Strategic Plan Needs Assessment

Report for West Lothian Health and Social Care Partnership

SUBMITTED BY AXIOM

September 2022

Prepared by:
Linda Roddie, Account Director
Axiom Consultancy (Scotland) Ltd
27 Woodside Place
Glasgow
G3 7QL

t: 0141 212 7980
e: linda@axiomconsultancy.co.uk
w: axiomconsultancy.co.uk
twitter: @AxiomInsights

Contents

Primary care and community health
Unscheduled/acute care
Carers
General adults

Appendix 3: List of teams engaged in the needs assessment

Appendix 4: Online survey questionnaires

1. Background, research objectives & methodology

1.1 Background

The Public Bodies (Joint Working) (Scotland) Act 2014 established the legal framework for integrating health and social care in Scotland and set out requirements for public service reform to improve performance and reduce costs based on a bottom-up, outcomes-based approach. The Act requires each Health Board and Local Authority to delegate some of their functions to Integration Joint Boards (IJB).

The IJB creates a single system for the planning, resourcing and operational oversight for a range of adult health and social care functions to ensure services are built around patient and service user needs and enables services to be designed with a focus on preventative and anticipatory care in communities. To support its work, it created two Locality Groups for West Lothian (East and West).

In 2019, the IJB launched its Strategic Plan (2019 – 2023) which set out its vision and strategic priorities to create a sustainable health and care system for West Lothian. It sought to encourage a shift to care at home or close to home, whole person-centred care, joined up working across professions and agencies and increased input for people, communities and staff in the planning and delivery of health and social care services.

Strategic commissioning plans were developed to support the Strategic Plan for the adult services which the IJB are responsible for commissioning and the NHS Lothian services which West Lothian host on behalf of the Health Board. A Financial Framework was developed within which the Strategic Plan and its underpinning Strategic Commissioning Plans required to be delivered. A Performance Framework for monitoring service delivery was also created outlining:

- National reporting against 23 core indicators, personal outcomes and quality measures and organisation/system data
- A Balanced Scorecard for Customer, Financial and Business, Internal Processes and Learning & Growth
- Benchmarking against those with similar geography, population, deprivation & community needs
- Data Sharing & Information Governance to assess and forecast needs, link investment to outcomes and provide sound governance and financial scrutiny

1.2 Research objectives

Recognising the progress that has been made, the IJB is now developing a new Strategic Plan. To ensure future services will meet the needs equitably, effectively and timeously and will deliver quality of service care recognising both current and future needs, West Lothian Health and Care Partnership (WLHSCP) commissioned a needs assessment to help inform the planning and re-design of adult services and its future commissioning strategy. This needs

assessment will also support the development of the IJB's Strategic Plan, the identification of strategic priorities and an outcome framework for the procurement of services

The needs assessment sought to address:

- What will the drivers be for future health and social care support in West Lothian?
- Are these similar across different communities?
- What type of services are needed and what is the necessary capacity?
- What does this mean for the future service mix and local service pathway, including investment and disinvestment decisions?
- What is needed to ensure that the overall system is functioning effectively, addressing potential service gaps and any areas of duplication?

1.3 Methodology

The needs assessment comprised of the following components:

- Discussions with service commissioners and strategic planners, including members of the IJB Strategic Planning Group
- A review of population and prevalence data (utilising existing data and addressing any data gaps)
- Interviews and an online survey with members of the community who have accessed services or who may need services in the future, including families and carers
- Interviews and an online survey with managers and staff from West Lothian Council, NHS Lothian and key partners including representatives of the Community Planning Partnership and providers in the independent, private and third sectors
- Mapping of current service provision and a review of the ecology of the provision.

This report presents the findings from the needs assessment and is structured as follows:

- Section2 of this report reviews the existing Strategic Plan and provides an overview of potential strategic priorities for the new Strategic Plan
- Section 3 of this report contains an overview of the national policy and strategic context for adult health and social care services
- Section 4 presents the population projections for the West Lothian area and the health and social care indicators, with comparisons against the averages for NHS Lothian and Scotland
- Section 5 presents an overview of the adult health and social care services in West Lothian
- Section 6 provides feedback on the issues with current service demand from HSCP staff teams
- Section 7 provides feedback from partner through the online survey
- Section 8 provides feedback from the public and support organisations through the online survey and qualitative discussions
- Section 9 outlines recommendations to inform IJB future Strategic Priorities.

2. Drivers for health and social care provision

2.1 Overarching health and social care policies and strategies

There are a number of national strategies which must underpin the commissioning and delivery of health and social care services.

2.1.1 National Health and Wellbeing Outcomes

In support of its National Performance Framework, the Scottish Government created national health and wellbeing outcomes to provide a strategic framework for the planning and delivery of health and social care services. These are outlined below and each Integration Joint Board (IJB) uses these to set their local priorities:

Table 1: National Health and Wellbeing Outcomes

Outcomes
People are able to look after and improve their own health and wellbeing and live in good health for longer
People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community
People who use health and social care services have positive experiences of those services, and have their dignity respected
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Health and social care services contribute to reducing health inequalities
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
People using health and social care services are safe from harm
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
Resources are used effectively and efficiently in the provision of health and social care services

Integration Joint Boards are accountable for delivering the National Health and Wellbeing Outcomes and a core suite of indicators were developed by the Scottish Government to measure IJB delivery. Data from these indicators have been used in this needs assessment to highlighted progress and remaining issues.

2.1.2 Independent Review of Adult and Social Care in Scotland

In 2021 the Scottish Government published findings from a review of adult and social care in Scotland. This identified key factors which required change to secure better outcomes.

Shifting the paradigm

The review suggested that strong and effective social care support required social care support to be underpinned by a human rights based approach. It specifically recommended

that it should enable people's rights and capabilities, be based on preventative and anticipatory collaboration and be a vehicle for supporting independent living.

Strengthening the Foundations
The review highlighted the need for system level change, with more effective problem solving and a scaling up of promising practice. It also recognised the need to strengthen the social care workforce, emphasising engagement, value and reward as well as increasing the focus on unpaid carers to enable them to continue to be a cornerstone of social care support.

Redesigning the System
The review emphasised the need for a new delivery system for social care support, involving those with lived experience in its design. It recommended a National Care Service and highlighted the need to transform the planning, commissioning and procuring of social care support is planned, based on partnership and relationships rather than competition.

2.1.3 National Care Service

The Scottish Government's ambition is for a National Care Service (NCS) that ensures people of all ages can access the support they need to live a full life by improving consistency and quality of provision. The NCS will be responsible for social work and social care support, including support for carers. It will also be responsible for planning and commissioning primary care and community health services.

The Scottish Government intends that the NCS will support everyone to live as independently as possible, supported in their homes, in their communities and among family and friends, whatever their needs and no matter where they live. The proposed Service suggests the need for a whole system approach to the planning and provision of community health and social care, involving the third sector as a co-producer of community health and social care. It is intended that the Service would focus on:

- Prevention, early intervention and rehabilitation to avoid the need for more costly action at a later stage
- Enabling people to move seamlessly between different types of care and support as their needs change
- Ensuring data and information moves with people throughout their care journey, from prevention and early intervention to acute and specialist provision and across sectors
- Enabling individuals who need care and support, their families and carers to have a say in their care needs
- Providing training, development and career opportunities for the social care workforce
- Providing greater support for carers and their health and wellbeing to enable them to maintain their unpaid caring role, if they wish.

The National Care Service proposal is currently out for consultation and it is not clear, at this stage how the Service will operate and what implications it may have on the planning, commissioning and delivery of social care support in West Lothian. It is recognised that until this has been made clear, the NCS could be a risk to the social care and support plans for the area in the future.

2.1.4 Self-Directed Support (Scotland) Act 2013

The Social Care (Self-directed Support) (Scotland) Act 2013 made the principles of choice and control central to care and support, and gave individuals full opportunity to take control of their support and their lives. Independent living underpins the Act to ensure that everyone has the information and support to make informed choices and articulate their desired personal outcomes, the opportunity to participate in decisions affecting their lives and are empowered to set the parameters of their risks to make choices which impact on their lives.

2.1.5 The Carers (Scotland) Act 2016

The Act came in to effect on 1 April 2018 to ensure better and more consistent support for carers and young carers so that they can continue to care, if they so wish, in better health and to have a life alongside caring. It is designed to support carers' health and wellbeing and help make caring more sustainable. The Act places a duty on local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria. It also requires:

- A specific adult carer support plan (ACSP) and young carer statement (YCS) to identify carers' needs and personal outcomes
- Local authorities to have an information and advice service for carers
- Local authorities to consider whether support should be provided in the form of a break from caring and the desirability of breaks from caring provided on a planned basis

2.1.6 NHS Pharmacy First Scotland

The NHS Pharmacy First Scotland service allows those registered with a Scottish GP Practice, residents in care homes and care settings, people experiencing homelessness and gypsy travellers to use a community pharmacy as the first port of call for treatment for a range of conditions and to obtain advice, treatment or referral to other healthcare teams if required. This service is intended to help people access the right care in the right place, without having to go to their GP practice or local Accident and Emergency Department for non-urgent treatment.

2.2 Health and social care policies and strategies for specific population groups

2.2.1 Integrated health and social care strategy for older people

The Scottish Government is developing a new integrated health and social care strategy for older people, which is currently under consultation. The strategy recognises that, in Scotland, someone aged 70 has on average three significant co-existing medical conditions and that this frequency increases with age. It also recognises that people living in the most deprived circumstances can expect to spend more than 20 fewer years in good health and that people, regardless of where they live or their background, may experience mental or physical conditions or functional limitations that can come with age.

The strategy, recognises that supporting people to age well and live well requires a multi-disciplinary and multi-agency response, and sets out factors which should underpin future health and social care for older adults:

- Prevention: Staying physically and mentally active can increase resilience, reduce the risks of dementia, delay frailty, widen social circles and help prevent falls
- Person-centred care: Older people must lead the decision making around their care and treatment and have their wishes recorded, shared with relevant health and social care professionals and acted on, including older people living in social deprivation and those without recourse to public funds
- Home first approach: Supporting people to live well and independently in their communities as they age, ensuring hospital care only occurs when necessary, with a seamless journey through hospital and access to specialist care in a timely fashion.

2.2.2 Mental Health 2017 - 2027

The strategy is based on:

- Prevention and early intervention at the commencement of illness
- Fast access to treatment and joined up accessible services for all
- Services that promote and support recovery-based approaches
- Multi-disciplinary teams in primary care to ensure every GP practice has staff who can support and treat patients with mental health issues
- Appropriate mental health professionals in Emergency Departments and through other out of hours crisis services
- Reducing waiting times for access to psychological therapies for all ages.

The strategy also indicates that Integration Authorities need to maximise the role of both clinical and non-clinical workers in primary care, such as Link Workers, to provide problem-solving, listening and signposting for physical, mental and social problems.

2.2.3 Mental Health (Care and Treatment) (Scotland) Act 2003

The Act, which came into force in 2005, increases the rights and protection of people with mental disorders, encompassing mental illness, learning disability and personality disorder. It places duties on local authorities to provide care and support services for people with mental disorders, based on respect for human rights, and ensures that care and compulsory measures of detention can be used only when there is significant risk to patient safety or welfare or to other people.

It also introduced changes to the development of community-based mental health services, involvement of service users and unpaid carers in decisions concerning treatment.

2.2.4 Standards of Care for Dementia

These standards relate to everyone with a diagnosis of dementia in Scotland regardless of where they live, their age, the supports they receive or the severity of their illness. The standards stipulate that people with dementia will:

- Receive a timely and accurate diagnosis and be provided with the information they need about their condition, treatments and support
- Receive the information and support they need to stay well and live with the challenges of dementia and be supported to remain as independent as possible.
- Be involved in decisions that are important to them now and in the future
- Be treated with dignity and respect and experience a person-centred approach to assessment and provision of a range of treatment, support and care
- Be able to easily obtain information and advice about supports and care services that are available locally in order to make informed choices, including advocacy services

The standards also require carers to be recognised and valued as partners in care and be supported in their role.

2.2.5 Coming Home Report

The Scottish Government wants people with learning disabilities and complex needs to lead full, healthy, productive, and independent lives in their communities. It recognised that some people with learning disabilities and complex needs are living far from home or in NHS hospitals, primarily due to a lack of suitable accommodation or lack of skilled service providers that can sustain support to people through periods of challenging behaviour.

The Report recommends that Integration Authorities:

- Develop options for access to crisis services, with a view to providing direct support to service provider or family placements which are at risk of breakdown
- Consider flexible support responses, to be used when placements experience significant difficulty and put people at risk of out-of-area or hospital placement
- Give greater consideration to family support for the family carers of people with learning disabilities and complex needs
- Take a more proactive approach to planning and commissioning services, including working with transitions teams, using co-production and person-centred approaches to commissioning and HSCPs working together to jointly commission services
- Identify suitable housing options, linking local commissioning plans and housing plans.

<u>Coming Home Implementation Framework</u>
A Short Life Working Group (SLWG) was established in 2020 to review delayed discharge and complex care to prevent hospital admissions due to challenging behaviour or service breakdown and reduce the number of delayed discharges and out of area placements for people with learning disabilities and complex care needs. Their review resulted in the Coming Home Implementation Framework.

The framework sets out a mission to greatly reduce out of are residential placements and inappropriate hospital stays by March 2024 and to enable a situation where out of area placements are only made through individual or family choice and people are only in hospital for assessment and treatment. The framework sets out a series of recommendations which include:

- Developing the Dynamic Support Register into a national tool, with a National Support Panel to provide support and oversight for its use
- A National Peer Support Network to enable the sharing of learning and good practice
- Additional work to explore the needs of people with enduring mental health conditions who are experiencing delayed discharge from hospital.

The framework recommends that Integration Authorities should:

- Plan the use of the Community Change Fund in accordance with the framework recommendations
- Enable collaborative work between health, social care and housing to consider if there are opportunities to better utilise current spend on complex care, including re-profiling out of area spend to be reinvested to meet an individual's needs more locally
- Improve planning at transition age to identify those at risk of future admission and consider early interventions to prevent crisis placements
- Develop multi-agency contingency planning for crisis
- Consider intensive support for existing placements as they start to fail
- Ensure potential for mediation is incorporated into commissioning care packages for complex cases
- Ensure there is appropriate available housing, including precenting the loss of tenancy when a person is admitted to hospital in a crisis and then experiences delayed discharge.

2.2.6 National Mission to reduce drug related deaths

The Mission seeks to save lives through fast and appropriate access to treatment and support, improved frontline drugs services (in place and working together including third sector), increased capacity in and use of residential rehabilitation and a more joined-up approach across policies to address underlying issues. The main focus of the National Mission is:

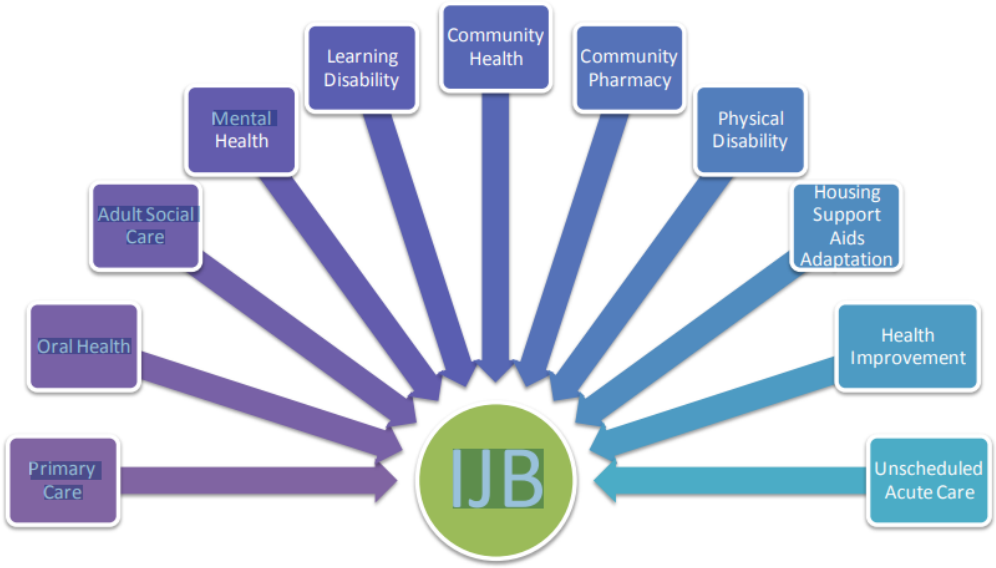
- Emergency life-saving interventions targeting those at risk
- Implementation of Medication-Assisted Treatment Standards - making support consistent, flexible, effective and faster
- Expansion on capacity in, and use of, residential rehabilitation
- Linking policies on poverty, deprivation, trauma and ACES with work on drug prevention and treatment
- Supporting people with multiple, complex needs - in addictions, homelessness and metal health settings and those in contact with the justice systems
- Improving services – including treatment and recovery in justice and care settings
- Addressing stigma – including within services.

3. Strategic Plan and the potential future strategic priorities

The Public Bodies (Joint Working) (Scotland) Act 2014 required each Health Board and Local Authority to delegate some of its functions to new Integration Authorities. In West Lothian this is the Integration Joint Board (IJB).

The IJB brings together the planning, resources and operational oversight for a substantial range of adult health and social care functions into a single system to ensure services are built around the needs of patients and service users and supports service redesign with a focus on preventative and anticipatory care in communities. The functions delegated are summarised in Figure 1.

Figure 1: Functions Delegated to the IJB



The West Lothian IJB also hosts Podiatry on behalf of NHS Lothian.

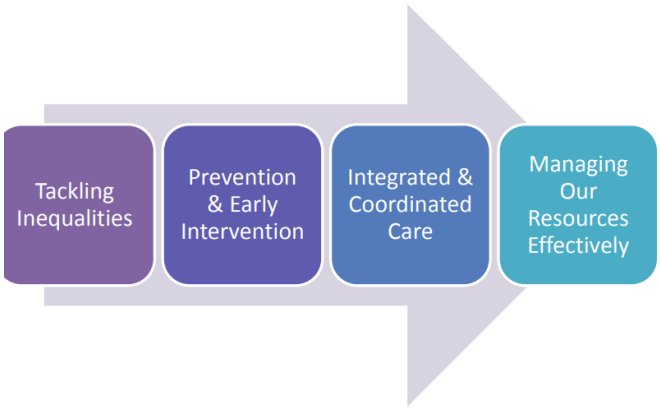
3.1 Current Strategic Plan

The current Strategic Plan, 2019 – 2023, sets out how the West Lothian Integration Joint Board (IJB) intended to deliver its vision "to increase wellbeing and reduce health inequalities across all communities in West Lothian" and to deliver the nine national health and wellbeing outcomes through strategic priorities and transformational change programmes.

The Plan has two defined localities within West Lothian, East Locality and West locality and each locality has its accompanying locality plan which defines the overarching Strategic priorities in relation to local need.

The2013 – 2019 Plan was based on the following four priorities:

Figure 2: Strategic Priorities



Health Inequalities: the systematic, unfair differences in population health that occur across social classes or population groups and which result in significant inequalities in health.

Prevention and Early Intervention: shifting the focus of services towards prevention of ill health and anticipating need for support at an earlier stage to prevent crises and enable individuals to make better health and well-being decisions and achieve better outcomes.

Integrated and Co-ordinated Care: ensuring the delivery of the right care, in the right place, at the right time for each individual to improve access to care planning and services. This included transforming day-to-day health care in the community, enabling people to be assessed, treated and supported at home and in community and providing a smooth and timely transition between services, including hospital and home.

Managing resources effectively: improve the patient experience, reduce waiting times and ensure people get faster access to the treatment they need through signposting people to the most appropriate resource to meet their needs and enable them to directly access a range of services without the need to go through their GP wherever possible.

The Strategic Plan recognised the vital role of the West Lothian workforce in the effective delivery of health and social care and committed to ensuring staff were fully engaged and able to contribute to the design and delivery of health and social care integration and have the knowledge and skills to respond to the changes envisaged are key priorities.

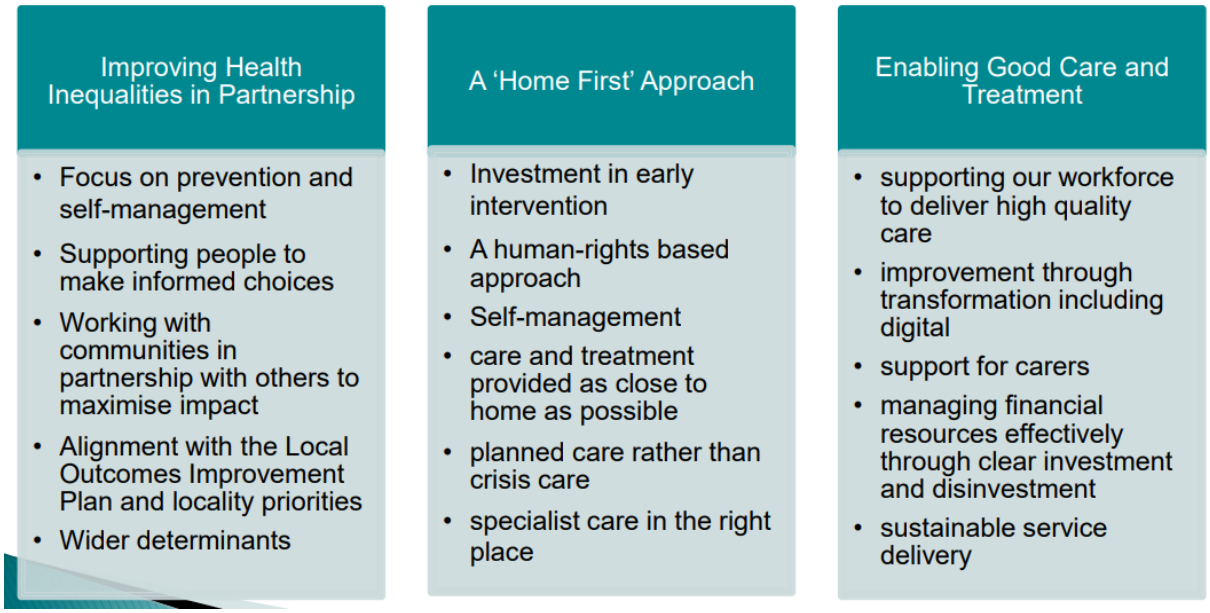
<u>Commissioning Plans</u>

To support achievement of the Strategic Plan, commissioning plans were developed for Older People (including those with dementia), Mental Health, Substance Misuse, Learning Disability, Physical Disability, Primary Care, Palliative Care and Unplanned Hospital Care.

3.2 Strategic Priorities for 2023-2027

The IIB Strategic Planning Group has started the process for identifying potential priorities for a new Strategic Plan. These are outlined below.

Figure 2: Potential Strategic Priorities



These potential priorities form the basis of the Strategic Needs Assessment to determine to what extent these are considered key across the IJB's stakeholder groups (partners, service users, carers, HSCP staff, commissioned service providers and community groups). The Needs Assessment will also identify any other needs which are considered to be a priority by each of the stakeholder groups.

<u>Improving Health Inequalities in Partnership</u>
There are many kinds of health inequality, and many ways in which the term is used, however they are ultimately about differences in the status of people's health. Health inequality is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status.

The current Strategic Plan (2019-23) identified the need to address health inequality, however it is recognised that this is a wider issue and one which needs to be addressed in partnership with other agencies and services across West Lothian

<u>Home First Approach</u>
The Home First approach aims to prevent unnecessary hospital attendances and admissions, to stop patients having lengthy hospital stays on wards and supports a move towards planned rather than crisis care with an emphasis on early intervention. Its premise is to provide the right care, in the right place at the right time and that this should be at home or close to home

unless the patient has specialist care needs which cannot be met by a Home First Approach. The Home First Approach is built around:

- Prompt assessment and rapid access to care and care planning across sectors
- Patient-centred care with people and families at centre of decision making
- Clear information, which is easy to access and includes what to expect and who to contact
- Information sharing within the constraints of confidentiality and governance.

The Approach was initially launched for older people and people living with dementia but has been expanded to incorporate aspects of the unscheduled care pathways, functions and process for adults 18 years and over.

Enabling good care and treatment

The proposed Strategic Priorities recognise key factors which should underpin delivery:

- A supported workforce
- Support for carers to enable them to fulfil their caring role, should they want to, without impacting on their own health and wellbeing
- A need to deliver care differently to ensure sustainability of service delivery
- A need to ensure effective use of financial resources.

4. Population profiling

4.1 Risk factors

Health and wellbeing are affected by many factors – those linked to poor health, disability, disease or death, are known as risk factors. A risk factor is a characteristic, condition, or behaviour that increases the likelihood of getting a disease or injury. Risk factors are often presented individually, however in practice they do not occur alone. They often coexist and interact with one another. For example, physical inactivity will, over time, cause weight gain, high blood pressure and high cholesterol levels. Together, these significantly increase the chance of developing chronic heart diseases and other health related problems.

In general, risk factors can be categorised into the following groups:

- Lifestyle
- Physiological
- Demographic
- Genetic.

These are described in more detail below.

Lifestyle risk factors

Lifestyle risk factors usually relate to 'actions' that the individual has chosen to take. They can therefore be eliminated or reduced through lifestyle choices. Examples include:

- Smoking tobacco
- Drinking too much alcohol
- Nutrition
- Physical inactivity.

Physiological risk factors

Physiological risk factors are those relating to an individual's body or biology. They may be influenced by a combination of genetic, lifestyle and other broad factors. Examples include:

- Being overweight or obese
- High blood pressure
- High blood cholesterol
- High blood sugar (glucose).

Demographic risk factors

Demographic risk factors are those that relate to the overall population. Examples include:

- Age
- Income
- Ethnicity.

Genetic

Genetic risk factors are based on an individual's genes. Some diseases come entirely from an individual's 'genetic make-up' whilst many other diseases, such as asthma, diabetes or cancer, reflect the interaction between the genes of the individual and environmental factors. There are also diseases are more prevalent in certain population subgroups such as diabetes amongst the South Asian population.

4.2 Health inequalities

4.2.1 Type of inequalities

Health inequalities are ultimately about differences in the status of people's health. But the term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status. Health inequalities can therefore involve differences in:

- Health status
- Access to care
- Lifestyle risks to health, for example, smoking rates
- Psychological risk factors and the wider determinants of health
- Geography with differences between levels of deprivation
- Impact of Covid 19.

Health status

Differences can be experienced in:

- Life expectancy
- Healthy life expectancy
- Avoidable mortality
- Prevalence of long-term health conditions
- Prevalence of mental ill-health
- Emergency hospital admissions.

Access to care

Access to care refers to the availability of services that are timely, appropriate, easy to get to and use, and sensitive to user choice and need. Inequitable access can result in particular groups receiving less care relative to their needs, or more inappropriate or sub-optimal care, than others, which often leads to poorer experiences, outcomes and health status. This includes:

- Access to preventive interventions and social services, as well as primary and secondary health care
- Information and service deliver communicated in an easily understandable or culturally sensitive way
- Ratio of service provision and uptake per head of population

Lifestyle risks

Research conducted by the Department of Health and the Kings Fund[1] indicates that lifestyle risks to health are more common in some parts of the population than in others. The distribution is patterned by measures of deprivation, income, gender and ethnicity, and risks are concentrated in the most disadvantaged groups. Individuals in disadvantaged groups are also more likely to engage in more than one risky behaviour.

Furthermore, evidence [2] suggests that some people's circumstances make it harder for them to move away from unhealthy choices, particularly if they are worse off in terms of socio-economic factors such as debt or poverty.

Psychological risk factors

Income determines people's ability to buy health-improving goods, from food to gym memberships. Living on a low income is a source of stress, and neurological evidence[3] suggests that being on a low income affects the way people make choices concerning health-affecting behaviours.

Studies by the World Health Organisation indicate that poor-quality and overcrowded housing conditions are associated with increased risk of cardiovascular and respiratory diseases, depression and anxiety. Households from minority ethnic groups are more likely to live in overcrowded homes and to experience fuel poverty.

Access to good-quality green space is linked to improvements in physical and mental health, and lower levels of obesity. Levels of access to green space are lower on average for people living in areas with lower average incomes and people from ethnic minority communities.

Unemployment is associated with lower life expectancy and poorer physical and mental health, both for unemployed individuals and their households. In addition, the quality of work, including exposure to hazards and job security, determines the impact that work has on health. People from lower income households and minority ethnic backgrounds tend to experience higher levels of work stress than those from other population groups.

Covid 19

Studies by the Department of Health and the Kings Funds has shown that Covid-19 has had an unequal impact on different population groups and has exacerbated existing health inequalities. Mortality rates from Covid-19 have been higher in more deprived areas than in less deprived areas which contributes to widening inequalities in life expectancy between the most and least deprived areas.

The pandemic also disproportionately affected ethnic minority groups and people living with disabilities. Whilst the picture is complex and differs between ethnic groups and over time, overall, ethnic minority groups experienced higher mortality from Covid-19, particularly

[1] Department of Health Chief Medical Officer Annual Report 2009; ** Estimates by The King's Fund based on Department of Health, Chief Medical Officer Annual Report 2009

[2] Sheehy-Skeffington, J and Rea, J: 2017 How poverty affects people's decision-making processes, Joseph Rowantree Foundation

[3] Mullainathan, S and Shafir, E: 2014, Scarcity: The True Cost of Not Having Enough

amongst Bangladeshi, Pakistani and Black Caribbean groups. Disabled people also experienced a greater risk of dying from Covid-19 than non-disabled people. Up to March 2022, the risk of death involving Covid-19 was 1.6 times greater for disabled women who consider their daily life to be 'limited a lot' (based on self-reported disability status in the 2011 census) compared to women without a disability, and 1.4 times greater for disabled men.

Covid-19 restrictions and the re-prioritisation of health care services to manage demand associated with Covid-19 also affected some groups more than others. For example, people with disabilities were more likely than non-disabled people to report both that Covid-19 restrictions had a negative impact on their lives and that their medical treatment was disrupted during the pandemic.

The longer-term impact of the pandemic is likely to widen health inequalities even further. Recent analysis by The King's Fund in England[4] has shown inequalities in the elective care backlog, with waiting lists in the most deprived fifth of areas growing by 55%, compared to 36% in the least deprived areas. Health inequalities are also likely to be exacerbated by growing disparities in the wider determinants of health linked in part to the pandemic, including around education, unemployment and financial insecurity.

4.2.2 Data and intelligence sources

As part of this needs assessment, published data has been sourced from a variety of sources:

- The Scottish Public Health Observatory (ScotPHO) which is managed by Public Health Scotland and gathers and compares data from official sources including NHS Scotland, the Office for National Statistics and a range of Scottish Government commissioned health and social care surveys. The data is produced at a Health Board, HSCP and locality levels and allows comparison across Scotland, across all 14 Scottish Health Boards and 32 Scottish Local Authorities
- The Scottish Burden of Disease which is a national, and local, population health surveillance system which monitors how diseases, injuries and risk factors prevent the Scottish population from living longer lives in better health. Burden of disease assessment help us to understand which diseases and injuries pose the greatest threat to population health and wellbeing, which is used to shape decisions on how to use limited resources for maximum population health benefit
- The Health and Social Care indicators, developed by Scottish Government to monitor integration, with data provided by all Scottish HSCPs
- Data provided by Health Boards on a range of care and treatment measures and published by Public Health Scotland on a monthly, quarterly or annual basis including NHS performs, waiting times, acute hospital activity and NHS bed information and Out of Hours activity

[4] Holmes, J and Jefferies D: BMJ 2021: Health inequalities and the elective backlog—understanding the problem and how to resolve it

- Data on social care activity published by Public Health Scotland, including Care Home Census and delayed discharges.

Data for the West Lothian area is outlined below in order to illustrate the extent of potential risk factors locally. The data sourced is captured and reported upon in different time periods and the needs assessment is based on the most up-to-date published data. Unless otherwise stated, the data has been obtained from the Scottish Public Health Observatory and refers to the year 20/21. Data is also presented at a locality level, where available.

4.3 Lifestyle risk factors in West Lothian

4.3.1 Tobacco

Smoking during pregnancy

The extent of smoking during pregnancy has continued to remain higher than the Health Board or Scottish average. The rate for West Lothian in 2020/21 was 16%, compared to 11% for NHS Lothian and 13.9% for Scotland.

Smoking attributable deaths

The extent of smoking attributable deaths was higher in West Lothian in 2017/18 (the most recent published data available), compared to the Health Board rates (296.9 compared to 283.7 per 100,00 respetively). However, it was lower than the Scottish average of 327.8 per 100,000.

The rate of smoking attributable deaths in West Lothian has also been decreasing, dropping by 24% from 368 per 100,000 to 296.9). This is a larger decrease than the Health Board average (20.5%) and almost twice that of the national decrease of (11.6%).

4.3.2 Alcohol

Alcohol related hospital admission

Alcohol related hospital admissions in West Lothian were higher than the average for the Health Board in 2020/21 (599.8 per 100,000 population compared to 549.6). However, the rate was lower than the national average of 621.3 per 100,000.

There wasalso been a slight increase in alcohol related hospital admissions in the 18 years between 2002/3 and 2020/21 in West Lothian of 0.7% (from 595.4 to 599.8 per 100,000 population). Whilst this is a small increase, it is increasing at a time where average admissions in NHS Lothian and in Scotland where decreasing by 12.6% and 16.4% respectively.

Alcohol deaths

Alcohol related deaths in West Lothian were very slightly higher than the five year average for the Health Board in 2020/21 (19.8 per 100,000 population compared to 19.4). The rate was slightly lower than the national average of 20.8 per 100,000.

There has also been a reduction in alcohol related deaths in West Lothian between 2002/3 and 20/21 in West Lothian of 11.2% (from 22.3 to 19.8 per 100,000 population).

However, whilst this is a reduction, it is half of the reduction in the rates in NHS Lothian (23.9%) and less than half the national reduction of 27% in the same time period.

Inequalities

Alcohol related hospital admissions in 20/21 were 88% higher in the most deprived areas in West Lothian than in the areas which are lest deprived. For example, they are 1095.6 per 100,000 population in SIMD 1 and 808.6 in SIMD 2 compared to the West Lothian average of 599.8. They were also 45% higher amongst the population living in West Locality, compared to those living in the East.

Alcohol related deaths are also 68% in the most deprived areas in West Lothian, with 32.2 per 1000,000 population in SIMD 1 compared to the West Lothian average of 19.8.

The reduction in alcohol related hospital admissions and alcohol related deaths have been less in West Lothian amongst the most deprived areas compared to the Scottish average. For example, alcohol related hospital admissions have in SIMD 1 areas have reduced by 295.1 per 100,000 in Scotland between 2002/3 and 2020/21, compared to 18.6 per 100,000 in West Lothian for the same time period.

4.3.3 Drugs

Drug related deaths

Drug related deaths in West Lothian were lower than the Health Board and Scottish average in 2020/21. Deaths were 11.4 per 100,000 in West Lothian, compared to 14.8 and 19 in NHS Lothian and Scotland respectively.

Drug related deaths have increased in the West Lothian area by two thirds (67.6%) between 2006 and 20019 from 6.8 to 11.4 per 100,000 population. Drug related deaths have also increased significantly across Scotland and, whilst this is a large increase in West Lothian, it is lower than the average increase in NHS Lothian (89.7%) and the Scottish average, where deaths have more than doubled (102%).

Inequalities

Drug related deaths in the most deprived areas are 84% higher than the average in West Lothian. These have also increased by 86% since 2002/3 in West Lothian. Death rates have been even higher nationally and have doubled in this time period.

Drug related hospital admissions in 2020/21 of people living in the West locality were almost double that of those living in the East (44% higher).

4.4 Physiological risk factors in West Lothian

4.4.1 Obesity

Maternal obesity

Maternal obesity rates were higher in West Lothian in 20/21 compared to the Health Board and Scottish averages. Just over a quarter of the pregnancies (26.7%) had maternal obesity, compared to 20.5% in NHS Lothian and 25.3% in Scotland.

Rates have also increased in West Lothian between 2002/3 and 20/21 by 3.5% from 23.2% to 26.7%. This increase is higher than the NHS Lothian average (0.5%) and the Scottish average (2.6%) for the same time period.

Maternal obesity is 29% higher in the most deprived areas in West Lothian, with similar slight increases (4.1%) in obesity rates in the most deprived areas compared to the Health Board and the Scottish average (3.8% and 3.4% respectively). It is 10% higher for women living in the West Locality compared to those living in the East.

4.4.2 Diabetes

Prevalence

Data from PHS for 2021/22 indicates that West Lothian had a higher rate of diabetes amongst its population than the average for the Health Board and Scotland (5.75 per 100 GP patients compared to 4.51 and 5.29 respectively). This is 8% higher than the Scottish average. Prevalence was 10% higher amongst GP practices in the West Locality.

The Scottish Burden of Disease data from Public Health Scotland indicates that the number of years of life affected by diabetes is higher in West Lothian than the Health Board and Scottish averages (813 compared to 705 and 744 respectively) and that this has remained higher since records began in 2014. The incidence of diabetes also increases with age.

However, the impact of diabetes on life expectancy has been decreasing in West Lothian over time, with a 13.7% reduction in years lost from 2014 to 2019. This is compared to a 10.8% reduction in NHS Lothian and an 8% reduction nationally.

4.4.2 Coronary Heart Disease

Prevalence

Data from PHS for 2021/22 indicates that West Lothian has a higher rate of CHD amongst its population than the average for the Health Board (3.54 per 100 GP patients compared to 2.94), but a lower rate compared to Scotland (3.63). Prevalence was 10% higher amongst GP practices in the West Locality.

Data from PHS for 2021/22 indicates that West Lothian a higher rate of stroke and TIA amongst its population than the average for the Health Board (2.15 per 100 GP patients

compared to 1.91), but a lower rate compared to Scotland (2.21). Prevalence was 7% higher amongst GP practices in the West Locality.

Hospital admissions

Patient admissions to hospital from Coronary Heart Disease has almost halved in West Lothian between 2002 and 2021 with a reduction of 49.4% from 619.1 to 313.2 per 100,000.

The decrease is slightly higher than the Scottish average (44.5%) but less than half of the reduction for NHS Lothian which was 109% in the same time period.

CHD hospitalisations had reduced by around 50% in both localities since 2002/3, although they were 5% higher amongst those living in the West Locality, compared to those living in the East

4.5 Demographic risk factors

The latest population statistics for West Lothian (National Records Scotland), indicates the area's population stood at 183,820 in June 2020, the 9th highest population Scotland. In the 10 years previous, the population in the local area had grown 19.5%, the second highest increase of all the local authorities in Scotland and two and a half times that of the Scottish average (7.6%).

Further increases in the local population are also projected, with a 5.9% increase predicted by 2028, three times the increase of the national average. The population is predicted to grow primarily by net migration into the area (4.9% rise, supplemented with births exceeding deaths by 0.8%). It is noted that there is projected to be approximately 12,000 new homes built in the West Lothian area by 2027.

Data from National Records of Scotland (NRS) also indicates that the male and female population in West Lothian is projected to increase by 6% and 5.7% respectively.

4.5.1 Age

Population age

There are differences in the population projections by age, as outlined in Table 1 below.

Table 1 Population projections by age

Age	Population size (2020)	Current % of Population	% Change by 2028	% Change in Scotland
16 to 24	18,108	9.9	12.7	0.2
25 to 44	47,452	25.8	-5.0	-5.5
45 to 64	52,115	28.4	44.1	24.5
65 to 74	17,855	9.7	74.9	31.6
75 and over	13,048	7.1	84.6	35.4

Table 1 demonstrates the considerable increase in population aged 45 and above, particularly those aged 65 and over. The increases in older adults in the West Lothian area is more than double that of the Scottish average.

It also means that the risk of increased ill-health amongst the population will increase with the increased numbers of older adults in the area. There are a range of conditions which are associated with ageing and which could become more prevalent in the West Lothian area, given the projected increase in older adults in the area. The data from the Scottish Burden of Disease Programme which measures the number of health years affected by a health condition, where available is outlined below.

Arthritis

The data indicates that the number of years of life affected by osteoarthritis is slightly higher in West Lothian than the Health Board and Scottish averages (393 compared to 383 and 389 respectively), however the extent of years affected have remained similar locally and nationally since records began in 2014.

Back and neck pain

The data indicates that the number of years of life affected by osteoarthritis is slightly higher in West Lothian than the Health Board and Scottish averages (1280 compared to 1239 and 1269 respectively), however the extent of years affected have remained similar locally and nationally since 2014.

Chronic obstructive pulmonary disease (COPD)

Data from PHS indicates a higher rate of COPD amongst its population than the average for the Health Board and across Scotland (2.63 per 100 GP patients compared to 1.96 and 2.39 respectively). The rate is 10% higher than the Scottish average. Prevalence was also 27% higher amongst GP practices in the West Locality.

The data indicates that the number of years of life affected by COPD is higher in West Lothian is 6.7% higher than the national average, however the reduction in the number of years affected has been higher in West Lothian than in NHS Lothian or across Scotland since 2014.

The data from ScotPHO also indicates a higher rate of COPD hospitalisations in West Lothian in 2019/20 than on average in the Health Board or across Scotland, with 256.5 per 100,000 compared to 189.6 in NHS Lothian and 230.0 in Scotland. This is 11.5% higher than the Scottish average.

In addition, the most deprived areas in West Lothian have 84% more COPD hospitalisations than the least deprived areas. The rates in the most deprived SIMD areas have also been increasing in West Lothian since 2003/4, contrary to the Health Board and national rates.

Dementia

Data from PHS indicates that West Lothian, in 2021/22, had a slightly higher rate of dementia amongst its population than the average for the Health Board and across Scotland (0.7 per 100 GP patients compared to 0.69 and 0.68 respectively). Prevalence was 30% higher amongst GP practices in the West Locality compared to GP practices in the East.

The data indicates that, whilst the extent to which years affected by dementia has increased is lower in West Lothian than nationally, the number of years of life affected by dementia is significantly higher in West Lothian than the Health Board and Scottish averages (1998 compared to 1750 and 1764 respectively).

Depression and anxiety

Data from PHS indicates that West Lothian, in 2021/22, had a higher rate of depression amongst its population than the average for the Health Board (7.27 per 100 GP patients compared to 5.95 for the Health Board area), although it is lower than the Scottish rate of 8.19 per 100 patients. Prevalence, however was 53% higher amongst GP practices in the East Locality compared to GP practices in the West.

The data indicates that the number of years of life affected by depression is significantly higher in West Lothian than the Health Board average (1239 compared to 1144) but slightly lower than the Scottish average of 1243), however the reduction in the number of years affected has been higher in West Lothian than in NHS Lothian or across Scotland since 2014.

The data indicates that the number of years of life affected by anxiety is significantly higher in West Lothian than the Health Board average (850 compared to 785) and similar to the Scottish average of 852), however the reduction in the number of years affected has been higher in West Lothian than in NHS Lothian or across Scotland since 2014.

Heart Disease

The data indicates that the number of years of life affected by Ischaemic heart disease is lower in West Lothian than the Health Board or Scottish average (2125 compared to 2160 and 2572 respectively) and similar to Scotland, the number of years affected has been reducing since 2014.

The data indicates that the number of years of life affected by Cerebrovascular heart disease is slightly lower in West Lothian than the Health Board average (1315 compared to 1307). The reduction in the number of years affected is also higher in West Lothian than either the Health Board or Scottish averages since 2014.

West Lothian had a higher rate of patients hospitalised with CHD than the Health Board average in 2019/20, with a rate of 313.2 per 100,000 compared to 283.1. However, the rate was lower that the Scottish average of 354.8.

The rate of people living in the most deprived areas in West Lothian and being hospitalised with CHD is 25% higher than in the least deprived areas. However, the rate has been more than halved by 52% between 2002/3 and 2019/20. This is slightly higher than the rate of decrease for the Health Board and 8% higher than the decrease for Scotland.

Falls

The data indicates that the number of years of life affected by falls is higher in West Lothian than the Health Board average (415 compared to 405) but lower than the Scottish average of 425). The effect of falls has been increasing across all areas since 2014, with the highest increases in West Lothian.

The Integration Indicator for Falls rate per 1,000 of the population who are 65 years and older shows a slight increase from 20.3 in 2016/17 to 20.5 in 2020/21.

4.5.2 Income

Data from the Scottish Public Health Observatory (ScotPHO) for 20/21 indicates that 11.5% of the West Lothian population are income deprived, which is the proportion of the population that are in receipt of income related benefits. This is higher than the Health Board, where 9.7% are income deprived and slightly lower than the Scottish average of 12.1%.

Rates of income deprivation were 41% higher amongst people living in the West Locality compared to those living in the East.

Data from the Scottish Public Health Observatory (ScotPHO) for 20/21 indicates that 8.9% of the West Lothian working population are income deprived. This is higher than the Health Board, where 7.4% are income deprived and slightly lower than the Scottish average of 9.3%. These rates are also considerably higher amongst people living in the West Locality compared to those living in the East (38% higher).

4.5.4 Ethnicity

The data for the 2021 Census in Scotland is not yet available. The most recent data on population identity is the 2011 census, in which 5.7% of the population in the West Lothian area identified themselves as being part of an ethnic minority group.

4.6 Overall life expectancy in West Lothian

ScotPHO data indicates that the rate of premature mortality from all causes in 2020/21 was higher in West Lothian than the Scottish average (435.5 per 100,000 population compared to 408.8) but lower than the Health Board average of 459.8. However, the reduction in the rate of all cause mortality in West Lothian from 2002/3 was significantly higher than both the Health Board and Scottish reductions.

Inequalities

The rate of all cause premature mortality is 40% higher in the least deprived areas in West Lothian, for example 569.3 per 1000,000 in SIMD 1 compared to 260 in SIMD 5.

Whilst the rate is higher, reduction in the rate of all cause premature mortality has been greater in West Lothian amongst the most deprived areas compared to the Scottish average. For example, alcohol related hospital admissions reduced in SIMD 1 areas by 229.8.1 per 100,000 in West Lothian between 2002/3 and 2020/21, compared to 141.0 per 100,000 in Scotland for the same time period.

Life expectancy for both males and females in 2020/21 is slightly lower for people living in the West Locality compared to those living in the East (3% lower).

4.7 Health conditions affected by inequalities in West Lothian

4.7.1 Asthma

Prevalence

Data from Public Health Scotland on disease prevalence for 2021/22 indicates that West Lothian had a slightly higher rate of asthma amongst its population than the average for the Health Board and across Scotland (6.7 per 100 GP patients compared to 5.88 and 6.35 respectively). Prevalence was also slightly higher amongst GP practices in the West Locality, by 0.10 per 100 patients.

Rate of admissions

The rate of asthma related hospital admissions was significantly higher in West Lothian in 2019/20 with 90.5 per 100,000 population compared to an average of 71.4 across the Health Board and 75.8 across Scotland. This was 19.4% higher than the national average.

Hospital admissions were also 39% higher amongst patients in areas of deprivation in West Lothian. For example, there were 120.5 admission per 100,000 population in SIMD 1 compared to 65.1 in SIMD 5. However, the rate of decrease of hospital admissions was more than double that of the Health Board and Scotland between 2002/3 and 21019/20

Admission rates were 58% higher amongst residents living in the West locality in 2020/21 compared to those living in the East. However, whilst admission rates had reduced from 2002/3 for those living in the West, they had increased by 7% for those living in the East locality.

4.7.2 Cancer registrations

The PHS data indicates that in 2021/22 West Lothian had a higher rate of cancer amongst its population than the average for the Health Board and across Scotland (3.34 per 100 GP patients compared to 3.02 and 3.07 respectively). This is 35.4% higher than the Scottish average. It could be that this is as a result of the work done by Improving the Cancer Journey which has increased the number of cancer detections in West Lothian. Prevalence was similar amongst GP practices in both localities.

The rate of cancer registrations was higher in West Lothian in 2019/20 with 639.8 per 100,000 population compared to an average of 625.9 across the Health Board, however the rate was lower than the Scottish average of 643.6.

Cancer registrations are 16% higher amongst the most deprived areas in West Lothian. The rates have been increasing in West Lothian in SIMD 2 and SIMD 3 areas since 2003/4, contrary to the trend across the Health Board and across Scotland.

Cancer registrations were 8% higher amongst the population living in the West Locality compared to those living in the East.

Bowel screening uptake was similar for residents in both East and West localities in 2020/21 at 60.8 per 100,000 population, amounting to an increase of around 30% since 2002/3. Figures for Breast Screening uptake are only available at the NHS Lothian level.

4.7.3 Mental health

Rate of prescription drugs for anxiety/depression or psychosis

The rate of prescription drugs for anxiety/depression or psychosis is slightly higher in West Lothian than the Health Board or for Scotland. Data for 2019/20 indicates that 20.3 per 100,000 people were prescribed drugs, compared to 17.2 per 100,000 in NHS Lothian and 19.7 in Scotland. The rate of increase from 2002/3 is comparable with the Health Board and Scotland at 2.7%.

Prescribing rates for people living in the most deprived areas in West Lothian were 36% higher than for those in the least deprived areas, with increases since 2002/3 of 3%, comparable to that of the Scottish average. Rates were 9% higher for people living in the West locality compared to those in the East.

Psychiatric hospital admissions

The rate of psychiatric hospital admissions was higher in West Lothian than the Health Board or for Scotland. Data for 2019/20 indicates that 279.3 per 100,000 people were admitted, compared to 238.3 per 100,000 in NHS Lothian and 242.8 in Scotland. This is 15% higher than the national average. However, the rate of admission decreased from 2002/3 by 37.5%, comparable with national decreases and slightly lower than the Health Board reduction.

Admission rates for people living in the most deprived areas in West Lothian were 81% higher than for those in the least deprived areas and the rate of reduction in admission has been lower at 29%, compared to the area average.

4.7.4 Emergency admissions

Data from Public Health Scotland for 20/21 indicates that West Lothian had a 4.5% higher rate of multiple emergency admissions of people aged 65 and above than the Scottish average (22,713 per 100,000 compared to 21,707 per 100,000). This is a 1.1% increase in the rate since 2016/17 in West Lothian, compared to a 15.2% decrease in the same timeframe nationally.

Repeat hospital admissions for those aged over 65 years were also considerably higher in 2020/21 for those living in the West Locality compared to those living in the East (11% higher)

4.8 Access to care in West Lothian- health

Living in access deprived areas

Data for 2017 from ScotPHO, indicated that 7.7% of the population lived in the top 15% most access deprived areas. This compares to 6.5% across the Health Board and 10.7% in Scotland.

Rates of access deprivation were 75% higher for people living in the East Locality, compared to those living in the West.

Rate of patient to GP

Data available for Public Health Scotland indicates that in 2020/21 West Lothian had a higher proportion of GP practice patients from SIMD areas 1-3 compared to the Scottish average (48% compared to 29%).

In October 2021, West Lothian had a 43% higher average practice list size than the Scottish average. West Lothian has had a higher average practice list size since 20211.

Access to hospital care

In 2020/21, the West Lothian hospitals treated a total of 76,086 episodes, this is an increase of 5% on the number of episodes in 2016/17. This is a different trend to the national picture, where the total number of episodes decreased by 17% and whilst there was a reduction in in-patient episodes from 2016/17, it is a lower reduction than nationally.

St John's Hospital had 1,860 admissions in 2020/21 (990 patients), with 1,850 discharges. This is an increase of 21% since 2016/17.

Compared to the total for all Scottish hospitals in 2020/21, the breakdown of episodes in West Lothian varies slightly:

- There was a lower proportion of inpatient episodes in West Lothian (76% compared to 81% nationally)
- A larger proportion of day cases (24% compared to 19%)
- A similar of elective admissions (both 5%)

The data from PHS indicates that St John's Hospital received 44,861 attendances in its A&E department in 2020/21, a reduction of 18.3% from 2016/17. This reduction is significantly less than nationally for the same period, which was a reduction of 27.4% and may reflect that there is no minor injuries unit in the West Lothian area.

The data for 2020/21 also indicates that the West Lothian hospitals treated a total of 44,809 new outpatient appointments, this is a decrease of 30% on the number of appointments in 2016/17. This is a similar trend to the national picture but a smaller reduction in appointments. Scotland wide the number of new outpatient appoints reduced by 41% over the same timeframe.

4.9 Access to care in West Lothian – social care

4.9.1 Rate of population receiving care

Data from PHS indicted that there was a total of 7,275 adults receiving social care support in West Lothian in 2021, 75% of whom were aged over 65 years. This is a slightly lower rate than the Scottish average of 78%.

The numbers receiving care in West Lothian have reduced by 10% since 2017, which is comparable with the 9% reduction in numbers receiving care across Scotland in the same time period.

The data also indicates that West Lothian had a higher percentage of people aged 65 and above requiring high levels of care at home, compared to the Scottish average, 42.69% compared to 38.14%.

4.9.2 Social care – care homes

Care home places

According to PHS data from care home census, there were 950 registered care home places in March 2022 in West Lothian. Over three quarters of these (77%) were in the private sector, with local authority places accounting for 17% of places and the voluntary sector having 8% of places.

The places were broken down as follows:

- Learning disability: 68
- Older people: 861
- Physical and sensory impairment: 21.

In 2020/21, there were 765 people receiving long stay care in care homes (the third lowest number since 2009). The data also indicates that, in March 2021, West Lothian had a rate of 28 care home places per 1,000 population. This is the fifth lowest rate amongst all Scottish local authorities and a 4% reduction on the rate in 2016.

Occupancy rates

Data published by PHS indicates that in March 2021, care homes in West Lothian had a high level of average occupancy of 88%. The occupancy rate varied by sector with local authority run homes being 78% occupied, and private and voluntary sector homes having occupancy rates in excess of 90%.

The data also indicates high levels of occupancy since 2016, although occupancy rates were higher for local authority homes at 91% (compared to 78% in 2021).

4.9.3 Social care – care at home

Home care

Data from PHS for Q4 in 2020/21 indicates that there was a rate of 11.2 per 1,000 people receiving home care in West Lothian. This is 10% lower than the Scottish average of 12.4 per 1,000 and a reduction of 3% from 2017/18.

The uptake, in West Lothian, of Options 1 and 2 for Self Directed Support is 1.0 and 1.6 per 1,000 population respectively. These rates are lower than the Scottish average for both options by 41% and 63% respectively.

People with intensive care needs

Data from PHS indicates that West Lothian has a slightly higher rate of people receiving care at home who have intensive care needs compared to the Scottish average. The data for 2020/21 indicates this was 67.8% of adults with intensive care needs compared to 63% for Scotland.

4.9.4 Extent of discharge delays

The Integration performance indicators for 2020/21 highlight that the over 75s in West Lothian spent 441 days in hospital despite being ready for discharge. This is 42% lower than the national average and 46% less than 2016.

The extent of discharge delays in West Lothian for health and social care reasons has reduced by 26% since June 2016 – July 2017, bringing it below the Scottish average

4.9.5 Supported to live independently

The data from PHS for 20/21 indicates that the uptake of Options 1 and 2 for Self Directed Support is considerably lower than the Scottish average for both options by 41% and 63% respectively

The Integration performance indicators for 2020/21 highlight that 70.4% of adults in West Lothian who are supported at home agreed that they were supported to live as independently as possible. This is lower than the Scottish average of 78.8%. Whilst the percentage of adults has reduced nationally since 2016, the reduction in West Lothian has been higher (7.1%, compared to the Scottish average of 3.9%).

The indicators for 2020/21 also highlight that only a quarter of carers (25.2%) in West Lothian felt supported to continue in their caring role, this is compared to 29.7% in Scotland. This is a 9% reduction from 2016, compared to a 10.3% reduction nationally.

4.9.6 Adults having a say in the provision of their support

The Integration performance indicators for 2020/21 highlight that 80.6% of adults in West Lothian who are supported at home agreed that they had a say in the help, care or support provided. This is 10% higher than the Scottish average of 70.6%.

Unlike the Scottish average which reduced by 8.2% since 2016, the percentage of West Lothian adults has remained virtually constant, with a slight reduction of 0.5%.

4.9.7 Co-ordination of support

The Integration performance indicators for 2020/21 highlight that 71.7% of adults in West Lothian who are supported at home agreed that their support was well coordinated. This is 5.3% higher than the Scottish average of 66.4%, however it has dropped by almost 10% since 2016 (a slightly greater drop than the Scottish average of 8.5%.

4.9.8 Impact in maintaining quality of life

The Integration performance indicators for 2020/21 highlight that 79% of adults in West Lothian who are supported at home agreed that they had a say in the help, care or support provided. This similar to the Scottish average of 78.1%. There has been a slight reduction in positive impact for both West Lothian and Scotland since 2106 of 3.1% and 5.3% respectively)

Unlike the Scottish average which reduced by 8.2% since 2016, the percentage of West Lothian adults who stated that they had a say has remained virtually constant, with a slight reduction of 0.5%.

4.10 Summary

The data suggests that health inequalities need to be a key issue within the Strategic Plan. An overview of the health and social care indicators for West Lothian is contained in Appendix 2, together with a summary of those that impact on the Home First approach.

There are indicators where West Lothian is performing better on inequalities than the average for NHS Lothian or for Scotland and indicators where performance is improving.

However, there are more indicators where the situation in West Lothian is worse than the average for the Health Board or for Scotland as a whole and a few where the situation has deteriorated further since 2016/17. Whilst there has been a similar reduction in other areas for a few indicators, for others the reduction in West Lothian has been at a greater rate with implications for priority need and the implication of the Home First approach

There are inequalities which affect populations in areas of deprivation more than the wider population. For almost all of these indicators, West Lothian has higher inequality than in the Health Board or nationally.

The data also demonstrates the level of inequality between East and West localities in West Lothian. In general, the level of inequality would appear to be higher for people living in the West locality, on almost all indicators.

5. Overview of service provision

Information on support services and organisations for adults in West Lothian is outlined in Appendix 2. This has been captured from a review of the TSI Service Locator, internet searches and discussions with staff and service users in this needs assessment.

The information provided indicates that:

- There are limited providers offering advocacy support and those that do are primarily based in Livingston but cover all of West Lothian
- There are no advocacy services in West Lothian that provide support specifically for ethnic communities (all are based in Edinburgh)
- Trauma support and counselling is limited in the area, with services generally concentrated in Livingston
- Most substance use support is based in Bathgate but covers all of West Lothian
- Community pharmacies are represented in all local areas, however not all pharmacies offer the same service
- There are a range of organisations (all private sector) that provide in-home support to enable adults to stay in their own homes. However, the reliance on private sector provision may create an affordability issue for some clients as some private sector providers charge £30 per hour, compared to £20.72 charged by the HSCP
- There are 9 providers who cater for dementia adults for in-home support, with rising dementia numbers this may offer an opportunity to support people to stay at home for as long as possible
- There are limited care home spaces for adults with mental health issues, learning disabilities or physical disabilities
- Care at home providers are generally experiencing capacity issues due to large numbers of vacancies and issues with retaining staff
- Day centre provision for older adults is limited
- There are a range of organisations offering befriending services, most based in Livingston and Bathgate but which cover all of West Lothian
- The support services for adult groups other than elderly appear more limited in the area, potentially making in-home support provision more difficult to provide
- Support for carers is limited across the area – with Carers of West Lothian, Alzheimer's Scotland and the Community Disability Service
- Many services are operating with a combination of telephone and online support and are intending to continue this – however the cost of living crisis may make it more difficult for people affected by poverty to obtain access to internet services. This issue may increase as a result of the cost of living crisis
- Improving the Cancer Journey programme has identified they are reaching those in most deprived areas, contacting all those diagnosed with a new cancer diagnosis offering options of a telephone and/or face to face session.

6. Service trends and doing things differently

6.1 Service trends

Services were asked if it would be possible to provide data which would demonstrate levels of activity and trends in that activity in West Lothian. However, the availability of data indicating demand and uptake of services has been limited due to much of the data available locally being considered management information. However, there have been a number of issues raised by HSCP staff and service providers in the needs assessment which appear to indicated trends within local services.

A list of services that engaged with the needs assessment is contained in Appendix 3. The feedback from the staff teams is presented below.

Older adults

- Loneliness is a key issue for older people, which affects their mental health. Visits to home is important, the previous home help service was vital in keeping contact with people and helping them have regular contact with people. This is not the purpose of the 15 minute visits
- Day care offers an opportunity for vulnerable adults to be cared for and remain safe during the day in larger numbers than care at home offers, as well as offering respite for families who are working and unable to support older adults at home during the day
- Overnight is often a difficult time for people, especially if there are continence issues. Providing overnight support is very difficult as there are few staff that work out of hours. Overnight slot would help support people and could prevent other health issues for occurring as a result of people being incontinent during the night. It is understood that there is a continence service in West Lothian although staff were not clear if they provided this support
- Option 2 for SDS is not promoted well (published data suggests uptake is very low in West Lothian).

Discharge Teams

- The Discharge to Assess teams have seen a significant increase in workload
- The numbers of care places have reduced, even amongst private sector providers (this has been noted from the published data). It also seems that some private sector providers are concentrating on self-funding residents, leaving fewer places for people who can't afford to pay
- It is getting difficult to get packages of care to enable people to be discharged. Care provides are looking to reduce their travel mileage which means people in more rural areas have to wait longer, delaying discharge. However, this issue is also affecting areas where the population has been increasing and demand has increased, such as Winchburgh
- There are particular problems in meeting the needs for clients who need double teams for their care (frailer clients). Care providers are struggling to meet this due to lack of staff

- There seems to be few places in care homes for long terms elderly care (there has been a reduction on availability due to reductions in care places as shown in the published data)

Acute

- Older adults being admitted to hospital because care at home is not suitable, putting them at increased risk of infection. These older people are not ill but are at risk from staying at home without considerable support
- To enable people to remain at home rather than admitted to hospital, practitioners felt that there would need to be an increase in Day Hospital provision. It is understood that there is a rapid access clinic with access to medica, nursing and allied health professional support – however, this was not mentioned by the practitioners in the discussions.

Adult social care

- There is an overlap of assessments because clients have more than one issue. Health and social care services operate their own assessments, often gathering the same information which is not shared. This often results in people not knowing what services are involved and who is responsible for care

Community hospitals

- An increase in the numbers of complex patients requiring considerable ongoing medical/ANP input
- The new ICF pathway has seen increase in patients with frailty requiring extended rehab before moving home/to nursing home
- Reduction in end stage dementia/frailty admissions. The majority are being identified at an earlier stage and moved to nursing homes directly, without coming into hospital

Community Occupational Therapy

- An increase in calls getting screened as critical/substantial in relation to need and risk and therefore being added to waiting list for assessment and intervention.
- Increased requests for more specialist/complex equipment as a result of clients' needs being maintained in the community
- Lengthening waiting lists - Clients with a terminal diagnosis are being added as high priority and seen within a week. This increase in clients needing urgent assessment then has an impact on the main waiting list
- Increases in clients with Motor Neurone Disease
- Increased numbers of clients presenting with dementia, risk assessments required for provision of equipment often resulting in the need for ground floor living to be looked into
- Increased support needs due to deteriorations in conditions amongst clients during the pandemic
- It was highlighted that more investment would be needed in out of hours OT and physio provision to support faster discharges at the weekends

Crisis Response

- Whilst there is a Crisis Care Team who provide 24hour/7 days per week support and this includes good links with the Falls Coordinator, practitioners felt that there were few other services that provide a crisis response service, which could make it difficult for SPoC should a crisis occur in the community

MSK

Just over a quarter of the Scottish population (28%) suffer from an MSK condition and 16% live with a long terms MSK pain condition.

171,900 adults in West Lothian have back pain, with 103,140 experiencing severe back pain. Back pain is more common in adults over 45 years of age, therefore, given the aging population in the West Lothian area, these numbers are likely to increase.

There were 9,884 referrals to the MSK service in 21/22 (6,018 new patients). This is a reduction of 10% on pre covid referrals. A third (33%) of consultations were conducted by telephone, which reflects changes to the service to comply with COVID regulations.

- 43% of referrals had chronic conditions. Levels of chronic pain referrals have increased significantly since Covid
- 59% had knee back or shoulder pain
- The number of GP referrals to the service has increased by 14% since 2018/19 – with a 13% increase from the GP practice based Advanced Physiotherapy practitioner
- In April 2022, there were 1,655 patients on the waiting list, with 70% of whom were waiting more than 4 weeks for an appointment and 28% over 12 weeks. This is comparable with the national average for the same month
- There is an average waiting list of 16 weeks. The Waiting List Initiative and its fundings is helping address waiting times
- Advanced practitioners can refer to the service which has reduced the need to see a GP, however there has been an increase in referrals to MSK physio service
- Whilst the core MSK physio service and the Primary Care Advanced Physiotherapy Practitioners record data on TRACK, General Practices do not use this system which makes it difficult to see the physio activity at GP level.

Mental health

- Challenges in supporting people with challenging behaviours issues at home. Behaviours often create problems with tenancies, resulting in evictions making it impossible to sustain any care at home. Housing recognises the issue and highlight that this client group needs considerable support to maintain tenancies (and their safety) and it is not clear what services are available in the West Lothian are to provide this (eg cooking, cleaning, assistance with finance) or who is responsible for commissioning the support.
- There are very limited support options for people who have distress but have no diagnosed mental illness. Trauma survivors are being referred to psychological services by GPs
- There is also a backlog in Out Patient Psychiatry

- There is a need to navigate people more effectively to access support. Whilst there is a 48 hour turnaround for referrals to the West Lothian Wellbeing Network, there are still issues with people finding the right support to meet their needs
- Referral pathways need to be clearer to the Wellbeing hubs, as some practitioners outwith those based in GP practices are not clear on what support is available
- Currently patients attending St Johns will not see the same practitioner across all their visits, making relationship building difficult
- The Practice Mental Health Nurse Service has enabled patients to access support more quickly, however there is no consistent system to record actions taken, which limits information sharing. Actions are recorded on different GP recording systems – which do not communicate directly with secondary care systems.

Alcohol and drugs

- There is an increasing number of younger adults who are being diagnosed with Alcohol Related Brain Damage and there is no accommodation for them locally and only 2 social workers who specialise in this area
- It is difficult to access support for people who have a dual diagnosis of mental health and substance use, although it was recognised that this was being addressed

Learning disabilities

- The ageing population will mean an increase in older people with dementia, including older people with learning disabilities with dementia for which there is no provision locally at present. This issue has been raised by Alzheimer's Scotland as a national concern
- The process for people with learning disabilities to access a GP is complex and lengthy which impacts on their ability to access health screening programmes (bowel, cervical, breast screening). Uptake of these screening programmes is reducing for this client group and regular check-ups often do not happen preventing earlier interventions
- People with learning disabilities also have difficulties in accessing rehabilitation as there is no direct pathway
- People often have more than one issue which is impacting on their health. A holistic assessment process would help address this. Whilst it is understood that there are national plans to improve the Health Checks collaboratively with Community Learning Disability colleagues, this was not highlighted by practitioners
- There is limited local support to enable people to sustain their tenancies or remain at home. The service review confirmed limited organisations providing in-home support
- Care home support it also limited, resulting in people going out of area
- The current eligibility criteria means that people with low and moderate learning disabilities are not assessed. This can mean that issues are missed which can esacalete at a later stage, some form of assessment would help support earlier interventions and prevention
- The eligibility criteria have also resulted in day services supporting people with a higher level of care need
- Closures amongst local community centres have made it more difficult for the Community Outreach Team to delivery outreach support in some communities, including those in Livingston

Neurodevelopmental disorders

- GP referrals for Autism and AHDH assessment have increased 150% per week (now around 8 – 10 referrals per week). There are two consultant but only three sessions can be dedicated to this work
- There is a long waiting list for referrals, with some people waiting up to 24 months
- There is also little local support available for people who have a neurodevelopmental disorder. Care can be commissioned through SDS to organisations in other areas

Primary care

- The growth in population and the planned new housing developments are creating challenges for GP practices. Practice list sizes are increasing
- Poor public transport links across West Lothian makes it difficult for patients in rural areas to access GP practices. Whilst this is not a health issue, it creates inequalities in access to health services for some populations
- Consideration is being given to a pharmacy hub to try and improve access to services
- Improving access to services could be addressed with more clinics held in GP practices in some areas (assuming transport is suitable), however there are limitations amongst some of the GP practices due to ageing accommodation

Podiatry

- The ageing population is increasing demand for podiatry services. This client group is unable to self manage their feet care
- Increases in diabetes cases also result in increased demand for podiatry service
- Digitalisation of the service is not considered to be possible. The digital approach during the pandemic identified that 80% of patients who received a first appointment by digital then required face to face interventions
- Treatment at home has proved difficult due to lack of suitable care environment within the home and there have been issues in accessing suitable community locations particularly in relation to multi-chair sites

Carers

- Little community based out of hours support available, most of the support in the area is Monday to Friday, 9am to 5pm
- Requests for support often come at crisis point, despite many carers having regular contact with health and social care services. There are potentially many missed opportunities to identify carers who need help at a much earlier stage
- There is little respite support or emotional support available for carers in the West Lothian area (this is confirmed in the review of local services conducted in the needs assessment)
- Concern that Home First could increase pressure on carers if additional carer support is not made available
- There needs to be a carer pathway so that they can access support earlier not at crisis point

General feedback

- There is a perception amongst some practitioners that Home First is for older adults only. It is not clear to practitioners how it applies to other vulnerable populations

groups including people with ARBD or learning disabilities who are being placed out of the area
- Practitioners were also not clear on how the needs of younger adults would be met by Home First as their care needs would be different

6.2 Suggestions for doing things differently

Workforce capacity

Workforce issues were regarded by almost all and service providers as the key issue which is preventing good care and treatment. This is affecting provision across all sectors. Service managers highlighted:

- Workforce capacity: virtually all services across the area are running with high levels of staff vacancies and sickness/absence. Managers believe there is a need to increase the pool of people available to take up posts. Some services are incurring significant costs to employ agency staff to fill gaps and are often competing with each other to fill posts. It is understood that the NHS Staff Bank is working to increase recruitment of ad hoc staffing with a skill mix to support gaps in care e.g Return from Retirement internal adverts
- Workforce capability: Some of workforce capacity issues are compounded by lack of training spaces. There are also issues with lack of career development in social care roles. This, combined with low pay rates, is making the posts unattractive
- Given the widespread nature of the workforce issues, managers suggested that there would be merit in adopting a partnership approach between St Johns and the HSCP to address common workforce problems such as the recruitment of Band 5 and Band 7 nurses. It is understood that NHS Lothian has a generic recruitment approach for Band 5 in place – it is not clear if staff were aware of this.

Role definition and role development

Many services are seeking to develop and enhance the role of the advanced practitioner to enable other roles to broaden their non-medical activity. This is seen as a potential solution to delays in access to assessment and treatment as well as taking pressure off of key bottle necks such as medical practitioner availability (due to high vacancy levels)

Broadening roles and offering greater career development and opportunities was also suggested as a means of addressing current difficulties in recruiting staff, particularly social care staff, through offering opportunities to enhance roles, transfer between service and upskill. It was hoped that this would help retain staff in services and address loss of personnel to other sectors, outwith health and social care.

Single Point of Contact

Pathways are being developed from a Single Point of Contact (SPoC) to all receiving urgent care services in order to improve access to rapid, seamless support for people that have urgent needs that can be safely met in the community. The intention is that developing and strengthening urgent care community pathways will help to reduce acute front door unplanned presentations and admissions as well as reducing the time from referral (by GP

Practices /Scottish Ambulance Service (SAS)/Care Homes) to intervention by appropriate urgent care team.

The SPoC is seen as an opportunity to rationalise the number of different assessments people who need care are faced with and also provide a greater opportunity for more effective information sharing amongst services.

Learning disabilities and physical disabilities

- Linking learning disabilities in with the SPoC would enable a clearer and more direct health pathways for people into services
- It would be beneficial if housing would be included in SPoC as there are many housing based solutions which might enable people with learning disabilities remain at home. SPoC offers an opportunity to centralise access points to services as people with learning difficulted often have more than one issue
- Any future pathway should include Third Sector provision to broaden support offerings and to capitalise on their local knowledge and expertise
- There may be an opportunity to discuss with Astley Ainslie the option of delivering more services locally to enable people with physical disabilities to access support closer to home. This would also help families who incur considerable travel costs going into Astley Ainslie from West Lothian on a regular basis
- There could be a greater focus on self-management for people with learning disabilities which would give them greater opportunity for self-management, where possible. This might also reduce referrals to OT as some people don't require high level interventions but do not know how to access other information and support
- Greater awareness of community level support would enable GPs to identify where short-term interventions are needed which could help people get return to self-management
- It would be beneficial to adopt the Holistic Needs Assessment approach used in Improving the Cancer Journey as this includes an assessment of the wider determinants of health as well as health related issues. Social policy has the All About Me assessment but it is not shared outwith social policy
- Closer partnership with the Supported Employment Service would more support for people to maximise work opportunities and have more independence
- More support is also needed to help people transition between services. Support is available initially but is needed for longer to ensure transition has been successful.

Mental health

- There is an opportunity to look at wider use of advanced roles where nurses, AHPs or pharmacists can take some work currently done by consultant psychiatrists; and also a role for the third sector in crying out ASD assessments
- The approach could also be adopted for Out Patient Psychiatry, where at present only a medical staff member can see patients. A triage meeting can signpost referrals to the most appropriate service
- A digital drop in was developed for mental health patients where a bi-monthly drop in was created as part of the regular review process. It is understood that this reduced the waiting list for patients to see the consultant at their first visit. The service is

reviewing its digital options with a view to considering whether a digital drop may be of benefit.

Primary care

Primary care are piloting a new CADM criteria for District Nursing, which is embracing the transforming nursing roles approach. This will include staff managing common acute presentations as well as frailty assessments. By using the complexity tool, District Nurses identify frailty within the caseload. District nursing teams will initially focus on patients with severe frailty, often nearing end of life. The information will be put onto TRAK and shared with the GP, and the primary care pharmacist. For any admissions, there will be a 'supported discharge' review within 72 hours of discharge home. It is anticipated that this will:

- Increase the number of frailty presentations within a DN caseload
- Offer new ways to support/manage our patients
- Reduce emergency admissions
- Reduce the workload of the GP

Older People's Services (Social Care)

- Linking in with Colleges and schools to explore the opportunity for developing a career structure for social care staff. This includes the options for enabling people to change role to broaden experiences
- Enabling the Home Safety Service to alert another service if a home visit is needed after the last home visit has been made at night. Other areas use this as a way of older people alerting services when they need assistance during the night (such as dealing with incontinence). This helps reduce infections – which are a key issue with older people can result in hospital admissions. This could be a separate service which could sit alongside the new care at home framework
- Could there be an opportunity to work with private sector providers who are not on contracts with the HSCP to promote Option 2. This is not seen as being promoted currently

Community Occupational Therapy

- Waiting times are now being managed proactively as the OT Service has had to change its approach to how clients are assessed- initiatives such as the bathing bus have been introduced (whereby a person is assessed and provided with a piece of equipment on the visit as appropriate)
- Use of health assessments to justify need for community resources – preventing duplication of efforts and utilising staff proactively to increase capacity for allocations.

Community Pharmacy

- Serial prescribing which will reduce patient need to contact GP for repeat prescriptions and help support providing Care Close to Home
- Opportunities to increase preventative role, including health monitoring for conditions such as diabetes, high blood pressure

Community Equipment Service

- CES has noted an increase in spend as a result of increased demand for equipment provision.
- Storemen have required to complete periods of overtime during periods of high demand to ensure service provision remains to a high standard.

Podiatry

- The service is looking at its interface with other services that support people to remain at home. It is hoped by doing this, there can be an earlier identification of podiatry issues to prevent escalation of disease
- The services is exploring if the introduction of a Contact Centre for all referrals has helped reduce inappropriate referrals being placed on the service waiting list
- Has introduced a rolling upskilling programme for the workforce to develop advanced practitioners who could be non-medical prescribers

Physiotherapy/MSK

- Whilst first appointments need face to face contact, some reviews could be conducted by telephone and through Near Me
- Liaison with Xcite has enabled drop-in sessions to be introduced for gym based exercises. It is hoped that this will enable people to receive support at times which are more suited to them
- The Physiotherapy Community Pain Management Classes are to be expanded to include a new Introductory/Taster session to pain management. These will be offered across West Lothian and in areas of greatest deprivation to improve access to this patient group. A digital class will also be available. This will be combined with an increased number of the current pain management programmes and gentle exercise classes.
- Links are being created with the local Wellbeing Hubs to facilitate greater participation in local social events and activities on completion of these programmes.

Nursing homes

- Concern was expressed at the reduction in nursing home accommodation in the area and it was suggested that nursing homes need to play a greater role in enabling people who need care to stay in the community and that this would require a closer partnership between the sector and the HSCP

General challenges

- Practitioner preference for face-to-face consultation, reducing the opportunity for digitalization of consultations, particularly in primary care settings
- Accessing information between health and WLC systems has been challenging, although it is understood this is improving
- Practitioner awareness of what support is available in the community is variable, with information often out of date. Public awareness is also limited and there may be a role for the Third Sector Interface and its Service Locator database. The database is currently based on organisations providing the information and it is not known to what extent it is up to date. It may be possible to enhance this. There has been an increase in visit to the West Space website of 300% in the last 12 months, suggesting

that there is an appetite for people to source information on services which can support their health

Carers

- Community Hospitals are a key source of treatment but they do not tend to refer or signpost people for carer support. This is a missed opportunity for helping carers to find support
- A clear referral pathway for services to carer support organisations would help people find support quicker and at an earlier stage. It would be beneficial to consider how the SPoC might provide a clearer referral pathway for carers
- Providing staff with training about unpaid carers and their role would help staff better understand how to support carers and would help the HSCP fulfil its statutory requirement under the Carers Act

7. Partner feedback

An online survey was developed and a range of partners were invited to complete the survey. These included:

- Members of Community Regeneration Teams
- Housing Teams
- Community Councils
- Community Planning Partners
- Members of the Third Sector Interface
- Members of the Mental Health Wellbeing Network
- Members of the Carers of West Lothian Network
- Adults with Disability Providers Forum.

The survey sought feedback on:

- Top three priorities for health and social care in West Lothian
- Reaction to the Strategic Plan priorities
- How could health and social care be improved in West Lothian
- What role could partners play in delivering the aims
- What new ways of working could benefit any suggested changes.

Fifteen responses were received and the feedback is outlined below.

7.1 Top 3 priorities for health and social care in West Lothian

Respondents highlighted a range of priorities. The most common were related to:

- Access to services and support
- Support for independent living
- Improving partnership working

7.1.1 Access to services and support

Eight respondents suggested that improving access to services and support was one of their top priorities. This included:

- Access to GP services (including face to face access)
- Access to dental services (which respondents felt was poor after Covid)
- Access to out of working hours health services as most are only offered Monday to Friday, 9am to 5pm, when people are at work
- Access to mental health services, including emergency support
- Enabling a one door approach to accessing health and social care provision

7.1.2 Support for independent living

Six respondents suggested that ensuring effective and full support care packages were available to enable people to live independently was key, including:

- Housing which was specific for vulnerable population groups such as elderly and those living with disability
- Timely care packages to support discharge from hospital and stop lengthy delays
- Ensuring packages for care fully met people's needs and were sustainable over time
- Increasing provision available for people living with disability

7.1.3 Improving partnership working

Five respondents suggested that there needed to be greater partnership working between health and social care, other agencies and the Third Sector, especially in relation to providing services and accessing advice.

7.1.4 Other priorities

A range of other priorities were highlighted by respondents:

- Increasing the focus on early intervention and prevention
- Looking at people's needs more holistically
- Shortening waiting time
- Improving GP premises.

7.2 Reaction to strategic priorities

Eight out of the 15 respondents stated that they felt the priorities of Tackling Healthy Inequalities in Partnership, Homes First and Enabling Good Care and Treatment were appropriate. However, they suggested that there was a need to provide more detail on the context behind the priorities and how they had been determined. It was also suggested that more detail needed to be provided on the difference between Home First and Care in the Community.

A further three respondents stated that the first two priorities were appropriate but found the third priority (Enabling Good Care and Treatment) too vague to comment.

Of the remaining four respondents two did not understand what was meant by health inequalities and two were unsure if the Home First approach was focused only on the elderly, rather than other population groups. There was also some concern as to how the HSCP would find the staff to deliver Home First, given the well publicised problems in recruiting and retaining social care staff.

Respondents also highlighted the needs for:

- A greater focus on mental health provision in the aims
- Improving wellbeing, post Covid
- An increased focus on the needs of elderly carers
- Workforce training on delivering person-centred care.

7.3 How health and social care could be improved in West Lothian

Three key issues were commonly highlighted by respondents as requiring improvement in West Lothian:

- Access to mental health services
- Pathways to support
- Greater partnership with other agencies and the Third Sector.

7.3.1 Access to mental health services

Four respondents suggested that there was insufficient focus on the impact that mental health had on people, particularly their behaviour, and that a greater focus was needed to look at the wider impacts of mental ill-health on individuals to provide the support they would need.

Respondents also wanted to see a greater focus on wellbeing following the pandemic.

7.3.2 Pathways to support

Four respondents suggested that there needed to be clearer ways of supporting people to access the support that they needed and that there needed to be closer working relationships between health and social care teams to enable people to receive the correct support in a timely fashion.

7.3.3 Greater partnership with other agencies and the Third Sector

Four respondents suggested that more effective support could be provided if health and social care teams worked more closely with other agencies and the Third Sector. They suggested:

- The need for wider consultation on plans to change services as this has an impact downstream on agencies and partners outwith the HSCP and the demand for their services
- Referral processes and pathways could include Third Sector provision if a different approach was taken to commissioning services, with more emphasis on including non HSCP delivery in the service mix.

7.3.4 Other improvements

Suggestions for other improvements included:

- The need to ensure staff and funding was available to sustain support in the community through Home First
- Offer a choice of face to face and digital engagement, as digital does not suit highly vulnerable population groups
- Benchmark performance with other IJBs in Scotland
- Provide staff with appropriate development and remuneration.

7.4 Role of partners in helping to deliver aims

Respondents suggested that partners could play a bigger role in supporting delivery of the strategic aims but that, in order to identify what role could be there needed to be:

- More involvement by partners in decisions on services, particularly changes to service provision and eligibility criteria and on service targets
- A greater recognition amongst the strategic planners that other agencies, including the Third Sector, could have a larger role in the planning and delivery of services
- A greater commitment to working with local organisations to deliver local priorities.

Respondents suggested that, if a partnership approach was adopted, a number of benefits would arise, including:

- More opportunities to identify and support people who are just below eligibility thresholds but still require support
- Improve communications between agencies and services and improve continuity of service delivery
- Enable a more flexible approach to delivering support by identifying the most appropriate partner to deliver services.

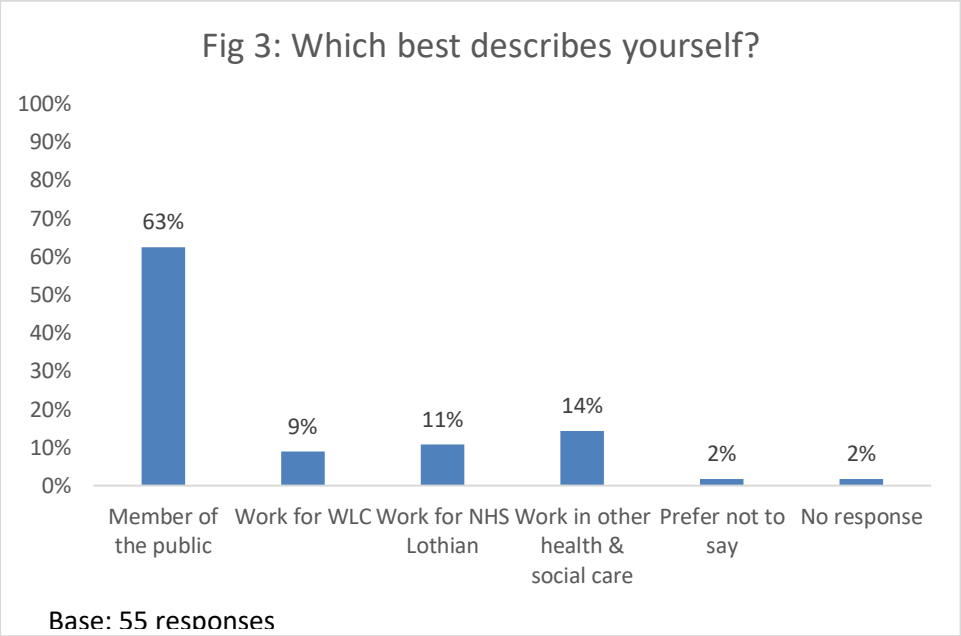
7.5 New ways of working to support changes

The respondents highlighted potential changes to working practices and benefits if new ways were adopted, including:

- A wider pathway would enable referring to services outwith the HSCP, helping to reduce waiting times and potentially provide better transitions between services
- Pathways which included out of hours provision would also help address waiting times
- Break down barriers between statutory and voluntary sectors to reduce silo working
- Greater inclusion of other agencies in Third Sector, Community Planning Partnerships and local community organisations would enable a more meaningful partnership
- Greater involvement of service users in the planning of services to highlight the potential consequences and impacts of change

8. Public and support service feedback

An online survey was developed and promoted through a combination of press release, Third Sector social media feeds and intranet and social media feeds for WLC, NHS Lothian and the HSCP. A total of 55 responses were received to the survey, two-thirds of whom were members of the public (including service users, carers and residents) with the remaining respondents being people who worked in support services in West Lothian (see Fig 3 below).



In addition to this group and individual discussions were conducted with a total of 36 people, representing:

- Advocacy organisations representing people with mental health issues, learning disabilities and physical disabilities
- People living with mental health issues and their families
- Older adults with dementia and their carers
- People living with physical disabilities
- People with learning disability and their carers.

Their feedback is detailed below.

8.1 Survey feedback

Respondents to the survey were asked to provide feedback on:

- The proposed aims within Tackling Health Inequalities, what the HSCP current does well and what needs to be improved
- The proposed aims within Home First, what the HSCP current does well and what needs to be improved

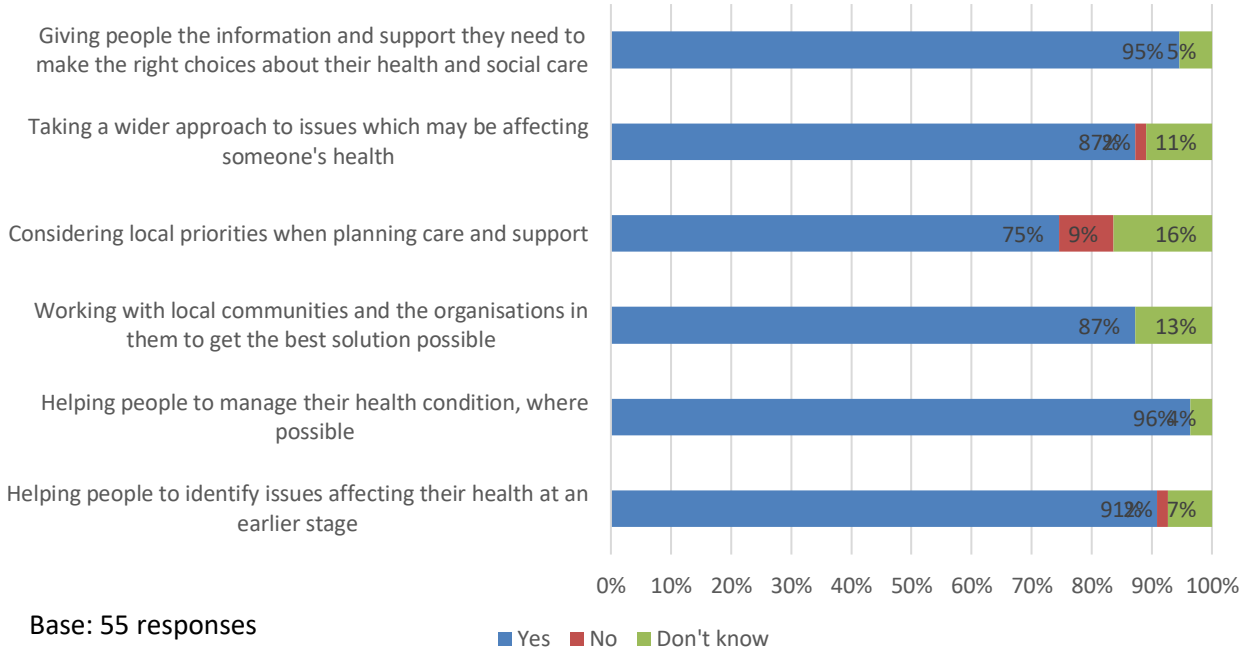
- The proposed aims within Enabling good care and treatment, what the HSCP current does well and what needs to be improved
- Their own top 3 priorities.

8.1.1 Tackling Health Inequalities aims

Reaction to aims

The majority of respondents indicated that all the suggested aims were important to them (see Fig 4 below), although considering local priorities when planning care and support was the least important in the Survey. The majority of those who did not consider it important were members of the public.

Fig 4: Which of the following are important to you (please tick all that apply)?



Base: 55 responses

What is done well

Fifteen respondents listed what they thought that the HSCP did well. Those that described themselves as members of the public suggested the following:

- Working with local communities and organisations to get the best solution possible
- Supporting St John's Hospital, rather than centralised services
- Giving people the help and support they need to make the right choices about their health and social care
- The support provided by Carers of West Lothian.

Those who work in support services tended to suggest staff commitment to service provision.

What needs to improve

Thirty four people suggested issues which needed to improve, whilst 5 respondents stated that nothing required improvement. The issues are outlined below.

Areas of improvement raised by members of the public:

- Access:
  - More GP's, more appointments
  - Make it easier to see a GP in person rather than phone consultations
  - Easier access to visit doctors face to face
  - More respite provision
- Cost and choice of provision
  - Give people more choice as to how their care is delivered
  - Make community facilities free or a token cost
- Support for people with physical disabilities:
  - Ensure adequate funding to provide support for vulnerable / disabled people
- Support for mental health provision
  - More follow through is needed. The police don't follow up or file a vulnerable person report or there is a standard letter from social work asking to make contact to then be tole is the CPN responsibility. I rarely meet with my consultant psychiatrist who prescribed medication yet have issues getting med consistency by GP who no one seems to talk to!
- Support for carers:
  - Easier access for unpaid carers to get help and support
  - Much clearer jnformation about what services are available. Not just being "signposted" to other people such as Carers of West Lothian. If someone needs help the last thing they want to do or might be able to do is be told to look up a website or try phoning another agency that they need to explain all their concerns and needs to.
  - More actual support for ALL unpaid carers including parent carers
  - Keep better contact with families
- Joined up working:
  - Coordination and communication between services involved in a persons care MUST be a priority. My main weekly contacts are my NHS Psychologist and a HSCP CPN. They don't communicate with each other.
  - A more integrated and sympathetic approach for someone whose condition impacts on several systems; e.g. for someone with MS, continence products come from two separate providers, one of which questions the rate of usage of the products!
- Person-centred approach:
  - I have a health condition called dissociative seizures which falls under the FND bracket and hardly any health care professionals know what my seizures are. Even though there is so much research and facts about it they dismiss us and this is wrong
  - Spending more time with the recipient to make sure the right needs are being met, maybe over a few visits. Sometimes its a case of quick assessment or rushed assessment (as the Social worker assigned has been given too many cases) and therefore makes quick decisions not always in the best interests of

the recipient.... or the wrong decision. Also, follow ups when any care package is given to make sure the recipient is getting the right level of care or upgrading it to the next level if required.

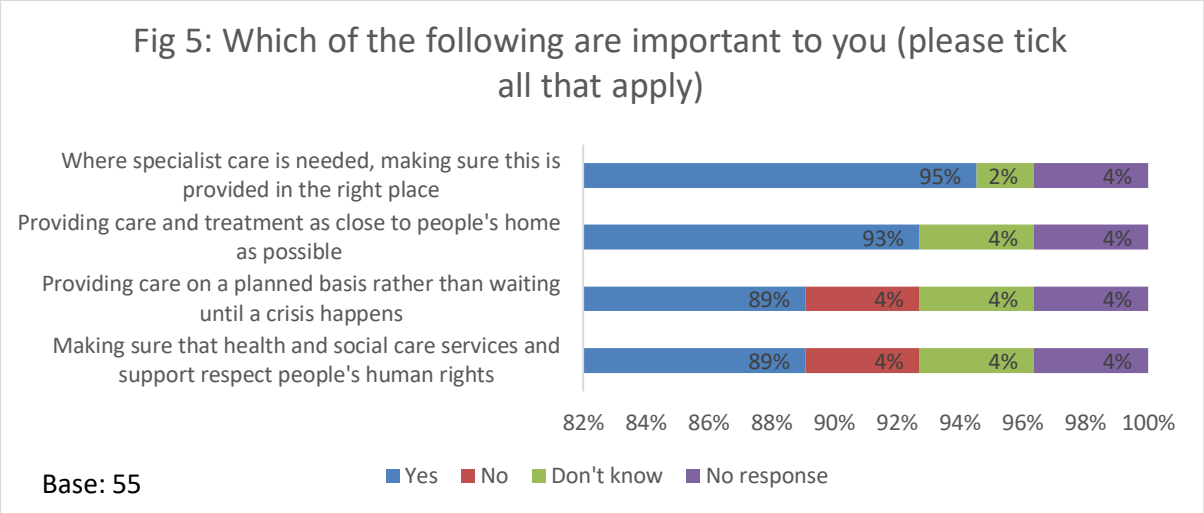
- Availability of information:
    - Better signposting to services/resources in the area
    - Communicate what is available- I am disabled and vulnerable but know nothing
    - Transparency of what is available and easy free access and signposting to services with increased availability
    - Elderly people miss out on support & potential help as everything is online & they are unaware of support they may be entitled too.

Areas of improvement raised by people working in support services were:

- Access:
    - Resume services post Covid to reflect increase in number of people needing support
    - Wider availability of services in West Lothian. Most health services are centralised in Edinburgh, where possible its makes sense that we need satellite units in West Lothian
- Cost and choice of provision
    - Be more transparent about the cost of social support as people take on services they think are free and are then billed at a later date
- Support for people with Learning Disabilities:
    - Huge lack of resources for adults with Learning Disability, including those with mild learning disabilities, needs more support hours, day services and respite. There is nothing once they leave school – supported employment would help this group of people in particular
    - Lack of services for people across the learning disability spectrum of ability impacts heavily on mental health through loneliness, boredom and anxiety - virtually no respite and so people end up being admitted to hospital unnecessarily and then becoming delayed discharges due to lack of safe accommodation and sufficient care in the community
    - More services for people with a learning disability. This includes services for all ages. Currently unpaid carers are plugging the gap in services and at some point this is going to give.
- Support for Mental Health provision
    - More services for Mental Health users, more groups, there are none for Personality Disorders, more CBT Training, more Social Workers
- Person-centred approach:
    - Services should be person centred , with robust assessments in place to ensure people get the right help at the right time

5.1.2 Home First aims

The overwhelming majority of respondents thought all the aims were important to them. Almost all of the respondents who stated that the aims were not important to them or did not know were members of the public.



What is done well

Eleven people suggested issues which needed to improve (5 of these were members of the public), whilst 6 respondents stated that nothing required improvement (2 of these were members of the public). The areas that the public considered were done well are:

- Keeping on top of every detail for each family
- Short term planning
- Providing specialist services
- My CPN from the HSCP centre is fantastic and supports me as best she can however due to service demand, I feel that it's becoming more difficult to access her time during crisis

The areas which people who work in support services considered were done well are:

- Health and Social care staff appear to be committed to giving people the best service that they can and that policy allows
- I think people's human rights are usually identified and respected.
- Specialist care seems to be provided in the right places
- Working with NHS service REACT

What needs to improve

Twenty-eight people suggested areas for improvement, 17 were members of the public.

Improvements suggested by members of the public were:

- Access to services:

    - Shorter waiting times and more communication
    - Stop building new homes without the supporting infrastructure
- Providing local services:
    - Services should be delivered locally by West Lothian decision makers. Or those in Edinburgh that don't know West Lothian. Leave local services with local bodies to run and resource them properly
    - Providing care and treatment near home
    - More local availability
- Support for mental health:
    - Coordinate care between the person and all people supporting that person ie psychologist, CPN, gp, psychiatrist etc. Also communicate clearly and honestly with the individual being supported to eliminate anxiety and uncertainty around diagnosis, treatment, medication etc. instead of deterring a person from seeing their records, be open about what's happening. I have previously found out about clinically diagnosed mental health conditions by accident seeing a GP summary, years after they were clinically diagnosed! This should not happen.
- Providing person centred care:
    - Systems that serve people rather than requiring people to fit in with the systems needs. Of course to do this, the health & care systems need to be properly resourced.
    - Within care the move away from person care to technology is unfair on the older generation. I feel this is failing already just look at GP services, uploading pictures of rashes etc to website, older people cannot do this I think it's shocking & the amount of misdiagnosis because of this is unthinkable. I think when it comes to care it needs to be person centred approach definitely.
    - More specialist facilities with specialist trained nurses and carers
- Linking with other organisations:
    - Promising certain types of help at the assessment but not acting on this and making the recipient feel helpless and alone. Also follow ups from referrals i.e. paramedic referrals, but these are then forgotten about by the relevant team at the Council and help is not forthcoming or arrives too late.
    - An effective approach is to base outcomes on person and community centered planning. This includes drawing on the expertise of national and local support organisations, particularly in respect to rare syndromes.

Improvements suggested by people working in support services and WLC were:

- Access to services:
    - Quicker times getting the help in place
    - OT assessments taking ages, people not accepting support who need it because it costs them money they can't afford
- Affordability:
    - Many service users receive social support from care providers from an allocated provider. Several had not received a letter or invoice for non-residential contributions and assumed that they did not have to pay for the

service, only to receive a large bill months later. The financial assessment only considers incomings and rent/mortgage and council tax as outgoings and not any other bills or debt. This is unrealistic and the large bills are scaring people into cancelling their services and cause undue stress and anxiety. The assessment needs to be transparent from the beginning and services should not begin until the service user is aware of the cost.

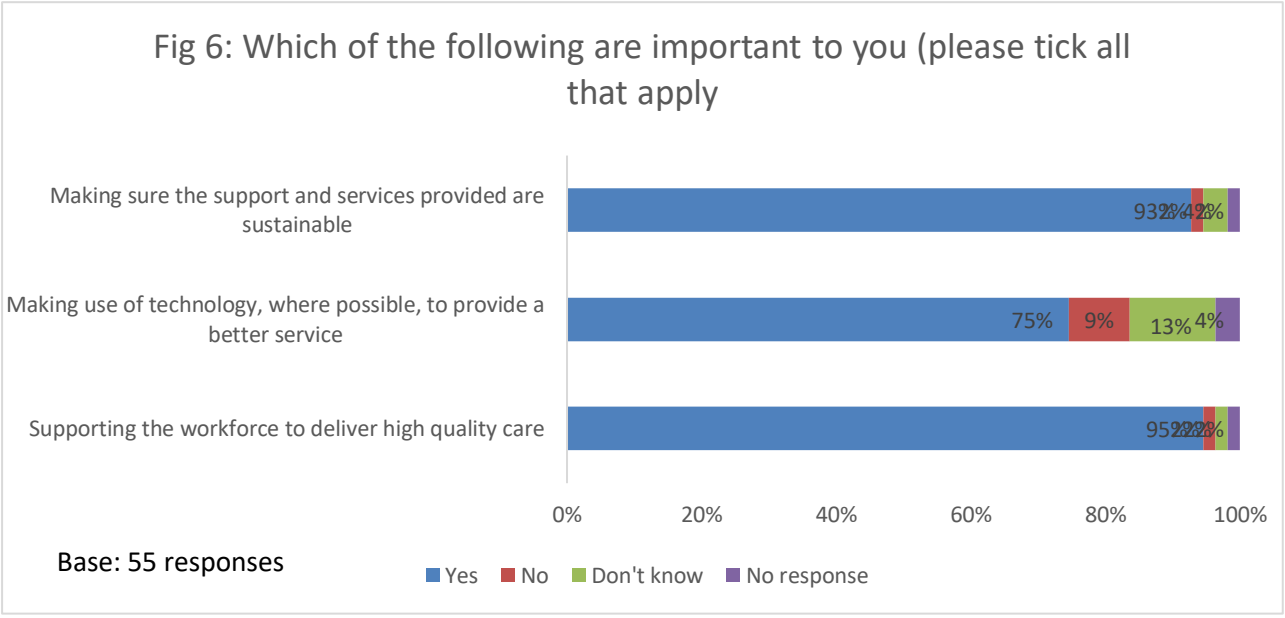
- Support for Learning Disabilities:
  - Lack of social services (care packages/day centres/activities/respite) for adults with Learning Disability negatively impacts on mental health. This leads to crises and increasingly to Adult Support and Protection concerns. Therefore forward planning is vital, particularly for people who are transitioning to adult services, those who are vulnerable to exploitation, those with limited ability to keep themselves safe, those who live with ageing relatives and those whose health is gradually declining.
  - We need to have more services available for the number of individuals with a Learning Disability.
- Support for Transition:
  - Especially more support with transitioning from child to adult services. Parents need to be aware of guardianship, different options relating to day service, moving on in to supported care, payments and benefits etc...
- Sustainability:
  - Unfortunately if there was the staff and money available these services would be available in West Lothian. What is the point in asking what we would like - and what staff would love to provide- if there is only a pipe dream of it happening
- Providing person centred care:
  - Services at present are not person centred, particularly care provision, and they are not being tailored to the individual. Care providers are being allocated to people when they are not the right fit, cannot provide the right visit times, there is no matching of staff and when people complain about their service , not much is being done as there is a shortage and there is a fear that providers may end the package
  - Within care the move away from person care to technology is u fair on the older generation. I feel this is failing already just look at GP services, uploading pictures of rashes etc to website, older people cannot do this I think it's shocking & the amount of misdiagnosis because of this is unthinkable. I think when it comes to care it needs to be person centred approach definitely
  - Person-centered care is at an all-time low and service users feel that they are just a number and that they are a burden to the carer that attends to them. There are many service users who wish to change provider or are on the unmet needs list. It is virtually impossible to change provider at present, meaning that they are living with care that does not meet their needs or care that is sub-par, and the unmet needs list has around 400 people on it at the moment.

- Matching need:
    - Service users often report that the care providers do not stick to the agreed times on the care plan and often come late with no communication and they do not stay the allocated time that West Lothian Council are paying them for. Previously, care packages would be matched with care providers that matched a service users' needs as they had specific expertise or training, but due to the shortage in carers, social workers are now taking the first package that has a space and service users have expressed that the pairings do not always work. There are service users who have care plans that are out of date, that have not had a review done for some time, when they should be twice yearly and have not had risk assessments done or updated. I would like to state that this is not all providers, but I have service users who have experienced this with several that are contracted by West Lothian Council.
- Training:
    - The standard of training from care providers is not as high as it previously was and there are service users who are getting carers that are not trained for their condition or the equipment they may use, putting the service users and carers at risk of injury.

8.1.3 Enabling good care and treatment aims

Once again, the aims for Enabling Good Care and Treatment were important to the majority of all respondents. However, the members of the public who responded to the survey were less keen on the use of technology, with a just under third (30%) stating that this was not important to them or that they weren't sure how important (see Fig 6 below)

Fig 6: Which of the following are important to you (please tick all that apply



Base: 55 responses

What is done well

Twelve people suggested what they thought was currently done well, 7 of whom were members of the public. Care for the elderly and support for unpaid carers by COWL were the key issues highlighted by the public.

Those respondents who worked in social care suggested:

- Use of video meetings has helped foster connections between professionals from different services since the pandemic necessitated working from home.
- Staff support for carers
- Staff advice and support
- Amount of staff training.

What needs to improve

Twenty five respondents suggested improvements, 17 of whom were members of the public. The suggestions from the members of the public for improvements needed were:

- Access to services:
    - Why can't it be easier to make an appointment with Social Services instead of being made to leave a message and then waiting to get called back. Unpaid carers work as well as care. They can't always be near a phone if they are waiting. There needs to be a better way to access help. For people new to caring the system is a minefield. There needs to be a guiding system in place to help.
    - Every town and city should have local services for families who might not manage to travel out of local area
- Support for Learning Disabilities
    - When these people reach crisis, there are so few options because there is no flex in the system to support people with complex needs at short notice.
- Support for carers
    - More support for unpaid carers
    - More help for unpaid carers
    - Unpaid carers not paid enough money and not supported, my husband has been a carer for years and hasnt had carers assessment done.
    - Pay carers a decent wage instead of ripping up the Steelyard every couple of years.
    - There is no provision for unpaid carers in assessments of the recipient. I feel focus is mainly on the recipient and the carer is left to struggle on. Nothing is really offered to them in the way of help. Just maybe a suggestion to join West Lothian carers group, which I am already a member of, but this group is only a sticking plaster and not really a great deal of help with carers issues or the person you are caring for. There needs to be a lot more support for carers, especially sole carers, as after all we are saving the Council a lot of money by giving up our lives to care for our loved ones. Offering respite for people we are caring for would be a great help and give us a much needed break.
    - Encourage unpaid carers to identify as such to health, social and council services.

    - much more support for unpaid carers. I don't mean someone to talk to on the phone but actually physical help with their caring and respite.
- Staff wellbeing
    - Recruitment and retention of 3rd party organisation care staff is even more of an issue now than pre-pandemic when it was already a huge problem. Some of this is due to organisations making promises about care they can deliver which are not followed through - Positive Behavioural Support is commonly promised and not delivered.

- Staff training
    - Better available actual person centred training. Better wages and conditions Proper supervision of work
    - Too many new staff and not enough retention of those qualified
- Technology:
    - The technology involved in setting up a simple repeat prescription needs a drastic overhaul. It should not take repeated attempts to order medication.

The suggestions from people working in health and social care for improvements needed were:

- Support for carers
    - More respite needs to be offered to unpaid carers and assessments need to be done with their needs in mind more often
    - The Learning Disability services rely on the good will of these people and the level of challenging behaviour some handle and the constant attention that their charges require of them is often extreme, especially when they are working to make ends meet or have their own health problems.
    - As a society we hugely undervalue carers which contributes to their low pay and sense of professional self worth. They also have far less in the way of an upward career path than in many other jobs.
    - Review families where elderly parents are the sole carer and what services there are, to meet the patients' needs.
- Staff wellbeing
    - I am seriously concerned about staff well-being and morale. Lack of options for social services is causing significant distress for staff who joined their professions to help people and are now feeling that most of their patient/client interactions are negative simply because there is so little any of us can do for people with resources being so limited.
    - The number of staff vacancies in health and social care is frightening because it leaves everyone else only able to firefight which is exhausting and demoralising and is demonstrably leading to burnout and people leaving. Individuals, families and carers understandably vent their frustration and distress at whoever they are in contact with and more support is needed for the professionals facing that distress.
- Staff training
    - To provide better quality training/qualifications for nurses and care staff.
- Sustainability:
    - Sustainable funding rather than "projects" and services which are suddenly scrapped because funding's withdrawn

8.1.4 Personal top 3 priorities

Thirty-six people provided their own priorities, 22 of whom were members of the public.

The top priorities for the public were:

- Better support for unpaid carers (5)
- Better access to mental health services, including early intervention (4)
- Providing person centred care (2)
- Respite care (2)
- More access to GP (2)
- Increase number of GPs and staff (2)
- More services for people with disabilities (2)
- Day services
- Person centred training for staff
- Continuity of care
- Continued investment in St Johns
- Residential support for people with ASD
- Better staff pay for those on lower paid role
- Faster assessment
- Health promotion and education that doesn't patronise people or guilt-trip them about their lifestyle choices
- More suitable housing for folks with mobility and /or health issues
- Ensure that West Lothian council control large aspects of care
- Increased awareness of services available
- Improve coordination and communication between service providers.

The top priorities for people working in support services were:

- Staff recruitment and retention (3)
- More services for people with learning disabilities (2)
- More services for people with disabilities (2)
- Better support for unpaid carers (2)
- Faster assessment (2)
- Management support of staff (2)
- More support for personality disorders
- Proving correct care package
- Minor injuries drop in
- 6 monthly review of service to adjust packages where needed to ensure services are used effectively and where they are truly needed.

8.2 Service user feedback

Discussions were held with groups, individuals, carers and advocates from the following service user groups:

- Mental health
- Older adults with dementia
- People living with physical disabilities
- People with learning disability.

The discussions focused on:

- What is important to them in their care
- What were the key challenges and concerns impacting on their health and wellbeing.

The feedback from each of the service user groups is detailed below.

8.2.1 Mental health

Providing care and treatment at home

Participants were highly supportive of the aim of providing care and treatment at home or close to home. Maintaining a sense of belonging in the local community was very important to people, however there were a number of concerns raised in relation to the sustainability of this approach:

- Affordability: The increases in the cost of living were concerning individuals as to how they could afford care to enable them to remain at home. There were several examples where people had incurred debt which they were struggling to pay. Advocacy services indicated that they had received upwards of 30 call from concerned individuals or family members in the last two months regarding the affordability of care at home charges. Some people had received letters from debt collection agencies regarding outstanding payments. There were concerns regarding the potential for further deterioration in people's mental health as a result of the stress this was causing
- Staffing shortages: There were examples where individuals had a care package in place but where the care provider had been unable to provide the care at home. Whilst participants liked the idea of Home First, they were skeptical at how this could be delivered with the staffing issues in social care. There were also some examples where people had been billed for care which the care providers had been unable to deliver due to lack of staff. The advocacy services indicated that there were an increasing number of calls regarding care companies not delivering the hours set out in the care packages
- Timeliness of care: There were examples of individuals waiting several months for access to psychiatry and psychology services. Whilst the service provided by The Brock with therapeutic support was highly rated, people wanted to have more opportunities like this.

Providing information to make informed choices

Participants were unclear as to how to access information on services and support available. They highlighted difficulties in contacting the Advice Shop, as well as a lack of awareness of where else to approach for assistance. It is understood that appointments are not available at the Advice Shop before the end of September, which as one participant stated:

"It's a long time to wait when you are panicking about how to pay your bills"

There is also a preference for face to face contact as some people do not have access to the internet or find it difficult to communicate through social media. This has made it difficult for some to access support, as many organisations only offer face to face on a limited basis, such as one afternoon each week.

Providing specialist care

The advocacy service highlighted that there was no support for people with personality disorders and that they received regular calls from people who had issues with their houses and neighbours due to challenging behaviours, some of which had resulted in loss of tenancies or requests to move houses, which can take up to 5 months to sort out.

Difficulties for people who expressed suicidal thoughts were also highlighted. The advocacy service was aware of people who had attended St Jon's A&E but had been told that they could not be admitted due to the advice in their care plans. The advocates indicated that, whilst this may be the appropriate action, there are no other support services locally to help these individuals.

Other issues raised

There were a number of other concerns raised by participants:

- The advocacy services highlighted an increasing number of people with mental health issues who were approaching them for help with food and utilities. Whilst foodbanks are available, it is difficult to access support over the weekend, meaning that some people could be without food for up to three days at a time
- The extent to which utility costs were eating into people's benefit monies, leaving little left for food
- The advocacy service highlighted difficulties in accessing the mental health team for HMP Addiewell. Whilst there was a dedicated person for healthcare in the Prison, this seems to have ceased, with contact now reverting to letters as opposed to telephone, resulting in significant delays in responses to enquiries.

8.2.2 Older adults with dementia

The discussions with older adults with dementia focused on their home life and the support they receive through Day Care services. Discussions were conducted with the support of day care staff.

People are referred to the Centre by Social Work. CPNs can also refer but it is mostly through the Social Work pathway, using the Getting to Know Me form. All staff receive dementia

specific training. Most support is group based, but staff can provide 1:1 support for people when needed. This can happen at any time if people become distressed.

The Day Centre has been assessed by the Care Commission to take up to 14 people with dementia up to Level 2. Whilst the Day Centre is contracted to provide support by the HSCP Tuesday to Thursday each week, it supplements this funding by providing privately funded spaces on a Monday. The Centre hopes to increase this private option to include Fridays as a means of securing additional funding support. No spaces are available to HSCP funded individuals on these days.

All but one of the individuals lived at home, three had care packages with four visits a day, and one was living at home without a package of care. All the families providing support were in full time employment. One person lived in sheltered accommodation.

Attendees came from across Livingston and Polbeth. Visits to the Day Care Centre, which is open Monday to Thursday, ranged from 2 days to three days a week and people are brought to and from the Centre by taxi. None of the people who took part in the discussions attended any other support services or organisations other than the Day Centre.

In talking with the people living with dementia, it was apparent that being able to remain in their own homes is very important to them. It provides them with continuity and enables them to remain close to family. However, all but one of the day care attendees living at home were receiving in-home support to enable them to retain their independence.

The attendees spoke very highly of the Day Care Centre and its staff and it was very apparent that they enjoyed the social contact which this allowed them. People who were in earlier stages of dementia commented on the important of this to them, as these people commented:

"It makes me feel better coming here. I would be stuck in the house all day every day without it. I have carers who come in, and they are lovely, but they are only there for a short time. If I didn't have here, I would be very, very lonely"

"I can't wait to come here. We get company, we laugh a lot, and we do games and exercises. I love it".

"I love the chats we have, it means such a lot coming here".

8.2.3 People with learning disabilities

The discussions with adults with learning difficulties were conducted with people attending Pathways in Livingston, with the support of day care staff. Pathways is based in Livingston. It supports up to 85 people who attend on various weekdays. Support can be provided for people up to the age of 65, up to 5 days a week.

The women had been attending Pathways for a number of years, visiting the Centre between 2 and four days a week. All lived at home with family members and attend Pathways through HSCP funded transport or are dropped off by family members.

There is a range of activities on offer each day, including arts and crafts, cooking skills, exercises and days trips. Everyone attending Pathways has a weekly timetable which sets out activities for the days they attend.

Pathways links up with other organisations that support people with special needs, including a charity offering art therapy in Glasgow (Life with Art) and Enable. Other out of area activities organized include ten pin bowling.

Some of the attendees also volunteer in other organisations and facilities such as Almondvale Gardens, the Foodbank and local care homes. People also go to the Kirkton Campus at Oatridge College for gardening activities and attend Xcite for activities such as football. Oatridge College also offers certificates in a range of skills.

Links have also been made with local community organisations which offer activities not specifically developed for people with learning difficulties, such as the Men's Group and Singing for Health which are arranged by SPARK in Craigshill. There are also plans to link up with local community hubs to enable people to attend more day time activities.

Instructors also come in to help deliver a range of activities in Pathways, including guitar lessons, drumming lessons, dance and drama. Health and wellbeing sessions are also offered and there are interest groups including History and Culture Around the World.

Prior to Covid, some of the people attending Pathways also took part in clubs in their local communities in the evenings and weekends, however these stopped due to Covid and have not re-started. This means that the participants are heavily reliant on Pathways for their social contact and activities.

The opportunity to meet with others was very important, as these participants commented:

"It's great meeting up with everyone, I miss is when I am not here".

"I look forward to coming here. I get up and get ready … I love it"

"I wish this was on all the time, I would come every day to see everyone… I don't really see anyone when I am not here"

"I go to art, I do baking – I am a really good baker. I am starting to learn the guitar as well"

They also highlighted the impact that the loss of other support options in the local area has had on their lives.

"I used to go to a lot of things but now I just stay at home when I am not here"
"I can go out with Mum and Dad, but they work so I do that at the weekend"

"I miss going out – I hope the stuff starts again".

It was also very apparent that the participants wanted to stay at home. They liked being with their families and talked about their parents, their siblings and their pets. Their family life was very important to them.

8.2.4 People living with physical disabilities

The discussions were held in the Ability Centre in Livingston, with support provided by Centre staff.

People are now referred to the Ability Centre by Social Work or CRABIS from across West Lothian. Until recently, it has been possible to self refer but now people are required to meet separate eligibility and contribution criteria. Staff and participants suggested that this had resulted in some people stopping attending the Centre as they were unable to self-fund. There was a waiting list, pre-Covid but this has reduced to around 30 referrals which are waiting on Social Work assessment now.

One of the participants receives outreach in East Whitburn, organised by the Ability Centre. Outreach is provided in 8 locations across West Lothian but, according to staff and participants, the numbers attending have reduced.

"Because there are criteria people need to meet there are very few people who get outreach, there were only 3 at mine this week"

Social contact

The opportunity to meet other people who are living with disability was highlighted as very important by participants

" I would be sitting at home all day by myself otherwise"

"I would be doing nothing if I couldn't come here"

"I could get 1:1 support at home but I prefer to come her, I don't want to be on my own at home"

"You can relate to other here because we all have a disability – its peer support, its vital"

"If you are suddenly not able to work, like me, it's a big change. I got very down and these people helped me through it, coming here really helped"

General support and signposting

The participants also seek help from Centre staff on a range of other issues, including filling in applications for housing, blue badges etc. Participants find it difficult to use online support.

"I have problems with my sight – so I can't use the computer"

"I am not able to use the computer due to my disability so I get help here. I am not sure what I would do if I couldn't come here"

The participants suggested that there were few alternatives for support in the West Lothian area. Many of the other organisations are not specific to people with disabilities and others which do offer support, such as CoWL, meet infrequently.

Participants also value the advice from the staff. There were several examples where staff had helped signpost people to other support.

"It's hard to know where to go for help, so I usually ask here. If the staff don't know, someone else who comes here will"

Access to services

Accessing GP appointments was highlighted as an issue for participants, as well as the telephone based appointments.

"I find it difficult to get through to my GP and then I find it difficult to describe what I want over the telephone. I would be more comfortable if I could see them"

"If your cognitive ability isn't good, it can be difficult to communicate by phone"

Follow up after discharge was also raised as a key issue.

"When you come out of hospital it can be quite challenging and it would be better if there was some follow up to see if the care package is working or not. There is often to contact and Social Work close you case after the package is put in place so there is a huge delay in getting them back involved."

Other needs

Participants thought it would be beneficial if other agencies could link in with the Ability Centre.

"If the Police could drop in that would be great. People are very vulnerable at home and it would be good to see how we could be more safe"

There was also a concern about what would happen once people reached 65, as this is the age limit for the Ability Centre.

"Once you get to 65 there is really only Braid House, but that has people who are much older – that's not great if you are 65, its not that old. It seems crazy that you don't get a pension till you are 67 but services stop at 65".

Participants also indicated that their disability can often affect their mental health. They suggested that access to a counsellor would be helpful. It is understood that this had been made available in the past through Disability West Lothian but had been stopped when the tender was won by Capability Scotland.

Access to benefits advice was also considered beneficial.

"Disability Scotland could tell us what grants were available, how to access holidays etc but that's not here now"

The Advice Shop attend one day a month but this can be overwhelmed if there are a lot of people wanting help. Participants felt that this was not often enough.

9. The way forward

The population and health prevalence data and the feedback from staff, partners and service users indicates that the proposed Strategic Priorities of Tackling Health Inequalities in Partnership, Home First and Enabling Good Care and Treatment are appropriate. Whilst the public tended not to understand the term "health inequalities", the issues which they raise in this needs assessment relate to key physiological and demographic risk factors and inequality issues such as health status, access to care and wider determinants of health including income, housing and social isolation. These factors were also highlighted by staff and partners.

The key priorities for service planning, commissioning and delivery, which the data and feedback highlight are discussed below in terms of building on current approaches and addressing remaining gaps.

9.1 Building on current approaches

There are a number of indicators which are worse than the Scottish average but have been improving and some improving at a rate which is faster than the national average. It is recognised that there has been a considerable focus on addressing hospital discharge delays and preventing people from being admitted to hospital in West Lothian as part of the current Strategic Plan and there are a number of indicators which reflect improvements in these issues:

- Prevalence of CHD, stroke and TIA – although the rate of people and being hospitalised with CHD from deprived areas is 25% higher in the most deprived areas, the rate has more than halved since 2002/3, which is a faster decrease than across the Health Board and across Scotland
- Psychiatric hospital admissions (although these were 15% higher in 2020/21 than the Scottish average)
- Preventable and repeat emergency admissions
- Delayed discharges amongst the over 75s
- The extent of discharge delays for health and social care reasons reduced significantly brining it below the Scottish average
- A slightly higher rate of people receiving care at home than the national average
- Adults supported at home agreeing that their support was well co-ordinated.

In addition to this, there has been improvements, compared to the national average, in indicators which are known to be related to health inequalities:

- Smoking attributable deaths
- Alcohol attributable related deaths
- Premature mortality from all causes – although this is 40% higher in the most deprived areas, it has been reducing faster in West Lothian than the Scottish average
- Impact of diabetes on life expectancy.

Consideration is given below to how actions which are being taken at service level could build on these improvements, ensuring that the progress made is not lost and also addressing key factors related to these issues which have been raised by members of the public, staff or partners.

9.1.1 Increasing access to care

Primary care

The national published data indicates a higher proportion of people in West Lothian live in the top 15% access deprived areas. There are a higher proportion of GP patients living in the most deprived areas and GP practices are continuing to have a greater practice list than the Scottish average. These indicate potential issues with access to primary care, a factor which featured heavily in the feedback from the public and one which has the potential for worsening due to the large numbers of new houses planned for West Lothian in the next few years.

Access to primary care underpins early intervention and prevention and can help prevent unplanned or emergency hospital admissions. Lack of access to primary care can result in escalation of health issues which can translate into conditions requiring hospital admission such as infections (an issue raised by some staff in the needs assessment). Feedback from the public indicates a desire for local care and care at home but the data for the area highlights issues with emergency, preventable and repeat hospital admissions generally, and particularly amongst people living in deprived areas.

Primary care in West Lothian has already started to take action on access issues with the inclusion of other practitioner roles in GP practices, such as Physiotherapy, reducing the need for people to see a GP for certain health issues and the piloting of an extension to the District Nursing role to address common acute presentations and frailty assessments.

Community Pharmacies are also delivering support for minor injuries and illnesses through Pharmacy First and Pharmacy First Plus. With pharmacies being located in communities across West Lothian, this offers an opportunity to address some of the access issues if it is possible to increase the care and treatment role of local pharmacies. Although, it recognised that this might be limited due to a lack of qualified pharmacists nationally.

Pathways

Another key aspect of enabling access to support closer to home will be ensuring people know what support is available and are directed quickly, effectively and consistently to that support.

<u>Single Point of Contact (SPoC)</u>
The SPoC being piloted, could offer an effective pathway to ensure people can access appropriate primary care. If this could be enhanced by access to a comprehensive information portal outlining what support if available within localities, this could help people to make informed decisions about their care and treatment. The Third Sector Interface has a Service Locator portal which could perhaps be enhanced to address this information gap.

Mental health

The introduction of the Community Wellbeing Hubs and the Mental Health and Wellbeing Network offers people the opportunity of accessing support for issues affecting mental wellbeing such as anxiety, depression and stress, conditions which are increasing particularly in areas of deprivation across West Lothian.

Mental health and wellbeing have been raised by both members of the public and staff as issues of greater concerns post-Covid. Feedback from the public suggests a lack of awareness of how to access support and also difficulties in accessing GPs. There are Mental health Practice Nurses within GP practices who can refer people to the Hubs and it may of benefit to raise public awareness of this existing pathway.

9.1.2 Screening

Whilst the instance of cancer is considerably higher than the Scottish average, the data shows an increase screening uptake, particularly bowl screening, which indicates that more people are being screened. This, and the introduction of the Improving Cancer Journey in West Lothian, is likely to be related to the increase in cancer registrations. Whilst this is an increase in incidence, it can also reflect an increase in earlier identification of individuals and enabling earlier treatment.

However, the increasing is not mirrored equally across the population. Feedback from staff suggests that screening checks are not being applied consistently for people living with learning disabilities. Gaps in screening checks are being identified by staff in day care services and raised with primary care, however not all adults with learning disabilities receive day support. With an increasingly ageing population and people with learning disabilities living longer, the incidence of cancer and the number of years affected by cancer for these adults is likely to increase. It would seem essential to ensure that they receive the same screening checks as other adults in the population.

9.1.3 Age related care

The demographic and population projection data for West Lothian shows a population where older adults are increasing in number and will form a greater proportion of the population over time. The numbers of people aged 65 to 74 is expected to increase by 75% by 2028 and those aged over 75, equating to approximately an additional 13,000 and 11,000 respectively.

Improvements have been made in West Lothian to the numbers of people affected by Ischaemic or Cerebrovascular heart disease, however there are a number of other health issues which worsen with age and which are likely to be more prevalent in the future and where the number of years of life affected by these issues are already higher than other areas in Scotland, namely:

- Dementia which is also more prevalent in areas of deprivation in West Lothian
- Depression and anxiety which are more prevalent in areas of deprivation in West Lothian, where prescribing rates are also higher
- Osteoarthritis

- Back and neck pain
- COPD and COPD hospitalisations
- Falls which are increasing at a higher rate than the Scottish average.

The increasingly ageing population in the area suggests that the demand for care and treatment for these issues will increase over time and data from MSK services and feedback from staff in community hospitals and day care services suggest that demand for care and support for these health conditions is already being experienced. The expansion of the primary care teams and the development of advanced practitioner roles amongst non-medical teams in GP practices across West Lothian offers the opportunity for people to access care locally and to prevent the escalation of health issues through earlier intervention and linking with Third Sector organisations.

There has also been considerable work done in MSK services through the Waiting List Initiative which has reduced the waiting times from 16 weeks to 12 weeks, despite an increase in referrals. The learning from this approach could potentially inform other services to address waiting list challenges as speed up access to services. In addition, the approach taken in Psychiatry to adopting a digital approach to review appointments could also offer an opportunity to increase access and reduce waiting times if this could be rolled out in other services.

9.1.4 Hospital admissions

Feedback from managers and staff in this needs assessment indicates that hospital admissions have been reducing this year, however the published data and the feedback from hospital based staff is not yet reflecting this. Data is showing no reduction in emergency admissions and an increase in the number of hospital episodes, contrary to the national figures which show a decline of between 15% and 17% respectively. There is a concern amongst staff and members of the public that, with the lack of social care staff and the lower proportion of residential beds per head of population in West Lothian, further pressure will be placed on hospital services to accommodate vulnerable and frail people. Feedback from hospital teams indicates that there have been recent incidences where this has occurred. It would be beneficial to continue to monitor this.

9.1.5 Working practices

The staff highlighted that many of their patients/clients have multiple health and social issues which impact on their lives and that the process to assess people's needs did not reflect this. Staff and carers highlighted that people often had a number of assessments conducted by different services, providing the same information repeatedly. Limitations in information sharing amongst services was also highlighted, resulting in people being asked for the same information on multiple occasions. The members of the public, in particular, highlighted a desire for more joined up working among services and a more person-centred approach.

Streamlining the assessment process and including questions on the wider determinants of health would seem to offer an opportunity to provide patient and families with a more person centred approach and enable services to free up time and staffing. There are already

examples of wider assessment process which could be adopted, including the Holistic Needs Assessment used in the Improving the Cancer Journey, which includes capturing information on physical and emotional health, availability of carer support and wider determinants including benefits, debt and housing.

9.1.6 Support for carers

Whilst there is support for Home First, feedback from carers and advocacy organisations highlighted concerns at the levels of support available for carers. Participants felt that Home First could increase the demands on unpaid carers in families. Feedback from service users from vulnerable population groups (people living with dementia, learning difficulties or physical disabilities) indicated the important role families played, and continue to play, in enabling them to remain at home.

It is recognised that the HSCP provide funding to Carers of West Lothian, have a carers specific fund for people who are unpaid carers and that there is carers strategy being refreshed which highlights areas for carer support for the future and which reflects feedback from the recent Carers Survey. Whilst there has been an increasing focus on carers since the Carer Act in 2016, feedback from carers in this needs assessment suggests that there is not a consistent approach across statutory services for conducting assessments for Adult Carer Support plans. Several carers suggested that they had not been assessed or that the assessment process was still focused on the patient/client and did not truly assess the carers needs.

9.2 Key priorities for the future Strategic Plan

The published data indicates a substantially lower rate per head of population in West Lothian for care home places. Feedback from staff and providers suggests that residential and day care services are increasing their focus on people who can self-fund their care, as a means of addressing funding limitations.

One of the key concerns expressed by staff, providers, community organisations, carers and service users participating in this needs assessment is the sustainability of the Home First aim. This is essentially due to two issues – availability of people to provide the care (paid and unpaid) and the affordability of care provision.

Whilst the data has indicated the success of the approach taken in addressing delayed discharges in the area and that there is a proportionately higher number of people in the area who are cared for at home than the Scottish average, the feedback from staff and service providers suggests that issues are developing with discharges which may impact on the continued success. Discussions have highlighted:

- Difficulties experienced by hospital discharge teams in securing timely packages of care for patients
- Difficulties now affecting a wider range of geographical areas, including those where there has been new housing developments and therefore larger populations.

9.2.1 The health and social care workforce

The creation of a National Care Service is under consultation at present. This is intended to address the difficulties in delivering social care across Scotland. However, it is not known at this stage, how this will be implemented.

Meantime, there has been a considerable amount of work undertaken in relation to workforce planning and it is recognised that there is a Workforce Strategy about it be finalised for the HSCP. This addresses the organisational needs across all services for which the IJB has responsibility.

However, the workforce and delivery capacity are impacting on all care providers in all sectors. It would be beneficial, therefore to separate out measures aimed at encouraging retention of the existing workforce and those aimed at recruiting new people into the workforce.

Discussions with the services in the needs assessment has highlighted approaches which are being take to address role responsibilities and training and development to enable non-medical staff to undertake a wider remit.

It has also been recognised that there is a need to increase the total workforce that can provide health and social care and that this necessitates making social care, in particular, more attractive as a career option. Given the extent of the workforce issues, there is an opportunity to involve other sectors (private and third Sector) that provide day care and residential and nursing care in developing solutions to this issue.

A partnership approach between primary, community and acute sectors to addressing recruitment and retention issues in key roles including nursing and allied health professionals within the acute sector has also been suggested as part of the future workforce planning.

9.2.2 Ageing population

The population data indicates an increasingly ageing population, within substantial increases in the number of people who will be aged 65 to 74 years of age and those aged over 75. These are estimated to increase by over 13,000 and 11,000 respectively by 2028. The needs assessment highlights:

- Increasing prevalence of dementia generally
- Increasing prevalence of dementia amongst population groups with other complex health conditions such as people living with learning disability or physical disability
- Support services in the community which enable people to remain at home tend to have an upper age limit of 64 (which is lower than the current state pension age)
- A gap in services for “younger” older adults i.e those aged 65 to 74.

The nature of these conditions means that there will be an increasing number of people who are likely to need support to prevent hospital or care home admissions. There are a number

of private sector organisations that provided in-home care for these adults, however there may be affordability issues arising from the cost of care.

With the projected increase in population numbers and the likely increase in demand for support, there will almost certainly need to be an increase in community provision and residential care. There may be an opportunity for a partnership approach with the private and third sectors to plan for meeting that demand.

9.2.3 Pathways

Discussions with service users, carers and some service providers has suggested that there is a lack of clarity about what support is available in West Lothian. As well as making an information portal available with information on services and support and how to access them, the introduction of the Single Point of Contact (SPoC) offers an opportunity to enable more effective signposting to services and support.

In addition to this, adoption of a No Wrong Door approach is used in several local authority areas across the UK to help people access services. The approach aims to break down service silos and enable people to get to the right support no matter which service they contact. There is normally one single shared assessment, with information shared with other services as required and one person, the first point of contact, supporting the individual to ensure they are navigated to the service they need. This could fit well with the SPoC approach.

9.2.4 Gaps in provision

The needs assessment has highlighted gaps in provision for which there is increasing demand for support:

- Distress services and pathways
- Neuro developmental disorders
- In-home support for people with challenging behaviours
- Local support for people with physical disabilities
- Respite and specific support for elderly carers

Distress services and pathways

Feedback from staff indicates that there has been a general increase in people being referred to mental health services where there is no diagnosable mental illness but where there is mental distress, often arising from experience of trauma. These individuals are not suitable for mental health interventions. Concerns around emotional wellbeing were raised by members of the public and advocacy services in this needs assessment.

In addressing this demand for support, there needs to be:

- A clear distress pathway for referrals and support

- The pathway needs to be widely promoted to ensure awareness amongst practitioners and services that come into contact with people experiencing or having experienced distress
- Greater linkages with organisations that specialise in distress support.

Neuro developmental disorders

Feedback from staff suggests that there is a substantial increase in the numbers of people being referred for NDD assessment and that the waiting list is increasing. There is a need to increase the assessment capacity within West Lothian and to develop care pathways following assessment for those requiring support.

9.2.4 Partnership working

In-home support for people with challenging behaviours

Feedback from staff and support organisations working with people with challenging behaviours, such as people with personality disorders and people with dual diagnoses of mental ill-health and problematic substance, suggest that it is difficult to maintain these adults in their own homes or tenancies due to their behaviours. As a result, these adults are more at risk of homelessness and worsening mental health.

There are limited options for in-home support for these adults from other organisations. There is a mental health framework with a range of providers, however, it is often not possible to find care for this group of people. It would be beneficial to consider, with partners in housing and in the Third Sector, how tenancy support could be enhanced to prevent homelessness.

Local support for people with physical disabilities

The families of people with physical disabilities can incur considerable travel costs taking their loved one to the Astley Ainslie Hospital on a regular basis. Staff suggested that there may be an opportunity to discuss with Astley Ainslie the option of delivering more services locally to enable people to access support closer to home.

Respite and specific support for elderly carers

Carers and support organisations that participated in the needs assessment were concerned at the potential impact of Home First on unpaid carers. With an increasing ageing population, concern was particularly expressed regarding an ageing unpaid carer population with an increasing risk of the caring role impacting on their own health.

Whilst there is an increasingly elderly carer population, many younger carers also work. Participants highlighted a need for respite, both during the day and for a longer break. Respite provision is currently very limited amongst care home providers in the area. There is concern that, if the health of unpaid carers is adversely affected, particularly elderly carers, this will impact on discharge planning and also on unplanned hospital admissions.

9.3 In summary

The recommendations outlined above will enable the IJB to develop a Strategic Plan which will incorporate the actions needed to enable achievement of the Strategic Priorities of Tackling Health Inequalities in Partnership, Home First and Enabling Good Care and Treatment.

They build on progress to date and also address key gaps in support provision which are not only affecting particularly vulnerable population groups, but also are preventing the implementation of the supporting care at home and care close to home which is vital to delivering the Home First ethos

Appendix 1:

Health and Social Care Indicators - Overview

Indicators which are better than the Scottish average or improving

West Lothian picture	Indicators
Better than other areas	Drug related deaths (but still increased by 2/3rds since 2006)
Worse but improving - Indicators decreasing faster in WL	• Smoking attributable deaths • Impact of diabetes on life expectancy • Premature mortality from all causes (40% higher in the most deprived areas) • Rate of people hospitalised with CHD
Worse but improving - Indicators decreasing but more slowly in WL	• Alcohol related deaths • Psychiatric hospital admissions • Preventable & repeat emergency admissions • CHD, stroke and TIA

Indicators which are worse than the Scottish average and deteriorating

West Lothian picture	Indicators
Worse and deteriorating	• Alcohol related hospital admissions – slight increase, contrary to other areas • Maternal obesity rates & faster increase • Rate of diabetes & number of years of life affected • Prescription drugs for anxiety, depression or psychosis (comparable with other areas)

Indicators and deprivation

Health conditions which are worse in deprived areas in WL	
Asthma (hospital admissions	Decreasing but 39% higher in areas of deprivation
Cancer*	Cancer registrations increasing and 16% higher in most deprived areas (contrary to the Health Board and national average)
Mental health	• Prescribing rates for drugs for depression, anxiety or psychosis were 36% higher in deprived areas • Psychiatric admission rates were 81% higher with a lower rate of reduction
Prescribing	• Prescribing rates were 36% higher than for those in the least deprived areas.

Indicators where deprivation difference is 10% and above	West Locality	East Locality
Alcohol related hospital admissions	45% higher	
Drug related hospital admissions	44% higher	
Maternal obesity	10% higher	
Prevalence of diabetes	10% higher	
Prevalence of CHD*	10% higher	
COPD rates*	27% higher	
Prevalence of dementia	30% higher	
Depression and anxiety		53% higher
Prevalence of asthma	10% higher	
Asthma related hospitalisations	53% higher	
Repeat hospital admissions (over 65s	11%	
Rates of access deprivation	75% higher	

Health risks with age

West Lothian picture	Conditions
Number of years of life affected by age already higher than the Health Board and Scottish averages	• Osteoarthritis • Back and neck pain • COPD (including COPD hospitalisations) • Dementia • Depression and anxiety (but is reducing at a faster rate) • Falls (and increasing at a greater rate locally than in the Health Board or nationally)
Number of years of life affected by age currently lower than the Health Board or Scottish averages:	• Ischaemic heart disease (and has been reducing since 2104) • Cerebrovacular heart disease (with a faster rate of reduction since 2014)

Indicators and Home First

Indicators which support delivery of Home First
• The over 75s almost half the number of days in hospital despite being ready for discharge than national average • Slightly higher rate of people receiving care at home than the national average (2.3%) • 71.7% of adults in West Lothian who are supported at home agreed that their support was well co-ordinated (5.3% higher than the Scottish average) • Extent of discharge delays in West Lothian for health and social care reasons has reduced by 26% since June 2016 – July 2017, bringing it below the Scottish average • 7,643 occupied bed days (20/21)which were subject to a delayed patient discharge. Lower rate caused by health and social care delays compared to Scottish average

Challenges for Home First
• Lower rate of people receiving home care in West Lothian • Lower proportion of adults who are supported at home and agreeing they were supported to live as independently as possible. Higher reduction than national average • Higher % of people aged 65 and above requiring high levels of care at home • Considerably lower uptake of Options 1 and 2 for SDS • Only a quarter of carers in West Lothian felt supported to continue in their caring role

Challenges for Care Close to Home

- Care homes have high average occupancy rate of 88% - private and voluntary sector homes having occupancy rates in excess of 90%
- Lower rate of care home places - fifth lowest rate amongst all Scottish local authorities

Challenges for reducing unplanned admissions

- Increase in number of episodes treated in West Lothian hospitals contrary to national trend
- Increased number of hospital admissions
- Reduction in in-patient episodes from 2016/17 is lower than nationally
- A& E attendances at St John's Hospital reduced but less than the national average
- New outpatient appointments in West Lothian reduced from 2016/17, although reduction is less than the national average

Appendix 2:

Available services and support

Older adults

Maintaining people at home

A: Housing with Care – supported housing

West Lothian Council, in partnership with Housing Associations, provides housing, care and domestic services for 222 tenancies for older people (60+) who have care needs. The aim of supported housing is to promote independent living through assisting older people with support needs to reside longer in their own homes as an alternative to other forms of care.

A team of Housing Support staff provides practical advice, support and assistance from 7.30am to 10.00pm, after which there is a sleepover member of staff who would respond to emergencies and short term acute illnesses.

The service uses Smart Technology which can be tailored to offer a wider range of support and which enables Housing Support to respond quickly in a crisis or emergency situation.

Tenants are encouraged to remain active and independent with staff providing general housing support, professional care and domestic care services. There is also a community hub with a restaurant/café.

The accommodation is available in:

- Armadale: 30 tenancies
- Blackburn: 24 tenancies
- Bathgate: 28 tenancies
- Broxburn: 30 tenancies
- Crusader Court, Livingston: 32 tenancies
- Mid Calder: 20 tenancies
- West Calder: 30 tenancies

  Whitburn: 28 tenancies

B. Housing with Care – sheltered housing

Additional sheltered housing (60 tenancies), managed by WLC, are located in Bathgate

C. Retirement Housing

A range of Housing Associations offer retirement housing across West Lothian (618 tenancies)

- Armadale: 36 studio and one bedroom flats
- Bathgate: 102 flats
- Blackburn: 37 flats
- Broxburn: 71 flats
- East Calder: 26 cottages
- Fauldhouse: 33 flats
- Linlithgow: 27 one bedroom flats
- Livingston: 117 flats
- West Calder: 35 flats

- Winchburgh: 24 flats
- Whitburn: 76 flats
- Uphall: 32 flats

An additional 91 tenancies are offered by Housing Associations for sheltered housing with meals:

- Armadale: 22 tenancies
- Bathgate: 29 tenancies
- Linlithgow: 40 tenancies.

D. Home Safety Service

WLC's Home Safety Service support people to remain living at home by providing equipment installed in their own home that is linked to specially trained advisers who will respond to all alarm calls for help.

E. In-home care support

There are 13 independent organisations that provide in-home care for older adults to help maintain them in their own homes. All of these organisations provide support across West Lothian.

F. Day care

Braid Health & Wellbeing provide a day care service in Livingston for older people with a range of social and practical support services. The Day Centre caters for WLC funded places and self referral places. It also offers an outreach service.

Day Centres are also available in Bathgate (Acredale House) and Whitburn (Answer House).

G. Respite care

Seven (7) nursing homes, all privately owned, provide short term/respite care for older adults. These are based in:

- Bathgate
- Broxburn
- Fauldhouse
- Linlithgow
- Livingston
- Whitburn

H. Rapid Elderly Assessment Care Team (REACT)

The REACT service works as an integrated hub and is a single point of contact for frail elderly people over the age of 75 during an episode of acute illness. The service aims to help reduce unnecessary hospital admissions and unplanned care, providing prompt comprehensive assessment for frail elderly people and delivering interventions through a rapid assessment clinic based at St John's Hospital or an assessment at home.

The REACT staff team consists of a multi-disciplinary team of geriatricians, nurse practitioners, specialty doctors, physiotherapists, occupational therapists, pharmacists, administrative staff and a social care co-ordinator. They liaise with and complement existing core hospital and community health and care services to provide effective multi-disciplinary assessment and interventions using shared decision-making process towards patient-centred goals

Patients can only be referred into REACT by Hospital staff and GP's.

I. Support at Home Service

This incorporates the Re Ablement, Falls Assessment and Prevention, Home Safety Service and Crisis Care.

Re Ablement

Re-ablement provides a short term assessment service, ordinarily for no longer than six weeks with regular reviews of progress. The service supports and encourages adults to do a range of daily living tasks needed for everyday life. The level of service depends on progress

At the end of the assessment, providing eligibility criteria are met for paid services the Team will discuss a care at home package.

Falls Assessment and Prevention

This service, staffed by a falls assessor, takes referrals and provides a falls assessment as the result of a fall in the community, the aim being to intervene quickly when someone has fallen to try and reduce the risk of further falls and admissions to hospital.

Home Safety Service

Home Safety Service offer a broad range of technology designed to keep someone safe at home or summon assistance in an emergency situation. Services are mainly used by older people or people with disabilities but can also support people with significant health problems.

Crisis Care

This is a 24-hour service which works directly in partnership with Careline and assists anyone in West Lothian who has fallen, raises an alert through their Telecare equipment or is experiencing a crisis. The team may offer short term support to enable those in crisis to stay at home, where appropriate.

The Crisis Care Team in partnership with the Scottish Ambulance Service have developed a falls pathway which can avoid the need for someone to be taken to hospital. The Scottish Ambulance Service will complete an assessment to determine if it is appropriate to leave someone at home with the support of Crisis Care.

J. Community Occupational Therapy

WLC's Community Occupational Therapy (OT) Service promotes independence for children, adults and older people living at home who have physical, mental or learning disabilities.
The service promotes independence by giving advice on how to carry out tasks differently, suggesting equipment to assist with self care tasks, recommending alterations to property to

make the environment more accessible and signposting to other agencies for further support and advice.

The service has eligibility thresholds and a financial assessment for the provision of equipment and adaptations based on ability to pay

A referral can be made by anyone via the OT Duty Team and cases should be allocated within 6 weeks of receipt of referral and and high priority cases within 7 days.

Maintaining people close to home

A. Residential care

WLC operated 4 residential care homes in West Lothian for people who have been assessed as no longer able to manage in their own home. These accommodate a total of 141 residents in:

- Livingston (69 residents)
- West Calder (40 residents)
- Whitburn (32 residents).

A range of private sector providers also offer approximately 41 places for older adults, primarily in Livingston, with 1 provider in Broxburn.

B. Nursing homes

All nursing home provision is within the private sector in West Lothian. Nine (9) providers cater for up to 550 residents:

- Armadale: 60 residents
- Bathgate: 120 residents
- Broxburn: 115 residents
- Fauldhouse: 57 residents
- Linlithgow: 80 residents
- Livingston: 118 residents

Other support

Advice Shop

Based in Bathgate, the Advice Shop offer a targeted service for anyone living in West Lothian and offers support and advice on a range of issues including benefits, energy, money/debt and housing.

Advocacy

EARS, in Livingston, provides support for older adults, attending meetings or appointments with/on behalf of service users, assisting writing letters, emails or making phone calls.

Befriending/social contact

A range of voluntary organisations offer befriending and/or social contact opportunities. The majority of these are in Livingston and Bathgate, with single organisations offering support in:

- Armadale
- Blackburn
- Broxburn
- Fauldhouse
- Linlithgow
- Mid Calder
- Whitburn
- Uphall.

Mental health

Maintaining people at home

A. Acute Care and Support Team (ACAST)

The ACAST service provides home treatment for adults under 65 years suffering acute mental health problems. The service offers an alternative to hospital admission and facilitates early discharge. It provides same day unscheduled mental health assessment.

The service, based in St john's Hospital, operates daily from 8.30am to midnight

B. Community Psychiatric Nursing Team

The CPN Team work to reduce the need for patients to come into hospital by providing a comprehensive assessment and care management plan for individuals and their families.

Based in St John's Hospital, it operates Monday to Friday 9am to 5pm and accepts multi-agency referrals.

C. Community Psychiatric Nursing Older Adults Team

The CPN Team provides a comprehensive assessment and care management plan for individuals over 65 years and their families.

Based in St John's Hospital, it operates Monday to Friday 9am to 4.30pm and accepts multi-agency referrals.

D. Elderly Day Services

This service provides assessment and treatment for people over the age of 65 years (under 65years if diagnosis of Dementia) who have mental health problems.
There is also a Specialist Healthcare Elderly Day Service which provides assessment and management for people with mental health problems whose needs cannot be met within mainstream day care.

Based in St John's Hospital, it operates Monday to Friday 9am to 4.30pm and accepts multi-agency referrals.

E. Older People's Community Mental Health Team

The team provides intensive assessment and treatment of people 65 years and over with a mental health illness, to provide care and treatment to the person in the community setting to prevent a hospital admission whenever possible. The team also supports early discharge from hospital back to the community setting.

The service is provided from St John's Hospital and is available 7 days a week with and out of hours service available to 8pm.

F. Community Outreach Team

Based in Bathgate, the Community Outreach Team (COT) and Day Services provides a community based service to people with severe and enduring mental illness and complex needs, promoting independence and enhancing coping strategies.

The service operates Monday to Friday to 5pm and accepts multi-agency referrals.

There is also an out of hours team which provides a weekend service from 10am to 6pm which supports existing clients of the Community Outreach Team.

G. Occupational therapy

The service provides OT assessment and intervention. Outpatients are referred through West Lothian Mental Health triage and directly from secondary care. Based in St John's Hospital, it operates Monday to Friday 9am to 4.30pm.

H. Strathbrock Mental Health Resource Centre

Based in Bathgate, the service is part of West Lothian Community Mental Health Day Services. The Centre caters for individuals with a severe and enduring mental illness who do not require an intensive input but benefit from ongoing support and assistance. The service work in partnership with a wide range of statutory and voluntary organisations and carers.

A weekly Continuing Care Clinic is held at the Centre along with Clinics at Carmondean, Dedridge and Linlithgow Health Centre's providing Clinical Care locally. Trained staff also provides an input to a Clozapine Clinic at St John's.

The service operates Monday to Thursday, 8.30am to 4.30pm and accepts multi-agency referrals.

I. West Lothian Wellbeing Network

The West Lothian Well-Being service works with charities and social enterprises in West Lothian to support mental health and wellbeing by helping people before they need to see a GP or go to hospital. The service is managed by West Lothian Social Enterprise Network.

It is a person-centred service that discusses people's needs and liaises with local partners' services to connect people to personalised support. The service is open to those aged 18 and over, living in West Lothian.

Referrals are received via an online self-referral form and a meetingis set up to discuss and expand on the help request. An agreed plan is made based on individual needs, permission to discuss anonymised information with potential support partners agreed and follow up contact agreed to discuss support options available.

I. Lanarkshire Association for Mental Health (LAMH)

The service supports people to remain living independently and safely in their own homes through the provision of housing related support. This service is voluntary and available for

as long as is needed. Support is available on a 1 :1 basis and includes finance and budgeting, debt advice, housing support, creating routines and developing coping mechanisms.
Referrals are received from Social Work or other mental health professional.

J. Bathgate House Day Service/81 Club

Bathgate House and the '81 Club provides Mental Health Day Services for adults aged 18+ in the form of Groups and Community Outreach to people suffering from severe and enduring mental health problems, who no longer need intensive support from the Community Outreach Team, but require ongoing involvement with services. Bathgate House also hosts two Depot clinics and one depot clinic in Whitburn.

Bathgate House works in partnership with West Lothian College and various voluntary sector agencies to provide a broad spectrum of opportunities.
The '81 Club is based in Whitburn Community Centre and provides the same service to adults in the Whitburn/ Fauldhouse area.

Bathgate House and the ’81 club operates Monday to Thursday 8.30am to 5pm and Friday 8.30am to 4pm. It has open referral access from multi-agencies.

K. In-home care support

There are 3 independent organisations that provide in-home care for adults with dementia to help maintain them in their own homes. All of these organisations provide support across West Lothian.

L. Respite care

One privately owned nursing home in Broxburn provide short term/respite care for adults aged 60+ with dementia.

M. Community wellbeing hubs

There are two (2) Community Wellbeing Hubs, one in Livingston and one in Boghall and all GPs in the West Lothian area can signpost to them. The Hubs have a team of NHS therapists and Community Link Workers, employed by Lanarkshire Association for Mental Health (LAMH).

They support people with common mental health difficulties such as anxiety, depression and stress who have been signposted by their GP practice.

N. Access2Employment Wellbeing Team

The Access2Employment Wellbeing Team offers coaching workshops and talking therapies for lone parents, people in a workless household or on a low income. Support is available via telephone and online.

O. Advocacy

There are 5 advocacy services who can support people living in West Lothian with mental health issues. These are:

- The Advice Shop in Bathgate, offers a targeted service for anyone living in West Lothian and offers support and advice on a range of issues including benefits, energy, money/debt and housing.
- The Mental Health Advocacy Project for people who experience mental health and/or addiction problems. Support is provided across a range of issues which may impact on mental health, including housing, benefits, criminal issues and caring responsibilities
- Wellbeing Scotland
- Passion4Fusion: Based in Edinburgh, Passion4Fusion provides advocacy support for people from ethnic minority groups across the Lothians
- MECOP: Based in Edinburgh, MECOP provides advocacy services for a range of ethnic communities.

P. Community mental health and wellbeing service

Health in Mind provide a community based mental health and wellbeing service for those aged 55 or over. Support is provided on a one-to-one or group basis and can be accessed by referral from another agency or self referral.

Q. Homeless Health Team

A partnership between WLC and NHS Lothian, the aim of the Homeless Health Team is to improve and maintain the mental health and well-being of homeless people. Two Community Psychiatric Nurses provide a flexible outreach service to people who have concerns about their mental health and are homeless or at risk of homelessness in West Lothian. The team:

- Provide assessment and implement planned nurse intervention and mental health support to people whilst in temporary accommodation
- Identify mainstream agencies which are best placed to meet the mental health needs of those who are homeless
- Provide support and advise on health issues to those working with homeless people
- Provide health promotion and education on mental health and wellbeing for clients and those supporting them.

R. Practice Nurse Mental Health Service

Each GP practice in West Lothian has access to a Mental Health practice nurse to support adults aged 18 – 64 who are experiencing mental health, stress, anxiety, depression, low mood, panic attacks or similar. The service sees patients requesting a GP appointment to assess mental health and signpost to appropriate help.

S. Counselling services

There are organisations offering counselling support by qualified counsellors which are available for people living in West Lothian:

- Polbeth Community Counselling for people experiencing depression, anxiety or loneliness
- The Bridge Counselling Service

- LGBT Health & Wellbeing provides a helpline and a free counselling service
- Wellbeing Scotland support to identify and access appropriate help and support to resolve practical issues getting in the way of recovery

T. Support groups

There are a range of organisations operating support groups which could accessed by people living in West Lothian. These include organisations offering:

- Social and networking activities to address isolation, anxiety, low mood etc
- Organistions supporting ethnic minority groups
- Financial resilience and wellbeing (The Bridge Financial Wellbeing Service)
- Befriending

U. Trauma support

- Two organisations offer bereavement support to adults, one of which is based in Livingston
- Two organisations offer support for bereavement through stillbirth or miscarriage. Support is provided through telephone and online
- Childhood sexual abuse: two organistions provide practical and emotional support for survivors of childhood sexual abuse. One is based in West Lothian and the other in Falkirk
- Suicide: Three organisations offer support to people affected by suicide. One is based in Livingston and the remaining two offer telephone and online support
- One organisation provides skills and support for survivors to move on from trauma

V. Online support

West Space is an online space for mental health and wellbeing information in West Lothian. It provides:

- Information about local mental health and wellbeing services and support
- A platform to promote positive mental health and wellbeing through connecting people to local activities and places
- Resources to support self-help and self-management.

There are also a range of apps available for people to download, including Headspace, Feeling Good and iThrive and telephone helplines such as Breathing Space

Maintaining people close to home

A. Pentland Court

Pentland Court at St John's Hospital supports adults aged 18+ to aid with severe and enduring mental illness in a 12 bed unit. The team, working collaboratively in partnership with community services and other support networks, provide clients with the opportunity to gain the confidence, skills and experiences to rebuild a meaningful life in the community.

B. Ward 1, Intensive Care Psychiatric Unit (IPCU)

The service provides 24 hour inpatient care for adults 18+ with acute mental health illness who require a secure environment and more intensive treatment. The 10 bed ward in St John's Hospital, supports early discharge from hospital back to the community setting.
Patients in Ward 1 also receive support from the Occupational Therapy team who provide assessment and intervention.

C. Ward 3, St John's Hospital

Ward 3 is a 12 bed Acute Psychiatric Assessment Ward for over 65 year olds. It supports early discharge from hospital back to the community setting. Patients in Ward 3 also receive support from the Occupational Therapy team who provide assessment and intervention.

D. Ward 17, St John's Hospital

The service provides 24 hour inpatient care in a 22 bed ward for adults 18+ with acute mental health problems that cannot be safely treated at home. Patients in Ward 17 also receive support from the Occupational Therapy team who provide assessment and intervention.

E. Residential homes

WLC operates one residential home, based in Livingston, for people over 65 with mental health problems.

F. Nursing homes

There are two privately owned residential homes who support residents aged over 60 years with mental health problems, one in Armadale and another in Broxburn.

Adults with dementia

A. Roseberry Wing, Tippethill Hospital

Roseberry Wing is a 16 bed Continuing Care Unit in Tippethill Hospital in Armadale for females over 65 years with dementia and requiring complex care, often due to stressed/distressed behaviours.

B. Maple Villa, Livingston

Maple Villa is a 12 bed Continuing Care Unit in Livingston for males over 65 years with dementia and requiring complex care, often due to stressed/distressed behaviours.

C. Nursing homes

All nursing home provision is within the private sector. Nine (9) providers cater for residents with dementia, providing nursing as well as personal care. These are based in:

- Armadale
- Bathgate
- Broxburn
- Linlithgow
- Livingston
- Whitburn

D. Day centres

The Roseberry Centre in Polbeth provides day care facilities for people with dementia and support people in Livingston, East Calder, Mid Calder, West Calder, Uphall and Pumpherston. In addition to events and activities, a befriending service is offerd as well as support for carers.

E. Dementia cafes

Dementia cafés offer a 'dementia friendly' place for people with dementia, their partners, families and friends to meet up for a chat and a coffee. Alzheimer Scotland operates Dementia Cafes in:

- Armadale
- Bathgate
- East Calder
- Fauldhouse
- Linlithgow
- Livingston
- Uphall
- Whitburn

F. West Lothian Dementia Resource Centre

Alzheimer Scotland's Dementia Resource Centres operates a resource centre for individuals who have a diagnosis of dementia, their families and carers, providing information and support, including access to a Dementia Advisor. Support includes:

- Carer support group
- Day opportunities for people in early, middle and late stages of dementia
- One-to-one support for people under 65
- A range of community activities and volunteering opportunities.

G. In-home care support

There are 9 independent organisations that provide in-home care for adults with dementia to help maintain them in their own homes. All of these organisations provide support across West Lothian.

H. Respite care

Seven (7) nursing homes, all privately owned, provide short term/respite care for older adults with dementia. These are based in:

- Bathgate
- Broxburn
- Fauldhouse
- Linlithgow
- Livingston
- Whitburn

Learning disabilities

Maintaining people at home

A. Day care

Eliburn Support Service
The service is operated by WLC , currently providing day care for up to 34 adults between 16 and 65 years with a significant learning disability and complex physical and health care needs. Adults have access to physiotherapy, speech and language therapy and nutrition.

The service, based in Livingston, is available Monday to Friday except for public holidays.

Pathways
Pathways, operated by WLC, provides day care support for up to 85 people with learning disabilities. It supports adults to achieve personal goals and help people to join activities like work, sport, learning, art and other hobbies.

B. In-home support

There are 3 independent organisations that provide in-home care for adults with learning disabilities to help maintain them in their own homes. All of these organisations provide support across West Lothian.

E. Respite care

Burnside in Uphall provides short breaks (respite) for up to six individuals, aged 16+, at any one time for up to a period of 14 days. The service provides respite support to carers as well as the chance for individuals to gain experience of living away from the family environment and learning a range of independence skills.

F. Community Learning Disability Team

The Community Learning Disability service provides specialist health care, advice and treatment to adults with a learning disability aged 16+ who are registered with a GP. This also includes advice and support for families / carers. The team supports other health and social care agencies to provide mainstream services to people with learning disabilities that will enable health improvement and reduce barriers when accessing services.

Recommended primary source of referral is through the GP however referrals are accepted from all sources.

G. Community Occupational Therapy

WLC's Community Occupational Therapy (OT) Service promotes independence for children, adults and older people living at home who have physical, mental or learning disabilities. The service promotes independence by giving advice on how to carry out tasks differently, suggesting equipment to assist with self care tasks, recommending alterations to property to

make the environment more accessible and signposting to other agencies for further support and advice.
The service has eligibility thresholds and a financial assessment for the provision of equipment and adaptations based on ability to pay

A referral can be made by anyone via the OT Duty Team and cases should be allocated within 6 weeks of receipt of referral and and high priority cases within 7 days.

H. Advocacy

Ace Advocacy West Lothian
ACE, based in Livingston, provides advocacy for adults aged 16 to 65 with a learning disability/additional support need, including Asperger syndrome and autism.

Advice Shop
Based in Bathgate, the Advice Shop offer a targeted service for anyone living in West Lothian and offers support and advice on a range of issues including benefits, energy, money/debt and housing.

EARS
EARS, based in Livingston employs two advocates to support individuals who have a learning disability and/or who are on the Autism Spectrum/ or have Asperger's or an acquired brain injury, on a one to one basis and group advocacy.

I Outreach

Community Inclusion Team
The Community Inclusion Team provides outreach programmes to enable people with a learning disability to be as actively involved as possible within their own communities. With the help of a key worker, individuals are encouraged to identify and develop a range of activities and support networks which will be an aid to the development of social learning and skills.

There are outreach groups in Bathgate, Broxburn, Livingston North, Livingston South and Whitburn., mainly based in the local community centre/partnership centre. Activities include interpersonal development, health advice,personal safety, ABE, accessing local sports facilities and work placements, self-travel training.

Number 6 – One Stop Shop
Based in Edinburgh, Number 6 offers outreach, play and leisure, social groups and social skills training for adults (16 and over) with High Functioning Autism (HFA) or Asperger syndrome (AS).

Scottish Autism
Scottish Autism provides outreach support to access social and leisure activities or liaise with other agencies in relation to training, employment and social welfare support. Outreach support can include the development of budgeting and independent living skills.

Scottish Autism also provides social independence group to provide an opportunity for individuals to meet and participate in social activities.

J. Other support

Disability West Lothian
Based in Pumpherston, Disability West Lothian provides information, practical equipment, training and workshops for people with learning disabilities in West Lothian

Maintaining people close to home

A. Deans House

Deans House, operated by WLC, is a purpose built unit comprising of four independent flats and six core ensuite bedrooms with shared communal areas. The House can accommodate 10 adults aged 16+. The aim of the service is to provide interim residential care with opportunities for residents to develop a range of skills necessary for them to move into more appropriate long-term accommodation.

B. Residential Homes

There are 11 private sector residential homes which can accommodate adults with learning disabilities. These are based in:

- Armadale (8 rooms aged 18+)
- Blackburn (4 rooms, younger adults)
- Broxburn (22 rooms younger adults, 5 rooms aged 18+
- Livingston (21 rooms younger adults, 5 rooms aged 54+).

There are no nursing homes in West Lothian that accommodate adults with learning disabilities and none of the homes provide respite care.

Physical disabilities

Maintaining people at home

A. Ability Centre Support Service

The Ability Centre in Livingston offers centre based and outreach service to adults aged between 16 and 65 who have a physical disability, based on assessed eligible need.

A variety of occupational, educational and therapeutic opportunities are available daily within the Ability Centre and each Outreach Group determines their own programme. Pre-employment skills, preparation and support is offered through the Supported Employment Service. Eligible adults aged between 16 and 65 with a physical disability can be referred for a centre based placement following an assessment of their needs.

B. Community Occupational Therapy

West Lothian Council's Community Occupational Therapy (OT) Service promotes independence for children, adults and older people living at home who have physical, mental or learning disabilities. The service promotes independence by giving advice on how to carry out tasks differently by suggesting equipment to assist with self care tasks, recommending alterations to property to make the environment more accessible and signposting to other agencies for further support and advice.

The Centre operates Monday to Friday 10am to 3pm and referrals to the service can be made by any service, with an aim to arrange an assessment visit to you within 6 weeks of referral.

Occupational therapy provides information on Community Occupational Therapy, Grants for Disabled People, Equipment and Adaptations and the Community Equipment Store.

C. Speech and Language Therapy

The Speech and Language therapy department, based at St Johns Hospital, provides a range of services that anticipate and respond to the needs of individuals who experience speech, language, communication and/or swallowing difficulties.

There is an open referral system, where referrals can be made by medical, nursing staff, other allied health professionals, education personnel, the patient themselves or parent/carer.

D. Sensory Support Service

The West Lothian Sensory Support Service is based in Livingston and provides advice, information, support and equipment for people who are deaf, deafened, hard of hearing, are experiencing sight loss (either partially sighted or blind) or who are deafblind (experiencing dual sensory loss).

The service is delivered by social work staff from both West Lothian Council and Deaf Action. The Deaf Action worker is a BSL (British Sign Language) user. The service can visit people in their own homes and assist with obtaining support based on an assessment of need. The

service can also refer to specialist services for assessment and provision of equipment or mobility training. There is a drop-in facility for BSL (British Sign Language) user every Tuesday from 1.30pm to 4.00pm at the Sensory Support Centre.

E. Community Rehabilitation and Brain Injury Service (CRABIS)

CRABIS, based in Bathgate, provides multi-disciplinary assessment and rehabilitation within the home or community setting to individuals over the age of 16 who have a physical disability and/or acquired brain injury. The service provides follow up and early intervention as required to individuals who have suffered a mild head injury.

The service is delivered by an experienced, multi-disciplinary team, including Occupational Therapists, Physiotherapists, Clinical Psychologists, Speech and Language Therapists and Rehabilitation Assistants. Its core aim is to improve the individual's independence, level of function, participation and quality of life.

Headway provides support and guidance to a network of locally-run groups and branches across the UK and Channel Islands. They offer a wide range of services, including brain injury rehabilitation programmes, carer support, social re-integration, community outreach and respite care.

F. Headway

Based in East Lothian, Headway UK provides support and guidance to a network of locally-run groups and branches across the UK and Channel Islands. They offer a wide range of services, including brain injury rehabilitation programmes, carer support, social re-integration, community outreach and respite care.

Maintaining people close to home

A. Residential homes

There are 6 privately owned residential homes which can accommodate people with physical disabilities (5 accommodate older adults, 1 accommodates young adults). They are based in Armadale, Broxburn and Livingston.

There are 2 privately owned residential homes which can accommodate younger adults with sensory impairment, one in Broxburn and one in Livingston.

B. Nursing homes

There are 4 privately owned residential homes which can accommodate people with physical disabilities (3 accommodate older adults, 1 accommodates young adults). They are based in Armadale, Broxburn and Livingston.

There are 3 privately owned residential homes which can accommodate older adults with sensory impairment. They are based in Armadalee, Broxburn and Livingston.

Substance misuse

Maintaining people at home

A. Community Addictions Service (CAS)

The Community Addictions Service (CAS) aims to enable individuals and families to take positive steps to recover from problematic alcohol and/or drug use. It offers specialised support and help to all adults including parents who are experiencing difficulties with alcohol and drugs. The team can refer clients to other services such as NHS Lothian for specialised treatment to become abstinent from substances or offer relapse prevention support to adults who need additional support to prevent lapse or relapse

CAS is one of four services working together, known as the West Lothian Addictions Care Partnership, to ensure clients are able to access the most appropriate help as quickly as possible. These services work together to provide access to drug and alcohol treatment, counselling and support and consist of:

- The Social Work Addictions Team
- NHS Addictions Service
- West Lothian Drug & Alcohol Service
- Change, Grow, Live

B. West Lothian Alcohol and Drugs Service (WLDAS)

West Lothian Drug and Alcohol Service aims to provide easily accessible, confidential and non-discriminatory services to reduce substance misuse related harm to individuals, families and the community of West Lothian.

Drop Ins
WLDAS offers drop-in services to access opiate replacement prescriptions, counselling, recovery or groupwork in Blackburn, Livingston and Bathgate.

Naloxon Drop Ins
There are drop-in centres in West Lothian to train people on administering Naloxon, which reverses the effects of an opiate overdose. Take Home Naloxon is also available by dropping into the NEON (a bus provide by NHS Lothian) available in Armadale, Bathgate, Livingston and Whitburn.

Counselling Support
WLDAS offers support and counselling to individuals, family members and carers who are affected by the use of alcohol and drugs. Visits are by appointment only.

Training
WLDAS delivers general and specialist training on a variety of drug, alcohol and tobacco related topics for a wide range of groups and agencies and user and community groups.

Awareness raising

WLDAS holds monthly student days to raise the profile of substance misuse as part of ongoing professional training and development and offers induction training for employers regarding alcohol, drug and tobacco use. Advice on the development and implementation of workplace substance polices, Employer & Employee advice, Counselling and Support are also available.

C. Cyrenians

Cyrenians offers after care support and services to those affected by alcohol and drug problems, providing a drop in facility based in Bathgate which offers activities, educational opportunities or supports people to return to work and a Recovery Café in Linlithgow.

D. Change , Grow, Live (CGL)

CGL works with adults to support their recovery from alcohol and drug problems, including those in prison or custody. Based in Bathgate, CGL offers information and advice, support groups and activities, working with adults who are stable on a prescription or abstinent to prevent relapse and develop coping skills and life skills.

There is a daily rehab programme community activities and wellness sessions. Sessions are currently provided online.

Referral can be made from agencies such as housing officers, mental health practitioners, social work and care agencies.

E. Breakaway Recovery Clinics

The Breakaway Clinics are run by staff from the Addictions Care Partnership in Bathgate, Broxburn, Linlithgow, Livingston and Whitburn. They offer a range of services, including:

- Information and advice
- Counselling
- Psychological interventions
- Individual therapy and group work
- Detoxification either at home or in hospital
- Blood Borne Virus screening, immunisation and advice
- Practical support for housing , financial issues, training and/or o employment.

F. In-home support

There is 1 independent organisation that provides in-home care across West Lothian for adults with problematic substance use to help maintain them in their own homes.

Adult social care

Maintaining people at home

A. Adult Social Care Enquiry Team (ASCET)

The team assess a person's needs to decide if care and support is appropriate, based on eligibility criteria. The team prioritise people who are at most risk based on safety and the risk of losing independence. Where the risk is lower, and the person is ineligible for access to paid services or support, the team provides information and advice.

Anyone can make a referral - including self-referral, family/friends/carers, GP or other professional. The service is available for adults over 18 years.

B. Support at Home Service

This incorporates the Re Ablement, Falls Assessment and Prevention, Home Safety Service and Crisis Care.

Re Ablement

Re-ablement provides a short term assessment service, ordinarily for no longer than six weeks with regular reviews of progress. The service supports and encourages adults to do a range of daily living tasks needed for everyday life. The level of service depends on progress .

At the end of the assessment, providing eligibility criteria are met for paid services the Team will discuss a care at home package.

Falls Assessment and Prevention

This service, staffed by a falls assessor, takes referrals and provides a falls assessment as the result of a fall in the community, the aim being to intervene quickly when someone has fallen to try and reduce the risk of further falls and admissions to hospital.

Home Safety Service

Home Safety Service offer a broad range of technology designed to keep someone safe at home or summon assistance in an emergency situation. Services are mainly used by older people or people with disabilities but can also support people with significant health problems.

Crisis Care

This is a 24-hour service which works directly in partnership with Careline and assists anyone in West Lothian who has fallen, raises an alert through their Telecare equipment or is experiencing a crisis. The team may offer short term support to enable those in crisis to stay at home, where appropriate.

The Crisis Care Team in partnership with the Scottish Ambulance Service have developed a falls pathway which can avoid the need for someone to be taken to hospital. The Scottish Ambulance Service will complete an assessment to determine if it is appropriate to leave someone at home with the support of Crisis Care.

C. Social Care Emergency Team (SCET)

The team provides emergency social work cover in relation to child and adult protection, statutory mental health assessments and family or care breakdowns.

The service is available out of hours, 7 days a week, including public holidays

D. In-home support

There are 13 independent organisations that provides in-home care across West Lothian for adults aged 18 and above to help maintain them in their own homes.

E. Criminal Justice Teams

Assessment and Early Intervention Team

The team operates a Court Social Work service at Livingston Court, prepares court reports for adults over 21 years who are awaiting sentence and provides bail supervision.

Community Payback Team

The team supports individuals on Community Payback Orders and Community Service and Delivery Orders and delivers offence-focused groupwork programmes. The team is responsible for the supervision of prisoners released on parole or licence.

Voluntary Throughcare

The team manages Drug Treatment and Testing Orders

Prison based social work team

The team provides a social work service to prisoners in HMP Addiewell who will be subject to statutory supervision on release. Prison-based Social Workers attend and contribute to Integrated Case Management meetings (ICMs) and are involved in release planning. As part of this, they prepare reports as required for the Parole Board, and have regular contact with community-based Social Workers and other appropriate services.

F. Advice Shop

Based in Bathgate, the Advice Shop offer a targeted service for anyone living in West Lothian and offers support and advice on a range of issues including benefits, energy, money/debt and housing.

Primary care and community care

A. GP practices

There are currently 22 GP practices across West Lothian. This will reduce to 21 when two practices merge later this year. The practice teams include GPs, Advanced Nurse Practitioners, Nurse Practitioners, Practice Nurses and Health Care Assistants. Practices are also supported by Advanced Physiotherapy Practitioners and Integrated Care Pharmacists, as well as having access to arrange of community health staff, including:

- District Nurses
- Midwives
- Community Psychiatric Nurses
- Physiotherapists
- Podiatrists
- Addiction Nurses
- Speech Therapists
- Advanced Dementia Practitioners.

Practice Nursing Team

The practice nursing team deal with minor illnesses, dressings, injections, contraception, vaccinations, cervical screening and treatment room services. There is also a phlebotomy service.

District Nursing Team

The district nurses proved flexible nursing care for people within their own home where there is a physical or medical reason for not attending the surgery.

Advanced Physiotherapy Practitioners

APPS work within the practice and support patients with a joint or muscle problem.

B. Podiatry

The Podiatry Service provides specialist clinics for diabetes, nail surgery and biomechanics. Treatment plans are based upon a patient's individual needs. Priority is given to those within high risk categories, for example, infection, ulceration, diabetic patients or patients with vascular disease.

The Service is available for St John's wards, day patients, outpatients, nursing homes and health centres. There is a limited domiciliary service for patients who are fully housebound (subject to a health and safety assessment).

Private sector

There is a private sector podiatry clinic which operates clinics in Livingston and Bathcgate.

C. Physiotherapy

MSK Physiotherapy Services help support people with MSK problems through education, advice, movement, exercise and other approaches. The team assesses and manages those

with specific (i.e. osteoarthritis, tendinopathy, post operative) and non specific (i.e. non specific back pain, non specific neck pain) MSK conditions.
Support is offered through:

- A Pain Management Programme
- GP Advanced Physiotherapy Practitioners (GP APPs)
- Spinal Advanced Physiotherapy Practitioners (Spinal APPs)
- Peripheral Advanced Physiotherapy Practitioners (Peripheral APPs)
- Hydrotherapy
- Gym Groups (at specified locations only)

Referrals to the service can be made by GPs or other healthcare practictioner.

Private sector
There are three private sector physiotherapy practices in West Lothian, two in Livingston and one in Linlithgow, offering physiotherapy and osteopathy.

D. Advanced Nurse Practitioner (Dementia)

This is a new role which has been introduced to deliver a Nurse-Led clinic for Dementia diagnosis, to reduce the waiting time for those referred by their GP.

E. Community Pharmacy

There are 34 community pharmacies in West Lothian:

- 17 in West locality
- 17 in East locality.

All the Pharmacies offer the following:

- Unscheduled care
- Medicines Care and Review Service
- Pharmacy First: the Pharmacy Strategy to encourage patients to contact their local pharmacy before their GP for minor injuries and ailments
- Emergency contraception
- Smoking cessation support
- Substance misuse/supervised services

Most of the provision is available Monday to Saturday, although 4 pharmacies open on a Sunday – these tend to be based in Supermarkets or Shopping Centres.

The extent to which other services are offered varies considerably, for example:

- Pharmacy First Plus, where the pharmacy provides a Pharmacist Independent Prescriber (PIP)-led service, is not available in 8 pharmacies (mostly in the East locality)
- Specialist support, eg stoma, palliative care, Hepatits C support etc is available in less than half of the Community Pharmacies.

Unscheduled/acute care

A. St John's Hospital

St John's Hospital is a teaching hospital, based in Livingston, that provides a range of hospital based services. It includes a 24-hour Accident and Emergency department and a range of specialist services including burns treatment and plastic surgery.

It also houses the Short Stay Elective Surgical Centre and hosts Lothian's specialist head and neck unit and the Hooper Hand Unit

B. Other support

Unscheduled care is also supported through:

- REACT: The service works as an integrated hub and is a single point of contact for frail elderly people over the age of 75 during an episode of acute illness. The service aims to help reduce unnecessary hospital admissions and unplanned care
- Crisis Care Team: a 24-hour service which works directly in partnership with Careline and assists anyone in West Lothian who has fallen, raises an alert through their Telecare equipment or is experiencing a crisis
- Out of Hours Nursing Service
- Lothian Unscheduled Care Service: provides out of hours primary medical services during times when GP practices are closed

C. Community Single Point of Contact (SPoC)

As part of Home First, an an Urgent Care Community Single of Contact (SPoC) is being piloted to provide professional to professional rapid access to community health and social and third sector teams.

The role of SPoC is to provide alternatives pathways to hospital front door presentation/ admission. The team will screen, triage, assess and develop an agreed plan. This plan will be communicated back to referrer, person, family and carers within 2-4 hrs to safely support a person within their familiar surrounding 'at home'. The intention is that developing and strengthening urgent care community pathways will help to reduce acute front door unplanned presentations and admissions as well as reducing the time from referral (by GP Practices /Scottish Ambulance Service (SAS)/Care Homes) to intervention by appropriate urgent care team.

Coordination of a person's care will be managed by the most appropriate team to avoid unnecessary duplication and multiple referrals.

The SPoC approach is being piloted with two GP practices; Linlithgow and Winchburgh and Out of Hours GPs teams.

Carers

A. Carers of West Lothian

Carers of West Lothian (COWL) is the carers organisation in West Lothian which has been commissioned to provide support to carers across the Health and Social Care Partnership. COWL offers a range of services, advice and support, including:

- Information and advice
- Training
- One to one emotional support
- Hospital based carer support
- Peer support groups
- Counselling
- Signposting and referral to support services
- Individual & group support for young carers
- Recreational Courses
- Short Break Funding
- Respitality

B. Other organisations offering support for carers

Alzheimers Scotland
The Dementia Resource Centre is based in Livingstone and there are Dementia Cafes in:

- Armadale
- Bathgate
- East Calder
- Fauldhouse
- Linlithgow
- Livingston
- Uphall
- Whitburn

Alzheimers Scotland also offers a carers group in Livingston.

Community Learning Disability Service
Offers advice and support for families / carers

Scottish Autism
Offers a helpline, advice and information for families and carers who are supporting someone with autism.

General adults

SPARK

Craigshill Good Neighbour Network (CGNN) was established 37 years ago to help address social isolation and loneliness in the local community. It provides a range of groups and events for adults each week which any adult in the local community is welcome to join.

Appendix 3:

List of teams and individuals engaging in the needs assessment

SMT - Finance, Performance and Transformation
Social Policy Group Managers Meeting
Weekly Health SMT
Commissioning and Transformation Group
West Lothian Health and Wellbeing Partnership (
IJB Strategic Planning Group
Adults with a Disability Providers Forum
Integration Joint Board Development Session
Mental Health Management Team
GP Cluster meeting (West)
Member of Mental Health Planning and Commissioning Board
Physical Disability Planning and Commissioning Board
Learning Disability Planning and Commissioning Board
Alcohol and Drug Partnership
Mental Health Providers Forum
Mental Health Wellbeing Network
St John's Hospital SMT
St John's Hospital Charge Nurses
Community Councils
Podiatry Management Team (Hosted Service)
Representatives from Community Regeneration Teams
Mental Health Teams
Adult Services
Discharge Planning Teams
Community Pharmacy
Day Care Services
Ability Centre
Mental Health Advocacy Project
EARS
Autism & Learning Disability Teams

Individuals

Jeanette Whiting
Jo McPherson
Rob Allen
Karen Love
Pauline Cochrane
Fiona Huffer
Carol Holmes
Mike Reid
Claire Ross
Neil Ferguson
Pat Welsh
Linda Yule
Greg Stark
Ashley Goodfellow
Gillian Amos
Katie McBride and Gillian Edwards
Anne Riley
Lorraine Bolton
Alan McCloskey
Robbie Preece
Alison Milne
Alison Wright, CoWL
Orla Crummey

Appendix 4:

Online survey questionnaires