East Lothian Health and Social Care Partnership:

Planning Older People's Services

Challenge statements and inequalities evidence briefing

Produced by East Lothian Partnership and Place team
(Directorate of Public Health and Health Policy-NHS Lothian)

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Introduction

The aims of this paper are to provide additional evidence to the challenge statements outlined in the East Lothian Health and Social Care Partnership (ELHSCP) Provision Options Development paper[1] and to apply an inequalities lens to understand the implications that the statements may have for different population groups. As with any other age group, older people are not a homogenous group, and their social circumstances vary across the county.

We have provided relevant evidence and data where these are available to support our response and highlighted where further exploration of data would be beneficial.

The following challenge statements developed by ELHSCP are the ones we felt most appropriate for us to address from a public health perspective. It would however be important to apply an inequality lens to any service changes proposed to satellite or care home bed provision, and we would be happy to support this later if required.

Intermediate Care	There is increasing demand and public request for Intermediate Care Services to prevent unplanned hospital admissions and help people avoid delayed discharge from hospital. **How can we ensure Intermediate Care is made a priority for future care provision?**
Palliative Care	The number of people being supported to die at home, or in a homely setting in East Lothian is lower than the Scottish average. **What improvements can be made to enable dying at home to be a more accessible choice for East Lothian residents?**
Care at Home	There is a shortage of care at home services, which is more severe in some areas than others. Recruiting staff into these roles is extremely difficult. **How can we support individuals to stay independent in their own homes, when faced with staffing and resource shortages?**

How can we ensure intermediate care is made a priority for future care provision?

Definition of intermediate care

Intermediate care is an umbrella term for the collection of services which aim to promote faster recovery from illness; prevent unnecessary acute hospital admission; prevent premature admission to long-term residential care; support timely discharge from hospital; and maximise independent living. Four models of intermediate care are available and include: bed-based intermediate care, crisis response, home-based intermediate care, and reablement. Intermediate care is provided by a range of different health and social care professionals and tends to be time-limited over a few days

[1] Provisioning Strategy Project - Options Development | East Lothian Council

or weeks[2]. Across East Lothian, examples of intermediate care services available include the East Lothian Community Hospital, the Emergency Care and Falls Service, the Technology Enabled Care (TEC) team, East Lothian Rehabilitation service and the East Lothian Physiotherapy Led Pain Management Service (ELPMS)[3].

In 2012, the Scottish Government described intermediate care as key to enabling people to live independent lives in their own communities and released a framework to help HSCPs design and improve services in their localities[4].

The evidence to support intermediate care

The National Audit of Intermediate Care (2017), which reviewed intermediate care services across NHS England found that intermediate care improved patient flow between care settings, reduced delayed discharges, and reduced unnecessary hospital and long-term care admissions. It also found that engagement with intermediate care had the potential to improve dependency scores, with 93% of people who had received support from home-based services, 94% of bed-based services, and 91% of reablement services either maintaining or improving their scores upon discharge[5].

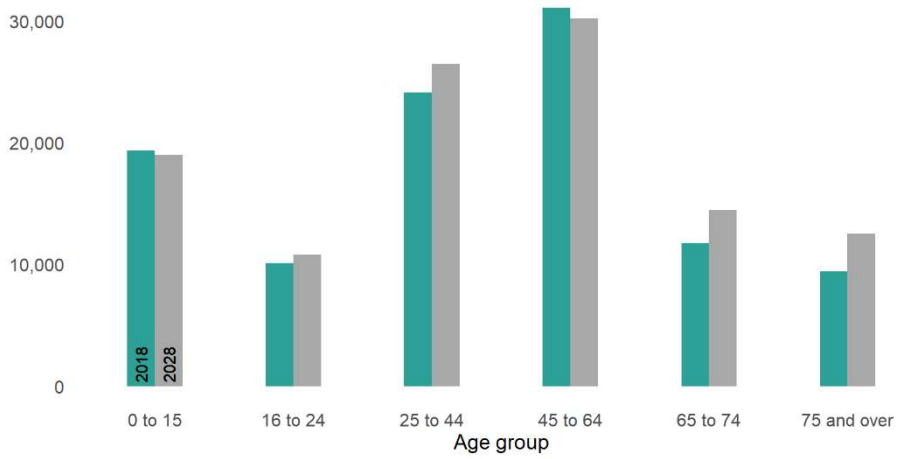
A recent scoping review of 133 studies explored the effectiveness of intermediate care for middle aged and older adults and reported value across 4 different service models of hospital-based, at home, bed-based and blended hospital/community intermediate care. Value included a reduction in hospital readmission rates across all 4 models, and improved function and self-rated health across selected others. However, as the studies were heterogenous in terms of type of intervention, patient group, and delivery context, the authors cautioned that it was still important for local services to assess the effectiveness of their own unique services in terms of function, healthcare utilisation, and costs[6]. If not already agreed, it would therefore be important for ELHSCP to define a set of core indicators upon which to evaluate its own intermediate care services, as evidence of impact would support the case for future prioritisation.

The need for intermediate care

East Lothian is an ageing population that is estimated to experience a 23% and 33% increase in adults aged 65-74 and 75+ years between 2018-2028, respectively[7] (Figure 1). Across Scotland, the number of emergency admissions has been increasing over the past 20-years and much of this is thought to be associated with an ageing population[8]. It is therefore reasonable to assume that with a growing ageing population, East Lothian residents will place increasing demands on acute services and intermediate care options to reduce this should remain a priority.

Figure 1: East Lothian population number by age group, 2021 and 2028

[2] Recommendations | Intermediate care including reablement | Guidance | NICE
[3] Intermediate Care Report summary | East Lothian Council
[4] Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland - gov.scot (www.gov.scot)
[5] s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC (Providers)/2017/NAIC England Summary Report - upload 2.pdf
[6] The effectiveness of intermediate care including transitional care interventions on function, healthcare utilisation and costs: a scoping review - PMC (nih.gov)
[7] East Lothian Council Area Profile (nrscotland.gov.uk)
[8] Acute Hospital Activity and NHS Beds Information for Scotland (publichealthscotland.scot)



Source: East Lothian Council Area Profile (nrscotland.gov.uk)

Community engagement has also demonstrated that support in old age and intermediate care are of increasing importance to East Lothian residents themselves. In 2021, an East Lothian survey found that 27% of residents reported that improvements in care of the elderly was a priority area, compared to only 5% in 2019[9]. Similarly, community engagement undertaken in 2022 as part of the Community Hospitals and Care Home Provision Change Board, found that people in East Lothian would prefer to stay in their own homes for as long as possible, and should they require it, that they would prefer that any support is provided at home or in a homely setting[10].

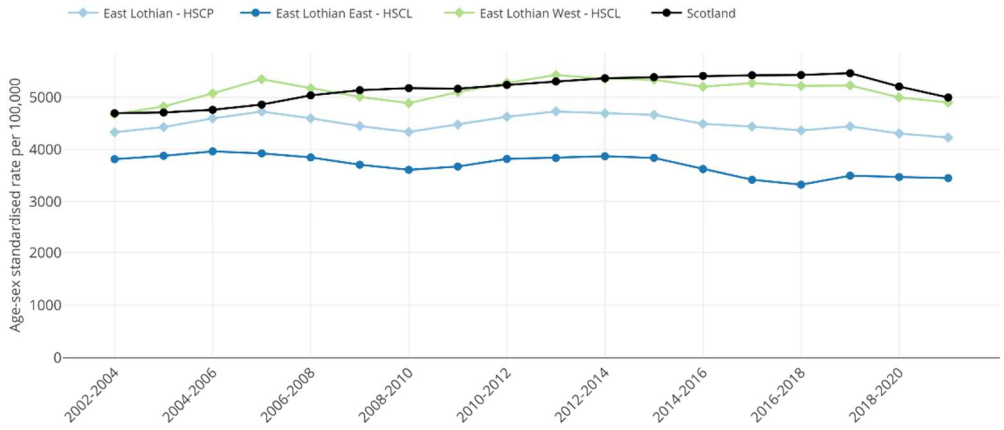
Whilst there is already a wealth of intermediate care provision across East Lothian, there is scope for ongoing development. In 2021/22 the Health and Social Care Experience Survey revealed that 72% of East Lothian adults who are supported at home agreed that they were supported to live as independently as possible, which was lower than the Scotland average of 79%[11]. In addition, between 2018-2020, multiple emergency hospital admission rates in East Lothian residents aged over 65-years were 4,228 per 100,000 population. As Figure 2 illustrates, whilst this rate was lower than the Scottish average, there was variation between the East and West of the region, which suggests there may be scope for improvement particularly in the West[12]. Considering the possible underlying explanations for this trend, research has demonstrated that socioeconomic deprivation is associated with a higher rate of unplanned hospital admissions[13], and that multi-morbidity, which is more prevalent in areas of socioeconomic deprivation, is also associated with higher rates of unplanned hospital admissions[14]. Therefore, it may be that the higher rates of multiple emergency hospital admissions in the West compared to the East of East Lothian correlates with the higher prevalence of socio-economic deprivation in this area (as measured by the Scottish Index of Multiple Deprivation (SIMD)). Alternatively, in line with the inverse care law, it may be that access to and utilisation of intermediate care (which aims to avoid acute hospital admissions) is lower in the

[9] East Lothian by numbers | Statistic, facts and figures | East Lothian Council
[10] Planning for an Ageing Population Summer Engagement Feedback Report | East Lothian Council
[11] Core suite of integration indicators 4 July 2023 - Core suite of integration indicators - Publications - Public Health Scotland
[12] ScotPHO profiles (shinyapps.io)
[13] Payne R, Abel, G, Gurthre B and Mercer S. The effect of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study. CMAJ. 19 March 2023. Available from: https://doi.org/10.1503/cmaj.121349
[14] University of Glasgow - Research - Glasgow Research Beacons - Addressing Inequalities - Tackling the spiral of multimorbidity

West[15]. Further analysis of multiple emergency hospital admissions by population demographics such as age, sex, socio-economic position and underlying cause of admission, and use of intermediate care by geography and socio-economic position would help to build a clearer understanding of these trends. Finally, in July 2023, East Lothian residents aged 75+ years experienced 197 delayed discharge bed days for standard reasons[16]. With an estimated average daily bed cost of £262 in 2019/20, it is important to drive this number as close to zero as possible[17]. There therefore appears to be an ongoing need for intermediate care, which could help address the needs to support independent living, reduce emergency hospital admissions, and avoid delayed discharges.

In addition to impact, developing an agreed set core set of indicators from routinely available population and health and social care data to evidence the need for intermediate care could help it to remain a future priority area.

Figure 2: Multiple emergency hospital admissions aged >65-years across East Lothian and Scotland, 2002-2020



Source: ScotPHO profiles (shinyapps.io)

Inequalities in intermediate care

In its 2018 quality standard for intermediate care, the National Institute for Health and Care Excellence (NICE) states that service providers should ensure that people are not excluded from intermediate care based on whether they have a particular condition (such as cognitive impairment) or live in particular circumstances (such as prison or temporary accommodation)[18].

The literature and data exploring equity of access to intermediate care appears to be relatively limited but a handful of studies and articles relating to this theme were identified. The United Nations describe health inequalities in access to health care in old age for a range of reasons.

[15] Inverse care law | The King's Fund (kingsfund.org.uk)
[16] Delayed discharges in NHSScotland monthly - Figures for July 2023 - Delayed discharges in NHSScotland monthly - Publications - Public Health Scotland
[17] Delayed discharges in NHSScotland annual - Annual summary of occupied bed days and census figures – data to March 2021 (planned revision) - Delayed discharges in NHSScotland annual - Publications - Public Health Scotland
[18] Quality statement 1: Discussion about intermediate care | Intermediate care including reablement | Quality standards | NICE

Relevant to East Lothian, they highlight a risk of inequalities being experienced by older people in rural areas, who can be more prone to shortages of skilled health workers, and whose limited mobility and poorer transport links can make travel to and from health facilities more difficult[19].

Among the academic literature, a study exploring transitional care of older ethnic minority patients found that in the first instance, older people from ethnic minority groups potentially had a greater need for intermediate care services as they were more likely to have increased multi-morbidity and complexity, higher readmission and non-scheduled visits to emergency departments, and longer inpatient rehabilitation stays than older white patients. They also found that older people from ethnic minority groups faced additional barriers to intermediate care due to[20]:

- Differing norms, values, beliefs and/or communication patterns
- A lack of awareness of services available
- Poorer health literacy
- Lack of social networks
- Difficulty articulating preferences and values
- Poorer communication with health and social care professionals
- A greater distrust of health services

A further study exploring social inequality in navigating intermediate care for older people in Norway highlighted that access to and experience of intermediate care differed between socio-economic groups. Like older people from ethnic minority groups, it reported that older people from areas of deprivation often had greater morbidity, which led to a greater need for healthcare. This is supported by Scottish data; Figure 3 below highlights socio-economic inequalities in hospital readmission rates[21] whilst Figure 2 above highlights the higher multiple hospital emergency admission rates for adults aged 65+ years in the West of East Lothian, which is known to have higher area deprivation than the East.

The Norwegian study also observed that those from more affluent backgrounds were more likely to have greater social capital and other resources that enabled them to better navigate the system. For example, more affluent older people were more likely to have relatives with higher health literacy and education who were better able to advocate for their needs. Older people from more affluent backgrounds were also observed to have characteristics that helped them better fit into the system. For example, having less complicated health issues, engaging with staff in an active way, and being able to articulate a wish to return home were felt to give more favourable conditions in which to negotiate care needs with health and social care professionals[22].

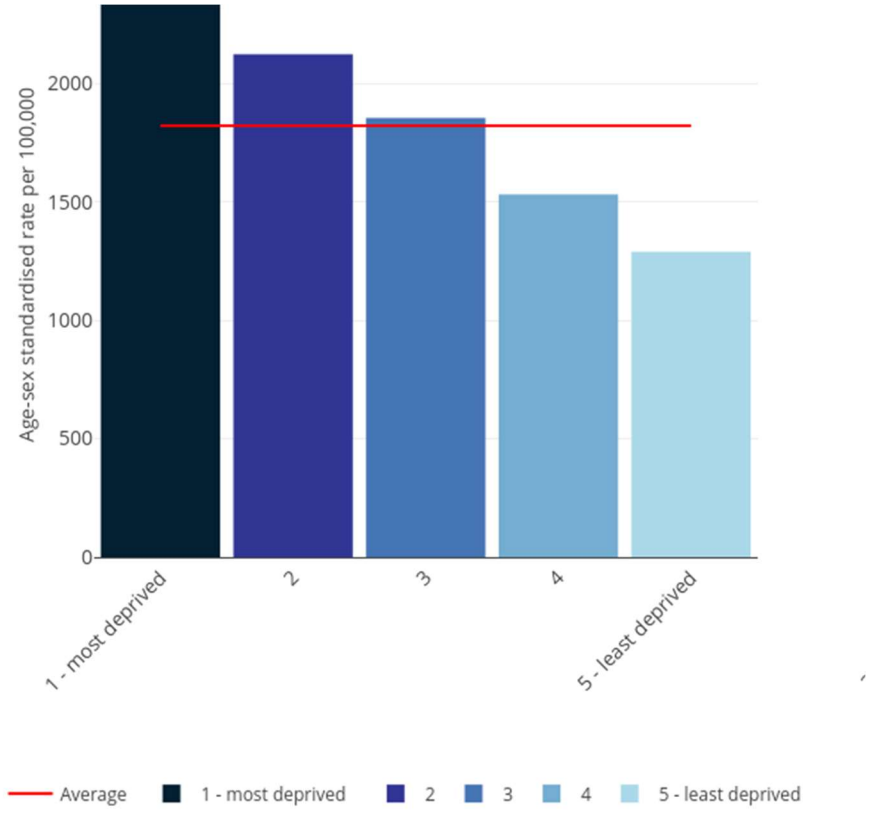
Whilst limited, the literature illustrates potential inequalities in the need for, access to and experience of intermediate care systems. It is therefore important that equity of access for all population groups is prioritised in the ongoing development of intermediate care services across East Lothian.

It is suggested that integrated impact assessments (IIAs) are used at the service design stage to pre-empt and address any barriers that different population sub-groups may have in accessing

[19] Health-Inequalities-in-Old-Age.pdf (un.org)
[20] Transitional care of older ethnic minority patients: An integrative review - Dolu - 2023 - Journal of Advanced Nursing - Wiley Online Library
[21] ScotPHO profiles (shinyapps.io)
[22] Social inequality in navigating the healthcare maze: Care trajectories from hospital to home via intermediate care for older people in Norway - ScienceDirect

intermediate care, and that service evaluation includes stratification by characteristics such as age, sex, SIMD, urban-rural location, and ethnic group.

Figure 3: East Lothian data on repeat emergency hospitalisation in the same year by deprivation group (SIMD) 2012/13 - 2014/15



Source: ScotPHO profiles (shinyapps.io)

What improvements can be made to enable dying at home to be a more accessible choice for East Lothian residents?

Why place of death is important

Place of death can be a critical contributor to the quality of death for an individual and their family and friends around them. It has an impact on their psychological, physical, social and spiritual comfort and may provide the possibility for family and friends to be present during the final days and hours of an individual's life. Wherever a person dies, whether at home, in a hospice, care home or hospital the end-of-life care is provided by health and social care professionals to people of all ages living and dying with any advanced or progressive health condition.

However, preferences for place of death are not categorical choices; they are highly contingent and determined by the support available for the health and social challenges that the local populations face and for individuals, choice of place can change as health deteriorates and needs change [23].

As a proxy measure, dying at home will not always equate to quality. How home is experienced is likely to be quite different for people and so dying at home is not always meeting the patient preference for place of death nor a measure of quality of care. Assumptions that a death at home is 'good' and a death in hospital is 'bad' can be over-simplifications or even misleading but the key point here is that choice should be equitable, and the patient's dignity respected.

Existing research shows that people from more socio-economically deprived areas are less likely to die at home compared to people from higher socio-economic areas[24]. Similar trends apply to receiving palliative care or dying in a hospice. Across Scotland and the UK, evidence shows that they are more likely to be admitted to hospital for the last 3 months of their lives. This demonstrates the relationship between the availability of good medical or social care and the inverse care law where care and access to care varies inversely with the needs of the population. Those who need it most access it least [25].

While there is growing awareness that place of death is not a reliable quality indicator, there is, as yet no consensus on what measures should be used nationally[26]. While other types of quality measures are available, they all have limitations: outcome metrics are often too complex for non-specialist settings; bereavement surveys are mostly retrospective and so use carers' experiences as a proxy for individuals' experiences[27].

Place of death is not a high priority to all patients close to the end of life, particularly compared with issues such as receiving good symptom management[28]. Often the preference for death at home changes over time, decreasing as illness progresses and sometimes dying at home is more a preference of the family or close relative.

Experiences and need are very different for individuals and place of death should be driven by those so perhaps the most important thing to focus on is the process and quality of end-of-life care which ultimately ends with the place of death being where the person wants and needs to be.

Need

In East Lothian the number of people being supported to die at home or in a homely setting is below the Scottish average. More people are dying in hospital. Further exploration of the local data that drives this is key to better inform and support policies, resource allocation, planning and commissioning of services to enable more people to die at home.

Data that is available tends to focus on hospital stays in the months before death versus time in the community as well as hospital deaths. There is little data to be found that relates to process, outcome and experience of people, including people in receipt of end-of-life care, bereaved carers

[23] Do Patients Want to Die at Home? A Systematic Review of the UK Literature, Focused on Missing Preferences for Place of Death (plos.org)
[24] Socioeconomic position and use of healthcare in the last year of life: A systematic review and meta-analysis | PLOS Medicine
[25] Structural Inequalities and Dying at Home During COVID-19 – Policy Scotland (gla.ac.uk)
[26] spcare.bmj.com/content/bmjspcare/early/2022/07/12/spcare-2022-003841.full.pdf
[27] Dying well at home: commissioning quality end-of-life care (kingsfund.org.uk)
[28] Do Patients Want to Die at Home? A Systematic Review of the UK Literature, Focused on Missing Preferences for Place of Death - PubMed (nih.gov)

and professionals that are involved in end-of-life care and how a decision is made about where a person dies [29].

Having a fuller understanding of need is increasingly important because of the underlying trends in population ageing, which mean that deaths (and therefore palliative care needs) will increase substantially over the next 20 years. This will have notable implications for formal service provision as well as informal (unpaid) care at a time when community-based health and care services are already under pressure and there are challenges with recruitment and retention of staff. The HSCP must reshape supply in line with need and ensure that they have a clear overview of quality and inequalities, so that issues are identified and acted on.

Inequalities in end-of-life care and location of death

It is well established that there are inequalities in access to end-of-life care services and quality of care[30]. From the literature we know that there are significant variations in the types of end-of-life services people access, which in turn suggests there could be significant levels of unmet need across East Lothian. We have touched upon the difference between socio-economic groups and the likelihood of accessing quality end of life care above.

Based on the literature, we know that the following factors are likely to play a role in inequalities in access to end-of-life care and place of death [31]:

- The availability and extent of family support
- Staff capability to identify individuals at the end of life, and confidence to plan care with them
- Access to services – not all areas have hospices located nearby, and availability of out-of-hours services can be limited in some areas
- The type of illness and disease group
- Rurality – people living in rural areas may have less access to palliative and end-of-life care services than others in urban or suburban areas which may lead to them having to be hospitalised
- Ethnicity – people from ethnic minorities generally have lower rates of referrals to end-of-life care services and higher levels of dissatisfaction with services
- Religious beliefs – they are often important to families but sometimes misunderstood by service providers
- Homelessness, with health care staff often ill-equipped to support and provide adequate care to people who are homeless at the end of life
- People living with dementia or a learning disability are more likely to experience gaps or poor co-ordination of end-of-life care
- LGBTQ+ people may access palliative and end-of-life care services late or not at all, and their partners can feel isolated or unsupported during bereavement

The lack of data on the quality of end-of-life care provided at home means that we do not know about the current prevalence of all these inequalities across different parts of East Lothian. We are also unclear about how these inequalities intersect as a person may be affected by several of them

[29] Dying well at home: commissioning quality end-of-life care | The King's Fund (kingsfund.org.uk)
[30] Inequities in palliative care - deprivation (mariecurie.org.uk)
[31] Dying well at home: commissioning quality end-of-life care (kingsfund.org.uk)

at one time. People from lower socio-economic groups are also less likely to receive specialist palliative care.

Suggested approaches to improving dying at home or in a homely place

The following approaches could help to understand need and potentially ensure everyone dies in the place they choose:

- Encourage recording of preferred place of death. An English study found that patients were six times more likely to die at home (in their preferred place of death) when this was recorded in end-of-life plans [32]
- A focus on population health is key to identify people likely to require end of life care, understanding need and using this understanding to facilitate the development of relevant services and supports for people approaching end of life across health, social care and the wider system of public services and community support. Essential to this is taking a system wide approach rather than by individual organisation.
- Analyse activity across primary and secondary care data to understand total health care usage in the last few months of life and how that might be used to identify opportunities for preventive or anticipatory interventions. Examples include out-of-hours care, 24-hour advice lines and pharmacies throughout the night, and reliance on accident and emergency (A&E) attendances in the last three months of life which may strongly suggest there is significant unmet need for end-of-life care at home.
- As per the Scottish Government framework for end of life and palliative care, normalise the discussion about death and dying across the life course. Use a public health approach to death "good life, good death, good grief".
- Plan and implement a programme of work to engage with a number of population groups to better understand their needs and preferences, and whether they were currently encountering any barriers to accessing end-of-life care.

Further questions

Similar to research done in England it would be helpful to explore the following in East Lothian:

1. What are the main reasons that more people are dying in hospital, how is that data gathered and where is it recorded?
2. What do we know about the quality of end-of-life care for people who die at home, and any inequalities experienced by particular groups in the population?
3. What are ELHSCP doing to measure and assure the quality of end-of-life care for people who die at home, including any inequalities experienced by particular groups in the population?
4. Joint commissioning and what does that look like in ELHSCP for the provision of end-of-life care?
5. Is there a local partnership end of life strategy?
6. What training around end-of-life care for care workers is available and does it link with community development approaches to normalising death in the community?

[32] Driessen A, Borgstrom E, Cohn S. Placing death and dying: Making place at the end of life. Soc Sci Med. 2021 Dec;291:113974. doi: 10.1016/j.socscimed.2021.113974

A person's preferred place to die often goes unrecorded in their notes (nihr.ac.uk)

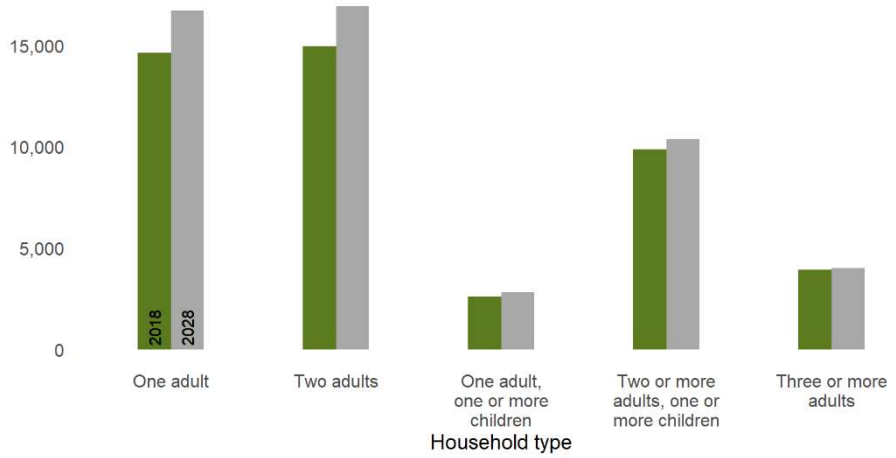
How can we support individuals to stay independent in their own homes, when faced with staffing and resource shortages?

The need to support individuals to stay independent at home

As previously documented, the results of community engagement highlight that older people in East Lothian would prefer to stay in their own homes for as long as possible. This echoes UK-wide literature that has explored housing needs and preferences in older age[33]. The desire to remain at home has been explained by the attachment that people have with their home and the association home has to an individual's sense of privacy, freedom, identity and self-esteem[34].

The demand for services to support older people to remain independent at home is growing as East Lothian experiences a growing ageing population, and as older people live longer with more complex conditions. There is also evidence that factors such as living alone, loneliness, ageing without children and being a carer can impact health and experience of care in older age[35]. Between 2018 and 2028, the household type of 'one adult' in East Lothian is projected to experience a 14% increase (Figure 5). By age group, it is projected that there will be a 44% increase in the number of households where the household reference person (HRP) is aged 80-84-years[36]. The need to support individuals to stay independent at home for longer is therefore increasing.

Figure 5: Projected number of households by household type, 2018 and 2028



Source: East Lothian Council Area Profile (nrscotland.gov.uk)

The challenges to supporting individuals to remain independent at home

The services to meet this increasing demand, however, are faced with challenges such as staff shortages, stretched budgets and service reductions. For example, between April 2021 and March 2023, East Lothian experienced a 2,000-hour-per-week reduction in care at home provision from

[33] Housing for older people (parliament.uk)
[34] age_uk_briefing_state_of_health_and_care_of_older_people_july2023.pdf (ageuk.org.uk)
[35] age_uk_briefing_state_of_health_and_care_of_older_people_july2023.pdf (ageuk.org.uk)
[36] East Lothian Council Area Profile (nrscotland.gov.uk)

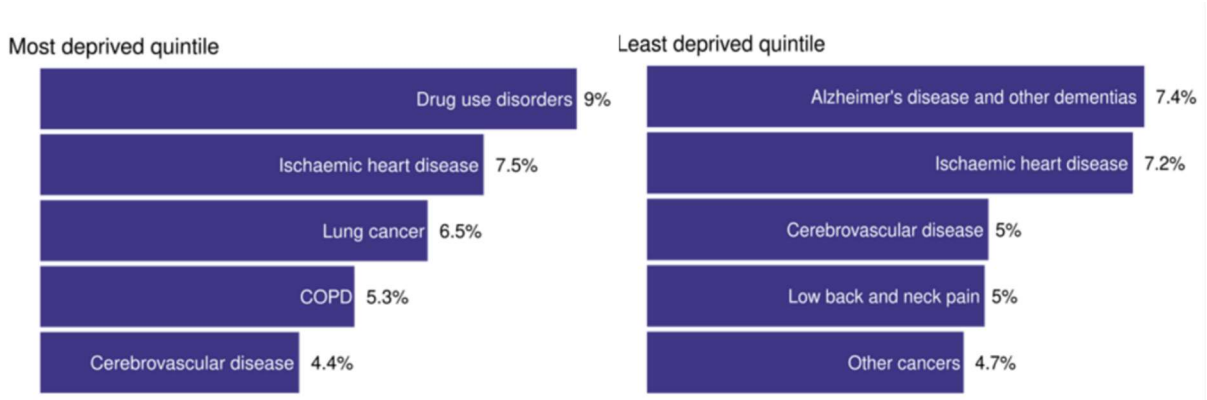
external providers[37], whilst in 2021 47% of Scottish social care services reported staff vacancies[38]. Fulfilling the wish of East Lothian residents to stay independent in their own homes for longer is therefore increasingly challenging to achieve.

The opportunities to better support independence at home

In the context of finite resources and increasing demand, more investment in prevention activity could help people to stay independent in their own homes for longer and curb the demand on limited health and social care services. This is highlighted in the Scottish Government's Older People's Health and Social Care Statement of Intent (2021) which outlines 5 areas of focus, the first of which is prevention[39]. Frailty, which is defined as a health state related to the ageing process in which multiple body systems gradually lose their in-built reserves, is one area where focused prevention efforts could support independent living. It is estimated that frailty affects 10% of people aged 65+ years and 50% people aged 85+ years and costs UK healthcare systems £5.8 billion per year. In 2023, the British Geriatric Society published a blueprint for preventing and managing frailty and older people which makes 12 recommendations to achieve these goals[40].

Developing a better understanding of and addressing the underlying causes that lead to emergency hospital admissions or long-term care could also help people to remain independent in their homes for longer. Figure 6 shows data from 2019 which outlines the leading individual causes of ill-health and early death in the most and least deprived quintiles in the East Region of Scotland[41]. Using similar data to understand the burden of disease among older adults in East Lothian could help to identify what prevention or early intervention activity could help people to remain independent at home for longer and could help inform what level or type of community care need will be required.

Figure 6: Leading individual causes of ill-health and early death by proportion in the most and least deprived quintiles in the East Region of Scotland (SIMD 2020)



Source: Scottish Burden of Disease Study 2019 (scotpho.org.uk)

Finally, there are also prevention opportunities among the wider determinants of health. For example, suitable housing is essential to support independent living. Data from the 2011 census

[37] Integration Joint Board (IJB) Annual Performance Reports | East Lothian Council
[38] Staff vacancies 2021.pdf (careinspectorate.com)
[39] Health and social care for older people: statement of intent - gov.scot (www.gov.scot)
[40] Introduction to Frailty | British Geriatrics Society (bgs.org.uk)
[41] Scottish Burden of Disease Study 2019 (scotpho.org.uk)

showed that of those aged 65+ years in East Lothian, 67% lived in owner-occupied housing, 26% in social rented sector, 4% in the PRS and 2% in 'Other'[42]. This highlights the need for housing of all tenures to be both accessible and adaptable for older people. Additionally, a recent survey of East Lothian residents (n=94) which asked about future housing needs found that 61% were unsure or did not feel that their current home would be suitable for their future needs. On further questioning, the ability to manage stairs, properties being too large, garden maintenance, access to baths/showers and having an upstairs bathroom were identified as the leading causes of concern[43]. This highlights a potential need to support older people to transition into accommodation that will be more appropriate for their needs and enable them to remain independent at home. Using housing as an example, it will therefore be important for the ELHSCP to continue to offer their expertise in supporting policies and plans such as local housing strategies, which will impact upon the wider determinants of health for older people in East Lothian.

To conclude, as part of plans to help people remain independent at home for longer in the context of limited resources, it would be worthwhile considering the role and opportunities for prevention and early intervention in reducing demand.

Inequalities in remaining independent at home

Inequalities accrue across the life course, and health inequalities in old age often reflect accumulated disadvantage linked to factors such as gender, location, and socio-economic status. In Scotland, it is well documented that people from more deprived backgrounds are more likely to enter old age in poorer health than those from more affluent backgrounds[44]. It is also known that older adults who live alone are more likely to attend accident and emergency departments and have emergency hospital admissions than those living with others[45]. Data from East Lothian (Figure 7) indicates that single adult dwellings are more common among those from more deprived backgrounds, which further suggests that living independently at home may be more challenging for those from more deprived backgrounds. It should be noted, however, that this is for all adults and so the trend may differ if restricted only to older age[46].

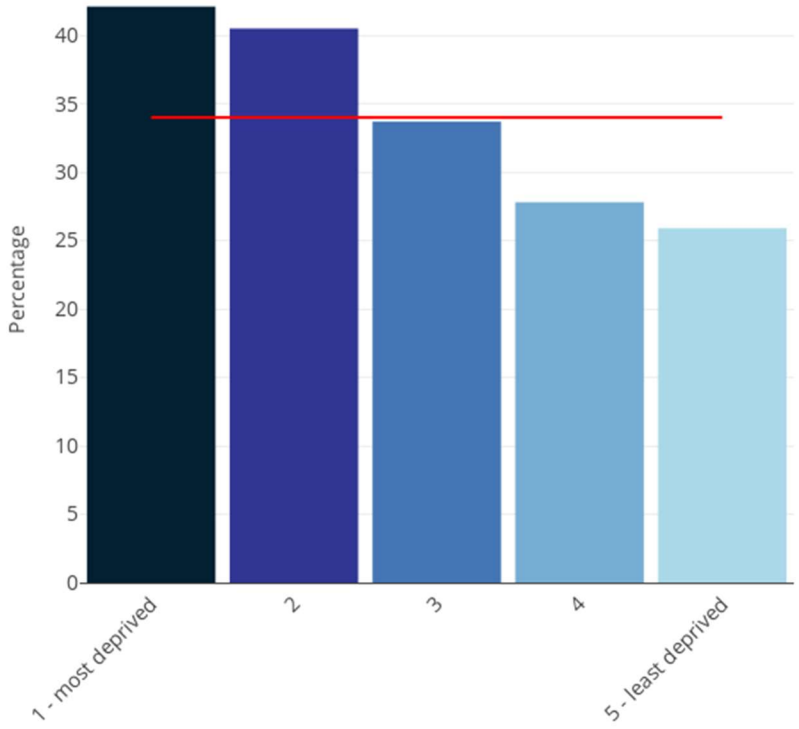
Figure 8 demonstrates the areas of higher deprivation across East Lothian, as measured by SIMD. In alignment with the concept of proportionate universalism[47], it would be appropriate to assign resources to help people remain independent at home in proportion to need, i.e., with resource assigned throughout all of East Lothian but with the geographical areas and/or population groups with increasing need being assigned an increasing proportion of resource.

As documented in both this and other sections, population sub-groups can face inequalities in their need for, access to and experience of intermediate care. It is therefore important that even in the context of limited resources, that services are delivered in a way that is proportionate to need and that is accessible to all.

[42] Housing Need and Demand Assessment of Older People in East Lothian, 2022

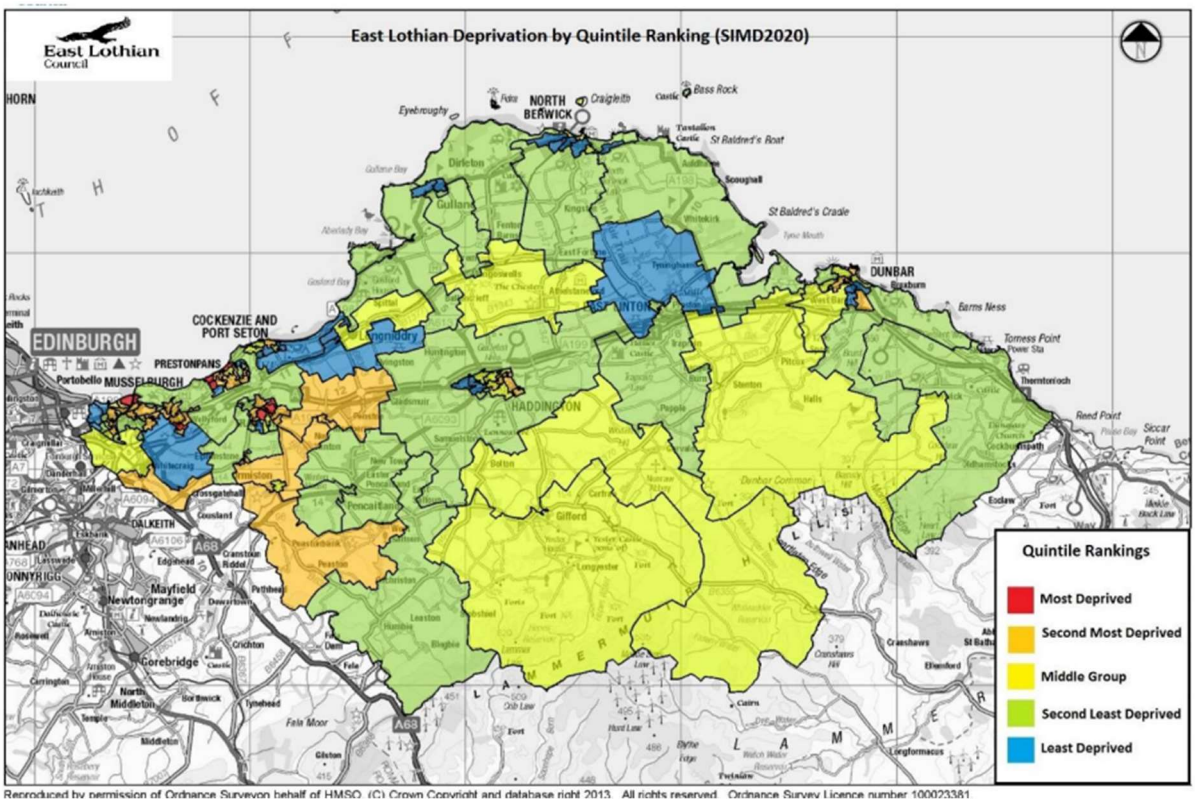
[43] futurehousingneedsofolderpeoplesurveyanalysis-complete.pdf (eastlothianconsultations.co.uk)
[44] Older people - Population groups - Public Health Scotland
[45] The association between living alone and health care utilisation in older adults: a retrospective cohort study of electronic health records from a London general practice | BMC Geriatrics | Full Text (biomedcentral.com)
[46] ScotPHO profiles (shinyapps.io)
[47] Proportinate universalism and health inequalities (healthscotland.com)

Figure 7: Single adult dwellings by deprivation group in East Lothian, 2021



Source: ScotPHO profiles (shinyapps.io)

Figure 8: Map of East Lothian Deprivation by SIMD (2020) quintile



Source: East Lothian by Numbers

Conclusion

Viewing these East Lothian HSCP challenge statements through an inequality lens provides a useful opportunity to consider what the evidence base and our understanding of the local population can tell us about how such policy and service changes might have unequal impacts upon different population groups. This report summarises relevant evidence and data (where available) however, for a number of the statements, we have identified areas which would benefit from further local exploration to inform future policy. Older people are not a homogenous group and their social circumstances vary across the county hence applying an inequality lens in future work will be an important element of ensuring the HSCP is meeting its commitments to address inequalities of outcome.