INTEGRATED HEALTH AND SOCIAL CARE

WEST LOTHIAN WORKING FOR WELLBEING

West Lothian

Integration Joint Board

Strategic Delivery Plans

A Home First Approach

Background

The West Lothian Integration Joint Board (IJB) Strategic Plan 2023-2028 sets out the Board's ambitions and priorities for continued development and improvement of health and social care services in West Lothian over the next 5 years and describes how we will deliver the IJB's vision of:

"Working in partnership to improve wellbeing and reduce health inequalities across all communities in West Lothian"

To take forward this vision we are committed to:

- recognising and taking account of the different needs of vulnerable groups when we plan, design and deliver services
- ensuring that all adults are supported to live their lives as well as possible
- supporting people to achieve their potential to live independently and
- enabling people to exercise choice over the services they use in line with the principles of Self-Directed Support (SDS)

The Strategic Plan identifies the following strategic priorities that will be progress to achieve the IJB's vision:

The strategic priorities have been developed to reflect the transformational change that is required to improve the health and wellbeing outcomes for people in West Lothian and recognises the challenging demographic and financial landscape faced by public services in Scotland.

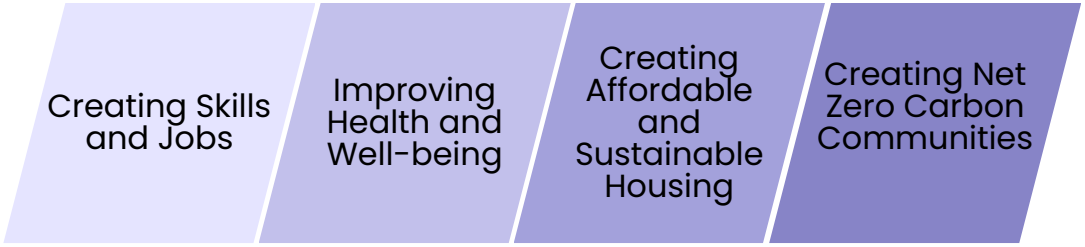
To deliver the strategic priorities and intentions set out in the IJB Strategic Plan, a delivery plan for each strategic priority has been developed and is underpinned by a medium-term financial planning framework.

Background

The delivery plans outline how we will deliver the nine national health and wellbeing outcomes through our strategic priorities and transformational change programmes against the background of demographic, and financial challenges.

The delivery plans are also aligned with the Community Planning Partnerships (CPP) Local Outcome Improvement Plan (LOIP) and identify where the work of the IJB contributes to the delivery of the local outcomes identified within the LOIP, in particular:

The current LOIP and Community Planning Partnership's Locality Plans are currently under review. The Community Planning Partnership has agreed that the LOIP should focus on the 'added value' that the CPP can bring to issues, build on the value of working collaboratively whilst not duplicating activity that is currently ongoing. The new LOIP will therefore focus on the following four pillars:



Our delivery plans take account of a range of strategies and plans highlighted in appendix 2 of the Strategic Plan

The delivery plans take account of the importance of providing good quality housing to support a range of needs as reflected within our Housing Contribution Statement. The Housing Contribution Statement is an integral part of West Lothian Integration Joint Board's Strategic Plan, and the purpose is to explain the way in which housing and related services in West Lothian support improvement in health and social care outcomes.

A number of accommodation requirements and support requirements have been identified through the development of the draft West Lothian Local Housing Strategy and in conjunction with Social Policy. These relate to the following groups:

- People with Learning Disabilities
- People with Mental Health Issues
- Older People
- People with Physical Disability
- Homelessness and Housing Options
- Young people
- People at risk of Domestic Abuse
- Refugee Provision

Background

The IJB is committed to working with our partners, service users, their families and the wider community to find effective and sustainable solutions and achieve the best outcomes for the people of West Lothian. This includes working with community planning partners to address underlying social inequalities that contribute to health inequalities, with poorer health outcomes in some population groups.

The delivery plans will build on the existing partnership working to reduce health inequalities and improve health outcomes across all communities in West Lothian.

A Strategic Needs Assessment (SNA) was undertaken in 2022 with people who use our services, carers, staff and IJB partners. The SNA told us that the main challenges to be addressed in our Strategic Plan were around:

- key physiological and demographic risk factors,
- inequality issues such as health status,
- access to care and
- wider determinants of health including income, housing, and social isolation

Feedback also highlighted the need to ensure:

- unpaid carers are supported to meet their own individual needs as well as the person they care for
- that the workforce is fully engaged and supported to deliver high quality care and
- that it is clear what support is available to individuals in West Lothian and where they can find this

Localities

How health and social care services are delivered locally can have a significant impact on addressing the main health and wellbeing challenges within an area. In West Lothian we have two defined localities across which health and social care services will be planned and delivered – the East Locality and the West Locality. There are significant differences in health and well-being outcomes between the East and West locality with an ageing population, poor health, deprivation, and unemployment more prominent in the West Locality than in the East Locality.

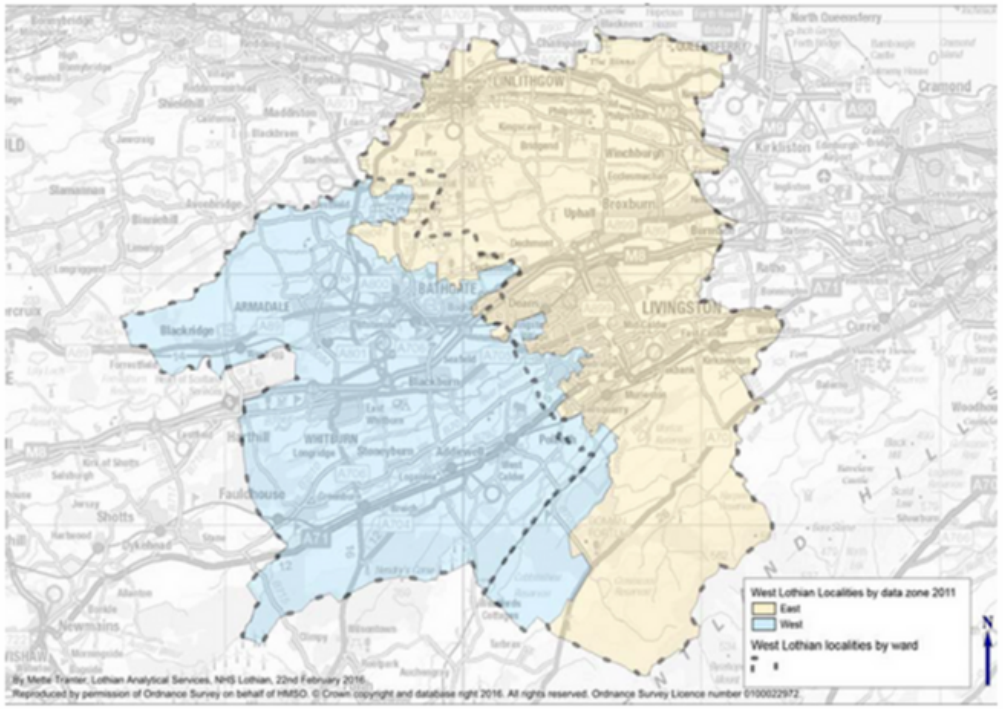


Figure 11: Map of East and West Localities: Lothian Analytical Services 2015: Ordnance Survey, HMSO 2015

Background

We recognise that health and wellbeing inequalities will not be substantially improved when policies and services work in isolation. The gap can only be reduced through a joined up co-ordinated approach were organisations, services, individuals, and their carers work together in partnership. We commit to working with a range of partners including our workforce, service users and carers, localities, and communities, the third sector and the Community Planning Partnership alongside many others.

By transforming the way adult health and social care is provided will enable the partnership to address more effectively the significant increase in health and wellbeing Inequalities occurring nationally and locally.

A delivery plan has been developed to take forward each priority, inform our strategic commissioning and focus on ensuring that the IJB fulfils its statutory duty to achieve best value, while delivering, developing, and commissioning services that are person centred, take a human rights-based approach and are outcome focused. To achieve this, we have worked closely with our strategic partners as well as the third and independent sectors.

Each delivery plan details the programmes and projects that will contribute to the delivery of each strategic priority. An overview is provided of the actions required, the project/programme, lead and alignment to the nine National Health and Wellbeing Outcomes.

The next steps will involve the development of a performance management framework to underpin each delivery plan. The performance framework will measure progress and impact in relation to each of the priorities outlined. We will also establish outcome measures for all actions within each delivery plan and review the interdependencies of each of these actions with other areas across the three strategic priorities.

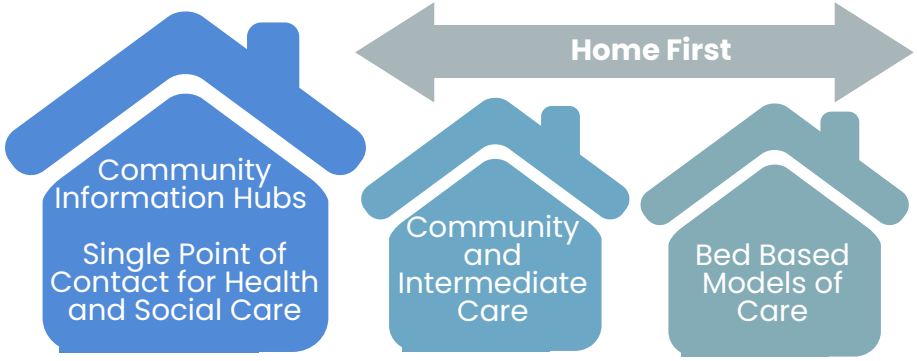
The delivery plans will be kept under review and will be updated annually to ensure the vision and aims of the Strategic Plan are delivered. The plans are underpinned by our medium-term financial planning framework, enabling us to inform the planning and prioritisation of future health and social care services in West Lothian.

Strategic Delivery Plan

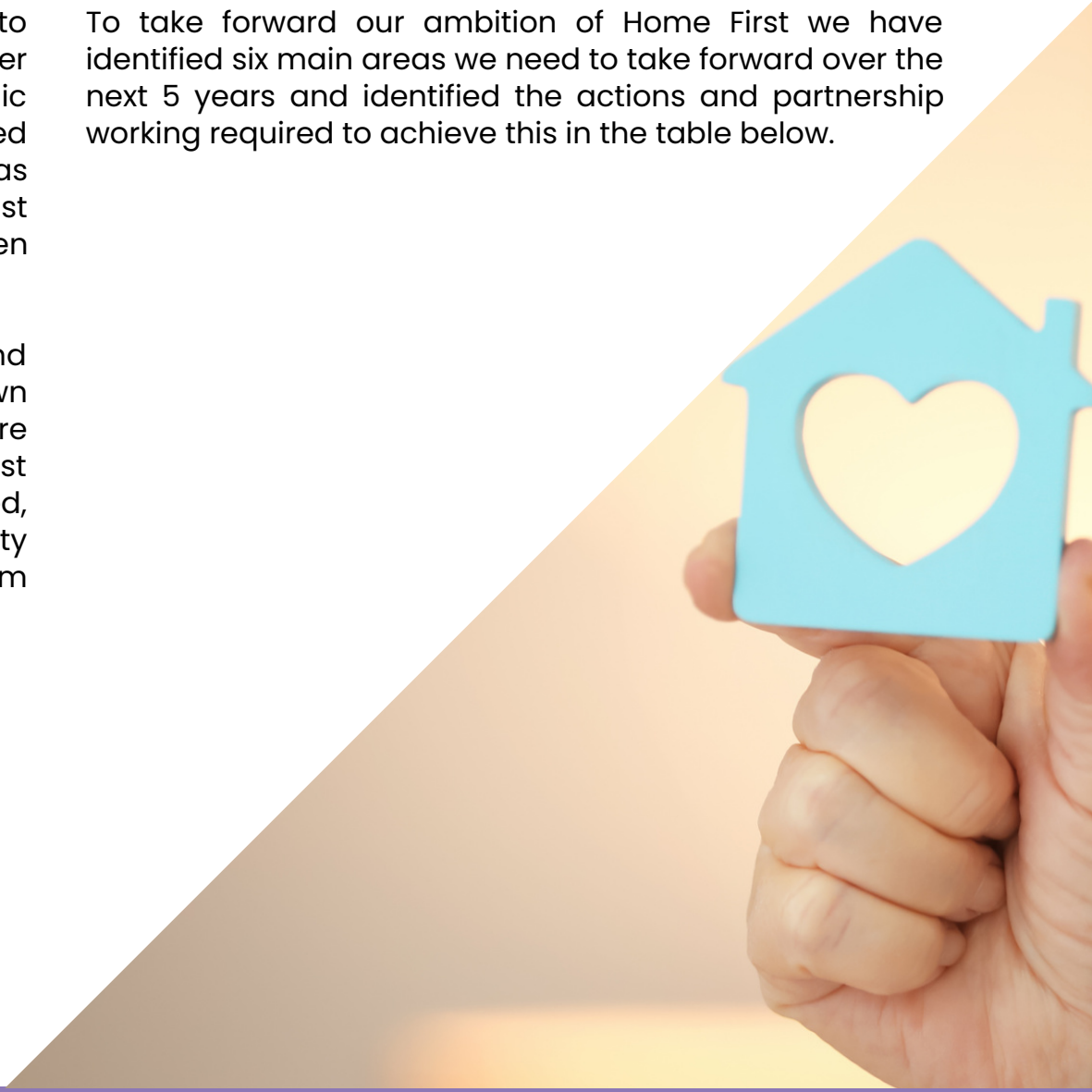
Strategic Delivery Plan
A Home First Approach

Home First is the overall ambition of our programme to transform the way that we deliver care to adults and older people. In line with the Scottish Government's strategic direction, we are working to ensure that people are supported to remain at home or in a community setting for as long as possible. Hospitals are place for people who need specialist short-term care and should therefore only be considered when care cannot be delivered in any other care setting.

We are focused on developing new ways of working and models of care to manage people within their own communities, with admission to an acute hospital only where there is a clinical need for this to happen. The Home First approach includes planning for acute hospital bed, unscheduled care, end of life care, dementia and community supports such as Care at Home to ensure a whole system approach as detailed below:



To take forward our ambition of Home First we have identified six main areas we need to take forward over the next 5 years and identified the actions and partnership working required to achieve this in the table below.



Home First Approach	**Strategic Aims** • Take a "Home First" approach with coordinated care, support and treatment as close to home as it can be • Deliver planned care whenever possible • Take a right based approach which places people at the centre • Involve citizens, communities, staff, carers, and other stakeholders as experts • Improve outcomes for people through more seamless partnership working • Drive improvement in service delivery through transformation

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Investment in Early Intervention and Prevention					
Proactive and longer-term planned care	2A1	Development of a proactive and longer-term, planned care model within primary care settings in West Lothian, focusing on frail older adults and adults with longer-term health conditions/frequent attenders.	General Manager Primary Care and Community Services	1, 2, 3, 4, 5, 9	• Reduction in hospital presentation and admission for excavation of Long term conditions (LTC), frequent attenders, frailty • LTC, Frequent attenders and frailty to be defined as project progresses.

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Investment in Early Intervention and Prevention					
Falls prevention	2A2	Development of an integrated falls pathway (including Technology Enabled Care) within the intermediate care/longer term care functions which focusses on early intervention and prevention of falls and rehabilitation to prevent subsequent falls if someone has already fallen	Chief Allied Health Professional	1, 2, 4, 7, 9	Reduction in Scottish Ambulance Service (SAS) conveyance rates
Managing frailty in the community (e-frailty)	2A3	Within the proactive care model, develop a test of change to integrate community and acute frailty teams, utilising the e-frailty tool to proactively identify and case manage frail patients in order to prevent deterioration and hospital attendance.	General Manager Primary Care and Community Services	1, 2, 3, 4, 5, 9	• All GP practices have all patients identified as being frail are entered into e-frailty system • People tracked by e-frailty changes and plans put into place via proactive care function (tracking and short term intervention and monitoring back to health and social care baseline) • Reduction in presentations/re-admission rate of frail patients

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Investment in Early Intervention and Prevention					
Short term breaks for carers	2A4	Analysis and understanding of level of respite required within older peoples services and models to deliver.	Senior Manager Older People Services	3, 5, 6	Capacity meeting demand, carers feedback
Community Connections	2A5	Continue to embed Community Connections to optimise prevention and early intervention within local communities - requires to be evaluated to see if this will continue	Business Support Officer	1, 4, 5, 6, 9	Reduction in referrals to Adult Social Care Enquiry Team (ASCET) for formal assessment

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
A Human-Rights Based Approach: Participation					
Anticipatory Care Planning (ACP)	2B1	Strengthen and increase the use of ACP across organisational boundaries within the context of proactive and local community models of care. With a particular focus on high risk groups	General Manager Primary Care and Community Services	1, 2, 3, 4, 5, 9	All appropriate people have access to an agreed anticipatory care plan - Regular audit of records
Discharge Planning & Service user/Carer/Family involvement (Carers (Scotland) Act 2016)	2B2	Strengthen process for involving patients, families and carers in discharge planning and assessment processes in the context of planned discharge date (PDD within) St Johns Hospital (SJH).		1, 2, 3, 4, 5, 6, 7, 8, 9	• Agreed pathways, process and SOP across organisational boundaries • Patient/Carer discharge information leaflets
Promotion of Self Directed Support (SDS) Options	2B3	Increase the promotion and use of SDS Options (from baseline) to meet individual needs. Increasing choice and control of individual needs and choice and control as to how their support and care needs are delivered.	Senior Managers - Adult Services / Older People Services	1, 2, 3, 4, 5, 6, 7, 8, 9	Quarterly Audits of use of SDS options (establish baseline)

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
A Human-Rights Based Approach: Empowerment of Rights Holders					
Adults with incapacity	2C1	Develop efficient and effective processes and pathways to support those who require measures under the AWI act including Guardianships to safely facilitate their discharge from hospital. Develop of a campaign to improve uptake of Power of Attorney (POA)	General Manager Primary Care and Community Services	1,2,3,4,5,6	• Reduction in days in delay associated with people awaiting Guardianship • Agreed SOP

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Self-Management					
Technology-enabled care	2D1	Embed promotion of technology enabled care (TEC) options within assessment process to increase use and impact of TEC, supporting self-management (i.e. to support management of longer-term conditions)	General Manager Primary Care and Community Services / Senior Manager Older Peoples Services	1,2,3,4,5,6,7, 8,9	• Increase ratio of those supported at home with technology enabled care rather than in person care • Impact of demographic growth on care at home provision - manage demographic growth via hybrid approaches to care as opposed to in person care
Promoting third sector and voluntary sector services to enable people to manage their own physical,social and mental well-being	2D2	Build the infrastructure and capacity in the community to support people to self mgt (interface SPoC, Community Connections and wider teams)	General Manager Primary Care and Community Services	1,2,3,4,5,6,9	Increase number of people being supported by third sector partners

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Care and Treatment Provided as Close to Home as Possible					
Front Door Access to Community Delivery (SPoC)	2E1	Continued development of the WL community Single Point of Contact with a view to fully embed in longer-term locality-based care models and expand the service to increase impact on front door presentations at SJH.	General Manager Primary Care and Community Services	1,2,3,4,5,6,7, 8,9	• Reduction in hospital presentations • Adherence to 2-4 hour "plan in place" KPI when requiring urgent care • Reduced duplication of assessment and visits by multiple community teams • Patient/Referring Professional experience
Local Community Delivery Model	2E2	Develop a vision/options for a local community delivery model for delivering integrated, multidisciplinary community services closer to home (test of change)	Head of Health	1,2,3,4,5,6,7, 8,9	Delivery model agreed with implementation plan
Community Bed based Care	2E3	Determine short, medium and long term requirements for care home beds and HBCCC beds in community hospitals, identifying options for bed provision closer to home and developing proposals to consolidate HBCCC Dementia beds to a single community hospital setting, reducing the overall number of beds in line with need.	Head of Health/ Senior Manager Older People Services	2,3,4,5,8,9	Demand and Capacity data capture to evidence that the needs of the population are being met in the right place

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Care and Treatment Provided as Close to Home as Possible					
Intermediate Care	2E4	Review and consider future approach to intermediate care delivery within the context of Home First and alignment with interim care arrangements if appropriate	General Manager Primary Care and Community Services	1,2,3,4,5,6,7, 8,9	• Reduction in people presenting at acute front doors • Increase in number of people cared for in the community
Older People Day Care Services	2E5	Review older people services and model of support offered via public engagement and a co-produced approach with inclusion of Technology Enabled Care (TEC)	Senior Manager Older People Services	1,2,3,4,7,9	TBC
Adults Day Care services	2E6	A full redesign and modernisation of Adult Building based day services is progressed which will see individuals being able to access day support which is person centred and meets their agreed outcomes and aspiration. Where appropriate day service will be provided within their own local communities	Senior Manager Adult Services	1,2,3,4,5,7	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Care and Treatment Provided as Close to Home as Possible					
Care at Home - Contract Mgt	2E7	• Maintain, review and develop the Care at Home Oversight Group arrangements • Provide relevant information to inform assurance level decision making around Care at Home provision in West Lothian • Review data weekly held in systems to ensure accuracy and quality of data reporting • Benchmark and engage with other Health and Social Care Partnerships to establish Care at Home best practice • Work closely across all HF transformation projects	Senior Manager Older People Services	1,2,3,4,9	• Care at home Oversight Group is effective, action and risk driven and able to assess care at home assurance level. • Quality, accurate data is reported to care at home Oversight Group.
Complex Mental Health and Addictions Housing Needs	2E8	Review with partners including Housing, as part of Rapid Rehousing Transition Plans (RRTP). Needs for people who cannot manage a mainstream tenancy identifying and commissioning, where appropriate, accommodation that suits their needs in particular considering the houaing / care needs of people who have ongoing mental disorder, ongoing use of alcohol and/ or drugs and those with Alcohol Related Brain Damange (ARBD)	General Manager for Mental Health and Addictions	2,3,4,5,7,8,9 ,	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Planned Care Rather Than Crisis Care					
Assessment and Review Function	2F1	• Streamline assessment and review processes for care at home, care home and other pathways • Ensure strength-based approach to assessment • Ensure best use of resources when assessing people's needs i.e. tech • Proactive management of unmet need and matching • Create capacity within the care at home provision • Review in partnership with service users, carers family and wider stakeholders	Senior Managers - Older People Services/ Adult Services	1,2,3,4,5,6,7, 8,9	• Develop WLHSCP agreed pathways and process (inc SOP)for Assessment and Review (Care ath Home, Care homes and other pathways from assessment process) • Reduce waiting times for individuals requiring assessment and ensure where possible people are not dependent on formal care and support • Care at home services provided and unmet needs are monitored and reviewed frequently • Appropriate and timeous support and assessment prioritised for unpaid carers

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Planned Care Rather Than Crisis Care					
Assessment and Review Function continued					• Evidence that SDS options are consistently applied within assessment process • greed single assessment and review pathways/ processes across both community and hospital
Planned Date of Discharge (Discharge without delay)	2F3	Fully implement PDD to all SJH wards with agreed roles and responsibilities with regard to the setting and review of planned dates of discharge and discharge planning generally.	General Manager Primary Care and Community Services	1,2,3,4,5,6,7, 8,9	Agreed pathways, process and SOP across organisational boundaries

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Specialist Care in the Right Place					
Dementia	2G1	Improve pathways for people with dementia, including: expanding community supports such as Dementia Friendly Communities and other general support activity; improving the pathways to diagnosis and access to PDS; improved care for people with dementia in other acre settings including acute medical hospitals	General Manager for Mental Health and Addictions	1,2,3,4,5,6,7, 8,9	TBC
Older Peoples Mental health and Addictions Care	2G2	Review and improve the functional mental health pathways for older people, including access to drug / alcohol services	Clinical Nurse Manager/ General Manager for Mental Health and Addictions	3,4,5,7,8,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Specialist Care in the Right Place					
Respiratory	2G3	• To implement respiratory investment by introducing and strengthening • - Rapid access to assessment and treatment within 2 hrs to prevent unnecessary hospital admission and reduce the pressure on our acute front door (by embedding respiratory specialist practitioners within H@H aligned to SPOC) with advice to Flow Centre as needed • - Strengthen GP-led primary Multi Disciplinary Team (MDT) to manage respiratory patients who are at risk of a future admission or emergency presentation (i.e. patients with high symptom burden, frequent exacerbations) and allow them to be proactively managed to remain in the community by providing a new model of proactive care	Hub Manager	1,2,3,4,5,6,7, 8,9	• Number and percentage of referrals that prevent hospital presentation/ admission • Percentage of referrals assessed with 2-4 hours • Patient and Service User experience
Palliative Care	2G4	• Complete 'as-is' mapping of current West Lothian pathways • Create a baseline dataset • Strengthen existing pathways	Chief Nurse	1,2,3,4,5,6,7, 8,9	• Accurate baseline dataset completed • Define emerging priority actions aligned to new pathway maps using baseline data and 'as-is' maps to target gaps.

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Specialist Care in the Right Place					
Front Door	2G5	Develop integrated acute front door model (EMA/SDEC) that optimises alternative community pathways through SPoC and H@H	General Manager Primary Care and Community Services	1,2,3,4,5,6,7, 8,9	Reduction in front door presentations converting to admission pathways
Review of housing with care and make recommendations	2G6	Establish a potential model of service to deliver that is both sustainable and affordable. The review will consider further integration of Assisted Living model and focus on ensuring tenancy-based support continues to provide assessed level of care	Senior Manager Older People Services	1,2,3,4,5,9	TBC
Redesign of Deans and Burnside facilities	2G7	• Re-designing of Deans house into four self-contained flats flats for permanent living. Reviews of all residents within Deans will be required to consider their current and future needs and how best to meet these • Re-designing short break provision moving from the Burnside Respite facility to five ensuite bedrooms within Deans House. Work will be required to review the ongoing requirements of individuals within Burnside to determine the requirements for short breaks going forward	Senior Manager Adult Services	1,2,3,4,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Specialist Care in the Right Place					
Improve bed based adult mental health care pathways	2G8	Work with Lothian HSCPs to reduce non-West Lothian occupancy in Ward 17 and 1 and reduce bed complement in Ward 17 to allow for improvements in care / privacy / dignity. Review and improve psyhciatric rehab pathways, by extending the pathway out of Pentland Court; Commision Secure mental health beds on the REH site	General Manager for Mental Health and Addictions	3,4,8,9	TBC
Ending the Exclusion	2G9	Implement local recommendations from Ending the Exclusion and The Way Ahead, reports into ensuring that people with both mental health problems and addictions can revive effective, integrated care	General Manager for Mental Health and Addictions	1,3,4,5,7,8,9	TBC

Contract Information- A Home First Approach

Contract	Annual Value (£)
Adults with Disability Framework	£7,600,000
Care at Home Framework	£14,638,000
Residential Accommodation & Outreach - Substance Misuse	£10,642
Residental Accommodation (LD/Complex Care)	£491,484
Day Centre - Learning Disabilities	£412,784
Care at Home Block Contract	£357,263
Older People Day Centres	£519,834
Mental Health Advice & Support	£65,000

Contract Information- A Home First Approach

Contract	Annual Value (£)
Community Outreach Support (Older People) (The Food Train)	£99,090
Scotland Excel - National Care Home Contract	TBC
Independent Living Service - Learning Disabilities (Bathgate & Uphall Station)	£516,120
Residential Accommodation/Respite Physical Disabilities	£616,902
Learning Disabilities - Supported Living	£229,302
Learning Disabilities - Core & Cluster (Lammermuir)	£227,260
Housing with Care/Sheltered Housing for Older People	£200,464