REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 27 June 2024

BY: Chief Officer

SUBJECT: East Lothian IJB Annual Performance Report 2023/24

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1 PURPOSE

1.1 To present the East Lothian Integration Joint Board Annual Performance Report for 2023/24.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Review this report, and in doing so, recognise the achievements of East Lothian Health and Social Care Partnership and individual services during 2023/24, and commend the contribution made by staff, volunteers, and partner organisations throughout the year.

2.2 Note that there may be changes to the National Integration Indicators data once the final data set is published by Public Health Scotland at the start of July, and that a final version of the Annual Performance Report (APR), incorporating any changes, will be sent to IJB members for information prior to publication at the end of July.

2.3 Whilst there is no requirement within the statutory guidance for IJBs to formally sign-off APRs, it is requested that IJB members give approval for the publication of the 2023/24 APR as appended, subject to any minor changes as noted in recommendation 2.2 above.

3 BACKGROUND

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report (APR) covering the period 1 April to 31 March by the end of July each year.

3.2 The East Lothian IJB Annual Report for 2023/24 describing performance in planning and carrying out integrated functions from 1 April 2023 to 31 March 2024 has been developed and can be found at Appendix 1.

3.3 The report includes details of performance in relation to the Core Integration Indicators and additional Ministerial Steering Group Indicators. The current, appended version of the report contains data released by Public Health Scotland for management purposes only and may change prior to publication of the final data in early July. The report will be updated once the data is finalised and shared with IJB members as per recommendation 2.2.

3.4 The APR also describe progress made throughout the year in relation to the planned activity outlined in the Annual Delivery Plan for 2023-24. The report is structured to reflect the IJB's 7 strategic objectives as defined in its Strategic Plan for 2022-25.

4 ENGAGEMENT

4.1 No specific engagement was carried out in relation to the development of the Annual Performance Report.

5 POLICY IMPLICATIONS

5.1 Development and publication of an IJB Annual Performance Report reflects the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy.

7 DIRECTIONS

7.1 Consideration of directions is not required in relation to the Annual Performance Report.

8 RESOURCE IMPLICATIONS

This paper has no specific resource implications.

9 BACKGROUND PAPERS

9.1 None.

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DATE	14th June 2024

2023/24

Annual Performance Report

East Lothian Integration Joint Board

Contents

Introduction

Welcome to this year's Annual Performance Report. In it you will read about our performance, including ways in which we have continued to develop health and social care services in East Lothian during 2023/24.

The achievements described have been made possible by the hard work and commitment of our staff who have adapted, innovated, and responded to the numerous and varied challenges that have come their way.

You will also see examples of how we have worked with third and independent sector colleagues and local community groups to support the health and wellbeing of East Lothian residents, developing new and innovative ways of responding to individual needs. The support of these groups has been crucial in delivering services in 23/24, supporting the HSC to meet its strategic objectives.

We continue to focus on developing services based on what is important to and needed by individuals, reflecting their goals and priorities, and supporting them to be as active and independent as possible. We have included a number of case studies that help to illustrate some of the ways in which services meet people's very specific needs and wishes.

This report covers a year in which the Integration Joint Board (IJB) was presented with very difficult decisions as a result of the increasingly challenging financial context faced by the public sector across the country. IJB members worked with the HSCP Officers to develop a financial recovery programme in the latter part of the year, culminating in a set of savings proposals being agreed at the March 2024 meeting of the IJB.

Whilst difficult, the financial recovery actions were identified as being necessary to balance the 2023/24 budget and to help ensure longer term sustainability. Projected overspends for future years, and ongoing financial uncertainty at a national level mean that the IJB will be faced with further difficult decisions in future years. We are committed to early and ongoing financial planning to ensure that all our budget decisions are well informed and support the most effective and efficient use of resources.

East Lothian's growing and ageing population adds to this challenge in terms of how the IJB uses available resources to meet the growing level of demand for health and social care services. Census figures identified that East Lothian's population had grown by 12.6% between 2011 and 2022, the second fastest rate in Scotland, and a 9.8% growth in over 75s.

Engagement with individuals, communities, staff, partner organisations, and other stakeholders has underpinned much of our activity during 2023/24. Engagement will continue to play a vital role in guiding the service development and transformation activity needed to ensure that health and social care services deliver the best possible outcomes for the people of East Lothian now and in the future.

About this Report

East Lothian Integration Joint Board (IJB) Strategic Plan

East Lothian Integration Joint Board agreed its current Strategic Plan in October 2022. The Plan identifies the IJB's 7 strategic objectives for 2022-25:

1. Develop services that are sustainable and proportionate to need
2. Deliver new models of community provision, working collaboratively with communities
3. Focus on prevention and early intervention
4. Enable people to have more choice and control & provide care closer to home
5. Further develop / embed integrated approaches and services
6. Keep people safe from harm
7. Address health inequalities

An Annual Delivery Plan (ADP) is produced yearly outlining planned activity to support delivery of the IJB's strategic objectives for the coming year. Responsibility for delivery of activities detailed in the ADP is assigned to either Change Boards or to specific HSCP Officers / Teams. The East Lothian Strategic Planning Group maintains oversight and monitors progress in relation to the ADP.

This Annual Performance Report describes how East Lothian Health and Social Care Partnership (ELHSCP) services have contributed to the delivery of the East Lothian IJB Strategic Objectives during 2023/24. The report's structure is based on the 7 strategic objectives, with a section dedicated to each of these.[1] There is also a section outlining performance in relation to National Integration Indicators and one on financial performance.

You can view the full East Lothian IJB Strategic Plan for 2022-2025 here.

[1] Many of the activities described in the main report contribute to more than one Strategic Objective. However, for practical reasons the Annual Performance Report is structured so that each activity is matched to the Strategic Objective it is most relevant to.

National Integration Indicators – How We Performed

The Scottish Government published a Core Suite of 23 National Integration Indicators in 2015. The Ministerial Strategic Group for Health and Social Care later developed a set of additional indicators. Between them, these indicators provide a means for Health and Social Care Partnerships to measure progress in delivering the National Health and Wellbeing Outcomes.

The tables below provide the more recent available data for each of these indicators, along with the figure for Scotland and trend information where available / appropriate. Data for the Core Suite of Indicators is published on the Public Health Scotland website, the most recent publication can be found here.

Core Suite of National Indicators

(i) Scottish Health and Care Experience Survey (2021/22)

Nine of the national integration indicators are based on data from the biennial Scottish Health and Care Experience (HACE) survey (table 1). The most recent survey was in 2021/22, you can the data for that survey in the 2021/22 Annual Performance Report.

(ii) Operational Performance Indicators

The Core Suite of indicators includes a number of indicators based on hospital and other health and social care service activity, along with data from National Records of Scotland's death records. Performance against each of these indicators is shown below.

It should be noted that, where indicated (indicators 12, 13, 14, 15, 16, and 20), the figures given are for calendar year 2023. Calendar year 2023 is used as a proxy for 2023-24 due to the national data for 2023-24 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and other Health and Social Care Partnerships.

All proxy data shown in the tables below should be considered management information. An updated version of this section will be completed when the latest MSG figures are released on the 2nd of July. Due to this, the latest Scottish data has only been included for indicators 17, 18, 19, and 20.

Performance Symbols Key					
Improvement (compared to previous year).	✓	Similar to previous years / slight change (compared to previous year).	–	Negative direction (compared to previous year).	✗
Performance above the Scottish level.	✓	Performance around the same as Scottish level.	–	Performance below the Scottish level.	✗

11. Premature mortality rate for people aged under 75 per 100,000 persons (by calendar year)								
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**Comparison**	East Lothian performance has improved in the most recent year (2022). The East Lothian mortality rate for people aged under 75 has remained lower than the Scotland rate for all years since 2016.
East Lothian	372	333	313	342	375	357	✓	
Scotland	425	432	426	457	466	442	✓	

12. Emergency admission rate for adults (per 100,000 population)								
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023**	**Comparison**	Performance has declined from the previous year but has improved over the past 6 years. However, MSG indicator data indicates a reduction in the actual number of admissions from the previous year. East Lothian's admission rate has been lower than the Scottish rate for all years recorded since 2018/19.
East Lothian	10,071	10,964	10,088	10,434	9,165	9,685	✗	
Scotland	12,283	12,529	10,963	11,639	11,273	11,614	✓	

13. Emergency bed day rate for adults (per 100,000 population)								
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023**	**Comparison**	Performance improved, the East Lothian rate of emergency bed days decreased from the previous year and is the lowest recorded rate since 2021/22. The East Lothian emergency bed day rate has been lower than the Scotland rate for four of the six years since 2018/19.
East Lothian	103,451	100,497	106,640	116,812	115,986	102,945	✓	
Scotland	121,126	119,667	102,772	115,135	119,806	110,257	✓	

14. Readmission to hospital within 28 days of discharge (rate per 1,000 discharges)								
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023**	**Comparison**	East Lothian performance declined in the most recent year but has improved over a 6-year trend. The East Lothian rate of hospital readmissions within 28 days has been lower than the Scotland rate since 2018/19.
East Lothian	100	102	117	104	88	91	✓	
Scotland	103	105	120	107	102	104	✓	

15. Proportion of last 6 months of life spent at home or in a community setting								
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023**	**Comparison**	East Lothian Performance improved since the previous year. A 2% improvement can be seen in the East Lothian figure over the last 6 years. 2023 is the first year in which East Lothian has had the same proportion as Scotland since 2018/19.
East Lothian	87%	87%	89%	88%	88%	89%	✓	
Scotland	88%	88%	90%	90%	89%	89%	✗	

16. Falls rates per 1,000 population aged 65+								
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023**	**Comparison**	East Lothian had a higher recorded falls rate than the previous year. The data suggests that the East Lothian rate of falls has been the same or higher than the Scottish rate for three years since 2018/19.
East Lothian	19	23	23	22	21	23	✗	
Scotland	23	23	22	23	23	23	—	

17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections								
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**Comparison**	East Lothian's performance did not change from the previous year. The proportion of East Lothian care services graded 'good' or better has been higher or the same the Scotland proportion for all years since 2017/18.
East Lothian	85%	84%	85%	86%	77%	77%	—	
Scotland	85%	82%	82%	83%	76%	75%	✓	

18. Percentage of adults with intensive care needs receiving care at home								
	2018	**2019**	**2020**	**2021**	**2022**	**2023**	**Comparison**	East Lothian's performance did not change from the previous year. The percentage of adults with intensive care needs receiving care at home in Scotland has been higher or the same as East Lothian since 2018.
East Lothian	61%	63%	63%	64%	62%	62%	—	
Scotland	62%	63%	63%	65%	65%	65%	✓	

19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)								
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Comparison**	East Lothian's performance declined in the latest year. The rate has increased each year since 2021/22. The number of days people aged 75+ spend in hospital when they are ready to be discharged has been significantly lower in East Lothian than Scotland from 2018/19 onwards.
East Lothian	641	327	258	153	206	238	✗	
Scotland	793	774	484	748	919	902	✓	

20. Percentage of health and care resources spent on hospital stays where the patient was admitted in an emergency							
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**Comparison**	Up to date data is not available in relation to this indicator.
East Lothian	21.8%	22.0%	24.5%	23.1%	22.8%	✔	
Scotland	23.2%	23.3%	24.1%	24.1%	24.0%	✔	

There are a further four National Indicators which cannot be reported on currently as national data is not yet available or there is no nationally agreed definition for the indicator as yet. These indicators are:

- Indicator 10 - % of staff who say they would recommend their workplace as a good place to work.
- Indicator 21 - % of people admitted to hospital from home during the year, who are discharged to a care home.
- Indicator 22 - % of people who are discharged from hospital within 72 hours of being ready.
- Indicator 23 - Expenditure on end of life care costs in last 6 months per death.

Ministerial Strategic Group (MSG) Indicators

The indicators shown below were developed by the Ministerial Strategic Group for Health and Social Care. Health and Social Care Partnerships have been required to set their own targets for each of these indicators – East Lothian's are shown in the table below. These figures are based on reports released for management information only. Due to different configuration of services, figures for the hospital / hospice categories may not be comparable across partnership areas. **An analysis of the data by East / West localities is available at Appendix 1 below.**

Performance Symbols Key					
Improvement trend	✓	Performance similar to previous years / only slight change	—	Downward trend	↓

Indicator	2018/19	2019/20	2020/21	2021/22	2022/23	2023	Trend	6-year Trend	
1. Number of Emergency Admissions (18+)	8,182	9,030	8,264	8,482	7,579	**8,307**	↓	↓	There were 728 more emergency admissions than the previous year.
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	67,856	67,541	66,857	73,240	77,024	**70,745**	✓	↓	There were 6,279 fewer unscheduled hospital bed days than the previous year.
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	455	2,900	6,725	7,141	7,239	**7,010**	**Issue with data[2]**	-	No analysis possible currently.

[2] Data completeness issues for June 2022 (92%), September 2022 (97%), December 2022 (92%), and March 2023 (90%)

Indicator	2018/19	2019/20	2020/21	2021/22	2022/23	2023	Trend	6-year Trend	
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	281	2,493	6,577	6,921	6,962	**6,942**	**Issue with data[3]**	-	No analysis possible currently.
2iii. Number of Unscheduled Hospital Bed Days – Mental Health (18+)	15,572	14,001	12,632	13,304	13,713	**12,115**	✔	✔	There were 1,598 fewer unscheduled mental health bed days than the previous year. This was the lowest level in 6 years.
3. New Accident and Emergency attendances (18+)	21,176	21,305	17,923	21,226	21,254	**21,088**	✔	✔	There were 178 fewer A&E attendances than the previous year. This was the second lowest level in 6 years.
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	7,839	4,781	3,935	2,672	3,251	**3,044**	✔	✔	There were 207 fewer beds days lost to delays than the previous year.

[3] Data completeness issues for June 2022 (92%), September 2022 (97%), December 2022 (92%), and March 2023 (90%)

Indicator	2018/19	2019/20	2020/19	2021/22	2022/23	2023	Trend	6-year Trend	
5. Percentage of last six months of life spent in community setting	87.4%	87.1%	88.7%	87.7%	88.1%	-	✓	✓	The percentage of time spent in a community setting in the last 6 months of life increased slightly.
6. Percentage of the population at home – supported and unsupported (aged 65+)	96.7%	96.7%	96.6%	96.6%	96.5%	-	–	–	The percentage of people supported at home stayed at around the same level as the previous year.

Strategic Objective 1 – Develop services that are sustainable and proportionate to need

1.1 - Planning older people's services

Meeting the health and social care needs of a growing and ageing population remains a key priority for the East Lothian IJB. The Planning Older People's Services project continues to build upon the work of the Community Hospitals and Care Homes Change Board to help ensure that we have the services and resources in place to support people to live in their own homes for as long as possible.

Community engagement is at the centre of the project's approach, with the project team working closely with East Lothian residents and communities to collectively identify options for the future development of high quality sustainable services for older people. The first round of engagement activity ran from August to December 2023, connecting with communities, staff and the third sector to gather as many views and ideas as possible.

In total, 2,458 individual pieces of feedback were received. The feedback was then categorised into 19 themes shown in the infographic below. After analysing the feedback, a total of 314 suggestions were identified. These were then consolidated into a long-list of 105 options. A copy of the full Communications and Engagement Report can be found here.

Building on this extensive engagement, the team began to work collaboratively with an Independent Community Panel to explore and model the short-list options that met the project's hurdle criteria[4]. The next steps will include a full options appraisal exercise, public consultation period, and final recommendations report to be presented to the IJB in early 2025.

[4] You can view the Hurdle Criteria Results Report here.

1.2 - Developing Intermediate Care

Developing intermediate care services remains a high priority for the IJB going forward. As well as delivering better outcomes for our population, Intermediate Care services make better use of resources, ensuring that services are more sustainable in the longer term.

The National Institute for Health and Care Excellence (NICE) suggests that intermediate care services 'help people recover, regain independence, and remain at home'. The four key principles of intermediate care are shown in the infographic below.

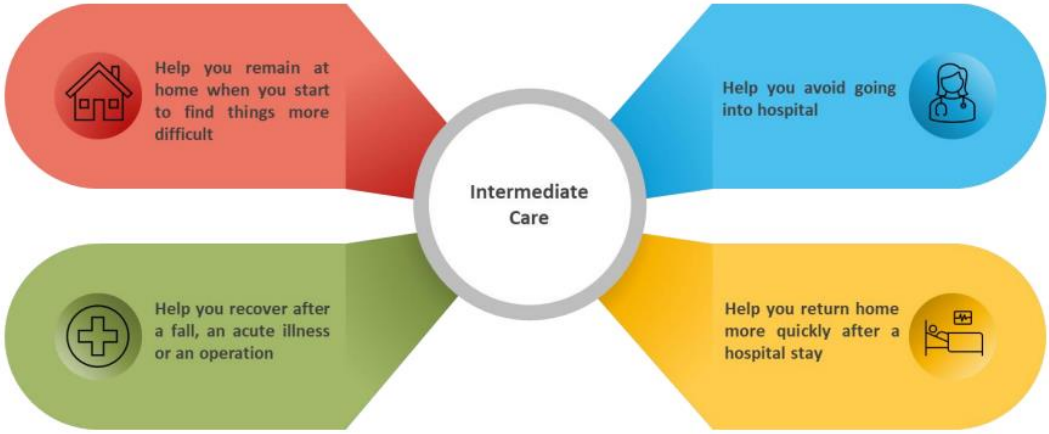


Diagram 1 - The Four Key Principles of Intermediate Care – Nice

ELHSCP continued to build on and develop a range of Intermediate Care services during 2023/24, these services include:

- Hospital at Home
- Discharge to Assess
- Telecare
- Care at Home / Hospital to Home
- Falls Services
- Emergency Care Service
- Musculoskeletal Service
- Community Respiratory Pathway
- Physiotherapy
- Occupational Therapy

You can read more about developments in relation to some of these Intermediate Care services during 2023/24 below.

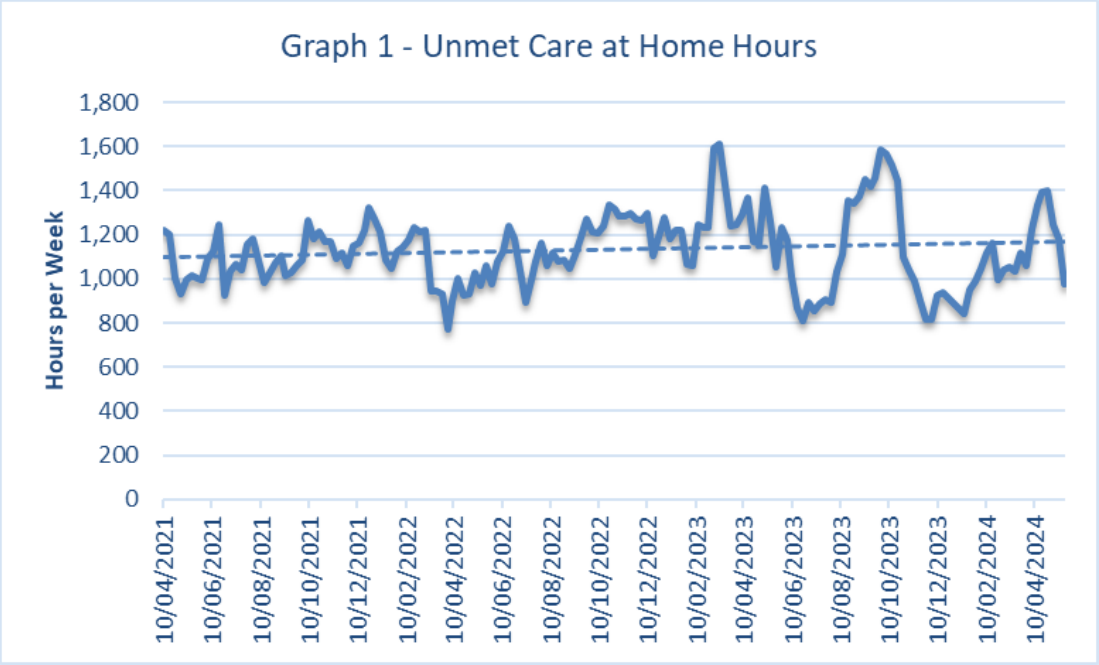
1.3 Care at Home services

Health and Social Care Partnerships across the country have faced significant challenges in recent years in relation to the delivery of Care at Home (C@H) services. This is due to people increasingly requiring more complex packages of care, alongside issues faced by providers in relation to recruiting and retaining staff and increased operating costs.

Care at Home services in East Lothian are delivered by a combination of HSCP managed services and services delivered by external providers. The number of hours per week delivered (for people over 65) by external providers had reduced by 3% by the end of 2023/24, whilst the number of hours provided by internal care at home services had increased by 25%

HSCPs are required to report weekly to the Scottish Government on 'unmet need'. This includes providing data on the number of people who have been assessed as requiring social care but who are still waiting for a package of care and the number of hours of care still to be delivered. This provides an effective measure of the extent to which social care provision is meeting local need.

Graph 1 below shows that the level fluctuated throughout the year, the number of hours of unmet need was lower at the end of 2023/24 compared to the start.



Effective planning for the provision of care at home is key element of the IJB's strategic objective to develop and deliver sustainable end proportionate social care services. A Care at Home Change Board was established in 2022/23 to lead on the delivery of a Care at Home Transformation Programme.

Activity during 2023/24 included building on an analysis of data on current and projected care at home costs, supply, and demand to develop a 'Test of Change' model for care at home provision to be piloted in 2024/25.

Praise for our Homecare Service

Our Homecare Service received praise from the Care Inspectorate following an unannounced inspection in September 2023. The service was given a four-star rating and inspectors noted 'warm, respectful, and compassionate interactions between staff and people using the service' and that:

> '…staff took the time when providing care, this ensured positive outcomes for people and a level of care that met people's needs and preferences.'

The team has since started implementing a number of improvements that were discussed with the Care Inspectorate, which will further enhance delivery of the service.

1.4 Supporting hospital flow

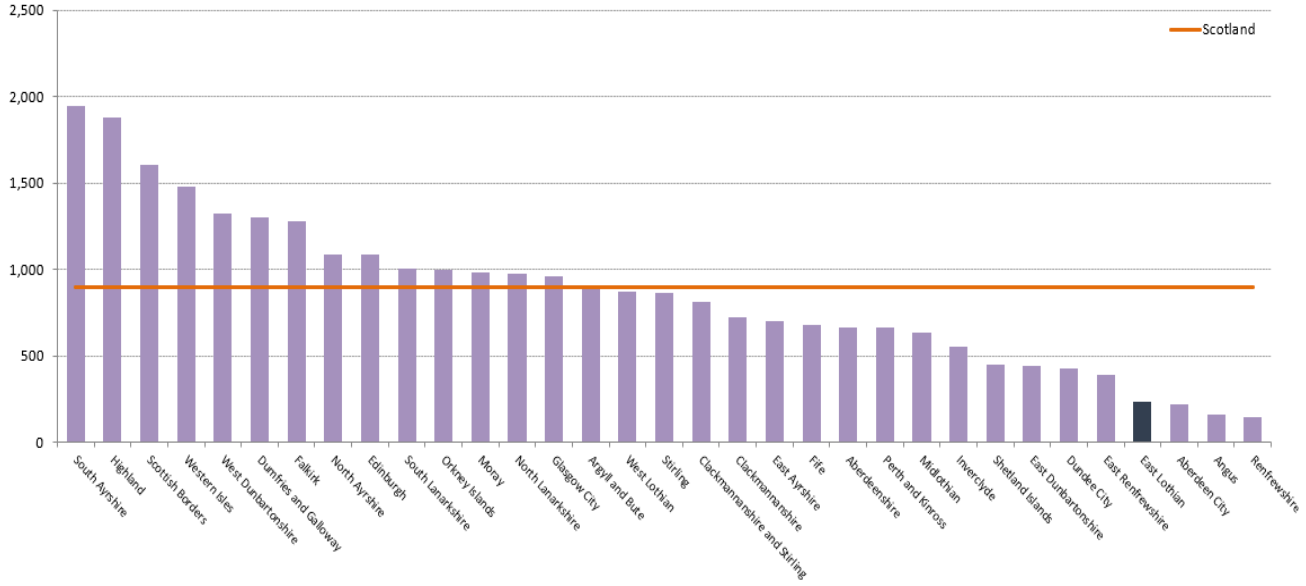
East Lothian HSCP has a strong performance record in preventing hospital admissions and maintaining low delayed discharge rates. This is achieved through services working collaboratively to prevent unnecessary admissions and to ensure that patients do not remain in hospital longer than medically necessary. Services contributing to this include the range pf Intermediate Care services listed above, as well as the Capacity and Flow (Discharge) and Care Broker teams and the Integrated Care Allocation Team (ICAT).

We continued to perform well in relation to maintaining a low level of delayed discharge during 2023/24. However, this became more challenging during the last quarter of 2023/24 when delays increased to a higher than normal level for East Lothian. This was due to a number of factors, including temporary closure of a number of care homes due to Large Scale Investigations, as well as higher than usual attendances at Accident and Emergency and an increase in unscheduled admissions.

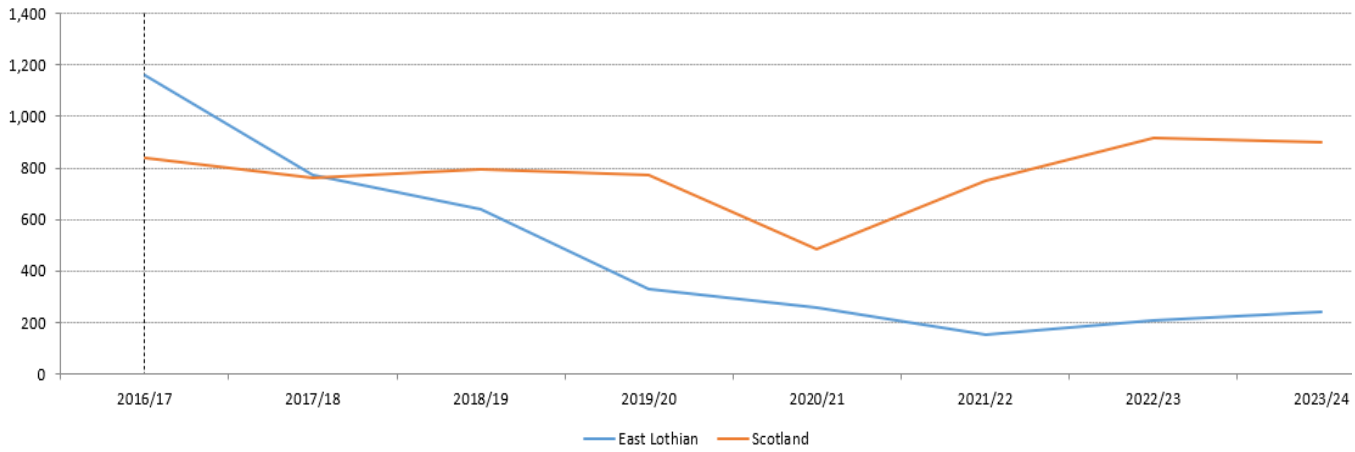
As a result of these challenges later in the year, the total number of delayed discharges for 2023/24 increased to 238 per 1,000 population, compared to 206 the previous year. This was still significantly lower than the Scottish rate of 902 per 1,000 population and East Lothian remained a high performer in relation to other local authority areas, ranking 4th as shown in graph 2.

Graph 3 shows East Lothian's performance since the early years of health and social care integration, demonstrating a significant reduction to 2019/20 and a steady maintenance thereafter.

Graph 2 – Days people 75+ spend in hospital when ready to be discharged, per 1,000 population (2023/24) – National Outcome Indicator 19



Graph 3 – Days people 75 and over spend in hospital when ready to be discharged, per 1,000 population (2016/17 - 2023/24) – National Outcome Indicator 19



Integrated Care Allocation Team (ICAT)

Our Integrated Care Allocation Team (ICAT) continued to provide an effective, collaborative approach to assessing people's care and support needs and identifying options for meeting these needs. The plays a key role in preventing hospital admission where possible and reducing the time people stay in hospital when they are fit to be discharged.

ICAT meetings bring together Social Work, Nursing, Occupational Therapy and Care Broker staff. Multi-disciplinary discussion enables a more comprehensive consideration of what an individual needs. This can often result in the care / support developed for the individual being more appropriate than what was originally requested. The team's collective knowledge of local services and community resources is also valuable and can allow a more creative approach to meeting needs.

The ICAT is also able to maintain a clear overview of care availability and care demand. This means that when care packages are closing, the care that becomes available can be quickly reallocated to where it is most needed.

Daily Flow Huddle

A Daily Flow Huddle was introduced in July 2022 to help reduce the number of delays for people leaving hospital. The Huddle brought together staff from a range of HSCP services, along with HSCP managers, and colleagues from acute hospital sites. Meetings were held online and provided a daily opportunity to review East Lothian patients across Lothian hospitals. This helped to support a pro-active, multidisciplinary approach to tracking and monitoring patients and planning their discharge home.

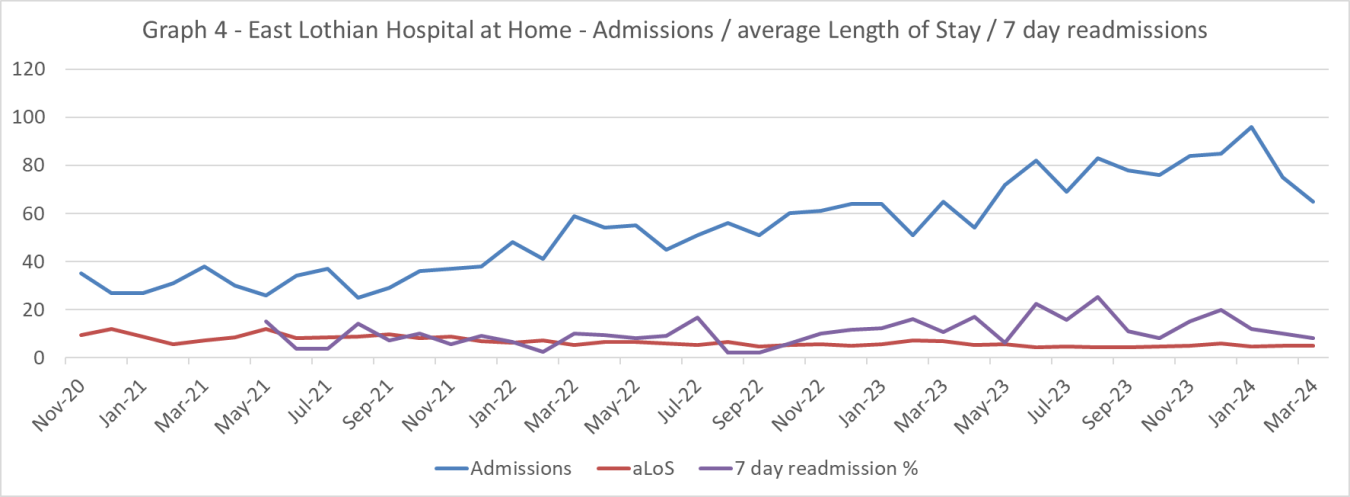
East Lothian Hospital at Home Service

The East Lothian Hospital at Home (H@H) service provides acute, hospital-level care in a home context for conditions that would otherwise require acute hospital inpatient care.

There has been a substantial and continued increase in patient numbers following investment from the Scottish Government and Health Improvement Scotland to recruit more registered nurses and purchase essential equipment.

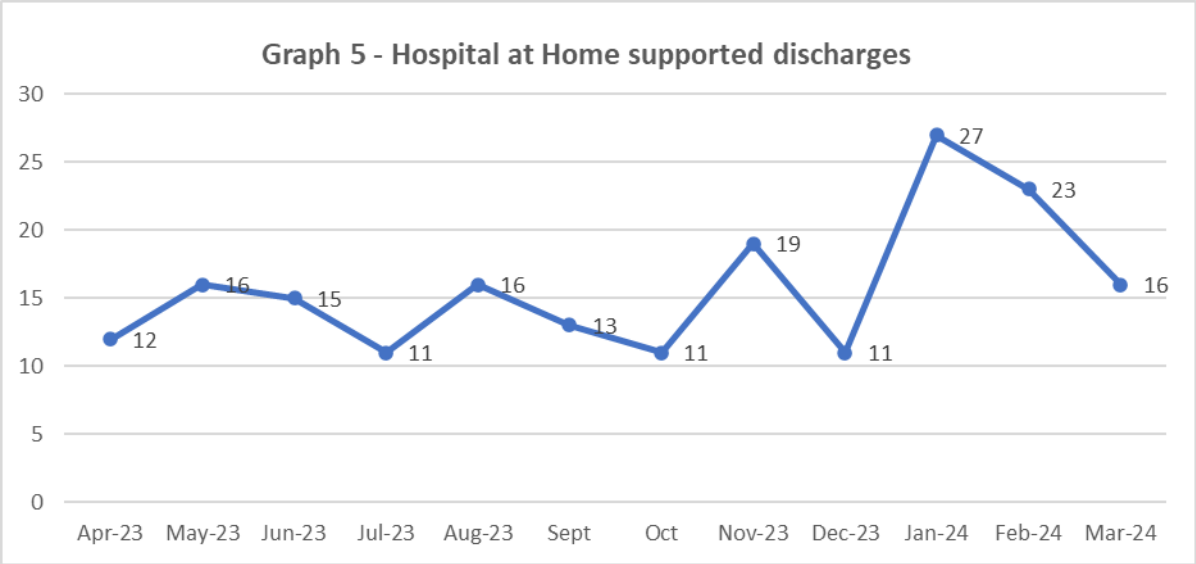
The graph below demonstrates the increase in numbers to the H@H service and the average length of stay (aLoS) which had fallen and remained low despite increased patient numbers.

In December 2023, the Scottish Government asked all H@H services across NHS Lothian to work collaboratively to optimise alternative referral pathways to support reducing patient attendances and admissions. The aim was to increase capacity by 10% which we achieved by accepting referrals from the Scottish Ambulance Service and Lothian Unscheduled Care Service at the weekends and by increasing awareness of the service in both front door areas and GP services.



The H@H service works closely with the front door Frailty Team and Acute Medical Unit / Medical Assessment Unit and have seen an increase in the number of supported discharges which we will continue to build on. The H@H service can provide intensive heart failure management, IV/SC[5] fluids, IV antibiotics, and short-term oxygen in the patient's own home to reduce the length of the hospital stay. Graph 5 shows figures for H@H supported discharges by month, with a total of 190 for the year.

[5] Intravenous / Subcutaneous



East Lothian Inreach Project

The East Lothian Inreach Project was developed in response to a request from NHS Lothian to all HSCPs in relation to forward planning in response to the extreme, sustained pressures anticipated for winter 2022/23.

The Inreach Project was initially delivered as a pilot over 2022/23, involving East Lothian AHPs[6] working with colleagues at the Royal Infirmary of Edinburgh (RIE) and the Western General Hospital (WGH). The pilot was evaluated positively, and funding was agreed to continue delivering the project through to the end of March 2024. The project team works closely with wider East Lothian HSCP teams to support optimising patient flow. Developments since the start of the project are summarised below.

October 2022 to November 2023:

- East Lothian assessment embedded at earliest point following East Lothian patients' arrival / admission to the Royal Infirmary of Edinburgh (RIE), followed by ongoing intervention by the team as appropriate until the patient was ready to be discharged.
- 662 patient discharges facilitated and onward referrals to over 40 different sources of support.
- During this phase, the project saved an average of 7 bed days per patient discharged withing the Discharge to Assess[7] Pathway, resulting in mitigated cost savings of £378, 679 (taking into account staff costs).

[6] Allied Health Professionals (AHPs) are a group of clinicians who provide care to people across a range of care pathways and in a variety of settings – in this instance, the AHPs involved included Occupational Therapists and Physiotherapists.
[7] Discharge to Assess supports people to leave hospital when they are medically fit to do so, continuing their care and assessment at home or in a community setting.

December 2023 to March 2024:

- Inreach approach adapted to reflect the Pan-Lothian Early Supported Discharge (ESD) Model, focussing on the first 72 hours following admission.
- Patients handed back to be supported by the RIE AHP team if they did not fit the ESD criteria.
- Since the Inreach project began, Discharge to Assess referrals from the 'front door' (Accident and Emergency or Acute Medical Unit) increased.
- However, Discharge to Assess referrals from RIE inpatient wards decreased when patients were handed back to the RIE AHP team after the 72-hour ESD period.

Mental Health Inpatient Beds

Work continued during 2023/24 to reduce the number of East Lothian mental health inpatient bed days, with the ambition to work within our commissioned bed base[8]. Inpatient bed use varied throughout the year, but with lower than average use during summer and through to Christmas. Graph 6 below shows a continued downwards trajectory over a two year period.

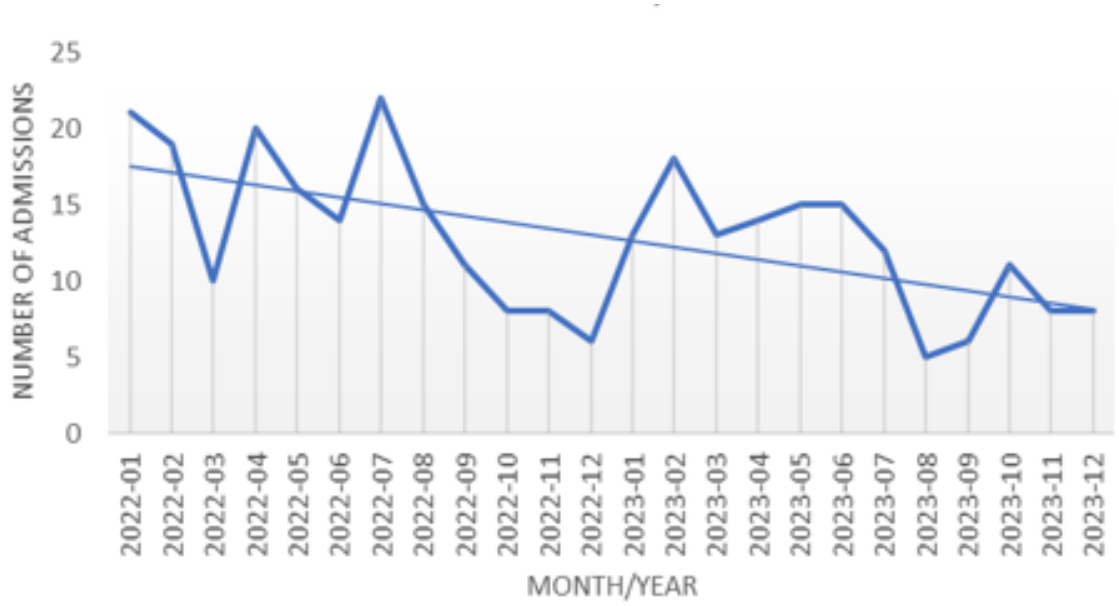
A three times weekly local 'Activity Huddle' involving the IHTT (Intensive Home Treatment Team) and CMHT (Community Mental Health Team) helps to support hospital flow by reducing unnecessary admissions and ensuring timely hospital discharge. Also key to the approach is a focus on PDDs[9] and Mental Health teams collaborating closely with colleagues from across services (for example, ICAT and Housing).

We have also introduced a Clinical Nurse Specialist role to help develop closer links between the CMHT, IHTT and inpatient services. This role provides specialist, senior input to teams supporting unwell people in the community who may be at high risk and helps to avoid admission where possible. The role also helps ensure a smoother discharge process to IHTT and CMHT.

There are a range of services in East Lothian that can contribute to keeping people out of hospital where appropriate. These include the PTS (Psychological Therapy Service); CWIC MH (Care When it Counts Mental Health service); and DBI (Distress Brief Intervention) – you can read about some of these under Strategic Objective 3 below.

[8] East Lothian IJB commissions NHS Lothian to deliver Mental Health inpatient services (beds).
[9] Planned Date of Discharge should be identified at the earliest possible opportunity in a patient's hospital stay and should engaging with the patient, carer, and family to plan for when the person is likely to be discharged.

Graph 6 – Royal Edinburgh Hospital admissions for East Lothian resident – 2 year trend



Orthopaedic Rehabilitation Ward at ELCH

A new Orthopaedic Rehabilitation Ward was opened at East Lothian Community Hospital (ELCH) in September 2023, providing supporting to patients from across the Lothians. Development of this provision at ELCH was part of NHS Lothian's Orthopaedic Recovery Plan aimed at reducing waiting times for elective surgical cases.

Development of the ward directly benefits East Lothian patients who have undergone surgery through offering inpatient, post-operative rehabilitation closer to home. It is also helping to further develop the extensive rehabilitation services at ELCH, developing staff skills and expertise.

Feedback in relation to the ward has been extremely positive:

'It's so lovely, it doesn't feel like a hospital. I'm already well on my way to recovery. The staff are always on hand to back you up and give you confidence. It's a very special place, and everyone in it is special' (Patient)

Hosted Services

Hosted services are operationally managed by an HSCP on behalf of two or more IJBs[10]. During 20023/24, a number of NHS Lothian services were transferred from Edinburgh HSCP to East Lothian HSCP to be managed on a 'hosted services' basis for all four Lothian IJBs. At the time of transfer, East Lothian was not hosting any services, whilst Edinburgh had a significant proportion of all the NHS Lothian hosted services. The purpose of the transfer was to help reduce pressure on Edinburgh HSCP.

The hosted services transferred to ELHSCP include:

- Inpatient and outpatient specialist rehabilitation services for amputee and neuro-rehabilitation at Astley Ainslie Hospital.
- The Cardiac Rehabilitation Service at Astley Ainslie Hospital.
- Inpatient and outpatient specialist acquired brain injury rehabilitation service at the Robert Ferguson Unit in the Royal Edinburgh Hospital.
- The specialist sexual health service at the Chalmers Centre.

Although responsibility for management of these services sits with the ELHSCP, as opposed to the IJB, the HSCP hosts these delegated services on behalf of East Lothian IJB (as well as the other three Lothian IJBs), so the IJB has a role in relation to oversight of service delivery for East Lothian patients.

Activity in relation to hosted services during 2023/24 focused on ensuring a smooth transition of the services to East Lothian management based on close engagement and communication with service staff and managers.

[10] Services can also be hosted by other NHS Directorates.

1.5 Commissioning

Health and social care services delegated to East Lothian IJB are delivered in a number of ways. Whilst the majority of services are directly provided by the HSCP or via 'hosted' or 'set-aside' arrangements[11], a significant proportion are delivered via commissioning arrangements with third and independent sector providers.

The approach we take to commissioning is important in terms of helping to ensure that commissioned services are provided in a way that reflects our vision and values and contribute to the delivery of our strategic objectives.

The IJB agreed the East Lothian HSCP Commissioning Strategy at its meeting in February 2023. The new Strategy includes a number of 'commissioning intentions and key market messages' that will guide activity in this area going forward. These reflect the IJB strategic objectives, as well as committing to an outcome focused approach, and to ethical commissioning that takes into account factors beyond price, including fair work, terms and conditions, trade union recognition, sustainability of services, and environmental impact.

A Market Facilitation Statement was developed during 2023/24 to support the Commissioning Strategy and was agreed at the May 2024 meeting of the IJB. This statement aims to help the IJB, HSCP and service providers to plan for future service delivery and sets out key pressures and summarises current supply and anticipated demand. You can view the statement here.

1.6 - Supporting effective & sustainable Primary Care

Demand on primary care services will continue to rise as the number of people living in East Lothian increases and older people make up a greater proportion of the overall population. We continued to witness significant pressure on general practice and other primary care services in East Lothian during 2023/24. The Scottish Government Budget announcement in December 2024 presents an additional challenge in terms of our ability to support effective and sustainable primary care provision.

The IJB has direct responsibility for the development and delivery of a range of primary care services. The approach to development of these services is detailed in the East Lothian Primary Care Improvement Plan (PCIP), and you can find out more about PCIP primary care services under Objective 4 below. As well as helping to reduce workload for GP practices, these 'PCIP services' have allowed new approaches to service delivery to be developed, with the aim of providing more accessible services for patients.

The HSCP also plays a number of other roles in relation to primary care, including strategic planning, infrastructure development and supporting GP practices in their key role as primary care service providers – some examples are given below.

East Lothian GP Cluster Activity

The East Lothian General Practice Cluster provides a forum for general practices to work collaboratively to improve the quality of clinical services. Each general practice is represented on the Cluster Group by a Practice Quality Lead. The Cluster's workplan (East Lothian Primary Care Quality Improvement Plan) identifies priorities for quality improvement activity, and sub groups have been established to work on areas of clinical priority.

Primary Care Premises

The IJB's 2020 Primary Care Premises Strategy identifies the communities and primary care buildings regarded as being the highest priority for capital investment. These priorities, along with priorities identified by the other Lothian IJBs, have been ranked by NHS Lothian to help determine future capital investment.

The replacement and upgrading of North Berwick Health Centre, Haddington Health Centre, and a new healthcare facility in Blindwells remain the three priorities for primary care capital development in East Lothian but this is dependent on capital funding from the Scottish Government.

1.7 Supporting delivery of sustainable Care Home provision

A new Care Home / Home First Project started at the end of 2023, with the aim of increasing the proportion of people discharged home from hospital, as opposed to being discharged to a care home placement - reflecting the 'Home First' principle. The project is based on the need to ensure that available care home places are used for people with the highest level of appropriate need. Although this approach is in part driven by the need to deliver financial savings, it also results in better outcomes for individuals and reflects a common desire for people to remain in their own homes for as long as possible.

The main elements of the project include:

- Establishing a Social Work Hospital Discharge Team to carry out early assessment and care package design, with an emphasis on identifying alternatives to care home admission (to be launched in 2024/25).
- Management scrutiny of all care home referrals via a newly established Resource Panel.
- Increasing the identification of cases for early intervention through enhanced management of the Adult Social Work Duty Team.
- Review admissions to identify where they could have been prevented.

The early stages of the project (December 2023 to March 2024) delivered a 5% reduction in private care home places.

Strategic Objective 2 – Deliver new models of community provision, working collaboratively with communities

2.1 Transforming Community Services

Transforming how we deliver community services continues to be a key strategic priority for the IJB. The Community Transformation Programme aims to develop innovative approaches to social care, working alongside communities and third sector partners to develop capacity and solutions, adopting a 'co-production' approach. Some examples of development activity during 2023/24 are provided below.

Resource Coordinator Service

Our Resource Coordinator Service supports people with learning disabilities to access community-based activities where they do not require a Resource Centre based service. The service continued to develop during 2023/24, with 113 people accessing a variety of sessions across East Lothian (currently in Musselburgh, Tranent, Port Seton, Prestonpans, Haddington, and Dunbar).

The community based sessions focus on physical activity and skills development – these include life skills, college outreach, arts and crafts, cooking, mindfulness, yoga, gardening, bowling, swimming, and table tennis. Development of sessions is guided by feedback from people using the service.

One of the main aims of the Resource Coordinator service is to develop links with local community groups and other organisations in order to increase community capacity and support inclusion.

An evaluation tool is being developed to capture the views of people using the service and to inform its ongoing development.

While the Resource Centre Service is currently managed by the HSCP, there are plans to look at alternative models for provision from 2025 onwards.

Neighbourhood Networks

Neighbourhood Networks provide peer support in people's local communities to help people establish a life in which they are more active and independent, and less reliant on formal support services.

Members of Neighbourhood Networks are supported to develop skills such as independent travel, cooking, budgeting, employment skills, volunteering, and general life skills. Neighbourhood Networks

can help people to feel less isolated and lonely by giving them a sense of belonging and involvement and helping to develop their confidence and self-esteem.

We continued to develop Neighbourhood Networks in East Lothian over 2023/24. There are now five Networks in place in Musselburgh, Tranent, Haddington, and Dunbar; two of these are 'Transitions Networks' for young people moving from children to adult services.

Each Network can support 10 active members. Once people have moved through the Network they can become Associate Members who can stay in touch, maintaining their social connections and offering peer support to active members. In the last reporting period there 33 active members across Networks and 13 Associate Members.

Musselburgh members have been working with LEAD Scotland, and the majority of them have now achieved National Units SCQF Levels 2-6 in Numeracy. Neighbourhood Networks has organised a certificate presentation to celebrate this achievement.

'…. it's brilliant I can independent travel now. I don't need to depend on my Mum driving me' (Neighbour Network Member)

'I can't believe the change in A, his confidence has grown so much. I am so proud of how A has developed, and his Independent Travel Outcome Score has improved so much from when we did his Support Plan' (Carer)

Older People's Day Centres

Older people's day centres play a key role in promoting the independence and confidence of older people with complex needs and their carers. We carried out a tendering process during 2023/24 to identify organisations to provide day services on longer term contracts in order to support the sustainability of these services. Providers were identified and contracted to provide person-centred, outcome focused care and support in locations across East Lothian. A new Personal Outcomes Framework has been developed and is now a core part of the commissioning process.

East Lothian Community First Service

The East Lothian Community First Service was launched in October 2022 and continued to develop throughout 2023/24. Community First is delivered by VCEL (Volunteer Centre East Lothian) with funding from East Lothian HSCP.

Community First provides support to people who are struggling with their health and wellbeing, helping them to access community services. It also provides support to people leaving hospital, as well as helping to prevent hospital admission / readmission. There were 326 referrals to the service during 2023/24. In response to feedback, the service lowered its age criteria from 50+ to 35+.

The service is based on 'what matters to you' conversations, helping people to explore the opportunities available to them and carrying out 'goal setting' using a strengths based approach (focusing on what people can do rather than on what they cannot).

People using the service have identified needs related to social isolation, financial hardship, food poverty, benefits issues, carers stress, housing, relationship breakdown, mental health, physical health, hospital appointments, and substance use.

The following story is an example of the support available through Community First. We have changed personal details.

Eddie's Story

Eddie is in his 70s and lives alone. His daughter stays nearby but works full time and has a young family so struggles to spend as much time with her Dad as she would like and worries that he is lonely. Eddie had hip surgery earlier in the year and has other medical issues that mean he can struggle with everyday tasks. His mobility is also an issue, and he is anxious about leaving the house alone and panics when he needs to attend medical appointments, though is reluctant to ask for help, and doesn't want his daughter to have to take time off work to go with him.

Eddie was referred to Community First by one of the HSCP's Physiotherapists. Through chatting with one of the Community First Workers, Eddie admitted that he often felt lonely, and his days felt long. He had also lost a lot of confidence since his operation, and this was effecting his independence. He felt guilty that his daughter worried about him and often seemed stressed.

Eddie was matched with a Community First volunteer who helped support him to gain confidence out and about using his walking stick and getting on and off buses, as well as suggesting some other options to make things a bit easier.

After 12 weeks of receiving support from Community First, Eddie had started to take the bus into town on his own to wander around the shops and go for coffee. He had also made use of patient transport to attend a medical appointment and felt that would be something he would be happy to do again. Eddie hadn't been keen to join any local groups, but now knew about at a café run at the Hollies Centre and thought he might visit at some point.

Eddie's daughter was put in touch with Carers of East Lothian to see if there was anything that would help her in her caring role, and she reported feeling much more positive and less stressed having seen how much happier her Dad was.

Musselburgh Meeting Centre – A place to be me

Dementia Friendly East Lothian (DFEL) opened the Musselburgh Meeting Centre in April 2023, bringing a new, evidence-based approach to supporting people living with dementia and care-partners. The Meeting Centre receives grant funding from East Lothian IJB, and HSCP staff have been involved in supporting the development of this work.

Meeting Centres are social clubs offering warm and friendly expert support to people with mild to moderate dementia, families, and friends. They are a valuable community resource, helping people adjust to the psychological, social, and practical changes dementia brings.

There are 11 key features that make a Meeting Centre, including a trained and stable support team, everyone in the Centre being 'in it together', and the centre being a regular social club in a community setting. In this environment, friendships and confidence build, people learn new things and re-connect with activities they love or have done over a life time. Centres are based on person-centred support, cognitive stimulation and psych-motor therapy, and the power of peers. Meeting Centres foster a sense of belonging and community, helping people with dementia maintain social connections and reduce feelings of isolation.

DFEL continued to grow the Musselburgh Meeting Centre over 2023/24, by the end of the year there 12 Members living with dementia were attending the Musselburgh Centre, along with care-partners coming along on a drop-in basis. The Centre also hosts a carers-space facilitated by Open Arms Carers and Carers of East Lothian. DFEL is leading on development work looking at how this model could be rolled out across East Lothian.

Below is one of many stories from Members about how coming to the Meeting Centre has changed their lives. We have changed personal details.

Erica's Story

Erica lives with dementia and joined the Centre a year ago. Her son, Martin was struggling to provide support and things came to a head when Erica was hospitalised after a fall.

Erica was clearly anxious and wary when she came in and said very little. Martin took the lead and spoke on Erica's behalf. He was anxious Erica might fall again and stayed by her side, suggesting she sit down and use her stick. We could see Erica's frustration and struggle to speak out, exacerbated by problems finding the right words and understanding what people were saying.

As we got to know each other, Martin felt confident to 'nip out' to the shops or bank. With Martin away, Erica decided to play dominoes with other members. We saw her relax and her first smile was when she won the game. Now Martin often drops Erica off and comes back in time for cuppa at the end of the session and a chat with other members and carers.

Over the year, Erica has grown in confidence and has found opportunities to do new activities, including things she can't do at home. For example, Erica speaks out more, claiming her own space and voice - often asking Martin to stop speaking or to please go away. She is more socially connected, actively engaged in the life of the Centre, and conversing with the other members. Even if the words aren't quite right, this is a place where life with dementia is understood, and no one is judged. Erica has also found a sense of purpose and meaning by doing the washing up, baking cookies and serving food. All things she'd stopped doing at home due to lack of confidence and Martin's concerns for her safety. Erica's fresh fruit plate was a work of art. Erica says: "Despite this [dementia] I know I can still do things – I'm not finished yet!"

Coming to the Meeting Centre created opportunities for Erica and Martin to feel safe and supported to spend time apart; to build new relationships with people in the same boat and do new things. At the Centre we find ways to reconnect people to the things, people and activities that make life worthwhile, even daily tasks that we can take for granted. As Erica says - "[it] feels like me again".

Musselburgh Meeting Centre is helping us to understand more about ways of helping people manage life with dementia and to develop skills and experience we can share with others. Dementia Friendly East Lothian is working with partners to develop the Meeting Centre approach across East Lothian so that more people can benefit and can 'be me again'.

You can find out more about Dementia Friendly East Lothian here.

East Lothian Exercise Pathway

Work to develop the East Lothian Exercise Pathway continued during 2023/24. The purpose of the pathway is to engage people in physical activity, and to maintain this participation over the longer-term. It aims to provide support to people with long-term health conditions, as well as to patients completing rehabilitation.

The Exercise Pathway initiative has been developed collaboratively by ELRS and Enjoy Leisure and informed by engagement with a range of community stakeholders. A Steering Group guides ongoing development, taking a 'Experience-based Co-design' approach. The Steering Group is led by the Chair of Lammermuir Community Council and also includes representation from Ageing Well, Live Well, VCEL and East Lothian Council.

An initial pilot was launched in December 2023 covering 4 GP practices, before being extended to cover all 15 GP practices at the start of March 2024. By the end of 2023/24, over 60 referrals had been received,

2.2 Working with communities

Participation and Engagement

A new IJB Participation and Engagement Strategy was launched in 2022/23. The Strategy commits to the further development of existing participation and engagement arrangements, as well as strengthening the focus on engaging with people whose voices tend not to be heard via existing channels, and on learning from 'lived experience'[12] whenever possible. You can view find out more about the East Lothian IJB Participation and Engagement Strategy here.

We carried out several major pieces of engagement work during 2023/24, including in relation to Planning for Older People's Services; the East Lothian Independent Advocacy Plan; Deaf Social Work Service and BSL (British Sign Language) Plan; and continuing engagement with carers.

In an effort to reach as many people as possible, we have done our best to engage with people at their own meetings and events, for example, at service user groups, community council meetings and community days, and this has proved to be very successful. We have also made good progress in engaging with people with lived experience, including care experienced people and people affected by adverse childhood experiences. We also began to develop links and engage with BME (Black and Minority Ethnic) groups in East Lothian.

An example of one of our larger scale engagement exercises in relation to the Planning Older People's Services project can be found on page 14 above.

[12] The term 'lived experience' refers to first-hand experience of specific issues and / or of using related services.

Strategic Objective 3 – Focus on prevention & early intervention

3.1 East Lothian Rehabilitation Service (ELRS)

East Lothian Rehabilitation Service (ELRS) delivers a wide range of services in East Lothian. More information on these services and their performance during 2023/24 can be found in the ELRS Annual Report (available on the East Lothian IJB web pages). The information below provides a summary of activity related to delivery priorities detailed under Strategic Objective 3 in the HSCP's Annual Delivery Plan. ELRS services also contribute to a number of other IJB Strategic Objectives.

Smart TEC

TEC (Technology Enabled Care) can be used to help people to remain as active, independent, and safe as possible in their own homes and in the wider community. TEC can be used alongside or as an alternative to care provision, helping to reduce demand on resources.

The Telecare team carries out assessments and delivers interventions at the Well Wynd Hub; during home visits; or via phone calls. A range of equipment can be provided including community alarms and pendants; devices to help detect falls; and environmental sensors to keep people safe (for example, in relation to fire safety). The team also provides training in TEC awareness to HSCP and Housing teams, helping to promote a 'TEC first approach'.

There was a continued growth in referrals to the team during 2023/24 and an additional increase to workload due to its role in supporting the analogue to digital transition.

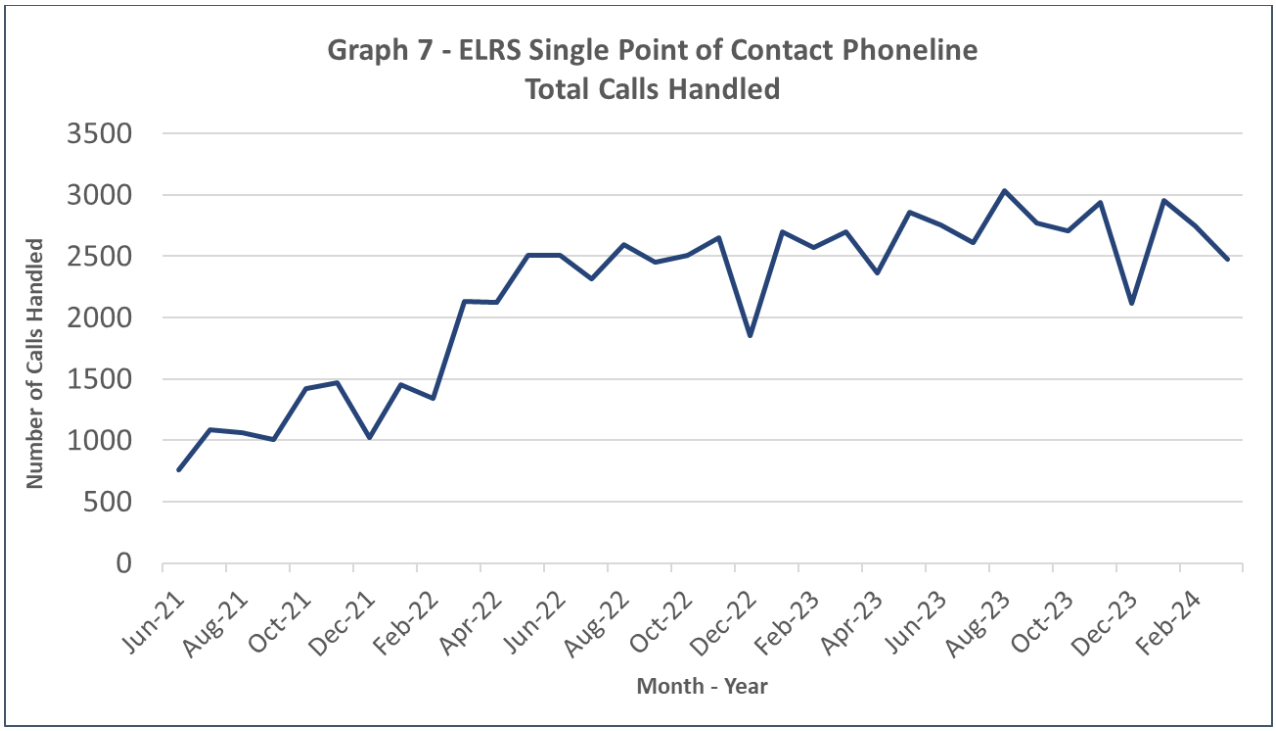
- The team received 1,077 referrals during 2023/24.
- 3,950 interventions were delivered over the year.
- The number of people using the telecare service increased from 2,429 at the start of the year to 2,541 at the end.
- By the end of the year the service had replaced 55.9% of analogue stock to digital alarms.
- 92 TEC awareness sessions were delivered to staff.

ELRS Single Point of Contact

ELRS's Single Point of Contact (SPOC) system is now well established, with phonelines working to capacity. This allows people to contact the service directly through one central system, and then speak to the professional who is best placed to deal with their enquiry. The SPOC can be used for self-referral, professional referral, or enquiries from existing patients.

Use of the SPOC gradually increased since its introduction in 2021. Almost 52,500 calls have been handled since the phoneline was launched, with over 32,300 of them taking place during 2023/24 –

this is shown in graph 7 below. (monthly totals during 2023/24 ranged from 3,031 in August 2023 to 2,115 in December).



Digital Platform

A digital platform, 'Access to a Better Life in East Lothian' was launched in March 2022, providing information and tools to support people to manage their own health and wellbeing. The platform includes information on the LifeCurve[13], support on self-management, and details of how to contact and self-refer to ELRS services, as well as an interactive Body Map and Smart House.

Despite extensive activity to promote use of the platform, the total number of page views fell from 48,922 in 2022/23 to 45,260 in 2023/24, use of the LifeCurve element also reduced. It was felt that the level of user engagement with the platform did not reflect the resources invested, and given the financial constraints facing the IJB, it was agreed to terminate the contract with the provider. The platform content was migrated to the ELHSCP website during March 2024, ensuring that this valuable resource is still available.

You can visit the digital platform here.

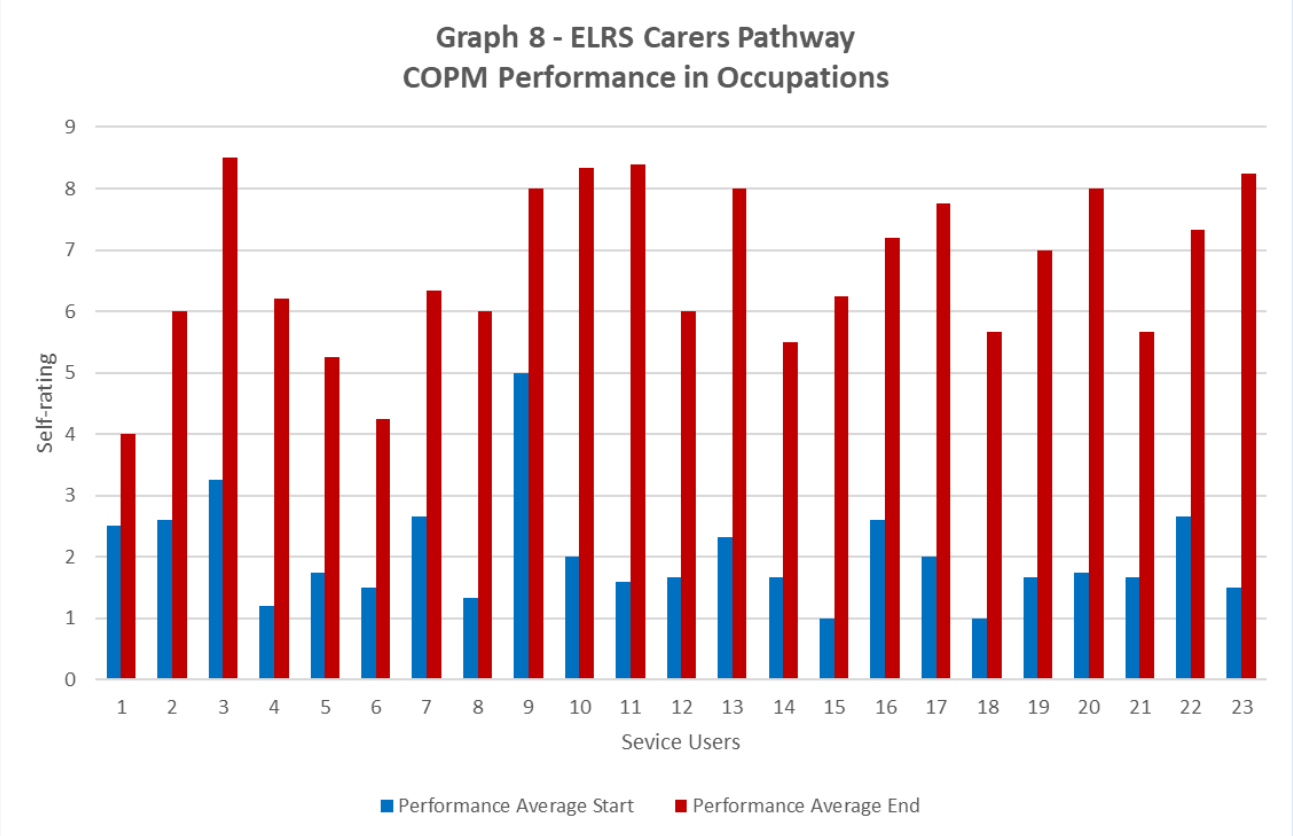
[13] Find out about LifeCurve here.

East Lothian Carers Pathway

An Occupational Therapy led Pathway for unpaid carers was introduced in 2022 and continued to develop during 2023/24. The purpose of the Carers Pathway is to help to ensure that carers gain access to the support they need to maintain their physical, emotional, and mental wellbeing, and to help them achieve a balance between their caring role and other aspects of their lives. Referrals to the Pathway can be made by Adult Social Work teams, Carers of East Lothian or from other HSCP services.

Referrals grew throughout the year as the pathway continued to be promoted across the HSCP and other organisations. By the end of 2023/24, a total of 107 new referrals had been received, bringing the total number to 143 since the pathway was introduced. Demand exceeded capacity and a waiting list was established to manage referrals.

Each carer is offered a COPM[14] assessment at the start and end of their involvement, and scores have been found to significantly improve as a result of the intervention (see graph 8 below).



[14] The Canadian Occupational Performance Measures (COPM) is a person-centred outcome measuring tool used to set intervention goals and to monitor progress in relation to these goals.

Feedback has been extremely positive, comments include:

- ‘The input I received and the impact this had on my thinking went well beyond anything I might have expected.’ (Service User)

- ‘Prevented breakdown of the situation, allowed and enabled the person cared for to remain at person.’ (Community OT)

- ‘We would not have achieved the positive therapy outcomes we had with our patient if it wasn’t for his carer and the support she was given from the OT Carer Pathway.’ (Speech and Language Therapist)

3.2 Falls Prevention & Management

Falls can have a significant impact on people's health and wellbeing, making early intervention and prevention a priority. Falls are the most common cause of emergency hospital admission for adults in Scotland, resulting in significant financial costs and putting pressure on hospital beds, care packages and rehabilitation services.

An East Lothian Falls Service and a Falls Project Manager post were established in 2022 following a scoping project. Further development of the service took place during 2023/24., including work to streamline referral pathways. Training and awareness raising were also key activities, including delivery of a successful county wide Falls Week Campaign in September 2023.

There were a total of 373 referrals to the Falls Service during 2023/24 and 1,521 interventions were delivered. Support was provided to 289 people on a 1:1 basis and 84 people benefitted from group sessions in the form of 'Steady On' Falls Prevention classes.

3.3 Mental Health & Wellbeing – Prevention & Early Intervention

Many people will experience issues with their mental health at some stage in their lives. For some, these issues will be more complex and require a higher level of treatment and support from mental health services. For others, issues may be less complex, and will benefit from early, lower-level interventions to support individuals to cope and to improve their own mental wellbeing. This section describes a number of developments that took place during 2023/24 in relation to services providing a preventative / early intervention approach.

CWIC Mental Health

The CWIC (Care When it Counts) Mental Health service is unique to East Lothian, with experienced Mental Health Nurses and Occupational Therapists making up the multi-disciplinary team. The service provides easily accessible help and support to people presenting with a mental health issue. The team takes a holistic, person-centred approach to understand the specific needs of each patient.

Demand for the service was high throughout the year, with the small team delivering around 5,400 appointments. An unprecedented level of demand and the complexity of need contributed to waiting times increasing to around 7 weeks as the year progressed. Work is ongoing to reduce waiting times, recognising how valuable ease of accessibility is to patients and their families.

Feedback on the service continued to be very positive:

> 'This service was like a hub to join everything together, and it worked very well. Without this service I feel that I would not have been able to make changes to my program as quickly or effectively. This was an extremely beneficial service. I found the practitioner genuinely caring, and very approachable. She did not judge. She guided me to make my own actions and decisions. I hope this service continues to be offered, as it was, for me, life changing.' (CWIC MH Patient)

> 'I have worked in the CWIC mental health service for 2 years and from the very beginning have been proud to be part of a team that provides mental health support for those in the community who need it. The role can be challenging at times, particularly with the increase in the demand and mental health needs of patients attending primary care. Teamwork is key to the ongoing success of the CWIC Mental Health team as is the desire to continue to help those presenting with mental health issues.' (CWIC MH team member)

Ritchie's Story

Ritchie first contacted the CWIC Mental Health Team last year following a recent move to East Lothian to study, having found out about the service online and getting in touch by phone. They told the Mental Health Occupational Therapist (OT) a bit about their history of self-harm and suicide attempts and that they had been on a waiting list for an Autism assessment with their local CAMHS[15] Team. Ritchie's initial request was to be placed on a waiting list for an Autism assessment, as it appeared they had been removed from previous list. They also requested support with a letter for Disability Support Services from the University and advice on support with Gender Identity.

CWIC offered follow ups over the next few weeks with our Mental Health OT. Support was given around safety planning as Ritchie had been struggling with suicidal feelings and self-harm. Concern was noted about presentations out of hours and with emergency services. There was liaison with the Community Mental Health Team about prioritising a Psychiatry review and agreement was made around medication changes and Autism assessment.

Ritchie felt positive about the proposed treatments and was able to work on distress tolerance as well as on discussing around trauma with their OT. A Psychology referral was made, along with a referral to a third sector organisation who could provide Ritchie with additional support.

Distress Brief Intervention (DBI)

This year saw the launch of a new Distress Brief Intervention (DBI)[16] service offering accessible support to people in distress. People referred to the DBI service are seen quickly and provided with 'compassionate, problem solving support, wellness, and distress management planning, supported connections and signposting – reducing both immediate distress and empowering ability to manage future distress.'[17] The service is funded by East Lothian IJB, and delivered by Penumbra.

People can be referred to the DBI service by our IHTT (Intensive Home Treatment Team) and CWIC MH services. Over 250 referrals were received in the first year of the DBI service. More than half of referrals are for people experiencing depression and low mood, although support is also provided in relation to anxiety, suicidal thoughts, and self-harm.

[15] Child and Adolescent Mental Health Service.
[16] Distress in this context is defined as 'An emotional pain which led the person to seek help, and which does not require further emergency service involvement' (www.dbi.scot/aim/)
[17] Aim - Distress Brief Intervention Scotland (dbi.scot)

The DBI team regularly participates in the three times per week mental health ‘activity huddle’, ensuring early discussion and planning about who they may be able to support, and providing an opportunity to seek multidisciplinary discussion around complex presentations.

Face to face DBI sessions started in Musselburgh towards the end of 2023/24, and a there are plans to develop a second outpatient base in Haddington.

3.4 Improving the management of long-term conditions

Growing numbers of people are living with long-term conditions, and this is set to continue to increase over time as more people live longer. Supporting people with self-management of long-term conditions results in better outcomes and quality of life for them, as well as helping to reduce pressure on health and social care services.

This is why developing approaches to improving the management of long-term conditions has been identified as a strategic delivery priority for the IJB. Examples of activity taking place in 2023/24 in relation to this priority include:

- The expansion of outpatient services and clinics at East Lothian Community Hospital, including those related to the management of long-term conditions (see page 49).
- Activity to raise awareness of and improve public information on the range of primary care services that people can access directly to support their health needs, including dedicated web pages and a printed booklet. (see page 49)
- Information on managing long term conditions on the 'Access to a Better Life in East Lothian' digital platform (see page 37).
- Delivery of an initiative led by the East Lothian GP Cluster and funded by the HSCP to increase the number of people using a blood pressure home monitoring system.

Strategic Objective 4 – Enable people to have more choice and control and provide care closer to home

4.1 HSCP Primary Care Services

Primary Care services in East Lothian have changed significantly since the inception of the IJB with more choice of services available, which has improved accessibility, quality, and patient outcomes.

Where patients in the past would have contacted their General Practitioner, there are now more choices for patients as the HSCP has developed primary care teams and the role of the community pharmacist has expanded to offer services through the Minor Ailments Scheme, Pharmacy First and Pharmacy First Plus.

HSCP primary care services continue to develop to improve patient experience and make efficient use of the funding and resources available. The following provides a description of activity during 2023/24. You can find out more information about primary care services here.

Care When It Counts (CWIC)

The Care When it Counts (CWIC) service supports GP practices by offering same-day appointments with a team of clinical professionals. The CWIC service can currently be accessed by patients registered at Riverside Medical Practice (Musselburgh), Inveresk Medical Practice (Musselburgh), Tranent Medical Practice, and the Harbours Medical Practice (Cockenzie and Port Seton). A multifaceted approach by the team led to a 60% increase in appointments available in 2023 compared to 2022 and provided over 25,000 appointments in 2023/24.

The CWIC multidisciplinary team has a strong improvement culture and a clear focus on providing high quality care through a great training environment. The approach was recognised nationally with the team shortlisted for the final of the Royal College of Nursing Learning in Practice Award.

CWIC continues to play a key role in supporting the development of Advanced Nurse Practitioners and Physician Associates in East Lothian. These roles will become increasingly important in meeting future demands on primary care services driven by a growing and older population.

Most of the clinical team in CWIC have been supported by the HSCP to complete their clinical training and CWIC also supports staff from community pharmacists and other HSCP services to become Independent Prescribers. Supporting the training of Physician Associates has led to these postholders being available to work in other ELHSCP teams, specifically the Care Home Team, Hospital At Home, and Medicine for the Elderly in ELCH.

Community Treatment and Care Service (CTAC)

The Community Treatment and Care Service (CTAC) is a nurse-led service delivering clinics across East Lothian. CTAC provides a range of services to patients of all ages in a treatment room setting. In 2023/24, clinics were offered in Dunbar, North Berwick, Haddington, Musselburgh, Tranent, Cockenzie and Prestonpans.

Demand on service continued to rise during 2023/34. This included a 23% increase in demand for wound management and 28% increase in bilateral dressing. Without an increase in funding, this made it necessary to pause the ear care service provided by CTAC to allow the team to focus on other clinical priorities.

A day in the life - the CTAC Service

On a typical day, CTAC nurses will each see around 20 patients providing a variety of clinical treatments including wound management, Vitamin B12 injections, suture and stiches removal, Doppler assessment, and phlebotomy.

Wound care is the service provided most frequently by CTAC staff. Patients come to CTAC with a range of different types of wounds, all of which require prompt and accurate assessment and treatment. Examples of different types of wounds we see are:

- Chronic wounds (most commonly leg ulcers).
- Traumatic wounds.
- Burns.
- Surgical wounds.

Patients who come to CTAC with wounds will receive a holistic assessment that involves nursing staff asking for a variety of information. This will include questions about the history of the presenting complaint, the patient's medical history, medications, and subjective symptoms.

Following clinical assessment, the CTAC Nurse will recommend a treatment plan which may include a dressing plan. They will also advise on how frequently the dressing will need changed and whether the patient will require further assessment.

Patients with leg ulcers may require a scan called a Doppler scan as part of their holistic assessment. The Doppler scan assesses the patient's vasculature and circulation using an ultrasound machine and is done in the CTAC clinic. By calculating the patient's ankle/brachial pressure index (ABPI), the CTAC Nurse can assess whether the patient is safe to commence compression therapy as part of their treatment plan. Depending on the results of the Doppler scan, the patient may require to be referred to other services such as the vascular team.

Pharmacotherapy Team

During 2023/24, the Pharmacotherapy Team focused on undertaking activities to directly support GP practices and on the delivery of cost-effective and safe prescribing initiatives.

The team also continued to deliver other important workstreams, including polypharmacy reviews and the expansion of serial prescribing[18], albeit at a much reduced pace as a result of significant workforce pressures and increased demand driven by East Lothian's growing population.

There were challenges during 2023/24 in relation to medicine shortages, notably diabetes treatment and ADHD drugs, and these had a significant impact on the Pharmacotherapy team's workload.

Despite these challenges, the team has undertaken innovative project work including:

- Scheduling medicines reconciliation work to reduce time spent on it.
- A Quality Improvement project to ensure medicines reconciliation is undertaken by the most appropriate person.
- Trialling the pharmacy technician role in monitoring high risk medicines.
- Tracking prescription requests for stoma and nutrition products to identify duplicates and reduce workload and cost.

Education, training, and development continues to be a priority for the team, with individuals completing a variety of courses and achieving professional qualifications a range of levels.

Work also began during 2023/24 on developing a pharmacotherapy hub in Musselburgh Primary Care Centre. Once established this will free up much needed space in GP practices; support pharmacists to deliver more clinical; provide mutual support for pharmacy technicians; and enable a more effective training and mentoring environment.

[18] A serial prescription is a prescription for medicines to treat long term conditions – these prescriptions last for 24, 48 or 56. This helps to reduce practice / pharmacy workload and is more convenient for patients.

Primary Care Vaccination Programme

The Primary Care Vaccination Team provides the majority of adult vaccinations in East Lothian, including COVID, Seasonal Influenza, Pneumococcal, and Shingles. Last year the team administered over 116,000 vaccinations.

The team work from four sites in Dunbar, Haddington, North Berwick, and Musselburgh and also provide vaccinations in Care Homes and for people who are housebound.

A day in the life – The Primary Care Vaccination Team.

The Primary Care Vaccination Team is a multi-professional team operating across the County. The team runs clinics in four East Lothian locations, as well as providing vaccinations in care homes and at home for people who are housebound. The East Lothian vaccination bus is also available to deliver pop-up clinics in a range of additional locations for people who may find it difficult to get to one of the existing clinics.

Each vaccinator in the team will typically see between 50 and 100 patients on a busy clinic day. As well as administering the vaccine, vaccinators are also responsible for screening each patient for eligibility and suitability as well as gaining informed consent.

During each appointment, the vaccinator will discuss the vaccination with the patient, address any concerns or issues prior to vaccination and maintain accurate records both written and electronically. Registered vaccinators also have to adhere to government policies, PGDs (Patient Group Direction) and the Green Book.

The work of the vaccination service has grown and become more complex. There is now a year-round programme, with vaccinations provided every week in East Lothian and the team being required to provide different vaccination programmes on the same days.

The busiest period is during autumn and winter when most of the COVID and Seasonal Influenza vaccinations are given. Shingles and Pneumococcal vaccinations are also delivered from January until the end of March (but these continue to be given anytime during the year when required). Recent years has also been a Spring COVID programme, and in 2024 there will be a new vaccination programme for Respiratory Syncytial Virus (RSV) starting in late summer.

As well as all these programmes the team also provide many non-routine vaccinations which include Hepatitis B; Tetanus; Measles, Mumps and Rubella (MMR), and Human Papillomavirus Virus (HPV).

The team now provides over 116,000 vaccinations a year and has one of highest levels of vaccine uptake in Scotland.

Right Care, Right Place

As described above, primary care services have changed significantly in recent years, with more services now being delivered outwith GP practices, and people being encouraged to access different primary care options without having to go via their GP.

As well as the HSCP delivered PCIP services listed above, individuals can go directly to NHS Inform, NHS 24, or their local pharmacy for support. Other primary care services include local dentists and opticians.

The HSCP has developed a Primary Care Communication Plan aimed at raising awareness of the range of services available, providing information on how to access them, and encouraging people to contact these services directly rather than going to their GP first.

The first part of this Communication Plan was delivered in early 2023, with the launch of a new Primary Care Health Services web page.

4.2 East Lothian Community Hospital Outpatient and Day Services

East Lothian Community Hospital (ELCH) provides local inpatient care, as well as an ever-growing number of outpatient services and clinics, reflecting our Strategic Objective to provide care closer to home where possible. The number of outpatients seen in OPD1 ELCH has grown from around 30,000 in the last years of Roodlands Hospital[19] to just under 79, 000 appointments offered in 2023-2024, the DNA (Did Not Attend) rate is sitting at 6.7%. A further 4,637 patients attended the Endoscopy and Minor Procedure Unit, with a DNA rate of 9.1%.

Across all out-patient services delivered at ELCH (mental health, CTAC, vaccinations, dentistry, podiatry etc) the total number of attendances was 114, 587 with a DNA rate of 6.6%

During 2023/24, there were 241 nurse-led patient monitoring clinics available at ELCH (285 of these were cancelled) and a DNA rate of 15.5%. This allows patients to have routine checks without the need for a Consultant appointment in a hospital out with East Lothian (unless test results require). We also changed our approach so that clinics became generic rather than speciality specific.

Key developments during the year included:

- Escalating the number of nurse-led minor operations clinics at ELCH with 332 appointments attended in 2023/24 (up from 118 the previous year).

- Progressing plans to double capacity for Dermatology Ultraviolet Phototherapy treatment at ELCH, reducing further the number of East Lothian residents having to travel into Edinburgh for twice weekly sessions (over 10-12 weeks).

- Increasing the capacity and use of the Endoscopy and Day Services Unit at ELCH so that it now offers up to 30 sessions a week. However, the unit's ability to fully use this capacity was restricted by the availability of operators.

- The ongoing development of teaching / training by the Endoscopy and Day Service Unit at the hospital's state-of-the-art facilities and lecture theatre. This included the Unit achieving JAG Accreditation[20] in October 2023, making it the first NHS facility in Scotland to achieve this status. Although growing waiting lists have resulted in JAG accreditation lapsing, the Unit continues to meet the other accreditation criteria, reflecting the continued high standards of quality service provision.

[19] The transfer of Roodlands Outpatient Department to the new East Lothian Community Hospital began in March 2018, with all other services moving to ELCH by the end of 2019.
[20] This accreditation is awarded by the Royal College of Physicians Joint Advisory Group (JAG) on Gastrointestinal Endoscopy.

- Increasing the length of Ultrasound clinics and offering Endoscopy sessions on Saturdays throughout January, February, and March to address appointment backlogs and offer more patient choice.

- Working with the Haematology Unit at the Edinburgh Cancer Centre to provide Intravenous (IV) therapy at ELCH as an alternative to travelling to the Western General. We have expanded the service to include older East Lothian residents who require treatment for anaemia via either blood transfusion or intravenous iron therapy.

- Exploring the potential to provide support to the Royal Infirmary of Edinburgh venesection service to help address their waiting list and to the Western General Hospital's Out-Patient Antibiotic Therapy (OPAT) service (both would be delivered within our existing staffing establishment).

- Exploring the possibility of being able to offer phlebotomy clinics and line care to remove the need for patients to either wait on a District Nurse appointments or attend an acute hospital in Edinburgh.

Working together for better outcomes

Mrs F attended East Lothian Community Hospital for an appointment for a chest x-ray but fainted whilst being assessed by one of the Consultants. The Consultant suspected that this was due to her having significant anaemia and felt that an emergency admission for urgent blood transfusion would have to be considered. However, Out Patient Department staff helped to provide support and the ELCH endoscopy team was able to accommodate Mrs F for a unit of blood that afternoon. Transport was arranged and she was able to return home that same day.

Mrs F continued to be reviewed by the Hospital @ Home team over the weekend who were pleased to report her dizzy episodes were resolved. Subsequently, care was safely handed back to her GP.

The skills, experience, and knowledge of staff at the hospital, and a willingness to work together to respond to the patient's immediate needs resulted in a number of positive outcomes:

- Mrs F received the urgent assessment and treatment she needed without being admitted to an acute hospital.
- Mrs F and her daughter fed back how pleased they were with this outcome – her daughter would have struggled to visit if she had been admitted.
- The risks associated with acute hospital admission for frail elderly people were avoided.
- Hospital bed days were saved.

4.3 Re-imagining Adult Social Work

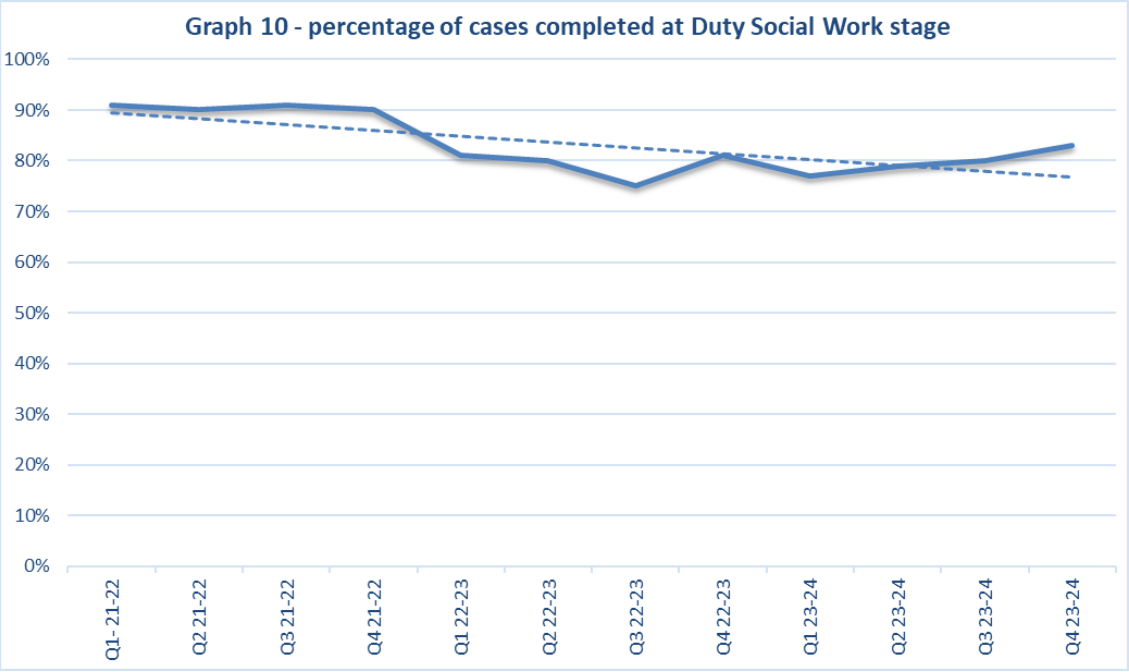
Our current operating model and support structures were introduced in 2021 following work with IRISS to 're-imagine' the approach to Social Work services for adults in East Lothian and continued to deliver strong performance during 2023/24.

This now well established approach involves dealing with as many cases as possible at 'first point of contact' through our duty system, rather than people being added to a waiting list for assessment. The result has been to reduce the waiting list for adult social work assessment to consistently at or around zero (from a high of over 200 in 2021).

Carrying out assessment at as early a stage as possible results in better outcomes for individuals in terms of services being able to take a more preventative or early intervention approach. This can help to prevent their situation deteriorating and their care needs becoming more significant, or a crisis situation emerging. Keeping waiting lists as low as possible also helps to reduce 'hidden risk' in terms of people with high, but unknown, levels of need waiting to be assessed.

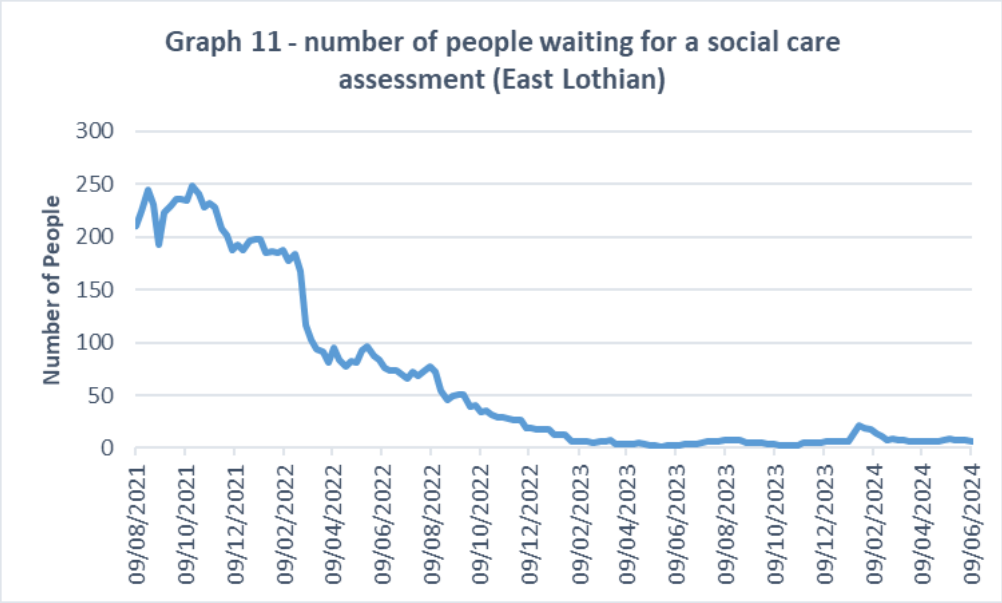
Further development is planned in relation to embedding an early intervention and prevention approach to the duty system. This will focus on identifying individuals who would benefit from early intervention and visiting them within 48 hours of referral, as well as ensuring same day onward referral for rehabilitation services if needed.

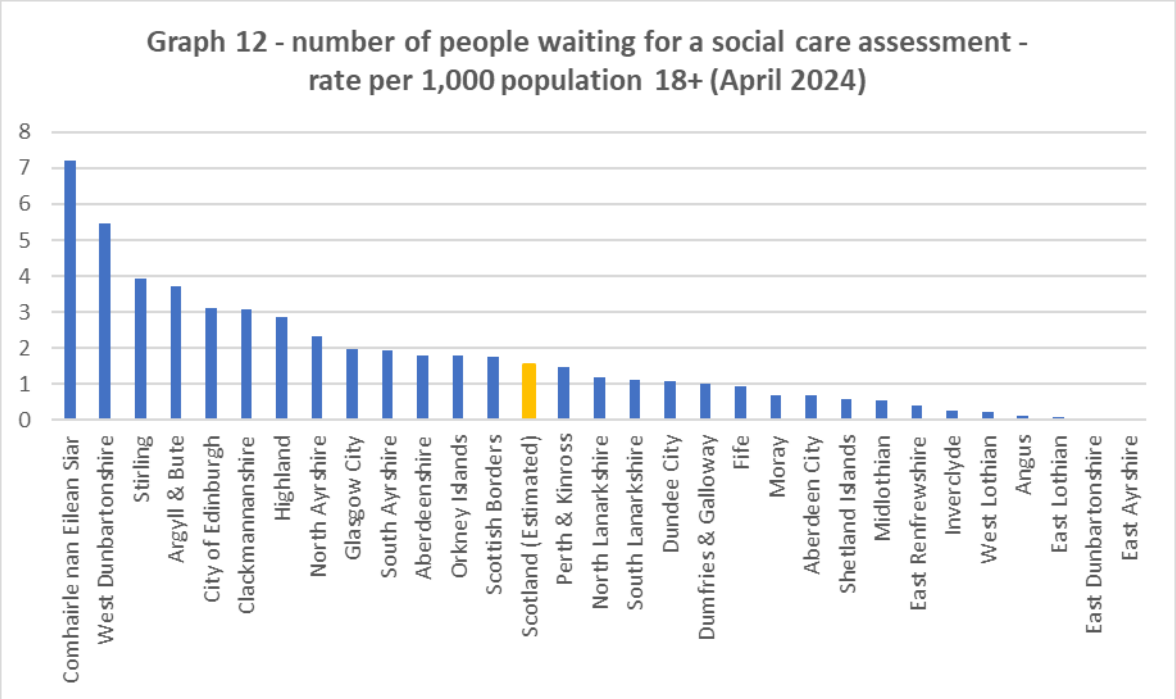
Graph 10 below shows a consistently high percentage of cases continued to be completed at duty social work stage during 2023/24, rising from 77% at the start of the year to 83% by the end of quarter four.



Graph 11 demonstrates shows a sharp reduction in the waiting list for assessment from the introduction of the new operating model in 2021, with this being sustained throughout 2023/24. Comparison across local authority areas is shown in graph 12, highlighting the strength of East Lothian's performance in a Scottish context.

Targets around assessments were introduced in late 2023/24 and will be reported on in next year's Annual Performance Report. These include social work assessments for people in hospital being allocated within 24 hours of referral and community assessments being allocated within 2 weeks. A further target has been set around the completion of assessments within 28 days.





People requiring a social care assessment and Care at Home services (Public Health Scotland)

4.4 Dementia

Post Diagnostic Support

Post Diagnostic Support is currently provided for one year following a diagnosis using the Alzheimer Scotland 5 Pillar Model of Post Diagnostic Support (PDS). This is in line with the Dementia Strategy for Scotland. The service offers advice and support to help people understand the condition and to signpost them to services they may find helpful. Post Diagnostic Support can also assist with the development of a person-centred plan, as well as providing support for carers.

Alzheimer Scotland were successful in their tender for 2022 and since being awarded the contract has increased their Link Worker staff to 3.5 full time equivalent workers. Increased funding to the service has had a positive impact in significantly increasing the number of people receiving PDS (up from 99 people in April 2022 to 198 people in November 2023) while also cutting waiting times for the service in half from the highest point last year.

Alzheimer Scotland are also currently developing a series of Post Diagnostic Support groups which will run for 6 weeks to target those on the waiting list for the formal 1 year support service. The groups will provide an introduction to formal PDS support; deliver sessions on memory skills/tips/tricks and technology; enable people to learn more about dementia; share information on local community connections; and provide support to help people cope with stress. The groups will also help to promote peer support and to increase uptake of the formal PDS service.

Dementia Strategy

A final version of the East Lothian Dementia Strategy was signed off by the Integration Joint board in October 2023. Further consultation was then completed with people with lived experience of dementia through attendance at the Dementia Friendly East Lothian Annual Gathering to determine the priorities for implementation. People with dementia and their carers told us their priorities were for us to improve the Diagnostic process, the provision of information, increasing access to community activities and peer support, and tackling stigma associated with the illness. This feedback will be incorporated into an implementation plan which will be developed to take forward the actions from the strategy.

Musselburgh Meeting Centre

East Lothian's first Meeting Centre was opened in April 2023, providing support to people living with dementia and their care-partners. You can read about developments during 2023/24 on page 32 above.

4.5 Supporting Carers

East Lothians second local Carers Strategy was published in June 2023 and will help to guide activity in this area over the next three years. Highlights from the first year of implementation are summarised below, under each of the strategy outcomes.

Outcome 1 - Carers are identified and can access support

Adult and particularly our Young Carers services supported a growing numbers of carers during 2023/24. Carers of East Lothian (CoEL) suggested that although numbers of carers have been relatively steady, complexity of situations and therefore support required has increased.

A pilot project is being developed to support people in hospital to be identified earlier and have more access to support while the person is in hospital and once discharged into the community.

Outcome 2 – Carers are well informed and have access to information and advice.

Commissioned support services for Adult and Young Carers are performing well, with both exceeding agreed Key Performance Indicators. Additional funding has been agreed in 2024/25 to minimise the impact of a significant funding cut to the Young Carers Service (YCS) from another partner, this should allow the service to maintain its current level of provision and continue to offer opportunities for breaks from caring to Young Carers.

Work is ongoing to provide better information to people and carers across HSCP services and partner organisations. Specific examples include the re-introduction of post diagnostic support groups for people diagnosed with dementia (delivered by Alzheimer's Scotland) and development of carer specific information sessions (by CoEL and partners) for people caring for those living with dementia.

Outcome 3 - Carers are supported to maintain their own physical, emotional, and mental well-being.

An ELHSCP and CoEL project team updated the local Adult Carer Support Plan (ACSP) during 2023/24 and continues to work to ensure that the principle of carers rights is embedded in Plans. Implementation of the new Plan began in March 2024. A review will be carried out following the first six months of use and will include gathering carer feedback. The new ACSP is outcome focused and will enable the HSCP to gather information on where outcomes could not be met, which will help to inform future priority setting.

Outcome 4 – Breaks from caring are timely and regularly available.

East Lothian Short Breaks Services Statements have been updated and made available across East Lothian. It is recognised that there are difficulties in carers accessing regular breaks at a time and place to suit their individual needs. Next steps are to establish a short breaks working group to explore the issue and address some of these barriers. This will include a review of carers access to SDS (Self Directed Support) options.

In relation to older people's access to residential respite, the HSCP has made changes to policy addressing the gap between the rate that was paid for residential respite and the market rate for this type of support.

Outcome 5 – Carers are supported to have a life outside of their caring role and can achieve a balance between caring and other aspects of their lives.

The Carer Support Planning process aims to promote good conversations with carers to establish 'what matters to them' and what difference support can make to achieve the best outcomes. The Occupational Therapy Carers Pathway is another means of helping to support people to achieve this balance (see page 38 above).

Outcome 6 – Carers are respected by professionals as Equal Partners in Care and are appropriately included in planning and delivery of both the care and support for the people they care for and services locally.

Carers of East Lothian are delivering a programme of "Think Carer" training to educate the workforce on respecting and valuing carers as Equal Partners in Care. New educational materials produced by NHS National Education for Scotland are being promoted nationally and locally by HSCP workforce development.

Outcome 7 – Local communities are supported to be carer friendly.

Awareness raising work is ongoing and includes ensuring communications are carer aware. HSCP and Carers organisations support many other local organisations (including day centres and East Lothians first Meeting Centre) therefore making our communities more carer friendly through partnership.

The Carers Change Board continues to oversee developments around carer support and has an advisory role in agreeing use of the Carers Act budget allocation from Scottish Government. In 2023/24, a small grant process was run offering support to community organisations offering carer support at a local level. A detailed breakdown of use of the Carers Budget during 2023/24 is contained at Appendix 2.

The Community Care Worker dedicated to Carer Support continues to develop the role and has increased links with other carer support organisations (particularly Carers of East Lothian and the Occupational Therapy Carers Pathway). The worker can support carers to access personal budgets and also works closely with the Carers of East Lothians 'Time for me' worker.

4.6 Palliative and End-of-Life Care

Our Strategic Plan highlights our commitment to delivering high-quality palliative and end-of-life care through a number of multidisciplinary teams in home, community, and hospital settings. Our aim is to provide patients with choice whilst reducing the reliance on acute hospital beds in favour of community-based care. This approach provides the care needed by patient whilst also supporting families and carers.

During 2023/24:

- Our Hospital to Home and Care at Home services worked closely with Hospice at Home to provide care packages in the community.

- District Nursing and East Lothian Palliative Care Team worked together to support end of life care in people's homes where this was their wish. The Palliative Care Team supported over 400 patients / families during 2023/24.

- St Columba's piloted the use of a virtual ward. This provides support for up to 14 days for people in their own home when they would otherwise require inpatient admission to a hospice to meet their palliative care needs. Our Palliative Care Team works closely with St Columba's colleagues in relation to the virtual ward.

- The Palliative Care Team delivered a monthly wellbeing group to support people to make contact with others and to access additional support services. The team works collaboratively with partners to deliver the group, for example, with St Columba's delivering 'fatigue management' and 'compassionate neighbours' sessions.

- The Palliative Care Team introduced 'Bunny Buddies' to help foster open communication and bring comfort, helping children in families facing end-of-life-care and bereavement. You can read more about Bunny Buddies here.

The Planning Older People's Services engagement programme and hurdle criteria exercise (see page 14 above) identified palliative and end of life care an area for further consideration during the next stage of the programme. It has been agreed to carry out a review and mapping of current provision to identify any gaps and / or opportunities for service development.

Strategic Objective 5 – Develop and embed integrated approaches and services

5.1 Integrated Teams and Approaches

Integration of Care at Home Services

At the start of 2023/24, we began work to integrate our Hospital to Home and Homecare services. As part of integration, both teams started to make use of 'OnePlan' software for care planning and coordination.

Integration of the teams brought immediate benefits in terms of supporting the development of shared care plans and enabling the care of service users to be shared across staff teams. This resulted in a more flexible and efficient use of resources and increased resilience of service provision. This can be seen to be reflected in the growth of the number of hours of care provided throughout the year (see page 16 above).

Access to Primary Care

Testing of an approach involving direct professional to professional links between the Substance Use Service (SUS) and CWIC (Care When It Counts) Service took place during 2023/24. This activity was developed in recognition of the challenges people supported by the Substance Use Services often face in accessing primary care services.

The introduction of direct links between professionals in each of the services involved in the trial was shown to help improve access to physical health interventions for patients involved and will continue on a permanent basis. There are plans to roll out this approach to Adult Mental Health Services during 2024/25, again with the aim of supporting people using these services to access primary care.

Enhanced Learning Disability Service

The ongoing development of an enhanced Learning Disability (LD) Service in East Lothian is proving to be successful in delivering better outcomes for local people. Learning Disability Social Work, Adult Community Resources and the Community Learning Disability Team were brought together to take an integrated, multidisciplinary approach to support more complex and high risk learning disability patients, especially those with significant health needs or mental health issues.

The enhanced service offers 24 hour support, providing continuity and delivering positive experiences and better outcomes in a safe environment. The service also contributes to the prevention of hospital admissions, timely discharge, and a reduction in carer stress. The approach also makes best use of resources which is particularly important given the workforce and social care provision issues currently faced by services. Service delivery is based on a care-coordination model, which ensures that the right people are involved with the individual at the right time, the first time.

5.2 Pathways

We identified reviewing patient pathways as one of our delivery priorities under Strategic Objective 5. The term 'patient pathways' refers to the journey from a person's initial contact with a service, through to their subsequent interaction with the service and related services, through to discharge if / when appropriate.

One example of patient pathway development activity that took place during 2022/23 was in relation to the 'Complex Care Assessment Pathway'. This pathway relates to the patients likely to need Hospital Based Complex Clinical Care (HBCCC) or a Care Home placement. Development of the pathway aims to ensure that the patient's journey is managed smoothly and efficiently; that actions and decisions are clearly recorded; and that patients, their carers, and families are provided with the information they need to make decisions at key points in the journey.

Other examples include the development of the ELRS Carers Pathway (see page 35), and work focused on promoting direct patient access to HSCP delivered primary care services (page 30).

Review of access to Mental Health Services

Last year we reported on progress with the review of access to mental health services and described activity aimed at improving access and patient pathways. In 23/24 work continued to review the 'front door' of East Lothian Joint Mental Health Team to create a single point of access. Consultation across a variety of stakeholders was completed and an initial pathway defined. Work on this is ongoing.

The ADHD[21] pathway has been successfully implemented in ELHSCP. The pathway is consultant led, but a training plan is in place to build a nurse led model in time. Current capacity allows approximately 100 patients to be assessed per year, although the waiting list had grown to nearly 1000 patients by the end of the year. The service will continue to explore resource-effective models of assessment and treatment during 2024/25 with the aim of reducing the waiting list.

ASD[22] commissioned assessments were paused in 2023/24 due to a governance issue with assessment outcomes unable to be recorded in TRAK. As a result, the waiting list has grown to approximately 300 patients.

Older Adult Mental Health Services

Older Adult Mental Health Services continued to develop and deliver effective, streamlined mental health support for older adults. During 2023/24, activities included:

[21] Attention Deficit Hyperactivity Disorder.
[22] Autism Spectrum Disorder.

- Twice weekly huddles involving community and inpatient services, supporting collaborative working, and helping to ensure smooth and timely discharges to either community based care or further 24 hour care.

- Providing training on Stress and Distress to care home staff and supporting care home residents with both pharmacological and non-pharmacologic interventions. A weekly huddle involving all services providing support to care homes helps to enable joint working and information sharing, and also benefits from input from the Care Inspectorate.

- Supporting people living in their own homes who have severe and enduring mental illness, including those with dementia. This included close collaboration with external providers and voluntary organisations to provide a wider range of support options reflecting individual need.

- Delivering a memory assessment service linking in with the Post Diagnostic Support Service provided on a commissioned basis by Alzheimer Scotland.

- Exploration of the potential development a Rapid Response Team to provide a more intensive home treatment option for people over the age of 65.[23] Although there was support for this development, the current financial position does not make it viable in the immediate term.

The development and delivery of the activities described above reflect commitments outlined in the National Dementia Strategy and the East Lothian Dementia Strategy – you can read more about the East Lothian Strategy on page 55.

[23] Currently this type of service is only available for adults under 65 or over 65s with a functional illness, therefore does cover people with dementia or delirium.

5.3 Meeting housing needs

Local Housing Strategy

East Lothian's Local Housing Strategy (LHS) 2024-2029 was adopted in April 2024 following extensive engagement during which over 1,300 voices were heard. To ensure that health was strongly embedded withing the LHS, a Health Integrated Impact Assessment (HIIA) was facilitated by Public Health Scotland's Population Health Team, with a range of stakeholders taking part in a workshop to consider the health impact of the draft LHS.

To oversee the delivery of the LHS, a Housing Partners Board was established in May 2024. Membership of the Housing Board includes senior managers from across the Council's Housing Service and HSCP and representatives from East Lothian's Tenants and Residents Panel (ELTRP).

Work is ongoing to develop a Housing Contribution Statement (HCS) to formalise the link between the new LHS and East Lothian IJB's Strategic Plan. The Housing Contribution Statement is a statutory requirement and links the strategic processes of housing, health, and social care at a local level. Once complete, the HCS will outline the Council's contribution to the strategic objectives identified in the IJB's Strategic Plan through the delivery of housing and housing related services, whilst taking into consideration the current financial context and population pressures.

It is anticipated that the Housing Contribution Statement will be presented to the IJB for approval in autumn 2024.

Housing, Health, and Social Care Strategy Group

A Housing, Health and Social Care Strategy Group was formed in 2023 to help support joint working at a strategic level across relevant Council and HSCP services. A key purpose of the group is to ensure that respective strategies are aligned. Once the Housing Contribution Statement is in place, the group will play an important role in overseeing related activity.

Review of housing adaptations across tenures

Housing support services, such as aids and adaptations, are delegated to East Lothian IJB under the Public Bodies (Joint Working) (Scotland) Act 2014. The funding process for housing adaptations in East Lothian is complex and varies depending on tenure and type of adaptation.

Funding pressures related to adaptations have become increasingly evident in recent years due to rising material and labour costs and an increased level of demand as a result of growing need. Following discussion between partners during 2023/24, it was agreed that a review should take place. The review will look at how to ensure the best use of resources to meet the needs of East Lothian residents regardless of housing tenure.

Housing to meet specific needs

The HSCP continues to work in partnership with East Lothian Council Housing colleagues to develop core and cluster housing using a range of models to best meet individual needs.

A total of 40 units of core and cluster housing have been developed in East Lothian over the last five years. This has included the introduction of a core and cluster development for individuals with mental health conditions to replace previous bedsit provision. The development comprises of 8 individual flats alongside a staff base providing 24/7 care and support by a specialist provider.

There is still a need for further development of appropriate housing options for people with mental health conditions being discharged from hospital, as well as options to meet a range of other complex health and support needs.

The East Lothian Local Housing Strategy for 2024-2029 includes a commitment to developing 12 additional units of core and cluster housing per annum to meet a ranging of complex health and support needs.

Elder Street

Elder Street in Tranent is a supported accommodation and rehabilitation resource for up to 10 people with complex mental health needs. The provision focuses on offering between 6 and 12 months of supported accommodation as part of people's journey back to independent community living. The service is provided on a 24 hour basis, 7 days a week by Carrgom, with inreach support from a number of external providers.

Challenges have emerged in terms of the flow of people through the service. Individuals supported at Elder Street gain tenancy rights whilst at Elder Street and can then experience long waits to be rehoused beyond their recovery work being completed. Discussions with Housing colleagues are planned to look at options for resolving this.

At the end of 23/24 the provider commission was put out to tender. Penumbra have been successful in the tender process. This provides an opportunity to review delivery of the service, within contract limitations, to improve quality and flow.

5.4 Transitions

Population predictions for East Lothian suggest that at least 30 young people with some level of support need will transition from Childrens to Adult Services each year. Support required by young people may include care at home, day support, respite, or supported employment.

Planning for young people's transition from child to adult services is already well established in East Lothian, with transition referrals made at an early stage and contact and multidisciplinary meetings taking place on a regular basis. The young person is allocated an Adult Services Social Worker well in advance of them moving to Adult Services, and the young person and their family are involved and supported throughout.

A new East Lothian Transitions Framework was finalised in 2023/24 reflecting the 'Principles of Good Transitions'[24] and placing further emphasis on putting the young person at the centre of the planning process. The Framework formalises existing processes, defining the responsibilities of those involved and identifying the expected milestones and timescales.

[24] 'Principles of Good Transitions 3' - Scottish Transitions Forum

Strategic Objective 6 – Keep people safe from harm

6.1 Adult Support and Protection

Detailed data in relation to the East Lothian Adult Support and Protection service performance is reported in the EMPPC[25] Annual Report. This will be available on the EMPPC website in the autumn once completed. Quarterly newsletters describing Public Protection activities and including articles on a range of related topics are also available on the website. This section highlights some elements of performance and gives examples of service development activity during 2023/24.

Activity levels

There were 659 referrals categorised as Adult Protection in East Lothian during 2023/24 – a decrease of 19% from the previous year, but slightly above the 2021/22 rate (by 2%).

We changed the way in which 'Duty to Inquiries' (DTIs) and 'Investigations' were defined in September 2023, and this is reflected in the data for 2023/24. This change involved a move towards a 'One Inquiry' approach, recognising that inquiries may or may not be carried out on the basis of powers under the Adult Support and Protection (Scotland) Act 2007. A total of 751 Inquiries (with and without powers) were completed in 2023/24, compared to 782 the previous year. This is reflective of the lower number of referrals received.

Service development

We continued to develop our approach to performance management and improvement in relation to Adult Support and Protection (ASP) services during 2023/24, this included:

- Implementing updated Adult Support and Protection Procedure, ensuring alignment with the Scottish Government's revised Code of Practice.
- Developing our approach to data managing to comply with revised national data requirements.
- Ongoing improvements to recording templates to ensure that the right information is captured to support evidence-based risk assessment.
- Carrying out a range of audit activities including 'dip' audits; peer audits; focussed audits in relation to screening of police concerns; and cross-team audits. Finding of audits fed into continuous improvement cycle.

[25] East Lothian and Midlothian Public Protection Committee (EMPPC) is the local strategic partnership responsible for the overview of local policy and practice in relation to Adult Protection, Child Protection, MAPPA and Violence Against Women and Girls.

- A significant amount of activity also took place during 2023/24 in preparing for and participating in a joint inspection of adult support and protection – details are provided below.

- Rolling out a programme of 'train the trainer' sessions in relation to Adult Support and Protection for care home staff.

Adult Support and Protection Inspection

An inspection of adult support and protection in East Lothian reported 'clear strengths' in measures in place to ensure that adults at risk of harm are safe, protected and supported.

The Care Inspectorate led on the joint inspection, in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland. The inspection covered services provided by the HSCP and by Police Scotland.

Inspectors described the approach taken to adult support and protection inquiries as 'robust' and noted that it was 'evident the partnership is on a positive improvement journey', having made considerable progress to date, with further improvement activity planned.

It was noted that almost all adults at risk of harm who required a risk assessment had one completed. The quality of risk assessments was suggested to have improved significantly following the implementation of the Type, Imminence, Likelihood and Severity (TILS) framework.

The Partnership's approach to referrals was considered to be very effective and it was noted that 'person-centred engagement and consultation with the adult at risk of harm was evident throughout the delivery of all key processed', with 'good examples of sensitive, trauma informed practice'.

As well as a scrutiny of social work, health, and police records of adults at risk of harm, the inspectors also issued a staff survey and conducted staff focus groups to discuss adult support and protection practices of adults at risk of harm. The final report reflected that the Partnership's vision was well understood, and there was synergy between the Public Protection Committee and Critical Services Oversight Group.

A number of areas for improvement were highlighted in the final report. These included ensuring appropriate procedural guidance is kept up to date and effectively disseminated to staff. The report also suggested that 'a multi-agency approach to audit would help strengthen joint improvement work', and that this should involve frontline staff from across organisations.

The full inspection report can be viewed on the Care Inspectorate's website.

6.2 Reducing harm from substance use

MELD Contact Service

The MELD (Midlothian and East Lothian Drugs) Contact Service continues to provide information and advice regarding substance use. Acting as a first point of contact for people wishing to engage in recovery services, the Contact Service offers a brief assessment and triage on to appropriate services to meet the needs of the individual, including access to the East Lothian Substance Use Service (ELSUS) Rapid Access Clinic. During 2023/24 the service expanded its provision to offer an Out of Hours service and currently operates from 9am to 9pm, Monday to Friday.

In September, MELD and MELDAP[26] were asked to give a presentation to Health Improvement Scotland about the achievements of the Contact Service. The presentation focused on the role of the Contact Service in supporting implementation of the Scottish Government's MAT Standards (see below). The service has been identified as an excellent example of a single point of entry into Recovery Services and was subsequently submitted as a good practice case study to Public Health Scotland (PHS).

During 2023/24:

- There were 1,286 enquiries to the Contact Service (159 during the Out of Hours service).
- 25 people were directed to East Lothian Substance Use Service following a triage assessment.
- 39 people were directed to East Lothian Rapid Access Service.
- 311 people were triaged to MELD following a triage assessment (89 during Out of Hours).

MELD is also commissioned to order, distribute, and report on Take Home Naloxone (THN) and Nyxoid Kits27 and distributed 258 kits during 2023/24.

Medication Assisted Treatment (MAT) Standards

The introduction of Medication Assisted Treatment (MAT) Standards is a key element of the Scottish Government's strategy to tackle the rise in drug related harms and deaths and to promote recovery. MAT Standards are described as 'evidence based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland'.

Responsibility for implementation of the MAT Standards lies with health and social care service providers, including HSCPs. The MAT Standards framework has a number of elements aimed at ensuring Medication Assisted Treatment is accessible, safe, effective, and based on a person-centred approach.

The Scottish Government set a target for the full implementation of MAT Standards 1 to 5 by April 2023, followed by Standard 6-10 being fully implemented by April 2025. East Lothian HSCP has

[26] Midlothian and East Lothian Drugs and Alcohol Partnership.
[27] Naloxone is a medication that temporarily reverses the effects of opioid overdose and is available to anyone at risk of overdose. Naloxone is available in injectable form or as a intra-nasal spray (Nyxoid).

worked with Midlothian and East Lothian Drugs and Alcohol Partnership (MELDAP) to deliver a level of performance ahead of both target dates. This has been achieved through the considerable collective effort of all partners. Some of the key activities have included:

- Full implementation of same day access for assessment and treatment, 5 days a week, with people coming either via MELD Contact Service (see above), triage, external referral, or self-presentation. In the first four months of MAT Standards implementation, 25 people accessed the same day service and the median time between first contact and starting a prescription was 2 days.

- Supporting people to make an informed choice about medication options and dosage in primary and secondary care settings. This resulted in a steady uptake of Buvidal. Buvidal is a prolonged release medication that can be administered weekly or monthly, making it easier for people to stick to their planned medication and also offering a more convenient option for people in work or education.

- Ensuring that people who have experienced a Near Fatal Overdose (NFO) are contacted within 24 to 72 hours after services have been notified and provided with harm reduction advice and support and encouragement to engage with treatment services.

- Development of a low threshold café model by MELD in targeted areas, with cafés established in Tranent and Prestonpans in early 2023.

- Carrying out engagement with people with lived experience to help inform developments related to implementation of the MAT Standards. This work is led by MELD and involves peer support staff engaging with people who use services, family members, and staff.

6.3 Justice Social Work

East Lothian Justice Social Work Service's vision is to 'reduce the risk of harm caused by crime within our community' by contributing to the following outcomes:

- Promoting greater equality of opportunity, enabling our service users to lead more fulfilling lives.
- Making our communities safer places to be by addressing offending behaviour.
- Our interventions are proportionate and based on individual risk, need and responsivity.
- We reduce reoffending through fostering a sense of belonging and involvement in our community.

The service has a Business Plan in place (for 2021-24) and publishes an Annual Report each autumn, which includes a comprehensive Improvement Plan.

Activities during 2023/24 included:

- The roll out of Structured Deferred Sentences (SDS) took place throughout 2023/24 and are now available to low and high threshold service users. The option of Structured Deferred Sentences has helped to further strengthen our early intervention and prevention approach and 'provides social work support to individuals who may need a short term intervention to address needs but who do not require the level of supervision of a Community Payback Order'[28].

- The Community Payback Work Team continued to develop options for unpaid work for service users. This included introducing classroom based sessions to deliver induction, group work, learning opportunities, and inputs from partner organisations (e.g., the Scottish Fire and Rescue Service and CHANGES).

- We also delivered presentations to senior leaders in East Lothian Council to promote the 'One Council' approach to providing Community Payback placements within Council services. The delivery of Once Council placements will begin in 2024/25.

- The service has continued to build on its approach to engagement with service users and local communities. In 2023/24, this included delivering a 'month of engagement', as well as carrying out the annual Community Payback Order survey and entry / exit questionnaires with service users. Feedback gathered through engagement activities helps to inform delivery and development of services.

- A new Community Justice Outreach (CJO) Nurse was introduced in 2023/24 to support service users' health needs including those related to drug and alcohol use, mental health, and minor

[28] Structured Deferred Sentence - Community Justice Scotland

physical health needs. You can read more about this post and the impact it can have in the case study on page 71 below.

In terms of level of activity over 2023/24:

- 173 Community Payback Orders (CPOs) were issued for East Lothian residents – this was an increase of 7% from the previous year (from 162 CPOs) and a 36% increase since 2020/21.
- 113 of the CPOs issued had a Supervision Requirement (51 included unpaid work) – this was broadly similar to the previous year.
- 280 Justice Social Work Reports were requested – 94% were completed within the timescale of two working days prior to the return to court date – this was just ahead of performance the previous year.

More detailed information and data on performance is available in the Justice Social Work Annual Report and the Chief Social Work Officer Annual Report, both of which are published late autumn and are available on the East Lothian Council website.

James's Story

James was placed on a Community Payback Order after his conviction for disruptive and/or antisocial (in effect, breaches of the peace) offences, which took place over the course of a few months. He told his social worker that he had stopped drinking alcohol as he thought this was a cause of his offending, and that he had been engaging with local substance use services for psychosocial support and with mental health services for therapeutic support relating to childhood trauma and PTSD[29].

Specific mental health treatment commenced, and this seemed to cause James's distress which he thought he could only cope with by drinking alcohol. The combination of alcohol use and mental health issues resulted in James frequently attending A&E in crisis. This continued for around six weeks with James becoming known to NHS managers as a 'frequent attender'. Additional support was provided to James in the community, but he was 'stuck' and found it difficult to see a way out of what felt, for him, a real predicament. James was at increased risk of further offending as a result of his alcohol use, and that combined with poor mental health put him at potential risk of harm to himself as well.

In order to address the risks related to increased likelihood of offending, Justice Social Work (JSW) arranged for James to meet with the Community Justice Outreach (CJO) Nurse. The CJO Nurse is a newly created post, initially developed to assess JSW service users in relation to their drug and alcohol use, but quickly evolved to support access to front line health services in the community as well as mental health and (minor) physical health interventions. James met with the CJO Nurse regularly in a local office rather than a Health setting. He had a safe space to speak about his feelings with a medical professional trained in both mental health and substance use interventions.

Some weeks later, JSW were asked to attend a meeting to discuss 'frequent attenders' at A&E and it was noted that James had not been attending A&E to the point where his absence was noticed. JSW reviewed case records and noted that James had stopped attending A&E when he started engaging with the CJO Nurse. It appears that intervention from JSW via the CJO Nurse has had a significantly positive impact on James personally, as well as more broadly a positive financial impact on the Partnership in terms of reduced crisis presentations at A&E.

This is James's story, but the CJO Nurse has also intervened with JSW service users presenting with wound infections as a result of Intravenous drug use and arranged for antibiotics to be prescribed by their GP, which will also reduce the need for emergency treatment and/or admission to hospital. Whilst the role is relatively new, the impact is already significant.

[29] Post Traumatic Stress Disorder

Strategic Objective 7 – Address Health Inequalities

The inclusion of Strategic Objective 7 in the IJB Strategic Plan reflects the IJB's recognition of the key role it plays in relation to reducing health inequalities[30] in East Lothian.

Many of the activities described in this report contribute to reducing health inequalities. However, a number of specific activities also took place during 2023/24 to further develop our approach to reducing health inequalities, some of these are described below.

Developing an understanding of health inequalities

We published a Joint Strategic Needs Assessment[31] (JSNA) in 2023 and will continue to build on this, particularly in terms of developing content to help enhance our understanding of health inequalities. A steering group has been established to oversee this work.

The JSNA brings together a wide range of data on the East Lothian population, including demographic information and data related to health and other outcomes. The JSNA was important in helping to inform the current IJB Strategic Plan and has also been a useful resource in relation to the development of a number of other strategic planning activities.

You can view the current JSNA here.

IJB members took part in a Development Session in April 2023 to help further their understanding and awareness of equalities and health inequalities. This included an input on IIAs, and further highlighted the importance of these in terms of guiding IJB decision making.

There have also been a number of inputs to both the IJB and the HSCP Senior Management on Anchor Institutions[32] and HSCP Officers are involved in a Working Group led by East Lothian Council to consider how the IJB and HSCP services may contribute to local activity.

Equalities, planning, and decision making

Integrated Impact Assessments (IIAs) are carried out by public bodies to help consider the potential impacts, negative and positive, on people, the environment and the economy when developing policies and making service decisions.

[30] Health inequalities can be defined as systematic, unfair differences in the health of the population that occur across social classes or population groups. Find out more about health inequalities here

[31] You can read more about the Joint Strategic Needs Assessment process here.

[32] Anchor Institutions refers to large scale organisations, usually non-profit / public sector, that play an important role in the locality they are 'anchored' and can impact on the health and wellbeing of their local communities.

During 2023/24, we continued to develop our approach to carrying out IIAs, with more HSCP staff completing training and an increased number of IIAs being completed. By the end of the year, a total of 24 IIAs had been carried out.

The completion of a number of IIAs was required in relation to financial savings proposals presented to the IJB at its March 2024 meeting. These saving were required to allow the IJB to set a balanced budget and address a projected financial gap of over £11m. The proposals related to a number of service areas, with potentially significant impacts for people using these services. The completion of 14 individual IIAs, as well as a cumulative IIA (assessing the overall impact of these savings combined) helped to inform the IJB's decision making and to identify actions that could be implemented to reduce negative impacts identified. The completed IIAs will also form the basis on ongoing monitoring of the impact of the IJB decisions.

Equalities Champions have been introduced across HSCP services, with the role of promoting awareness and understanding of equalities. Champions also lead on screening activities in their service area, carrying out IIAs when needed.

Our financial performance 2023/24

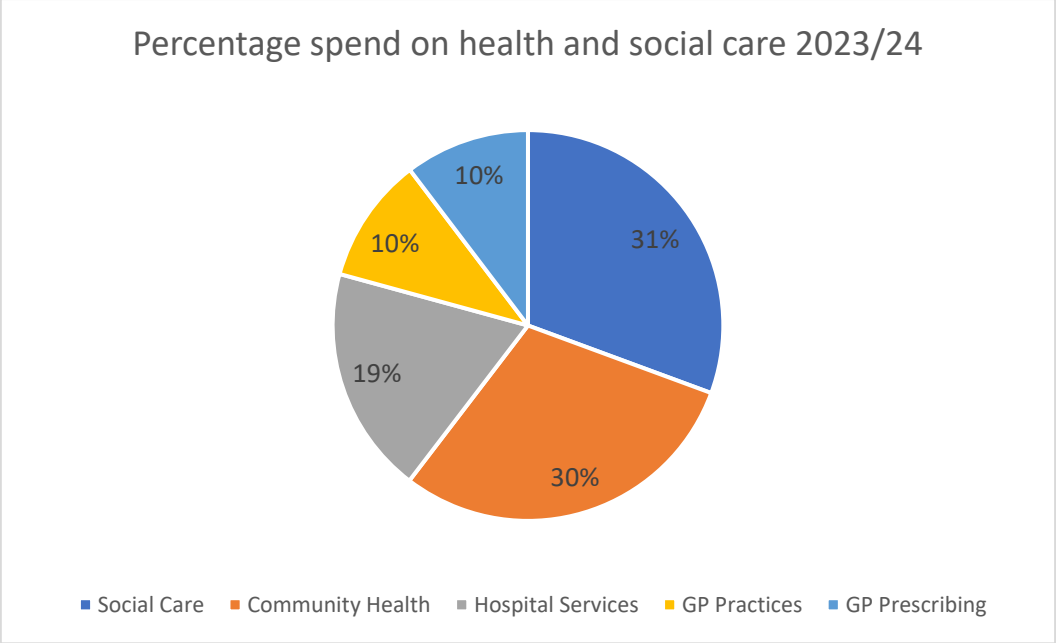
East Lothian Integration Joint Board is funded by financial allocations from its partners – East Lothian Council and NHS Lothian. These allocations include funding provided by the Scottish Government to local authorities to support the delivery of the Real Living Wage for the providers of adult social care. These funds then make up the budget that the IJB has available to deliver the functions (services) that have been delegated to it by the partners. The operational management of these services is provided by the partners and the partners report the financial position against the appropriate budget to the IJB

Although the IJB has broken-even in the financial year 2023/24 (achieved financial balance), this has only been made possible through additional funds having been made available by NHS Lothian and the use of the IJB's reserves.

IJB Budgets	Annual Budget £000's	Expenditure 2023/24 £000's	Variance £000's
Health - Core Services	110,842	110,264	578
Health - Hosted Services	20,003	19,604	399
Health - Set Aside Services	26,227	27,944	(1,717)
Adult Social Care	68,531	69655	(1,124)
Position before Adjustments	**225,603**	**227,467**	**(1,864)**
Addition Funds from NHS Lothian	740	-	740
Transfer from Reserves	1,124	-	1,124
Final 23/24 Position	**227,467**	**227,467**	**0**

The overspend in the health budgets being significant additional demand within those services delivered at the Acute Hospitals (The Royal Infirmary of Edinburgh and the West General Hospital) and additional demand for social care services within East Lothian.

The chart below shows how much of the IJB's spend in 2023/24 (in percentages) has been used to provide social care services, health services in the community, hospital based services and the services provided by the GP practices in East Lothian.



Reserves

At 1st April 2024, the IJB has both earmarked reserves (that is funds held for a specific purpose) and general reserves (funds to be used to support the management of the financial risk) totalling c. £10.0m, During the financial year the IJB has used a very significant element of both categories of reserves – the impact on the general reserve is shown above) and the closing balance is c. £4.3m.

2024/25 Financial Outlook

The IJB has continued to develop its five year financial plan, and this identified a financial pressure in 2024/25 of £10.8m. This is a result of additional demand for the IJB services, a requirement to deliver a recovery programme to address the overspend in 2023/24 and unfunded inflationary pressures (pay awards, drug and clinical services costs and the increased costs from third party services providers). The IJB has agreed a series of actions to bring this 2024/25 position back into balance and this is detailed in the IJB's 2024/25 budget setting paper which was approved by the IJB at its March 2024 meeting. This can be found here.

Appendix 1 – Ministerial Steering Group Indicators by East Lothian Localities

Indicator	Locality	2018/19	2019/20	2020/21	2021/22	2022/23	2023
1. Number of Emergency Admissions (18+)	EL **East**	3,992	3,260	2,932	3,162	2,787	**3,060**
1. Number of Emergency Admissions (18+)	EL **West**	5,190	5,770	5,332	5,320	4,792	**5,247**
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	EL **East**	26,786	26,742	24,773	29,600	28,782	**27,711**
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	EL **West**	41,070	40,799	42,084	43,640	48,242	**43,034**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	EL **East**	-	576	2,153	3,099	3,243	**3,317**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	EL **West**	455	2,324	4,572	4,052	3,996	**3,693**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	EL **East**	-	523	2,131	3,028	3,248	**3,287**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	EL **West**	281	1,970	4,446	3,893	3,719	**3,655**
2iii. Number of Unscheduled Hospital Bed Days – Mental Health (18+)	EL **East**	8,401	8,273	6,144	6,921	6,358	**6,438**
2iii. Number of Unscheduled Hospital Bed Days – Mental Health6 (18+)	EL **West**	7,171	5,728	6,488	6,383	7,355	**5,677**
3. New Accident and Emergency attendances (18+)	EL **East**	6,640	6,763	5,849	7,405	7,166	**7,055**
3. New Accident and Emergency attendances (18+)	EL **West**	14,536	14,542	12,074	13,821	14,100	**14,033**
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	EL **East**	3,293	2,469	1,615	1,040	1,277	**990**
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	EL **West**	4,259	2,241	2,294	1,601	1,912	**2,025**

Appendix 2 – Carers Act Funding Use

2023/24 Projects	**Budget 23/24**	**Comments**
Total Carers budget to IJB	**£1,549,000**	
Project Description	**£**	
Carers of East Lothian	475,864	Adult Carer support provider
East Lothian Young Carers Service	191,268	Young Carer support provider
Carers of East Lothian hospital carer support worker	19,455	Pilot project funded as 21-hour post through CoEL
Time for me Grants	25,000	Short breaks for carers
Partner Grants	31,300	Small grants process
Carer's strategy implementation	3,784	Carers engagement events and contribution to carers week 2024
Support services	22,208	Supporting individuals therefore reducing impact on carer
Individual Carer budgets	5,000	
Post - Carer Support - 21 hours	51,378	Mental Health Officer to support guardianships
Carers Strategy Officer - 28 hours	47,587	
CCW role to support Carers work	47,454	Adult Carer Support Plans and carer support
East Lothian Rehabilitation service	59,181	Occupational Therapy Carers Pathway
Transformation Project - Day centre outreach	264,000	Community based carer support services and breaks from day centres
Respite bed	78,493	Block booking
VCEL Community First	37,000	Carer identification and support
Musselburgh Meeting Centre	89,313	Carer support for people living with dementia
Leuchie @ home	58,211	Carer breaks
Equipment	504	
Dementia Friendly East Lothian	42,000	Development worker for meeting centre model
2023/24 Projects Sub-Total	**1,549,000**	