East Lothian Health & Social Care Partnership

Planning Older People's Services

Options modelling and development summary report

July 2024

V 1.0 Approved 17/07/24

Contents

Background ... 3
Community Engagement ... 3
Hurdle Criteria Assessment ... 4
Options Modelling and Development ... 5
Process ... 6
Outcome of the modelling and development exercise ... 6
Next Steps ... 11
Revised timeline ... 11
Closing remarks ... 11
Appendix 1: Modelling and development summary reports by theme ... 12
Care at Home ... 12
Intermediate Care ... 14
Care Homes ... 16
Communication ... 19
Community ... 21
Day Centres ... 23
Dementia ... 27
ELHSCP Strategy, Operations and Staffing ... 30
Finance and Investment ... 39
Hospitals ... 40
Minor Injuries ... 44
Palliative and end of life care ... 46
Partnership Development ... 48
Pathways and referral routes ... 54
Primary Care ... 55
Technology ... 57
Transport ... 61

Background

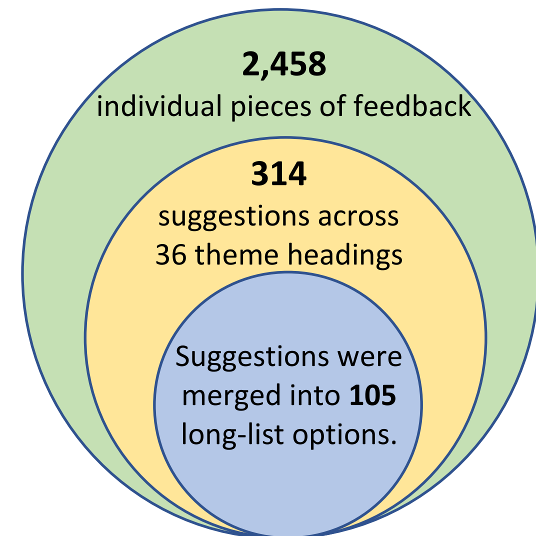
East Lothian's population is changing. People are living longer, and previous research has informed East Lothian Health and Social Care Partnership (ELHSCP) that many older people want to stay in their own homes for as long as possible[1].

ELHSCP is responsible for delivering effective older people's services. It wants to support individuals to make this choice become a reality. However, this cannot be achieved by ELHSCP alone. It needs to draw on the support, past-experiences and insights of county citizens and communities to continuously develop services to meet the needs of East Lothian's growing ageing population.

Community Engagement

ELHSCP arranged a series of community engagement events from August to December 2023, which formed the first part of a co-design process to develop the future provision of health and social care services for older people in East Lothian[2].

These events allowed ELHSCP to directly engage with 702 people, including community groups, Area Partnerships, members of the public, people with lived experience, staff groups, professional leads, carers, volunteers, medical professionals, third sector and independent advocacy organisations. There was also a focused workshop with East Lothian Integration Joint Board (IJB) members. A further 141 people gave their responses via an online survey and 11 completed printed questionnaires.



The engagement activities generated 2,458 pieces of feedback on how we can deliver or improve older people's services in East Lothian. Within this feedback, 314 suggestions were found across 36 theme headings.

These suggestions were then merged into 105 long-list options which progressed to the next stage of the Planning Older People's Services project development – an assessment of the long-list of options against pre-set hurdle criteria.

[1] https://www.eastlothian.gov.uk/pfap
[2] https://www.eastlothian.gov.uk/downloads/file/33891/provisioning_strategy_project_-_communications_and_engagement_report_aug-dec_2023

Hurdle Criteria Assessment

This activity involved each 'long-list' option being assessed against 4 conditions that needed to be overcome or met to progress to the next stage:

<u>Hurdle Criteria</u>

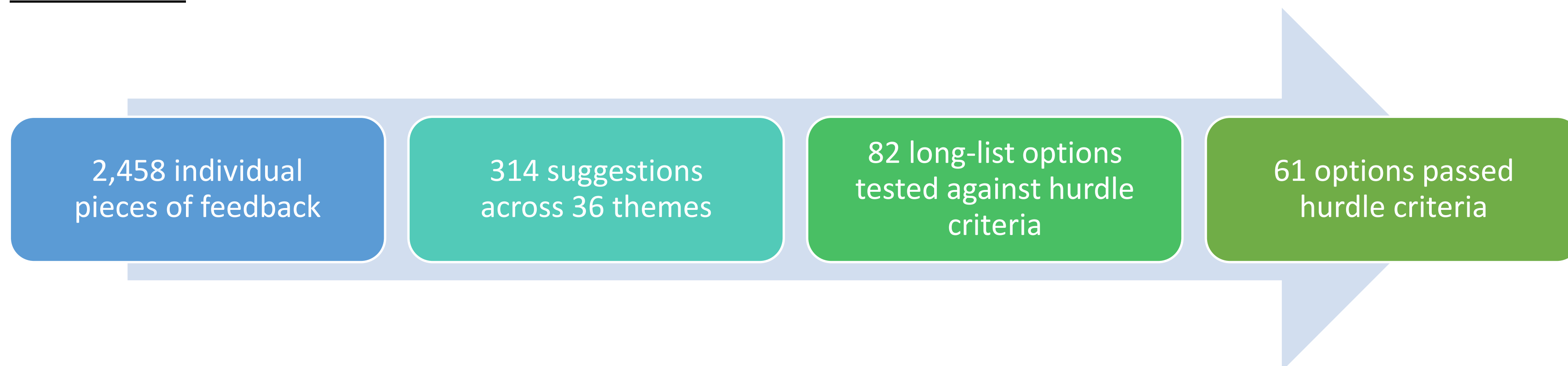
1. Will the option lead to increased wellbeing and improved outcomes for service users in East Lothian?
2. Will the option enhance service and clinical sustainability and is it able to evolve and adapt to meet future need? (e.g., does it meet the health and wellbeing needs of the present population, without compromising those of future generations?)
3. Will the option provide fit for purpose infrastructure that supports East Lothian's current and future older population?
4. Will the option achieve long term financial viability?

In preparing for the exercise, the 105 long-list options were able to be merged further, reducing the long-list options to a total of 82.

Of the 82 long-list options that were considered during this exercise, 61 were identified to progress to the short-list.

A full copy of the Hurdle Criteria Exercise results can be found on our project website.

<u>Process to date</u>



Options Modelling and Development

A summary of the short-list main themes is illustrated below.

Figure 1 - Planning Older People's Services Short-list main themes

Process

Of the 61 options that passed the hurdle criteria exercise, at the outset:

- 22 options were categorised as either action already underway or business as usual,
- 39 options were chosen to be go through the modelling and development exercise.

A report template was developed to guide senior managers on what should be considered for each of the 39 options. Officers were asked to consider strategic priorities, financial implications, timescales, staffing and workforce, procurement and commissioning, market conditions and demand, relevant data, anticipated benefits, outcomes and service impacts, strengths, weaknesses, opportunities, threats, risks and any related ongoing workstreams.

Appendix 1 provides a summary of the modelling and development reports for each option, and justification as to whether the option:

- will proceed to the options appraisal (next stage),
- has been regarded as an action already underway,
- will not progress further within the scope of the POPs project.

Outcome of the modelling and development exercise

16 options are recommended to proceed to the options appraisal.

40 options are regarded as action already underway / business as usual.

5 options are recommended to be withdrawn from further consideration at this point.

Figure 2 - Summary of options modelling and development results

The options progressing to the options appraisal exercise include:

Intermediate Care:	• ***Option 77***: *We should develop additional step-down services to ensure timely and safely managed discharges from hospital and ensure that older people are ready to go home.* • ***Option 53***: *We should look for opportunities to engage with the Leg Club Movement, designed to care for people suffering from or at risk of chronic leg disease within a social model of care.* • ***Option 79***: *Explore alternative and innovative approaches to intermediate care.* • ***Option 80:*** *As per the findings of the Provision Change Board, ELHSCP should increase investment in intermediate care services to ensure that we fulfil our strategic objectives, and our hospital / care home bed numbers are sufficient to meet our needs.* • ***Option 84:*** *We should invest in additional outreach services with appropriate transport to facilitate.*
Community:	• ***Option 6:*** *Consider introducing lunch clubs or some form of outreach service surrounding meal prep / delivery for the most socially isolated and vulnerable in East Lothian.*
Day Centres:	• ***Option 100:*** *We should explore the potential for using day centres as a respite opportunity for unpaid carers further.*
Dementia:	• ***Option 57:*** *We should review and develop provision of services to people living with young onset dementia. Care homes, day centres and a variety of other core services are not tailored to meet people's individual needs.*
ELHSCP Operations:	• ***Option 37:*** *We should develop a 24-hour helpline / single point of contact for providers, professionals and service users to provide guidance, assistance, advice regarding placement breakdowns, hospital admissions / discharge, out of hours support and a full-service directory.* • ***Option 58:*** *We should commission and structure health and social care services in a way that moves away from the older people / generational / geriatric model. We need to develop more intergenerational services for East Lothian residents throughout people's lifespan.*

Minor Injuries:	• ***Option 93:*** *We should develop a specific East Lothian minor injuries service to complement existing central provision (for example, services Minor Injuries services in Edinburgh). Full options development and appraisal would be required.*
Palliative and End of Life Care:	• ***Option 11****: Palliative and End of Life Care should be reviewed and mapped throughout East Lothian.* • ***Option 14:*** *We should develop an end-of-life care sheet that contains simple contact information, reassurance, and guidance for those caring for a relative at the end of their life.*
Primary Care	• ***Option 95:*** *We should introduce polypharmacy reviews and ensure that they are not exclusive to care home settings. (Polypharmacy reviews are important for people who are regularly prescribed five or more medications. Their aim is to ensure that the medications are effective, the patient isn't experiencing side effects and that all the medicines the patient is taking are still necessary.)*
Technology:	• ***Option 85****: We should explore better use of technology and associated services to allow people to remain within their own homes for longer.*
Transport:	• ***Option 104****: Transport links to key health and social care sites should be reviewed and developed in collaboration with ELC colleagues and existing service providers. Consideration should be given to commissioning services or developing volunteer initiatives. Wider transport considerations related to the provision of intermediate care should also be reviewed and developed. Good practice should be explored nationally.*

The options which are not being taken forward to the options appraisal exercise include:

Care Homes	• ***Option 31/32:*** *ELHSCP should scope and consider building / developing new care home sites as per the findings of the Community Hospitals and Care Homes Provision Change Board final report.* In line with recent balanced budget decision making and the IJB's ongoing 5-year financial planning, the building or development of new care home sites is no longer a possible option. This suggestion shall therefore not progress to the options appraisal exercise.
Hospitals	• ***Option 69:*** *Edington and Belhaven satellite hospitals should close with all community hospital beds located within East Lothian Community Hospital (ELCH). Consideration should be given to opening ELCH Ward 6 on a more permanent basis.* In order to achieve a balanced budget for 2024-25, the IJB approved the permanent closure of the inpatient beds associated with the Belhaven and Edington Hospitals. The IJB also agreed that following the discharge of all current patients, ward 6 at East Lothian Community Hospital would also close. As these actions are now being undertaken, option 69 shall not progress to the options appraisal exercise.
Primary Care	• ***Option 74****: ELHSCP should undertake a whole-system review for GP appointments. Accessing appointments and services can be particularly problematic for older people and those with mental-health conditions.* The Primary Care Directorate is currently reviewing telephony data across most practices in East Lothian to better understand the challenges around access to GP appointments. Given existing workstreams, improvement actions and the constraints of working to a nationally defined GP contract, a new whole-system review of GP appointments would be unfeasible and a duplication of other work. Further work is also being undertaken to review access to HSCP managed primary care services. As a result, it was concluded that option 74 shall not progress to the options appraisal exercise.

Technology	• ***Option 88:*** The *different IT systems we use across health and social care should be harmonised. We should have one cloud-based system that we can all feed into.* While option 88 would be fully supported by ELHSCP, harmonisation and development of integrated management information systems is an agenda that is larger than East Lothian Health and Social Care Partnership alone. Such an exercise would need to be taken forward by NHS Lothian, East Lothian Council and possibly at a national level by the Scottish Government. While ultimately highly desirable, a technological integration of this magnitude is out with scope of the Planning Older People's Services options, and therefore will not form part of the options appraisal.
Technology	• ***Option 89****: We should give Care Home staff access to TRAK in order to assist with continuity of care, care planning and discharge planning.* Providing external access to personal data would require approval from Information Governance and the completion of Data Protection Impact Assessments. While it was acknowledged that having access to wider patient information would be beneficial for care home staff, this is outweighed by the significant risks, and such a proposal would not be supported by NHS Lothian. ELHSCP is committed to sharing relevant information in a timely and accurate manner with care home teams to ensure that appropriate care is provided, however this option will not progress further to the options appraisal exercise.

The remaining options are considered work in progress:

The remaining 40 short-listed options are either already being taken forward within existing workstreams, projects or programmes, or the Senior Management have committed to incorporate them as a direct result of the *Planning Older People's Services* project.

Full details of each of these options are outlined within Appendix 1.

For each of the 'work in progress' options, the project team will endeavour to provide an update on how and where this option has been taken forward within the final *Planning Older People's Services* report.

Next Steps

We have now completed the first four stages of the Planning Older People's Services Project with the next step being the options appraisal exercise. This is scheduled to take place on 30 July 2024 by the Project Team and Independent Community Panel[3]. It will involve each option being assessed in terms of desirability, feasibility, and viability.

The options appraisal exercise is intended to narrow the number of options, (ideally to a maximum of 5 options), that will be taken forward to the public consultation stage and thereafter the Integration Joint Board for final consideration.

Revised timeline

Please note that the project timeline has been updated to take account of recent budget setting and financial recovery activity, the upcoming general election, and to ensure sufficient time is allocated to plan the consultation period.

A stakeholder and community update newsletter (#4) will be published in July 2024.

Figure 3 - Project timeline graphic

Closing remarks

The Planning Older People's Services project team would like to thank all stakeholders, the Independent Community Panel and Senior Managers for their continued support and engagement with this process.

[3] https://www.eastlothian.gov.uk/downloads/file/34184/independent_community_panel_handbook

Care at Home

Care at Home

Option 21: In order to improve outcomes, stability, service provision, terms and conditions and control over the market, careful consideration should be given to expanding the internal (HSCP) Care at Home service.

Option 23: There should be a wholesale review of scheduling and time management within Care at Home services (internal and external).

Option 25: We should review what constitutes the essential elements of a care package. Care-at-home services have cut back on the application of creams, administration of basic medications (e.g. eye drops), bathing and meal prep. This option has strong links to moving away from time-and-task model to a more outcome-focused approach that builds personal connections. There are also strong links with delaying discharge.

Option 8: (Intermediate Care) Volunteer befriender or sitter services should be explored to support people receiving care-at-home or end-of-life care, with specific focus on those with limited or no family and friends.

Report: Option 21, 23 and 25 were considered and modelled within a single report, alongside Option 8 by our Strategic Planning and Commissioning Officer with the lead responsibility for Care at Home.

Assessment: Our existing Care at Home Change Board is currently developing a locality-based care co-ordination model, which is bespoke to each community's needs. This will incorporate Technology Enabled Care (TEC), community third sector, intermediate care, rehabilitation, District Nurses and Care at Home, the latter being potentially commissioned via block contract with defined service level outcomes.

Option 21 previously formed part of the CAP Gemini Care at Home Review in 2023 with a recommendation not to expand internal services due to them being financially unsustainable with a preference for development of the locality-based care co-ordination model being the suggested course of action.

It is however recognised that existing internal services are a key partner within the new locality model and their role will be further enhanced alongside external providers in particular working in an outcome focused and collaborative manner.

Outcome: The development of the locality-based care co-ordination model and a proposed test of change will incorporate and explore each of the options in question (8, 21, 23 and 25).

It is therefore suggested that this work does not form part of the *Planning Older People's Services* options appraisal as it is being progressed via existing workstreams.

Option 18: We should develop and introduce locality-based block contracts with target outcomes for delivery of care-at-home/ intermediate care services. (There is potential for a pilot focused on internally provided care-at-home services in a local area, where commissioning and retaining external provision has been challenging).

Outcome: Option 18 was considered *Action already underway / business as usual* following the hurdle assessment criteria exercise.

This option is being taken forward by the Care at Home Change Board as part of the development of a locality-based care co-ordination model.

It is suggested that this option does not form part of the *Planning Older People's Services options appraisal* as it is being progressed via existing workstreams.

Intermediate Care

Option 53: We should look for opportunities to engage with the Leg Club Movement, which is a global initiative, designed to care for people suffering from or at risk of chronic leg disease within a social model of care.

Outcome: **Further scoping and risk assessment of the Leg Club Movement is needed, particularly in relation to which Health and Social Care Partnership professionals might have capacity to take this piece of work forward.**

It was acknowledged that there may be associated costs (initiation, staffing and recurring) but that an approach of this nature might act as early intervention and prevention measures in terms of chronic leg disease.

Option 77: We should develop more step-down services to ensure timely and safely managed discharges from hospital and ensure that older people are ready to go home.

Intermediate Care

Option 79: Alternative and innovative approaches to intermediate care should be explored further by ELHSCP (e.g. [1] Midlothian Community Respiratory Team; [2] 24 hour supported living services for older people in Glasgow; [3] Richmond Fellowship integrated day services for people with dementia; [4] Expansion of the Active and Independent Living Clinic at Well Wynd; [5] Pilot Intrapreneurship Programme by the Lens / Dumfries and Galloway HSCP [small grants / project investment]).

Option 80: As per the findings of the Provision Change Board, ELHSCP should increase investment in intermediate care services to ensure that we fulfil our strategic objectives, and our hospital / care home bed numbers are sufficient to meet our needs. The following services featured prominently in engagement phase 1: (1) Hospital at Home / Hospital to Home; (2) Care at Home; (3) Mental Health services; (4) Technology Enabled Care (TEC); (5) Day Centres; (6) Community hubs; (7) Occupational Therapy and Physio; (8) Pain Management.

Option 84: We should invest in more outreach services with appropriate transport to facilitate - like a roaming heart failure nurse, respiratory nurse, antibiotic nurse etc.

Report: Option 77, 79, 80 and 84 were considered and modelled within a single report by our Head of Operations.

Assessment: The final report[4] of the *Community Hospitals and Care Homes Provision Change Board 2021/22* and associated *Intermediate Care report* highlighted the breadth and depth of intermediate care services being provided throughout East Lothian and the benefits now being realised due to earlier investment.

Recommendation 3 of the final report encouraged the IJB to focus on extending Intermediate Care resources, develop new and more intermediate care provision and noted that it should be a key priority for further investment. Intermediate care is already a key strategic priority for the IJB.

The IJB remains committed to developing intermediate care services to provide care closer to home and ensure that East Lothian's population can remain within their own communities for as long as possible. Provision of efficient and effective intermediate care is also vital to alleviate pressure on hospital and care home beds.

Examples of ongoing development work include:

- Care at Home Change Board and associated developments.
- Implementation of the Dementia Strategy.
- Enhancing the use of technology within the East Lothian Rehabilitation Service.

Further information on the types of intermediate care currently available across East Lothian can be found within the *Change Board Intermediate Care Summary Report[5].* It is the Health and Social Care Partnerships intention to establish a small working group to explore current intermediate care provision and identify development / investment opportunities to build upon provision as per the recommendation of the previous Change Board final report.

Outcome: **Considering the recent balanced budget setting activity and East Lothian's growing population of older people it remains imperative that the IJB place intermediate care development at the heart of their future strategic priorities and directions.**

[4] https://www.eastlothian.gov.uk/downloads/file/33131/community_hospitals_and_care_homes_provision_change_board_final_report_2021-22
[5] https://www.eastlothian.gov.uk/downloads/file/33016/intermediate_care_report_summary

Care Homes

Option 31/32: ELHSCP should scope and consider building / developing new care home sites as per the findings of the Community Hospitals and Care Homes Provision Change Board final report (e.g., developing Belhaven site, redeveloping Eskgreen site, site in Preston Seton and Gosford, leasing entire building from current provider).

Report: Option 31, 32 and 34 were considered and modelled within a single report by our Head of Operations.

Assessment: On 28th March 2024 East Lothian IJB agreed their balanced budget for 2024-2025, which included the permanent closure of the inpatient hospital beds at the Edington (9 beds) and Belhaven (6 beds), as well as the decommissioning of the Abbey and Blossom House Care Homes.

These proposals outlined escalating concerns about the outdated building infrastructures, at the Belhaven and Abbey sites, which despite ongoing maintenance repairs are still not fully meeting health and care standards. The Abbey has an inadequate provision of showering/bathing facilities for the number of residents and does not fully comply with infection protection and control protocols. While occurrences at the Belhaven site related to security, fire hazards and lone working are posing risks to staff and residents on the premises.

Later this year both these care homes will close. Residents will be fully supported to move to an alternative care home of their choosing. A staged process will be planned and communicated to each resident, and where appropriate, their relatives. Likewise, staff will be consulted with and supported. This process will take time. It will be undertaken sensitively in line with statutory and regulatory guidance. Independent advocacy will be involved to help residents make the right choice for them.

Outcome: **In line with recent balanced budget decision making and the IJB's ongoing 5-year financial planning, the building or development of new care home sites is no longer a possible option.**

Consequently this option will not form part of the *Planning Older People's Services* options appraisal.

Option 34: If ELHSCP is unable to build or develop new Care Home sites, then consideration should be given to commissioning additional social work funded beds within existing care homes.

Assessment: In terms of commissioning additional social work funded beds, the Health and Social Care Partnership encourage all local care home providers to sign up to the National Care Home Contract (NCHC), which allows us to place Social Work funded residents. However, the NCHC does not stipulate what level of Social Work funded residents there should be or the balance with self-funding beds. For private homes to remain viable, it is often vital that they maintain a higher proportion of self-funders, the level of which is set by the home as a private business.

Although, there has been a marked increase in the NCHC price set for local authority residents over the last two years, this remains well below the self-funding market price. The Health and Social Care Partnership continues to negotiate and engage with private providers as we attempt to secure favourable splits between Social Work funded and self-funding beds. The NCHC is currently under review although there are currently no timescales for completion.

Outcome: **In light of the above information, and current financial situation, it is suggested that these options do not form part of the *Planning Older People's Services options appraisal*.**

However, it is strongly recommended that HSCP Senior Management and Officers collaborate with and support key community stakeholders in North Berwick and Dunbar in relation to exploring alternative uses for the Abbey, Edington and Belhaven sites (closely related to option 71 – see page 31/32 for further details).

This collaboration and an update will be featured within the final report of the *Planning Older People's Services* project despite not being considered as part of the options appraisal process.

Option 33: Professional support and training networks should be established between the Oak Tree Ward (ELCH) and care homes. Care home staff would benefit from the support / advice and additional training / awareness raising related to dementia, stress / distress and managing complex behaviours.

Option 35: ELHSCP should introduce an awareness raising and training programme for all care home staff related to supporting residents and family members with mental health issues. This could be linked with other issues (e.g., dementia, stress and distress, complex behaviours).

Option 36: We should develop and expand the role of the East Lothian Care Home Assessment, Support and Education Team (e.g., single point of contact, training for Care Home staff, short-term intensive support service to help keep complex cases local rather than moved to specialist provisions).

Report: Options 33, 35 and 36 were considered together by the General Manager for Acute and Ongoing Care.

Assessment: When the East Lothian Care Home Assessment Support and Education (ELCHASE) service was established, its aim was to provide assessment and support for people with dementia when they experience emotional and cognitive difficulties that result in distressed behaviour. The aim was to intervene early to provide an evidence based, formulation, which was person centred and offered strategies to prevent behaviour from escalating. ELCHASE also provided staff training across the care homes based on the Promoting Excellence Framework.

Recently the service has experienced several workforce challenges and as such is no longer providing the staff training element to care homes. An element of this service provision has been picked up by a temporary Band 7 member of staff who is currently delivering a rolling programme of stress and distress training across the East Lothian Community Hospital wards and Care Homes throughout East Lothian.

Following discussions with the Chief Nurse and relevant General Managers, it is the Partnerships intention to establish a Care Home meeting that focuses on the role and remit of ELCHASE in terms of supporting care homes, focusing on early intervention, prevention of admission, discharge planning and education. It is acknowledged that training for carers, families and care at home staff is also necessary due to number of admissions directly from the community.

Outcome: **Considering the ongoing developments and commitment to form a new working group it is suggested that options 33, 35 and 36 do not form part of the *Planning Older People's Services options appraisal*.**

Communication

Option 24: There is a lack of understanding and awareness related to Care at Home services. We must improve awareness and understanding in relation to the variety/type of assistance available, which providers are operating in East Lothian and who they support, and promote career/job opportunities.

Report: Option 24 was considered *action already underway / business as usual* following the hurdle assessment criteria exercise with development and modelling considered by our Senior Communications Adviser.

Assessment: The ELHSCP website has recently been updated with a dedicated section related to information and advice about "Care Assistance at Home"[6]. Over the coming months, this section will be expanded to provide further detailed information and advice for individuals, and their relatives, about the range of care at home services, and how they can be accessed.

The ELSHCP Communications Team is working with a variety of internal services to provide a range of printed literature in relation to self-directed support; purchase of key safes / external rails; meals at home; and home care – care at home services.

Outcome: Due to ongoing developments and improvements, **it is suggested that Option 24 does not form part of the *Planning Older People's Services* options appraisal.**

[6] https://www.eastlothian.gov.uk/info/210583/assessment_and_support

Option 81: We should promote and raise awareness of intermediate and community-based care. This may help to manage expectations, ensure the population know what is available and possibly improve recruitment.

Report: Option 81 was considered *action already underway* / *business as usual* with development and modelling considered by our Senior Communications Adviser.

Assessment East Lothian Rehabilitation Service previously owned a public facing website: 'abetterlife.eastlothian.gov.uk'. Instead of being stand-alone, the content of this website has now been integrated into the corporate ELHSCP website. This has allowed for enhanced management, development and promotion of the pages. It also provides members of the public with a more accessible means of finding self-guided support and information on intermediate care services.

The new webpages provide support and information relating to Smart Home technology; self-help body map; slips, trips and falls advice; falls prevention advice; Technology Enabled Care (TEC); and Musculoskeletal primary care services. Discussions are underway to further develop the information and ways in which East Lothian Rehabilitation Service (ELRS) and intermediate care services can be promoted within these webpages.

Further to the online developments, the ELRS have established a monthly Tuesday morning radio feature in partnership with East Coast FM, to promote the different aspects of their service, and how individuals can take more control over their daily lives to improve their independence.

The ELRS also regularly share advice, top tips, demonstration videos and information about their services via their Social Media Platforms: Facebook and X (formerly Twitter).

Outcome: **Due to ongoing developments and improvements, it is suggested that Option 81 does not form part of the *Planning Older People's Services* options appraisal.**

Community

Option 6: Lunch clubs or some form of outreach service surrounding meal prep / delivery for the most socially isolated and vulnerable should be introduced across East Lothian.

Report: Option 6 was considered and modelled by our Planning and Performance Service Manager who also takes the lead on Day Centres.

Assessment: Many of our existing older people's day centres evolved from being lunch clubs but now support older people with complex care needs, as regulated services under the Care Inspectorate. Day centres should be seen as separate to the option under consideration, but form part of a pathway for people whose needs are too complex to attend a lunch club or community kitchen.

There are several lunch clubs and community-based kitchens already throughout East Lothian, which provide food with social interaction and the opportunity for meaningful activity. There are a variety of different models (e.g., Pencaitland Lunch Club; Our Community Kitchen; Fa'side Community Kitchen; The Hollies; Bite and Blether; Longniddry Wednesday Club; MILAN) that go beyond the provision of food. The most effective models are community led and provide social interaction/connection, meaningful activity, and healthy food.

Funding for the development of community-based services (through Carers Act Funding) has allowed day centres to offer meal delivery to more older people within the local community, which has proved to be valuable if a person chooses not to attend a community resource.

What is clear is that lunch clubs and community kitchens can play an important role in supporting older people to remain at home for longer, foster community links and maintain their health and well-being. They fit well into preventative approaches designed to optimise independence. Lunch clubs are relatively simple to set up and can be very adaptable to the resources available within any given community either geographical or shared interest. They also mobilise a huge volunteer effort often provided by older people themselves.

Taking a community development approach with key partners and with a strategic commitment at IJB level this option would support people to stay closer to home, in their own home or in a homely setting, whilst also helping to tackle social isolation and offering nutritious food.

Outcome: **Further development would support early intervention and prevention, demonstrate co-production with communities, represent an excellent invest to save opportunity, and support strategic commitments outlined with the Dementia and Carers Strategies.**

Option 51: We should develop and build upon existing volunteering schemes within communities (e.g., volunteer transport schemes, Gifford Community Volunteers, First Responder Groups, befrienders, buddy systems, food delivery / meal share, telephone support and check in, end of life support). This may help with social isolation, building community spirit, transport difficulties, mental health and poverty. Could be particularly useful in more rural locations and new housing developments.

Outcome: Option 51 was considered *action already underway* / *business as usual* following the hurdle assessment criteria exercise and is closely aligned with the development of a locality-based care co-ordination model.

The whole system approach and development of this model will incorporate the enhanced use and development of volunteering schemes in collaboration with Volunteer Centre East Lothian (VCEL) and other third sector partners.

It is therefore suggested that this option does not form part of the *Planning Older People's Services* options appraisal as it is being progressed via existing workstreams.

Day Centres

Option 49: ELHSCP should explore and develop an outreach service in collaboration with Day Centres. Service could potentially support carers, care at home provision and those at end of life.

Report: Option 49 was considered *action already underway / business as usual* with feedback provided by our Strategic Planning and Commissioning Officer with a lead for Carers.

Assessment: The ELHSCP has developed excellent relationships with day centres over the last few years and additional funding has been allocated, via Carers Act funding, for centres to explore models of outreach support in their local communities. Service hours and staff registration mean centres are not best placed to take on traditional care at home tasks, but they offer great opportunities for social support, breaks for carers, and to people who may not want or are not able to access building-based services, which could include people nearing end of life.

Out of nine centres, eight now offer community-based support that complements their building-based service. Link officers will continue to work with centres to encourage development of their outreach model. Any pilot of locality-based services as suggested under option 18 will include the day centre and exploration of their role within the locality approach.

Outcome: As work is already well underway and further consideration is due to be given as part of the development of more locality-based models, **it is suggested that this option does not form part of the *Planning Older People's Services Options Appraisal* exercise.**

Option 56: Day Centre provision should be extended to evenings and weekends.

Report: Option 56 was considered and modelled by our Planning and Performance Service Manager who also acts as the Link Officer to Day Centres.

Assessment: Older people's day centres have a key role to play in promoting independence and confidence of older people with complex needs and their carers by making local centres accessible and supportive. The recent service design and commissioning process has focussed on the challenges and costs of delivering a blended centre and outreach model.

The needs analysis identified that the service in highest demand amongst older people across all the geographical areas in East Lothian is replacement care, accounting for over 60% of referrals to social work department and a significant proportion are for people affected by dementia. The day centre provision is the main means of delivering this support. Discussions around what older people want in the future indicate the move towards a blended model of centre based and community support will better meet the needs of the group at the right time and place.

Nine Day Centres were successful in being awarded a contract for day centre provision for Monday to Friday in January 2024. Evenings and weekends were not included in the requirements due to lack of demand and insufficient HSCP funds. A recent needs analysis highlighted the complexity of the work undertaken in centres; increased costs and financial pressures for all centres as they are operating both centre and outreach (worsened by substantial increases in utilities and food costs); the impact of significant gaps in care at home provision; and major gaps in the availability of replacement care, for carers and cared for people across all geographical areas.

The service model has been developed in partnership with older people and their carers and aligns with national policies and guidance as well as the strategic plan for the Partnership including a focus on early prevention and intervention; reducing isolation; promoting self-directed support; addressing health inequalities; reduction in carer stress; working with people to maintain, improve or maximise independence.

To date, demand has been limited for centre-based support in evenings and weekends. One day centre is trialling services for weekends as an outreach activity; this involves taking the day centre users out in a small group for 5 hours to give the carers a break rather than use of the centre building. There is clear evidence from the engagement from the carer's strategy and the outreach work from day centres that replacement care and sitter-based services are a priority.

Following the recent service design and commissioning process there is insufficient evidence to support this approach. The following actions have been proposed:

1) Further monitoring of demand via quarterly link officer reviews;
2) An evaluation of the pilot being delivered by one day centre;
3) Further consideration of developing increased replacement care opportunities for carers at weekends and evenings via the development of a sitter service, to be taken forward via the Carers Change Board.

Outcome: Due to the significant development work already undertaken and ongoing and a commitment to review and adapt services as appropriate, **it is suggested that this option should not form part of the *Planning Older People's Services options appraisal.***

Option 100: We should explore the potential for using day centres as a respite opportunity for unpaid carers further.

Report: Option 100 was considered further by our Strategic Planning and Commissioning Officer with the lead for Carers.

Assessment: Day centres already provide a large amount of support to unpaid carers as a source of respite. All older people attending day centres live in the local community and most will have a carer who experiences respite as a result. Even where carers do not live with the person, the support may mean a break from phone calls or just peace of mind knowing they are well looked

after. Funding for development of community-based services (through Carers Act Funding) has allowed centres to offer this to more older people within the local community and supports the core service.

Day centres could be utilised to offer further respite opportunities to unpaid carers within service hours or at evenings and weekends but under existing contracts centres are only required to provide a buildings-based service

Monday to Friday so further resource would be required to support development. The Link Officer for day centres has committed to exploring whether centres are seeing demand for further respite provision.

Proposed development of an ELHSCP short breaks hub, giving information to carers on breaks from caring will start by exploring carers need for a break and as part of this can discuss whether day centres offer the kind of breaks carers are looking for. Feedback from previous engagement is that traditional building-based services do not meet individual needs in terms of flexibility and individualised support, community-based support is more able to achieve this but is more resource intensive due to the 1:1 support that is offered.

Centres are a great local resource and efforts to increase what they offer in relation to carer respite could add increased value and make them more sustainable in future. Much development to support centres to offer carer respite has happened over the last few years and without significant changes to contract arrangements it is difficult to see how centres could provide additional respite.

Outcome: **Consideration should be given to whether there are other organisations better placed to provide respite to carers such as care at home agencies that already meet registration requirements and have contract arrangements in place with staff supporting out of hours working.**

Dementia

Option 47: We should develop an awareness raising campaign and training programme in relation to dementia, including training for hospital staff, care home staff, day centre staff, carers, and other identified groups.

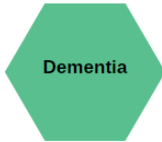
Report: Option 47 was considered *action already underway / business as usual* and feedback was provided by our Strategic Planning and Commissioning Officer with the lead for our Dementia Strategy.

Assessment: The content of this option forms a key part of the new Dementia Strategy and will involve collaboration across several teams, including, the NHS Care Home Team Education and Support, ELCHASE, the Quality Improvement Team and Planning and Performance dementia lead. The following bullets summarise progress to date:

- Hospital staff – training to be rolled out by the Dementia Specialist Improvement Lead based at East Lothian Community Hospital across medical for the elderly wards.
- Care Home staff – increase in capacity within ELCHASE service is required to enable care homes to continue to access face to face stress and distress training (please refer to options 33, 35 and 36 on page 13 for further details).
- Quality Improvement Team – ongoing work with Lothian Care Academy in developing specialist dementia stress and distress training that will be available to care home and care at home staff.
- Dementia strategy – has incorporated an action to develop training for carers supporting people with dementia including techniques for coping with stress and distress and will form part of the associated implementation plan.

Outcome: Due to the significant progress and development work already made due to the development and implementation of our Dementia Strategy, **it is suggested that this option not form part of the *Planning Older People's Services options appraisal.***

Option 57: We should review and develop provision of services to people living with young onset dementia. Care homes, day centres and a variety of other core services are not tailored to meet people's individual needs.



Report: Option 57 was considered further by our Strategic Planning and Commissioning Officer with the lead for our Dementia Strategy.

Assessment: Data gathered during development of the East Lothian Dementia Strategy showed that in 2022 East Lothian currently had an estimated 72 people with young onset dementia. This number is projected to remain static by 2040 (reducing slightly to an estimated 69 people), as East Lothian's population changes and increases will largely be in the age groups over the age of 65. Figures of those with an actual diagnosis of young onset since 2014 showed that 4 people were between the ages of 45-54 and 36 people between the ages of 55-64.

While a gap in services has been identified for people with young onset dementia through the work on the East Lothian Dementia Strategy, we need to bear in mind that development of these services must be proportionate to the needs of people with dementia in East Lothian as a whole. In 2022 there were estimated to be a total of 2,104 people with dementia of which only 3.4% were under the age of 65.

Development of a dedicated local care home provision or local day centre support for a small number of people under the age of 65 is not a viable option.

Outcome: **The work that needs to be done is around adapting and tailoring current services to better suit those with early onset dementia and providing a dedicated training programme for staff to support these individuals.**

Developing a range of community services remains a key priority in the dementia strategy, as it will benefit people with dementia of all ages. Identifying means of providing 1:1 support to meet people's personal outcomes, will make the support available more sustainable and adaptable.

Officers recommend that ELHSCP look at increasing local provision of community activities and services for people with early onset dementia and progress and scope joint commissioning with a neighbouring authority. However, it would not recommend that specialised care homes or day centres are developed given the low numbers of people that this would impact.

Option 59: In the spirit of people remaining within their own home / community for as long as possible, there should be sufficient dementia services within the community to achieve this.

Report: Option 59 was considered *action already underway / business as usual* and feedback was provided by our Strategic Planning and Commissioning Officer with the lead for our Dementia Strategy.

Assessment A summary of ongoing workstreams is included below:

- Increasing care at home capacity through the care at home workstream (locality-based model and use of Scotland Excel Framework).
- Increasing access to intermediate care.
- Increasing access to community-based activities and services that have been incorporated into the dementia strategy. This will include looking at increasing access to day centre support through evening and weekend services, befriending support, development of a new day centre in Musselburgh area, roll out of the meeting centre model to 5 satellite areas, developing the Post Diagnostic Support model from the current 1 year model to provision over the lifetime that people have dementia, developing further peer support for both people living with dementia and their carers.

Through delivery and implementation of our Dementia Strategy, increased development and investment in intermediate care and the strategic priority to enable older people to stay closer to home, in their own home or in a homely setting we are already well placed in terms of this option.

Outcome: **It is therefore suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

ELHSCP Strategy, Operations and Staffing

Option 7: ELHSCP should raise awareness of Future Care Planning (previously known as Anticipatory Care Planning) and ensure that it is embedded within health and social care practice.

Report: Option 7 was considered *action already underway / business as usual* and feedback was provided by our Senior Communications Adviser.

Assessment: ELHSCP is taking inspiration and best practice advice from the recent roll out of Anticipatory Care Planning within Edinburgh HSCP. Activity was summarised as follows:

- East Lothian Quality Improvement Team has been working with East Lothian care homes to promote Future Care Planning (FCP) training available on the NHS Lothian website[7] via Lothian Care Academy.
- ELHSCP is linking with Alzheimer Scotland Link Workers to roll out of Future Care Planning for people who will be in receipt of Post Diagnostic Support.
- With the individual's consent, the Key Information Summary (KIS) held on TRAK will be updated with a person's FCP requests, which can be accessed and used by emergency services / out of hours services if needed.
- Primary Care Teams are in discussion with Edinburgh teams to learn from their roll out of FCP, the updating of the KIS health records, and how to best adapt this for East Lothian's audiences.
- The ELHSCP website will be updated with key information about FCP, linking to the advice detailed on the NHS website[8].

Outcome: **As this option is being progressed and adopted, it is suggested it does not form part of the *Planning Older People's Services options appraisal.***

[7] https://services.nhslothian.scot/carehomes/education-and-training/acp-training/
[8] https://services.nhslothian.scot/futurecareplanning/

Option 37: We should develop a 24-hour helpline / single point of contact for providers, professionals, and service users to provide guidance, assistance, advice regarding placement breakdowns, hospital admissions / discharge, out of hours support and a full-service directory.

ELHSCP
Strategy
Operations
Staffing

Report: Option 37 was considered further by our Senior Communications Adviser.

Assessment: ELHSCP already has a 24-hour accessible website, which is being developed to provide a full-service guide to the health and social care services available in East Lothian, linking to supporting commissioned services, and third sector organisations.
There are additionally a wide range of existing telephone helplines available during office hours as follows:

- East Lothian (Council) Contact Centre is used to direct all social work / social care enquiries.
- ELRS have a direct telephone number for physiotherapy / occupational therapy and MSK assessments / appointments.
- CTACS and CWIC Mental Health share a phone line providing direct access to for patients to make appointments.
- Care at Home Service have own direct telephone number.
- Learning Disabilities have own direct telephone number.
- ELCH reception desk can direct calls to wards and OPDs.
- MELDAP have direct “The Contact Service” for drugs, alcohol and substance use related services and enquiries.

There are also further services available out of hours:

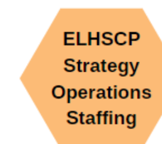
- NHS24 provide out of hours specialist health care advice via 111.
- East Lothian residents can contact the Emergency Social Work Service (ESWS) for situations that can't wait until social work office hours.

It is acknowledged that establishing a single point of contact or service directory would be beneficial to support older people to access the right care, in the right place and at the right time. However, a dedicated, all inclusive, telephone helpline would be extremely costly to establish and operate in both the short and longer term.

Outcome: **The following next steps were suggested by the Senior Communications Adviser:**

- ELHSCP continues to develop its website, providing an information resource for each of its services, including referral pathways and direct contact details.
- Where there is a potential to link services, e.g., East Lothian Rehabilitation Service, Primary Care and Social Work, a scoping exercise to develop a single point of contact telephone phone line should be considered to link connected services within existing provisions.
- It is also recommended that ELHSCP consider creating a printed ELHSCP directory of primary contact numbers to be made available for public distribution.

Option 40: A review of working relationships and lines of communication should be undertaken between health and social care services. Particular focus on GP practices to Care Homes; Oak Tree Ward (ELCH) to Care Homes; Occupational Therapy to Care Homes; Hospital discharge planning to Care Homes; Hospital at Home to GP practices; District Nurses to GP practices; Hospital discharge to Social Work.



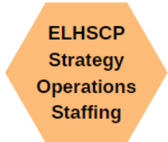
Report: Option 40 was considered *action already underway / business as usual* and feedback was provided by our Senior Communications Adviser.

Assessment: A summary of the actions taken to date is included below:

- The Chief Nurse currently chairs a professional leads meeting, including GPs and Clinical Nurse Managers across ELHSCP, that meets on a bi-monthly basis. At their next meeting, a discussion about internal integration communications opportunities will be added to the agenda.
- In addition, a District Nursing Review is already taking place, which includes a specific focus on developing media and communication strategies. This review incorporates representatives from acute, Allied Health Professionals, GPs and wider NHS Lothian links. The review is scheduled to conclude in October 2024.
- The learnings from this District Nurse review, will feed into the above-mentioned wider discussion about cross-service integration communication practices and how communication and working relationships can be enhanced between health and social care services.

Outcome: **As this option is already being progressed it is suggested that it does not form part of the *Planning Older People's Services options appraisal.***

Option 42: There are often long-delays in recruitment processes when it comes to employing new staff within ELC/ELHSCP care homes (and other services) often resulting in candidates accepting jobs elsewhere in the meantime. ELHSCP should work in collaboration with ELC Human Resources to review the process and attempt to streamline.

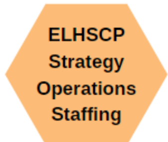


Report: Option 42 was considered *action already underway / business as usual* and feedback was provided by our Organisational and Workforce Development Manager.

Assessment: They confirmed that unfortunately due to the sensitivity of the posts and the current budget situation, there is no opportunity to streamline our current recruitment processes. There is a requirement for additional scrutiny and checks to ensure that we remain within budget and that the staff recruited pass the required pre-employment checks.

Outcome: **Due to this it is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 58: We should commission and structure health and social care services in a way that moves away from the older people / generational / geriatric model. People are living longer, long-term health conditions are not exclusive to 65+, care homes are generally not appropriate for younger people, mental health services for 65+ are limited, many people die before the 65+ mark etc. We need to develop more intergenerational services for East Lothian residents throughout people's lifespan.



Report: Option 58 was considered further by the Strategic Planning and Commissioning Officer who led on the ELHSCP Commissioning Strategy and Market Facilitation Statement.

Assessment: ELHSCP currently commission and deliver services in line with the IJB Strategic Plan and its own Commissioning Strategy.

Our approach and structure largely mirror medical systems within the NHS, national policy, legislation, and funding arrangements. One key area where East Lothian differs from the majority is in relation to Children's Services not forming part of the Integration Joint Board responsibilities and delegated functions.

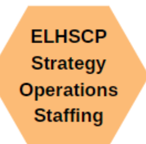
By embracing our own Commissioning Strategy, Market Facilitation Statement, and the findings of the Feeley Report, ELHSCP and IJB will focus more on care closer to home, intermediate care provision and outcome led care planning that places the person's individual needs, rights, and preferences above questions of affordability. Whilst developments and person-centred planning must be seen within the wider financial context it is key that assessments are the product of a full understanding of the individual's needs in the first instance rather than a decision-making process fuelled by financial limitations and structural bias from the outset.

Outcome: **A wholesale change to the generational approach to medicine and social care may not be achievable locally.**

However, our commissioning and local service delivery could adopt less stringent parameters. Instead focusing on delivering partnership services that rely on building compassionate relationships, breaking down barriers and focussing on the needs of the individual, rather than services, organisational structures, and financial bottom lines.

Intergenerational approaches and initiatives could provide health and social benefits throughout the lifespan and communities, with a particular focus on children, young people, and older people.

Option 66: We should review existing flow centre processes and infrastructure to ensure that staff are sufficiently trained to challenge and discuss all relevant care pathways and options.



Report: Option 66 was considered further by the Head of Operations within ELHSCP.

Assessment: A Flow Centre Navigation Programme Board is currently in place across NHS Lothian, with a detailed work programme that covers the following key workstreams:

- Develop workforce model with associated resources.

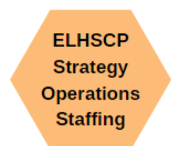
- Clinical pathways review board for pathway development and monitoring.
- Communication and engagement.
- Scope opportunities and plan future service delivery.

The Programme Board is Chaired by an NHS Lothian Director and includes representation from Acute, Primary Care and HSCP representatives. For ELHSCP the nominated representative is the General Manager for Primary Care. The Flow Centre Navigation Programme Board reports into the NHS Lothian Unscheduled Care Tactical Committee and then into the Unscheduled Care Board Chaired by the East Lothian Chief Officer.

Significant existing modelling surrounding pathway reviews and monitoring processes has already been undertaken as part of the boards work.
Ensuring that pathways and the skills of the workforce are optimised, are key to ensure that patients can access the right care at the right time. This is core to the strategic objective of care closer to home, reducing unnecessary admissions into acute hospitals, maximising resources, and developing our workforce.

Outcome: Given that there is an existing programme board, governance arrangements and workstreams ongoing across NHS Lothian related to the development of the Flow Centre, **it is suggested that this option should not form part of the *Older People's Services options appraisal.***

Option 76: We should adopt more collaborative commissioning approaches with community groups, taking account of elements of gender responsive budgeting and human rights.



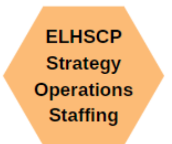
Report: Option 76 was considered and modelled by our General Manager for Planning and Performance.

Assessment: ELHSCP currently has a collaborative approach to commissioning, which is reflected in our overarching Commissioning Strategy and Market Facilitation Statement. In addition, Integrated Impact Assessments are completed on any new policy development or service change. This includes commissioning services to meet strategic objectives, which ensure we address any potential inequalities arising from our commissioning practices.

It would be prudent for ELHSCP to continue to review and take appropriate action to ensure it remains engaged with community groups when commissioning services. Communication and engagement strategies need to be developed in service (re)design and when commissioning services. It is important that these engagement strategies are effective in their delivery and ensure a balanced and wide-ranging voice is considered and represented.

Outcome: As this option and approach is already embedded within practice and supports existing IJB strategic priorities, **it is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 92: Staffing and workforce development should be better organised, advertised and facilitated at an ELHSCP level. This includes development of career pathways, training / development opportunities, reviewing job titles / roles to ensure they are reflective, and expectations are clear.



Report: Option 92 was considered *action already underway / business as usual* and feedback was provided by our Organisational and Workforce Development Manager.

Assessment: The ELHSCP Workforce Development Team have developed career pathways and training opportunities where appropriate. When teams require further training or advice regarding job reviews, this is provided when requested and is monitored within the Workforce Plan and Workforce Steering Group.

Outcome: As this is an ongoing piece of work with appropriate review and monitoring processes in place **it is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 98: We should explore cluster geriatricians / senior clinicians being made available for queries related to the increasing number of older people being cared for within their own homes and the community.

ELHSCP Strategy Operations Staffing

Report: Option 98 was considered further by the Clinical Director.

Assessment: Currently there is a single geriatric consultant in East Lothian who provides informal e-mail advice to GPs and primary care colleagues. It is acknowledged there are not robust systems in place for recording this advice on TRAK, ensuring timeous response, ensuring messages are not lost in other email traffic, holiday cover, etc.

Professionals can also seek advice from the Hospital at Home team in urgent scenarios where the aim is to avoid admission. To address this development of an 'advice-only' geriatric referral pathway via SCI Gateway (electronic web-based referrals portal used for all GP referrals) is being explored, which would make the process more robust, responsive, and accessible and would be auditable from a secondary care perspective. Following review this option was deemed to be in progress and incorporated within existing workstreams.

Outcome: **It is therefore suggested that it does not form part of the *Planning Older People's Services options appraisal.***

Option 101: The remit and role of the Care Broker Team should be developed and expanded. Some Social Work functions could be transferred, achieving better promotion and oversight of SDS, and a central point of contact for queries.

ELHSCP Strategy Operations Staffing

Report: Option 101 was considered further by the Adult Social Work Service Manager.

Assessment: The Care Broker Teams current remit primarily focusses on Care at Home Service Provision and purchasing of authorised care plans. They perform a primarily internal facing function with some communication with service users.

Development ideas are at a very early stage but include:

- Consideration is being given to how the role of the Care Broker Team could be developed and aligned with the developing
  locality model for Care at Home services, as part of a care co-ordination / community brokerage approach.
- More focus on care co-ordination, which is wider than care at home provision only and incorporates community supports and intermediate care as a whole.
- Nationally the conversation is about community broker teams having more of a presence and voice within communities. Roles and remits are expanding to include supporting Self-directed Support, direct payments, financial management and providing a more front facing service within communities.
- It is hoped that any changes to the Care Broker Team role and remit would help to support wider social work functions.

This scoping and development work is being taken forward by the Adult Social Work Service Manager as part of the ongoing Self-Directed Support (SDS) improvement project. Once initial scoping and development has been completed a paper will be prepared for presentation to the SDS improvement working group.

Outcome: **This option is already being scoped and developed as part of existing workstreams and as such it is suggested that it does not form part of the *Planning Older People's Services options appraisal.***

Finance and Investment

Option 72: NHS Lothian set-aside funding arrangements should be reviewed with a view to some funding being returned to local authority areas based on performance. Where local service improvements lead to reduced acute demand, this should be reflected from a funding perspective.

Report: Option 72 was considered by our Chief Officer.

Assessment: The IJB's Set Aside funding represents functions (services) that NHS Lothian (the Health Board) has delegated to the IJB related to services delivered by NHS Lothian on its Acute Hospital sites (largely the Royal Infirmary Edinburgh and Western General Hospital).

For 2024/25, the IJB has a total budget of £188.6m, of which the Set Aside budget is £18.7m. The IJB, through its Strategic plan may direct changes to the delivery of these services and therefore may move the funding resource from the Set Aside budget (the Acute Hospital services) to another part of the IJB's budget.

It is for the IJB to then decide which delivery partner (either the local authority or the Health Board) would receive such funding in line with the Strategic Plan. The Set Aside budget is currently overspent and the IJB is working with its partners to bring this budget back into balance.

Outcome: **As the IJB and HSCP are actively working with partners to monitor and review set-aside funding arrangements it is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Hospitals

Option 39: An audit of hospital readmissions should be completed to consider whether or not the pressure applied to get individuals discharged from hospital at pace is having a negative impact on their outcomes. Currently, appropriate discharge planning is not happening, information sharing is limited, and equipment is not put in place quick enough.

Report: Option 39 was considered by our Head of Operations.

Assessment: Several reports have already been compiled and reported in relation to hospital readmissions. The overall rate is tracked as part of Senior Management performance reporting. This reporting includes the number of readmissions to hospital within 28 days as part of the National Integration Indicators. Additional readmission rate reporting is included within the Local Government Benchmarking Framework, and it also features within the IJB Annual Performance Report.

Separate to this, regular NHS Lothian reporting via dashboard reports is considered regarding 7 and 28-day readmission rates. Based on the available nationally comparable data, East Lothian performs relatively well on the 28-day readmission rate, with 84.49 readmissions per 1,000 discharges compared to a national average of 101.7.

Further to the above, a request has been submitted to NHS Lothian Analytical Services to provide more detailed information at a patient level so that services can review readmissions to understand and identify potential improvements to the care pathway.

Outcome: **The audit and ongoing review of hospital readmissions is already embedded within existing practice and performance reporting, and it is therefore suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 65: Direct GP access to ELCH beds should be explored and simplified where appropriate (e.g., overnight monitoring, tests, supervision of medication, nurse led care, short term rehab / stabilisation).

Report: Option 65 was explored further by our Clinical Director.

Assessment: Provision of direct access to palliative care beds has been developed and implemented over the past six months. There is currently no direct access to hospital beds at East Lothian Community Hospital out with the palliative care route. Future work will be undertaken to improve and formalise the referral process and raise GP awareness of the option of direct admission for palliative care.

Direct admission to ELCH for more acute presentations would be complex and challenging to ensure safe care pathways. We are considering ways to optimise communication between GPs, hospital at home, medicine for the elderly and ICAT (Integrated Care and Assessment Team) to improve outcomes for patients and avoid admission to acute hospital wherever possible. Ongoing discussions are taking place between the Clinical Director, ICAT Service Manager and the Clinical Lead for Medicine to the Elderly.

General practice is vital for the ongoing care of the most vulnerable people in our communities including older people and those with mental health difficulties. The ongoing work and developments to improve access to services, through the Primary Care Implementation Plan and development of Multi-disciplinary Care Teams, is focussed on allowing GPs more time with the people who benefit most from continuity of care.

Effective delivery of general practice is at the forefront of delivering care within the community and enabling people to remain within their own homes for as long as possible, avoiding the need for unnecessary admission to hospitals or care homes.

Outcome: **Pursuing direct GP admissions to ELCH would incur some significant risks and therefore alternative processes to address these scenarios are being considered. Due to this it is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 69: Edington and Belhaven satellite hospitals should close with all community hospital beds located within East Lothian Community Hospital (ELCH). Consideration should be given to opening ELCH Ward 6 on a more permanent basis.

Hospitals

Report: Option 69 was considered by our General Manager for Acute and Ongoing Care.

Assessment: On 28th March 2024 the IJB approved the permanent closure of the inpatient beds associated with the Belhaven and Edington Hospitals and all inpatient beds are now located within East Lothian Community Hospital. Some of the patients originally associated with the Belhaven and Edington beds were originally moved to ward 6 within the Community Hospital and as such they have since been informed of the IJB decision and discussions will continue to plan their safe discharge from hospital. Once these patients have been discharged it is the HSCP's intention to close ward 6 because there is currently not a need for them, and it is an IJB strategic priority to support people to remain within their own home or a homely setting for as long as possible.

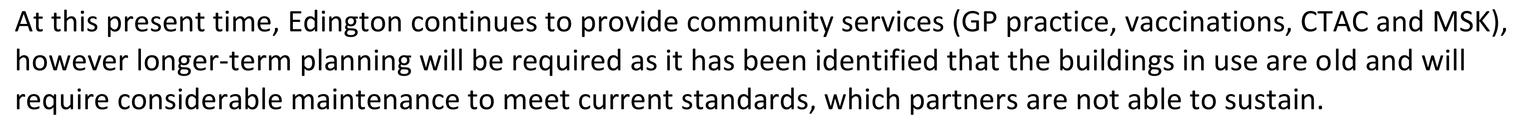
Outcome: **It is therefore suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 71: Edington and/or Belhaven sites should be redeveloped as larger ELHSCP / Local Authority-run sites. Consideration to be given to protected step-up and step-down provision, palliative care, care home beds, community respite and community hub approach.

Hospitals

Report: Option 71 was considered by our General Manager for Acute and Ongoing Care.

Assessment: The Scottish Government has confirmed that there is no capital funding to build new facilities and our NHS Lothian and East Lothian Council partners have also confirmed that these sites cannot be developed as ELHSCP / Local Authority run sites as no funding is available to support this.



At this present time, Edington continues to provide community services (GP practice, vaccinations, CTAC and MSK), however longer-term planning will be required as it has been identified that the buildings in use are old and will require considerable maintenance to meet current standards, which partners are not able to sustain.

Capital Planning and NHS Lothian have confirmed that following the approval of the IJB on 28th March 2024, that the Belhaven asset is now surplus to requirements. The following actions will be taken:

1) Capital Planning will advise Scottish Government that Belhaven is now surplus to requirements. This will be subject to a public meeting.
2) Capital Planning to liaise with and review any notes of interest from public services and this will include East Lothian Council.
3) Capital Planning will liaise with community groups (e.g., Area Partnerships, Community Council and Health and Wellbeing Groups) in line with the Community Empowerment Act.
4) Aiming to market in Summer 2024.
5) General Manager for Acute and Ongoing Care to discuss relocation of services with fellow General Managers within the Health and Social Care Partnership.

Outcome: **Due to the above developments, it is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Minor Injuries

Option 93: We should develop a specific East Lothian minor injuries service to complement existing central provision (for example, services Minor Injuries services in Edinburgh). Full options development and appraisal would be required.

Report: Option 93 was explored and modelled by our Clinical Nurse Manager for Day Services (Endoscopy and Out-Patients).

Assessment: Currently the provision of a minor injury service within East Lothian is managed by either localised GP contracts or by attending, virtually or face to face, acute hospitals based in Edinburgh (Minor injuries units at the Royal Infirmary of Edinburgh [RIE] and Western General Hospital [WGH]), along with the Emergency Department at the Royal Hospital for Children and Young People (RHCYP).

Data obtained from NHS Lothians Tableau Dashboards shows that 3,633 patients attended Minor Injuries Units (MIUs) at the RIE and WGH in 2022/2023, these numbers have remained consistent since the pandemic in 2020. However, data for 2019/2020 (pre-pandemic) reports 5,555 attendances at the units.

When data is filtered for East Lothian residents above 65 years of age attending Minor Injury Units in Edinburgh it shows that 497 attended in the financial year 2022/2023, a decrease from the 565 attendances the previous year. In the year prior to the pandemic (2019 to 2020) a total of 659 attended the units in Edinburgh. NB: Excluded from these figures are East Lothian residents attending St Johns' Hospital for treatment for which an assumption has been made that the numbers will be minimal and those attending the RHCYP since all attendances are coded to the Emergency Department rather than to minor injuries.

Previously a limited number of East Lothian residents could also access a designated Minor Injury Service within their community in the east of the county. However, in 2012 the service based in Belhaven Hospital Dunbar closed and in September 2021 the minor injuries services at the Edington Hospital in North Berwick became unviable and nursing staff were transferring to East Lothian Community Hospital. The service previously provided at the Edington Hospital was not widely publicised, consequently awareness of this service across East Lothian does not appear to be significant.

Potential options for future provision include:

1) Status quo – current provision of the Minor Injuries service for East Lothian residents would continue to be delivered by the three centres in Edinburgh.
2) Expand current local CTAC / CWIC services, which would require significant financial and nursing investment.
3) Expand current nurse practitioner service with an expanded remit.
4) Develop a standalone Minor Injuries Unit at East Lothian Community Hospital.

Outcome: **In conclusion there is a case for a Minor Injuries service to be developed within East Lothian Community Hospital in a similar vein to the unit at the Western General Hospital. However, there are significant financial and staffing implications to consider alongside careful consideration of competing strategic priorities within a particularly challenging financial climate.**

Potential issues requiring further consideration include:

- Transport – public transport links between coastal and rural communities in East Lothian and the East Lothian Community Hospital.
- Radiology support – support would be required from Radiology colleagues and no discussions have taken place to date.
- Staffing – experienced and trained minor injuries staff currently based in Edinburgh would be required to developed and support the East Lothian service, which would allow time for East Lothian staff to develop the requisite skills before taking over the service.
- Financial – the cost of developing the services and ongoing funding. This has close links to option 72 and the reallocation of set aside funds in option 33.

Palliative and end of life care

Option 11: Palliative and End of Life Care should be reviewed and mapped throughout East Lothian. This exercise should include:

1) Hospice provision for East Lothian residents (e.g., Hospice beds and services, Hospice at Home).
2) The potential for a death doula service.
3) Awareness raising campaign incorporating Power of Attorney, planning in advance, available supports and services.
4) Creation of a dedicated internal / commissioned palliative care team.
5) Single point of contact including support to Care Homes, individuals and families.
6) Provision of palliative and end of life care within care homes.
7) Training, workforce development and support for carers (particular focus on upskilling care home staff).
8) Partnership working with Macmillan, St Columba's and Maria Curie.
9) Provision of services to those under 65.
10) Review of unscheduled care service and how palliative and end of life care changes could impact it.

Option 14: We should develop an end-of-life care sheet that contains simple contact information, reassurance, and guidance for those caring for a relative at the end of their life.

Report: Option 11 and 14 were considered by our Chief Nurse.

Assessment: There is already a huge amount of work regarding palliative and end of life care with a focus on people being cared for either at home or at least within the authority area. We continue to have strong links with St Columba's hospice with some patients either being cared for within the hospice or within the virtual ward with consultant support and support from our palliative care team. Our palliative care nursing team remains small but continues to develop working in partnership with other community nursing teams and other organisations to deliver end of life and palliative care within the community.

Data shows that there has been an increase in the number of bed days within ward 1 at ELCH for palliative and end of life. A further review of this is needed.

A potential gap has been identified in relation to Care Home residents as the palliative care team do not currently support them on a regular basis. This support is generally provided by the HSCP care home team. There are currently 2 designated palliative care beds within the Abbey Care Home and a review of these designated palliative care beds is now required considering the recent IJB balanced budget decisions.

A gap has been identified in the spiritual care and bereavement support provided within East Lothian, especially within the East Lothian Community Hospital. Work is ongoing to address this but may be limited by current resources available.

The Partnership Palliative Care Strategy Group meet on a quarterly basis, chaired by the Chief Nurse. This group will support the further development of the palliative and end of life care strategic direction considering the Planning Older People's Services findings. The group includes colleagues from other palliative care and third sector organisations within East Lothian.

Ongoing strategy work is being undertaken nationally and with St Columba's. Any local work will need to remain cognisant of this.

East Lothian has an active role in the pan-Lothian palliative care managed clinical network.

Initial scoping by Chief Nurse to review current services is in place. Further scoping is required with plans to bring stakeholders together to review existing services, review data and to establish priorities moving forward. The Partnership Palliative Care Strategy Group already meet quarterly and are having early discussions regarding a potential ½ day development session.

Outcome: **The development of the palliative and end of life care strategy and strategic direction should be considered business as usual but will be considered further as part of the *Planning Older People's Services options appraisal.***

Partnership Development

Option 1: ELHSCP should collaborate with partner organisations (e.g., Connected Communities, Libraries, Enjoy Leisure, VCEL, Education and Children's Services, Neighbourhood Networks, Penumbra etc) to develop robust programme of activities for older people to tackle social isolation, mobility, fuel poverty, health and wellbeing. Could this be incorporated into a more focussed social prescribing approach.

Report: Option 1 was considered *action already underway / business as usual* and feedback was provided by our General Manager for Planning and Performance.

Assessment: The HSCP has several collaborative actions already in place to address the issues contained within this option, with a particular focus on social isolation and we work closely with third sector, East Lothian Council and NHS Lothian to ensure work is co-ordinated and there is no duplication.

Some areas, such as poverty are led by the Council[9], while others, such as the Community Link Workers service is led by the HSCP. We continue to work with partner organisations to develop a focused approach to social prescribing, which also sits with NHS Lothian partners. On all these themes, a joined-up approach which is well publicised and easily accessed is key to success.

Further work on co-ordination of the communication, engagement and publicity of this work is necessary, as although services are available in several areas, it appears from the *Planning Older People's Services* engagement that these are not well known.

Outcome: **As ELHSCP actively collaborate with partner organisations on a wide variety of programmes, initiatives, and services it is suggested that this option should not form part of the *Planning Older People's Services options appraisal.***

However, the HSCP has noted that further publicity and awareness raising on this collaborative work would be beneficial to stakeholders and partner agencies.

[9] https://www.eastlothian.gov.uk/downloads/file/31877/east_lothian_council_poverty_plan_2021-2023

Option 4: We should develop links with East Lothian schools and Queen Margaret University to encourage volunteering opportunities (two way), intergenerational links / older friends' scheme, awareness raising, and career development related to the older people agenda. Particular opportunity to establish links between local schools and care homes.

Report: Option 4 was considered *action already underway / business as usual* and feedback was provided by our Organisational and Workforce Development Manager.

Assessment: ELHSCP Workforce Development Team is actively reaching out to Universities and Colleges across Edinburgh and the Lothian's, and High Schools within East Lothian. The team regularly attends recruitment events to share career development opportunities, which include volunteering and locum positions. These sessions and engagement are monitored for impact within the Workforce Plan and Workforce Steering Group.

Outcome: **Because this option is very much an ongoing piece of work, it is suggested that it does not form part of the *Planning Older People's Services options appraisal.***

Option 5: ELHSCP, in collaboration with partner organisations, should develop and hold a health and social care career day to increase awareness of providers, training / job opportunities, career pathways and community benefits. Ideal opportunity to work in collaboration with Queen Margaret University and existing health and social care providers.

Report: Option 5 was considered *action already underway / business as usual* and feedback was provided by our Organisational and Workforce Development Manager.

Assessment: ELHSCP have committed to holding regular recruitment events within the East Lothian Community Hospital, with the first event in September 2023, which was specifically aimed at nursing vacancies. The latest event, in February 2024, included all teams from across the HSCP. Now that these events have been established, we will work with and invite other partner organisations to participate.

Outcome: **Because this option is very much an ongoing piece of work, it is suggested that it does not form part of the *Planning Older People's Services options appraisal.***

Option 28: ELHSCP should collaborate with East Lothian Council planning department and Care Home providers to inform and influence future developments. ELHSCP should share information and data on demographics, inequity of access, geographic spread of existing homes and local needs. Future developments should take into consideration community connections, co-location with other services, local provision of health and social care services (e.g., GP) and their capacity.

Report: Option 28 was considered *action already underway / business as usual* and feedback was provided by our Strategic Planning and Commissioning Officer with the lead on Care Homes.

Assessment: The HSCP already link in with Housing Strategy and Planning partners via the established Housing and Health and Social Care Strategic Group. The purpose of this group is to maintain strategic links and partnership working across HSCP, Public Health, Planning and Housing services as respective plans/strategies are developed and carried forward. This group will also oversee the development and strategic delivery of the Housing Contribution Statement. Data and demographics related to care home provision has and will continue to be shared with Planning partners via this group.

Outcome: **It is suggested that this option does not form part of the Planning Older People's Services options appraisal as work is already underway with established links and reporting pathways.**

Option 44: ELHSCP should work in closer collaboration with Education partners to establish stronger links between care homes, hospitals, older people, and young people. Examples could include work placements for older children, career development and information, play sessions for younger children, reading clubs and outreach opportunities for care home residents to visit schools to mentor / buddy or vice versa.

Report: Option 44 was considered *action already underway / business as usual* and feedback was provided by our Organisational and Workforce Development Manager.

Assessment: The Workforce Development Team have strong links with the Employability Teams within all East Lothian High Schools, attending various events, liaising with careers advisors, and providing mock interview opportunities. This

ensures that there is an awareness of health and social care opportunities within East Lothian including apprenticeships.

Outcome: **As this is an ongoing piece of work that is already incorporated within existing workstreams, it is suggested that it does not form part of the *Planning Older People's Services options appraisal.***

Option 90: ELHSCP should review and update their engagement and communications and workforce development plans taking in to consideration the following: 1) building stronger and sustainable relationships with ongoing ELC engagements and developments (e.g. Place, Poverty, Local Development Plan, Local Housing Strategy, Planning Department); 2) Working with Education Department and local institutions (e.g. Queen Margaret University, Edinburgh College) to promote health and social care career opportunities, pathways and work placements / experience; 3) Collaboration with ELC Human Resources.

Report: Option 90 was considered action already underway / business as usual and feedback was provided by our Senior Communications Adviser.

Assessment: ELHSCP development plans are updated on an annual basis.

Engagement Plans: The HSCP equalities and engagement officer works closely with East Lothian Council engagements and developments, sharing feedback, observations, and comments from our activity with relevant East Lothian Council departments and vice-versa.

In recent months East Lothian Council has taken a more strategic approach to its public engagement consultations, with enhanced inter-departmental scheduling of public surveys, to consolidate and share findings wherever possible. ELHSCP is actively involved in this process and East Lothian Council are currently developing their Participation and Engagement Strategy with input from a multi-service sub-group in order to co-ordinate future engagement and consultations.

Promoting career opportunities: ELHSCP's Workforce Development Team is actively reaching out to Universities and Colleges across Edinburgh and the Lothians, attending recruitment events, and sharing career development opportunities. Similarly, the workforce team have proactive engagements with each of the East Lothian High Schools

attending various events, liaising with careers advisors, providing mock interview opportunities to ensure that there is an awareness of health and social care career opportunities within East Lothian including apprenticeships.

Collaboration with East Lothian Council Human Resources: ELHSCP work with East Lothian Council Human Resources daily, providing updates on recruitment opportunities, engaging in staff discussions, placements, and ongoing personnel concerns.

Outcome: **It is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 91: ELHSCP should collaborate with NHS Lothian Public Health Partnership and Place Team to review DNA (did not attend) data for East Lothian residents and consider potential service improvements.

Report: Option 91 was considered action already underway / business as usual and feedback was provided by our Strategic Planning and Commissioning Officer with the lead for the Planning Older People's Services project.

Assessment: The NHS Lothian Public Health Intelligence Team have undertaken a piece of work to review Did Not Attend (DNA) data across Edinburgh and the Lothian's and initial findings have now been shared with ELHSCP. An initial review of the findings suggests that East Lothian's DNA rate is relatively in line with neighbouring authorities. Colleagues within NHS Lothian's Public Health Intelligence Team will continue to update and work on the DNA data set with further findings and information shared in due course.

Outcome: **It is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 103: We should explore opportunities to link in with the Fire Service and their fire safety checks in terms of assessing frailty, adaptations and equipment.

Partnership Development

Report: Option 103 was considered *action already underway / business as usual* and feedback was provided by our General Manager for Access and Rehabilitation.

Assessment: The HSCP and Scottish Fire and Rescue Service have a well-established partnership working relationship linking on a variety of matters including fire safety checks, hoarding and adult support and protection.

Further opportunities for partnership working will be explored as part of business as usual.

Outcome: **It is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Pathways and referral routes

Option 38 ELHSCP should review all referral pathways and patient / family journeys through the health and social care system in order to identify gaps, improve and streamline processes and ensure that they remain outcomes-focused, and person-centred at all times.

Report: Option 38 was explored by our Head of Operations.

Assessment: Currently there are a high number of pathways across the health and social care system including unscheduled care, scheduled care, diagnostic, inpatient, day case, outpatient, cancer, admitted, non-admitted etc. that can and do support patients and their families. Many of these have been reviewed by multi-disciplinary teams or are part of wider pieces of ongoing improvement work (for example the Unscheduled Care Programme Board).

It is acknowledged that streamlining processes would benefit patients and their families and would help with supporting financially sustainable services, however this option in its current form is unlikely to be a deliverable piece of work. Reviewing all referral pathways would be extremely resource intensive and very time consuming.

Outcome: **A more targeted approach, if relevant data was available, to review priority pathways may be a suitable alternative. It is therefore suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Primary Care

Option 74: ELHCSP should undertake a whole-system review for GP appointments. Accessing appointments and services can be particularly problematic for older people and those with mental-health conditions.

Report: Option 74 was considered and reported on by our Clinical Director.

Assessment: The development of the PCIP (primary care improvement plan) and MDT (multidisciplinary team) services, driven by 2018's 'new' GP contract, and the ongoing work related to improving these care pathways and optimising resource management, are all focussed on creating capacity within general practice. The primary aim of all this work is to improve access and availability of appointments.

The volume and type of appointments required are complex and vary both across the county and from practice to practice. This variation depends on local demand and demographics, deprivation, rurality, availability of other services in each locality, team makeup, etc. Issues related to access to GP appointments have significant financial implications, but the work described above is covered by the Primary Care Improvement Fund (PCIF) which is ringfenced. The Primary Care Directorate are currently reviewing telephony data across most practices in East Lothian to better understand the challenges around access to GP appointments.

Given existing workstreams, improvement actions and the constraints of working to a nationally defined GP contract, a new whole-system review of GP appointments would be unfeasible and a duplication of other work. Plans are being developed by the ELHSCP primary care team to evolve primary care services across the county as equitably as possible, while taking account of the dual challenges of deprivation and rurality, which are also responsive to the needs of individual localities and practices.

Outcome: **It is therefore suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 95: We should introduce polypharmacy reviews and ensure that they are not exclusive to care home settings. (Polypharmacy reviews are important for people who are regularly prescribed five or more medications. Their aim is to ensure that the medications are effective, the patient isn't experiencing side effects and that all the medicines the patient is taking are still necessary.)

Primary Care

Report: Option 95 was reviewed and considered by our General Manager for Primary Care Services.

Assessment: Currently the pharmacotherapy team undertake polypharmacy reviews for Care Home residents. They also complete circa 11,000 medicine reconciliations each quarter. General Practice will also undertake polypharmacy reviews although provision is likely to vary between practice teams and the HSCP does not hold data on the number of reviews completed.

There is an opportunity to increase the number of polypharmacy reviews in East Lothian and to develop a coordinated approach, but this may be limited due to the current demand on primary care services in East Lothian.

There is a strong invest to save case associated with polypharmacy reviews and ultimately reducing the prescribing spend. Further scoping work would be required by the pharmacotherapy team and East Lothian Cluster quality lead.

The following general benefits were identified during the modelling:

- Reducing adverse drug events.
- Optimising medication regimens.
- Improving medication adherence.
- Preventing falls and frailty.
- Addressing quality of life concerns.

Outcome: **This option should be considered further as part of the *Planning Older People's Services options appraisal.***

Technology

Option 85: We should explore better use of technology and associated services to allow people to remain within their own homes for longer. Examples include 24 hour supported living services for Older People, non-invasive home motion sensors, Near Me, Community Alarm Systems and smarter working / information sharing between staff groups.

Report: Option 85 was considered and reported on by our General Manager for Access and Rehabilitation.

Assessment: Assessment of the use of consumer technology and telecare solutions[10] are core practice across all pathways and staff groups within our rehabilitation service. Assessment and provision are always considered options in preference to formal care. There are ongoing health information system (HIS) integration challenges which impact on service delivery efficiencies and patient experience.

Investment has been made in development of a community flat ('Wellwynd Hub[11]') in Tranent with a second hub under development in Dunbar. The hub is used by the Telecare and Technology Enabled Care (TEC) team to assess and demonstrate technology solutions as well as undertake training with staff (across the Partnership). We are about to embark on a quality improvement project with a company called Panacea to look at using remote monitoring devices within our community pathways with the aim to personalise reablement interventions, reduce duration of reablement episode, reduce the requirement for packages of care and thus increase capacity with community services and increase patient's functional outcomes.

Near Me has been used by staff in small numbers since COVID but further scope and potential is recognised – further scoping work will be required.

Planning is ongoing to develop the 2nd community hub in Dunbar with the service aspiring to have a 3rd hub in the west cluster in the future.

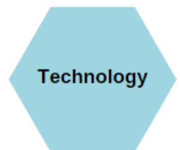
[10] https://www.eastlothian.gov.uk/telecare
[11] https://www.eastlothian.gov.uk/news/article/13108/wellwynd_hub_wins_chartered_institute_of_housing_excellence_award

We are in the process of redeveloping the levels of technology training from basic (all ELHSCP staff) to advanced clinical application, to be responsive to staff needs and ensure these essential conversations are completed with patients at the earliest point in their journey to promote a proactive approach.

Enhancing the use of technology and increasing digital choice is essential to support developing an efficient, sustainable rehabilitation service that is agile to respond to the changing needs of the population. The remote monitoring technology project is currently being piloted as a vendor-funded project as the technology has not yet been implemented in a reablement model. Following a feasibility evaluation led by the rehabilitation service, if appropriate a business case will be developed considering further implementation and scalability. It is anticipated that the project will result in savings in care requirements and an increase in capacity within community services, which would equate to increased hospital discharges and reduced total occupied bed days.

Outcome: **This option should be considered further as part of the *Planning Older People's Services options appraisal.***

Option 86: We should review the existing community alarm system and processes in order to ensure they are fit for purpose, flexible to needs and making use of technological developments.



Report: Option 86 was considered and reported on by our General Manager for Access and Rehabilitation.

Assessment: The telecare team is a small team of 5 FTE Tec Officers (one of which is a 2-year temporary post) and one 0.8 FTE team manager. The team have a current client base of 2,539 service users across East Lothian. The service offers a range of equipment including community alarms, fall detectors, bed, door, heat, and smoke detectors. The team cover a range of duties from assessment, installation, fault fixing, maintenance and decommissioning of equipment. The team use Jontek Answerlink as their work platform, for asset management, client data and workflow management, along with other supplier device management platforms for the digital enabled alarms.

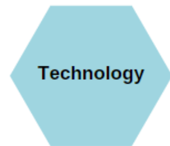
The team are currently undergoing a service provision change due to the national change to the telephony infrastructure from analogue telephone lines to digital. This change has greatly impacted the team in relation to changes of telecare technology, learning new equipment and terminology, increased workload and facing challenges that were not experienced with analogue. The team must change over 2,100 alarms by December 2025, which is the deadline for this project. This activity is currently 54% completed.

The analogue to digital project is the main priority for the telecare team. There is a desire to look at proactive technology but currently there is not the capacity or focus to take this forward. In terms of reviewing the current telecare service, there are plans underway to scope working more in line with Occupational Therapist teams for closer working and clinical governance. There is also potential scope for the telecare team to utilise Mosaic in line with East Lothian Occupational Therapy and Social Work.

A service review was completed in 2023 but further scoping and modelling is required to ensure the team has capacity and resilience to grow and develop to continue to support the Health and Social Care Partnership with its use of technology enabled care to provide quality care for East Lothians Older population.

Outcome: **It is suggested that this option does not form part of the *Planning Older People's Services options appraisal* due to existing priorities within the telecare team taking precedence and an acknowledgement that a review of this nature will be beneficial and appropriate in future.**

Option 88: The different IT systems we use across health and social care should be harmonised. We should have one cloud-based system that we can all feed into (care at home providers, NHS staff, day centre, HSCP staff etc), within the limits of GDPR and information-sharing agreements. If a whole-system approach is impossible or unmanageable, then consideration should be given to shared care planning systems.



Report: Option 88 was considered and reported on by our General Manager for Access and Rehabilitation.

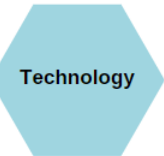
Assessment: The General Manager and rehabilitation service would fully support a harmonised IT system but noted that this would need to be taken forward by partners within NHS Lothian, East Lothian Council and possibly nationally by the Scottish Government.

A fully integrated management information system would support local and national policy and likely improve outcomes for individuals. Harmonisation and development of management information systems is an agenda that is larger than East Lothian Health and Social Care Partnership alone.

A good example of ongoing developments within this field is the *Microsoft 365 Cross-Organisation Collaboration Programme,* which is a National Programme jointly owned by the Scottish Government and COSLA that is striving to roll out basic cross-organisation collaboration and sharing[12].

Outcome **It is therefore suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 89: We should give Care Home staff access to TRAK in order to assist with continuity of care, care planning and discharge planning.



Report: Option 89 was considered by our Head of Operations.

Assessment: Current access to TRAK (NHS Lothian's management information system) is restricted to Health and Social Care Partnership staff (primarily NHS Lothian) who have undergone appropriate training. Access to patient information is also governed by Data Protection, Patient Confidentiality, data, and IT security requirements.

Advice has been sought from NHS Lothian Information Governance on the possibility of opening access to TRAK. Initial advice is that it is *"unlikely NHS Lothian would allow access".* Any proposal coming through would require approval from Information Governance and the Caldicott Guardian and be supported by completion of Data Protection Impact Assessments (DPIA).

It is however acknowledged that there is potential that by having access to wider patient information, Care Home teams may be better informed as to the needs of clients, supplementing their own assessments. However, the Head of Operations would not support this option being recommended to the IJB, due to the significant risks associated with granting access to patient information to non-NHS Lothian employees.

Outcome: **It is therefore suggested that this option does not form part of the *Planning Older People's Services options appraisal*. However ELHSCP is committed to sharing relevant information in a timely and accurate manner to ensure that appropriate care is provided.**

[12] https://sway.cloud.microsoft/N8x1Y7DfB3flGOUe

Transport

Option 94: When referrals are being made for secondary care services and appointments being planned, travel distance and accessibility should be considered for the older person. This system should be reviewed, streamlined and improved.

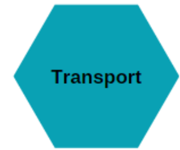
Report: Option 94 was considered *action already underway / business as usual* and was reported on by our Equalities and Engagement Officer.

Assessment: Contact has been made with NHS Lothian's Equalities Lead, to raise this option and related engagement feedback from an equalities and Fairer Scotland Duty perspective.

Plans are in place for both parties (ELHSCP and NHS Lothian) equalities officers to meet and discuss this matter further.

Outcome: As any further work would be primarily from an NHS Lothian perspective and initial discussions are already underway **it is suggested that this option does not form part of the *Planning Older People's Services options appraisal.***

Option 104: Transport links to key health and social care sites (e.g., ELCH, GP practices, day centres, care homes) should be reviewed and developed in collaboration with ELC colleagues (e.g. transport, planning, infrastructure, Connected Communities) and existing service providers (e.g. Handicabs, Royal Voluntary Service, local taxi companies).



Consideration should be given to commissioning services or developing volunteer initiatives. Wider transport considerations related to the provision of intermediate care should also be reviewed and developed. Good practice should be explored nationally (e.g., Pingo services, taxi card schemes, patient transport).

Report: Option 104 was considered further by our Chief Officer.

Assessment: Although transport is not a delegated function to the IJB and responsibility primarily sits with East Lothian Council, the HSCP does recognise its importance and the challenges surrounding access to and from Health and Social Care services.

Equality of access to services, rurality, centralised services, travel times and isolation have all been key themes throughout the *Planning Older People's Services project* and implementing any meaningful change is severely affected by the IJB's limited financial envelope.

Outcome: **This option should be considered further as part of the *Planning Older People's Services options appraisal.***