West Lothian Integration Joint Board Annual Performance Report 2017/18

Foreword

Welcome to the second Annual Performance Report of West Lothian Integration Joint Board (IJB). Our report highlights some of the work of the IJB over the reporting year April 2017 to March 2018.

During the year we have embarked on an ambitious change programme to reshape the way we support adults in our communities and have continued to develop our engagement with service users, partners and staff to explore how we can work together to shape our health and social care provision and transform how we meet local needs and improve outcomes for our communities.

We are not unique in the challenges that we face and recognise that the pace of change needs to improve. While we are still working to develop more integrated teams, we are building on our strong track record of partnership working, and sharing learning through our networks, to deliver innovative services that will respond to people's needs and expectations.

In the coming year we will be reviewing the Strategic Plan. This plan will set out how the IJB will plan and deliver services over 5 years from 2019 – 2023, using the integrated budgets under our control. We are currently consulting on our priorities and will work with the Strategic Planning Group to prepare the new plan to ensure it reflects the views of a wide range of service users, carers and partner organisations that work in West Lothian.

We would like to acknowledge the significant effort of all the NHS Lothian and West Lothian Council staff supporting the IJB in its second full year of operation and look forward to building on the progress that has been made during 2018/19.

Jim Forrest
Chief Officer

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2017 /18 Performance at a glance

92% of adults are able to look after their health very well or quite well
(Scotland 93%) 2015/16 -94%

80% of adults supported at home agreed that they are supported to live as independently as possible
(Scotland 81%) 2015/16 -88%

77% of adults supported at home agreed they had a say in how their help care or support was provided
(Scotland 76%) 2015/16 -81%

76% of adults supprted at home agreed that their health and scoial care services seemed to be well coordinated
(Scotland 74%) 2015/16- 82%

84% of adults receiving any care or support rated it as excellent or good
(Scotland 80%) 2015/16- 82%

75% of people had a positive experience of the care provided by their GP practice
(Scotland 83%) 2015/16 -78%

82% of adults supported at home agreed that their services and support had an impact on improving or maintaining their quality of life (Scotland 80%) 2015/16 -82%

42% of carers feel supported to continue in their caring role
(Scotland 37%) 2015/16 -36%

85% of adults supported at home agreed they felt safe
(Scotland 83%) 2015/16 -87%

Premature mortality rate is 409.6 per 100,000 persons
(Scotland 425.2) 2016/17 -411

Emergency admission rate is 11,162 per 100,000 population
(Scotland 11,959) 2016/17 -11,923

Emergency bed day rate is 93,600 per 100,000 population
(Scotland 115,518) 2016/17 -104,218

Readmission rate to hospital within 28 days is 96 per 1000 population
(Scotland 97) 2016/17 -109

89% of the last 6 months of life is spent at home or in a community setting
(Scotland 88%) 2016/17- 88%

Falls rate is 19 per 1000 population over 65 years
(Scotland 22) 2016/17 -20

87% of care services have been graded "good" (4) or better in Care Inspectorate inspections
(Scotland 85%) 2016/17 - 85%

67% of adults with intensive care needs are receiving care at home [2016/17 result 2017/18 data n/a]
(Scotland 61%)

The number of days people spend in hospital when they are ready to be discharged is 1177 per 1000 population (Scotland 772) 2016/17 -822

20% of health and care resource is spent on hospital stays where patient was admitted as an emergency
(Scotland 23%) 2016/17 -23%

Introduction

This annual report highlights progress in achieving the IJB's ambitions throughout 2017/18, using key performance data and good practice examples of activities to demonstrate how we are working together to improve local outcomes.

Our Vision is ***to increase wellbeing and reduce health inequalities across all communities in West Lothian.***

Our aim is to ensure people get the right care, at the right time, in the right place and are supported to live as independently as possible. Our Strategic Plan focuses on four strategic priorities which link to the nine National Health and Wellbeing Outcomes set out by the Scottish Government:

1. ***Tackling inequalities*** through focusing our efforts on those who most need care and support
2. ***Prevention and early intervention*** approaches to enable people to manage their own health and wellbeing to stay healthy and more independent for longer
3. ***Integrated and coordinated care*** which puts people at the heart of what we do and empowering and supporting them to ensure they can remain at home or in a community setting for as long as possible
4. ***Using our resources wisely*** to focus on what will make the biggest impact and ensure best value is achieved

National Health and Wellbeing Outcomes

Performance Review

A suite of performance indicators (PIs) have been identified to allow the IJB to measure progress in achieving health and wellbeing outcomes. These PIs are regularly monitored and scrutinised by the Integration Joint Board. This annual report includes a selection of these PIs to illustrate how we are doing. 2017/18 data is provided where available; where, 2017/18 data hasn't yet been published, the latest data available is included. Performance is compared to previous period and/or national average:

Red = performance is declining above tolerance level;

Amber = performance is declining but within tolerance level;

Green = performance is improving.

The Health and Care Experience (HACE) Survey is undertaken every two years therefore information is not available for 2016/17. The 2015/16 results have been recalculated by the Scottish Government with new waiting and may be different from previous reports.

OUR PERFORMANCE AGAINST THE NATIONAL HEALTH AND WELL BEING OUTCOMES

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

How are we doing?

Indicator	2016/17	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
% of adults able to look after their health very well or quite well.	94% (HACE 2015/16)	92%	↓ 2%	↓1%	93%
Rate of emergency admissions per 100,000 population for adults.	11,923	11,162	↓6.4%	↓6.7%	11,959
All people newly diagnosed with dementia will have a minimum of one year's post-diagnostic support	183	234	↑28.8%	n/a	n/a
Alcohol Brief Interventions sessions delivered in priority setting of Primary Care	3227	2565	↑29% above target of 1987	n/a	n/a

92% of people in West Lothian are reporting that they are able to look after their health very well.

Emergency admissions

Our rate of emergency admissions in 2017/18 has improved with a reduction of 6.4% compared to 2016/17 and is better than the Scottish average. West Lothian's population is growing and expected to increase by 10,000 over the next 5 years. At the same time the over 75 years population will increase by 25%. Therefore, it is important that we continue our focus on prevention of unnecessary hospital admissions and supporting more people at home to further reduce the number of emergency admissions.

Post Diagnostic Support

We recognise how important it is for people to have the opportunity to speak to someone when they receive a life changing diagnosis of dementia and for them to be supported to make decisions regarding their future care and to find out how to live well day to day in their community. We have redesigned how we deliver on the commitment to provide up to one year's worth of post diagnostic support. The changes we have made have enabled a significant increase (28.8%) in the number of people receiving post diagnostic support and reduced the waiting times from referral to support being given from 6 months to 6 weeks.

Alcohol and Drugs

Alcohol Brief Interventions (ABIs) contribute to the overall objective of reducing alcohol-related harm by helping individuals to reduce their drinking to within sensible guidelines. In 2017/18, West Lothian delivered a total of 2,565 ABIs; exceeding the target of 1,987 by 578 (29%).

Ageing Well Project

Ageing Well is a partnership project with classes run in partnership with organisations such as Alzheimer Scotland, OPAL and Craigshill Good Neighbour Network.

The aim of the project is to improve, maintain and promote the physical and mental health and wellbeing of older people in West Lothian and improve their quality of life through a programme of activities and services. The project offers free or low-cost activities and targets those in need to try and reduce isolation, loneliness and increase opportunities for older people to be active in their community.

In 2017/18, 33,456 visits were recorded to activities such as tea dances, buddy swimming, tai chi, walking football, social events, etc.
The project has a bank of volunteers who assist with the activities, have a wealth of knowledge and experience and play a huge role in the success of the project. With strong partnership links in the community the project will continue to strengthen these links, build new partnerships and offer new activities to keep our older generation active in the community.

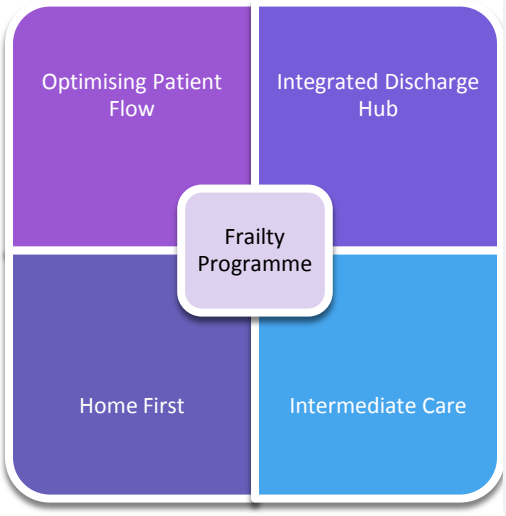
Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

How are we doing?

Indicator	2016/17	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
Emergency bed day rate per 100,000 population for adults.	104,218	93,600	↓ 10.2%	↓19%	115,518
Readmissions to hospital within 28 days of discharge per 1,000 admissions.	109	96	↓11.9%	↓1%	97
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1000 population	822	1177	↑43%	↑52.5%	772
Proportion of last 6 months of life spent at home or in a community setting.	88%	89%	↑1%	↑1%	88%
Percentage adults with intensive care needs receiving care at home.	67%	n/a		↑6%	61% (2016/17)
Percentage of adults supported at home who agreed that they are supported to live as independently as possible	88% (HACE 2015/16)	80%	↓8%	↓1%	81%
Percentage of people aged over 75 who live in their own home	92.2%	n/a		↔	92.1% (2016/17)

Performance indicates that we are working together well to shift the balance of care to more care at home or in a community setting. 80% of people receiving care felt they were supported to live as independently as possible. Whilst this is a little lower than our previous performance it is similar to the Scottish average (81%). There has been a steady improvement in the amount of time people spend at home at the end of life (89%) and we have seen a 10.2% reduction in the number of hospital bed days due to emergency admissions which means people are spending less time in hospital after being admitted as an emergency. In addition, there has been an 11.9% reduction in people being readmitted to hospital within 28 days of discharge.

However, we are facing a major challenge with the number and bed days associated with delayed discharges. The deterioration in our performance is largely due to difficulties in sourcing sufficient capacity to provide care and support at home and in care homes. We have a substantial programme of work in place across the whole system which seeks to further reduce emergency admissions, readmissions and improve our performance on delayed discharges.



Frailty Programme

The population of frail elderly people is expected to increase over the next 5 years along with the projected 25% increase in the over 75 years population. This will increase demand across the whole health and social care system. The Frailty Programme has been refreshed to ensure care is provided in the most appropriate setting be that in hospital, at home or through our community services.

Wherever possible people will have their care delivered within the community and when admission to hospital is required this will be actively managed to promote recovery and enable discharge home as soon as possible.

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

How are we doing?

Indicator	2015/16	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	81%	77%	↓4%	↑1%	76%
Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated	82%	76%	↓6%	↑2%	74%
Percentage of adults receiving any care or support who rated it as excellent or good	82%	84%	↑2%	↑4%	80%
Percentage of people with positive experience of the care provided by their GP Practice	78%	75%	↓3%	↓8%	83%
Percentage of people who feel they are listened to	87%	89%	↑2%	↓4%	93%
Percentage of people who feel they are treated with compassion and understanding	93%	91%	↓2%	↑2%	89%

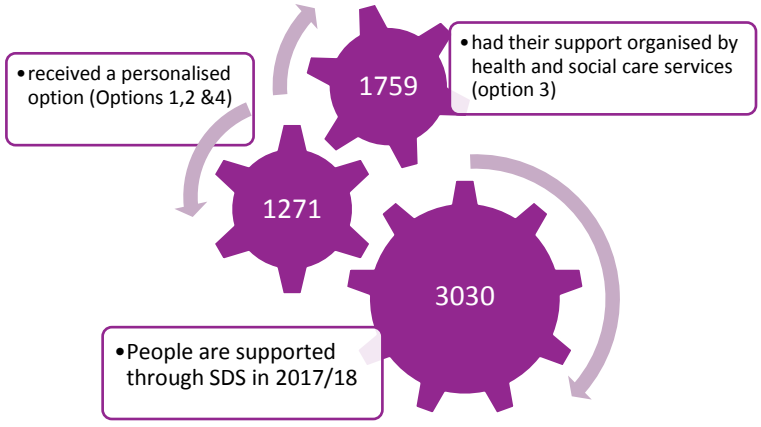
Taken from the Health & Care experience survey these measures are directly relevant to our strategic priorities of maximising choice and control, promoting continuous improvement and contribute to our ongoing desire to ensure that personal experience and user voice influence quality improvement.

Results reflect a positive experience with 77% of people having a say in how their care was provided and 84% rating the care they received as excellent or good. 89% of people feel they are listened to and 91% considered treated with compassion and understanding. Although 75% reported having a positive experience of care within their GP practice this is below the Scottish average and a key area for improvement. The proportion of people who felt their care was well coordinated has reduced since 2015/16 but at 76% remains above the Scottish average of 74%.

Self-Directed Support (SDS)

The Social Care (Self-Directed Support) (Scotland) Act 2013 puts people in control of designing and managing their care. Through supported self-assessment, people develop personal plans that build on their existing supports and can be supported through community and health and social care resources. We aim to help people and support them to make the most appropriate choice of option under the SDS legislation.

- SDS Option 1 - people choose to take control of purchasing and managing their own care and support
- SDS Option 2 - people choose the organisation they want to be supported by and the Partnership transfers funds to that organisation, for care and support to be arranged in line with the personal plan
- SDS Option 3 - people choose for social work services to arrange and purchase their care and support
- SDS Option 4 - people choose more than one option



Outcome 4: Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services

How are we doing?

Indicator	2016/17	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	82%	82%	↔	↑2%	80%
Proportion of services graded "good" (4) or better in care inspectorate inspections	85%	87%	↑2%	↑2%	85%

Gig Buddies

More and more people with learning disabilities live in local communities and people of all ages tell us that they want meaningful things to do and to have opportunities to build social relationships. The achievement of those aspirations, however, can be difficult and sometimes people need help in building friendships and natural networks.

A recent survey by the West Lothian Learning Disability Forum highlighted that people were interested in participating in a wide range of activities with social opportunities in their local community available during the day, in the evenings and at weekend. In response to this, the Gig Buddies project was established in West Lothian last year and aims to link music fans with a learning disability with other music lovers for gig nights, or whatever other activities they enjoy doing together. The vision is for people with a learning disability to know they can stay up late and choose how they live their lives and to create a community of people who share the same interests, regardless of their disabilities and differences.

In October 2017 the official West Lothian launch event took place at Howden Park Centre. This was an inclusive evening of live music showcasing musicians with additional support needs, run as part of the 'Real Gigs in Real Venues' initiative. Eighty people attended the event which was incredibly well received, with people asking for similar events in the future.

In February 2018 Gig Buddies hosted a live music event in Bathgate at the Midnight Breakfast Club. The Gig Buddies project works hard with music venues to encourage people with a learning disability to go to their local venue and know that it's a place where they are safe and welcome. This is something which will be expanded throughout 2018 with the new Gig Buddies Partner Venues initiative.

People continue to sign up to the project and pairings are being established allowing people to get out and about and share their interests. The project would welcome new members and volunteers who are interested in being buddies. Buddies receive training and undergo suitability checks. Overall Gig Buddies is developing strongly in West Lothian and there is an exciting year ahead.

Outcome 5: Health and social care services contribute to reducing health inequalities

How are we doing?

Indicator	2016/17	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
Premature Mortality Rate per 100,000 population	411	409.6	↓1.4	↓15.6	425.2
Male life expectancy at birth	77.9 years	78.3 years	↑0.4 years	↑1.2 Years	77.1 Years
Female life expectancy at birth	80.5 years	80.8 years	↑0.3 years	↓0.3 Years	81.1 years

The core integration measure of premature mortality among people aged 75 and under shows positive progress with a sustained reduction from 447 to 409.6 per 100,000 populations over 5 years and although life expectancy is improving there remain significant differences in health outcomes between the most and least deprived in West Lothian. Addressing health inequalities is not just about providing quality health and social care services, it involves working with local partners such as Housing, Employment and the Community Planning Partnership to create a better physical, social and economic environment for all.

Refreshing the Anti-Poverty Strategy

The refreshed West Lothian Anti-Poverty Strategy has an overall purpose to minimise the impact of poverty on the people of West Lothian and reduce the differences in income and life chances between different parts of our community. The aims of the strategy are to:

- Protect people in West Lothian from the worst extremes of poverty and deprivation;
- Enable and empower people to access opportunities to become financially resilient;
- Tell a different story about poverty and increase understanding and reduce the stigma;
- Work collaboratively with partners, and
- Use our collective voice to lobby the Scottish Government, UK Government and any other relevant organisations to bring about change.

The Anti-Poverty Strategy has considered the current landscape and changing nature of poverty combined with the voices of local communities, organisations and people with direct, lived experience of poverty.

Partners will work towards these aims through a range of actions which will target resources and share best practice.

First Steps to Health and Wellbeing

First Steps to Health & Wellbeing supports people with long term conditions to self-manage and increase their functional capacity. The project is committed to reducing health inequality by targeting deprived communities and individuals with the aim of promoting and supporting initiatives to improve the health of the community as a whole.

Promoting the health and wellbeing benefits of an active lifestyle and encouraging professionals to promote self-help techniques and alternatives to prescribing and other service dependencies promotes independence and positive self-management, improves health and wellbeing and will contribute effectively to control of health and social care costs.

In 2017/18, 15,367 referrals from GP practices engaged with Xcite. A recent evaluation suggests that the project can improve both the physical and mental health of patients referred over the 12 weeks of their participation. 41% of those completing the initial programme continue to exercise, double the programme target of 20%.

Outcome 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 wellbeing

How are we doing?

Indicator	2015/16	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
Percentage of carers who feel supported to continue in their caring role	36%	42%	↑6%	↑5%	37%
Percentage of carers who feel they have a good balance between caring and other things in their life	65%	64%	↓1%	↓1%	65%
Percentage of carers who had a say in services provided for the person they look after	50%	50%	⇔	↑4%	46%
Percentage of adults who agreed local services are well coordinated for the person they look after	47%	45%	↓2%	↑5%	40%

Caring without enough support in place can have a huge impact. Whether caring is full-time, or it is part of a stressful mix of work and other family responsibilities, many carers find they do not have the time or energy to maintain relationships, stay in work, or look after their own health and wellbeing. The Health and Care Experience Survey results indicate an improvement in the proportion of carers feeling supported to continue in their caring role and above Scottish average levels of satisfaction in carers having a say in how services are provided and how well coordinated these are.

The Carers (Scotland) Act 2016 came into effect on 1st April 2018. The Act details the advice, information and support which unpaid carers are entitled to in order to support them in their caring role enabling them to maintain their health and wellbeing and to have a life alongside caring. The Act also applies to young carers supporting their right to be children first. The Act recognises that carers should be able to decide how much care they are willing and able to provide.

The Act places a range of duties on health and social care and in implementing the Act, West Lothian has:

- Developed Adult Carer Support Plan/Young Carer Statement Frameworks
- Developed and introduced eligibility criteria for support for unpaid carers
- Commissioned the ongoing provision of independent information and advice services for all carers
- Provided briefings on the Act to all relevant staff and provided training on emergency planning in partnership with the third sector
- Worked with colleagues to promote the requirement to involve carers in discharge planning
- Produced leaflets, provided presentations and developed online information to promote the Act
- More information is available via this link ***Carer Support***

Outcome 7: People using health and social care services are safe from harm

How are we doing?

Indicator	2016/17	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
Percentage of adults supported at home who agreed they felt safe	87%	85%	↓2%	↑2%	83%
Falls rate per 1000 population aged 65+	20	19	↓1	↓3	22
Number of households receiving telecare	4360	4380	↑20	n/a	n/a
Number of new telecare installations	780	757	↓23	n/a	n/a

The core integration indicators demonstrate positive performance with 85% of people supported at home feeling safe and the falls rate among people aged 65+ reduced to 19 per 1000.

Technology is an important element of our strategy to support older people for as long as possible in their own home. Technology Enabled Care (TEC) delivers new and innovative ways to help assess and monitor individuals using the latest technological advancements and allows people to take control of their own health conditions while remaining independent and living at home. TEC programmes that have been rolled out include:

- MyCOPD: This allows sufferers to manage their COPD independently, reducing reliance on GP and hospital visits.
- Activity Monitoring: This system gathers data on an individual's daily activities as part of the assessment process.
- GPS: This system provides details of the wearer's location to another mobile/tablet or call centre.
- Florence: Allows people to be more in control of their own healthcare e.g. for BP monitoring or medication prompts rather than visiting the GP surgery or hospital.

Steven's Story

Steven had been found on 3 occasions wandering, or lost on his way back from local shops, and was returned home by police**.** Following a lengthy hospital admission, a case conference was arranged. At this point it was felt Steven did not have capacity, and was at risk remaining in the community and that long-term care was his best option. This was not what he wanted and his granddaughter who is very supportive of her grandfather respected his wishes. It was agreed that a trial at home could be arranged. As part of this it was agreed property exit sensors would be fitted and that he would have an assessment for a GPS tracker. Following discussion with Steven and his granddaughter, the Canary System was installed**.** The Canary System was able to identify Steven's clear and structured routine over a period of time which enabled the services to reduce their support visits. At this point it was also agreed to introduce the use of the One Touch GPS tracker. The One Touch has the functionality of a falls detector which allowed Steven to maintain his independence and a geofence was set up which sends alerts to his granddaughter should he be walking out with the specific geographic area set for him. This means that she is aware at any time if there are issues with her grandfather.

Steven is able to sustain living independently with 2 visits daily for medication and meal support and charging of GPS tracker from one of our care providers. Despite initial reservations both Steven and his granddaughter are confident in the use of the One Touch technology, and are reassured that the use of this small piece of technology will assist in keeping him safe and able to remain living at home which was what he always wanted.

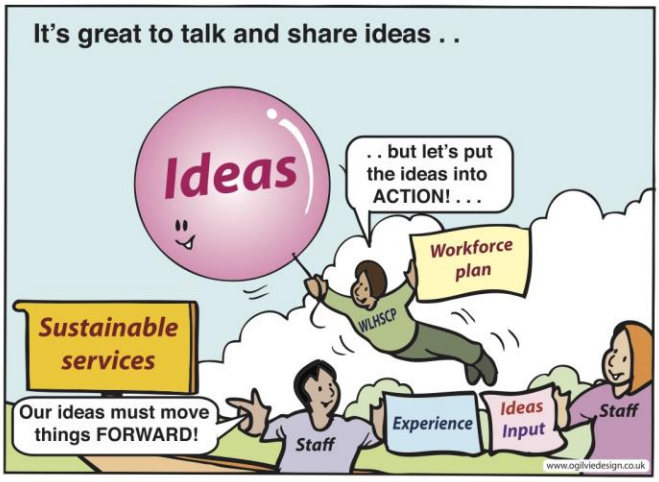
Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

How are we doing?

Indicator	2016/17	2017/18	Compared to previous Result
Percentage of staff who consider themselves to be well informed	80%	80%	⇔
Percentage of staff who say they are appropriately trained and developed	75%	76%	↑1%
Percentage of staff who say they are involved in decision making	72%	73%	↑1%
Percentage of staff who consider they are treated fairly and consistently with dignity and respect	78%	79%	↑1%
Percentage of staff who say they are provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community	77%	79%	↑2%

Our staff survey results are very positive with staff considering themselves to be well informed with fair and equal opportunities for development. Our workforce are critical to the effective delivery of health and social care and we aim to ensure they are able to contribute to the design and delivery of health and social care and have the knowledge and skills to respond to the changes we envisage.

Quality Improvement Award: The team delivering Electro-Convulsive Therapy at St John's Hospital has recently won the Quality Improvement Award for Simulation Teaching from the Scottish ECT Accreditation Network. The multi-disciplinary team implemented staff training to improve patient safety in rare but potentially life-threatening complications which may occur during ECT and Anaesthesia. Alongside the Quality Improvement Award Liz Horne (ECT Nurse Coordinator) won the ECT Nurse of The Year which is a fantastic achievement for both her and the service.



Workforce Planning

We have held staff engagement events across the partnership to support development of our Workforce Plan. The focus has been on identification of the challenges and actions required to future proof our workforce, including the need to be agile and support transformational change.

Graham Ogilvie, a graphic facilitator, translated our discussions into graphics, producing a story board of the event. The rich pictures produced (some are included in this report) will be used by teams to facilitate further discussions

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services

How are we doing?

Indicator	2016/17	2017/18	Compared to previous Result	Compared to Scottish Average	2017/18 Scottish Average
Percentage of health and care resource spent on hospital stays where patient was admitted as an emergency	23%	20%	↓3%	↓3%	23%
Proportion of last 6 months of life spent in a large hospital	11.8%	11%	↓0.8%	↑1.4%	9.6%
Proportion of last 6 months of life spent at home or in a community setting	88%	89%	↑1%	↑1%	88%

At 20% the level of health and care resource spent on emergency hospital care is below the national average of 23% and we have seen the percentage of the last 6 months of life spent in a large hospital reduce to 11% with a corresponding increase in percentage of time spent at home or in a community setting increasing to 89% demonstrating a positive shift in the balance of care.

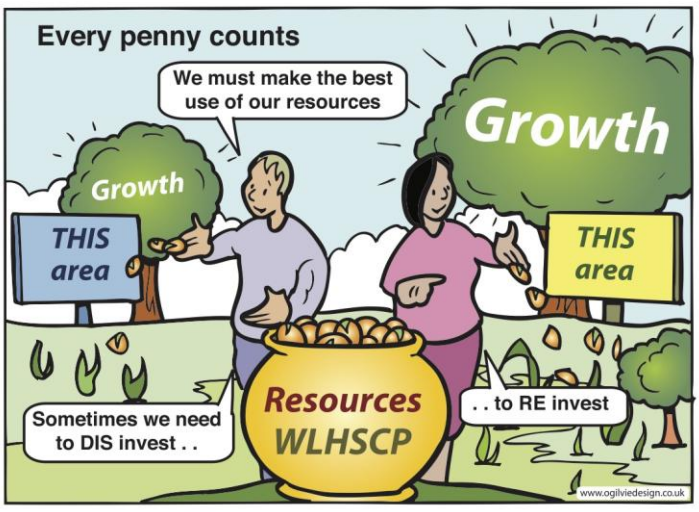
Transforming Services

We aim to make the best use of our shared resources by working with our partners, communities and with individuals and their carers to inform where and how our services are delivered and consider if we can achieve this in a more efficient way. A sustainable health and social care system will require change over time to improve health and wellbeing outcomes. We have established transformational change programmes to focus on:

- Redesign of Frailty Pathway
- Redesign of Mental Health services to improve access and promote positive mental health
- Promoting choice, independence and inclusion for people with a learning disability to ensure they can live in the community wherever possible
- Implementation of the new GP Contract and development of more integrated teams around GP Practices to support sustainability of Primary Care, improve access to services and enable GPs to spend more time with the people who need them most

Signposting

To improve patient experience, reduce waiting times and ensure people get faster access to the treatment they need we are signposting people to the most appropriate resource to meet their need and wherever possible, enable them to directly access a range of services.



West Lothian - East Locality Profile
Summary

2016/17
ISD: 2018

102,611
people live in the East locality

Female 51.1% | Male 48.9%
NRS: 2017

0-15: 2016, 2026, 2041 +1.1%

16-64: 2016, 2026, 2041 +2.4%

65+: 2016, 2026, 2041 +69.2%

The East locality has an aging population which is rising faster than the national average

almost **1 in 4** people will be over the age of 65 by 2041 NRS: 2018

6.7% of working age population claiming incapacity benefits

10.7% of adults claiming PIP/ DLA/AA disability benefits

1.5% of working age population claiming out of work benefits

11.3% over the age of 60 claiming Pension Credits
DWP: 2017

13.9% NRS: 2017
of the East locality population reside within the 20% most deprived areas in Scotland

30.2%
of people over the age of 65 live alone
NRS: 2018

18%
people aged 15 and over prescribed medications for depression and anxiety
ISD: 2018

Highest and lowest life expectancy at birth

88.2 Linlithgow North
83.0 Knightsridge & Deans North
Livingston (Dedridge East) **76.9**
Craigshill **73.6**
80.5 **77.9** West Lothian average
ScotPHO: 2013

19.2%
of adults provide unpaid care
Scottish Government: 2018

10,977
acute emergency hospital admissions per 100,000 people

381
alcohol-related admissions per 100,000 people
ISD: 2018

West Lothian - West Locality Profile
Summary

2016/17
ISD: 2018

77,519
people live in the West locality

Female 50.8% | Male 49.2%
NRS: 2017

0-15: 2016, 2026, 2041 +1.1%

16-64: 2016, 2026, 2041 +2.4%

65+: 2016, 2026, 2041 +69.2%

The West locality has an aging population which is rising faster than the national average

almost **1 in 4** people will be over the age of 65 by 2041 NRS: 2018

9.4% of working age population claiming incapacity benefits

12.5% of adults claiming PIP/ DLA/AA disability benefits

2% of working age population claiming out of work benefits

16.4% over the age of 60 claiming Pension Credits
DWP: 2017

19.3% NRS: 2017
of the West locality population reside within the 20% most deprived areas in Scotland

35.2%
of people over the age of 65 live alone
NRS: 2018

19.2%
people aged 15 and over prescribed medications for depression and anxiety
ISD: 2018

Highest and lowest life expectancy at birth

83.5 Bathgate & Boghall
80.2 Bathgate West
Whitburn **75.4**
West Calder & Polbeth **74.8**
80.5 **77.9** West Lothian average
ScotPHO: 2013

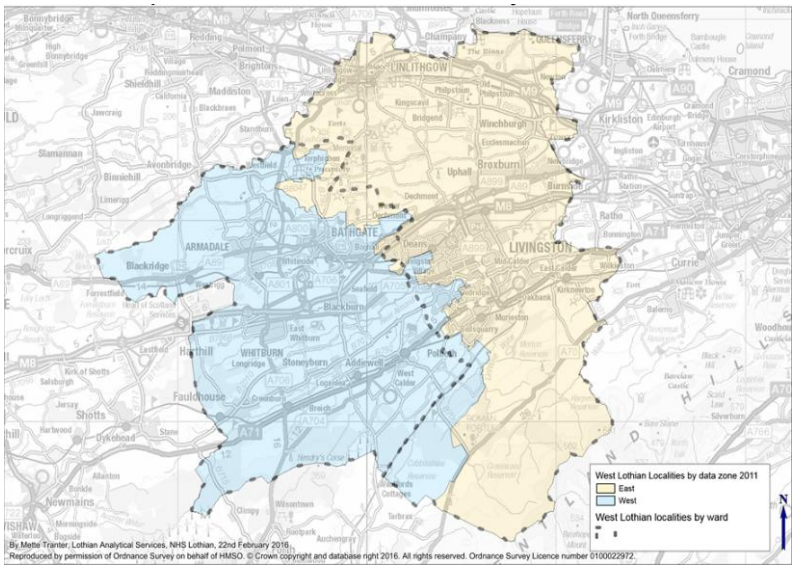
19.2%
of adults provide unpaid care
Scottish Government: 2018

12,023
acute emergency hospital admissions per 100,000 people

512
alcohol-related admissions per 100,000 people
ISD: 2018

Localities

Within West Lothian we have defined two localities across which health and social care services will be planned and delivered. The localities provide a key mechanism for strong local, clinical, professional and community leadership and will ensure services are planned and led locally in a way that is engaged with the community and contributing to effective strategic commissioning.



Locality groups have been formed with a broad cross section of the identified key stakeholders. The main function of the locality groups is to be responsible for the planning, design and delivery of the Locality Plan, in line with the IJB's Strategic Plan and Scottish Government Locality Guidance.

The East and West Locality Profiles indicate that both localities have an aging population which is rising faster than the national average, poor health, deprivation and unemployment are more significant in the West than the East with differences in life expectancy, life chances and health and well-being. It is also important to recognise that significant differences also exist within each of the localities for example there are 8-10 year differences in life expectancy at birth between the most and least deprived communities.

The Community Planning Partnership (CPP) is developing locality plans for regeneration areas, based on the datazones in the bottom 20% of the Scottish Index of Multiple Deprivation. The regeneration plans aim to tackle local issues on the ground to improve the daily lives and life chances of people living in our most disadvantaged communities, and to target specific interventions to address deprivation and economic exclusion. We are engaging with stakeholders and communities to develop our locality plans which will be aligned to and compliment the regeneration plans with the aim of making the best use of our collective assets and resources.

Inspection of Services

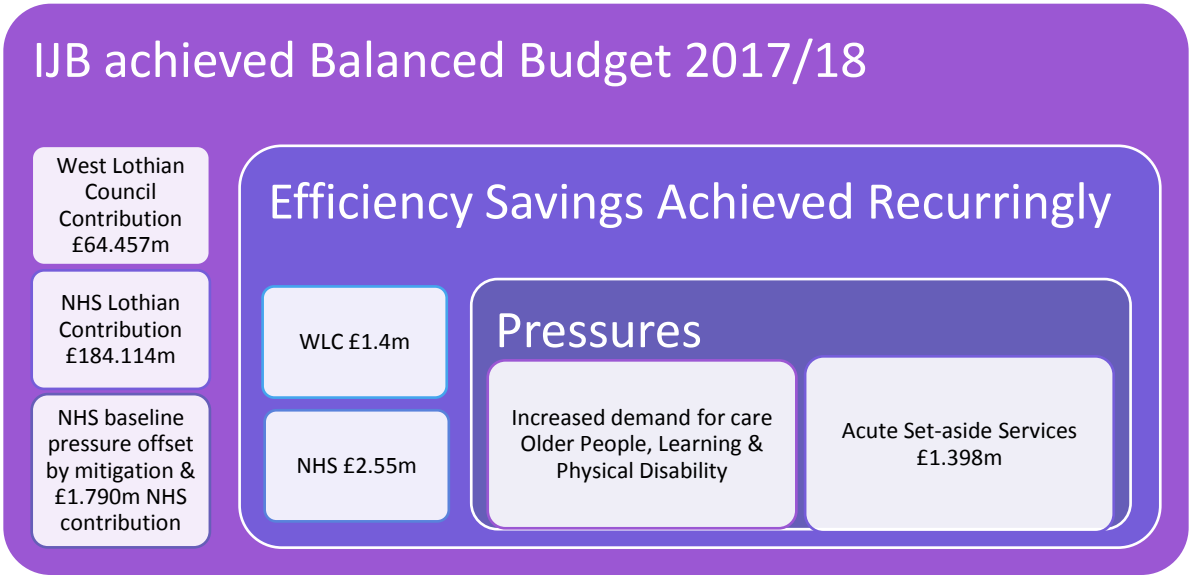
The Care Inspectorate undertook both scheduled and unscheduled inspections across a range of IJB Care Home and Support Services during 2017/18. 89.5% of the 19 services inspected achieved grades of 4 (good) and above.

	Grading Awarded by the Care Inspectorate at Latest Inspection						
Quality Themes	**Excellent (Level 6)**	**Very Good (Level 5)**	**Good (Level 4)**	**Adequate (Level 3)**	**Weak (Level 2)**	**Unsatisfactory (Level 1)**	**Not Assessed**
Care and Support	1	12	3	0	0	0	**0**
Staffing	0	6	7	1	0	0	**5**
Management and Leadership	0	7	10	2	0	0	**0**
Environment	2	13	3	1	0	0	**0**
Total	**3**	38	**23**	**4**	**0**	**0**	5

The Mental Welfare Commission undertook four inspections within mental health inpatient facilities during 2017/18. Recommendations from these inspections relate to improving the quality of care plans, prescribing of *as required* medication and improving the patient environment and policies. These recommendations are being taken forward by the Mental Health Management Team.

Financial Performance and Best Value

Financial management, governance and accountability arrangements for IJB delegated functions are set out in the West Lothian Integration Scheme and the IJB Financial Regulations.



Summary of Financial Position

In 2017/18 the IJB has achieved a balanced budget position despite there being many pressures on the system. We have worked closely with NHS Lothian to mitigate the funding shortfall down to £1.79 million with this balance being funded by NHS Lothian through their achievement of an overall breakeven position.

IJB delegated services saw continued demand growth during 2017/18. Within community care, both elderly care home and care at home demands /expenditure increased significantly reflecting a growing elderly population who are living longer with more complex needs. Growth in demands within learning and physical disability care also increased significantly, reflecting increasing needs and a shift in the balance of care from health to community care in line with integration objectives.

Within health delivered services, by far the most significant pressure related to Acute set-aside services where there was an overspend of £1.398 million. Junior medical staffing pressures relating to seven day working, non-compliant rotas and the use of locum staff to cover rotas was a major contributing factor to the overspend. In addition, difficulties in recruiting and the resulting requirement for agency staff in Accident and Emergency and General Medicine areas has also been a key contributing factor. Substantial work has been undertaken to improve the prescribing budget position for 2017/18 including prioritisation of additional funding and the introduction of a new effective prescribing fund of £2 million for 2017/18 across Lothian, and pressures in this area, while still evident, have reduced substantially.

Expenditure on services commissioned by the IJB from its Partner agencies is analysed over Adult Social Care, Core Health Services, Hosted Health Services, and Acute Set-Aside Services within the financial ledgers of West Lothian Council and NHS Lothian.

	Unaudited Budget £000	Actual Expenditure £000	Variance Over/() Underspend £000
Core Health Services	109,804	110,443	(639)
Hosted Services	22,701	22,453	248
Set Aside Services	33,327	34,726	(1399)
Non-Cash Limited Services	18,282	18,282	(0)
Additional Contribution NHS Lothian	1,790	0	1,790
Total Health Services	185,904	185,904	0
Social Care Services	64,457	64,457	0
Total	250,361	250,361	0

Overall, recurring savings of £3.95m were delivered against the productivity and efficiency plan.
The unaudited accounts for the IJB are available here-
http://coins.westlothian.gov.uk/coins/submissiondocuments.asp?submissionid=39184

Best Value

Best Value is about creating an effective organisational context from which Public Bodies can deliver key outcomes. The IJB has the same duty as the Council and Health Board to achieve Best Value. West Lothian IJB therefore expects that the partners will adhere to the principles of Best Value to secure continuous improvement in performance whilst maintaining an appropriate quality to cost balance and maintaining regard to economy, efficiency and effectiveness in carrying out the Directions of the Board.

The following five themes are considered to be the foundation on which to deliver good outcomes by ensuring that they are delivered in a manner which is economic, efficient, sustainable and supportive of continuous improvement.

Vision and Leadership

The IJB has agreed a Strategic Plan which sets out its key aims and ambitions and which guides the transformation of devolved health and social care services led by the Chief Officer and Senior Management Team. The Strategic Plan has been developed in close consultation with a wide range of stakeholders. The IJB have agreed Health and Care Delivery Plans and thematic Commissioning Plans in place for its key programmes and care groups. Each programme is supported by a performance framework against which progress is monitored.

Effective Partnerships

The IJB has an agreed Engagement & Participation Plan to support effective engagement with stakeholders and partners in development of plans for service redesign. The IJB works collaboratively within the Community Planning Partnership and with statutory bodies, the third and independent sectors in delivery of its Strategic Plan and the Health and Wellbeing Outcomes.

Governance and Accountability

The governance framework sets out the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB undertakes an annual review of its governance arrangements and is able to demonstrate structures, policies and leadership behaviours which demonstrate good standards of governance and accountability. In particular the development of a Strategic Plan in consultation with stakeholders, the robust financial planning arrangements and the publication of this Annual Performance Report give a clear demonstration of our best value approach.

The IJB have an established Audit Risk & Governance Committee with scrutiny powers in relation to risk management, corporate governance and internal and external audit reports. The Committee meets quarterly and the public has access to its meetings and meeting papers.

The Strategic Planning Group has been set up in accordance with legislation and guidance which again meets in public in relation to development, review and progressing of the Strategic Plan

The Health and Care Governance Group, chaired by a Board member, provides a focus for clinical and social care issues and concerns and to advise the Board where appropriate. The Group will have oversight of all service change proposals to ensure that quality of care and service delivery is not compromised.

Use of Resources

The financial planning process forms the basis for budget agreement each year with NHS Lothian and West Lothian Council. Performance against the Financial Plan is reported to the IJB on a regular basis throughout the year. All significant service reviews considered by the IJB are supported by an effective option appraisal. The current challenging financial climate reinforces the importance of managing expenditure within the financial resources available and this requires close partnership working between the IJB as service commissioner and NHS Lothian and West Lothian Council as providers of services.

Performance Management

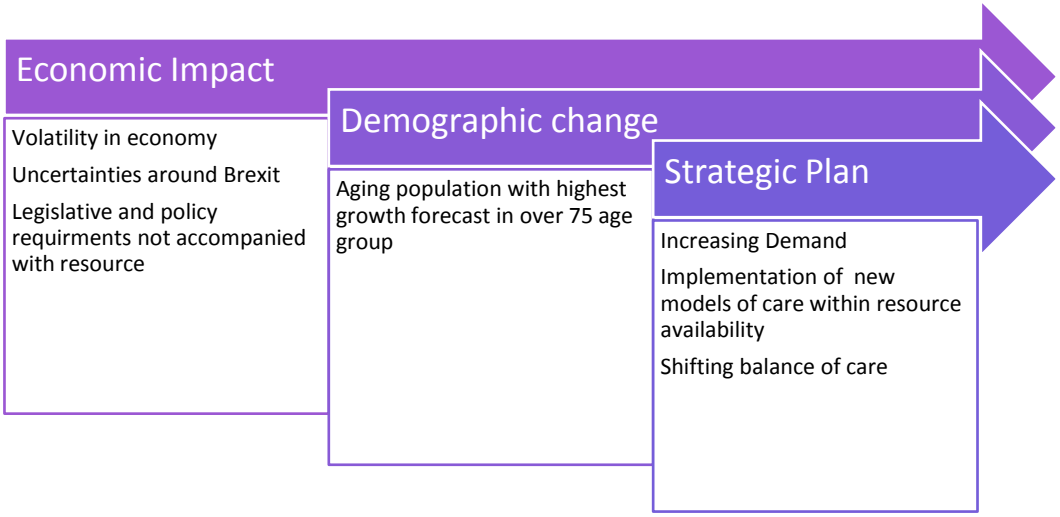
The IJB's Performance Management focuses firmly on embedding a performance management culture throughout its activities. Regular reports on performance are provided to the IJB on all key integration and local indicators.

Future Financial Plans and Outlook

The 2018/19 budget contributions from NHS Lothian and West Lothian Council have been taken account of in Directions issued to Partners for 2018/19. While the council contribution represents a balanced budget position, the NHS Lothian contribution represents a funding shortfall compared to forecast expenditure of £1.953 million (equivalent to 1.3% of the Health contribution). Taking account of this, it will be important that action is taken during the year to identify options to manage this pressure and ensure a balanced position is achieved for 2018/19.

The IJB has a statutory responsibility for delegated health and social care functions in relation to the strategic planning of future health and social care delivery. Plans for this are developed via the health and social care management team and council and NHS Lothian staff supporting the IJB. The IJB's Strategic Plan and strategic commissioning plans will help inform decisions around prioritisation of resources, new models of service delivery and disinvestment decisions, all of which will be necessary in the medium-term financial planning process associated with health and social care services.

As part of the agreed IJB Directions to NHS Lothian and West Lothian Council, there is a requirement for the Partners to work with the IJB on the preparation of a medium-term financial strategy for IJB delegated functions. This reflects that strategic planning of future service delivery and financial planning are intrinsically linked. An informed approach to future service delivery must take account of assumptions around available resources as resource availability will be a key determinant in shaping future service delivery. There are significant risks over the medium terms which are summarised below:



It is important moving forward to 2018/19 and in future years that expenditure is managed within the financial resources available and this will require close partnership working between the IJB as service commissioner and NHS Lothian and West Lothian Council as providers of services. The risks highlight the requirement for robust financial planning which is integrated with the strategic commissioning plans.

Annual Review of Strategic Plan

The Strategic Plan takes account of the integration delivery principles and the National Health and Wellbeing Outcomes. The Act also includes provision for review of the Strategic Plan and this is undertaken on an annual basis. Based on the most recent review of the Strategic Plan, the IJB have agreed that a new Strategic Plan should be developed to drive forward the transformational change required in health and social care. Since the previous Strategic Plan was agreed in early 2016, it has become evident that the strategic and financial challenges impacting on performance and delivery require the Strategic Plan to be refreshed. It is proposed that the Strategic Plan will cover a five-year period which will be consistent with the five-year financial plan period for IJB functions. This will allow for integrated strategic and financial planning over 2018/19 to 2022/23.

In preparation for the development of the refreshed Strategic Plan public consultation has commenced on the Vision, Values and Strategic priorities for the IJB and Health and Social Care Integration.

Key priorities for 2018/19

Financial	•Establish medium term financial plan linked to revised Strategic Plan
Strategic Plan	•Refresh Strategic Plan linked to financial plan •Consultation on Priorities and revised plan
Unscheduled Care	•Improvement focus to optimise patient flow, avoid unnecessary admissions and actions to reduce delayed discharges
Primary Care	•Promote sustainability in Primary Care through implementation of the new GMS Contract and Primary Care Improvement Plan
Community Care	•Develop framework for new Care at Home Contract •Implement eligibility criteria for care at home
Workforce	•Develop medium term workforce plan •Organisational Development to support new ways of working
Engagement & Communication	•Engagement with key stakeholders and wider communities
Locality Plans	•Locality engagement and consultation •Develop locality plans aliged with regeneration plans
Carer Support	•Implementation of Carers Act 2018 •Work with partners to identify carers
Inequalities	•Promote prevention and early intervention activities •Work with partners to address root causes of inequalities