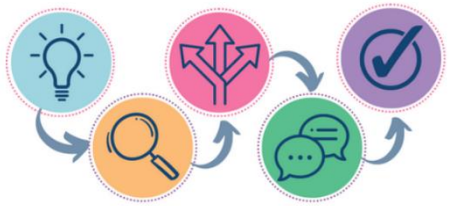
East Lothian Health & Social Care Partnership

Planning Older People's Services
Final Report


Approved by POPS Project Team on 7th January 2025, Strategic Planning Group on 30th January 2025 and IJB on 20th February 2025.

Version 1.2

Contents

1.0 Foreword

The publication of this report marks 2 years since the *Planning Older People's Services* (POPS) work began when the East Lothian Integration Joint Board (IJB) tasked the Senior Management Team with progressing the recommendations from the *Community Hospitals and Care Homes Provision Change Board* final report[1]. A lot has changed during that time, and we are facing significant challenges in the delivery of a balanced health and social care budget for 2024/25 and beyond.

The formative Change Board recommendations highlighted the development of intermediate care as a priority in East Lothian and the POPS work further supports this finding alongside the other suggested priorities of palliative and end of life care, polypharmacy and technology.

To prepare health and social care services for significant demographic growth, an ageing population and to alleviate unrelenting pressure on bed-based services we must embrace the IJB's commitment to:

- Developing sustainable health and social care services.
- Focusing on early intervention and prevention.
- Increasing access to community-based services.
- Shifting the balance of care from hospital to homely settings.
- Keeping people safe.
- Tackling health inequalities.

Since taking on the role of Chief Officer of East Lothian Health and Social Care Partnership (ELHSCP) my drive has been about collaboratively improving services to ensure people receive the right care and treatment, at the right time and as close to home as possible. The POPS findings support this focus and provide reassurance that communities and partners are on board, aligned with the IJB's priorities and eager to collaborate. I am particularly encouraged by the formation of the Independent Community Panel and appreciate stakeholders ongoing commitment to this long-term vision and approach to strategic planning. Within ELHSCP we want all stakeholders to be part of the conversation, and we need the experience of all our citizens and communities to help support older people to live independent lives for as long as possible.

I fully support the findings of the POPS project and look forward to integrating and building upon the work as part of shifting the balance of care and developing sustainable health and social care services. East Lothian Health and Social Care Partnership is fully committed to ensuring that key stakeholders and the local community have continued opportunities to engage, collaborate and actively contribute to the planning and development of health and social care services.

Fiona Wilson
Chief Officer
East Lothian Health and Social Care Partnership

[1] www.eastlothian.gov.uk/downloads/file/33131/community_hospitals_and_care_homes_provision_change_board_final_report_2021-22

2.0 Summary of findings

The POPS project has completed two rounds of community engagement and explored a variety of suggestions and ideas as part of its work. The first round of engagement (August – December 2023) invited people to share their views and ideas about the future of older people's services and the second round (16 September 2024 – 8 December 2024) was a 12-week public engagement and consultation exercise seeking feedback on the projects four identified priorities and process:

1. Palliative and end-of-life care
To review palliative and end of life care services throughout East Lothian including the development of an end-of-life care sheet.

Palliative care is defined as an approach that improves the quality of life of patients and their families who are facing problems associated with life-limiting illness, usually progressive.

2. Polypharmacy
Introduction of wider scale polypharmacy reviews (not exclusive to care home settings) to ensure patients are taking the medicines they need.

In its simplest form the term polypharmacy means "many medications".

3. Intermediate Care
Investment in existing intermediate care services, including step-down, and development of new care approaches to support independent living at home.

Intermediate care services are provided to patients after leaving hospital or when they are at risk of being sent to hospital.

4. Use of technology
To explore better use of technology and associated services to allow people to remain independent and within their own homes for longer.

Those with lived experience, wider communities, providers, and staff were supportive of the identified priorities[2] and provided positive feedback in relation to the project approach and process. Further to feedback on the suggested priorities and approach, other key messages included:

- A willingness and appetite for ongoing and continued collaboration between stakeholders and the IJB when planning and developing future health and social care services. This was particularly important to community groups looking to explore and develop local solutions.
- Support for development and continuation of the established Independent Community Panel.

[2] www.eastlothian.gov.uk/download/downloads/id/34926/provisioning_strategy_project_-_engagement_and_consultation_feedback_report.pdf

- A need for increased awareness of available health and social care services.
- More focus on prevention and early intervention to address health inequalities, deprivation and managing the challenges associated with an ageing population.
- Less jargon and use of more straightforward language when talking about health and social care.
- Improved communication and joint working between organisations, departments, and providers in order to take a more holistic approach to health and social care (e.g. NHS Lothian and East Lothian Council at the highest level; Health and Social Care Partnership; Public Health; Planning and Development; Housing; Connected Communities; Enjoy Leisure; VCEL; Area Partnerships etc).
- Frustration that the identified priorities may continue to be focussed on statutory services rather than collaborating on community led services.

POPS has been a live project and as findings have been reported back to the IJB, Senior Managers and Officers have adapted and updated the annual delivery plan. As a result, progress against each of the identified priorities is already well underway. With the IJB strategic plan and priorities due to be refreshed and updated for a June 2025 publication, this report and its findings are well placed to inform and influence the future direction of East Lothian's health and social care services for older people and beyond. More detail and suggestions can be found in relation to each of the proposed priorities within section 5 of this report.

3.0 What did we set out to do?

The original remit of the POPS project was to take forward the findings and recommendations from the *Community Hospitals and Care Home's Change Board* in early 2023. This earlier piece of work was the basis for the ELHSCP Chief Officer forming the POPS project and it recommended intermediate care as the key priority. Initially care home beds and local inpatient beds were also within scope of the POPS work but this changed as part of balanced budget discussions and actions in March 2024. As well as identifying intermediate care as a priority our earlier *Planning for an ageing population*[3] engagement in April to September 2022 told us that:

- People would prefer to stay independently, in their own homes for as long as possible.
- If people needed care, they would prefer to have it at home, or in a homely setting and not go into hospital.
- They wanted more 'Intermediate Care Services'.

From the outset POPS has aimed to work with East Lothian residents, communities, providers, and staff to collectively identify possible options and priorities to support the development of high-quality sustainable services for the older people of East Lothian. As part of this commitment, an Independent Community Panel[4] (ICP) was formed, featuring a representative cross section of our key stakeholders. This panel met regularly throughout the project, acting as a critical friend by helping us to get our engagement and process right. Members of the panel represented a wide range of views and experience, and they had three main roles:

1) Oversee and shape the engagement process.
2) Be part of the shortlisting and options appraisal process.
3) Engage with their local communities.

As a collective, the Project Team and Independent Community Panel set out to identify, design, and develop services together with the people of East Lothian.

To be successful, the project aimed to find options and ideas that were realistic and achievable and would deliver high quality care and support to East Lothian's current and future population. Our project priorities were to:

- Deliver high quality care and support to East Lothian's current and future older population, at the right time and in the right place.
- Ensure services for older people are sustainable and adaptable to the current financial climate, the impact of the COVID-19 pandemic and national policy.
- Engage with communities within East Lothian to ensure co-production of services that will allow for equality of service across our diverse population.

[3] www.eastlothian.gov.uk/downloads/file/32759/planning_for_an_ageing_population_summer_engagement_feedback_report
[4] www.eastlothian.gov.uk/downloads/file/34184/independent_community_panel_handbook

3.1 What challenges do we face?

East Lothian is growing: East Lothian's population increased from 99,717 in 2011 to 112,300 in 2022 (12.6%). Our % increase in population between 2001 and 2022 was over three times higher than the % increase in Scottish population, 7.4% (source).

The population is ageing: the 65 to 74 age group has increased by 53.1% from 2001 to 2022 and the 75+ age group by 52.5% during the same period (source).

Our health declines as we live longer: generally, health declines as we age, with an increased risk of developing chronic conditions such as dementia, diabetes and arthritis (source). In East Lothian life expectancy for men is 79.3 years, compared to healthy life expectancy of 63.7 years, for women life expectancy is 82.9 years, compared to healthy life expectancy of 65.3 years (source).

We become frail as we age: with reduced physical and mental health capacities making us more vulnerable to multimorbidity (having more than one health condition). Having multiple conditions can reduce quality of life and increase disability (source).

Unmet need and access to services: there is currently substantial unmet need in the community which, in turn, is leading to pressure on carers and community services as well as bed-based care (including acute hospitals) as frail older people are admitted in the absence of other support. This has led to increased levels of delayed discharges and longer lengths of stay, adding to the demands on Health and Social Care services (source).

Inequality and discrimination accumulate as people age: as our population ages, it is likely that inequality will increase too. Discrimination and structural inequality accumulates throughout people's lives, meaning that gaps in wealth and health are greatest in later life (source).

We face a challenging financial climate: IJB's face extremely difficult decisions due to the current financial landscape. In setting a balanced budget for 2024/25, savings in excess of £10 million need to be delivered. The current financial climate has resulted in increased financial pressures across the public sector, with the rate of inflation and the costs of goods and services significantly impacting daily operational delivery of services (source).

Health and social care workforce challenges: we must develop and retain a sustainable, skilled workforce with attractive career choices and fair work where all are respected and valued for the work they do (source)

Health inequality: in the most affluent areas, people live longer in good health, compared to those living in deprived areas. For almost all conditions, there is a gradient of progressively poorer health with rising levels of deprivation. East Lothian consists of 6 wards and 132 data zones, of which 8 are in the 20% most deprived in Scotland (source).

4.0 How did we do it?

4.1 Gathering interested people

We formed a Project Team[5] of Senior Officers and Trade Union representatives in February 2023 on the instruction of the Chief Officer of ELHSCP. A Project Manager was identified with support from Communications and Engagement colleagues to take forward the newly named *Planning Older People's Services* project.

With support and advice from the Consultation Institute we developed our case for change, options development process, engagement and communications plans, and achieved our Certificate of Consultation readiness in August 2023[6].

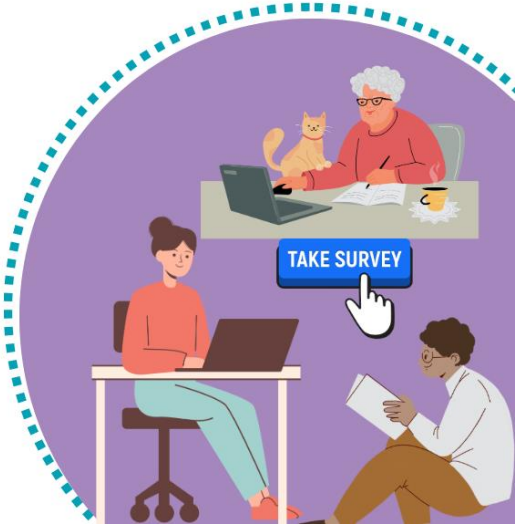
Following an extensive stakeholder mapping exercise the decision was taken to form an *Independent Community Panel*[7] containing a representative group of stakeholders and chaired by the Chief Executive of our local third sector interface (Volunteer Centre East Lothian). The main role of the Panel was to oversee and shape our engagement, participate in the shortlisting and options appraisal process and engage with local communities. The first meeting of our Panel also took place in August 2023.

4.2 Collecting feedback

The Project began its first round of community engagement events in August 2023, which included a variety of engagement opportunities including online and paper surveys; face-to-face and virtual engagement sessions, held with communities, staff, the third and independent sectors; and individual interviews to gather as many views as possible.

We asked people to put forward ideas, suggestions, and feedback on what we could do to:

- Increase the provision of intermediate care.
- Address the challenges with supply and demand for care at home services.
- Help more people to die in the place of their choosing.
- Address issues of equitable access to services.
- Build sustainable health and social care services.



[5] www.eastlothian.gov.uk/downloads/file/33467/provisioning_strategy_project_-_terms_of_reference
[6] Copies of all project documents can be accessed on our website under the *Context Documentation* section
[7] www.eastlothian.gov.uk/downloads/file/34184/independent_community_panel_handbook

Between August and December 2023, ELHSCP hosted over 44 events, 36 of which were in person, the remaining either virtual or hybrid. These events allowed ELHSCP to directly engage with 702 people. A further 141 took part in our online survey and 11 in printed questionnaires.

In total 2,458 individual pieces of feedback on how to improve or deliver older people's services in East Lothian were collected.

Information was also gathered from the feedback and responses obtained from the IJB Strategic Plan Health, Housing and Place Engagement (April – July 2022), the Dementia Strategy and the Planning for an Ageing Population engagement in 2022. The 2,458 pieces of feedback were categorised into 49 separate themes, which were further condensed into the 19 recurring key themes. A copy of our full engagement report for this phase is available online[8].

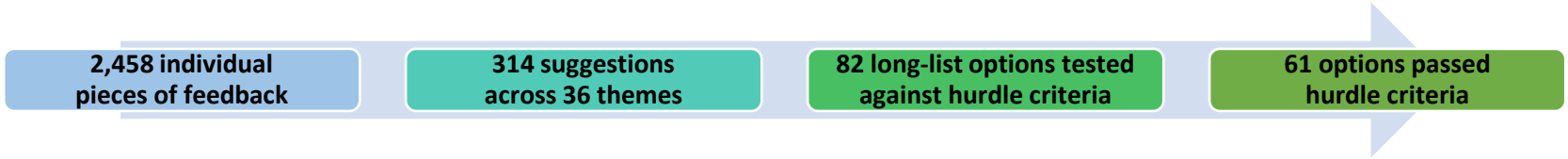
4.3 Creating a long list of options and testing

The 2,458 pieces of feedback received from the first round of engagement incorporated 314 actionable suggestions for developing older people's services. These were then combined into 105 long-list options. These 105 options were then assessed against 4 pre-set hurdle criteria[9], by the overarching Project Team and the Independent Community Panel.

Each of the long-list options were assessed against the following 'core' hurdle criteria:

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?

Of the 105 options considered, 61 progressed to a short list and the next stage.



[8] www.eastlothian.gov.uk/downloads/file/33891/provisioning_strategy_project_-_communications_and_engagement_report_aug-dec_2023
[9] www.eastlothian.gov.uk/downloads/file/34073/provision_strategy_project_-_hurdle_criteria_results_report

4.4 Creating a short list and assessing options

The next phase was to investigate and model each of the 61 short list options.

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.

The scoping and modelling involved assessing demand, finding resources, considering financial implications, looking at projected timescales, benefits, and risks. Each option was allocated to a senior member of staff within ELHSCP for further consideration and development.

Outcome of the modelling and development exercise

16 options were recommended to proceed to the options appraisal.

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

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

The refined short list of 16 options then proceeded to an Options Appraisal Exercise undertaken by our Project Team and Independent Community Panel members. Members collaborated and agreed upon a set of criteria to apply based on three core themes (desirability, feasibility and viability). Upon completion of the exercise 7 options were identified as front runners and these were further consolidated in to the 4 priorities in section 5 below. A full copy of our option appraisal results is available online[10].

For the options that did not go ahead from the options appraisal or were regarded as action already underway at the development stage a supporting document has been prepared to provide stakeholders with an update on each[11].

[10] www.eastlothian.gov.uk/downloads/file/34579/provisioning_strategy_project_-_options_appraisal_results
[11] www.eastlothian.gov.uk/download/downloads/id/34927/provisioning_strategy_report_-_options_update_report_nov_2024.pdf

5.0 Identified Priorities

5.1 Palliative and End of Life Care

What do we mean?

Palliative care is defined by the World Health Organisation as an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-limiting illness, usually progressive. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems whether physical, psychosocial, or spiritual.

What are we doing already?

As one of our existing strategic delivery priorities (4.6 – Palliative and End of Life Care) our Chief Nurse, with the support of the Palliative Care Strategy Group and other stakeholders are progressing a number of workstreams:

- A scoping exercise in relation to current and future delivery is already underway.
- An Integration Joint Board development session took place on 22nd August 2024.
- A 'Virtual Ward' supported by St Columba's team has been implemented, tested and is generating positive feedback.
- Collaborative work continues with St Columba's and Marie Curie, with a focus on supporting patients and families (for example, through complementary therapies and initiatives such as 'bunny buddies'[12]).
- Ongoing development of collaborative working between Hospital to Home and Care at Home services and Hospice at Home to provide care packages related to palliative and end-of-life care.
- A review of spiritual care has found some gaps at East Lothian Community Hospital which are being looked at currently.

Nationally the Scottish Government recently published its draft *Palliative Care Strategy: Palliative Care Matters for All*[13]. This strategy illustrates a national approach and commitment to ensuring that everyone who needs it can access well-coordinated, prompt and high-quality palliative care, care around dying and bereavement support based on what matters to them. The draft strategy is currently out for consultation with a closing date of 10th January 2025.

[12] www.eastlothian.gov.uk/news/article/14330/bunny_buddies_a_heart-warming_initiative_supported_by_nhs_lothian_charity
[13] www.gov.scot/publications/palliative-care-matters-consultation-paper/pages/1/

What did you tell us about this priority?

> *Palliative care is not just about dying but living well, with dignity.*

> *Choice and options are vital throughout.*

> *We need education and awareness raising amongst staff and communities.*

> *Having the right conversations at the right time.*

> *Respect and dignity are paramount.*

> *Caring for someone within their own home can make you feel isolated and exhausted.*

Responses from the 12-week engagement and consultation regarding this priority focused on six areas:

- The importance of having meaningful conversations with loved ones about their preferred views and wishes for end-of-life care, and having plans in place to support, not just medically, but holistically, legally and financially.
- The provision of palliative and end-of-life care services. How and where services are allocated, located, delivered and the staffing provision to support ongoing and future demand.
- The importance of choice; understanding what options are available to people when it comes to end-of-life care, so that they can plan, discuss, and consider the options before they need it.
- Reflections of people with lived experience and the support that was / was not available to them and the impact this had.
- A request for more education on the difference between palliative and end-of-life care; how individuals can live well during palliative care; and support to help guide people how to have conversations about death and dying.
- Suggestions and best practice experiences from across the UK, Europe and beyond.

Suggestions for the future

Palliative and end of life care is something we all have in common, and we all appreciate how difficult it can be to have prompt conversations with our loved ones. The most important things to the people of East Lothian are choice, dignity, respect, easily understood information and support for carers and family members. By improving palliative and end of life care we can deliver better outcomes for all East Lothian's population and support everybody in this challenging time of their lives.

1) Palliative and end of life care should remain a key strategic priority for the Integration Joint Board during its 2025 refresh of the IJB Strategic Plan.
2) Further to the above, a Palliative and End of Life Care Strategy / Delivery Group should be formed within the revised IJB Programme Board structure.
3) Chief Nurse to link in with Lothian Palliative Care Managed Clinical Network and ensure that our own local developments align with the wider work of the Network.
4) A local Palliative and End of Life Care Strategy and / or workplan should be developed that compliments the National Strategy and Lothian Palliative Care Managed Clinical Network workplan. This strategy should consider our growing population, growing number of people dying from multiple diseases associated with different disease groups and balancing the need for personal choice and people's rights with what we can realistically provide within financial constraints.
5) Support networks and services for family and carers, during and after the fact, should be scoped as part of the ongoing scoping exercise.

5.2 Polypharmacy

What do we mean?

As people age, they become more vulnerable to having multiple health or medical conditions. They can often be complex in nature or classified as chronic conditions. To treat these conditions, older people are often given a number of different medications. This is known as polypharmacy, "many medications".

What are we doing already?

As part of the IJB's commitment to improving the management of long-term conditions (3.4 – Improving the management of long-term conditions) a Pharmacotherapy Hub has been set up at Musselburgh Primary Care Centre providing a centralised location to support General Practice across East Lothian. This strengthens collaboration and provides peer support, as well as improving efficiency, building resilience and freeing up space in GP practices. The Hub has already helped free up capacity to allow more polypharmacy reviews to be completed.

Nationally NHS Scotland and Scottish Government have identified polypharmacy as a specific area of interest and focus with various national programmes of work underway to support this ("15 box grid"). The Scottish Government concluded its consultation on its draft *Prescribing – achieving value and sustainability*[14] guidance on 8th September 2024.

What did you tell us about this priority?

Responses to the recommendation of polypharmacy review from the 12-week engagement and consultation process were very supportive, with people commenting on the perceived benefits of reviews, and some individuals providing experience where a medicine review had supported their overall health and wellbeing.

There was concern about the amount of medication that is being prescribed, and calls for people to feel more empowered to question whether or not medication was needed, and feel confident to request a medicine review. Futher requests were made for better communication links between acute hospitals, GP Practices and Pharmacies so reviews of medication could be undertaken, especially following stays in hospital. Feedback also called for enhanced labelling of medication, so individuals would know what each medication was for, so they could understand why they were talking it.

> *From personal experience medicine reviews are beneficial.*

> *We need to empower individuals to ask themselves "Do I really need this?"*

> *Patients need to have a better understanding of each of their medications and what they are for.*

> *Very supportive of idea and wide recognition that there are lots of unused medicines out there.*

[14] www.gov.scot/publications/achieving-value-sustainability-prescribing-consultation-draft-guidance/

Suggestions for the future

Pharmacotherapy and polypharmacy reviews in particular present an opportunity for the IJB to first and foremost improve outcomes for individuals, but also ensure that our prescribing spend is as efficient as possible. If we can successfully dedicate more time and resources to undertaking polypharmacy reviews for the frailest in our communities, then we will contribute towards our local commitment to shifting the balance of care from hospital to homely settings and reducing demand on bed-based services in the longer term.

1) There should be continued development of the existing Pharmacotherapy Team with particular attention paid to freeing up suitably qualified professionals to undertake polypharmacy reviews. By increasing our capacity we will move closer to undertaking reviews for frailer individuals within the community.
2) An awareness raising campaign should be considered to encourage personal responsibility and ownership in terms of understanding medications, seeking assistance and clarity from prescribers, and safely disposing of unused medicines.
3) We should work collaboratively with East Lothian GPs to develop a co-ordinated approach to undertaking polypharmacy reviews.
4) The East Lothian Cluster Frailty Workstream should be expanded to include all GP practices in East Lothian, allowing us to develop our local data on the number of people who may benefit from a polypharmacy review within the community.
5) Polypharmacy data metrics and analysis should be developed and incorporated within the IJB performance framework to raise profile and improve strategic oversight of progress.

5.3 Intermediate Care

What do we mean?

Intermediate care services are provided to patients, usually older people, either leaving hospital or when they are at risk in the community to help support their independence and reduce the likelihood of unnecessary admissions to hospital.

What are we doing already?

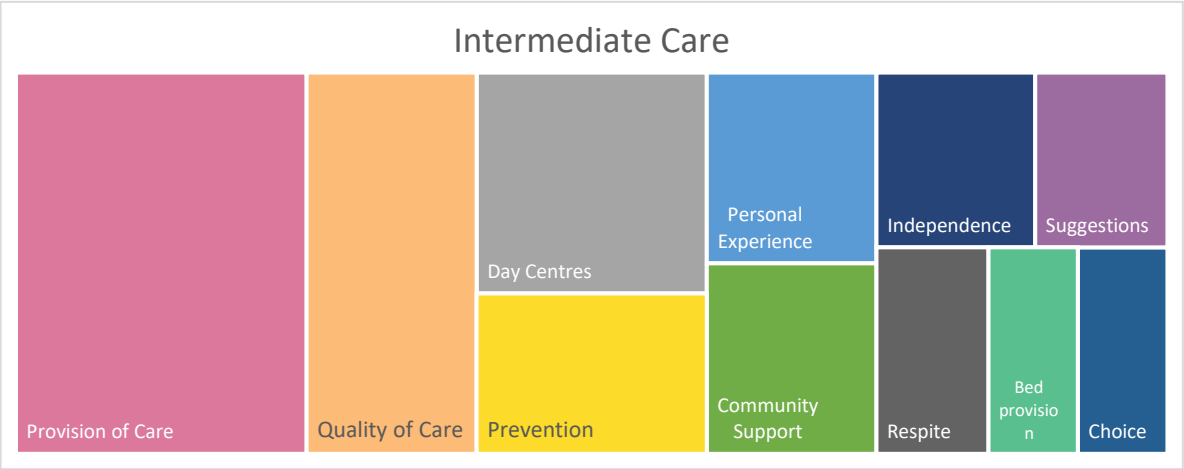
Developing intermediate care is one of the core priorities within the IJB strategic plan and annual delivery plan (1.2 – Developing Intermediate Care). It is the cornerstone of delivery of prompt interventions within the community, helps with managing the growing pressures associated with hospital admissions and delayed discharge, and should be on the front line of developing services with more of a prevention focus. There are numerous active workstreams including the development and expansion of the Home Care / Hospital to Home integrated service, the Enhanced Discharge to Assess Project, the Care at Home Change Board work to review and redesign services, implementation and delivery of the commissioned Community First Service, and the ongoing work related to increased choice and availability of community-based support (e.g. meeting centres, Day Centre Outreach services).

There is still no comprehensive overview or reference point for available intermediate care services in East Lothian and it would be worthwhile to build upon the previous *Intermediate Care Report Summary*[15], completed during the *Community Hospitals and Care Homes Provision Change Board* work to build a complete picture of existing services, inform future priorities and identify unmet need.

What did you tell us about this priority?

Due to the wide scope of Intermediate Care services, themes related to this priority ranged from the provision of care, to the quality of care, prevention measures, day centres, community support, bed provision, respite, as well as the need for choice and independence.

While feedback referred to existing provision of care services, the largest concern was about sustainabilty of Intermediate Care Services in the future, and having adequate resources, in particular staffing provision, to meet the growing needs of an increasing ageing population.



[15] www.eastlothian.gov.uk/downloads/file/33016/intermediate_care_report_summary

Suggestions for the future

Existing intermediate care should be mapped and information on available services distributed to all. Through intermediate care we have an opportunity to shape our future health and social care services with a preventative and community focus whilst also relieving some of the pressure on the acute, primary care and bed-based services. As per the findings of the *Community Hospitals and Care Homes Provision Change Board final report* and supported by the Scottish Government *Preventative and Proactive Care Programme*[16] and NHS Lothian's *Strengthened Approach to Prevention across the Lothian Health and Care System*[17] our number one priority should be developing intermediate care services through co-production and partnership working, focusing on earlier intervention and prevention wherever possible, ensuring choice and flexibility in approaches, and assisting the population of East Lothian to remain living within their own communities and with as much independence as possible. The lack of additional resources or investment and challenging financial climate will mean that this work is about pivoting, adapting and maximising what we already have in order to improve our health and social care services.

[16] sway.cloud.microsoft/6fTsDwwwkHmI5QLL?ref=email
[17] www.eastlothian.gov.uk/download/meetings/id/24958/a_strengthened_approach_to_prevention_across_the_lothian_health_and_care_system

When developing intermediate care we must see past statutory and 'traditional' models of service delivery and work with local communities, groups and providers to develop sustainable services that are fit for locally identified priorities and contribute to IJB strategic priorities. Herein lies our key co-production opportunity and the scope to build upon engagement to date.

1) Intermediate Care should remain a key strategic priority for the Integration Joint Board during its 2025 refresh of the IJB Strategic Plan.
2) Further to the above, Intermediate Care work should be taken forward by a Programme Board within the revised IJB Programme Board structure. This should ensure a whole system approach to developments, shared learning and alignment of workstreams with IJB strategic priorities.
3) IJB and ELHSCP to collaborate with the Independent Community Panel to explore intermediate care opportunities and local needs.
4) ELHSCP to collaborate with partners and key stakeholders to scope existing intermediate care provision. This information can then be used build locally led service models that focus on early intervention and prevention and building sustainable community-based services.
5) A directory of available services and supports should be developed to raise awareness amongst the public and providers.

5.4 Technology

What do we mean?

Better use of data and digital technology is critical to how we drive improvements in health and social care and should be a key part of our reform and transformation of services for the future. Through enhancing our use of technology, we can unlock opportunities for collaboration and partnership working.

The potential benefits and opportunities that technology offers in the context of health and social care could be limitless but are ultimately bound by affordability, lack of infrastructure, data protection, skill gaps and negative perceptions / attitudes.

What are we doing already?

Much of our technology related activities are contained within our East Lothian Rehabilitation Service (ELRS) development strategic priority (3.1) and to a lesser extent our falls prevention and management work (3.2). We are working hard to raise awareness of consumer technology opportunities across related workstreams, embedding technology enabled care (TEC) throughout ELRS, development and promotion of a patient self-management platform and making better use of data analytics to plan services.

Nationally, Scottish Government published *Greater access, better insight, improved outcomes: a strategy for data-driven care in the digital age*[18] in February 2023, which set out how we can work together to transform the way that people access their own data to improve health and wellbeing, and how care is delivered through improvements to our systems. As part of this overall approach the *National Digital Platform*[19] is also being developed to help with staff having access to relevant information but also to provide the public with access to their own information.

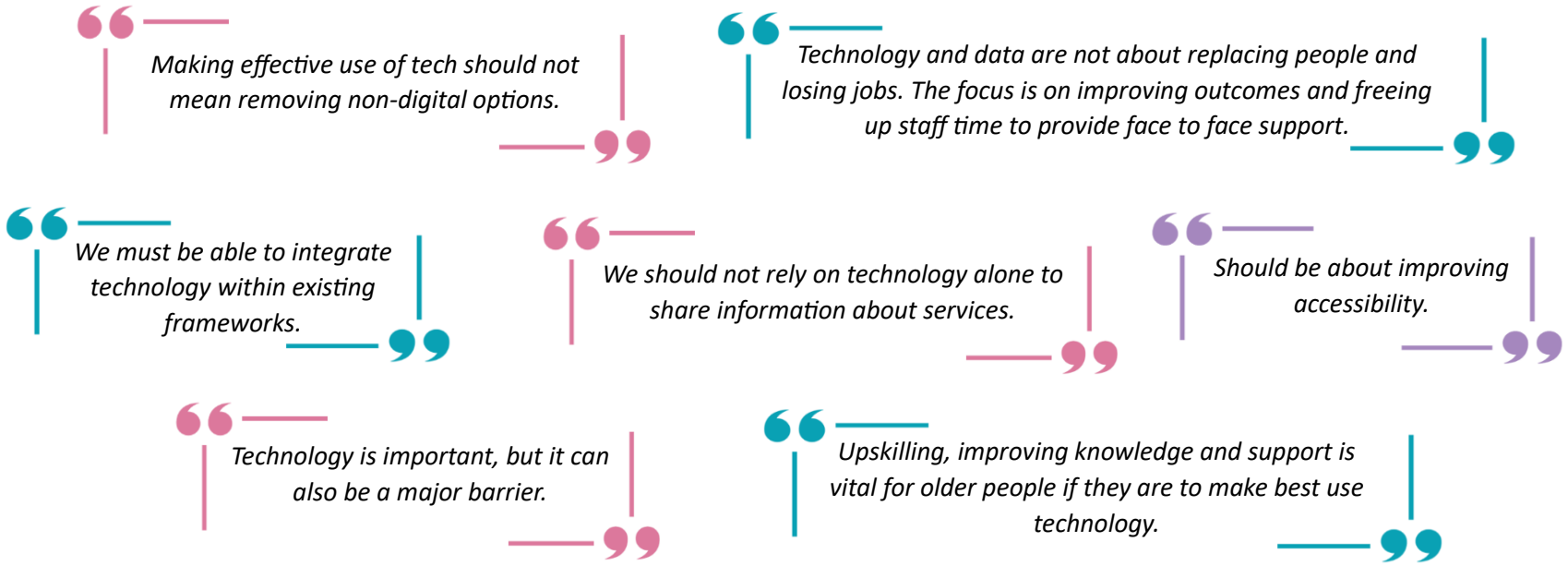
Further to this, *Digital Health and Care Scotland*[20], which is part of the Scottish Government's Digital Health and Care Division, have a well-developed Technology Enabled Care (TEC) workstream[21] that focusses on the use of simple technology to support more people to access care from home or closer to home.

What did you tell us about this priority?

The responses to the priority to explore better use of technology, fell into three distinct categories: positive, 45%, negative 23%, and cautionary 32%. The technological benefits of integrated information processing and communication were noted, as were the technological advances that can support people to live more independently at home. However, there was caution regarding the overuse and reliance on technology. Emphasis was made that technology should not replace the importance of human contact, and personalised service delivery. Concern was raised over the increasing focus on sharing information online,

[18] www.gov.scot/publications/data-strategy-health-social-care-2/
[19] www.nationaldigitalplatform.scot/
[20] www.digihealthcare.scot/
[21] www.digihealthcare.scot/our-work/technology-enabled-care-tec/

creating barriers to access, especially for older people who can be digitally discriminated against as they may not have access to the internet, or been as knowledgeable compared to younger generations.



Suggestions for the future

East Lothian needs to take a whole system approach to technology in health and social care. Lessons can be learnt from earlier and ongoing work within the Rehabilitation Service and good practice examples like the Well Wynd Hub in Tranent. We need to work towards:

- Using technology and data to improve patient care.
- Using technology and data to deliver more proactive care and support at home.
- Using data to support analysis and planning to improve outcomes.
- Adopting innovative technologies (e.g. smartphones; wearable devices; artificial intelligence; 3D printing; virtual reality; internet enabled devices and monitoring).
- Improving data quality and effective record keeping across health and social care.
- Engaging with and making best use of national workstreams through *Digital Health and Care Scotland*.

Technology needs to be embraced and embedded across all our IJB strategic priorities taking the following factors into consideration:

- We need to build trust in how we use data and technology.
- Development and implementation of new approaches should take place alongside meaningful stakeholder involvement. This includes building staff capability and skills through a process of continuous improvement and change.
- Exploring intergenerational opportunities to seek input from young people and education establishments on embracing technology and making best use.
- We must remain mindful of digital exclusion and alternative approaches that support more 'traditional' accessibility to the same information.
- As a Health and Social Care Partnership we need to work better with data and analytics to improve outcomes for individuals and support our key partners to do the same.
- Where technology has cost saving implications, we should always be upfront about this when making the case for change.
- Information sharing and access to relevant data needs to be more integrated across IJB functions. It is neither right or fair that individuals need to share their story on multiple occasions and have their personal data recorded multiple times to accommodate services. Wherever possible we should strive to have shared records in line with GDPR, the Data Protection Act and information sharing principles.

My suggestions for the future are:

1) Technology should be a key strategic priority for the Integration Joint Board during its 2025 refresh of the IJB Strategic Plan. Technology should be a key consideration and concurrent theme throughout the IJB strategic priorities.
2) Further to the above, Technology work should be taken forward by a Programme Board within the revised IJB Programme Board structure. This programme board should ensure that technology is embedded across all other relevant workstreams and a whole system approach is adopted to technological developments within health and social care in East Lothian.
3) Awareness raising and training for all health and social care staff and senior leaders on the benefits and potential applications of technology and data within a health and social care context.

6.0 What did you tell us about our engagement practices?

Overall responses regarding the engagement process for the POPS project were positive, with many remarking on how open and honest if felt. Respondents were grateful for the range and depth of information shared, and the numerous ways that they had been able to get involved in the process.

Concern was raised that some of the language used could be technical, and therefore not as accessible to a wider audience. Additionally, it was noted that some people were disengaged from the outset, as they did not believe 'older people's services' was something that would be relevant or of interest to them.

The largest concern regarding the engagement process was with regards to what will happen next. With one respondent articulating:

> *"There are many good things in this consultation, but my great fear is when the decisions are made the finances aren't available."*

Other comments included:

	*Folk are quite negative regarding surveys as they think nothing much ever happens. This shows it does and I know some of these things will take years to be in place, but at least the vision is there for even myself getting older.* (ICP Member)
	*You have done amazing work making members of the community feel heard and helping them understand so much about the partnership and the wider context.* (ELHSCP Staff Member)
	*Now you have identified your priorities, implementation will required involvement at all levels.* (Consultation feedback, Oct 2024)
	*I get the feeling East Lothian Health and Social Care Partnership is focused on making and delivering change and speaking to people.* (Consultation feedback, Sept 2024)
	*It is very important to be asked about what we want, and to have the opportunity to have a say, because these services will impact and affect me.* (Consultation feedback, Oct 2024)
	*Congratulations on the process of planning POPS and the quality of the information. My view is that the process has been well thought out and well led.* (Consultation feedback, Oct 2024)
	*This is a massive challenge and opportunity for us all, we really, really, need a compelling and shared vision to make it work. That includes culture shift for us all, valuing all our assets and roles equally.* (Third sector provider)

7.0 Recommendations and next steps

7.1 Recommendations

1) The East Lothian IJB should adopt the four suggested priorities (palliative and end of life care; polypharmacy; intermediate care; and technology) and embed them within the refreshed strategic plan and updated Programme Board structure. The findings and specific suggestions contained within this report should be progressed further by relevant Senior Managers and Officers as part of the revised Programme Board structure.

2) The East Lothian IJB should retain and develop the Independent Community Panel as a key engagement and participation function. The Panel should form part of a strategic planning and decision-making feedback loop that ensures key stakeholders, particularly those with lived experience, are informed and consulted on key discussions and developments on an ongoing basis.

3) ELHSCP Officers should update and refresh our existing engagement and communications strategies to reflect the role of the Independent Community Panel and take consideration of other key project findings such as: raising awareness of services; accessibility of information; use of technical language; and accessible information standards.

4) When considering further financial recovery actions for 2024/25 and working towards a balanced budget position for 2025/26 and beyond as part of the East Lothian IJB 5-year financial plan, officers should remain mindful of the findings of this report, with particular reference to building community capacity and exploring innovative and sustainable intermediate care services.

5) ELHSCP Officers to continue to collaborate with NHS Lothian Public Health, East Lothian Council Area Partnership Health and Wellbeing sub-groups, 3rd sector partners / interfaces and community groups to explore and develop early intervention and prevention approaches that support IJB strategic priorities and deliver intermediate care and support.

6) ELHSCP Officers to continue to work with NHS Lothian Public Health and East Lothian Council data analysts to improve our Joint Strategic Needs Assessment and use of data and analytics when it comes to informing strategic decision making and service development.

7.2 Conclusion

Planning Older People's Services is not necessarily about older people or living longer but developing a range of services and supports that are available throughout the lifespan, improve outcomes and enable people to live healthier and independent lives within their own homes for as long as possible.

This project has generated lots of healthy debate and discussion surrounding the challenges we all face, and we are now presented with an opportunity to continue developing services in a more collaborative and open environment. East Lothian IJB needs to continue its partnership working with East Lothian Council and NHS Lothian colleagues and embed local communities' participation in its future planning and strategic decision-making processes. Without the support and dedication of the Independent Community Panel representatives and all those who participated in the process, this report and its findings would not have been possible.

Delivering any form of meaningful system change within the current financial environment will be extremely challenging, however investing in the proposed priorities will contribute towards improved population health, improved outcomes, sustainable services and reducing the future burden on the health and social care system. With the help of a 5-year financial plan and the support of all our stakeholders we will be better placed to escape the cycle of in year recovery actions and move on to addressing our strategic priorities and improving long-term outcomes for East Lothian's population.

Many thanks to all those who took part in and supported this piece of work.

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Project Documentation

All project documentation covering initiation, community updates, full engagement and consultation findings, options appraisal and development reports, background data and much more can be accessed on the *Planning Older People's Services* web page:
https://www.eastlothian.gov.uk/info/210673/about_east_lothian_health_and_social_care_partnership/12797/planning_older_peoples_services/5

If you have any questions or cannot find what you are looking for then please e-mail our engagement mailbox (engagement-hscp@eastlothian.gov.uk) for assistance.

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Version Control

Version	Date	Note
v0.1	18/11/24	Initial draft prepared.
v0.2	25/11/24	2nd draft prepared.
v0.3	28/11/24	Draft document shared with Project Team and Independent Community Panel for consideration and comment
v0.4	17/12/24	Suggested changes incorporated.
v0.5	30/12/24	Engagement and consultation content added and draft finalised.
v1.0	10/01/25	Design and graphics added to final document.
v1.1	28/01/25	Amendment to page 8, section 4.2.
v1.2	20/02/25	Final report and recommendations approved by East Lothian IJB.