West Lothian Integration Joint Board

Annual Performance Report 2018/19

Foreword

A review of our performance during the past year enables us to reflect on how well we have done against the strategic proprieties set out in our Strategic Plan but also allows us, importantly, to identify where we still have further work to do.

We have made very good progress this year through continuation of our ambitious transformational change programmes and through our focus on people receiving the right care, at the right time, in the right place and by the right people. It takes time for the impact of transformational change to be realised but we are already seeing some very positive results from the changes we have put in place. We recognise, however, that we still have much to do if we are to rise to the demographic, financial and workforce challenges facing us but our ambition to deliver positive outcomes for the people of West Lothian remains firm.

A review of our Strategic Plan was undertaken during the course of the year and following an extensive period of consultation with a wide range of stakeholders, a new plan was approved by the Integration Joint Board in April 2019. The plan retains the commitment to increasing wellbeing and reducing inequalities across all communities of West Lothian and our future plans will include working with partners to focus more on early intervention and prevention.

Underpinning our performance this year has been a real sense of partnership working between our staff and our partner providers. The benefits to our community of developing more streamlined services with people working in an integrated way across the whole system is key to effective delivery of future services.

With the focus on early intervention and prevention in mind, extensive work has taken place during 2018/19 to develop two Community Wellbeing Hubs which will be based in the East and West localities. The Hubs will house multi-disciplinary teams of health professionals and community link workers who will offer supports to people with mild to moderate mental health problems who otherwise may find it difficult to access support services at an early stage.

Our ability to discharge people requiring ongoing care and support in the community from hospital remained challenging in 2018/19. The problems were mainly as a result of being unable to supply enough home care services and care home places to meet demand. The latter half of the year, however, saw significant improvement in our performance as some of the strategies we put in place began to take effect. We hope to be able to sustain and build on the progress we have made this year during the course of next.

A key development in our efforts to improve discharge planning has been the creation of a new Integrated Discharge Hub at St John's Hospital. The Hub opened in December 2018 and has brought together multi-disciplinary teams from the NHS, social work and Carers of West Lothian to improve planning and decision making for people being discharged from hospital who require ongoing care and support. Staff are working together in one location and multi-agency meetings are held daily to

make decisions with people and their families about how care and support will be provided at home or other community setting. Early indications are that discharges are happening much faster through improved communication within the teams, and the ability to have conversations at a much earlier stage in the discharge planning process is viewed very positively by all. We are using our experience of developing the Hub to redesign how people are assessed for support in future with an aim that this is done at home as far as possible rather than in a hospital setting.

I hope the West Lothian Integration Joint Board's Annual Performance Report provides you with an overview of our performance against the nine National Health and Wellbeing Outcomes and gives a flavor of the work being done across our partnership to improve how are services are delivered to people living in West Lothian.

Jim Forrest
Chief Officer
West Lothian Integration Joint Board

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Introduction

Purpose of the Report

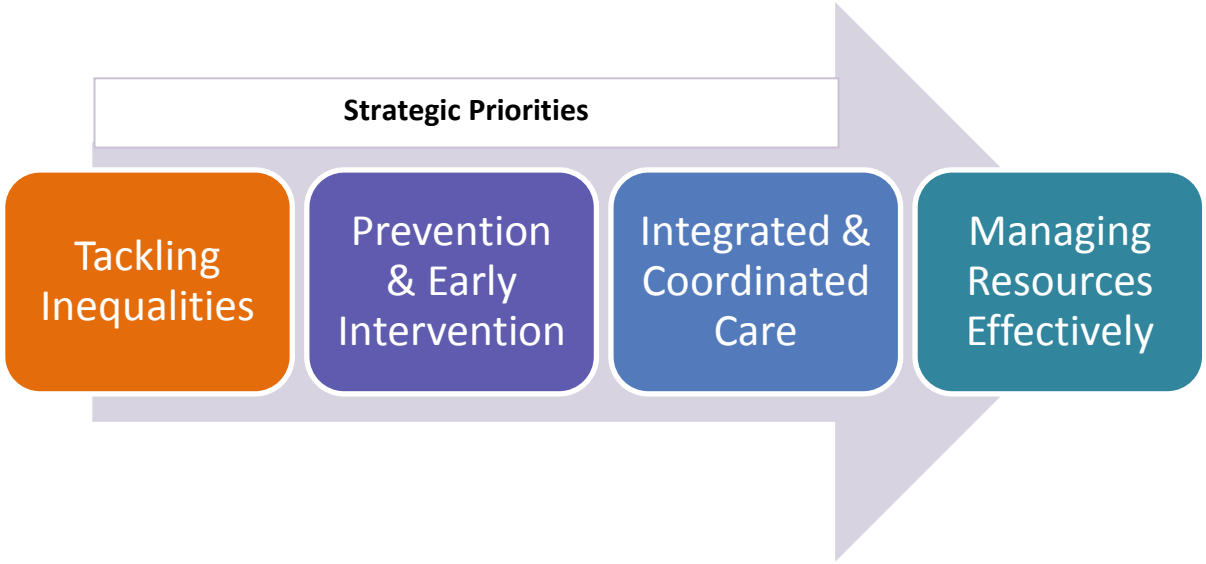
The Public Bodies (Joint Working) (Scotland) Act 2014 established a legal framework for the integration of health and social care services in Scotland. In West Lothian an Integration Joint Board (IJB) was established on 1st April 2016 and is responsible for planning and setting direction for the majority of integrated health and social care services for adults in the area.

The IJB is required to assess how it has performed in the areas it has responsibility for and to publish an annual performance report. This report sets out an assessment of progress toward the IJB's vision to increase wellbeing and reduce health inequalities across all communities of West Lothian. It also considers:

Strategic Plan

The IJB developed a long term strategic plan for the period 2016 to 2026 which set out its key priorities. The Strategic Plan is reviewed annually to ensure consistency with policy, economic and social circumstances. Consideration is also given to whether the plan continues to reflect values, available resources and priorities for health and social care. The last annual review identified challenges which were having an impact on performance and delivery of the IJB's strategic outcomes and it was agreed therefore that a replacement Strategic Plan needed to be developed during 2018.

A new Strategic Plan for 2019-23 was prepared through consultation with stakeholders to take account of new legislation, national contract changes, market conditions and workforce challenges. The vision and values set out in the Strategic Plan remained relevant and had a good fit with those of NHS Lothian and West Lothian Council working in partnership. The new Strategic Plan, however, is more detailed in how the IJB intends to drive forward transformational change in health and social care and also makes sure that priorities fit the medium term financial plan.



Planning in Localities

Two localities have been established for planning purposes in West Lothian to ensure strong, local, clinical, professional and community leadership of health and social care services. Locality groups are leading the development of locality plans for the East and West localities of West Lothian and will take account of community plans, regeneration plans and local priorities related to inequality and poverty. The information below provides an overview of the population profile in each of the localities.

West Lothian IJB Locality Groups have been established for some time and each has members representing service-users, carers, the voluntary sector, housing providers, GPs, independent sector providers, community planning and community regeneration officers as well representatives from health and social care.

Consultation with the community has taken place to inform the development of locality plans including an online survey and paper based surveys in areas where lots of people pass through such as GP surgeries and St John's Hospital. Stakeholder groups were contacted to raise awareness of the consultation including community councils, equality forums, council and NHS Lothian staff, voluntary organisations and other community groups. Locality Group members circulated the consultation to their own networks and both council and NHS Lothian media publicised the consultation. Groups, especially hard-to-reach groups, were invited to request further support to take part in the consultation and meetings were held with those requesting them.

Whilst progress has been made in the development of locality planning, the IJB recognises that it is an area where further work needs to be done to ensure that strategic plans fit with local priorities. Locality plans for the East and West localities are currently under development and will be finalised during 2019.

Financial Reporting by Locality

Financial reporting is not currently broken down by locality. The IJB acknowledges that this is a priority for future development and will be progressed once locality planning is at more advanced stage.

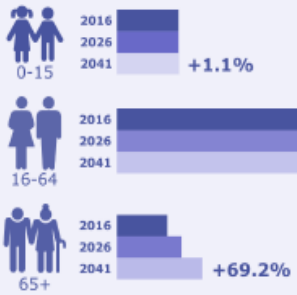
West Lothian - West Locality Profile Summary

2016/17
ISD: 2018

77,519 people live in the West locality

Female 50.8% | Male 49.2%

NRS: 2017



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

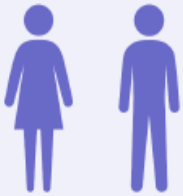
DWP: 2017

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

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

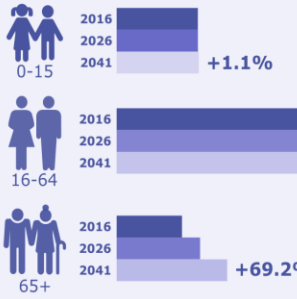
West Lothian - East Locality Profile Summary

2016/17
ISD: 2018

102,611 people live in the East locality

Female 51.1% | Male 48.9%

NRS: 2017



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

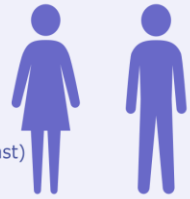
DWP: 2017

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

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

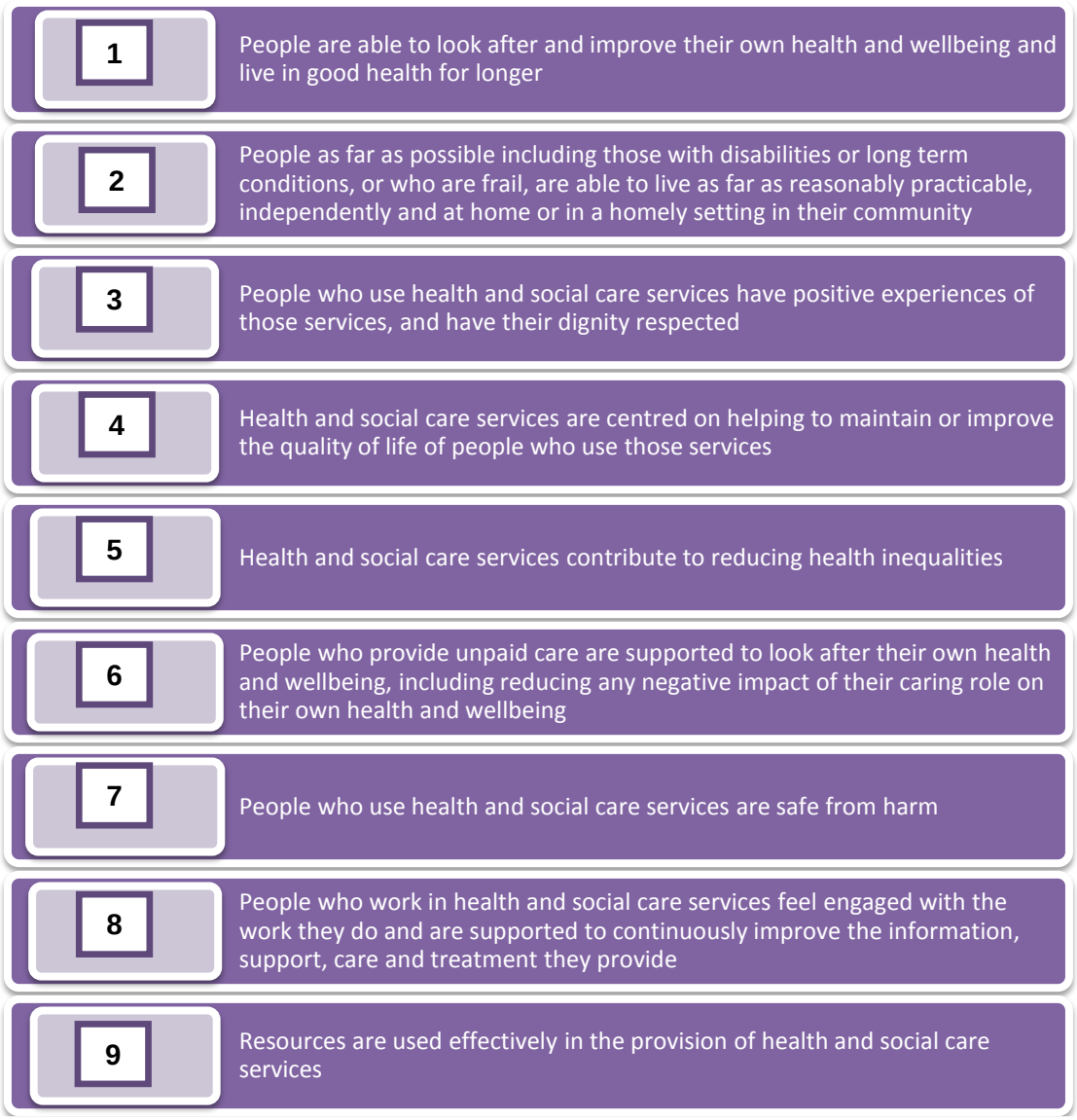
10,977 acute emergency hospital admissions per 100,000 people

381 alcohol-related admissions per 100,000 people

ISD: 2018

National Health and Wellbeing Outcomes

The nine National Health and Wellbeing Outcomes provide the foundation for the West Lothian Strategic Plan. The outcomes are high level statements by the Scottish Government setting out what health and social care partners are attempting to achieve through integration and how improvements can be made for people. The outcomes framework below has been used in this report to report progress in West Lothian.



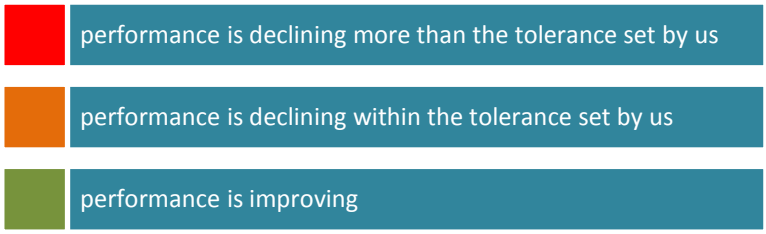
Performance Review

West Lothian IJB has developed a range of performance indicators to allow progress against health and wellbeing outcomes and integration indicators to be measured. Performance indicators are scrutinised regularly by the Integration Joint Board and the Strategic Planning Group to monitor progress against objectives and identify areas for improvement.

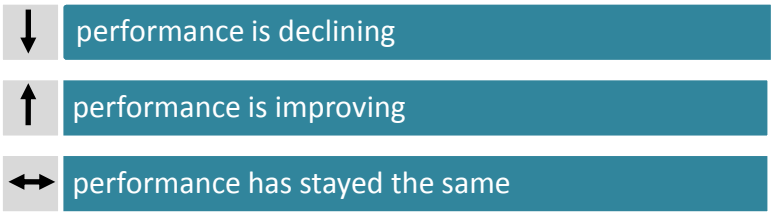
The annual performance report outlines how West Lothian is performing against the main indicators. Where available, data for 2018/19 is provided but where this has not been published, the latest data is included. There are comparisons in the report with previous performance and also with the national average.

It should be noted that some of the indicators use results from the Scottish Health and Care Experience Survey which is undertaken by the Scottish Government every two years. The last survey was completed in 2017/18 and will be done again in 2019/20 which means that there is no updated information available this year for inclusion in this report and is marked 'not available'.

A red, amber, green (RAG) rating system is used to explain progress.



Arrow are also used to show performance in West Lothian compared with previous years and compared with the Scottish average.



The next section of the report sets out how delegated functions performed throughout 2018/19 and provides examples of what was done to progress the IJB's priorities and National Outcomes. It should be noted that some of the data for 2018/19 remains provisional and is subject to final validation. It is not yet possible to make comparisons for the year 2018/19 with other areas of Scotland as this information is not yet published.

Performance - Health and Wellbeing Outcomes

Outcome 1

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

Indicator	2016/17	2017/18	2018/19	Compared to previous result
% of adults able to look after their health very well or quite well.	94% (HACE* 2015/16)	92%	Not available*	
Rate of emergency admissions per 100,000 population for adults	11,923	11,690	11,755	↑ 0.5%

*The Health and Care Experience Survey (HACE) is published every 2 years. The next survey results will be published in 2019/20

How we performed…..

The West Lothian population is growing faster than the Scottish average and this trend is expected to continue to 2041 when it is anticipated that there will be an overall increase of 12.8%. At the same time, the population of people aged 75+ in West Lothian will increase by 120%. Given the level of population growth and the growth in the number of people aged over 75, a slight rise in the number of emergency admissions is not unexpected. The rate of emergency admissions in West Lothian has been improving over recent years. This year, there has been a slight increase in the emergency admission rate but efforts continue to be made to ensure that people are supported to live well in their communities with the aim of reducing unnecessary admissions to hospital where possible.

Plans being developed during 2019/20 will focus on prevention and early intervention to ensure that people can be supported at home or other community settings as far as possible. This means ensuring that different types of care and support are available within the community and tat services can respond quickly to people's changing needs.

What we have done…..

Made available a range of technologies

myCOPD is a self-management tool that helps people with Chronic Obstructive Pulmonary Disease to manage their condition better. It can be used to help with inhaler technique, improve breathing, reduce fare ups and track medication. It works by the user logging on to a web based portal, from where they can access a range of self-care tools. The purpose of encouraging the use of myCOPD is to help people manage their COPD independently and reduce reliance on GP and hospital appointments. myCOPD can also be used by health professionals to check in with their patients remotely, track their condition, update medication and improve their overall care.

Florence text Messaging Service

'Flo' is a text messaging system that sends patients reminders and health tips tailored to their individual needs. Flo has had a huge impact on people's lives, revolutionising the way patients manage their own health. Since 2010 it has been used by more than 30,000 people in over 70 health and social care organisations in the UK. In West Lothian, Flo is being used in a range of GP practices as well as with a number of individual service users.

The technology behind Flo is fairly straightforward: doctors or other care professionals can adjust Flo for each patient, defining when messages should be sent, what information they are asking for and how the system should respond. Flo then sends regular text messages to patients helping them to monitor their health and share information with the person managing their care.

Prevention/Early Intervention

myCOPD

- ☑ myCOPD has been shown to correct 98% of inhaler errors without any other clinical intervention

Florence

- ☑ 'Flo' is being used in the management of Vitamin B12 injections and for medication reminders. It is also being used by patients to check blood pressure with a text being sent back to the appropriate health professional

Activity monitoring:

Web based assessment tools are used in an individual's home at the start of a care and support assessment to help with care planning. Data gathered during the assessment provides evidence which can be used to identify the right support for an individual and removes the need to make estimates or assumptions about how people live or daily living routine.

Small, wireless movement sensors are triggered as a person moves around their home and this data is then sent to the 'Just Checking' web-server where professionals and families can view activity charts. The charts are then discussed with individuals and their families during the assessment phase and agreement can be reached about the most appropriate types of care and support required, if any. For some people the use of technology enables independence to be maintained without the need for formal support.

Outcome 2

- People as far as possible 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

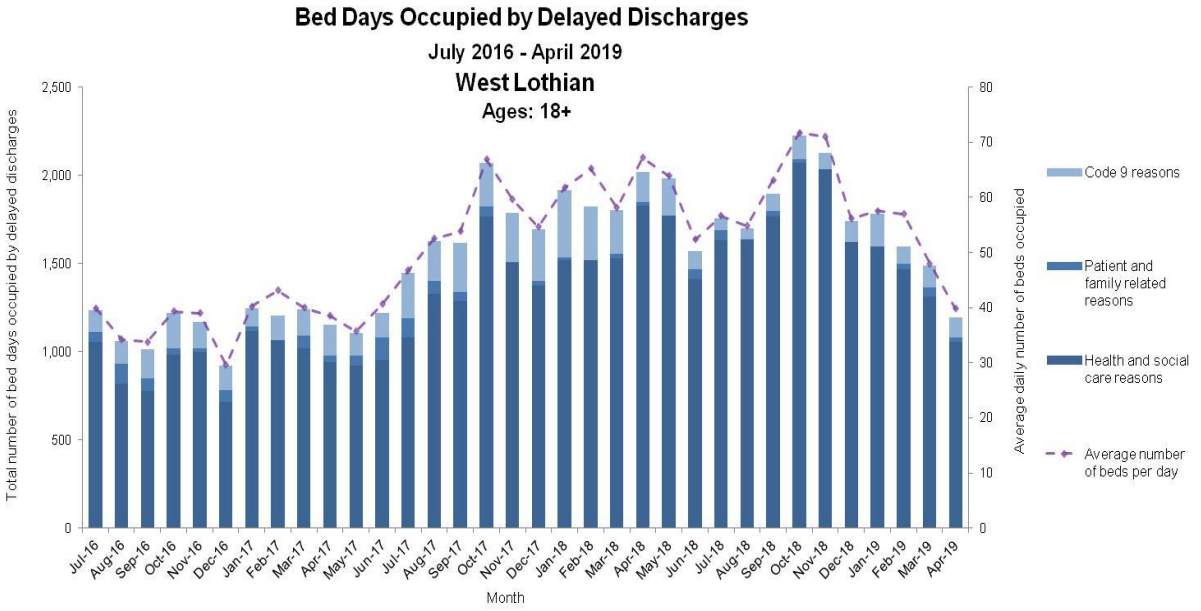
Indicator	2016/17	2017/18	2018/19	Compared to previous result
Emergency bed day rate per 100,000 population for adults	104,218	107,074	97,787	↓8.7%
Readmissions to hospital within 28 days of discharge per 1,000 admissions	109	104	104	↔
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1000 population	822	1139	1257	↑10%
Proportion of last 6 months of life spent at home or in a community setting	88%	89%	88%	↓1%
Percentage adults with intensive care needs receiving care at home	65%	67%	69%	↑2%
Percentage of adults supported at home who agreed that they are supported to live as independently as possible	88% (HACE 2015/16)	80%	Not available	Not available
Percentage of people aged over 75 who live in their own home	92.2%	92.4%	Not available	↔

How we performed…..

During 2018/19, significant challenges continued to be faced in relation to delayed discharges from hospital. Despite considerable effort, it remained very challenging to secure enough care at home and care home capacity in West Lothian to enable everyone who needed ongoing care and support at home to go home without delay.

A full programme of improvement activity was put in place which focused on redesigning the whole system to reduce emergency admissions, readmissions and improve performance on delayed discharge. As part of that programme, an Integrated Discharge Hub was established at St John's Hospital and there was investment in a test of change to look at the systems and process in place for matching packages of care. Impact of some of the changes was seen in the latter half of the year as the improvements began to take effect.

The table below shows the improving position in West Lothian from December 2018 to April 2019 in relation to bed days occupied by delayed discharges.



What we have done…..

Managing our Resources Effectively

Integrated Discharge Hub at St John's Hospital

A new Integrated Discharge Hub was launched at St John's Hospital in December 2018 bringing together staff from the hospital, community, social work and Carers of West Lothian in one place to work alongside inpatient teams, patients, carers and families. The intent was to improve hospital discharge planning and reduce the length of time people had to wait in hospital for arrangements to be made for ongoing care and support in the community.

The hub team holds daily, multi-disciplinary 'huddles' to discuss complex discharges working in partnership with the hospital inpatient teams, carers and families. The discharge planning process has been streamlined because everyone who needs to be involved in decision-making and discharge planning can be consulted almost immediately.

Improvements are already being seen such as: better communication, reduction in unnecessary delays and reductions in the average length of stay within the medical inpatient wards.

Integrated Discharge Hub

- ☑ Conversations and discharge planning are more joined-up and happening much earlier than previously
- ☑ every opportunity is taken to screen, assess and divert patients where appropriate to alternative community pathways
- ☑ involvement of carers means that barriers to discharge can be identified early
- ☑ evidence from case studies shows that patients have had a significantly improved journey and that the length of time spent in hospital awaiting discharge is reduced
- ☑ the new arrangements are showing that avoidable delays and duplication are reducing

What people have said about the hub……..

Many, many thanks to you all, we were very impressed and thankful for the professionalism and genuine support you gave us. (**Family member who received a service from the Integrated Discharge Hub)**

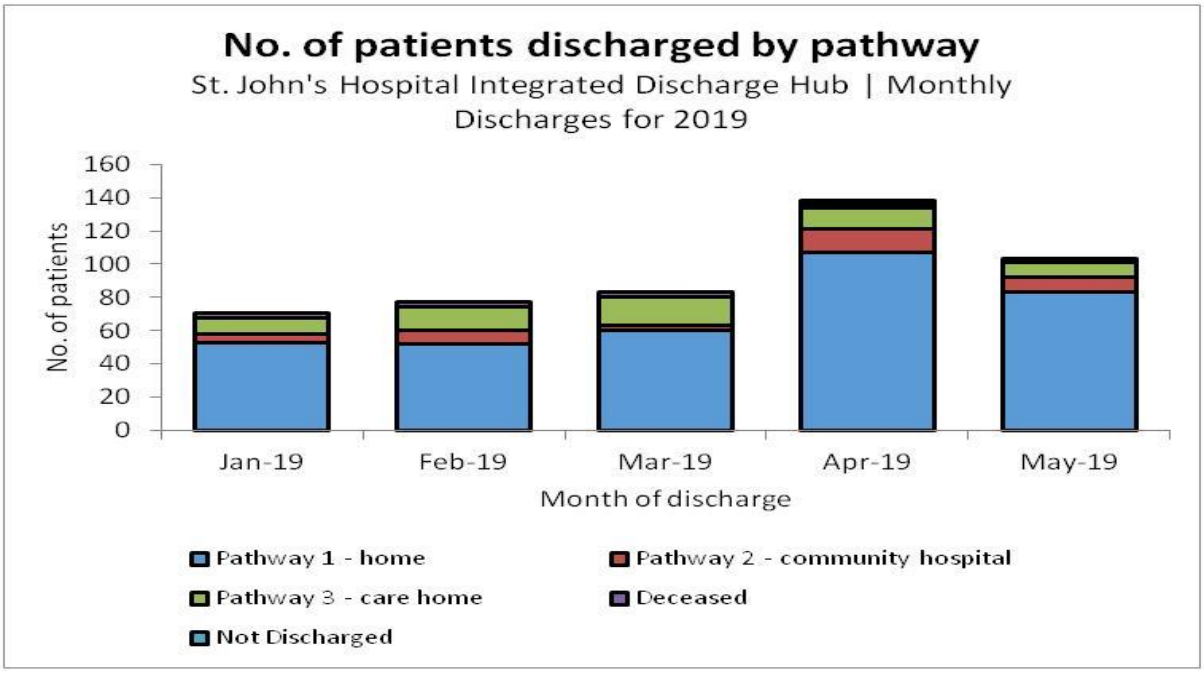
*I think that being part of the Hub is raising CoWL'S (Carers of West Lothian) profile within the hospital and other staff out-with the Hub are now seeing us as being part of the team, this is a situation that can only get better when we start spending more time in the hospital on a daily basis (**Carers of West Lothian)***

Rapid, efficient and effective discharge planning. Improved communication, efficiency, multidisciplinary team decisions that are resulting in more rapid safe patient discharging
(Discharge Nurse)

I think the Hellen Keller quote below describes the hub very well.
"Alone we can do so little; together we can do so much"
"The hub has united NHS and care services to enhance care for patients in the most effective way" **(Reablement Worker)**

The table below shows the number of people who have been discharged through the Integrated Discharge Hub since it opened in December 2018. It also shows where people were discharged to, with the vast majority of people going home in line with our vision to support people at home wherever possible.

During the course of the next year, work will take place to develop a 'discharge to assess' model which will mean that assessment for ongoing care and support will happen at home rather than in the hospital setting. It is anticipated that this will enable people to return home quicker and will ensure that there is focus on maximising independence through an enabling approach.



The Support at Home Service provides a range of care and support services for adults which promote independence and maximise opportunities for people to remain at home where possible. In addition to home care services, work has also been taking place to promote the use of GPS tracker supports to keep people independent and safe.

YOUR Meds the Support at Home Service is working in partnership with a pharmacy and a 'YOUR Meds' technology provider to trial a system which allows staff to make 'e-visits' to monitor service users taking their medication in real time from a central location.

The system uses visual and audible reminders to support people to take the right medication independently and at the right time. Action is only required if the service user doesn't take their medication and in many cases a simple reminder is all that's required.

Medication is received from the pharmacy in a blister pack which has a 'smart tag' containing a sim card. The card is programmed with the individual's medication regime.

Managing our Resources Effectively

Your Meds

- ☑ Promotes medication self-management
- ☑ Working in conjunction with care services can increase independence and reduce dependency for some unnecessary paid supports
- ☑ Safety checks are built in – if the required pod in the blister pack is not opened or the wrong pods are opened an alert is issued to the nominated responder

Prevention/Early Intervention

A family was referred for GPS tracker support following concerns about their family member wandering off and police being called to assist with finding him. Following a recent diagnosis of dementia their father was becoming lost and disorientated and the family contacted the Support at Home Service for help. A tracker device was provided. The person concerned liked to go walking independently and use of the tracker means he can do that whilst his family know that he can be traced at any time. The technology has also enabled the user and his wife to continue going on holidays together.

Yesterday my husband said he was going out for his usual walk but when I logged into the tracker he was actually on a bus to Edinburgh. We tried phoning him….he got off the bus and phoned me but not to say that he was lost but that he was in Wales. If we had not been able to track his movements, we would have had no idea where he was and we would not have been able to find him. My son works in Edinburgh and we were able to direct him to where his Dad was and he was picked up and brought home. If we had no tracker, we would have had to report my husband as a missing person.
(Family using GPS)

The Acute Care and Support Team (ACAST) is a team of mental health nurses with input from psychiatrists providing home treatment for adults suffering from mental health problems.

ACAST offers short-term, intensive home treatment as an alternative to in-patient care. The service is based at St John's Hospital and the team works throughout the West Lothian community. In 2018/19 additional funding was used to add a social worker and an occupational therapist to the team to ensure that people received the most appropriate care and support at the earliest opportunity.

Anticipatory Care Planning involves health and care practitioners working with people to have conversations to help them understand their condition and talk about the type of care they wish to receive. People have the opportunity to highlight what's important to them and set out their wishes.

Residents in nursing homes are frail with complex care needs, and unplanned hospital admissions are not always helpful. The GP lead for care homes in West Lothian worked with the Medicine of Elderly Team at St John's Hospital to develop an Anticipatory Care Planning summary document to record residents' wishes around, for example, transfer to hospital during episodes of ill health or at the end of life. A medical advice and emergency flowchart was created working with the Hospital at Home Team of the Rapid Elderly Assessment Care Team (REACT).

The REACT Care Home Team is working with care home staff to ensure there are good anticipatory care plans in place. The team is providing training for staff and developing a frailty passport to ensure patient care plans can travel with them and that their wishes are evident to everyone they meet on their journey. The team can support hospital avoidance and ensure medical treatment is provided at home where possible.

Prevention/Early Intervention

The Acute Care and Support Team (ACAST)

- ☑ 174 people were seen by the ACAST team in March 2019 compared with 89 people in March 2018
- ☑ 63% of people were able to go home
- ☑ 12% were admitted
- ☑ 17% were followed up by ACAST
- ☑ 2% received outpatient appointments
- ☑ 6% received another type of intervention

Integrated & Coordinated Care

Anticipatory Care Planning

- ☑ Acute hospital admissions were reduced in nursing homes which implemented anticipatory care planning documentation
- ☑ Realistic medicine practice is essential in this complex care group to agree care goals between patients, families, staff and GPs
- ☑ 2 Advanced Nurse Practitioners and 2 nurses have been appointed to support the needs of the nursing home population
- ☑ Impact will be evaluated post implementation

Outcome 3

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

Indicator	2015/16	2017/18	2018/19	Compared to previous result
Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	81%	77%	Not available	Not available
Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated	82%	76%	Not available	Not available
Percentage of adults receiving any care or support who rated it as excellent or good	82%	84%	Not available	Not available
Percentage of people with positive experience of the care provided by their GP Practice	78%	75%	Not available	Not available
Percentage of people who feel they are listened to	87%	89%	Not available	Not available
Percentage of people who feel they are treated with compassion and understanding	93%	91%	Not available	Not available

How we performed…..

The measures included under this outcome are taken from the Health and Care Experience Survey completed every 2 years. Information will next be available for 2019/20.

We remain committed to maximising opportunities for people to have choice and control over decision which affect them and to ensuring that care and support are person centred and of high quality. This commitment will be reflected in planning for the year ahead.

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What we have done…..

Social Policy Supported Employment Service supports adults with a disability to work towards paid employment and volunteering opportunities. Following a review, a new service was launched in late 2017 and has been further developed during 2018/19. Every service user has a designated Employment Development Officer (EDO) who provides one to one support to access work experience or volunteering opportunities, in-work support and internal and external training.

"The Supported Employment Service gave me the confidence and motivation to follow my dream, and it really did come true. I can't believe that I am about to become a Supervisor of a 5 star hotel and am only 18. I have made my mum, dad and sister so proud, and that is something I never thought I would do" ***(User of the Supported Employment Service)***

Tackling Inequalities

Supported Employment Service
In 2018/19 there were:

- ☑ 140 new referrals
- ☑ 67 positive job outcomes
- ☑ 103 people received in-work support
- ☑ 69 people on work experience
- ☑ Service was a finalist at West Lothian Council's Celebrating Success awards

Project Search - a one year programme for 18-24 year olds with Autism and/or a Learning Disability to gain work experience within a host employer. Programme is delivered in partnership with West Lothian College and a host business. In 2018/19 a new business partnership was established with NHS Lothian based at St John's Hospital.

Outcome 4

- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Indicator	2016/17	2017/18	2018/19	Compared to previous result
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%	Not available	Not available
Proportion of services graded "good" (4) or better in care inspectorate inspections	85%	87%	85%	↓2%

How we performed…..

There are lots of services and supports available in West Lothian to assist people in maintaining or improving their quality of life. The supports range from information and advice services to more formal supports through social work and health services. Some examples of those services are provided below.

The proportion of services graded as 'good' or better by the Care Inspectorate has remained fairly consistent although there was a very small fall in the number compared with last year. Not all services are inspected every year.

What we have done…..

Tackling Inequalities

The Brock supports the ongoing recovery of service users, people with long standing mental health problems. It aims to provide opportunities for people to develop new skills and improve their confidence thereby developing resilience and reducing risk of relapse. The model is to build on the strengths that people have in a safe and protective environment and can lead to new opportunities: educational or work skills related. There is no obligation for anyone to commit to employment or formal educational courses and the activities having their own therapeutic value to the service user are reason enough for engagement with the Brock. The Brock is a Scottish Charitable Incorporated Organisation (SCIO) and generates income through trade. In the Brock's case people grow garden plants, make garden furniture and craft which are sold. The monies generated are then reinvested in the activities of the Brock. The Brock also aims to promote social inclusion by integrating activities in the community. Currently the Brock is developing a "Mind garden" for the Strathbrock Partnership Centre which will provide a maintained garden space for staff and visitors of the Partnership Centre to enjoy. The Brock promotes mental health and wellbeing in ways which will allow stereotypes of mental illness and mental health problems to be challenged. As the public see people succeed in the Brock's developments, their assumptions of what mental health problems mean can be tested in a meaningful way.

West Lothian Psychological Approach Team for Dementia (WeLPAT) launched a **Link Worker programme**. Each West Lothian care home now as a qualified WeLPAT Link Worker. Regular Link Worker consultation clinics are being held in each home covering early intervention, coaching and support to promote preventative person centred strategies and care planning. This is in addition to direct referral for more intensive support.

Detect Cancer Early Programme

Craigshill Health Centre was involved in developing a new Good Practice Resource for GP practices. The guide provides 'a checklist of simple actions for GP Practices to support early detection of cancer within the practice population.' More information here: http://intranet.lothian.scot.nhs.uk/Directory/DetectCancerEarly/GPG/Pages/default.aspx

Prevention/Early Intervention

WeLPAT

In 2018/19:

- ☑ Had direct input with over 200 individuals in care homes experiencing distress
- ☑ 96% of referrals where WeLPAT has been involved have remained in the same placement and not been admitted to an OPMH inpatient ward or another escalated care unit.
- ☑ 40% of those referred have required the most intensive level of input
- ☑ Interventions have seen significant reductions in staff reported frequency and severity of distressed behaviours and level of caregiver stress and distress between start and end of input
- ☑ One third fewer admissions to older people's mental health wards

Outcome 5

❖ Health and social care services contribute to reducing health inequalities

Indicator	2016	2017	2018	Compared to previous result
Premature Mortality Rate per 100,000 population	411	409	410	↑1
Male life expectancy at birth	77.9 years	78.3 years	78.1 years	↓0.2 years
Female life expectancy at birth	80.5 years	80.8 years	81 years	↑0.2 years

How we performed…..

The core integration measure of premature mortality among people aged 75 and under shows positive progress. Although life expectancy has been improving there remains significant differences in health outcomes between the most and least deprived areas of West Lothian. There are also differences in the East and West localities overall.

Working closely with community partners remains a key priority to create a better physical, social and economic environment for the population of West Lothian. The ***Health and Wellbeing Partnership*** was established in early 2019 and brings partners together from across the Community Planning Partnership (CPP) to take forward the inequalities and prevention agenda at a strategic level

The Health and Wellbeing Partnership functions as the West Lothian Community Planning Partnership's forum for health, prevention and inequalities.

What we have done…..

Mental Health and Wellbeing Hubs

With a focus on early intervention and prevention, planning has taken place throughout 2018/19 on the development of community wellbeing hubs which will be based in newly refurbished community resources in Livingston and Boghall.

Located in each of the West Lothian localities, the hubs will offer supports to adults with mild to moderate mental health problems. Services will be provided through a community link worker and well-being service. There will also be support available from psychologists, community psychiatric nurses, mental health occupational therapists, mental health link workers, and practitioners offering mindfulness, Tai Chi, yoga and relaxation classes. The service will offer early intervention through a person-centred approach to help people manage their symptoms and improve their wellbeing.

Building work is complete and the service is expected to be available in June 2019.

Tackling Inequalities

Carers of West Lothian's Information and Advice Service for Adults with a Disability provides a range of supports on behalf of the HSCP . Supports include:

- ☑ Someone to talk to
- ☑ Benefits advice and support with form filling
- ☑ Signposting and referrals to other services
- ☑ Training opportunities
- ☑ Opportunities to have a say on local services
- ☑ Information on community supports

Supporting Older People to Stay Active, Independent and Connected

Cyrenians OPAL (Older People, Active Lives) service aims to maintain or increase older people's independence and well-being across the West Lothian Council area. The free service is funded through a collaboration with West Lothian Council, West Lothian Health and Social Care Partnership, and NHS Lothian and is available for those typically aged 60+.

The service is delivered by a team of dedicated, trained volunteers. Volunteers offer encouragement, companionship and support to help older people engage in social, leisure and community activities.

Through the groups programme, 13 regular social and activity groups are delivered across West Lothian which provide a welcoming and relaxed way of getting to know people. Through the One to One/Befriending service, support is offered to older people who additionally may be experiencing one or more of the following:

- Bereavement
- Returning home after a recent stay in hospital
- Living distantly from family or friends
- A Carer responsibility
- Depression and/or anxiety
- A recent/early dementia diagnosis

Outcome 6

- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing

Indicator	2015/16	2017/18	2018/19	Compared to previous result
Percentage of carers who feel supported to continue in their caring role	36%	42%	Not available	Not available
Percentage of carers who feel they have a good balance between caring and other things in their life	65%	64%	Not available	Not available
Percentage of carers who had a say in services provided for the person they look after	50%	50%	Not available	Not available
Percentage of adults who agreed local services are well coordinated for the person they look after	47%	45%	Not available	Not available

How we performed…..

The Carers (Scotland) Act 2016 was implemented on 1st April 2018. The Act is designed to help carers continue in their caring role whilst being supported to look after their own health and wellbeing. There is a requirement to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria. Where people are eligible for support, adult carer support plans and young carer statements are developed to identify carers' needs and personal outcomes. Since the Act was implemented, 124 adult carer support plans have been completed.

Carers of West Lothian is the organisation in West Lothian which has been commissioned to provide support to carers across the Health and Social Care Partnership. Development continues to take place to ensure access to information, advice and support to help carers maintain their health and wellbeing and to have a life alongside their caring responsibilities.

Carers of West Lothian has a representative on the West Lothian Integration Joint Board and on the East and West Locality Groups as well as a range of other groups and committees to represent the interests of unpaid carers in West Lothian. Involvement of Carers of West Lothian at a strategic level means that carers are helping to shape policy and strategy for health and social care services in West Lothian.

What we have done…..

Prevention/Early Intervention

Carers of West Lothian (COWL) is a well established voluntary organisation which offers a range of supports to carers and their families on behalf of the Health and Social Care Partnership.

Supports offered by COWL include:

- One to one emotional support
- Training
- Information and advice
- Hospital based carer support
- Signposting and referral to support services
- Counselling
- Carer support groups
- Recreational courses

Feedback from Counselling sessions run by COWL included:

"I seldom take the time to be kind to myself....finding it more natural to be kind to others! So it has been great focusing on how to do this. I have loved the phrase 'Gie yourself permission', as I often beat myself up about different challenges presented to me as a carer. "

An amazing service. Would not be who I am today without it. (The counsellor) has been amazing.

Feedback from Mindfulness sessions run by COWL included:

Carers said that they learned:
'How to take time for me without feeling guilty' and that 'Me time is okay'

The counselling sessions have really helped me during a difficult spell to realise my own value and self-worth. I have gained knowledge on new ways of coping (e.g. mindfulness). High quality service which I would thoroughly recommend. My counsellor was caring and compassionate.

Feedback from a young carer…..

Tackling Inequalities

"I know this may come as a bit of an odd email and you may not even remember me but I wanted to email and say the impact that WLYC had on me since I was really young. Specifically your support on our one to one meetings really helped me realise who I was and what I wanted to do because of WLYC I have decided to become a youth worker and I am currently in my first year at uni with over a year working in the field. It was momentous for me to be able to step away from being a carer and be who I am, you really inspired me and I've never forgotten the impact that you and young carers has had on my life."
March 19

Outcome 7

❖ People who use health and social care services are safe from harm

Indicator	2016/17	2017/18	2018/19	Compared to previous result
Percentage of adults supported at home who agreed they felt safe	87%	85%	Not available	
Falls rate per 1000 population aged 65+	20	20	19	↓1
Number of households receiving telecare	4360	4380	3708	↓15%
Number of new telecare installations	780	757	469	↓38%

How we performed…..

The Home Safety Service continues to supply telecare equipment to households in West Lothian. The equipment provides a 24 hour telephone link between the service user and 'Careline' via an alarm, help button and other sensors. Careline establishes the nature of the problem and if required, contacts nominated key holders or the emergency services.

The number of households receiving telecare fell by 15% following the introduction of a charge for the service which resulted in a number of existing and new customers deciding not to continue with the telecare service. The target for 2019/20 for households with telecare has been set at 3,750 to reflect future anticipated demand.

The number of new telecare installations also fell considerably during 2018/19. There was a 38% reduction in the number of new installations provided. The service is supported by a small team and staffing capacity was limited by unplanned staff absences. In addition, the introduction of a charge for the service, as well as an expanding external market offering greater choice for potential customers contributed to the reduced numbers.

What we have done…..

West Lothian Take-Home Naloxone Programme aims to contribute to a reduction in fatal opioid overdoses. Naloxone is a medication that temporarily reverses the effects of opioid overdose. The take-home naloxone programme was introduced by the Scottish Government in response to the rising number of opioid-related deaths. Naloxone can now be supplied without a prescription to:

- Someone using or previously using opiates and at potential risk of overdose
- A carer, family member or friend liable to be on hand in case of overdose
- A named individual in a hostel (or other facility where drug users gather and might be at risk of overdose).

Capital Improvement Work in Ward 17 (acute admissions for people experiencing mental illness) began in 2018/19 to refurbish and replace all internal fixtures and fittings to reduce risk.
All new finishes have been designed to remove or significantly reduce risk whilst trying to maintain pleasant surroundings and enhance the experience for staff and patients.

The WL Alcohol and Drug Partnership initiated a health needs assessment to assess the needs (prevention, care and treatment) of problem drug and alcohol users and their families in West Lothian and make specific recommendations to improve the patient experience of care and the health of people most at risk.

The assessment, undertaken by Public Health staff, has focused on people most at risk of significant harm or death from substance misuse with a view to improving access to services and retaining people within the service. The needs assessment will be used to develop a new strategic commissioning plan in 2019/20.

Prevention/Early Intervention

- ☑ For the first time in 18/19 all of the West Lothian Alcohol and Drug Partnership commissioned services distributed Naloxone
- ☑ Increased distribution by 15.4%
- ☑ 217 kits were distributed in 18/19 compared to 188 in 17/18
- ☑ 51 kits were used at the point of overdose.
- ☑ The plan for 19/20 is to further increase the distribution of Naloxone.

Integrated & Coordinated Care

A multi-agency approach under Adult Protection was undertaken to identify the long term health needs of a person with a profound learning disability at risk of self-harm.

The circumstances were very complex and challenging but multi-agency input enabled the person's wishes to be heard and appropriate care and support agreed. The individual's learning disability meant that they found it difficult understand complex issues and communicate verbally.

Working in partnership, social work, health and Police Scotland devised a method of communication that allowed the service user's views and experiences to be taken into account and enabled appropriate actions to be agreed to enable discharge home and ensure ongoing safety.

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

Indicator	2016/17	2017/18	2018/19	Compared to previous result
Percentage of staff who consider themselves to be well informed	80%	80%	80%	↔
Percentage of staff who say they are appropriately trained and developed	75%	76%	78%	↑2%
Percentage of staff who say they are involved in decision making	72%	73%	72%	↓1%
Percentage of staff who consider they are treated fairly and consistently with dignity and respect	78%	79%	79%	↔
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%	78%	↓1%

How we performed…..

Performance across the indicators identified to measure involvement and engagement of staff has remained consistently positive across all years of reporting. An involved and informed workforce is critical to the delivery of high quality services and to driving forward the transformational change needed to plan for the future.

Staff across health and social care are actively involved in the whole system transformational change programmes identified in the Strategic Plan. Staff as often best placed to identify changes which would bring about improvement and are encouraged to participate in quality improvement programmes in their own teams and individual areas of work. Continuous improvement is central to delivery of the Integration Joint Board's vision and it is encouraging to note that staff have viewed this aspect of their work very positively.

The partnership remains committed to ensuring that staff have opportunities for training and development and all staff should have regular meetings with their manager and an annual review to discuss performance and developmental needs.

What we have done…..

GP Advanced Physiotherapy Practitioner (APP) Service. General Practice in the UK is facing significant challenges around workforce and population needs. An improvement programme focussed on extending the multidisciplinary workforce in GP practices, recognising that physiotherapists are clinical experts in muscoskeletal (MSK) assessment, diagnosis, management and referral.

Managing our resources effectively

Dementia Post Diagnostic Support Team

- ☑ 265 referrals in 2018
- ☑ Following increased staffing and training explored ways to reduce waiting times were explored
- ☑ Engagement with stakeholders - carers, Alzheimer's Scotland and 3rd Sector partners took place
- ☑ Work was done to speed up support, reduce waiting times and further develop the service
- ☑ A test of change is being carried out using a clinic based approach in partnership with Carers of West Lothian

Integrated & Coordinated Care

Over 250 care home and ward staff attended training on 'Essentials in Psychological care – Dementia provided by West Lothian Psychological Approach Team for Dementia (WeLPAT). Course evaluation demonstrated improvement in staff knowledge, confidence and attitudes towards distress in dementia.

Managing our Resources Effectively

Advanced Physiotherapy Practitioner Service for MSK

- ☑ Saw 2541 patients during 6 months in 2018/19
- ☑ 2341 (88%) of patients discharged or referred without a further GP appointment
- ☑ 124(5%) were referred for a GP appointment
- ☑ 176 (7%) were discussed with a GP
- ☑ Patients remained in Primary Care, onward costs avoided and need for GP appointments reduced

Dementia Post Diagnostic Support Team, received a marked increase in the number of referrals over the past 2 years for patients diagnosed with Dementia. Originally the team consisted of 2 Staff, with caseloads of 50 patients each. Due to the volume of referrals in late 2016- 2017, a waiting list of in excess of 150 patients had built up with a waiting time of up to 6 months for Post Diagnostic Support. A review of the demand and capacity was undertaken and it was identified that increased resources were required to prevent further increase in waiting times.

Prevention/Early Intervention

Rapid Elderly Assessment Care Team (REACT) has begun a quality improvement project involving people aged 65+ who have been admitted to Accident & Emergency or St John's Hospital 6 more times in the last year. The aim is to better understand the reasons for multiple admissions and ensure resources are targeted at preventing frequent attendance.

Outcome 9

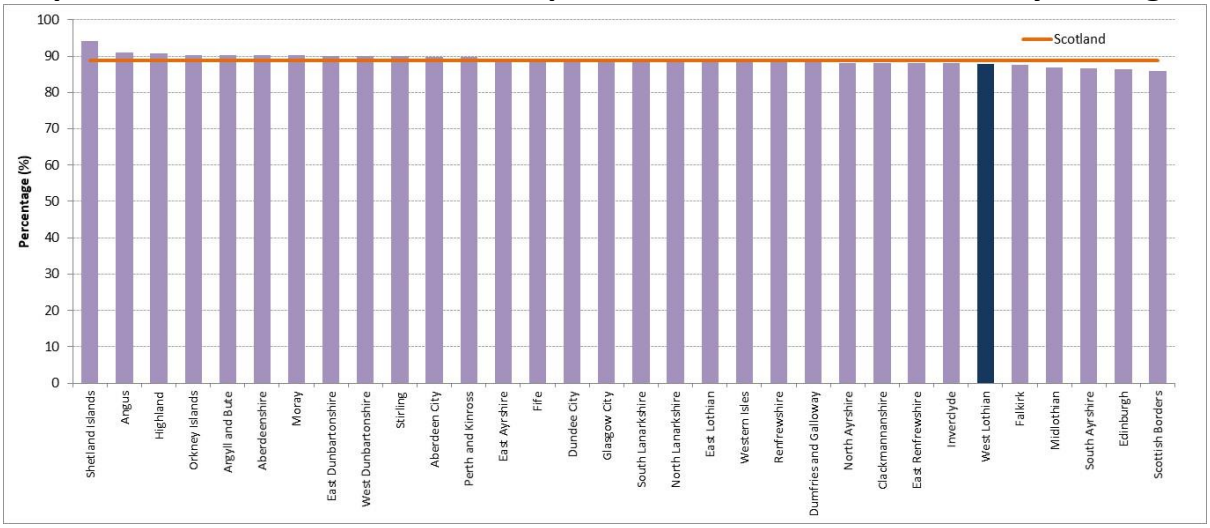
- Resources are used effectively in the provision of health and social care services

Indicator	2016/17	2017/18	2018/19	Compared to previous result
Percentage of health and care resource spent on hospital stays where patient was admitted as an emergency	23%	23%	22%	↓1%
Proportion of last 6 months of life spent in a large hospital	11.8%	11%	12%	↑1%
Proportion of last 6 months of life spent at home or in a community setting	88%	89%	88%	↓1%

How we performed…..

Although there has been a very slight decrease in the percentage of people spending the last 6 months of life at home or in a community setting, the graph below shows that West Lothian is performing well in its efforts to shift the balance of care to community settings.

Proportion of last 6 months of life spent at home or in a community setting



Transformational change programme continue to focus on shifting the balance of care and maximising use of resources through integrated approached to health and social care delivery. During 2019/20 strategic commissioning plans will be developed and will set out how resources will be spent on developing and delivering services in the following areas:

- Older people including Dementia
- Mental Health
- Learning Disability
- Physical Disability
- Alcohol and Drug Partnership
- Unscheduled Care
- Palliative Care

What we have done…..

Primary Care Implementation and Improvement Plan 2018-2021

In January 2018 GPs across Scotland voted for a new General Medical Services (GMS) contract developed by the BMA and Scottish Government. The contract promotes a balanced workload through a shift in work from GPs and GP practices which will see GPs as 'expert medical generalist' giving less care directly to patients and with greater emphasis on their roles as clinical leaders. A transition phase and additional funding will allow services to be developed which focus on close working relationships with a wider multidisciplinary team which will deliver more direct care.

In West Lothian, the Primary Care Improvement Plan includes the expansion of pharmacy support in GP practices, development of extended roles for practice nurse and district nurses, and review of treatment room services. Development event has been held to support practices with developments and a team of development officers has been appointed within the Health and Social Care Partnership to support practices with transformational change.

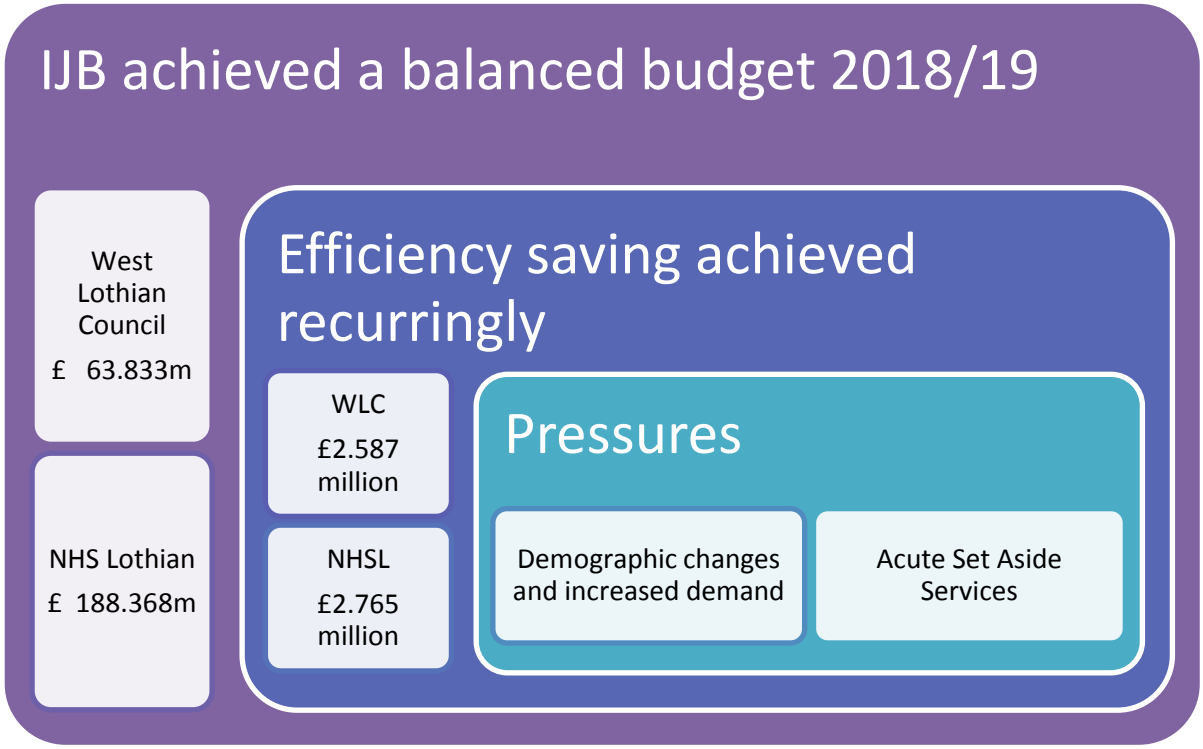
Managing our Resources Effectively

A service user transitioning from school to adult services with complex needs and challenging behavior received integrated support. Initial assessments had concluded that an expensive residential placement would be required to care appropriately for the individual and to ensure the safety of service users and the public. Working in partnership social work, NHS Lothian (Community Learning Disability Team) and a third sector provider, a Positive Behavioural Support (PBS) plan was developed. The successful implementation of this plan has allowed the service user to remain at home, with a complex and extensive package of support, which meets health and care needs and enhances quality of life. The complex package offers a more person-centred and cost effective placement than that proposed originally.

Financial Planning and Performance

Financial Planning

The Public Sector (Joint Working) (Scotland) Act 2014 requires each Integration Authority to publish an annual financial statement on the resources that it plans to spend in implementing its strategic plan. The total expenditure on IJB delegated functions for 2018/19 was £251.721 million. In addition, earmarked IJB reserves of £480,000 were also established in 2018/19. This was fully funded through contributions from West Lothian Council and NHS Lothian of £63.833 million and £188.368 million respectively.



Budget Summary

In 2018/19 the IJB has achieved a balanced budget position despite there being many pressures across health and social care services. The Board has worked closely with NHS Lothian and West Lothian Council on the financial management of IJB budget resources and funding required to deliver delegated IJB functions.

IJB delegated services saw continued growth in demand during 2018/19. Within community care, elderly care home 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.

Expenditure on services commissioned by the IJB from its partner bodies is analysed over Adult Social Care, Core Health Services, Hosted Health Services and Acute Set Aside services.

	Income £'000	Expenditure £'000	Variance £'000
Core Health Services	115,334	115,624	(290)
Hosted Services	20,783	20,649	134
Set Aside Services	30,982	32,583	(1,601)
Non Cash Limited Services	19,322	19,322	0
Social Care Services	64,629	63,543	1,086
Additional Partner Funding for 2018/19	1,151	0	1,151
Total	**252,201**	**251,721**	**480**

By far the most significant pressure in 2018/19 related to set aside services where there was an overspend of £1.601 million. Junior medical staffing pressures relating to the cost of discretionary points and ongoing 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 nursing 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 2018/19 including prioritisation of additional funding and this resulted in spend being managed within available 2018/19 budget resources. There remain significant risks around prescribing volumes and units going forward and this will require to be closely monitored. Acute drugs are also emerging as an increasing financial risk.

During 2018/19, budget savings of £5.352 million were delivered against the productivity and efficiency plan to help ensure spend on IJB functions was managed within budget resources available. Based on income and expenditure for 2018/19, earmarked IJB reserves of £480,000 were established.

Financial Performance

Reporting on the performance of delegated resources is routinely undertaken by the IJB in line with its approved financial regulations and Integration Scheme. The Integration Scheme details that when resources have been delegated by the IJB via strategic directions, NHS Lothian and West Lothian Council apply their established systems of financial governance. This reflects the IJB's role as a strategic planning body which does not deliver services directly, employ staff or hold cash resources. Budget monitoring of IJB delegated functions is undertaken by finance teams within West Lothian Council and NHS Lothian working with budget holders to prepare information on financial performance. The IJB Chief Finance Officer works closely with these teams to provide information on operational budget performance to the Board in respect of delegated health and social care functions.

Future Financial Plans

The 2019/20 budget contributions from NHS Lothian and West Lothian Council have been taken account of in directions issued to partners for 2019/20. While the council contribution represents a balanced budget position, the NHS Lothian contribution represents a funding shortfall compared to forecast expenditure of £2.067 million. Taking account of this, it will be crucial that early action is taken to identify options to manage this pressure and ensure a balanced position is achieved for 2019/20.

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.

With regard to future years, health and social care services will be faced with significant challenges to meet demands and operate within tight constraints for the foreseeable future. In line with the Board's agreed approach to IJB financial planning, budget plans have been and continue to be developed across IJB health and social care functions with the objective that overall health and social care considerations are taken into account in joint IJB / Partner financial planning.

Taking account of this, an updated four year financial plan was reported to the Board on 23 April 2019. Based on current planning assumptions, IJB resources are estimated to increase by over £12.4 million over the four year period to 2022/23. Based on inflationary and demand growth assumptions, this is estimated to result in a budget gap of £26.3 million of over the four year period compared to assumptions of available funding. At this stage, £19 million of saving options have been identified against this requirement and work is progressing to identify further savings using a robust project management approach.

Best Value

The Local Government (Scotland) Act 2003 places a duty on Local Government bodies to secure Best Value. As a Section 106 body under the 2003 Act, Integration Joint Boards have the same statutory duty to secure best value.

The statutory duties of the 2003 Act are:

- The duty of Best Value, being to make arrangements to secure continuous improvement in performance (while maintaining an appropriate balance between quality and cost); and in making those arrangements and securing the balance, to have regard to economy, efficiency, effectiveness, the equal opportunities requirements and to contribute to the achievement of sustainable development;

- The duty to achieve break-even in trading accounts subject to mandatory disclosure
- The duty to observe proper accounting practices
- The duty to make arrangements for the reporting to the public of the outcome of the performance of functions

The above duties apply to the IJB other than the duty to secure a break-even in trading accounts which is not relevant to the IJB as it does not have trading accounts.

Best Value Framework and Compliance

A report on the proposed Best Value approach was considered by the Audit, Risk and Governance Committee on 12 September 2018 and approved by the Board on 24 September 2018.

Taking account of all the relevant factors including Legislation, Ministerial Guidance and Audit Scotland Guidance, the agreed area relevant in assessing the achievement of best value for the IJB are shown below.

- Management of Resources
- Effective Leadership and Strategic Direction
- Performance Management
- Joint Working with Partners
- Service Review / Continuous Improvement

It was agreed for each of these areas there would be an annual assessment of how the IJB has demonstrated best value in the delivery of delegated functions. This would be achieved through an Annual Statement of Compliance that would be produced by the Chief Finance Officer, considered by the IJB senior management team and reported to the IJB Audit, Risk and Governance Committee for consideration. The Annual Statement of Compliance will be used to inform the Governance Statement within the annual accounts and the Annual Performance Report. It was further agreed that the Annual Compliance Statement should be proportionate reflecting the IJBs role as a strategic planning and commissioning body, rather than an operational delivery body. The 2018/19 Best Value Annual Statement of Compliance can be accessed from the link.

Inspection and Regulation of Services

The annual performance report requires Integration Joint Boards to report on inspections by: Healthcare Improvement Scotland, Social Care and Social Work Improvement Scotland (The Care Inspectorate), Audit Scotland, Accounts Commission and the Scottish Housing Regulator which relate to delegated functions.

Inspections by the Care Inspectorate

The Care Inspectorate grades services as part of fulfilling its' duty under section 4(1) of the Regulation of Care (Scotland) Act 2001 and publishes inspection reports to provide information to the public about the quality of care services. Full inspection reports for all services can be accessed via the Care Inspectorate's website http://www.careinspectorate.com

Services Inspected During 2018/19

Not all services are inspected by the Care Inspectorate annually. The services inspected in West Lothian in 2018/19 were:

- Burnside Respite Service
- Deans House
- Housing with Care
- Support at Home Services

No requirements or recommendations were made for those services.

In addition, four care homes were inspected during the year:

- Burngrange Care Home
- Craigmair Care Home
- Whitdale Care Home
- Limecroft Care Home

Requirements, recommendations and improvements were made as follows following those inspections:

- Burngrange Care Home – one area of improvement in relation to care planning
- Craigmair Care Home - one area of improvement in relation to care planning
- Limecroft Care Home – three requirements were made in relation to quality assurance, recording accidents and the approach to managing falls. One recommendation was made in relation to staffing levels.

Improvement plans were put in place for all requirements, recommendations and areas of improvement identified.

Other Scrutiny Bodies

There were no other inspections carried out during the year by the other scrutiny bodies listed.

Significant Decisions and Directions

Significant Decisions is a legal term defined within section 36 of the Public Bodies Joint Working (Scotland) Act 2014. It relates to making a decision that would have a significant effect on a service out with the context of the Strategic Plan. The Integration Joint Board did not make any significant decisions during the year out with the scope of the Strategic Plan. All decisions made by the West Lothian Integration Joint Board are available via papers hosted on West Lothian Council's website.

The Board issued four overarching Directions during 2018/19 to NHS Lothian and West Lothian Council. Additional strategic Directions have been developed during 2019/20 to reflect strategic decisions made by the IJB.

Key Priorities for 2019/20