INTEGRATED HEALTH AND SOCIAL CARE

WEST LOTHIAN WORKING FOR WELLBEING

West Lothian

Integration Joint Board

Strategic Delivery Plans

Improving Health Inequalities In Partnership

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.

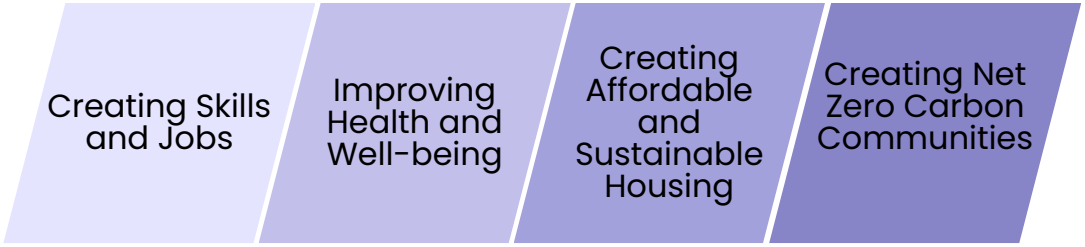
To deliver the strategic priorities and intentions set out in the IJB Strategic Plan, a delivery plan for each strategic priority has been developed and is underpinned by a medium-term financial planning framework.

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.

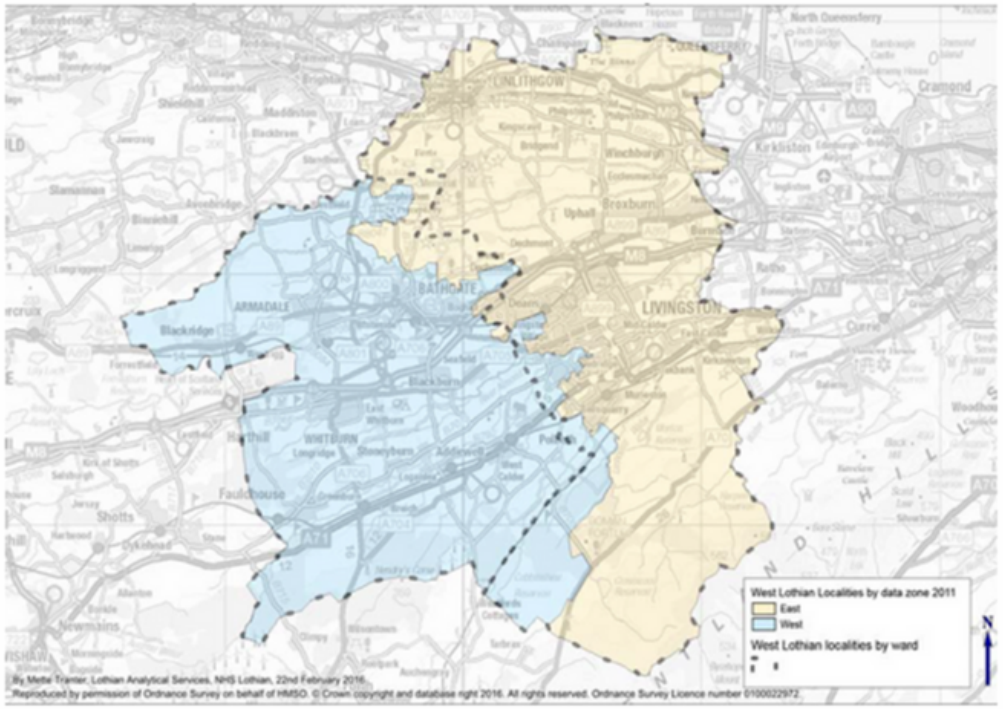


Figure 11: Map of East and West Localities: Lothian Analytical Services 2015: Ordnance Survey, HMSO 2015

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
Improving Health Inequalities in Partnership

Health inequalities are systematic, unfair differences in the health of the population that occur across social classes or population groups. In West Lothian there are still significant inequalities in health between people who are socially and economically well off, and those who are socially disadvantaged. There is an 8-year difference depending on where people live. People living in the most deprived communities can also have poorer physical and mental health throughout their lives with almost every health indicator showing progressively poorer health as indicators of deprivation increase. Research highlights the importance of addressing fundamental determinants of health inequalities such as poverty, income, employment, wealth, and housing to effect change. The causes of inequalities in health are complex and therefore can only be improved by working in partnership.

To deliver on our vision for West Lothian over the next 5 years we have developed our Health Inequalities plan (Appendix 1) with the above factors at the forefront of this. We will be prioritising actions around areas including Primary Care, Screening, Support for unpaid carers, ensuring our work aligns with the CPP and local priorities and addressing risk factors for health inequalities through a preventable approvable.

Improving Health Inequalities in Partnership

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
- Enable access to timely information, advice and support enabling people to make decisions about their own well being
- 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
Focusing on Prevention and Supporting People to Self Manage					
Primary Care Access to services and waiting times	1A1	Establishment of dedicated teams (Care Home, Frailty, Vaccination)to help residents remain well and live in the community as long as possible	General Manager Primary Care and Community Services	1,2,3,4	TBC
	1A2	Delivery of Pharmacotherapy via the Practice Pharmacy and Practice hub which manages services including acute and repeat prescriptions, medicines reconciliation and serial prescribing		4,5,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					

Primary Care Access to services and waiting times	1A3	• Addressing access issues within GP practices through the inclusion of other practitioner roles in all GP practices which are:
		  ◦ GP Advanced Practice Phyisotherapists (GPAPPs) who provide first contact appointments for patients,
		  ◦ Practice Mental Health Nurses (PMHNs) who provide first contact appointments for patients
		• Community Link Workers via Lanarkshire Association for Mental Health (LAMH) work within Community Wellbeing Hubs as part of a Multi Disciplinary Team to provide non medcalised support to people based on their individual needs
		• Phelbotomists and Health Care Assistants who assist in blood taking
		• Establishment of pharmacy first model - support accessed via Community Pharmacist for minor ailments and prescribing
		• Establishment of a Physio Pain Clinic and enabling public (eligibility criteria) to access exercise support
			General Manager Primary Care and Community Services	1,2,3.4.5,9	TBC

	1A4	A local delivery model has been put in place for the 23/24 vaccine delivery which will take place in GP practices and Partnership buildings with the ambition to establish this long -term		1,3,4,5,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Primary Care Access to services and waiting times	1A5	Community Treatment and Care (CTAC) delivered in line with the Memorandum of Understanding (MoU) including phlebotomy, chronic disease monitoring, treatment of minor injuries and minor procedures.	General Manager Primary Care and Community Services	1,2,3,4,5,9	TBC
	1A6	Explore development of Urgent Care considering anticipated Scottish Gov on PCIP Urgent Care reforms		1,2,3,4,5,9	TBC
	1A7	Development of GP cluster working with the development of two cluster groups (one in both East and West) to take forward quality improvement across practices and improve the patient experience		3,4,5,8,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Pharmacy Continue to ensure good provision of pharmaceutical services in West Lothian across the four core and additional pharmaceutical service areas	1A8	Continue to implement and deliver the 16 recommendations a set out in the Community Pharmacy Care Services Plan (PSCP) 2021, ensuring continued focus on Medication Care review of service serial prescribing and implementation of the local Care Home Community Pharmacy Service	Pharmacy	1,3,4,5,8,9	Refer to PSCP 2021
	1A9	Pharmacy First and Pharmacist independent prescribers to support out of hours services and unscheduled care		1,3,4,5,8,9	Refer to PSCP 2021
	1A10	Continue to implement the new roles and services for Pharmacy in relation to woman's health and wellbeing and digital solutions such as e-prescribing and e-dispensing as detailed in the NHS Recovery Plan 2021-2026		1,3,4,5,8,9	Refer to PSCP 2021
	1A11	Continue to deliver on the role of pharmacy around Sexual Health and Blood Born Virus Services A Recovery Plan for Sexual Health and Blood Borne Virus Services(2021)		1,3,4,5,8,9	Refer to PSCP 2021
	1A12	Continue to deliver services as part of the response to rises in drug related deaths as detailed in The Medicated Assessment Treatment Standards: access, support and choice (2021)		1,3,4,5,8,9	Refer to PSCP 2021

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Mental Health Improve access to Mental Health services and reduce waiting times for Neuro-developmental Disorders (NDD) Assessment	1A13	In collaboration with adults with lived-experience of NDD and their families, friends or carers we will improve assessment and support including significantly improving the diagnostic pathway, specifically developing third-sector routes to assessment; reviewing delivery of psychosocial interventions; reviewing ways to support people with NDD into employment; improving the competence of health and social care workers to work with people with NDD	General Manager for Mental Health and Addictions	1,3,4,9	New service will be operational
	1A14	To improve the way people transition from Children and Young People to adult mental health services in collaboration with CAMHS and the CYP Mental Health Oversight Group set up to look at transitions	Service Manager CMH/Clinical Nurse Managers	4	Review will be complete with action plan developed

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Mental Health Universal and Primary Care Mental Health Services	1A15	Agreeing a defined 'mental health offer' to include: place based approaches relating to the prevention of mental health problems	General Manager for Mental Health and Addictions	1,2,3,4,5,9	TBC
	1A16	Improved access to universal Mental Health prevention measures		1,2,3,4,5,9	TBC
	1A17	An improved pan-Lothian digital interface and access to simple effective self management strategies		1,2,3,4,5,9	TBC
	1A18	Review current 'Common mental illness' services to improve integration (e.g. Hubs, Primary Care MHNs; Mental Health Ots) and locality working		1,2,3,4,5,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Mental Health Unscheduled Mental Health and Distress Pathway	1A19	Working with people with lived-experience and their carers, and stakeholders including Primary Care, Police, Scottish Ambulance Service, ED Education and Mental Health services to develop a streamlined pathway for people with mental ill health and/or distress to include trialling the DBI programme Developing a P2P line for between ACAST and SAS and implementing Time, Space, Compassion	General Manager for Mental Health and Addictions	1,2,3,4,5,6,7, 9	TBC
	1A20	Work with housing, police and community safety to develop integrated community structures to support early identification and support for people with mental health crises		1,2,3,4,5,6,7, 9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Learning Disabilities Promote uptake of Annual Health Checks to all people aged 16 and over who have learning disabilities given the increased risk of this group developing long-term conditions from both genetic and lifestyle factors.	1A21	Commisonning approach reviewed to ensure health screening is identified as a component of effective care planning for adults with Learning Disabilities	Senior Manager Adult Services	1,4,5,8	Health Screening will be included in the tender for the adult framework Performance measure added to the contract monitoring
	1A22	Development of a plan to to utilize learnings from the Health Equality Framework to improve uptake of screening and inform service development		1,4,5,8	Plan developed and delivered
	1A23	Ensuring access to screening opportunities is accessible to the population in West Lothian considering demographic and socio-economic factors.		1,3,4,5,9	Increase in screening in areas.demographics with low uptake

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Podiatry The ageing population is increasing demand for podiatry services	1A24	Explore the interface Podiatry shares with other services that support people to remain at home for early identification and to prevent escalation of podiatry related health issues	Head of Podiatry	2,4,5,9	TBC
	1A25	Exploring if the introduction of a Contact Centre for all referrals has helped reduce inappropriate referrals being placed on the service waiting list		2,4,5,9	TBC
	1A26	Introduction of a rolling upskilling programme for the workforce to develop advanced practitioners who could be non-medical prescribers		2,4,5,8,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Carers Ensuring support is available for unpaid carers within and outwith their caring role to enable them to lead a full life and look after their own health and wellbeing thereby supporting future success of the Home First through enabling vulnerable population groups to remain at home	1A27	Collaborative working with partners to achieve a support network and deliver high level services to ensure unpaid carers are supported to meet their own individual needs and the needs of the person they care for	Senior Manager Adult Services	1,3,4,5,6,8,9	TBC
	1A28	Promote short break respite opportunities and explore alternative types of breaks to suit all carers	Senior Manager Adult Services/Carer Lead	1,6	TBC
	1A29	Expand the use of digital and technology advances o support the carer and the cared for person to remain safely and independently at home		1,2,6,9	TBC
	1A30	Support to access financial and benefits advice for carers and their cared for person		1,2,3,4,5,6	TBC
	1A32	Fund and advice information and support service for unpaid carers. (Currently Carers of West Lothian)		6	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Alcohol and Drug Partnership (ADP) Reduce the use and harm from alcohol and other drugs - support local delivery of the National Mission to reduce drug deaths and associated national priorities	1A33	Implement the ADP Strategic and Delivery Plans including delivery of the actions below, ensuring the involvement of lived experience communities in service design, prioritisation, monitoring and evaluation	ADP Lead	1,3,4,5,7,8,9	TBC
	1A34	Working with partners including those within Education, Public Health and other CPP colleagues to develop and implement a preventative strategy for harm from alcohol or drugs		1.3.4.5.7.8.9	TBC
	1A35	Full implementation of Medication Assisted Treatment (MAT) Standards	General Manager for Mental Health and Addictions	1.3.4.5.7.8.9	TBC
	1A36	Implementation of Alcohol Treatment Standards and local alcohol pathways (when developed) to reduce Alcohol Related Deaths and other alcohol related harm		1.3.4.5.7.8.9	TBC
	1A37	Undertaking system wide Rights Based workshops with all relevant services around problematic drug and alcohol use across all related services.	ADP Lead	1.3.4.5	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Alcohol and Drug Partnership (ADP) Reduce the use and harm from alcohol and other drugs - support local delivery of the National Mission to reduce drug deaths and associated national priorities	1A38	Undertake asset based recovery community development, aftercare, and wider employability opportunities for lived/living experienced communities	General Manager for Mental Health and Addictions	1.3.4.5.7.8.9	TBC
	1A39	Ensure people within justice settings receive equivalence of support when accessing support for problematic drug and alcohol use.		4.5.7.8.9	TBC
	1A40	Work with colleagues in children and family services to reduce the harm to children / young people from drugs or alcohol including implementation of forthcoming Young People's treatment standards	WL Mental Health Advocacy Service/ADP Lead	1.3.4.5.7.8.9	Greater involvement of communities within ADP Governance, service design, and delivery

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Alcohol and Drug Partnership (ADP) Reduce the use and harm from alcohol and other drugs - support local delivery of the National Mission to reduce drug deaths and associated national priorities	1A41	Involvement of LLE communities in service design, monitoring and evaluation, ADP prioritisation	WL Mental Health Advocacy Service/ADP Lead	1.3.4.5.7.8.9	TBC
	1A42	Implementation of Young peoples treatment standards (when developed)	General Manager for Mental Health and Addictions	1.3.4.5.7.8.9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Focusing on Prevention and Supporting People to Self Manage					
Adult Services – Ongoing and continued support of ensuring that young people are identified at the earliest opportunity and where appropriate are support with a clear plan that will support their transition from children's services to adult services	1A43	Review the current transition policy and make necessary updates	Senior Manager Adult Services	3,4,5,6,9	TBC
	1A44	Establish and embed multi-agency transitions group providing oversight of all young people in transition		3,4,5,6,9	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Supporting People to Make Informed Choices					
Whole Systems Approach (WSA) To reduce obesity and type 2 diabetes using a Whole Systems Approach	1B1	To develop and implement a Whole Systems Approach in one area of West Lothian (Whitburn) with a focus on children, families and health inequalities. Learning will be shared across West Lothian.	Population Health Project Manager/Consultant in Public Health	1,4,5	TBC
Power of Attorney (POA) Increasing the use of Power of Attorney sessions where appropriate	1B2	Work with third sector partners to extend the number of sessions offered to support with Power of Attorney Working group to be established to take this forward	Head of Health	1,2,3,4,5,6	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Working with Communities in Partnership with Others to Maximise Impact					
Physical Disabilities Local support for people with physical disabilities	1C1	Explore making services more accessible locally to people with Physical Disabilities and their families as opposed to travelling out with the area to access the care they require	Senior Manager Adult Services	1,2,3,4,5	TBC
Carers Breaks from caring and specific support for older carers	1C2	Explore options for breaks for caring and specific support for older carers to maintain the health and wellbeing of carers and prevent unplanned hospital admissions and negative impact on discharge planning.	Senior Manager Adult Services/Carer Lead	2,6	TBC

Priority Area	Ref	How We Will Achieve This	Lead	NW Outcomes	How We Will Measure How Well We Are Doing
Wider Determinants					
Working Practices	1D1	Encouraging a more streamlined Wider Assessment Process which includes capturing information on wider determinants of health such as availability of carer support, debt and housing.	Senior Manager Adult Services/Older People Services	4,5,8,9	Deprivation differences between east and west locality >10% i.e access deprivation , alcohol related hospital admissions
Housing Continue to develop a range of 'core' housing models to enable people with learning disability to live within local communities	1D2	Continue the development of the Core and Cluster model of housing to ensure additional core services are available in West Lothian, having regard for the efficiency of £774,000 detailed in the West Lothian Transforming your Council Strategy.This will include other housing providers such as Registered Social Landlords (RSL)	Senior Manager Adult Services/ Project Manager Mental Health Team	2,4,9	No of adults with a learning disability living outwith traditional residential settings

Contract Information - Improving Health Inequalities in Partnership

Contract	Annual Value (£)
Community Services for Older People, prevention, early intervention & collaborative working	£268,884
Scotland Excel Meals Contract	£7,500
Community Link Worker & Wellbeing Practitioner Service	£423,537
Housing Support & Supported Accommodation for Vulnerable due to Young Age	£691,993
Sensory Impairment Framework	£67,686
Scottish Huntingtons - Support & Advice incl financial	£14,442
Domestic Abuse Refuge & Outreach	£132,437
Gig Buddies - Community Support	£35,430

Contract Information - Improving Health Inequalities in Partnership

Contract	Annual Value (£)
Alzheimers Advice & Support	£65,000
Advocacy Learning Disability	£64,485
Advocacy Mental Health	£222,850
Advocacy Older People & Physical Disabilities	£96,165
Advice & Support Adults & Older People (LCIL)	£38,000
Children Affected by Parental Substance Misuse	£127,848
Therapeutic Support Service Psychological Interventions for those affected including Families -ADP	£527,000
Recovery Service - ADP	£282,000

Contract Information - Improving Health Inequalities in Partnership

Contract	Annual Value (£)
West Lothian Assertive Outreach for hard to Reach Groups (ADP)	£367,147
Ageing Well Project	£27,500