 for approval.

C TERMS OF REPORT

ADP commissioning plan

The West Lothian Alcohol and Drugs Partnership (ADP) is a multi-agency partnership set up in 2008 that has strategic responsibility for coordinating actions to address local issues with alcohol and drugs. Its membership includes: West Lothian Council, NHS Lothian, Police Scotland, Third Sector, HMP Addiewell

The current ADP Commissioning Plan 2015-2018 (Appendix 1) was developed with the collaboration and support of all the partners. As is now standard approach for strategic commissioning in the IJB, the plan was informed by an independent needs assessment.

Local outcomes and additional key performance indicators were agreed by the partnership as part of the development process of the delivery plan. Thereafter extensive stakeholder engagement was conducted to inform the development of the final plan.

The plan has four main themes aligned to the seven national ADP outcomes and other local priorities based on the needs assessment:

1. Prevention
2. Early Intervention
3. Recovery
4. Community Safety

A range of service interventions were developed with resource allocation to address these. These commissioned services have various contractual and procurement arrangements including legal form, commencement dates, duration and possible extensions.

Scottish Government funding to ADPs

In 2015/16, £69.2 million was provided from across the health and justice portfolios for the purposes of supporting the work of Alcohol and Drug Partnerships on treatment services. The Scottish Government draft budget published in December included a reduction in the combined drug and alcohol funding from £69.2 million in the current financial year to £53.8 million in 2016-17.

The Cabinet Secretary for Health, Shona Robison, wrote to Health Board Chief Executives in early January 2016 stating her expectation that existing services, resources and outcomes would be maintained at 2015/16 levels and that increased Board baseline budgets were expected to go towards meeting the funding shortfall.

The Scottish Government subsequently confirmed ADP funding allocations to NHS Boards for 2016-17 in a letter of 4 July 2016 (Appendix 2). The result of this is that the ADP funding allocation for Lothian has reduced from £11.470 million to £8.887 million (23% reduction).

West Lothian ADP Funding

As part of its financial planning process for 2016/17, NHS Lothian has passed on the relevant share of increase in its baseline budget in 2016/17 to all Lothian IJBs along with the full Scottish Government allocation for ADPs. The budget resources available are however unable to redress the 23% reduction in direct Scottish Government funding for ADPs for 2016/17.

Final confirmation of West Lothian's share of the reduced ADP funding is still to be advised but it has been agreed at a Lothian level that each ADP service area will share equally, on a pro rata basis, the share of the funding reduction. Taking account of this the total budget reduction impacting on West Lothian commissioned services will be approximately £400,000 in 2016/17.

The existing ADP commissioned service commitments are based on an expectation of funding comparable to 2015/16 levels. Although contracts can be varied or terminated, a period of at least three months notice is required. In addition such a significant reduction to ADP services, without undertaking an appropriate assessment and prioritisation of service activities, would have risks to delivery of outcomes which relate to vulnerable people and disadvantaged communities.

This risk has been discussed at a Lothian level across ADP Partnerships and IJBs and there is a consensus that careful consideration is required on how available funding is prioritised going forward. In terms of West Lothian the total resulting one off pressure of £400,000 in commissioned services will require to be managed within overall budget resources available and the impact of this will be closely monitored during 2016/17.

Commissioning plan review

Taking account of the points noted above, it is recommended that the IJB agrees to an urgent review of the ADP commissioning plan with the objective of bringing investment in line with available resources from 1 April 2017. This review should draw on the existing needs assessment but otherwise the process should be similar to that to develop the plan in the first place. In particular it is considered essential that there is full engagement with all key stakeholders, including service users.

Although challenging in timescale, it will be necessary to conclude this review in time to be able to effect any contractual changes with due notice. To that effect it is proposed that a revised commissioning plan is presented to the IJB at its meeting of 29 November 2016.

D CONSULTATION

- West Lothian ADP
- Lothian ADP collaborative

E REFERENCES/BACKGROUND

- Letter from Cabinet Secretary for Health, Wellbeing and Sport to NHS Board Chief Executives, 7 January 2016

F APPENDICES

1. ADP Delivery (commissioning) Plan 2015-2018
2. Scottish Government ADP Funding Allocations, 4 July 2016

G SUMMARY OF IMPLICATIONS

Equality/Health	The revised commissioning plan will be subject to an equality impact assessment.
National Health and Wellbeing Outcomes	The commissioning plan addresses the relevant National Health and Well-Being Outcomes in accordance with the IJB Strategic Plan
Strategic Plan Outcomes	The commissioning plan is aligned to relevant Strategic Plan outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The Strategic Plan outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care
Impact on other Lothian IJBs	None

Resource/finance	Scottish Government funding for ADP investment has been reduced by 23% for 2016/17.
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014 and statutory regulations and guidance
Risk	There is a risk that outcome performance targets are not met as a consequence of reduction in commissioned activity.

H CONTACT

Contact Person:
Alan Bell, Senior Manager Community Care Support & Services
mailto:Alan.bell@westlothian.gov.uk

Tel 01506 281937

23 August 2016

Delivery Plan
2015 - 2018

Contents

1. Introduction

The West Lothian Alcohol and Drugs Partnership (ADP) is a multi-agency partnership set up in 2008 that has strategic responsibility for coordinating actions to address local issues with alcohol and drugs. Its membership includes:

- West Lothian Council
- Police Scotland
- NHS Lothian
- Voluntary Sector
- HMP Addiewell

This plan has been developed with the collaboration and support of all the partners. Local outcomes and additional key performance indicators were agreed by the partnership as part of the development process of the delivery plan. A small working group has taken responsibility for the overall process

2. Strategic Context

The West Lothian ADP Joint Commissioning Plan 2012-15 outlines our local vision and key priorities to address alcohol and drug use within West Lothian. The Joint Commissioning Plan was developed in response to the two key national strategies (and our local strategic documents that parallel them): *Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* (2008) and *Changing Scotland's Relationship with Alcohol: A Framework for Action* (2009).

The ADP Joint Commissioning Plan 2012 - 2015 had three sections:

Prevention & Early Intervention

Recovery from Problematic Substance Misuse

Community Safety and Youth Diversion

Development of the new joint commissioning plan has broadly maintained these three workstreams. These themes encompass the seven national ADP outcomes and other local priorities detailed later in the logic models of this plan.

2a. Review of Joint Commissioning Plan

In 2013-14 the ADP support team, reviewed our Joint Commissioning Plan to determine our progress against implementing local commissioning intentions. Specifically the review considered strategic changes, local outcomes and stakeholders' views to measure the ADP's success and progress. By utilising a strategic commissioning framework and the cyclical process under the 4 themes of, ANALYSE, PLAN, DO and REVIEW a self-assessment of our progress was completed. From this assessment various areas were scored and recommendations for improvements were developed. The review process indicates that the ADP was 68% on target at the midway point of the implementation period.

This work provided a useful summary and review of how the last Joint Commissioning Plan and Delivery Plan were developed. An improved method of development has been adopted for the Joint Commissioning Plan 2015 -18 and has included consultation amongst the partnership, with other relevant stakeholders and with service users, carers and the wider community. One of the strong recommendations from the ADP partners was to develop a robust performance framework ensuring that progress could be measured on a year by year basis as the ADP works together to deliver its local activities and outcomes. This should include national and local ADP outcomes with baselines and targets and potential to benchmark against other ADP areas with similar characteristics.

2b. WLADP Needs Assessment

During 2014, the ADP commissioned an independent needs assessment to further understand the needs, analyse the current provision and conduct a gap analysis. Other objectives of this research were:

- Identify and describe the profiles of service users for both alcohol and drugs
- Research prevalence of substance misuse (including New Psychoactive Substances) and needs for service in West Lothian in cognisance of the Census 2011 and West Lothian Community Planning Partnership Strategic Analysis 2012.
- Analyse and understand gaps with consideration for funding structure remaining unchanged in existing service provision including geographical

populations and quantity and quality of services provided to people with protected characteristics or other vulnerable groups;

- Identify areas of good practice, over provision and duplication of service provision;
- Provide information on the extent that services are accessible, suit the needs of clients and in the right location for service users cognisant of the geographical area and the public transport infrastructure
- Determine the extent to which the current services are meeting demand;
- Suggest ways for the partnership to redesign existing services to meet need more effectively and efficiently using current funding structure.
- Review and audit all services according to the Recovery Orientated Systems of Care Quality Standards and to ascertain level of alignment to the eight key principles ;
- Building upon and updating the substance misuse assessment within the West Lothian 2012 Community Planning Partnership Strategic Assessment.

The Needs Assessment was competitively tendered and awarded to an independent consultant. The work was completed over the summer of 2014 and Figure 1 provides an overview of the methodology and scope of the research and assessment. The needs assessment consulted with a wide range of service users, carers and family members who are affected by substance misuse. Additional work was undertaken to capture the views of those who do not currently use services or are treatment naïve.

The completed report benchmarked West Lothian ADP against Falkirk as this area was similar in context over a number of key areas. Both West Lothian and Falkirk are classified as “urban other” reflecting their semi rural status. Other similarities included life expectancy, employment and deprivation statistics. WLADP has decided to continue to benchmark against Falkirk for the duration of the delivery plan and this is a key feature in measuring our performance in the core indicators of this plan.

Figure 1 below demonstrates the process of the Needs Assessment and highlights the use of mixed methodology of quantitative information and qualitative information with a range of sources.

Stage 1	**Method**	
Review of existing datasets	Desk-based review of national and local datasets	
Stage 2	**Method**	**Sample**
Quantitative Survey	Online Survey	Managers of all specialist drug and alcohol services in West Lothian
	Case record audit	Random selection of 20% of each services case records
Stage 3	**Method**	**Sample**
Qualitative Surveys	Online Survey	All specialist service staff
	Paper-based Survey	Service users Non-service users
Stage 4	**Method**	**Sample**
Qualitative Survey	Semi-structured interviews	• Stakeholders • Providers
	Focus Groups	• Service users • Family members
Stage 5	**Method**	
Gap Analysis	Desk-based comparison of range and capacity versus need	
Stage 6	**Method**	
Analysis & Reporting	Completion and delivery of report	

Figure 1: - Process of WLADP needs assessment

The needs assessment produced six key recommendations which now form the basis of the next Joint Commissioning Plan and Delivery Plan 2015 – 2018 and inform all future commissioning decisions. These recommendations are:

1. The ADP should develop a clear framework for how service users and their families should be involved in the delivery, development and commissioning of drug/alcohol services

2. In West Lothian there is a disproportionately low level of work with couples, families and carers. Further work is required to identify a range of measures to complement the existing provision in the area.

3. All services should support the development of multi-agency protocols and pathways for people with mental health and substance misuse problems. This would include an appraisal of the training needs of staff working across these areas.

4. There should be a greater emphasis placed on the delivery of high quality psychological therapies, with adherence to evidence-based, manualised approaches with appropriate supervision arrangements in place.

5. Consideration should be given to re-establishing a substance misuse nurse liaison role within St John's Hospital to engage with patients with drug or alcohol related illness or injury.

6. The ADP should work with service providers to develop a quality improvement cycle based on the quality principles which incorporates both internal and external audit processes.

The ADP partnership has committed its resources to implement the recommendation within the needs assessment within the strategic direction of the group and its commissioned services.

3. Governance and Financial Accountability Arrangements

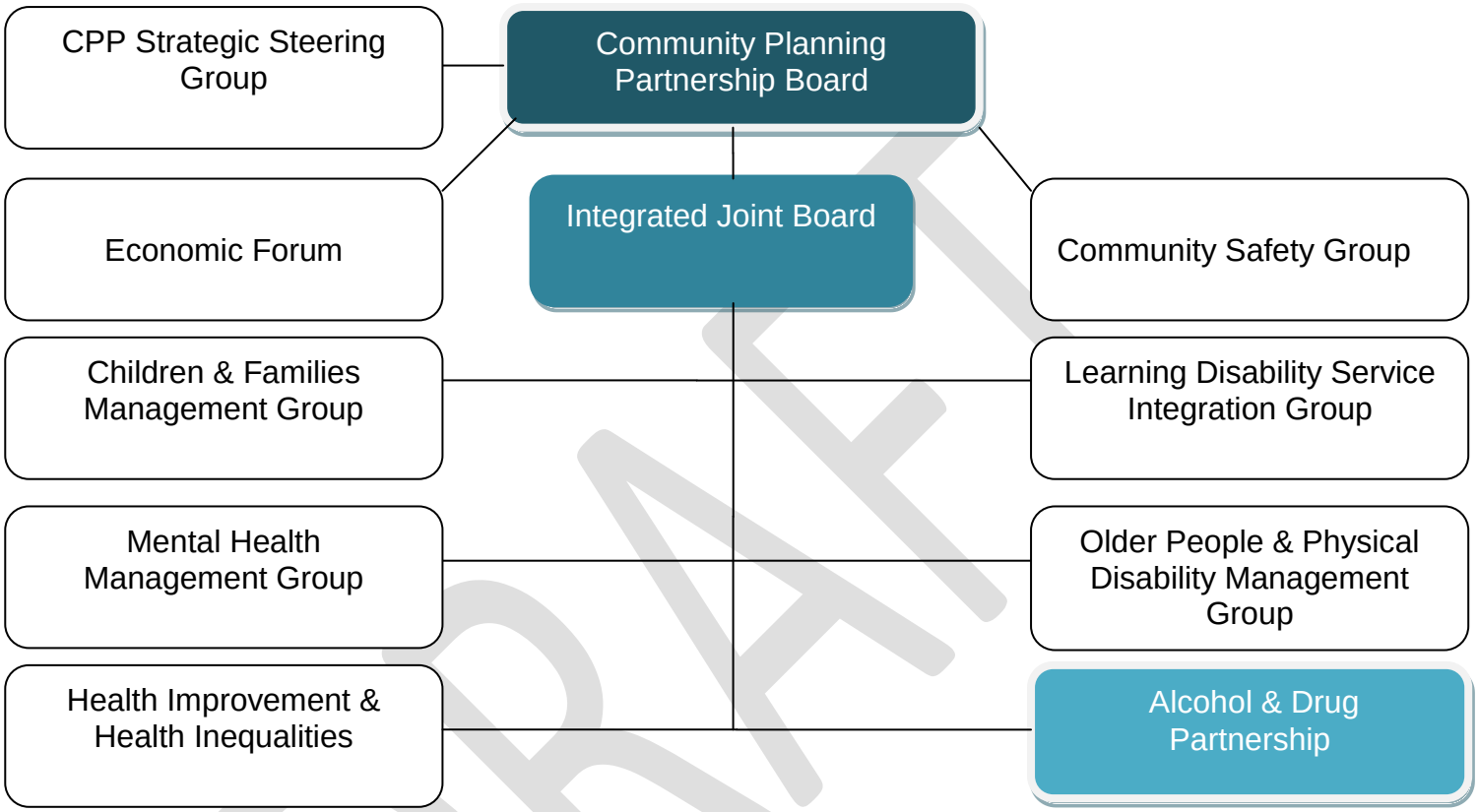
Outcomes and monitoring are included in both the Single Outcome Agreement (SOA) and in the HEAT targets and standards. The SOA 2013-2023 sets the strategic direction upon which the plans and strategies of community planning partners should be based and the national ADP outcomes have been aligned to our local SOA outcomes. The principal line of accountability is into the Community Planning Partnership (CPP) through the Community Health and Care Partnership (CHCP) sub-committee which will be replaced by the Integrated Joint Board (IJB). All key strategic plans including the Joint Commissioning Plans and Delivery Plans area approved by the IJB and key changes in strategy or policy are approved by this board.

Additional reporting on activity and trends are reported into the CPP either directly or through the Community Safety Partnership Board, West Lothian Council's Policy Scrutiny and Development panels and within the NHS. West Lothian ADP operates at both strategic and operational levels and includes representation from key agencies at all levels. Over the last year the partnership has sought to increase its membership to

include a wider representation of those who work with our service users. These have included agencies that provide benefit advice and support and advocacy services.

Financial governance around processes sits with West Lothian Council following their policies for contractual decision making through the ADP operational group's structure.

Figure 2. West Lothian Community Planning Partnership Governance Structure.



4. National Support and Partnership Working

West Lothian ADP makes full use of a number of national bodies in order to deliver on its outcomes, recognising the unique support that can be offered by these agencies:

National ADP Advisors:

- To provide guidance and support for annual reports and for production of delivery plans
- To offer direction and facilitate responses to reviews and including ministerial priorities
- To offer advice and support in meeting HEAT standards for ABI delivery and Alcohol and Drug Waiting times

Alcohol Focus Scotland:

- To assist in the development of alcohol overprovision report to the local licensing board
- To provide support and guidance on whole population approaches to be included in the Delivery Plan 2015 -18.

Scottish Drugs Forum:

- To assist in the review and the development of the local Naloxone programme;
- To assist in the development of recovery for service users through the Addiction Worker Training Programme.

Scottish Families affected by Alcohol and Drugs:

- To support in the development of outcomes for family and carers accessing services for support;
- To assist in set up and maintenance of family support groups;
- To offer mapping and gap analysis for family support throughout West Lothian.

STRADA

- To co-ordinate development of the Drug and Alcohol Workforce
- To offer and evaluate training undertaken as part of the Workforce Development Strategy.

5. Delivery Plan - Workstreams

For this plan the partnership has recognised the key difference between preventing substance use problems and intervening early to prevent further harm from substances use. To reflect this distinction the partnership wishes to increase its workstreams to four to reflect that different strategies and approaches are needed, though for convenience this is still contained within the one logic model.

The four workstreams are:

1. **Prevention**
2. **Early Intervention**
3. **Recovery**
4. **Community Safety**

5a. Prevention

Logic Model – Appendix 1

ADP National & Local Outcomes

Prevalence, Health, Families, Local Environment and Community Safety

Prevention work must focus on two levels of work, focusing on approaches which will affect the whole population's attitude towards consumption of alcohol and directing prevention work towards those who are most at risk.
In line with the Christie Commission's (Scottish Government 2011) key priorities "*Emphasis on early intervention and prevention by moving resources upstream",* the partnership has increased its commitment and resources to preventing substance misuse developing with those who are most at risk. The role of prevention is also recognised in the West Lothian's Single Outcome Agreement Prevention Plan. The local prevention plan outlines a collective approach to the prevention agenda across the CPP. One of the key priorities has been to identify possible gaps in existing service provision, or opportunities for earlier work that would reduce demand, or avoid or delay the need for more expensive reactive interventions at a later point.

For West Lothian ADP, work in this area will focus on whole populations and also reach certain targeted groups including early years, children and young people and key work is detailed below:

Whole population approaches will include:

- Encourage substance misuse education, prevention, early intervention and support policies to be developed for educational establishments, workplaces and voluntary sector organisations. Engaging with healthy working lives to support a consistent approach and reduce duplication.

- Work in partnership with the licensing forum, senior health promotion specialists within the NHS and Alcohol Focus Scotland to develop a comprehensive report of evidence to support the adoption of an overprovision statement.

- Continuation to build a body of evidence in relation to the social, health, mental health and community harms caused by the overuse of alcohol in West Lothian.

- ADP support team to engage with and work in partnership with the West Lothian Licensing Forum to offer support on the five licensing objectives as detailed in Scotland's licensing system.

- Workforce development around non-traditional staff coming into regular contact with those affected by substance misuse in order to take action to prevent substance misuse issues developing.

- Working closely with Police Scotland colleagues to support the "Best Bar None" initiative.

- To continue funding the prevention project with Young People managed by Community Action Blackburn.

The work with targeted groups will include:

- The partnership will explore ways of working with maternity and health visitors and targeting the additional resources (0.5 FTE midwife and 0.5 FTE Health Visitor)

from NHS Lothian towards vulnerable pregnancies at risk of foetal alcohol syndrome and neonatal abstinence syndrome.

- Promoting the use of Rory and Oh Lila in primary and nursery schools across West Lothian.

- Commissioned service with West Lothian Alcohol and Drug service (WLDAS) will develop a learning resource pack for primary schools in partnership with Fallahill Primary school and West Lothian Education service to be rolled out across West Lothian in year 2 and 3 of the delivery plan. This school is in an area of deprivation where alcohol and drug prevalence is higher than some other areas of West Lothian.

- Resilience, coping skills and confidence training as part of a substance misuse approach for secondary schools and youth services, clubs and uniformed organisations commencing with a pilot in Whitburn Academy. This will primarily focus on education and information about new psychoactive substances. Again this school was chosen as it is based in a ward where alcohol and drug prevalence is high.

- Alcohol Diversion Fund is grant funding provided by West Lothian Council to all wards to ensure that hard to engage and at risk young people are provided with alternatives to drinking alcohol, are encouraged to change attitudes towards alcohol and are signposted to relevant services to meet their needs.

- Ensure that substance misuse education is included in detached youth work and other youth focused interventions with groups who may be at increased risk of substance misuse and its associated risks for young people.

- Circle/WDLAS contracted Family Recovery service adopts a whole family approach to prevent the continued cycle of social isolation and service deprivation for those families affected by substance misuse. This service works with parents to ensure that children still meet outcomes relating to the NICE indicators for excellence and to prevent children and young people's exposure to the risks of developing a substance misuse issue into their adolescence and adulthood.

- Carers of West Lothian's dedicated young carer's project has been resourced for a one year pilot to offer carer's support to young people who are caring for a parent or relative who is misusing substances with the aim of preventing the risk of these young people developing a substance misuse problem.

- Social Norming activities in partnership with NHS Lothian Public Health Specialists, Voluntary Sector and Education Department to address the peer pressure around and the misconception of the prevalence of alcohol use amongst West Lothian's young people.

Prevention Funding Table

INITIATIVE	SERVICE	ADP SG Funds per annum	ADP WLC Funds	ADP NHS Funds
Workforce Strategy development	STRADA	£26,000		
Community Action Blackburn Initiative	Community Action Blackburn	£17,675		
Rory and Oh Lila Learning Resource	Alcohol Focus Scotland	£10,000 (1st Year)		
WLDAS Primary School learning resource pack	WLDAS	£7,590		
WLDAS training in Secondary Schools (NPS)	WLDAS	£7,776		
Whole Family Support	Circle		£94,385	
Carers of West Lothian Young Carer's Substance Misuse Project	Carers of West Lothian	£35,000 (pilot)		
Social Norming Project	Voluntary Sector Provider & NHS Lothian	£20,000 (pilot)		
ADP Support	ADP Support	£20, 917		
TOTAL		**£144,958**	**£ 94,385**	**£ -**

5b. Early Intervention

Logic Model – Appendix 1

ADP National & Local Outcomes

Prevalence, Health, Families, Community Safety and Local Environment

Problematic alcohol use is one of the greatest causes of health and social harm in West Lothian, and our central priority remains addressing alcohol consumption across all sectors of West Lothian society by continuing work around early identification and intervention with those beginning to develop problems. We will continue to offer ABI and referral to treatment services to those in police and prison custody, those attending A&E, young people involved in youth diversion work and older people.

In terms of drug use, the ADP will continue to work closely with young people experiencing deprivation to prevent experimental and recreational drug use from developing into physical and psychological dependence, thus preventing potential harm to the individual, their families and the wider community.

The ADP also reinforces its commitment to work with those who are not yet in recovery to minimise the harm caused by substance misuse by intervening early to reduce the continuation of behaviours leading to further harm. This work will also continue to promote the benefits of recovery.

Whole population approaches under the early intervention elements of this plan are:

- To implement and support the work of the newly formed Substance Misuse Policy in Schools working group. This group plans to reform West Lothian Council's Substance Misuse in Schools Policy and provide better links to the ADP and providers.

- Support Alcohol Brief Interventions (ABIs) for those who are drinking heavily but not in need of treatment both via the ABI Local Enhanced Service and ADP contracted service. This work will have a focus on those in deprived areas reflecting the correlation between binge drinking and deprivation. This will result in training for prison staff and those working in primary care.

- To continue to support the ABI programme in training Social Work, Health and Voluntary Sector staff in the delivery of ABI and to support new ways of recording this work.

- Continue to support early intervention work completed by Community Action Blackburn and its community projects for a further year. This work had outcomes around addressing young people's attitudes to alcohol and developing a community that supports low level use of alcohol.

- Work to address professional and social stigma towards those who misuse substances via the partnership work involved in the STRADA Workforce development strategy.

- Continued development of a body of evidence to support the need for an overprovision statement enabling the local licensing board to demonstrate its commitment to the five licensing objectives.

Early intervention work also focuses on specific targeted groups including those who have additional vulnerabilities such as mental health, young people, older people and offenders. During 2015 -18, the ADP aims:

- To continue to provide counselling, support and referral to treatment for young people and young offenders from the ages of 12 to 25 who are misusing substances.

- To continue to provide a direct addiction service to West Lothian Council's Early & Effective Intervention project which is a multidisciplinary referral group working to

act quickly and early enough to divert children and young people from criminal activity often associated with the use of substances

- To commence the Young Almond Project which provides intensive one to one support to young women who are involved with risk taking behaviours, anti-social behaviour and misusing substances causing increased levels of harm.

- An older people's project in partnership with Adult Social Work teams to deliver ABIs and early intervention work with those whose alcohol use is resulting in poorer outcomes for physical and mental health.

- To continue to fund the voluntary sector's Alcohol Liaison service at St John's hospital. This work intervenes with those who have had an alcohol related incident or accident causing a presentation at A&E or hospitalisation. The Needs Assessment highlighted an approach for this work to be co-ordinated with the work of the NHS and this will be developed further during the delivery plan.

- To sustain the tenancy support offered by West Lothian Council to those with mental health and substance misuse focusing on early intervention and preventing loss of housing or other problems significantly worsening as a result of substance use.

Some early intervention work includes the reduction in health harms caused by substances. This involved employing harm minimisation work to prevent the health and/or housing or financial situation worsening for these individuals. These include

- Continuing ADP funding for the Specialist Alcohol Service in partnership with the West Lothian Council. This service offers social work assessment of needs where chronic alcohol use has resulted in difficulties with day to day living skills or self-neglect, posing significant risk of hospitalisation or homelessness. These clients often have poor physical/mental health and do not respond well to traditional methods of treatment for their alcoholism. Work focuses on providing a care plan to intervene early enough before capacity, mental and physical health deteriorates beyond reparation.

- To continue to fund in partnership with NHS Lothian the needle exchange programme as part of the NEON bus and the pharmacy exchange. These provide injecting equipment, advice on injecting, naloxone delivery and encouragement and assistance in accessing treatment and other support.

- To continue to work in partnership with NHS Lothian with the Blood Borne Virus Prevention group and to ensure all clients with drug use are informed of where they can access immunisation against hepatitis B and prevention advice from contraction of all Blood Borne Viruses.

- To continue to part fund the Pan Lothian Drug Related Death Review Co-ordinator and to ensure that the prevention action plan is delivered in West Lothian. This work includes the Take Home Naloxone (THN) Programme and the assertive outreach response to non-fatal overdoses.

Early Intervention Funding Table

INITIATIVE	SERVICE	ADP SG Funds	ADP WLC Funds	ADP NHS Funds
Young Almond Initiative	WLC		£50,000	
Specialist Alcohol Service	WLC		£22,173	
Drug Death Co-ordinator	NHS Lothian	£8, 000		
Harm Reduction Service	NHS Lothian	£19, 631		
ABI Delivery Programme	WLDAS & NHS Lothian	Funds included in Moving On Contract		
ADP Support	ADP Support	£20, 919		
Family Recovery Service	WLDAS	£91,985		
ABI Specialist Support Service	NHS Lothian			£11, 000
Local Enhanced ABI Delivery Programme	NHS Lothian			£74,000
TOTAL		**£140, 535**	**£72,173**	**£85,000**

5c. Recovery

Logic Model – Appendix 2

ADP National & Local Outcomes

Recovery, Health, Families, Community Safety and Services

The ADP remains committed to recovery and the definition provided in the Road to Recovery, 2008 “a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society**.** Furthermore, it incorporates the principle that recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment**.** In short, an aspirational, person-centred process**”.**

This ADP delivery plan has been shaped by both national and local drivers such as the Christie Commission report, the Road to Recovery and Changing Scotland's Relationship to Alcohol.

Work during the last delivery plan focused on the three principles of recovery encouraging every treatment/rehab service to recognise that recovery is the ultimate aim and the ADP should provide many routes to recovery. This evolved during the life of the plan to a full service redesign to lay the building blocks for a recovery orientated system of care including an easier access to services, a re-commissioning process to develop services which placed recovery at the heart of the organisation, challenging providers to review practices against the evidence base and recognising the value of family inclusive practice. Over 2013, the ADP with its partners has focused on ensuring that recovery is not only core to our model of care but that the system is robust and sustainable.

The needs assessment conducted last year, included a review of the four key recovery services and their adherence to the ROSC principles. This has provided a baseline for the ADP and commissioned services ensuring that those seeking recovery are offered the highest levels of care in order to achieve and sustain recovery. The ADP has established a ROSC Quality Assurance group to address parts of the care system which are not fully adhering to the quality principles and to achieve excellence through continual monitoring and review. Work is currently underway to invite service users as part of the standard membership of this group. It is expected that this portion of the Needs Assessment will be repeated to ensure a culture of continuous improvement within the ADP and its commissioned services.

The ADP intends to recommit to the recommendations within the Opiate Replacement Therapy (ORT) review and has chosen to redefine its ORT aim to "Reduce drug related deaths by 15% by 2018". The ADP has a bespoke action plan to address this and works on a pan Lothian basis with the NHS Lothian/ADP Drug related Death Steering Group. The role of this work is to continue to review deaths, create preventative actions and evaluate and measure the effectiveness of this plan.

West Lothian has a growing recovery community with a number of active mutual aid groups which meet on a regular basis. All ADP commissioned services are encouraged to ensure that all services users are supported to attend mutual aid groups as well as participating in service user involvement activities.
The needs assessment consulted a broad scope of service users and included those who disengage or have never engaged with services. The concluding report highlighted areas of improvement for the ADP and a move from consultation to collaboration with those who have lived experience is clearly the next step for the ADP. A series of rapid improvement events in a conversational café style are organised over the summer of 2015. It is planned that from this the ADP can move forward in a more collaborative approach and work together with service users to provide the right opportunities to work in partnership with the ADP and the services.

More specific ADP recovery work around whole populations is included below:

- Continued development of a workforce strategy including ADP providers, partners and wider stakeholders. This will involve a commitment from the ADP and partners to address gaps within current knowledge, skills and competencies especially in

line with the ROSC Quality Principles. It is expected that this work will increase access to services and improve the number of those experiencing recovery.

- Commitment to increase the visibility of recovery in all communities within West Lothian by engaging with those in the local environment via a stronger ADP social media presence and increased engagement in positive news stories about recovery and the work of the ADP.

- To engage communities in recovery work by creating recovery sites or spaces that are accessible to all and that include members of the community not directly affected by substance misuse. This approach should address the stigma in communities and create communities that support and increase individuals in recovery.

Work focusing on targeted groups within the next three years will include:

- A whole family approach to support and reduce the number of children affected by substance misuse (CAPSM). This service is a partnership between Circle and WLDAS with Circle providing support to family members and WLDAS working with children and Young people who have developed their own substance misuse problems and associated risk taking behaviours.

- WLADP will continue to commission services focused on providing recovery for adults who are misusing substances. Most of these services work in partnership forming the Addiction Care Partnership. This is a fully established ROSC approach to enable clients and patients the best opportunity to recover fully from problematic substance misuse. The key features are:

    i) Quick access via self referral at numerous Breakaway drop in clinics operating at different sites and times across West Lothian. Flexible services offering out of hours appointment and appointments in service users' homes enabling all access recovery;
    ii) Services across WLC, NHS Lothian and voluntary sector using the most recent high quality and evidenced informed interventions to enable change and progress forward in the recovery journey;
    iii) A strength based assessment offered to all clients which recognises the service user's abilities to recover and provides choice in the route for the route recovery. This varies from one to one counselling support, pharmaceutical intervention, recovery coaching, motivational interviewing or peer recovery support via mutual aid meetings. This list is not exhaustive and more detail is provided in the Recovery Logic Model in Appendix 2;
    iv) To protect the rights of service users by ensuring that all staff are appropriately qualified for work undertaken and demonstrate attitudes that support and promote the recovery of the service user. This activity occurs at operational level within the organisations but also as part of the ADP's contract monitoring responsibilities;
    v) Expectations that recovery plans are present for all clients/patients which look at other issues impacted by substance misuse. This should be person centred and considered a living document owned by the person on their recovery journey;

vi) It is expected that these are regularly reviewed to ensure that the desires of the service user are still relevant and that work is planned to meet these goals. This information is also shared anonymously with the ADP as part of contract and service monitoring. The Needs Assessment highlighted an inconsistency with reviews which will be amended by the ADP Quality Assurance group processes which has responsibility for ROSC compliance across the ADP;

vii) The ADP and its service providers are working towards a service user informed ROSC where all service users' voices are sought and heard. A number of providers have in place service user steering groups which are part of continuous improvement and including service users in the delivery of their service;

viii) All services seek to include family members at the request of the service user as part of best practice. This often involves education and information to help the family member to support recovery and understand the process of change but also to meet their needs as part of their own recovery.

- WLADP will continue to provide a specialist service for parents affected by substance misuse to promote the needs of children and young people living with a parent or parents who misuse substances and support recovery for this group as the most effective means of addressing the risks posed to children.

- WLDAS have recently been awarded a contract for providing psychological support to those affected by another's substance misuse. There are also a number of other services and groups working in partnership with the ADP which work exclusively with family members and carers to provide individual support. Work is planned with Scottish Families affected by alcohol and drugs to develop an outcome framework to measure the success of this work.

- WLADP has sought to strengthen its relationship with Carers of West Lothian with an intention to provide training for Take Home Naloxone and other education and information in the next year.

- Specialist groups who have additional vulnerabilities are a continuing priority for the WLADP and bespoke services will be funded during the delivery plan. These include:
    i. WLDAS Moving On Service which works with vulnerable groups including those who regularly present at A&E, short term offenders, those at custody suites, older people and those affected by mental health difficulties. This service adopts an assertive outreach approach as it is likely that these groups will not access service through the self-referral route. This service also works from multiple sites including the Job Centre to provide easier access for those seeking recovery and to train and support the non-traditional workforce.
    ii. WLDAS/Circle Family Recovery Service which works with young people experienced substance misuse problems.
    iii. Domestic And Sexual Assault Team a West Lothian Council service providing support to women and children affected by domestic violence

and sexual assault who are at risk from developing substance misuse problems.

iv. ELCA HMP Addiewell service offering counselling support and ABI delivery to all prisoners who have experienced alcohol or drug problems as part of their offending. The ADP has worked in partnership with NHS Lothian to extend this service provision to all prisoners within HMP Addiewell for all substance including NPS.

v. Specialist Alcohol Service offering care support to those who are most vulnerable to self-neglect, homelessness and are often subject to adult protection procedures

- Within the next three years the ADP plans to work closely with Mental Health colleagues to develop more robust referral routes to addiction services and prevent vulnerable service users with dual diagnosis not receiving follow up in the community. This will encourage recovery within this client group and also support harm reduction strategies in terms of Alcohol Related Brain Damage (ARBD).

- The ADP continues to fund and support the Lothian & Edinburgh Abstinence Programme. This service offers residential rehab to those affected by substance misuse issues followed by a two year after care programme.

- The ADP is working closely with NHS Lothian and other stakeholders in a service redesign of the Ritson Inpatient Detoxification Service. This will incorporate the ROSC principles and will improve alignment with after care and recovery opportunities in the community for service users post detox.

- The ADP continues to seek new and innovative ways of working inclusively with Service Users. This includes continuing to fund the Addiction Worker Recovery Training Programme provided by Scottish Drug's Forum on a year on year basis. The development of peer and volunteer opportunities in most of our services including the Recovery Service, NHS Lothian and WLDAS. The establishment of West Lothian's first service user Recovery Café in Linlithgow, funded partly by the ADP.
  In the last year WLADP has worked closely with Learning Disability Service Development Officer to develop an advocacy service for those affected by mental health and/or substance misuse. This service will assist ADP service users to develop an independent voice to question and challenge the service that are provided to them.

- The ADP has made a commitment to develop and build upon the success of Cyrenians Recovery Service using a Public Social Partnership model. It is expected that the Needs Assessment will form the basis of some of this work and this process should result in an improved moving on/after care service for those in recovery who wish to build a non-substance using lifestyle by maintaining their positive relationships, contributing and supporting the recovery of others and gaining skills to support their employability. It is planned that a new service will be in place during 2017.

Recovery Funding Table

INITIATIVE	SERVICE	ADP SG Funds per annum	ADP WLC Funds per annum	ADP NHS Funds
Recovery Service	Cyrenians	£250,000		
NHS Addiction Service	West Lothian NHS Addiction Team	£372,026		
Therapeutic Support Service	WLDAS	£484,927		
Moving On Service	WLDAS	£187,150		
Service User 1st Step Recovery Café	Linlithgow Service User Group	£1,000		
SMART Co-ordinator Support	SMART UK	£8,000		
Treatment Capacity		£60, 000		
ADP Support	ADP Support	£20, 917		
Advocacy Support Service	MHAP		£25, 000	
HMP Addiewell Counselling Service	ELCA		£35, 000	£67, 200
Domestic Abuse & Sexual Assault Team	WLC		£118,170	
Social Work Addiction Team	WLC		£275,796	
Addiction Worker Training Programme	Scottish Drugs Forum		£20, 792	
LEAP Residential Rehabilitation	NHS Lothian			£108, 000
Inpatient Alcohol Detoxification	NHS Lothian			£97,800
Substance Misuse Directorate	NHS Lothian			£193, 652
TOTAL		**£1,384,010**	**£474, 758**	**£466, 652**

5d. Community Safety

Logic Model – Appendix 3

ADP National & Local Outcomes

Community Safety, Local Environment, Health and Prevalence

The ADP recognises that within this stream of work partnerships must be integral and robust as community safety sits across several organisations within West Lothian. To this aim the ADP sits and provides updates to the West Lothian Reducing Reoffending Committee, the monthly Police Scotland Tactical and Co-ordinating meeting and the Child Protection Committee. The ADP also reports on a quarterly basis to the Community Safety Board sharing information across joint indicators about recovery and licensing provision in West Lothian.

Within the next delivery plan WLADP will undertake work with partners on a whole population basis:

- To provide support to the "Best Bar None initiative administered by Police Scotland to ensure that licensees are following best practise in regard to the five priorities within the Licensing Act.

- To offer support for Police Scotland with their "Campaign Against Violence" which focuses on tackling the problems caused by party houses where alcohol and drugs are a main feature.

- To develop with partners including Police Scotland a comprehensive report to support the development of an overprovision statement ensuring that local communities most at risk from alcohol related offending are protected by a reduced level of availability and consumption.

The ADP will continue to commission service for specific groups who are at high risk of committing offences due to the alcohol consumption

- WLDAS' Moving on Service* which has a remit to work with prisoners on remand or serving short sentences to prevent continuance of involvement with criminal justice agencies through repeat offending. This is a prison in-reach service providing easy access to service in the community and preventing lapse and/or relapse for those liberated from both HMP Addiewell and HMP Edinburgh.

- To improve the links between NHS Services for those being liberated from HMP Edinburgh and HMP Addiewell to ensure that there is a continuance of ORT therapies and reducing the likelihood of lapse and relapse.

- To contribute to the delivery of an ABI programme* in partnership with NHS Health Scotland and NHS Lothian for all those in custody suites arrested or charged with an alcohol related offence including violent offending.

- To provide with our partners NHS Lothian a psychological therapy service* to all prisoners in HMP Addiewell affected by alcohol or drug use especially where this was key feature in their offending behaviour with the aim of reducing reoffending.

- To fund a Young Almond Project* working with young women who have problematic substance misuse issues and are also involved in risk taking behaviour including offending.

* Funding for these services is included in other funding tables

6. ADP All Workstreams Projected Funding Table per annum

Below is the projected spend for the delivery plan per annum. This figure is likely to vary in years 2 and 3 as some projects are pilots and may not continue through the remainder of the plan. Expenditure is also subject to variation on a yearly basis dependent on income allocation from Scottish Government and West Lothian Council.

WORKSTREAM	ADP SG Funds	ADP WLC Funds	ADP NHS Funds	Total
Prevention	£144,958	£ 94,385	£ -	£239,343
Early Intervention	£140, 535	£72,173	£85,000	£297,708
Recovery	£1,384,010	£474,758	£466,652	£2,325,420
TOTAL	**£1,669,503**	**£641,316**	**£551, 652**	**£2,862,471**

7. Ministerial Priorities

Workforce Development

The Joint Scottish Government and COSLA statement "Supporting the development of Scotland's Alcohol and Drug Workforce" sets the aim of identifying a range of actions that are required to ensure that Scotland has a confident, competent drug and alcohol workforce which has a shared value base that is focused on improving the outcomes for individuals, families and communities. The statement also sets out learning priorities for all levels of the drug and alcohol workforce. ADPs, professional bodies and all the partnership agencies will have a role in the progression of this area of work. In July 2014, WLADP collectively agreed to commence work with STRADA to develop a comprehensive strategy for workforce development incorporating all partners to support a ROSC beyond the ADP service providers.

West Lothian ADP has completed stage one and stage two of the workforce development plan, with Stage three currently in development

Phase One

In October, WLADP hosted a joint event with Mid and East ADP bringing together strategic partners across both areas. This workshop focused on the development of high level outcomes for the development of the workforce. This produced 20 outcomes of short, medium and long term levels.

Phase Two

The second stage involved workforce consultation. West Lothian ADP organised two events in December 2014 and invited operational members of staff from West Lothian Council, NHS Lothian, voluntary sector alcohol and drug services, HMP Addiewell, Police Scotland and various tenancy support agencies. These workshops examined the practical implications of the outcomes established in the first stage. The participants also considered the activities and the reach which underpin the achievement of the outcomes.

STRADA has developed a West Lothian specific logic model which underpins the process and work during the third phase of the plan.

Phase Three

This involves a small working group developing a series of indicators to measure progress of the outcomes. This work has commenced but is in its early stages. It is planned that this work will be completed during the first year of the delivery plan. The ADP has made a funding commitment to activities which will enable it to reach its outcomes and improvement goal. The indicators will be used to assess the progress made on any training or staff development over next three years of this plan.

Opioid Replacement Therapies

In August 2013 the independent group, commissioned by the Scottish Government to gather evidence on opioid replacement therapies (ORT) for people with drug problems, published its recommendations.

WLADP has recognised the six key themes and implemented changes to the Recovery Orientated System of Care to incorporate the 12 recommendations made in the report.

In West Lothian we have already undertaken a great deal of work in terms of service redesign activities and commissioning to improve local service delivery and ensuring we have the right element in place for ROSC. In the last two years we have re-commissioned four services providing the opportunity to incorporate the quality principles in the service specifications and to re defined outcomes that focus entirely on recovery. The first tender focused on engaging and providing a service to vulnerable groups – some hard to reach - with substance misuse issues to address health inequalities and social exclusion. This incorporates prisoners, older adults, mental health and women. A new psychological therapy service due to commence in April 2015 will focus on providing high quality, evidenced informed therapeutic interventions to support those who are also engaging with Opiate Replacement Therapy. All clients are entitled to receive a strength based assessment, a comprehensive recovery plan which can include their families and regular reviews measuring progress and enabling a change in direction. The tendering process involves partners across the ADP partnership and also representation from service users both in the development of the service specification and in the evaluation of the bids.

WLADP intends over the next 18 months to re-commission the recovery through care/after care service using a Public Sector Partnership approach with the support of the Scottish Government Joint Improvement Team. This involves partners, stakeholders, those who are not currently commissioned by the ADP and service user representation. This process will allow the WLADP to fully develop services which adhere to the Self Directed Support Legislation. Alongside this it is planned that this process will deliver some real benefits and improvements to the ADP partnership and the delivery of this key service. These are:

- **Common interest** supersedes partner interest
- Treating all partners as equals
- **Mutual accountability** for tasks and outcomes
- **Sharing** responsibilities and successes
- Striving to develop and maintain **trust**
- **Willingness to change** what we do and how we then do it
- Pull together **collective strengths** to develop **innovative options** to help achieve and **maintain recovery** for those affected by substance misuse by producing **real outcomes through collaboration**
- Continued development of a **recovery community** based on the **real needs and wants of those with lived experience**
- Support **a preventative and early intervention** agenda
- Opportunity to develop **personalisation** in service delivery for service users in line with Self Directed Support legislation.

ORT Key Statement Aim

In 2013 the ADP agreed a key statement aim for ORT:

"By the end of 2016, 100% of all services users who receive substitute prescribing within West Lothian will be reviewed and have a working individual recovery plan in place".

There has been work conducted by the Cyrenians recovery service and primary care to meet this aim. This has involved identifying all those individuals being prescribed under the NES contract who may benefit from an assessment and review of their recovery needs. It is anticipated that this initiative will support those who are in receipt of treatment but not previously been proactively supported into benefitting from all of the potential recovery opportunities in West Lothian. This project is being conducted on a pilot basis with two GP practises as such it is unlikely that the ADP key statement aim can be fully recorded for all those accessing ORT treatment. The ADP will explore a different approach to achieving this aim and recording its performance.

The ADP has agreed to set a new ORT key statement for 2015 -18 delivery plan:

- **ORT aim for 2015 – 18: To reduce the number of drug related deaths by 15% each year**

Work has commenced on this under the West Lothian Drug related Death prevention plan and key work includes continuing to collect and monitor data about each death in West Lothian, to increase coverage of Naloxone beyond the 25% target and follow up non-fatal overdoses under a sharing protocol agreement with the Scottish Ambulance Service. The ADP providers have agreed to respond to non-fatal overdoses as referrals using an assertive outreach approach recognising that the best route to prevent drug related deaths is engaging people with recovery.

New Psychoactive Substances (NPS)

The prevalence of new psychoactive substances and services capacity and ability to respond to this emerging need was assessed within the scope of the WLADP Needs Assessment. The report concluded that NPS is becoming an increasing feature of clients presenting at drug services, A&E and mental health services. In terms of the need for service provision this is still unclear although a number of service providers and other stakeholders expressed concern about current prevalence and a lack of information within Lothian.

The ADP has made a commitment to continue to:

- Improving our knowledge and understanding of NPS use and its impact locally. Organisations are required to submit a pro forma on the use of NPS. This included providers and other services working with young people;

- Improve our responses to those using NPS by ensuring frontline staff have the knowledge and skills to support them and also by ensuring we have a clear pathway to support and advice for users who need it. In particular the ADP will look at training and awareness raising events for frontline staff. The ADP has worked in partnership with Crew 2000 to provide three training sessions in the last year on NPS to Criminal Justice staff, Alcohol and Drug Service, Police, HMP Addiewell, Education Partners and Social Work staff

- WLADP have opted to take a prevention and early intervention approach to NPS which is fully supported by our key partners NHS Lothian and Police Scotland. This means exploring what local measures can be taken to address the supply and usage of NPS. For example, partners in the Police Scotland and Trading Standards to consider what potential legislative and enforcement options might be available. The ADP will also review what effective prevention interventions might be available. The ADP will explore with our colleagues in education and health promotion what other specific steps can be taken to prevent young people from experimenting with these substances.

- Work in partnership with our commissioned service WLDAS with the Education department to develop a bespoke learning and information package for delivery within West Lothian Secondary Schools. This is currently in the pilot stage in one school with plans to roll out the learning resource following an evaluation.

- Collaborate with Pan Lothian colleagues and NHS Lothian on core messages for service users and front line staff. This includes recent changes to legislation, harm minimisation advice, self-care and access to recovery.

- Support and contribute to the West Lothian NPS working group established by WLDAS to co-ordinate local response based on analysis of information gathered and to work in partnership with all stakeholders on early intervention and prevention strategies.

The ADP commissioned a new service commencing on 1st April 2015 to provide psychological therapy and support to those affected by alcohol and drug misuse. This contract also includes a provision for responding to changes in substance misuse trends and increased prevalence of types of substance used. WLADP have contracted this service to be the primary service to develop an NPS specific service should prevalence increase to such a level.

Service User Involvement

Service User involvement remains a priority for the WLADP. In the 2014 Needs Assessment, the process involved seeking the views of those who are currently using services, have never used services or are previous users. Individual service users and

service user groups were consulted throughout West Lothian including family support groups for their views on prevalence, health, recovery, service delivery and their own involvement with the services commissioned on their behalf.

The Needs Assessment reached one recommendation specifically in regards to the development of service user involvement:

"The ADP should develop a clear framework for how service users and their families should be involved in the delivery, development and commissioning of drug/alcohol services".

The ADP Needs Assessment made further observations based on the views of service users consulted during the assessment period:

- 'There are a lot of people in West Lothian desperate to be in recovery. Given the right opportunities the recovery community will continue to grow and become more vocal and influential.'
- 'Be active in service user involvement groups to inform services what is needed. Train as SMART facilitators
- Work with their key worker to produce a personal recovery outcome plan.'
- 'Meet people in recovery, attend mutual aid or recovery focussed activities every week. Build recovery capital etc.'
- 'Be open to what is available in the local community.

The ADP had conducted a review of their approach to service user involvement following the principles within the "Hear our Voices" A framework for service user and carer involvement in drug and alcohol recovery services in the Lothians developed on behalf of the pan Lothian ADPs in 2012. The review concluded that in some key areas such as suggestions boxes/feedback boards, consistent communication to service users and carers of opportunities to share views, progression opportunities within and between services for peer supporters/ mentors/ researchers and a calendar of activities bringing service users and commissioners/planners together the ADP had made significant progress and needed to continue to build upon these activities moving forward into the 2015 -18 plan. However the ADP had failed to establish a calendar of events enabling service users and carers to take part in peer or volunteer activities nor had the ADP managed to develop an agreed cross-sector protocol on seeking views of carers.

Despite this the ADP has conducted some key work for service user involvement including funding expenses for a service user group to meet and attend Recovery related conferences and training, widespread consultation with service users in the development of a new service specification including the involvement of a service user in the evaluation panel and funding for a service user led recovery café. However the ADP recognises that progress in this area has not been as swift or as consistent as required by the ROSC Quality Principles. With this in mind the ADP has planned to work with service users in the development of a series of rapid improvement events in a conversational café style are organised over 2015 with the specific remit of service users developing the ways in which they want to be involved with the ADP and the commissioned services.

The ADP has also contributed funding to an independent advocacy service for those affected by mental health and substance misuse. Part of this work will include the development of a service user group to complement existing groups already established within West Lothian. The unique feature of this group will be its independence from the ADP and the potential to work collectively with those not using service from this independent position.

Whole Population Approaches

The ADP working group has detailed work to be conducted on a whole population basis both by the ADP service and by the ADP partners against each of the individual workstreams. This has more impact and a stronger place in the prevention and early intervention work at the point when the whole population is at risk from over consumption of alcohol and its associated risks to health, community safety and local environment.

The ADP has worked in partnership with Alcohol Focus Scotland in the last six months to highlight the risks of alcohol use and presented these findings both at a national and local level to the Community Planning Partnership to encourage a clearer link between this group and the ADP. A small working group was established in September 2014 to begin gathering evidence in relation to providing the Licensing Board with a dependable causal link between the overprovision of alcohol in West Lothian and the consequential harms. The Needs Assessment has been of critical importance to this as benchmarking against local and national datasets with comparable areas such as Mid Lothian and Falkirk indicate that West Lothian has a much more significant alcohol problem with more of the wider population consuming alcohol at harmful and hazardous levels. The ADP has planned to complete its work in August 2015 and will present information in four key areas to the licensing board for consideration in the development of its overprovision statement. These include health harms, community safety issues, child protection problems and alcohol aggravated offending.
The ADP plans to monitor the success of this though performance indicators demonstrating the number of on and off licenses granted and the number of licenses refused by the Licensing Board.

As recommended by Alcohol Focus Scotland, the ADP intends to continue to maintain a relationship with the local licensing forum and support the ADP lead for overprovision in challenging licensing decisions. The ADP also intends to continue to collect ward specific information about alcohol related discharges benchmarked against Falkirk ADP to highlight to the Community Planning Partnership and the Licensing Board the harms caused by overprovision of alcohol in West Lothian.

The ADP intends to work with NHS Lothian Senior Health Promotion Specialist on a Social Norming project focusing on alcohol consumption of young people within the next financial year. The ADP plans to work in partnership with West Lothian's further education establishments on a joint project looking at health messages around alcohol

and tobacco. If this initial project evaluates well then there are plans within the next three years to extend to other areas of West Lothian possibly with a younger age range.

8. Performance Framework

1. **HEALTH: People are healthier and experience fewer risks as a result of alcohol and drug use:** a range of improvements to physical and mental health, as well wider well-being, should be experienced by individuals and communities where harmful drug and alcohol use is being reduced, including fewer acute and long-term risks to physical and mental health, and a reduced risk of drug or alcohol-related mortality.

   Core Performance Indicators

   a) Drug related hospital discharges per 100,000 population three year rolling average over last 5 years.
   b) Drug – related mortality per 100,000 population three year rolling average over last 5 years.
   c) Alcohol related hospital discharges per 100,000 population three year rolling average over last 5 years.
   d) Alcohol-related mortality per 100,000 population three year rolling average over last 5 years.
   e) Prevalence of hepatitis C among injecting drug users.

   WLADP HEALTH OUTCOMES

   - **Reducing Health inequalities for those affected by substance misuse**
   - **Preventing health harms caused by substance misuse**

   Local Performance Indicators

   a) Number of usages of Naloxone by the Scottish ambulance Service (SAS).
   b) Number of non-fatal overdose referrals from the Scottish Ambulance Services
   c) Number of take home naloxone kits issued and % of coverage.
   d) Number of clients with severe and chronic alcohol misuse who have maintained or improved their physical or mental health

2. **PREVALENCE: Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others:** a reduction in the prevalence of harmful levels of drug and alcohol use as a result of prevention, changing social attitudes, and recovery is a vital intermediate outcome in delivering improved long-term health, social and economic outcomes. Reducing the number of young people misusing alcohol and drugs will also reduce health risks, improve life-chances and may reduce the likelihood of individuals developing problematic use in the future.

   Core Performance Indicators

   a) Estimated prevalence of Problem Drug Use Amongst 15-64 year olds.
   b) Estimated prevalence of injecting drug use amongst 15-64 year olds.

c) Percentage of 15 year old pupils who usually take illicit drugs at least once a month.
d) Percentage of 15 year old pupils who have taken an illicit drug in the last year.
e) Number of individuals drinking above daily and/or weekly recommended limits
f) Number of individuals drinking above twice daily (binge drinking) commended limits.
g) Number of individuals who are alcohol dependent
h) Proportion of 15 year olds drinking on a weekly basis (and their mean weekly level of consumption)

WLADP PREVALENCE OUTCOMES

- **Alcohol and other substances are less readily available and are used less by those in our communities**

Local Performance Indicators

a) Number of under 18s alcohol related hospital admissions.
b) Number of under 18s drug related hospital admission.
c) Number of NPS needle exchanges
d) Number of ABI delivered in West Lothian in primary care and social policy

3. **RECOVERY: Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use:** a range of health, psychological, social and economic improvements in well-being should be experienced by individuals who are recovering from problematic drug and alcohol use, including reduced consumption, fewer co-occurring health issues, improved family relationships and parenting skills, stable housing; participation in education and employment, and involvement in social and community activities.

Core Performance Indicators

a) Percentage reduction in daily drugs spend during treatment.
b) Reduction in the percentage of clients injecting in the last month during treatment.
c) Proportion of clients who abstain from illicit drugs between initial assessment and 12 week follow-up.
d) Proportion of clients receiving drugs treatment experiencing improvements in employment/ education profile during treatment.

WLADP RECOVERY OUTCOMES

- **People are supported to develop a non-substance misusing identity and lifestyle where they can develop skills to support and sustain recovery**

- **Those seeking recovery are supported to develop a non substance misusing identity and lifestyle where they can develop life skills, address their housing and financial needs, access meaningful daily**

activities, be supported into work or work-based activities and can have their voices heard in the development of strategies, polices and services affecting them.

Local Performance Indicators

a) Number of active mutual aid groups in West Lothian
b) Number of West Lothian individuals who are involved in service user activity across the partnership
c) Number of individual patients in Primary Care prescribed opiate replacement therapies.
d) Number of individual patients in specialist NHS treatment service prescribed opiate replacement therapies.
e) Number of individuals leaving the NHS treatment service ORT free
f) Percentage of clients injecting in the last year during treatment
g) Number of individuals reporting a reduction or abstinence from their primary substances
h) Number of individuals reporting improvement in one domain (housing, finances, relationships) at 12 weeks stage of treatment
i) ORT aim for 2015 – 18: To reduce the number of drug related deaths by 15% each year

4. **FAMILIES: Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances:** this will include reducing the risks and impact of drug and alcohol misuse on users' children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others.

Core Performance Indicators

a) Rate of maternities recording drug use per 1,000 maternities - three year rolling average.
b) Rate of maternities recording alcohol use per 1,000 - three year rolling average.
c) Child Protection Case Conference where parental alcohol abuse has been identified as a concern/risk. (Crude rate per 10,000 population of under 18s.)
d) Child Protection Case Conference where parental drug abuse has been identified as a concern/risk. (Crude rate per 10,000 population of under 18s.)
e) Proportion of positive ABI screenings in ante-natal setting

WLADP FAMILIES OUTCOMES

- **Children, young people are safe from harm and develop the resilience and coping skills they need to avoid negative outcomes.**

- **Family members, carers and friends are supported to develop knowledge, resilience, coping skills and are empowered to**

contribute to the service users' recovery plan as according to the Quality Principles

Local Performance Indicators

a) Number of children living in safe/stimulating home environments (measured by services on a quarterly basis)
b) Number of educational establishments using the learning resources of "Rory & Oh Lila"
c) Number of Young people offered support as a carer of a parent misusing substances
d) Number of adults offered support as a carer of someone misusing substances
e) Number of people engaging with family support measured on a quarterly basis

5. **COMMUNITY SAFETY: Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour:** reducing alcohol and drug-related offending, re-offending and anti-social behaviour, including violence, acquisitive crime, drug-dealing and driving while intoxicated, will make a positive contribution in ensuring safer, stronger, happier and more resilient communities.

Core Performance Indicators

a) Percentage of new clients at specialist drug treatment services who report funding their drug use through crime.
b) One year re-conviction frequencies rates (per 100 offenders) for offenders given a Drug Treatment and Testing Order.
c) Number of cases of Alcohol related offences (serious assault) recorded by the police per 10,000 population.
d) Number of cases of Alcohol related offences (vandalism) recorded by the police per 10,000 population.
e) Number of cases of Alcohol related offences (breach of the peace) recorded by the police per 1000 population.
f) Number of Community Payback Orders issued where alcohol and drug treatment is required, and proportion that are successfully completed.
g) Proportion of victims of a crime who reported that the offender was under the influence of alcohol.
h) Proportion of victims of a crime who reported that the offender was under the influence of drugs

WLADP COMMUNITY SAFETY OUTCOME

- **Communities and individuals are protected from alcohol and drug related harm.**

Local Performance Indicators

a) Number anti-social youth calls to police

b) Number of accidental dwelling fires where impairment due to alcohol and/or drugs was suspected.
c) Number of households were antisocial behaviour is a regular feature (party houses)
d) Number of drink driving offences
e) Number of test purchases failed against number undertaken.
f) Number of licences for on and off sales in West Lothian

6. **LOCAL ENVIRONMENT: People live in positive, health-promoting local environments where alcohol and drugs are less readily available:** alcohol and drug misuse is less likely to develop and recovery from problematic use is more likely to be successful in strong, resilient communities where healthy lifestyles and wider well-being are promoted, where there are opportunities to participate in meaningful activities, and where alcohol and drugs are less readily available. Recovery will not be stigmatised, but supported and championed in the community.

Core Performance Indicators

a) Percentage of young people who have been offered drugs in the last year.
b) Percentage of people perceiving drug misuse or dealing to be very or fairly common in their neighbourhood.
c) Percentage of people noting 'alcohol abuse' as a negative aspect of their neighbourhood
d) On sales premises in force per annum (Crude rate per 10,000 population aged over 18 years).
e) Off sales premises in force per annum (Crude rate per 10,000 population aged over 18 years).
f) Total premises in force per annum (Crude rate per 10,000 population aged over 18 years).
g) Personal licenses in force per annum (Crude rate per 10,000 population aged over 18 years).

WLADP LOCAL ENVIRONMENT OUTCOMES

- **Communities and individuals have attitudes towards alcohol that support low-risk drinking and prevent the use of other substances.**

- **Communities harvest cultures and attitudes that support recovery from problematic substance misuse.**

Local Performance Indicators

a) Net change in capacity for licensed on sales resulting from board decisions
b) Net change in capacity for licensed off sales resulting from board decisions.
c) Number of community based recovery activities throughout West Lothian

7. **SERVICES: Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery:** services should offer timely, sensitive and appropriate support, which meets the needs of different local groups (including those with particular needs according to their age, gender, disability, health, race, ethnicity and sexual orientation) and facilitates their recovery. Services should use local data and evidence to make decisions about service improvement and re-design

Core Performance Indicators

a) Number of alcohol screenings
b) Number of Alcohol Brief Interventions delivered in accordance with HEAT Standard
c) Percentage of clients waiting more than three weeks between referral to a specialist alcohol service and commencement of treatment
d) Percentage of clients waiting more than three weeks between referral to a specialist drug service and commencement of treatment.

WLADP SERVICE OUTCOMES

- **All ADP services can evidence adherence to the eight Quality Principles – Standard Expectations of Care and Support in Drug and Alcohol Services**

- **The ADP partners can evidence their commitment to the STRADA Workforce Development strategy.**

Local Performance Indicators

a) % of adults in services who attribute their recovery to the interventions and inputs received from the service, measured by a survey on a yearly basis
b) Number of providers meeting all eight of the Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services
c) Number of EQIA/ Rapid impact assessment completed within ADP by local services.
d) Number of service users engaging with the Advocacy Support Service
e) Number of service users engaging with service user involvement opportunities

9. Core Indicators & Improvement Goals

Health

1a) Drug related hospital admissions

(Source: ISD Scotland – SMR-01)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian	172	262	215	215	To reduce the number of hospital admissions in a 3 year rolling period by 10% by 2018.
Falkirk	100	70	123		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

1b) Drug related mortality

(Source: ISD Scotland – SMR-01)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian	21	13	5	5	To reduce the number of Drug related deaths in a 3 year rolling period by 15% by 2018.
Falkirk	5	11	11		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

1c) Alcohol related hospital admissions

(Source: ISD Scotland – NRS)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian	1146	1299	1086	1086	To reduce the number of hospital stays in a 3 year rolling period by 12% by 2018
Falkirk	759	649	791		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

1d) Alcohol related mortality

(Source: ISD Scotland – SMR-01)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian	26	33	41	41	To reduce the number of alcohol related deaths in a 3 year rolling period by 5% by 2018
Falkirk	37	35	29		

1e) Prevalence of hepatitis C among injecting drug users

(Source: HPS – NEVI))

ADP	2009	2011	WLADP Baseline	Improvement Goal
West Lothian	13	18	18	To reduce the number of positive diagnosis for Hep C among injecting drug users by 7% by 2018
Falkirk	23	32		

Prevalence

2a) Prevalence of problem drug use 15-64 age group

(Source: ISD Scotland – SMR-01)

ADP	2009	2012	WLADP Baseline	Improvement Goal
West Lothian	1500	1400	1400	To reduce by 10% over a 3 year rolling average by 2018
Falkirk	1054	1700		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

2b) Prevalence expressed as a percentage of injecting drug use 15-64 age group

(Source: ISD Scotland – SMR01)

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Falkirk					

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

2c) Percentage of 15 year olds who take illicit drugs at least once a month

(Source: ISD Scotland – SMR-01)

ADP	2006	2010	2013	WLADP Baseline	Improvement Goal
West Lothian	95	56	42	42	To reduce by 15% for the next SALUS survey.
Falkirk	54	48	81		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

2d) Percentage of 15 year olds who take illicit drugs at least once a year

(Source: ISD Scotland – SMR-01)

ADP	2006	2010	2013	WLADP Baseline	Improvement Goal
West Lothian	158	94	74	74	To reduce by 20% for the next SALUS survey.
Falkirk	99	66	116		

2e) Number of individuals drinking above daily/weekly recommended limits

(Source: ISD Scotland – SMR-01)

Health Board	2011	WLADP Baseline	Improvement Goal
Lothian	2039	2039	To reduce by 5% on a 3 year rolling period by 2018
Forth Valley	689		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

2f) Number of individuals drinking above twice daily recommended limits

(Source: ISD Scotland – SMR-01)

Health Board	2011	WLADP Baseline	Improvement Goal
Lothian	1015	1015	To reduce by 5% on a 3 year rolling period by 2018
Forth Valley	332		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

2g) Number of individuals who are alcohol dependent

(Source: ISD Scotland – NRS)

Health Board	2011	WLADP Baseline	Improvement Goal
Lothian	418	418	To reduce by 10% on a 3 year rolling period by 2018
Forth Valley	148		

3 year rolling average rates per 100,000 population, Scotland and Council area of residence

2h) Proportions of 15 year olds drinking on a weekly basis

(Source: ISD Scotland – SMR-01)

ADP	2006	2010	2013	WLADP Baseline	Improvement Goal
West Lothian	216	104	43	43	To reduce by 5% for the next SALSUS survey in 2017.
Falkirk	124	68	86		

Recovery

3a) Percentage reduction in daily drugs spend during treatment

(Source: ISD Scotland – SMR-01)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Falkirk					

3b) Percentage of clients injecting in the last month during treatment

(Source: ISD Scotland – SMR-01)

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Falkirk					

3c) Proportion of clients abstaining from illicit drugs between initial assessment and 12 week follow up

(Source: ISD Scotland – SMR-01)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Falkirk					

3d) Proportion of clients receiving drugs treatment experiencing improvements in employment/education profile during treatment

(Source: ISD Scotland – SMR-01)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Falkirk					

Families

4a) Maternities with drug use

(Source: ISD, SMR02)

Health Board	2009	2010	2011	NHS LOTHIAN Baseline	Improvement Goal
Lothian	982	1,368	1,432	1,432	
Forth Valley	85	94	121		To reduce by 5% by 2018

4b) Maternities with alcohol use

(Source: ISD Scotland – SMR-01)

Health Board	2009	2010	2011	NHS LOTHIAN Baseline	Improvement Goal
Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Forth Valley					

4c) Child Protection Case Conferences where parental drug use is identified

(Source: ISD Scotland – SMR-01)

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	102	173	149	149	To reduce by 8% on a yearly basis during the delivery plan 2015-2018
Falkirk	15	21	34		

4d) Child Protection Case Conferences where parental alcohol use is identified

(Source: ISD Scotland – SMR-01)

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	21	37	23	23	To reduce by 5% on a 3 year rolling average by 2018
Falkirk	15	25	48		

4e) Proportion of positive ABI screenings in ante-natal setting

(Source: ISD Scotland – SMR-01)

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Falkirk					

Community Safety

5a) Percentage of new clients at specialist drug treatment service who report funding their drug use though crime

ADP	2009	2010	2011	WLADP Baseline	Improvement Goal
West Lothian	53	57	29	29	To reduce by 10% on a 3 year rolling average by 2018
Falkirk	35	43	41		

5b) One year reconviction frequencies rates (per 100 offenders) for DTTOs

ADP	2009	2010	2011	WLADP Baseline	Improvement Goal
West Lothian	7	14	7	7	To reduce by 5% on a 3 year rolling average by 2018
Falkirk	8	2	6		

5c) Number of cases of alcohol related offences (serious assault) recorded by the police per 10,000 population

ADP	2010	2011	2012	WLADP Baseline	Improvement Goal
West Lothian	135	99	90	90	To reduce by 10% on a 3 year rolling average by 2018
Falkirk	81	70	59		

5d) Number of cases alcohol related offences (vandalism) recorded by the police per 10,000 population

ADP	2010	2011	2012	WLADP Baseline	Improvement Goal
West Lothian	2073	2295	1806	1806	To reduce by 15% on a 3 year rolling average by 2018
Falkirk	2033	1868	1480		

5e) Number of cases alcohol related offences (breach of the peace) recorded by the police per 10,000 population

ADP	2011	2012	WLADP Baseline	Improvement Goal
West Lothian	320	208	208	To reduce by 15% on a 3 year rolling average by 2018
Falkirk	1418	1198		

5f) Number of community payback orders issued where alcohol and drug treatment is required

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	2	5	5	5	To maintain number of CPOs during 2015 - 2018
Falkirk	51	57	64		

5g) Proportion of victims of crime who reported that the offender was under the influence of alcohol

Police Division	2013	WLADP Baseline	Improvement Goal
Lothian & Borders	20%	20%	To reduce percentage by 2% during 2015 - 2018
Fife & Forth Valley	24&		

5h) Proportion of victims of crime who reported that the offender was under the influence of drugs

Police Division	2013	WLADP Baseline	Improvement Goal
Lothian & Borders	10%	10%	To reduce percentage by 2% during 2015 - 2018
Fife & Forth Valley	15%		

Local Environment

6a) Percentage of young people who have been offered drugs in the last year

ADP	2006	2010	2013	WLADP Baseline	Improvement Goal
West Lothian	335	242	178	178	To reduce by 10% in a 3 year rolling average by 2018
Falkirk	178	140	251		

6b) Percentage of people perceiving drug misuse or dealing to be very or faily common in their area

ADP	2009	2012	2013	WLADP Baseline	Improvement Goal
West Lothian	75	18	28	28	
Falkirk	40	12	12		To reduce by 10% by 2018

6c) Percentage of people noting “alcohol abuse” as a negative aspect of their area

ADP	2009	2012	2013	WLADP Baseline	Improvement Goal
West Lothian	72	25	982	982	
Falkirk	84	22	22		To reduce by 10% by 2018

6d) On sales premises in force per annum (Crude rate per 10,000 population aged over 18 years)

ADP	2012	2013	WLADP Baseline	Improvement Goal
West Lothian	249	237	237	
Falkirk	228	222		To reduce by 5% by 2018

6e) Off sales premises in force per annum (Crude rate per 10,000 population aged over 18 years)

ADP	2012	2013	WLADP Baseline	Improvement Goal
West Lothian	153	157	157	
Falkirk	138	143		To reduce by 5% by 2018

6f) Total premises in force per annum (Crude rate per 10,000 population aged over 18 years)

ADP	2012	2013	WLADP Baseline	Improvement Goal
West Lothian	402	394	394	
Falkirk	366	365		To reduce by 5% by 2018

6g) Personal licenses in force per annum (Crude rate per 10,000 population aged over 18 years)

ADP	2012	2013	WLADP Baseline	Improvement Goal
West Lothian	1,073	1,202	1,202	
Falkirk	1,188	1,333		To reduce by 5% by 2018

Services

7a) Number of alcohol screenings

ADP	2006	2010	2013	WLADP Baseline	Improvement Goal
West Lothian					No information currently available. WLADP aims to reduce this indicator but cannot make this SMART without further information.
Falkirk					

7b) Number of Alcohol Brief Interventions delivered in accordance with HEAT Standard

Health Board	2011	2012	2013	WLADP Baseline	Improvement Goal
Lothian	17,093	18,275	23,735	23,735	To increase by 15% on a yearly basis by 2018.
Forth Valley	8,789	11,104	12,603		

7c) Percentage of clients waiting more than three weeks between referral to a specialist alcohol service and commencement of treatment

ADP	2012/13	2013/14	WLADP Baseline	Improvement Goal
West Lothian	14%	2.4%	2.4%	To maintain an over 90% mark on a yearly basis by 2018
Falkirk	18.9%	1.2%		

7d) Percentage of clients waiting more than three weeks between referral to a specialist drug service and commencement of treatment

ADP	2012/13	2013/14	WLADP Baseline	Improvement Goal
West Lothian	14.3%	2.7%	2.7%	To maintain an over 90% mark on a yearly basis by 2018
Falkirk	8.3%	0.9%		

10. Local Indicators & Improvement Goals

Health

1a) Number of usages of Naloxone by the Scottish Ambulance Service

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	82	82	To decrease by 5% by 2018

1b) Number of non-fatal overdose referrals from the Scottish Ambulance Services

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian			A new indicator and information has not previously been collated

1c) Number Take Home Naloxone kits issued and % coverage

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	160	170	212	212	To meet coverage % target set by SG on a yearly basis til 2018

1d) Percentage of clients with severe and chronic alcohol misuse who have maintained or improved their physical or mental health with support from Specialist Alcohol Service

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	88%	63%	79%	79%	To achieve an 80% target on a yearly basis til 2018

Prevalence

2a) Number of under 18s alcohol related hospital admissions

ADP	2013	WLADP Baseline	Improvement Goal
West Lothian	12	12	To reduce by 5% by 2018

2b) Number of under 18s drug related hospital admissions

ADP	2013	WLADP Baseline	Improvement Goal
West Lothian	* Number low and identifiable		To reduce by 5% by 2018.

2c) Number of NPS needle exchanges

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	26	26	To reduce by 15% on a yearly basis til end on 2018

2d) Number of ABI delivered in West Lothian in primary care and social policy

ADP	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	1,577	2,577	2,577	To increase by 25% on a yearly basis til end of 2018

Recovery

3a) Number of active mutual aid groups is West Lothian

ADP	2013	WLADP Baseline	Improvement Goal
West Lothian	33	33	To increase by 15% on a 3 year rolling average by 2018.

3b) Number of West Lothian individuals who are involved in service user activity

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					A new indicator and information has not previously been collated

3c) Number of individual patients in Primary Care prescribed opiate replacement therapies

snapshot figure in 4th quarter of the year

ADP	2012/13	2013/14	2014/15	WLADP Baseline	Improvement Goal
West Lothian	342	375	198	198	To reduce by 5% on a 3 year rolling period by 2018

3d) Number of individual patients in NHS Specialist treatment service prescribed opiate replacement therapies

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	264	264	To reduce by 5% on a 3 year rolling period by 2018

3e) Number of individual leaving the NHS Specialist Treatment service ORT free

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					A new indicator and information has not previously been collated

3f) Percentage of clients injecting in the last year during treatment

(Source: Extracted from SMR database)

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	33%	10%	31%	31%	To reduce the percentage of injecting drug users in service to 25% rolling 3 year average by 2018

3g) Number of individuals reporting a reduction or abstinence from their primary substance

(Source: From quarterly monitoring of 4 WLDAP funded service NHS, SWAT, WLDAS & ELCA)

ADP	2013/14	2014/15	WLADP Baseline	Improvement Goal
West Lothian	841	769	769	To increase by 10% on a rolling 3 year average by 2018

3h) Number of individual reporting improvement in one domain (housing, finances, relationship, mental health) at the 12 week review stage

ADP	2013/14	2014/15	WLADP Baseline	Improvement Goal
West Lothian	730	678	678	To increase by 10% on a rolling 3 year average by 2018

3i) ORT aim for 2015 – 18: To reduce the number of drug related death by 15% in a 3 year rolling period

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian	21	13	5	5	To reduce the number of Drug related deaths in a 3 year rolling period by 15% by 2018.

Families

4a) Number of children living in safe/stimulating home environments (SWAT & Circle services)

ADP	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	131	214	214	To increase number by 10% on a 3 year rolling average by 2018

4b) Number of education establishments using the learning resources of "Rory" & "Oh Lila"

ADP	2011	2013	WLADP Baseline	Improvement Goal
West Lothian	9	27	27	To increase number by 5% by 2018

4c) Number of Young People offered support as a carer of a parent misusing substances

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	29	29	To increase by 10% on an annual basis by 2018.

4d) Number of adults offered support as a carer of someone misusing substances

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	46	46	To increase by 10% on an annual basis by 2018.

4e) Number of people engaging with family support measure on a yearly basis

ADP	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	14	14	14	To increase by 25% by 2018 due to new individual support service

Community Safety

5a) Number of anti social youth calls to the police

ADP	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	1,872	1,925	1925	To reduce by 15% on a 3 year rolling average by 2018

5b) Number of accidental fire dwellings where impairment due to alcohol/drugs was suspected

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	24	24	To reduce by 5% on a 3 year rolling average by 2018

5c) Number of households were antisocial behaviour is a regular feature (party houses)

(recorded as a snapshot)

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	14	14	To reduce by 10% by 2018

5d) Number of drink driving offences

ADP	2014/15	WLADP Baseline	Improvement Goal
West Lothian	169	169	To reduce by 10% by 2018

5e) Number of test purchases failed against number undertaken

ADP	2013	WLADP Baseline	Improvement Goal
West Lothian	2/18 (11%)	2/18 (11%)	To reduce percentage to less than 10% by 2018

5f) Number of licences for on and off sales in West Lothian

ADP	2014	WLADP Baseline	Improvement Goal
West Lothian	401	401	To reduce by 5% on a 3 year rolling average by 2018

Local Environment

6a) Net change in capacity for licensed on sales (people)

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	693	-1380	100	100	To reduce capacity in on licensed premises by 5% yearly.

6b) Net change in capacity for licensed off sales (m2)

ADP	2012	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	672	-56	109	109	To reduce capacity in off licensed premises by 5% yearly.

6c) Number of community based recovery activities in West Lothian

ADP	2013	2014	WLADP Baseline	Improvement Goal
West Lothian	1	2	2	To increase by 75% by 2018 to reflect increased community/service user activity

Services

7a) Percentage of adults in service who attribute their recovery to the interventions and inputs received from the service

ADP	2013	WLADP Baseline	Improvement Goal
West Lothian	70%	70%	To increase to 85% on a 3 year rolling average by 2018.

7b) Number of providers meeting all eight of the Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					This is a new indicator and currently not measured improvement goal will be set after Year 1.

7c) Number of EQIA completed within ADP services

ADP	2013	WLADP Baseline	Improvement Goal
West Lothian	6	6	All services (6) to complete on annual basis by 2018.

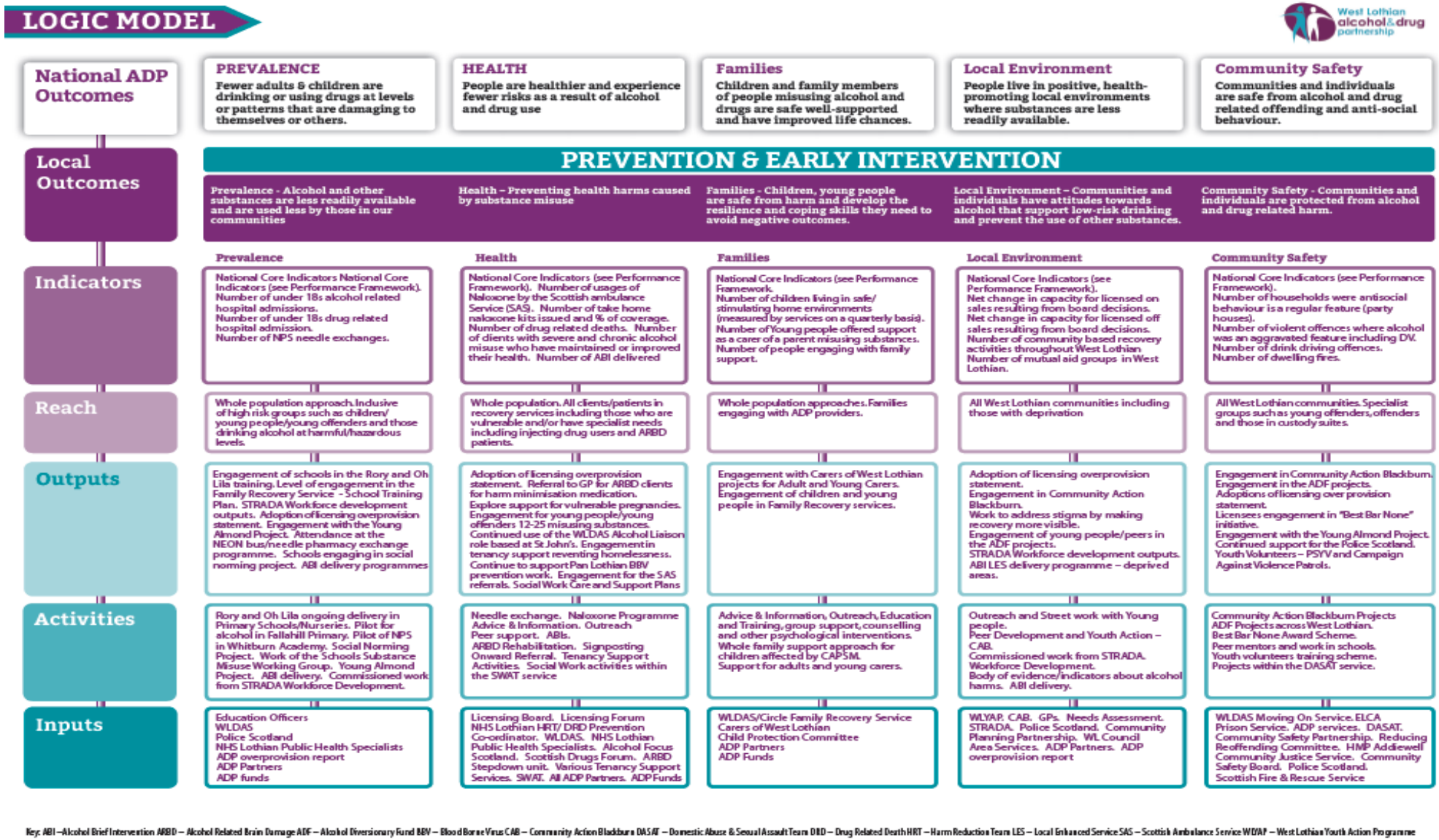
7d) Number of service users engaging with the Advocacy Support Service

ADP	2012/13	2013/14	2014/15	WLADP Baseline	Improvement Goal
West Lothian	25	22	26	26	To increase the engagement number by 20% on a yearly basis by 2018.

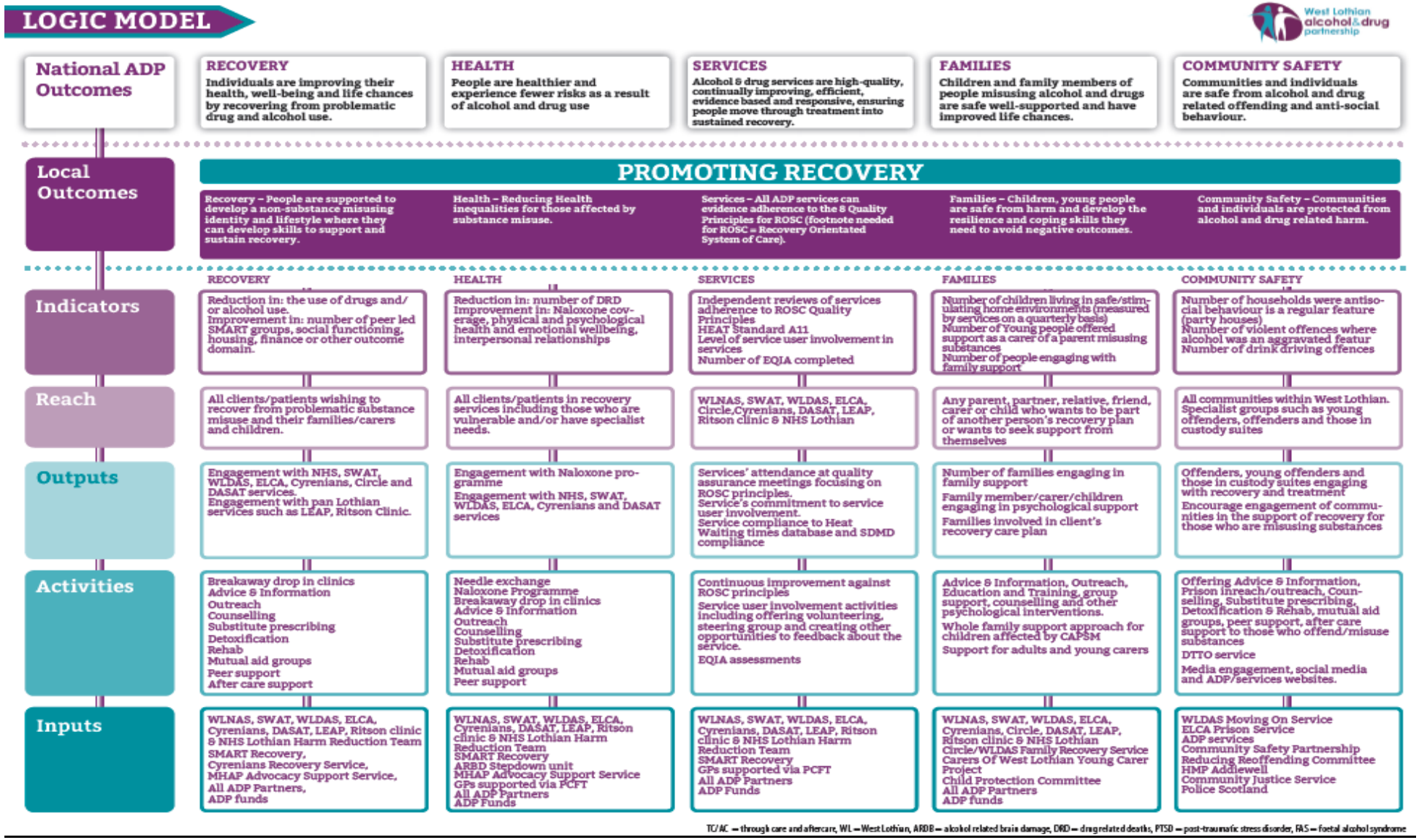
7e) Number of service users engaging with service user involvement opportunities

ADP	2009	2011	2013	WLADP Baseline	Improvement Goal
West Lothian					This is a new indicator and currently not measured improvement goal will be set after Year 1.

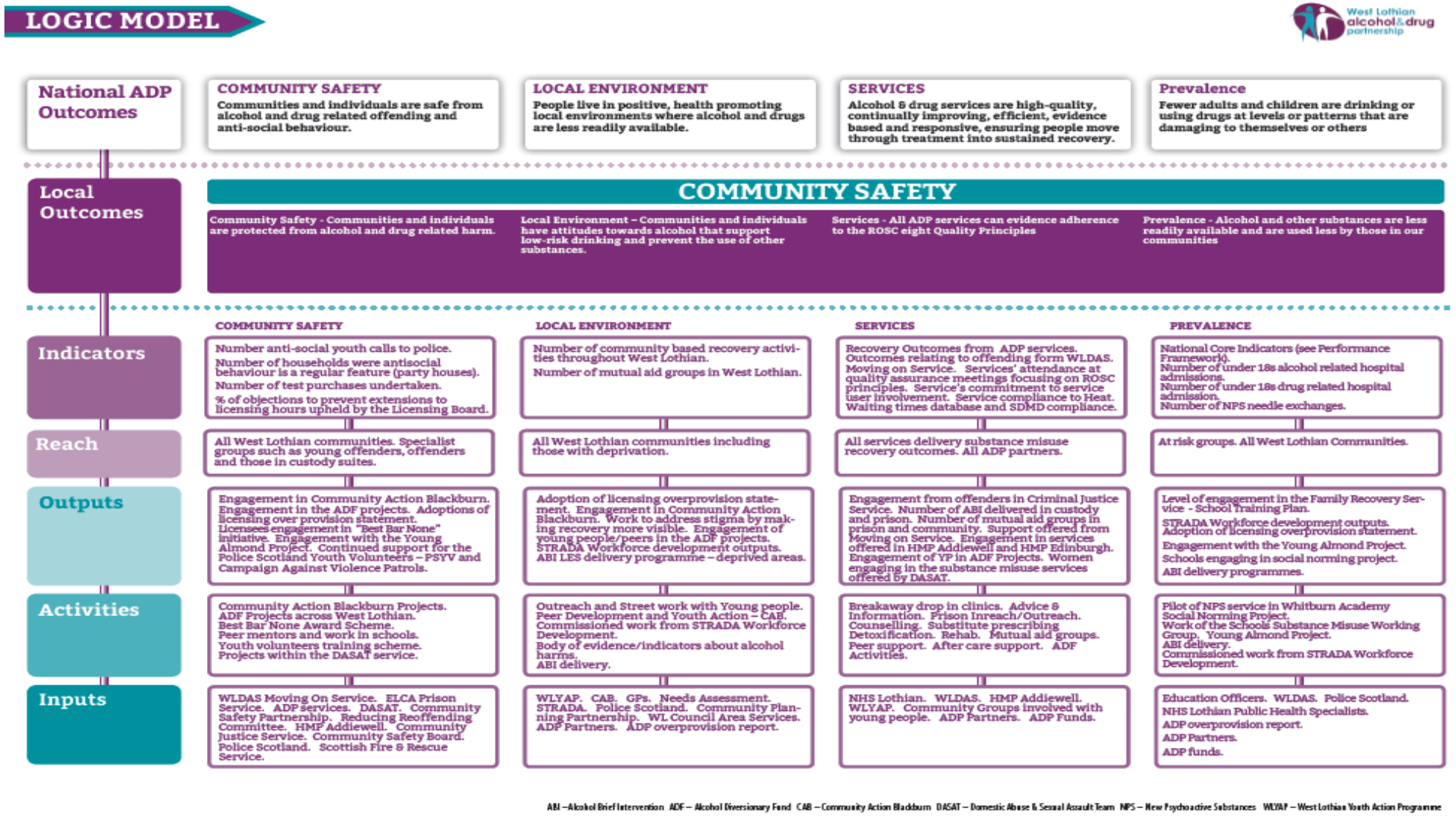
Appendix 1


LOGIC MODEL
West Lothian alcohol & drug partnership
National ADP Outcomes
PREVALENCE
Fewer adults & children are drinking or using drugs at levels or patterns that are damaging to themselves or others.
HEALTH
People are healthier and experience fewer risks as a result of alcohol and drug use
Families
Children and family members of people misusing alcohol and drugs are safe well-supported and have improved life chances.
Local Environment
People live in positive, health-promoting local environments where substances are less readily available.
Community Safety
Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour.
Local Outcomes
PREVENTION & EARLY INTERVENTION
Prevalence - Alcohol and other substances are less readily available and are used less by those in our communities
Health – Preventing health harms caused by substance misuse
Families - Children, young people are safe from harm and develop the resilience and coping skills they need to avoid negative outcomes.
Local Environment – Communities and individuals have attitudes towards alcohol that support low-risk drinking and prevent the use of other substances.
Community Safety - Communities and individuals are protected from alcohol and drug related harm.
Indicators
Prevalence
National Core Indicators National Core Indicators (see Performance Framework).
Number of under 18s alcohol related hospital admissions.
Number of under 18s drug related hospital admission.
Number of NPS needle exchanges.
Health
National Core Indicators (see Performance Framework). Number of usages of Naloxone by the Scottish ambulance Service (SAS). Number of take home naloxone kits issued and % of coverage.
Number of drug related deaths. Number of clients with severe and chronic alcohol misuse who have maintained or improved their health. Number of ABI delivered
Families
National Core Indicators (see Performance Framework.
Number of children living in safe/ stimulating home environments (measured by services on a quarterly basis).
Number of Young people offered support as a carer of a parent misusing substances.
Number of people engaging with family support.
Local Environment
National Core Indicators (see Performance Framework).
Net change in capacity for licensed on sales resulting from board decisions.
Net change in capacity for licensed off sales resulting from board decisions.
Number of community based recovery activities throughout West Lothian.
Number of mutual aid groups in West Lothian.
Community Safety
National Core Indicators (see Performance Framework).
Number of households were antisocial behaviour is a regular feature (party houses).
Number of violent offences where alcohol was an aggravated feature including DV.
Number of drink driving offences.
Number of dwelling fires.
Reach
Whole population approach. Indusive of high risk groups such as children/ young people/young offenders and those drinking alcohol at harmful/hazardous levels.
Whole population. All clients/patients in recovery services including those who are vulnerable and/or have specialist needs including injecting drug users and ARBD patients.
Whole population approaches. Families engaging with ADP providers.
All West Lothian communities including those with deprivation
All West Lothian communities. Specialist groups such as young offenders, offenders and those in custody suites.
Outputs
Engagement of schools in the Rory and Oh Lila training. Level of engagement in the Family Recovery Service - School Training Plan. STRADA Workforce development outputs. Adoption of licensing overprovision statement. Engagement with the Young Almond Project. Attendance at the NEON bus/needle pharmacy exchange programme. Schools engaging in social norming project. ABI delivery programmes
Adoption of licensing overprovision statement. Referral to GP for ARBD clients for harm minimisation medication.
Explore support for vulnerable pregnancies.
Engagement for young people/young offenders 12-25 misusing substances.
Continued use of the WLDAS Alcohol Liaison role based at St John's. Engagement in tenancy support reventing homelessness.
Continue to support Pan Lothian BBV prevention work. Engagement for the SAS referrals. Social Work Care and Support Plans
Engagement with Carers of West Lothian projects for Adult and Young Carers.
Engagement of children and young people in Family Recovery services.
Adoption of licensing overprovision statement.
Engagement in Community Action Blackburn.
Work to address stigma by making recovery more visible.
Engagement of young people/peers in the ADF projects.
STRADA Workforce development outputs.
ABI LES delivery programme – deprived areas.
Engagement in Community Action Blackburn.
Engagement in the ADF projects.
Adoptions of licensing over provision statement.
Licensees engagement in "Best Bar None" initiative.
Engagement with the Young Almond Project.
Continued support for the Police Scotland.
Youth Volunteers – PSYV and Campaign Against Violence Patrols.
Activities
Rory and Oh Lila ongoing delivery in Primary Schools/Nurseries. Pilot for alcohol in Falkhill Primary. Pilot of NPS in Whitburn Academy. Social Norming Project. Work of the Schools Substance Misuse Working Group. Young Almond Project. ABI delivery. Commissioned work from STRADA Workforce Development.
Needle exchange. Naloxone Programme Advice & Information. Outreach Peer support. ABIs.
ARBD Rehabilitation. Signposting Onward Referral. Tenancy Support Activities. Social Work activities within the SWAT service
Advice & Information, Outreach, Education and Training, group support, counselling and other psychological interventions.
Whole family support approach for children affected by CAPSM.
Support for adults and young carers.
Outreach and Street work with Young people.
Peer Development and Youth Action – CAB.
Commissioned work from STRADA.
Workforce Development.
Body of evidence/indicators about alcohol harms. ABI delivery.
Community Action Blackburn Projects
ADF Projects across West Lothian.
Best Bar None Award Scheme.
Peer mentors and work in schools.
Youth volunteers training scheme.
Projects within the DASAT service.
Inputs
Education Officers
WLDAS
Police Scotland
NHS Lothian Public Health Specialists
ADP overprovision report
ADP Partners
ADP funds
Licensing Board. Licensing Forum
NHS Lothian HRT/ DRD Prevention Co-ordinator. WLDAS. NHS Lothian Public Health Specialists. Alcohol Focus Scotland. Scottish Drugs Forum. ARBD Stepdown unit. Various Tenancy Support Services. SWAT. All ADP Partners. ADP Funds
WLDAS/Circle Family Recovery Service
Carers of West Lothian
Child Protection Committee
ADP Partners
ADP Funds
WLYAP. CAB. GPs. Needs Assessment. STRADA. Police Scotland. Community Planning Partnership. WL Council Area Services. ADP Partners. ADP overprovision report
WLDAS Moving On Service. ELCA Prison Service. ADP services. DASAT. Community Safety Partnership. Reducing Reoffending Committee. HMP Addiewell Community Justice Service. Community Safety Board. Police Scotland. Scottish Fire & Rescue Service
Key: ABI –Alcohol Brief Intervention ARBD – Alcohol Related Brain Damage ADF – Alcohol Diversionary Fund BBV – Blood Borne Virus CAB – Community Action Blackburn DASAT – Domestic Abuse & Sexual Assault Team DRD – Drug Related Death HRT – Harm Reduction Team LES – Local Enhanced Service SAS – Scottish Ambulance Service WLYAP – West Lothian Youth Action Programme

Appendix 2


LOGIC MODEL
West Lothian alcohol & drug partnership
National ADP Outcomes
RECOVERY
Individuals are improving their health, well-being and life chances by recovering from problematic drug and alcohol use.
HEALTH
People are healthier and experience fewer risks as a result of alcohol and drug use
SERVICES
Alcohol & drug services are high-quality, continually improving, efficient, evidence based and responsive, ensuring people move through treatment into sustained recovery.
FAMILIES
Children and family members of people misusing alcohol and drugs are safe well-supported and have improved life chances.
COMMUNITY SAFETY
Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour.
Local Outcomes
PROMOTING RECOVERY
Recovery – People are supported to develop a non-substance misusing identity and lifestyle where they can develop skills to support and sustain recovery.
Health – Reducing Health inequalities for those affected by substance misuse.
Services – All ADP services can evidence adherence to the 8 Quality Principles for ROSC (footnote needed for ROSC = Recovery Orientated System of Care).
Families – Children, young people are safe from harm and develop the resilience and coping skills they need to avoid negative outcomes.
Community Safety – Communities and individuals are protected from alcohol and drug related harm.
RECOVERY
HEALTH
SERVICES
FAMILIES
COMMUNITY SAFETY
Indicators
Reduction in: the use of drugs and/or alcohol use.
Improvement in: number of peer led SMART groups, social functioning, housing, finance or other outcome domain.
Reduction in: number of DRD
Improvement in: Naloxone coverage, physical and psychological health and emotional wellbeing, interpersonal relationships
Independent reviews of services adherence to ROSC Quality Principles
HEAT Standard A11
Level of service user involvement in services
Number of EQIA completed
Number of children living in safe/stimulating home environments (measured by services on a quarterly basis)
Number of Young people offered support as a carer of a parent misusing substances
Number of people engaging with family support
Number of households were antisocial behaviour is a regular feature (party houses)
Number of violent offences where alcohol was an aggravated featur
Number of drink driving offences
Reach
All clients/patients wishing to recover from problematic substance misuse and their families/carers and children.
All clients/patients in recovery services including those who are vulnerable and/or have specialist needs.
WLNAS, SWAT, WLDAS, ELCA, Circle,Cyrenians, DASAT, LEAP, Ritson clinic & NHS Lothian
Any parent, partner, relative, friend, carer or child who wants to be part of another person's recovery plan or wants to seek support from themselves
All communities within West Lothian. Specialist groups such as young offenders, offenders and those in custody suites
Outputs
Engagement with NHS, SWAT, WLDAS, ELCA, Cyrenians, Circle and DASAT services.
Engagement with pan Lothian services such as LEAP, Ritson Clinic.
Engagement with Naloxone programme
Engagement with NHS, SWAT, WLDAS, ELCA, Cyrenians and DASAT services
Services' attendance at quality assurance meetings focusing on ROSC principles.
Service's commitment to service user involvement.
Service compliance to Heat Waiting times database and SDMD compliance
Number of families engaging in family support
Family member/carer/children engaging in psychological support
Families involved in client's recovery care plan
Offenders, young offenders and those in custody suites engaging with recovery and treatment
Encourage engagement of communities in the support of recovery for those who are misusing substances
Activities
Breakaway drop in clinics
Advice & Information
Outreach
Counselling
Substitute prescribing
Detoxification
Rehab
Mutual aid groups
Peer support
After care support
Needle exchange
Naloxone Programme
Breakaway drop in clinics
Advice & Information
Outreach
Counselling
Substitute prescribing
Detoxification
Rehab
Mutual aid groups
Peer support
Continuous improvement against ROSC principles
Service user involvement activities including offering volunteering, steering group and creating other opportunities to feedback about the service.
EQIA assessments
Advice & Information, Outreach, Education and Training, group support, counselling and other psychological interventions.
Whole family support approach for children affected by CAPSM
Support for adults and young carers
Offering Advice & Information, Prison inreach/outreach, Counselling, Substitute prescribing, Detoxification & Rehab, mutual aid groups, peer support, after care support to those who offend/misuse substances
DTTO service
Media engagement, social media and ADP/services websites.
Inputs
WLNAS, SWAT, WLDAS, ELCA, Cyrenians, DASAT, LEAP, Ritson clinic & NHS Lothian Harm Reduction Team
SMART Recovery,
Cyrenians Recovery Service,
MHAP Advocacy Support Service,
All ADP Partners,
ADP funds
WLNAS, SWAT, WLDAS, ELCA, Cyrenians, DASAT, LEAP, Ritson clinic & NHS Lothian Harm Reduction Team
SMART Recovery
ARBD Stepdown unit
MHAP Advocacy Support Service
GPs supported via PCFT
All ADP Partners
ADP Funds
WLNAS, SWAT, WLDAS, ELCA, Cyrenians, DASAT, LEAP, Ritson clinic & NHS Lothian Harm Reduction Team
SMART Recovery
GPs supported via PCFT
All ADP Partners
ADP Funds
WLNAS, SWAT, WLDAS, ELCA, Cyrenians, Circle, DASAT, LEAP, Ritson clinic & NHS Lothian
Circle/WLDAS Family Recovery Service
Carers Of West Lothian Young Carer Project
Child Protection Committee
All ADP Partners
ADP funds
WLDAS Moving On Service
ELCA Prison Service
ADP services
Community Safety Partnership
Reducing Reoffending Committee
HMP Addiewell
Community Justice Service
Police Scotland
TC/AC – through care and aftercare, WL – West Lothian, ARDB – alcohol related brain damage, DRD – drug related deaths, PTSD – post-traumatic stress disorder, FAS – foetal alcohol syndrome

Appendix 3


LOGIC MODEL
West Lothian alcohol&drug partnership
National ADP Outcomes
COMMUNITY SAFETY
Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour.
LOCAL ENVIRONMENT
People live in positive, health promoting local environments where alcohol and drugs are less readily available.
SERVICES
Alcohol & drug services are high-quality, continually improving, efficient, evidence based and responsive, ensuring people move through treatment into sustained recovery.
Prevalence
Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others
Local Outcomes
COMMUNITY SAFETY
Community Safety - Communities and individuals are protected from alcohol and drug related harm.
Local Environment – Communities and individuals have attitudes towards alcohol that support low-risk drinking and prevent the use of other substances.
Services - All ADP services can evidence adherence to the ROSC eight Quality Principles
Prevalence - Alcohol and other substances are less readily available and are used less by those in our communities
COMMUNITY SAFETY
LOCAL ENVIRONMENT
SERVICES
PREVALENCE
Indicators
Number anti-social youth calls to police.
Number of households were antisocial behaviour is a regular feature (party houses).
Number of test purchases undertaken.
% of objections to prevent extensions to licensing hours upheld by the Licensing Board.
Number of community based recovery activities throughout West Lothian.
Number of mutual aid groups in West Lothian.
Recovery Outcomes from ADP services. Outcomes relating to offending form WLDAS. Moving on Service. Services' attendance at quality assurance meetings focusing on ROSC principles. Service's commitment to service user involvement. Service compliance to Heat. Waiting times database and SDMD compliance.
National Core Indicators (see Performance Framework).
Number of under 18s alcohol related hospital admissions.
Number of under 18s drug related hospital admission.
Number of NPS needle exchanges.
Reach
All West Lothian communities. Specialist groups such as young offenders, offenders and those in custody suites.
All West Lothian communities including those with deprivation.
All services delivery substance misuse recovery outcomes. All ADP partners.
At risk groups. All West Lothian Communities.
Outputs
Engagement in Community Action Blackburn. Engagement in the ADF projects. Adoptions of licensing over provision statement. Licensees engagement in "Best Bar None" initiative. Engagement with the Young Almond Project. Continued support for the Police Scotland Youth Volunteers – PSYV and Campaign Against Violence Patrols.
Adoption of licensing overprovision statement. Engagement in Community Action Blackburn. Work to address stigma by making recovery more visible. Engagement of young people/peers in the ADF projects. STRADA Workforce development outputs. ABI LES delivery programme – deprived areas.
Engagement from offenders in Criminal Justice Service. Number of ABI delivered in custody and prison. Number of mutual aid groups in prison and community. Support offered from Moving on Service. Engagement in services offered in HMP Addiewell and HMP Edinburgh. Engagement of YP in ADF Projects. Women engaging in the substance misuse services offered by DASAT.
Level of engagement in the Family Recovery Service - School Training Plan.
STRADA Workforce development outputs.
Adoption of licensing overprovision statement.
Engagement with the Young Almond Project.
Schools engaging in social norming project.
ABI delivery programmes.
Activities
Community Action Blackburn Projects.
ADF Projects across West Lothian.
Best Bar None Award Scheme.
Peer mentors and work in schools.
Youth volunteers training scheme.
Projects within the DASAT service.
Outreach and Street work with Young people.
Peer Development and Youth Action – CAB.
Commissioned work from STRADA Workforce Development.
Body of evidence/indicators about alcohol harms.
ABI delivery.
Breakaway drop in clinics. Advice & Information. Prison Inreach/Outreach. Counselling. Substitute prescribing Detoxification. Rehab. Mutual aid groups. Peer support. After care support. ADF Activities.
Pilot of NPS service in Whitburn Academy
Social Norming Project.
Work of the Schools Substance Misuse Working Group. Young Almond Project.
ABI delivery.
Commissioned work from STRADA Workforce Development.
Inputs
WLDAS Moving On Service. ELCA Prison Service. ADP services. DASAT. Community Safety Partnership. Reducing Reoffending Committee. HMP Addiewell. Community Justice Service. Community Safety Board. Police Scotland. Scottish Fire & Rescue Service.
WLYAP. CAB. GPs. Needs Assessment. STRADA. Police Scotland. Community Planning Partnership. WL Council Area Services. ADP Partners. ADP overprovision report.
NHS Lothian. WLDAS. HMP Addiewell. WLYAP. Community Groups involved with young people. ADP Partners. ADP Funds.
Education Officers. WLDAS. Police Scotland.
NHS Lothian Public Health Specialists.
ADP overprovision report.
ADP Partners.
ADP funds.
ABI – Alcohol Brief Intervention ADF – Alcohol Diversionary Fund CAB – Community Action Blackburn DASAT – Domestic Abuse & Sexual Assault Team NPS – New Psychoactive Substances WLYAP – West Lothian Youth Action Programme

Directorate for Population Health
Health Improvement Division

E: alcoholanddrugdelivery@gov.scot

The Scottish Government
Riaghaltas na h-Alba

NHS Chief Executive
ADP Chair

Copies to:
NHS Director of Finance
Local Authority Chief Executive and Chief Financial Officers
Chief Officer of Integrated Joint Boards
ADP Co-ordinators

4 July 2016

SUPPORTING ALCOHOL AND DRUG PARTNERSHIPS TO DELIVER IMPROVED OUTCOMES FOR ALCOHOL AND DRUGS: 2016-17 FUNDING ALLOCATIONS

1. I write to confirm the Scottish Government (SG) funding allocation to the Alcohol and Drug Partnership(s) (ADPs) within your NHS Board area for 2016-17.

2. As you will be aware, policy responsibility for tackling drug misuse transferred from the Justice to Health portfolio as part of the budget setting process for 2016-17. This 2016-17 allocation you receive is, therefore, a combined amount for alcohol and drug purposes. The transfer of funding, and responsibility, will allow for better policy alignment and accountability within the wider health portfolio.

3. We are committed to tackling alcohol and drug harm, and ADPs play a key role. As you will be aware from the letter you received on 7 January 2016 from the Cabinet Secretary for Health and Sport, Shona Robison MSP, **there is a clear expectation that existing services, resources and outcomes are maintained at 2015-16 levels.**

4. ADPs should therefore receive the full funding allocation, applying those resources with full transparency and informed by a robust evidence based needs assessment.

5. 2016-17 allocations have been adjusted to meet the needs of local populations. Allocations reflect (i) changes in the NHS Scotland Resource Allocation Committee (NRAC) formula, (ii) updated alcohol consumption data, (iii) updated prevalence data. Further information on the formulae is provided in Appendix 4.

6. The allocations described in this letter along with the supplement allocation from NHS Boards as described in paragraph 4 of this letter represent the minimum

amounts that your ADP(s) should spend in 2016-17. We expect that additional resources, including funding, will be contributed by ADP partners. ADP Strategies, Delivery Plans and Annual Reports should set out all resources utilised in prevention, treatment, recovery or dealing with the consequences of problem alcohol and drug use in your localities.

Ministerial Priorities

7. 2016-17 funding is conditional upon ADPs demonstrating progress towards both national and locally relevant alcohol and drug outcomes, and also on the Ministerial priorities outlined below. Please note that the same broad Ministerial priorities are continuing in 2016-17, as with 2015-16, but we have sought to ensure that they are giving a clearer and consistent focus, expressed within specific themes. This is in response to feedback made at the ADP Chairs event we hosted on 22 October 2015. The 2016-17 Ministerial priorities are:

<u>Compliance</u>

- Compliance with the Drug and Alcohol Treatment Waiting Times Local Delivery Plan (LDP) Standard, including, increasing the level of fully identifiable records submitted to the Drug and Alcohol Treatment Waiting Times Database;
- Preparation of local systems to comply with the new Drug & Alcohol Information System (DAISy);
- Increasing compliance with the Scottish Drugs Misuse Database, both SMR25 (a) and (b).
- Compliance with the Alcohol Brief Interventions Local Delivery Plan (LDP) Standard.

<u>Quality improvement</u>

- Implementation of improvement methodology at the local level, including implementation of the *Quality Principles*: *Standard Expectations of Care and Support in Drug and Alcohol Services* and responding to the recommendations outlined in the 2013 report from the independent expert group on opioid replacement therapies;

<u>Harm reduction and reducing deaths</u>

- Interventions to reduce harm and prevent drug-related deaths, including supporting a death prevention strategy being facilitated through the Scottish Drugs Forum (SDF), as set out in the Ministerial letter of 6 August 2014, and delivery of local death prevention strategies and respective drug death monitoring group work;
- Support for effective prison throughcare and reintegration into the community, and responding to the particular needs of women. This also includes continued reach of naloxone in community, custodial and health care settings;
- Support the management of, and implications from, the New Psychoactive substances Act, which commenced on 26 May 2016, to further reduce harm;
- On-going implementation of a Whole Population Approach for alcohol, recognising harder to reach groups and supporting a focus on communities where deprivation is greatest;
- ADP engagement in improvements to reduce alcohol-related deaths.

Further information on Ministerial priorities is provided in Appendices 2 & 3.

Funding Allocations

8. The 2016-17 funding allocation for ADP(s) in your NHS Board area (Lothian) is £8,887,133. Where there is more than one ADP, the NHS Board should agree funding distribution with ADPs.

9. The 2016-17 and 2017-18 funding allocated for ADP (s) includes costs for ADP(s) compliance with Drug Alcohol Information System (DAISy).This will vary from area to area and Scottish Government national support team will provide support to individual ADP's on local migration arrangements. The data set has now been fixed and ADP's should be developing plans to adopt this in full.

10. Scottish Ministers reserve the right to withdraw all or part of this funding if funds are not used for the purpose intended; if improvement/activity is not demonstrated; or if value for money is not demonstrated.

11. If you have any queries, please contact Amanda Adams (0131 244 2278, Amanda.adams@gov.scot

Daniel Kleinberg
Acting Head of Health Improvement and Equality
Population Health Improvement Directorate

APPENDIX 1 – NATIONAL CONTEXT FOR ADP FUNDING

Measuring Success

The *Road to Recovery* drugs strategy[1], *Changing Scotland's Relationship with Alcohol: A Framework for Action on Alcohol*[2], the *National Delivery Framework for Alcohol and Drug Delivery*[3] and the *Quality Alcohol Treatment and Support* (QATS) report[4] continue to provide the national framework for delivering alcohol and drug prevention, treatment and support in Scotland.

The *Getting Our Priorities Right* (GOPR) guidance[5] provides a good practice framework for all child and adult service practitioners working with vulnerable children and families affected by problematic parental alcohol and/or drug use. It reflects the national *Getting It Right for Every Child* approach and the Recovery Agendas, both of which have a focus on 'whole family' recovery. GIRFEC is being threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families. This approach underpins the Children and Young People (Scotland) Act 2014, the Early Years Framework, Curriculum for Excellence and a range of programmes to support improvements in services.

We are committed to keeping outcomes and indicators under review as frameworks develop. We have developed a validated and peer reviewed Recovery Outcomes tool for use across ADP drug and alcohol services. Information on the ROW is available on the Social Services Knowledge Website (SSKS). The ROW tool will form part of the new Drug & Alcohol Information System (DAISy) to enable improved understanding and recording of service user outcomes. All relevant drug and alcohol services in Scotland will be expected to comply with the ROW tool dataset as part of DAISy, although the use of ROW tool itself is not mandatory. This year the SG National Support team will be supporting a number of ADPs to implement and embed the Recovery Outcome Tool into local ADP commissioned service delivery.

National Support

The SG ADP National Support Team is available to support your capacity building, sharing of learning and good practice amongst ADPs around priority areas including:

- improving skills to use data for evidencing progress against core outcomes;
- delivering recovery-oriented systems of care through system redesign (including the transition from prison back to community and the importance of ensuring effective pathways are in place to support through-care arrangements);
- implementing a whole population approach to addressing problem alcohol use; and
- strengthening SG engagement with the social work/care sector in relation to drug and alcohol policy objectives and drug and alcohol workforce development.

We strongly encourage ADPs to use the national support available to them as well as utilising local expertise. Please contact Susan.Weir@scotland.gsi.gov.uk in the first instance to discuss opportunities for support.

[1] http://www.scotland.gov.uk/Publications/2008/05/22161610/0
[2] http://www.scotland.gov.uk/Publications/2009/03/04144703/0
[3] http://www.scotland.gov.uk/Publications/2009/04/23084201/0
[4] http://www.scotland.gov.uk/Publications/2011/03/21111515/0
[5] http://www.scotland.gov.uk/Publications/2013/04/2305

Planning and Reporting Arrangements

In recognition of the work currently underway by the Care Inspectorate, (to provide an evidence-informed assessment of local implementation, measurement and quality assurance of ADP and service compliance with *The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services) ,* we expect that all ADPs that appropriately complete local Position Statements for that work will not be required to submit that information again through annual reports in 2016.

All ADPs should continue to report through the Standard Reporting Template, which has been updated for 2015-16 to reflect the ADP/Care Inspectorate work and also takes account of ADP Feedback provided, through last year's Reports and the ADP Co-ordinator event held in November 2015.

The **2015-16 ADP report should be shared with Scottish Government by 12 September 2016.**

We intend to contact all ADPs in January 2017, following publication of the Care Inspectorate National Report and individual ADP Reports, to seek some high level information around your ADPs top three priority activities following receipt of your individual report. We will then ask you in September 2017, as part of the annual reporting cycle, for an update on your progress in delivering on these activities.

The Scottish Government will continue to offer light touch feedback on your ADPs 2015-16 Annual Report.

We anticipate annual reporting for 2016-17 to be in the same format as for 2015-16, recognising the above, following receipt of your ADPs Care Inspectorate Report.

National Services Scotland, Information Services Division, continues to update the ScotPHO profiles which are invaluable in assessing performance against the National Core Indicators. The profiles can be accessed here: http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool.

Health and Social Care Integration

The *Public Bodies (Joint Working) Scotland Act 2014 – Integration of Health and Social Care commenced in April 2015*, and all 32 Health Board and Local Authority partnerships in Scotland have submitted their integrated health and social care plans to Scottish Government Ministers.

It is imperative that ADPs make effective connections into local decision-making and raise awareness of alcohol and drug issues to inform local priorities, ensuring Strategic and Delivery plans for alcohol and drug outcomes are embedded within new Health and Social Care arrangements.

APPENDIX 2 – MINISTERIAL PRIORITIES AND IMPROVEMENT GOALS FOR 2016-17

The Minister for Public Health and Sport has identified a number of priority areas for continued improvement in the delivery of the Alcohol Framework: *Changing Scotland's Relationship with Alcohol* and the national drugs strategy, The Road to Recovery.

These are as follows:

Compliance

1. Delivering the **LDP standard for drug and alcohol treatment waiting times,** whilst increasing the level of compliance and improving the quality of data submitted (Appendix 3 has further information on the LDP Standard). By **increasing the level of fully identifiable records submitted to the** Drug and Alcohol Treatment Waiting Times Database **(DATWTD), which will assist with the transition to DAISy** at the National Services Scotland Information Services Division, ISD, Scotland so that it accurately reflects the number of people engaging with drug and alcohol treatment services at local level and correlates with the information submitted to the national DATWTD, also held by ISD Scotland.. DAISy is now moving into a implementation and testing phase with the expected date for transition is Spring 2017. A full functional specification is currently being developed. The Full Business Case does not include costs for compliance by ADPs and these costs should be met from ADP allocations in 2016-17 and 2017-18.

ADPs, services and service users should be assured that when client identifiable data is entered on to DATWTD that it is treated as confidential. Please see attached link:
http://www.drugmisuse.isdscotland.org/wtpilot/DATWT_Use_of_%20Anonymous_Option.pdf.

Services entering data to the DATWTD are currently able to submit anonymous records (where the records are stripped of personal identifiers unique to individuals). When records are submitted as anonymous it is not possible to provide services, and commissioners of services, with information about the outcomes of treatment. This anonymity function will not be a part of DAISy. The outcome of treatment is a key component of public accountability for investment in this area and anonymous records should be entered to the DATWTD on an exceptional basis only, in accordance with Human Rights legislation and the guidance referenced above. ADPs and services are required to continue to take action to minimise the numbers of anonymous records and to continue to ensure that accurate data is available to inform accountability and the local planning, design and delivery of services tailored to individual needs. Client confidentiality should continue to be paramount as part of the delivery of effective services.

2. Continued **delivery and embedding of ABIs,** which are formally linked to the NHS Board Local Delivery Plan (LDP) as a LDP standard, states that NHS Boards and their ADP partners will sustain and embed ABIs in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.

The split between priority and wider setting delivery remains the same in 2016-17 as 2015/16: 80% delivery in priority settings, 20% in wider settings. NHS Boards and

their ADP partners are asked to consider ways to increase coverage of harder to reach groups, supporting the focus in communities where deprivation is greatest. All delivery should be planned, implemented and evaluated in line with the ABI LDP standard national guidance[6]. Data should continue to be reported through ISD and through the National Core Indicators in ADP Annual Reports.

The LDP standard supports the long-held vision that ABIs should be embedded in routine practice. It also supports the Quality Alcohol Treatment and Support (QATS)[7] report recommendation highlighting the role of ADPs in embedding ABIs and early intervention approaches within their services.

Quality Improvement

3. ADPs have been asked to implement improvement methodology locally, demonstrating how they will implement the alcohol and drug quality principles at a local level and how they are responding to the challenges outlined in the 2013 report from the independent expert group on opioid replacement therapies.

The ***Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services*** were published in August 2014. All ADPs are expected to implement the Quality Principles and assess local services' compliance with the Principles.

To gauge the effective implementation of the Quality Principles, the Scottish Government commissioned the Care Inspectorate to undertake a programme of validated self-evaluation across Alcohol and Drug Partnerships (ADPs) in Scotland. The aim of this work is to support the validation of ADP and services' self-assessment of performance and progress in line with the Quality Principles and this work is underway with ADPs partners and services across Scotland.

This is not an inspection by Care Inspectorate. It is intended to be a supportive and helpful process for all involved. The findings from this validation work will also be reviewed by the Scottish Government to consider and inform the future programme of national support that will further encourage and support delivery of continued improvements at ADP and service level.

The Scottish Drugs Forum are supporting the Care Inspectorate through helping facilitate consultation with ADPs, services and service users. The National Quality Development team will offer support to quality improvement processes and will negotiate this based on need and available resources.

At the end of this project (December 2016) the Care Inspectorate will provide:

- an anonymised national report of findings
- individualised summary briefings for each ADP area featuring strengths and recommendations for improvement.

This will also satisfy elements previously requested through the ADP annual report. Each ADP will be encouraged and supported to develop their own action plan to take forward identified local improvements.

[6] http://www.show.scot.nhs.uk/alcohol-brief-interventions/
[7] http://www.gov.scot/Publications/2011/03/21111515/0

To further support the work in ADPs and services, the Social Service Knowledge Scotland (SSKS) drug and alcohol portal has undergone a significant overhaul of its structure and content over the last year. The portal is now more aligned to the work being delivered in ADPs, with the topics section aligned to the core outcomes, Ministerial Priorities and a dedicated area to share good practice nationally. The digital platform is dedicated to sharing information on social care delivery. Everything here relates to policy, practice and personal/ professional development within social services in Scotland.

Harm reduction and reducing deaths

4. The Partnership for Action on Drugs in Scotland (PADS) group has been set up to consider how to best reduce problem drug use and complement the work of the established Road to Recovery strategy, with one of its priorities being harm reduction and reducing drug-related deaths. This continues to be a Ministerial Priority for ADPs in 2016-17, with particular focus on death prevention and reducing drug-related deaths. Whilst there is a lot of positive action being taken, further effort is required to tackle these matters. It is expected that ADPs will work closely and effectively with local partners, including in formal local groups, to agree and progress the most appropriate action informed by evidence and good practice, as well as engagement in national work, sponsored through PADS and the Scottish Drugs Forum

5. It is known that rates of ill health are higher amongst prisoners than in the general population, particularly in relation to mental health and addictions related conditions. People who become involved in justice settings tend to have below average engagement with health and other services. A proactive and planned approach is required to respond to the needs of **individuals in the justice system affected by problem drug and alcohol use, whether in the community, in community justice processes, or in custody,** and their associated throughcare arrangements. It is expected that **ADPs (including Health Board partners) and the Scottish Prison Service will work more closely to ensure a consistent process and sharing of information before, during and after an individual is in custody**. The National Prisoner Healthcare Network has specific workstreams to examine issues relating to healthcare throughcare, substance misuse, and new psychoactive substances (amongst other topics), and published reports on healthcare throughcare in February 2016 and substance misuse in March 2016.

6. The Scottish Government centrally funded and supported **National Naloxone Programme** concluded on 31 March 2016, after reimbursing 34,267 kits in the community and prison settings throughout the five year duration of the programme. From 1 April 2016, naloxone provision has been mainstreamed into individual NHS Boards, monitoring arrangements are being put in place to support local kit distribution by the NHS Boards.

The provision of first supplies of naloxone to the most at risk individuals, including those not in contact with treatment services, should remain a priority for ADPs and NHS Boards. The National Naloxone Advisory Group (NNAG) highlighted the importance of ensuring that take-home naloxone kits are supplied to all new clients receiving prescribed opiate substitute treatment, as well as those released from prison and discharged from hospital, all of whom are vulnerable to an increased risk of opiate overdose and drug related death.

The continuing provision of naloxone remains a Ministerial priority, as is the desire to improve access to, and confidence in using, naloxone. While the work of the NNAG has now concluded, the work in this areas will continue to be overseen by the PADS group and its Harm Reduction sub group. We will also continue to support the Scottish Drugs Forum and the roles of the National Naloxone Coordinator and the National Naloxone Peer Educator in 2016 -17

7. New Psychoactive Substances The UK Psychoactive Substances Act commenced on Thursday 26 May 2016. We expect ADPs to be clear about how they will support the new legislation. The Act creates new civil and criminal offences to produce, supply, offer to supply, possess with intent to supply, possess within a custodial institution, and import and export psychoactive substances. However, legislation alone will not solve the problem of NPS, and ADPs will need to respond to any local post Act implementation challenges. Potential challenges may include an increase in individuals accessing services and due to this, services should be alert to risks of severe withdrawal symptoms and increased health harms, including potential overdose due to bulk buying. NPS users may turn to other drugs and data should be analysed to examine emerging trends.

8. Continued Implementation of a Whole Population Approach for alcohol recognising harder to reach groups, supporting a focus on communities where deprivation is greatest.

Continue to implement a whole population approach and seek support from Alcohol Focus Scotland as appropriate. Alcohol Focus Scotland have produced a briefing outlining possible action ADPs can take to support whole population approaches across the range of ADP outcomes. This briefing can be accessed at http://www.alcohol-focus-scotland.org.uk/media/86446/whole-population-approach-briefing.pdf

In addition, the following links may be helpful to ADPs.

Office of National Statistics (ONS) Neighbourhood Statistics:
http://www.neighbourhood.statistics.gov.uk/dissemination/LeadPage.do?pageId=1001&tc=1435834906279&a=7&b=276988&c=fife&d=13&g=519425&i=1001x1003&m=0&t=true&r=1&s=1435834906279&enc=1

Scottish Neighbourhood Statistics (SNS) website – enter the range of ADP Postcodes (top left of the home page), or use an Area Profile for ADP area (lower right of the home page)
http://www.sns.gov.uk/

Final MESAS evaluation (includes discussion of WPA measures and alcohol-related mortality across Scotland, with a breakdown on areas of deprivation): http://www.healthscotland.com/uploads/documents/26884-MESAS__Final%20annual%20report.pdf

9. ADP Engagement in Improvements to Reduce Alcohol Related Deaths

ADPs should describe activities underway/planned to improve understanding of alcohol related deaths and/or to reduce these deaths, making effective use of national and local data where appropriate (see links to data sources below). If ADPs

are interested in using patient level data to understand acute health pathways for alcohol related deaths, please contact Christine McGregor in the Scottish Government Health and Social Care Analytics Division in the first instance (Christine.McGregor@gov.scot or 0131 244 3394).

In addition, the following links may be helpful to ADPs.

Definition of alcohol related deaths: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-related-deaths/coverage-of-the-statistics

National Records of Scotland information on alcohol-related deaths: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-related-deaths

ISD alcohol misuse publications: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/

Scotpho alcohol and health and wellbeing profiles: https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do

To deliver these Ministerial priorities, ADPs are asked to set their own improvement goals, measures and tests of change to drive quality improvement at a local level in line with continuous improvement methodology.

Local improvement measures for delivering these Ministerial priorities should be described in the ADP Reports due for completion in the autumn.

APPENDIX 3 – LDP STANDARD FOR DRUG AND ALCOHOL TREATMENT WAITING TIMES (2016-17)

1. Continuing to achieve the LDP Standard on access to drug and alcohol treatment services, by ensuring early access to appropriate recovery-oriented treatment, remains a joint Ministerial priority and is a key indicator of better outcomes for service users. The first stage in helping people to recover from problem drug and alcohol use is to support action across the country to provide a wide range of services and interventions for individuals and their families that are recovery-focused, person-centred, high quality and that can be accessed where and when they are needed.

The LDP standard supports sustained performance in fast access to services and requires that 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. The two HEAT A11 target "below the waterline" Key Performance Indicators remain as part of the LDP standard:

- Nobody will wait longer than 6 weeks to receive appropriate treatment
- 100% compliance is expected from services delivering tier 3 and 4 drug and alcohol treatment in Scotland

2. To provide a full picture of waiting times for people accessing specialist drug and alcohol treatment services, drug and alcohol treatment waiting times data for people accessing services in prison has been gathered since 1st April 2013 and forms part of the LDP Standard. Latest figures show that performance in prison is equally as strong as in the community with over 94% of people receiving appropriate treatment within 3 weeks of referral. It is expected that all prisons fully comply with this Standard.

3. Performance against the HEAT Standard will continue to be measured via the Drug and Alcohol Treatment Waiting Times Database (DATWTD) with national reports being published on a quarterly basis via the ISD website: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/ This will continue until the new national integrated Drug and Alcohol Information System (DAISy) is operational

4. It is expected that access to treatment is equitable across all areas and settings in Scotland and across drug *and* alcohol treatment interventions. We expect that ADPs and services undertake routine reviews of subsequent treatments to ensure that people are not waiting lengthy periods of time between interventions. We also expect that nobody will wait longer than 6 weeks to receive treatment and as such expect that any on-going waits are dealt with swiftly.

5. We would welcome a continued dialogue with local colleagues around any risks or issues which could impact on the delivery and sustainability of the LDP Standard. Please contact Tracey McFall (Tracey.Mcfall@gov.scot) to discuss any issues further.

APPENDIX 4 - FUNDING FORMULAE

1. The total funding available from the Scottish Government in 2016-17 for Alcohol and Drug Partnerships is £53.8m. **Funding allocations for subsequent years will be agreed following the next Scottish Government spending review.**

4. 2016-17 allocations have been adjusted to meet the needs of local populations. Allocations reflect (i) changes in the NHS Scotland Resource Allocation Committee (NRAC) formula, (ii) updated alcohol consumption data*, (iii) updated prevalence data**.

5. *Alcohol consumption data is from 2012-2014 Scottish Health Survey which have been calculated against the previous sensible drinking guidelines, not the New UK Alcohol Guidelines which published 8 January 2016.

7. ** The drug prevalence data is the estimated number of individuals with problem drug use by NHS Boards (ages 15 to 64); 2012/13, updated data published by ISD Scotland.

Alcohol Funding Formula	
7.5%	**92.5%**
Based on the number of local authorities (rather than ADPs) within the NHS Board.	92.5% based on the same distribution formula (NRAC) used in NHS Boards' general allocations, adjusted by an additional weighting factor that reflects the prevalence of drinking above recommended guidelines in each Health Board, based on Scottish Health Survey (SHeS) data.

Drug Funding Formula	
7.5%	**92.5%**
Based on the number of local authorities (rather than ADPs) within the NHS Board.	75% of which is based on the latest prevalence figures and 25% of which is based on the NRAC formula

The revised formula for Alcohol and Drugs have fixed rates of 7.5% to ensure that no NHS Board receives less than the previously agreed threshold of £85,000 for ADP support. This fixed rate is based on the number of local authorities in an NHS Board rather than the number of ADPs. We expect part of this funding allocation to be used to support the Partnership in its strategic role in implementing the local alcohol and drugs strategy

8. NRAC (NHS Scotland Resource Allocation Committee) assesses each NHS Board's relative need for funding, using information about its population size and characteristics that influence the need for healthcare in terms of hospital services, community services and GP prescribing. The main drivers of the NRAC formula are:
(i) share of the Scottish population living in the NHS Board area;
(ii) age structure of the population and relative number of males and females;
(iii) morbidity and life circumstances (e.g. deprivation); and
(iv) additional costs of delivering healthcare in remote and rural areas.

Integration Joint Board

Date: 23/08/2016

Agenda Item: 12

TECHNOLOGY ENABLED CARE PROGRAMME

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the Integration Joint Board of the West Lothian Technology Enabled Care Programme (WL TEC Programme) and the associated Scottish Government funding which has now been approved by the Scottish Government.

B RECOMMENDATION

1. To note the West Lothian Technology Enabled Care Programme (WL TEC Programme) and the associated Scottish Government funding which has now been approved by the Scottish Government.

2. To receive six monthly progress reports on the West Lothian Technology Enabled Care Programme.

C TERMS OF REPORT

Technology-Enabled Care (TEC) is defined as: where outcomes for individuals in home or community settings are improved through the application of technology as an integral part of quality cost-effective care and support. This includes, but is not limited to, the use of telecare, telehealth, teleconsultation, video conferencing (VC) and mobile health & wellbeing (mHealth).

West Lothian has recently had confirmation of funding of £515,000 by the Scottish Government TEC Fund to participate in the 2 year national TEC programme. This will enable us to build upon our original investment in telecare technology and accelerate commitment in line with emerging national and local priorities and technological developments.

The funding will allow us to expand the range of services offered and provide greater opportunity to an increased number of our service users in particular to

- Meeting the increase in demand for services from the growing elderly population and people with dementia to enable them to live as independently as possible within their own home
- Rebalancing the health inequalities in West Lothian
- Expand and integrated the routine use of TEC and ensure TEC becomes sustainable and embedded feature within health, housing and care support services.

We will be developing the use of TEC in the following areas (see Appendix 1 for more details):

1. **Expansion of home health monitoring** as part of integrated care plans. This includes SMS messaging for BP monitoring and wound management and exercise motivation for falls management programmes;
2. **Expanding the range and extent of Telecare use**, with a particular focus on upstream prevention to support hospital discharge and reduce the rate of readmissions. We will be implementing a range of equipment for activity monitoring, lifestyle monitoring, medication prompts, and exploring the potential of wearable technology to support health and wellbeing.
3. **Expanding the use of video conferencing** to support teleconsultations, training and reduce the need for face to face appointments

Targets will mean that over 600 service users in West Lothian should benefit from the Programme. This support will allow us to release resources and allow us to redesign services at scale which are aligned locally, more efficient, joined up and person-centred and sustainable in the future.

West Lothian Technology Enabled Care Programme (WL TEC Programme) has been established to progress activities and ensure the expected outcomes and deliverables are achieved. A structured programme management approach (see Appendix 2) will be followed to ensure control and delivery; this approach will also ensure that the programmed activity is fully evaluated thus informing decisions on future sustainability.

It is proposed to report to the IJB on the progress of the programme on a six monthly basis.

D CONSULTATION

- Strategic Planning Group

E REFERENCES/BACKGROUND

- National Technology Enabled Care Programme

- http://www.jitscotland.org.uk/action-areas/telehealth-and-telecare/technology-enabled-care-programme/

F APPENDICES

1. Outline of programme activity
2. Project Initiation Document

G SUMMARY OF IMPLICATIONS

Equality/Health	Projects initiated under the WL TEC Programme will be subject to an equality impact assessment.
National Health and Wellbeing Outcomes	The WL TEC Programme will support the relevant National Health and Well-Being Outcomes in accordance with the IJB Strategic Plan
Strategic Plan Outcomes	The WL TEC Programme is aligned to relevant Strategic Plan outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The WL TEC Programme outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care
Impact on other Lothian IJBs	None
Resource/finance	None
Policy/Legal	"A National Telehealth and Telecare Delivery Plan for Scotland to 2016: Driving Improvement, Integration and Innovation"
Risk	Identified separately for each project strand.

H CONTACT

Contact Person:
Alan Bell, Senior Manager Community Care Support & Services
mailto:Alan.bell@westlothian.gov.uk

Tel 01506 281937

23 August 2016

Appendix 1

Outline of programme activity

Expansion of home health monitoring as part of integrated care plans.

Florence simple telehealth	Florence has been designed by the NHS to support self-management and compliance using simple affordable and scalable technology; Simple telehealth is an NHS inspired and owned solution. "Flo" is used to enable patients to take responsibility for monitoring and managing their health condition, lifestyle and or treatment Initially we are introducing Florence to support the following projects:
SMS Messaging for BP Monitoring	Patients identified with hypertension (high blood pressure) will be provided with a BP Monitor from their GP and asked to text their BP results to the practice using the Florence text messaging system. It is anticipated that this will improve adherence and compliance with anti-hypertension medication and reduce "white coat syndrome".
Wound Management	WoundSense product is a single-use, sterile, disposable, moisture sensor which is placed on the wound at dressing change. The sensor is read for moisture level using a small, hand-held meter as required. Because the dressing is not disturbed the clinician, having read the moisture level, can take decisions as to the most appropriate time to change the dressing, decide on a change of dressing type or that the wound requires extra moisture if necessary. The patient or carer will take the moisture reading and text the result using Florence system when prompted by text to do so. Unnecessary home visits for dressing changes can thus be avoided and the patient benefits from reduced trauma of dressing changes, a less disturbed wound bed and better planning for nurse visits at home.
Falls management	People who have fallen are offered the opportunity to participate in Posture Stability Instruction (PSI) classes. The classes are very successful however the fall-out rates are extremely high when people are required to continue exercise programmes at home. By using 'Florence' text messaging system top sent reminders and motivational text messages, it is hoped we can improve adherence to exercise programmes.

Expanding the range and extent of Telecare use, with a particular focus on upstream prevention to support hospital discharge and reduce the rate of readmissions. We will be implementing a range of equipment for activity monitoring, lifestyle monitoring, medication prompts, and exploring the potential of wearable technology to support health and wellbeing.

Activity monitoring	Activity monitoring gives an up- to-the-minute picture of how a person gets on with their daily life, without being intrusive or depriving them of their privacy. By installing discreet wireless motion sensors and a plug-in controller, it creates a clear chart of daily living activity that can be viewed securely online. It shows e.g. when people are in or out; whether there are visits to the kitchen at mealtimes; what rooms are visited, how many times they are visited and for how long; if there's a natural routine to the day and the ability to see if where help is need or not. Activity monitoring allows a full assessment and ensures appropriate care planning. We are currently testing two forms of activity monitoring – Just Checking and Canary systems.
Lifestyle monitoring	Lifestyle monitoring systems can uses a pendant or smartwatch to monitor movement, support medication management and other reminders. Passive activity sensors are attached to movable objects around the home, like pillboxes, the refrigerator, front door, etc. The systems often use simple, inexpensive components such as accelerometers that know when an object is moved. Others use small power sensors to track electricity use or contact circuits that tell when a door is open or closed The systems are connected to the alarm receiving centre and will trigger alerts if presented with a set of pre-determined circumstances.
Medication prompts	There is a wide range of technological aids available in the market aiming to support medication management. Medication prompts can be set using wearable technology, by the use of Florence, lifestyle monitoring equipment and other bespoke technology. We are planning to test a range of equipment in order to determine the circumstances under which each potential option can best be used.
Wearable technology	Wearable technology can provide real time information, remotely to carers, on the level of stress and distress a patient with dementia is experiencing. This will allow carers to be altered to rising stress and distress in their patients and to attend to their needs as a priority. Thus, critical incidents of injury to self, other residents and care staff can be avoided.

Expanding the use of video conferencing to support teleconsultations, training and reduce the need for face to face appointments

Video conferencing	Introduce VC into care homes, sheltered housing and housing with care facilities
	To support staff to manage individual with distress and stressed behaviour and allow access to behavioural teams in support
	To consider the impact of vital sign peripherals with VC equipment to inform conversations with GP's regarding residents' conditions
	To support movement and activity classes and increase the cardiovascular activity of residents.
	The use of telephone conversation as an alternative to face to face consultation
	Review the potential of a night response service as an alternative to sleep over and waking night staff in a person's home.

Appendix 2

Data Label: Official Sensitive

West Lothian Health & Social Care Partnership | NHS Lothian | West Lothian Council

PROGRAMME INITIATION DOCUMENT

West Lothian Integration Joint Board

West Lothian
Technology Enabled Care Programme

Date:	July 2016
Author:	Lesley Broadley
Senior Responsible Officer:	Alan Bell
Service:	Social Policy

Project initiation document history

The source of the document will be found in the Control section of the project file which is stored in Meridio at -

Document history

Version	Date of issue	Reason for Issue
1	July 2015	Programme Initiation Document
2	July 2016	Phase 2 funding awarded

Revision history

Version	Date of issue	Reason for Issue
2	July 2016	Phase 2 funding awarded

Document approvals

This document requires the following approvals.

Electronic sign off required by	Position	Version	Date approval received
Alan Bell	Senior Manager	2	

Document distribution

This document has been distributed to the following:

Version	Date of issue	Name	Position

Contents

Programme definition

Purpose of document

The purpose of this document is to provide the Programme Board, Integration Joint Board and key stakeholders with an outline plan for Phase 2 of the West Lothian Technology Enabled Care Programme (**WL TEC Programme**).

Definition

The definition of Technology Enabled Care (TEC):
Technology enabled care is defined as - "Where the quality of cost-effective care and support to improve outcomes for individuals in home or community settings is enhanced through the application of technology as an integral part of the care and support process". This includes, but is not limited to, the use of telecare, telehealth, video conferencing (VC) and mobile health & wellbeing *(*mHealth).

Introduction

In December 2014 Scottish Government launched the TEC Programme. Bids for funding from the TEC Programme were sought from partnerships to significantly extend the numbers of people directly benefiting from technology enabled care and support .A bid was submitted on behalf of The West Lothian Technology Enabled Care Programme (WL TEC Programme) and was awarded £246,000.

In December 2015 Scottish Government launched Phase 2 of the TEC Programme. A bid was submitted on behalf of The West Lothian Technology Enabled Care Programme (WL TEC Programme) and was awarded £515,000.

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, the growing numbers of people with multiple conditions and complex needs and the ever-increasing number of hospital admissions and readmissions. These challenges are faced in an environment of budget reductions and rising expectations of our service users.

It is anticipated that technology enabled care will become mainstream and an integrated part of care planning.

Programme objectives, deliverables and desirables

National programme

The **aim** of the national TEC Programme is to enable the delivery of health and social care at home.

The **objectives** are:

- To accelerate spread across Scotland of a minimum of three effective innovations in technology enabled care: e.g. home monitoring, video technology and apps /on line resources
- To increase the capacity and capability to deliver technology enabled care in all NHS Boards, integration authorities and their partners
- To improve sustainability of technology enabled care within redesigned pathways

The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services.

West Lothian

The outline proposals, expected achievements and benefits for each workstream submitted in the West Lothian Programme Bid see Appendix A.

Programme scope and exclusions

The WL TEC Programme Board will act as a steering group to:

- Oversee, determine and contribute to the strategic direction and progress of technology related activities in West Lothian
- Promote and monitor TEC implementation plans and allocate funding
- Promote and coordinate participation in notional technology initiatives
- Communicate, exchange ideas, collaborate and benchmark on technology related activities with other local authorities, NHS teams and other stakeholders as required
- Enhance the visibility of technology based initiatives amongst IJB work streams and coordinate approaches
- Provide information and input in respect of technology based initiatives to support the prevention agenda and influence service planning and redesign
- Provide a source of views and input into technology related consultation exercises or other relevant options
- Address other inequities, variances and gaps in service provision
- Support the transition the WL TEC Programme into mainstream activities

Programme constraints

There are a number of possible constraints which will have an impact on this programme:

- The timescales preparing the bid for this programme did not facilitate widespread consultation and/or engagement with stakeholders and their proactive engagement, shared ownership and ongoing commitment is crucial to success, given the scale of the programme.
- Telehealth options are not widely utilised in Scotland, any proposals will need to work within the existing telecare infrastructure, finding the appropriate platform may prove challenging.
- Phase 2 of this programme must be completed by March 2018 to meet the deadlines set by the national TEC Programme; failure to do so may inhibit future bid submissions or require funding to be repaid.
- The national TEC Programme has been issued in parallel with the TEC Improvement Support Programme and involvement in this is implicit.
- Given the scale of the programme being undertaken, successful implementation of the TEC Programme will depend on the proactive engagement, shared ownership and ongoing commitment of all partners.

Programme assumptions

It is assumed that:

- Short-term changes may need to be made to existing team structures, processes and or budget allocations
- The programme will be supported by senior management and then developed as part of any subsequent implementation plans.

- Partners will realise the potential of technology enabled care and support the programme.
- There is a role for technology enabled care in reducing the number of people waiting to be discharged from hospital and in support of self-management.

Programme users and other interested parties

The main users, or recipients, on completion of the TEC Programme will be:

- Service users and carers assessed as requiring telecare from the local authority
- Service users and carers requiring telehealth and telecare equipment on discharge from hospital
- Service users and carers requiring support to self-manage
- Service users and carers requiring access to digital platforms for support and information

The other main users of the end result of this programme will be staff involved in assessment, outcomes-focused support planning and the arrangement, delivery or provision of support.

Programme interfaces

External

Table 1

The WL TEC Programme:

- Is sponsored by Scottish Government under the national TEC Programme.
- Works in partnership with the Lothian TEC Programme Board established to develop and deliver TEC across Lothian. Represented in that partnership are NHS Lothian and the four local authorities.

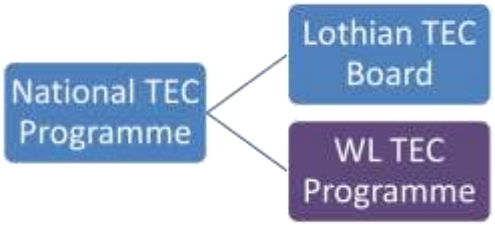


Table 2

Internal

The WL TEC Programme will report to the Integration Joint Board.

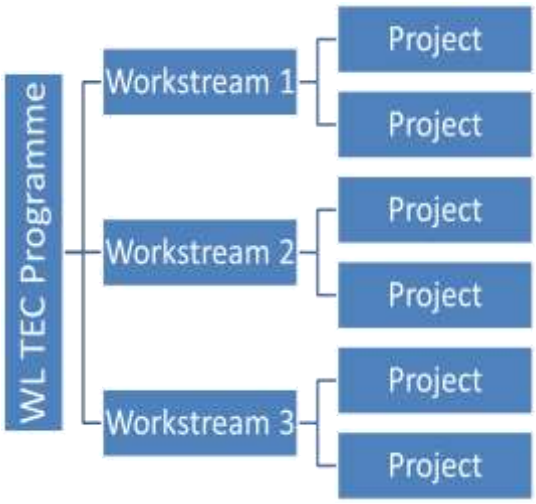
The programme will be aligned with existing services in West Lothian namely:

- 24/7 Crisis response and care management service (Crisis Care).
- Discharge Hub
- Falls management service
- Home Safety Service (HSS)
- Local Care Homes
- Lothian Unscheduled Care Service (LUCS)
- Medication management
- Older people assessment and care team (OPACT)
- Palliative care service
- Rapid Elderly Assessment Care Team (REACT)
- West Lothian Pathways Collaborative (WELPACT)
- West Lothian Reablement Team

Programme approach

The approach being adopted for the delivery of the WL TEC Programme is as follows:

- The WL TEC Programme will be a partnership led by Executive Sponsor - Director West Lothian IJB. The WL TEC Programme Board will be chaired by Senior Manager, Communities and Information.
- Delivery of programme objectives and benefits will be in workstreams in accordance with the national criteria.
- Membership of workstreams will reflect the roles, knowledge and expertise required for the delivery of the respective agendas.
- Regular performance reports on progress, development, implementation and evaluation will be provided in accordance with the requirements of the national TEC fund to assess impact and compliance with requirements locally and nationally.



- Each workstream may be at different stages in the cycle however a common base of operational detail will be required for each.
- Progress will be reported to the Integration Joint Board, the Lothian Board and the TEC Programme.

Business case

Outline business case

Shifting the balance of care towards enablement and intermediate care are core elements of national and local strategies to reshape our health, care and support services for older people and those with long-term conditions. Technology is fundamental to the development of such services and provides the opportunity to facilitate integration, improve the quality of life, reduce avoidable admissions/readmission to hospital, support early discharge and allow people to remain independent in their own home.

The reasons for developing and undertaking the West Lothian TEC Programme are to support the following:

National legislative drivers:

- Public Bodies (Joint Working) (Scotland) Act 2014
- Social Care (Self-Directed Support) (Scotland) Act 2013
- The National Telehealth and Telecare Delivery Plan for Scotland to 2016
- Reshaping Care for Older People: A Programme for Change 2011-2021.
- Caring Together – The Carers Strategy for Scotland 2010-2015

- Commission on the Future Delivery of Public Services – Christie Report 2011

Other drivers:

- Current and future demographic and budgetary pressures on health boards and authorities
- Services to be delivered to meet the needs of people which are accessible and responsive to local need
- Service users/ carers to be active participants in the design and delivery of their care and support
- Expanding the use of technology can help people to optimise independence and wellbeing at home
- People who directly benefit from technology with home health monitoring being identified as a service ready for wider application.

Expected programme benefits

See Appendix 1 for a breakdown of the expected benefits for each workstream.

Budget

In Phase 2 West Lothian has been awarded the following funding:

No	Workstream	Funding awarded (£k)	Comment
1	Expansion of home health monitoring	£196,158	
2	Expansion of video conferencing	0	Awaiting results of separate bid
3	Expansion of the use of Digital Platforms	0	WL will participate in a national programme
4	Expansion of the use of Telecare	£318,842	
5	Move to Digital Telecare	0	
Total awarded		£515,000	

Table 3

It is anticipated that the programme will be delivered by funding from the national TEC Programme and matched funded from existing resources. The TEC Programme has awarded funding for two years; however additional support may be provided on the successful delivery of workstream projects. Ongoing sustainability of activity supported by the fund will need to be considered in this context with clear exit strategies identified.

Known risks and dependencies

The main risks identified at the outset of this programme are:

- Conflicting priorities for programme team members could result in slippage
- Insufficient data on current performance of services
- Identifying appropriate telehealth equipment - being the early stage of development

- Lack of established methodology to evaluate the comparative benefits of relatively new approaches to supporting people at home
- Financial sustainability given funding initially awarded for two years
- Buy in from owners of current processes
- Conflict between meeting financial efficiencies and achieving priority outcomes

Team structure

The WL TEC Programme will be chaired by the Executive Sponsor: Alan Bell Senior Manager.

The TEC Programme Board will be responsible for programme governance and oversight and will report to the IJB.

The WL TEC Programme will report on progress to:

- National Technology Enabled Care Programme Board
- Lothian Technology Enabled Care Programme Board
- West Lothian IJB/Strategic Planning Group

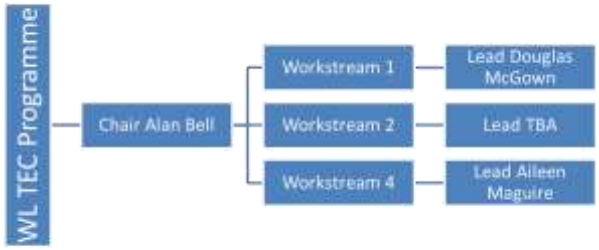


Table 4

Team Roles

Table 5

Details	Role	Details	Role
Programme Board	To provide overarching governance, oversight and leadership. ▪ Provide direction ▪ Agree the performance criteria ▪ Accountable for overall budget funding ▪ Identification & management of risk ▪ Resolve escalated issues ▪ Champion change	Chair	Responsible to the organisation for the success of the programme including: ▪ Chairs the Programme Board ▪ Leads the transformation agenda ▪ Manages programme and governance ▪ Challenges and coaches workstream progress ▪
Workstream Leads	▪ Reports to the WL TEC Programme Board ▪ Leads, manages, develops and support workstream projects ▪ Oversee progress of the Programme Workstreams against the Action Plans ▪ Report on workstream progress, and evaluation ▪ Develop action plans and report on progress ▪ Champions change, communication and engagement ▪ Understands and represent the requirements service users and carers ▪ Ensure risk management processes	Project Manager	This will be a dedicated, funded resource for a two-year period. Responsibility for planning, execution and closing of the programme including: ▪ Reports to the Executive Sponsor/Programme Board and Workstream Leads ▪ Liaison and coordination with National/Lothian TEC programmes ▪ Business/project management support to workstream and individual workstream leads ▪ Analysis and evaluation of best practice and guidelines of new emerging technologies ▪ Coordination of TEC activities across all partners

Details	Role	Details	Role
	established ▪ Ensure clinical and care governance		
Project Leads	▪ Reports to the Workstream Leads ▪ Manages, develops and supports individual projects ▪ Report on project progress, and evaluation ▪ Develop action plans and report on progress ▪ Understands and represent the requirements service users and carers ▪ Ensure risk management processes established ▪	IT	▪ Provides ad hoc advice on IT requirements and data sharing ▪ Provides advice on integration of technology and alignment with existing and future services
		Finance	▪ Set up appropriate accounting structures, reporting and control ▪ Provides ad hoc advice
Legal	▪ Providing effective legal advice, support and representation ▪ Ensure the WL TEC Programme implementation is compliant with all legislation, statutory requirements and regulations ▪ Minimise and manage legal risk	CPU	▪ Lead contract negotiations with suppliers or buyers ▪ Provide ad hoc advice on contracting and commissioning

Programme plan & key milestones

This Programme Initiation Document and the Programme Plan will act as the baseline for the WL TEC Programme and will be used to monitor progress in relation to both activity and timescales. Based on returns required by the National TEC Programme Board, a common template for project planning has been devised for each workstream and will be adapted for each individual project. See Appendix 3.

Individual project plans will feed into a top level Programme Plan which will be presented to the WL Programme Board at monthly meetings and for approval. The Programme Plan will be reviewed, amended and added to as required for the duration of the Programme.

Quality management strategy

Quality management of the WL TEC Programme will be the responsibility of the Programme Board and will be developed in accordance with the National Care Standards (NCS).

Risk management strategy

A Risk Management Strategy will be provided for each Workstream/Project.

Communication management strategy

The communication between the national TEC Programme Board, WL TEC Programme Board; and Programme Workstreams will be facilitated by the Project Manager and will be conducted as follows:

TEC Programme	▪ Regular returns required as and when directed by the Programme
Lothian TEC Programme Board	▪ Attendance at bi-monthly pan-Lothian meeting to report on progress/developments. ▪ Lothian sub-committees operational for each workstream on an ad hoc basis.
WL TEC Programme Board	Quarterly meetings: ▪ Sub-committees established for each workstream – attendance at meetings and reports on progress/developments provided. ▪ Project plan and timeline updated and issued to members ▪ Minutes circulated to members five days prior to meeting ▪ Progress update by Workstream Leads ▪ National/Lothian update by Project Manager
Workstream Leads	Monthly meetings ▪ Action plan/ notes circulated to workstream project leads ▪ Approving monthly report for TEC Programme ▪ Progress report to TEC Board quarterly ▪ Progress/monitor updates from project leads
Project Manager	▪ Recommendations and required actions passed to Workstream Leads ▪ Monthly reports collated and submitted to Workstream Leads for approval ▪ Monthly template submitted to national TEC Programme Board ▪ Quarterly reports to WL TEC Programme Board ▪ Report on progress to the Lothian TEC Board/TEC Programme
Workstream projects	Meetings schedule as per Terms of Reference ▪ Progress updates from members to Workstream Lead/ Project Manager as required
Service users and carers	▪ Run service user/carer focus groups ▪ Establish service user/carer fora to feedback regularly ▪ Evaluation

Table 6

Programme controls

This Programme Initiation Document and Programme Plan will be used as the baseline for the WL TEC Programme. Throughout the duration of the programme there may be requests for changes to the Programme Plan as a result of either internal or external factors.

All proposed programme changes which impact on the Programme Plan and the Workstream Action Plans must be considered by the WL TEC Programme Board for approval and decisions made by the board reported via the Workstream Leads.

Appendix A – West Lothian Technology Enabled Care (TEC) Bid

Appendix B – National Health & Wellbeing Outcomes

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 to reduce any negative impact of their caring role on their own health and well-being
7	People who use health and social care services are safe from harm.
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9	Resources are used effectively and efficiently in the provision of health and social care services.

Table 7

Appendix C – Outline Project Plan Template

Workstream/Short Life Working Group - TITLE

Phase 1 – Proof of concept and initiation

- Gather data for informed investment decisions
- Understand care pathways and patient flows
- Understand service user information flows
- Conduct AS-IS and TO-BE modelling
- Agree the service vision
- Understand the benefits the new vision would deliver
- Evaluate whether the necessary skills/environment exist
- Understand the financial implications and timescales
- Embed telehealth within relevant organisation(s)
- Agree a high level strategy to develop and deliver the vision
- Assign roles and responsibilities
- Create a clear business case to support decision making
- Create a communications plan for consultation and engagement
- Create clear plans to monitor and manage the programme

Phase 2 – Preparation and planning

- Move the vision into detailed plans through patient/service user consultation
- Consult with organisations which may be impacted upon
- Create a detailed service specification
- Source appropriate technology according to business needs
- Plan and deliver a training programme to meet business needs
- Determine how the impact of the programme will be evaluated

Phase 3 – Launch and execution

- Introduce the pilot implementation
- Pilot evaluation questionnaires
- Review all service delivery against the service plan
- Refine service delivery as required
- Ensure accurate documentation and training through refinements
- Check evaluation data is appropriate
- Close the pilot ready for mainstream launch

Phase 4 - Implementation

- Launch the mainstream service
- Refine service delivery as required
- Ensure accurate documentation and training through refinements
- Ensure service delivery matches the service specification
- Check the service is stable as deployments rapidly increase
- Conduct the service evaluation and report findings

Phase 5 – Performance & Control

- Investigate any pressing contractual or legal issues
- Ensure continued finance and resources
- Ensure alignment with strategic goals, cultural and political fit
- Continue communication campaign
- Reflect on progress made and pitfalls experienced
- Review evidence for future implementation/continuation
- Act upon mainstream, continue or abandon decision
- Close project

Table 8

West Lothian Integration Joint Board

Date: 23 August 2016

Agenda Item: **13**

2015/16 ANNUAL ACCOUNTS (UNAUDITED)

REPORT BY CHIEF FINANCE OFFICER

A PURPOSE OF REPORT

To provide the Board with the unaudited 2015/16 Annual Accounts of the West Lothian Integration Joint Board (IJB) for information.

B RECOMMENDATION

It is recommended that the Board notes the 2015/16 Annual Accounts that have been submitted to Audit Scotland for audit.

C TERMS OF REPORT

The Public Bodies (Joint Working) (Scotland) Act 2014 specifies IJBs should be treated as if they were bodies falling within Section 106 of the Local Government (Scotland) Act 1973. This requires annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (Section 12 of the Local Government Scotland Act 2003 and regulations under section 105 of the Local Government (Scotland) Act 1973).

The IJB accounts are proportionate to the limited number of transactions of the Board, particularly in 2015/16, given health and social care functions were not delegated to the IJB until 1 April 2016.

In line with the Local Authority Accounts (Scotland) Regulations 2014, the unaudited annual accounts were submitted to the appointed auditor by 30 June. Prior to submission, and in compliance with Regulations, the unaudited accounts were considered by the IJB Audit, Risk and Governance Committee.

The Annual Accounts appended detail the IJBs financial position for 2015/16 taking account of a date of establishment of 21 September 2015. The accounts also include a Management Commentary setting out the purpose and strategic aims of the IJB, and the Annual Governance statement previously approved by the Board.

D CONSULTATION

Relevant officers in NHS Lothian and West Lothian Council.

E REFERENCES/BACKGROUND

Audit, Risk and Governance Committee held on 24 June 2016.

F APPENDICES

West Lothian Integration Joint Board 2015/16 Annual Accounts (unaudited).

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted.
National Health and Wellbeing Outcomes	None.
Strategic Plan Outcomes	None.
Single Outcome Agreement	None.
Impact on other Lothian IJBs	None.
Resource/Finance	None.
Policy/Legal	In accordance with the provisions of the Local Authority Accounts (Scotland) Regulations 2014, the Audit Risk and Governance Committee considered the unaudited accounts prior to submission to Audit Scotland.
Risk	None

H CONTACT

Patrick Welsh, Chief Finance Officer, West Lothian Integration Joint Board
Tel. No. 01506 281320
E-mail: patrick.welsh@westlothian.gov.uk

23 August 2016

WEST LOTHIAN INTEGRATION JOINT BOARD

ANNUAL ACCOUNTS

YEAR ENDED 31 MARCH 2016

CONTENTS

Accounts of West Lothian Integration Joint Board (IJB) for the year ended 31 March 2016, prepared pursuant to Section 105 of the Local Government (Scotland) Act 1973 and in accordance with the terms of the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom.

Annual Accounts

Audit Arrangements

Under arrangements approved by the Accounts Commission for Local Authority Accounts in Scotland, the auditor with responsibility for the audit of the accounts of West Lothian Council for the period 21 September 2015 to 31 March 2016 is:

David McConnell, MA, CPFA
Assistant Director of Audit
Audit Scotland
4th Floor, South Suite
The Athenaeum Building
8 Nelson Mandela Place
Glasgow
G2 1BT

Statement

The audit of the West Lothian IJBs Accounts for 2015/16 is yet to be undertaken. The unaudited accounts will be presented to the Audit Risk and Governance Committee on 24 June 2016.

The certified accounts will be presented to the West Lothian IJB for approval following completion of the audit.

MANAGEMENT COMMENTARY

PURPOSE AND OBJECTIVES

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care in Scotland. The West Lothian Integration Joint Board (IJB) was established as a body corporate by order of Scottish Ministers on 21 September 2015 and is a separate and distinct legal entity from West Lothian Council and NHS Lothian. The arrangements for the IJBs 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.

The IJBs purpose is to set the strategic direction for the delegated functions through the development of a Strategic Plan. It receives budget contributions from the council and NHS Lothian to enable it to plan the delivery of delegated functions and deliver on strategic outcomes. It gives directions to the council and NHS Lothian as to the functions to be delivered and the resources available to deliver the functions.

Under the legislation and as part of the approved integration Scheme, the IJB has delegated responsibility for a wide range of health and social care functions including adult social care, general medical services, prescribing, a range of hosted services including Oral Health and Learning Disabilities. A range of acute hospital services are also delegated to the IJB.

The IJB meets on a six weekly basis and is made up of eight voting members, made up of four elected members appointed by West Lothian Council and four NHS Lothian non-executive directors appointed by NHS Lothian. A number of non voting members of the Board including the IJB Director and Chief Finance Officer, and service and staffing representatives are also on the Board as advisory members.

The IJB Audit Risk and Governance Committee and the West Lothian Integration Strategic Planning Group have been set up below the full IJB to support integrated policy and strategic development and to ensure IJB business adheres to the principles of good corporate governance.

IJB STRATEGIC AIMS

It has been recognised both nationally and locally that whilst health and care needs of individuals are closely intertwined, there is scope to further improve the coordination and integration of services. The way health and social care services are delivered can have a significant impact on shifting the balance of care from hospital to community care, reducing health inequalities and reducing emergency admissions and delayed discharge. Through the Strategic Plan developed it is aimed to:

- Shift the balance of care to provide more care delivered at home or in a homely setting rather than in hospital or other institutions
- Ensure care is person centred, with a focus on the individual and not just specific health and social care needs
- Further improve the joined up approach to working across professions and bodies delivering health and social care functions
- Ensure citizens, communities and staff involved in providing health and social care services will have a greater say in how these services are planned and delivered

In preparing the Strategic Plan a comprehensive review of all health, social and economic data relevant to integration planning was carried out. An important aspect of this is understanding the needs of the West Lothian population. West Lothian has a population of over 177,000 which accounts for 3.3% of the total population of Scotland. Of this population 19.8% are children (0 – 15 years), 59.4% are aged between 16 to 59 years and 20.8% are aged 60 years and over.

It is estimated that West Lothian's population will grow by 12% by 2037 increasing the total population to 196,664. However, the growth in the older age group populations will be very significant over this period with the 65 – 74 years group increasing by 57% and the over 75 age group increasing by 140%. The projected increase in the population of older age groups will place a significantly increased strain on health and social care services and will present a significant challenge. West Lothian also has a higher proportion of people living in the most deprived areas than other parts of Lothian and health indicators show a clear link between decreasing affluence leading to poorer health.

Taking account of West Lothian's needs the Strategic Plan has been developed to deliver the Scottish Government's nine national health and wellbeing outcomes for integration. These are the high level outcomes of health and social care integration which integration will be measured against.

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

- 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
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- 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 health and wellbeing
- People who use health and social care services are safe from harm
- 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
- Resources are used effectively and efficiently in the provision of health and social care services

Strategic commissioning of IJB functions will be a key element 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.

To achieve the best possible outcomes for people living in West Lothian, the following principles have been agreed to ensure a longer term strategic approach to commission:

- To implement outcomes based approach to the commissioning of care and support services
- To commission health and social care 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 and appropriate stakeholder involvement and consultation which includes service users, their carers and providers
- Positively engage, consult and communicate with the independent and voluntary sectors
- To ensure the approved procurement procedures are adhered to

FINANCIAL STRATEGY AND RESOURCES

While the IJB was legally established on 21 September 2015, the agreed delegated NHS Lothian and West Lothian Council functions and resources will not be delegated to the IJB until 1 April 2016. Therefore, for 2015/16 there will be very limited financial information to be included in the annual accounts.

Looking ahead, for 2016/17 the council approved its budget contribution of £66.685 million to the IJB as part of the 2016/17 revenue budget approved by Council on 23 February 2016. NHS Lothian are continuing to develop their 2016/17 revenue budget plans and at this stage indicative resources of £133.571 million have been advised.

At its meeting on 31 March 2016, the IJB agreed the approved council contribution and indicative NHS Lothian contribution would be allocated to partners, via Directions, to operationally deliver and financially manage IJB delegated functions.

The IJB Annual Financial Statement was also agreed by the Board and sets out indicative three year resources to 2018/19 of £600 million for IJB delegated functions.

MANAGEMENT COMMENTARY

A key element of the IJB role will be to influence future financial planning undertaken by NHS Lothian and West Lothian Council for delegated functions. This will be vital in ensuring the IJB strategic plan can be delivered and the objectives of integration including the shift in the balance of care are achieved.

Chief Officer

Date

STATEMENT OF RESPONSIBILITIES

STATEMENT OF RESPONSIBILITIES FOR THE STATEMENTS OF ACCOUNT

Responsibilities of the Integration Joint Board

The Integration Joint Board is required:

- to make arrangements for the proper administration of its financial affairs and to secure that it has an officer responsible for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973. In this Integration Joint Board, that officer is the Chief Finance Officer.
- to manage its affairs to achieve best value in the use of its resources and safeguard its assets; and
- to approve the Annual Accounts for signature

I confirm that these Annual Accounts were approved for signature by the West Lothian IJB Audit, Risk and Governance Committee at its meeting on 23 September 2016

Signed on Behalf of West Lothian Integration Joint Board

Councillor Frank Toner
Chair of West Lothian Integration Board

Responsibilities of the Chief Finance Officer

As financial officer I am responsible for the preparation of the Integration Joint Board's statement of accounts which, in terms of the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom ("the Code of Practice"), is required to give a true and fair view of the financial position of the Integration Joint Board at the financial year end and its income and expenditure for the year then ended.

In preparing the financial statements I am responsible for:

- selecting suitable accounting policies and then applying them consistently;
- making judgements and estimates that were reasonable and prudent;
- complying with Code of Practice;

I am also required to:

- keep proper accounting records which are up to date; and
- take reasonable steps to ensure the propriety and regularity of the finances of the Integration Joint Board;

Statement of Accounts

I certify the Statement of Accounts presents a true and fair view of the financial position of the West Lothian Integration Joint Board as at 31 March 2016, and its income and expenditure for the year then ended.

Chief Finance Officer :

Date : 3 June 2016

REMUNERATION REPORT

1. INTEGRATION JOINT BOARD

The voting members of the Integration Joint Board are appointed by West Lothian Council and NHS Lothian. The voting members of the Integration Joint Board and partner organisations are shown below.

Chair and Vice Chair

Frank Toner (Chair of Integration Joint Board) – West Lothian Council

Julie McDowell (Vice Chair of Integration Joint Board) – NHS Lothian

Other Voting Members

Danny Logue – West Lothian Council

Anne McMillan – West Lothian Council

John McGinty – West Lothian Council

David Farquharson – NHS Lothian

Martin Hill – NHS Lothian

Alex Joyce – NHS Lothian

2. SENIOR OFFICERS

The appointment of a Chief Officer is required by section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014. The Chief Officer is appointed by the Integration Joint Board on consultation with the Health Board and Local Authority. The Chief Officer is employed by NHS Lothian and, in line with the Act, is regarded as an employee of the Integration Joint Board for time spent on Integration Joint Board matters.

The services of the Integration Joint Board Chief Finance Officer have to be secured under the requirements of section 95 of the Local Government Scotland Act 1973. In relation to this, the requirement is for the Integration Joint Board to make arrangements for the proper administration of its financial affairs. The Chief Finance Officer is appointed by the Integration Joint Board to undertake this requirement and is employed by West Lothian Council.

3. REMUNERATION POLICY

The Integration Joint Board does not pay allowances or remuneration to voting board members. Rather, voting members are remunerated by their relevant partner organisation. In addition, the Integration Joint Board does not pay expenses for voting members.

The remuneration of the Chief Officer is set by NHS Lothian and has a contract of employment with NHS Lothian. In line with the Public Bodies (Joint Working) (Scotland) Act 2014, the Chief Officer is regarded as an employee of the Integration Joint Board when undertaking duties for the Board. This is estimated at 50% of the Chief Officer's time since appointment on 16 February 2016. In respect of this 50%, the post of the Chief Officer is funded by the Integration Joint Board and features in the Integration Joint Board remuneration report.

The statutory responsibility for the Chief Officer's employer pension liabilities rests with NHS Lothian. The remuneration report presents the pension entitlement attributable to the post of the Chief Officer although the Board has no formal ongoing liability. Rather the Integration Joint Board will be expected to fund employer pension contributions as they become payable during the Chief Officer's period of service. On this basis, there is no need to reflect a pensions liability on the IJB balance sheet.

Other officers, including the Chief Finance Officer, are not regarded as employees of the Integration Joint Board. Therefore, such officers do not feature in the Integration Joint Board remuneration report but may feature, as relevant, in the remuneration report of the employing partner.

4. REMUNERATION

Based on the above, the following remuneration is relevant to the Integration Joint Board annual accounts:

	Salary, fees and allowances £'000	Taxable expenses £'000	Total remuneration 2016/17 £'000	Total remuneration 2015/16 £'000
James Forrest	6	0	6	0

REMUNERATION REPORT

5. PENSION BENEFITS

The IJB Chief Officer took up post on 16 February 2016 and as such benefits earned as a consequence of undertaking the role of the IJB CO are not considered material for 2015/16. The contractual liability for employer pension contributions is considered to rest with NHS Lothian who is the contractual employer.

Chief Officer: **Chair:**

Date **Date**

ANNUAL GOVERNANCE STATEMENT

The West Lothian Integration Joint Board was established by parliamentary order on 21 September 2015 following approval of the West Lothian Integration Scheme by the Scottish Ministers. It is a body corporate, a legal entity in its own right, but it relies on support from officers employed by West Lothian Council and NHS Lothian in relation to the conduct of its business. It is subject to the Public Bodies (Joint Working) (Scotland) Act 2014 and secondary legislation directly relating to the integration of health and social care services, and indirectly in relation to regulatory regimes affecting devolved public bodies in Scotland.

Statutory and other Compliance

In its first six months of formal existence the Board has secured compliance with statutory and other requirements, as follows:

- Membership - its minimum membership (voting and non-voting) is set by statutory instrument, with the power to appoint additional members as it sees fit. The Board's membership is fully populated with an additional member having been appointed beyond the statutory minimum

- Standing Orders - the Board is required by statutory regulations to have Standing Orders to regulate its business, with some aspects stipulated in those regulations. Standing Orders were adopted at its inaugural meeting, and a review was carried out of them in April 2016. They comply with statutory requirements

- Committees - the Board has established an Appointments Committee, and an Audit, Risk & Governance Committee, with detailed remits and powers and with their membership clearly defined. They comply with statutory requirements and with the Board's Standing Orders

- Meetings - the Standing Orders adopted by the Board allow the public to have prior access to meeting agendas and reports, and to attend meetings of the Board and its committees, except in clearly defined and limited circumstances

- Strategic Plan - the Board established its Strategic Planning Group as required by legislation, with Terms of Reference approved by the Board covering membership, meetings and meetings procedures. Through the Group the Board approved and published its Strategic Plan prior to the delegation of the integrated functions on 1 April 2016

- Officers - through the Appointments Committee, the Board appointed its Chief Officer (Director) and it's Finance Officer as required by the legislation. It also appointed a Standards Officer in relation to its statutory Code of Conduct for Members, and that appointment has been approved by the Standards Commission for Scotland. An Internal Auditor has been appointed to carry out the Board's internal audit requirements and assist its Audit, Risk & Governance Committee

- Finance - the Board received reports in relation to financial assurance prior to the setting of budgets for the integrated functions by the council and the health board, and adopted Financial Regulations in relation to the conduct of its financial affairs, the maintenance of its accounting and financial records, and its annual accounts and financial statements

- Financial resources and Directions - prior to the delegation of functions, the Board received a firm financial commitment from the council and an indicative financial contribution from the health board which allowed it to receive further financial assurance and to timeously fulfil its statutory duty to issue Directions to the council and health board

- Code of Conduct - pending finalisation of arrangements for a Code of Conduct for Members, the Board adopted an interim Code based on the existing Model Code for Members of Devolved Public Bodies in Scotland, and members have registered their interests according to that Code. Those arrangements are in the course of being finalised now that a Model Code for Integration Joint Boards has been produced, and the Register of Members' Interests will thereafter be published and made available for inspection

Further Work Being Progressed

Through the Board and the Audit, Risk & Governance Committee, further work will be progressed and will be carried out in relation to governance of these particular aspects of the Board's statutory duties and powers:-

- Compliance with Integration Scheme – a review of the Integration Scheme commitments is being progressed to identify further governance requirements that require to be progressed. Although such commitments were given by the council and the health board, they are nevertheless significant for the Board due to its reliance on officers of the council and health board to enable it to do its business

- Annual Audit Plan – this is currently being developed and, upon approval, will be monitored through the Audit, Risk & Governance Committee

- Risk Management - a strategy, monitoring and reporting regime for risk is being developed and will be reported to the Board and Audit, Risk and Governance Committee

- Performance Monitoring and Reporting - similarly, a procedure for recording, monitoring and reporting on service and financial performance is being developed and will be reported to the Board for approval

- Accounting requirements - through the Finance Officer, the Board will require to agree an annual process to secure compliance with the legislation and accounting practices which apply to its annual accounts and financial statements

- Miscellaneous statutory regime compliance - as a devolved public body, the Board is subject to a variety of statutory regimes, such as freedom of information and data protection, and appropriate policies and procedures will require to be developed and approved to secure compliance

- Education and knowledge of members - the provision and uptake of adequate training for Board members will be addressed, due to its importance for good decision-making and the future development of the Board

System of Internal Control

The Board requires to carry out at least annually a review of its system of internal control and to report on that as part of this statement. The Board is still in its very early stages of its existence and is still to fully develop that system of control. As summarised above, the legal constitutional requirements of the Board have been put in place, and the structure is there to allow that system to be fully established and to be more formally reviewed in 2016/17 and future years.

CERTIFICATION

It is our opinion that reasonable assurance, subject to the matters noted above, can be placed upon the adequacy and effectiveness of the West Lothian Integration Joint Board's systems of governance.

Chief Officer:	**Chair:**
Date:	**Date:**

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

PURPOSE	**This statement shows the accounting cost in the year of providing services in accordance with generally accepted accounting practices**

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT FOR THE YEAR ENDED 31 March 2016

	2015/16			2014/15		
	Gross Expend £'000	**Gross Income £'000**	**Net Expend £'000**	**Gross Expend £'000**	**Gross Income £'000**	**Net Expend £'000**
Health and Social Care Functions	0	0	0	0	0	0
Corporate Services (Running Costs)	13	(13)	0	0	0	0
(Surplus) or Deficit on Provision of Services	**13**	**(13)**	**0**	**0**	**0**	**0**
Net Comprehensive Income and Expenditure	**13**	**(13)**	**0**	**0**	**0**	**0**

BALANCE SHEET

PURPOSE	**The Balance Sheet shows the value as at the Balance Sheet date of the assets and liabilities recognised by the Board.**

	Note	As at 31 March 2016 £'000	As at 31 March 2015 £'000
CURRENT ASSETS			
Short Term Debtors	4	5	0
CURRENT LIABILITIES			
Short Term Creditors	5	(5)	0
NET ASSETS		**0**	**0**
USABLE RESERVES		**0**	**0**
UNUSABLE RESERVES		**0**	**0**
TOTAL RESERVES		**0**	**0**

The Statement of Accounts present a true and fair view of the financial position of the Integration Joint Board as at 31 March 2016 and its income and expenditure for the year then ended.

The unaudited financial statements were authorised for issue on 24 June 2016 and the audited financial statements were authorised for issue on 23 September 2016

Chief Finance Officer: **Date: 3 June 2016**

NOTES TO THE FINANCIAL STATEMENTS

1. ACCOUNTING POLICIES

1.1 General Principles

The financial statements summarise the transaction of the West Lothian Integration Joint Board for the 2015/16 financial year and its position at the year end. The Integration Joint Board is required to prepare annual financial statements by the Local Authority Accounts (Scotland) Regulations 2014. The Annual Accounts have been prepared under the 2015 Code of Practice based on International Financial reporting Standards (IFRS).

The financial statements are prepared under the historical cost convention as modified for the valuation of certain assets.

1.2 Accruals of Income and Expenditure

Activity is accounted for in the year that it takes place, not simply when the payments are made or received.

1.3 VAT Status

The Integration Joint Board is a non-taxable person and does not charge or recover VAT on its functions.

1.4 Provisions, Contingent Liabilities and Assets

Not relevant

1.5 Events After the Reporting Period

Not relevant

1.6 Debtors and Creditors

Debtors and creditors are reflected in the financial statements to ensure that income and expenditure are properly shown in the financial year relevant to when the related activity takes place.

1.7 Reserves

The West Lothian Integration Joint Board currently holds no reserves.

2. RELATED PARTY TRANSACTIONS

The West Lothian Integration Joint Board was established on 21 September 2015 as a joint board between West Lothian Council and NHS Lothian. In 2015/16 there were financial transactions made relating to integrated health and social care functions as functions are not delegated by partners to the Integration Joint Board until 1 April 2016.

Corporate expenditure relating to running costs since the date of establishment on 21 September 2015 are shown below.

3. CORPORATE EXPENDITURE (RUNNING COSTS)

	31 March 2016 £'000	31 March 2015 £'000
Staff Costs	8	0
Insurance and Audit Costs	5	0
Total	**13**	**0**

NOTES TO THE FINANCIAL STATEMENTS

4. SHORT TERM DEBTORS

	31 March 2016 £'000	31 March 2015 £'000
Central Government Bodies	0	0
Other Local Authorities	5	0
Total	**5**	**0**

5. SHORT TERM CREDITORS

	31 March 2016 £'000	31 March 2015 £'000
Central Government Bodies	5	0
Other Local Authorities	0	0
Total	**5**	**0**

6. MOVEMENT IN RESERVES

	31 March 2016 £'000	31 March 2016 £'000
Usable Reserves – General Fund	0	0
Surplus/(deficit) on provision of services	0	0
Other comprehensive expenditure and income	0	0
Total comprehensive expenditure and income	0	0
Total	**0**	**0**

7. POST BALANCE SHEET EVENTS

No material issues

8. CONTINGENT LIABILITIES

No material issues

Integration Joint Board

Date: 23 August 2016
Agenda Item: **14**

IJB MEMBER INDUCTION

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the Board of the proposal for further progressing induction for the Board members.

B RECOMMENDATION

The board notes the content and dates of Board member induction as outlined in this report.

C TERMS OF REPORT

West Lothian IJB induction sessions were provided for Board Members on the 19th August 2015 with a view to providing a broad overview of key themes. This was well attended with 10 appointed members of the IJB attending. A further repeat session was run on the 9th February 2016 which targeted and enabled new non - voting members and senior managers to also participate in a briefing along similar lines.

It was subsequently agreed following a paper to the board that a series of orientation events would take place over the coming year for members to visit areas and learn about service specific initiatives .

This will enable members to familiarise themselves with local environments whilst being able to meet and interact with a range of teams providing care.

Appendix 1 outlines the dates and themes of each visit .

D CONSULTATION

None Required

E REFERENCES/BACKGROUND

1. Leading the Journey of Integration – a guide for Integration Joint Board members (produced by Scottish Government in conjunction with SSSC and NESS)

2. Leading for Outcomes – Integrated Working & Delivering Integrated Care and Support, The Institute for Research and Innovation in Social Services (IRISS)

F APPENDICES

Appendix 1 – Proposed Site Visits

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted. The relevance assessment can be viewed via the background references to this report.
National Health and Wellbeing Outcomes	
Strategic Plan Outcomes	
Single Outcome Agreement	
Impact on other Lothian IJBs	
Resource/finance	
Policy/Legal	
Risk	

H CONTACT

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Marion Barton, Head of Health
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Tel 01506 281010

Appendix 1

IJB Orientation Sessions

Date	Time	Venue	Theme	Lead
23 August 2016	1000hrs - 1200hrs	Craigmair or Colinshiel tbc	Older People	Alan Bell
5 October 2015	1400hrs -1600hrs	Strathbrock Partnership Centre	Mental Health (Mental Health and Wellbeing Awareness Day)	Nick Clater
29 November 2016	1200hrs -1330hrs	Forrest Walk, Uphall	Physical Disability	Pamela Main
31 January 2017	1000hrs – 1200hrs	Eliburn Day Centre	Learning Disability	Pamela Main
14 March 2017	1000hrs – 1200hrs	Civic Centre, Conference Room 3	Alcohol/Drugs also REACT, Crisis Care and Reablement services	Mairead Hughes / Alan Bell
20 April 2017	1400hrs – 1600hrs	Fauldhouse Partnership Centre	West Locality	Marion Barton
27 June 2017	1000hrs – 1200hrs	East Calder	East Locality	Jane Kellock

4

Date: 23 August 2016

Agenda Item: **15**

WORKPLAN FOR WEST LOTHIAN IJB 2016

Date of IJB meeting	Meeting to approve reports	Title of Report	Lead Officer	Action
August 2016		Commissioning Plan for Adults with Physical Disabilities	Alan Bell	
		Needs Assessment for Older People		
		Needs Assessment for Adults with Mental Health Problems		
October 2016		Commissioning Plan for Adults with Learning Disabilities		
		Commissioning Plan for Adults with Mental Health Problems		
		Six monthly review of performance		
		Engagement Strategy	Steve Field	
		Provision of Support Services	James Millar/Steve Filed	
December 2016		Commissioning Plan for Older People		
		Risk Register review		
March 2017		Strategic Plan annual review		
		Annual review of performance		

FOR FUTURE UNSPECIFIED MEETINGS		Lothian Hospitals Strategic Plan		
		Arrangements to liaise / cooperate with other Lothian IJBs		
		Community Planning Partnership / IJB relationship		
		SW Audit	Jane Kellock	
		JIT Evaluation Tool		
		NMC Revalidation	Mairead Hughes	
		REH Business Case		
		Recommendations from Mental Welfare Commission Report	Jane Kellock/Wendy Ramsay	