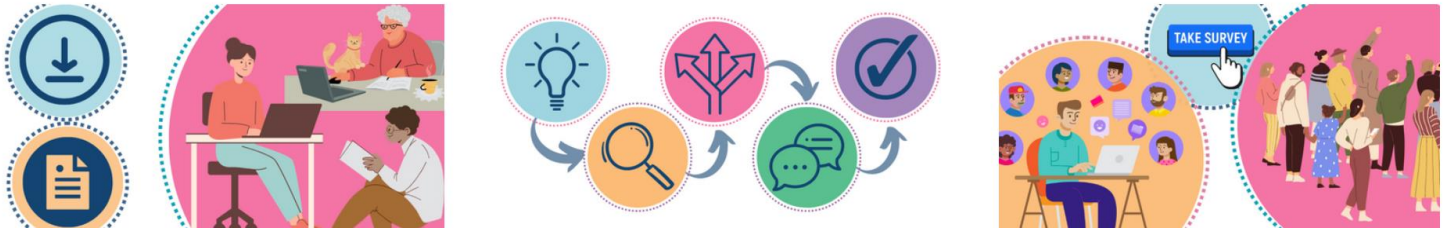
East Lothian Health & Social Care Partnership

Planning Older People's Services

Options Update Report

November 2024



Progress on options as of 30th November 2024

Approved for publication by POPS Project Team on 18th December 2024

Planning Older People's Services

Update on options considered work in progress or action already underway at modelling / development and hurdle criteria stages (July 2024)

For further information on each of the options listed below please refer to our *Options modelling and development summary report (July 2024)*.

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
Option 21: In order to improve outcomes, stability, service provision, terms and conditions and control over the market, careful consideration should be given to expanding the internal (HSCP) Care at Home service.	Care at Home Strategic Planning and Commissioning Officer, ELHSCP	The development of the locality-based care co-ordination model and a proposed test of change will incorporate and explore this option. The development of the locality-based care co-ordination model and a proposed test of change will incorporate and explore this option.	IJB annual delivery plan 2024-25: • **1.2.1** – Ongoing consolidation and development of range of Intermediate Care Services: ○ Continued review and development of interim care services (including care at home pilot – see below). ○ Further development and expansion of Home Care / Hospital to Home integrated service to create additional capacity, fully utilising One Plan, and reviews process – ongoing. ○ Enhanced Discharge to Assess project commenced in February 2024 bringing together Discharge to Assess (D2A) therapists, Emergency Care Service (ECS), and Care Capacity and Flow Team to facilitate discharges with initial care needs. Regular reporting on a monthly basis. • **1.2.2** – Delivery of programme to review and redesign Care at Home service provision: ○ Presentation of recommendations to SPG / IJB regarding a Test of Change Flexible Locality Model – May 2024. ○ Project Team formed to develop and implement the Flexible Locality Model. ○ Delivery of Test of Change project in Tranent from October (will run through to June 2025). ○ Care at Home Strategy to be developed in 2025.
Option 23: There should be a wholesale review of scheduling and time management within Care at Home services (internal and external).	Care at Home Strategic Planning and Commissioning Officer, ELHSCP		
Option 25: We should review what constitutes the essential elements of a care package. Care at Home services have cut back on the application of creams, administration of basic medications (e.g. eye drops), bathing and meal prep. This option has strong links to moving away from time-and-task model to a more outcome-focused approach that builds personal	Care at Home Strategic Planning and Commissioning Officer, ELHSCP		

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connections. There are also strong links with delaying discharge.			
Option 8: Volunteer befriender or sitter services should be explored to support people receiving Care at Home or end of life care, with specific focus on those with limited to no family and friends.	Care at Home Strategic Planning and Commissioning Officer, ELHSCP		
Option 18: We should develop and introduce locality-based block contracts with target outcomes for delivery of care at home / intermediate care services (there is potential for a pilot focused on internally provided care at home services in a local area, where commissioning and retaining external provision has been challenging).	Care at Home Strategic Planning and Commissioning Officer, ELHSCP		
Option 34: If ELHSCP is unable to build or develop new Care Home sites, then consideration should be given to commissioning additional social work funded beds within existing care homes.	Care Homes Strategic Planning and Commissioning Officer, ELHSCP	The National Care Home Contract does not stipulate what level of Social Work funded residents there should be or the balance with self-funding beds. For private homes to remain viable, it is often vital that they maintain a higher proportion of self-funders. The HSCP continues to negotiate and engage with private providers as we attempt to secure favourable splits between	IJB annual delivery plan 2024-25: • **1.7.2** – Develop approach to ensure that the best use is made of available care home capacity by effectively matching provision to need: o Progress continues to be made with the development of an agile Social Work Hospital Discharge Team. This aims to support early assessment and care package design, helping identify alternatives to care home admission. o A social work senior practitioner and an additional social worker have been moved from the main adult social work team to support the model.

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		Social Work funded and self-funded beds.	○ Management scrutiny of care home referrals taking place through a resource panel to ensure care home places filled by those with the highest level of need. ○ Hospital admissions being tracked to identify any that could have been prevented and to reduce the risk of readmission once people discharged home.
Option 33: Professional support and training networks should be established between the Oak Tree Ward (ELCH) and care homes. Care home staff would benefit from the support / advice and additional training / awareness raising related to dementia, stress / distress and managing complex behaviours.	Care Homes General Manager for Acute and Ongoing Care, ELHSCP	Following discussions with the Chief Nurse and relevant General Managers, it is the Partnerships intention to establish a Care Home meeting that focuses on the role and remit of ELCHASE in terms of supporting care homes, focusing on early intervention, prevention of admission, discharge planning and education. It is acknowledged that training for carers, families and care at home staff is also necessary due to number of admissions directly from the community.	IJB annual delivery plan 2024-25: • **1.7.1** – Continue to monitor quality and support improvement activity within care home provision: ○ Ongoing delivery and further development of the Care Home Huddle to support a multi-agency approach to monitoring care home quality and supporting improvement work. ○ Charging within local authority care homes has been reviewed to bring in line with CRAG (Charging for Residential Accommodation Guide) ○ Continue to deliver range of Quality Improvement (QI) activities, to include - falls and frailty support; pain management; embedding of HOPE workbook (spiritual care plan); and delivering My Health, My Care, My Home framework (future care planning). • **4.2.2** – Further development of role ELCH plays in relation to teaching, training and staff development: ○ Ongoing development of teaching / training by the Endoscopy and Day Service Unit at ELCH. • **4.8.1** – Crookston Care Home service redesign: ○ Review / evaluation of the current care model delivered at Crookston will be carried out to identify options for future provision and opportunities to deliver financial efficiencies. A paper will be submitted to the SPG / IJB once the review is complete. • **5.2.3** – Carry out a review of Older Adult Mental Health (OAMH) services *(stress and distress training)*: ○ Service provision options continue to be explored. ○ Stress and Distress training rolled out across East Lothian Care Homes to support moving away from Pharmacological interventions for stress and distress. Pilot has been running for
Option 35: ELHSCP should introduce an awareness raising and training programme for all care home staff related to supporting residents and family members with mental health issues. This could be linked with other issues (e.g., dementia, stress and distress, complex behaviours).	Care Homes General Manager for Acute and Ongoing Care, ELHSCP	Following discussions with the Chief Nurse and relevant General Managers, it is the Partnerships intention to establish a Care Home meeting that focuses on the role and remit of ELCHASE in terms of supporting care homes, focusing on early intervention, prevention of admission, discharge planning and education. It is acknowledged that training for carers, families and care at home staff is also necessary due to number of admissions directly from the community.	

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			6 months. To be evaluated. Initial observations show no change in rate or nature of referrals suggesting training is not having expected impact. ○ Single Point of Contact will all improve patient journey for this group.
Option 36: We should develop and expand the role of the East Lothian Care Home Assessment, Support and Education Team (e.g., single point of contact, training for Care Home staff, short-term intensive support service to help keep complex cases local rather than moved to specialist provisions).	Care Homes General Manager for Acute and Ongoing Care, ELHSCP	Following discussions with the Chief Nurse and relevant General Managers, it is the Partnerships intention to establish a Care Home meeting that focuses on the role and remit of ELCHASE in terms of supporting care homes, focusing on early intervention, prevention of admission, discharge planning and education. It is acknowledged that training for carers, families and care at home staff is also necessary due to number of admissions directly from the community.	IJB annual delivery plan 2024-25: • **1.7.1** – Continue to monitor quality and support improvement activity within care home provision: ○ Ongoing delivery and further development of the Care Home Huddle to support a multi-agency approach to monitoring care home quality and supporting improvement work. ○ Charging within local authority care homes has been reviewed to bring in line with CRAG (Charging for Residential Accommodation Guide) ○ Continue to deliver range of Quality Improvement (QI) activities, to include - falls and frailty support; pain management; embedding of HOPE workbook (spiritual care plan); and delivering My Health, My Care, My Home framework (future care planning).
Option 24: There is a lack of understanding and awareness related to Care at Home services. We must improve awareness and understanding in relation to the variety/type of assistance available, which providers are operating in East Lothian and who they support and promote career/job opportunities.	Communication Senior Comms Adviser, ELHSCP	The ELHSCP website has recently been updated with a dedicated section related to information and advice about "Care Assistance at Home". Over the coming months, this section will be expanded to provide further detailed information and advice for individuals, and their relatives, about the range of care at home services, and how they can be accessed. The ELHSCP Communications Team is working with a variety of internal services to provide a range of printed literature in relation to self-directed support;	Highlighted within *Planning Older People's Services Final Report* and being taken forward through review and delivery of ELHSCP Participation and Engagement Strategy and Communications Strategy.

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		purchase of key safes / external rails; meals at home; and home care – care at home services.	
Option 81: We should promote and raise awareness of intermediate and community-based care. This may help to manage expectations, ensure the population know what is available and possibly improve recruitment.	Communication Senior Comms Adviser, ELHSCP	East Lothian Rehabilitation Service previously owned a public facing website. Instead of being stand-alone, the content of this website has now been integrated into the corporate ELHSCP website. This has allowed for enhanced management, development and promotion of the pages. It also provides members of the public with a more accessible means of finding self-guided support and information on intermediate care services. Discussions are underway to further develop the information. Further to the online developments, the ELRS have established a monthly Tuesday morning radio feature to promote the different aspects of their service, and how individuals can take more control over their daily lives to improve their independence.	IJB annual delivery plan 2024-25: • **5.2.5** – Provide clear public and patient information to help people to get to the right primary care service: ○ Ongoing work with communications team to ensure people are aware of range of primary care services and how and when to access them. • **6.2.3** – Improve the availability and accessibility of information in relation to mental health and substance use (including alcohol) to promote self-management and access to services: ○ Ongoing delivery of Wellbeing Resource Hub at ELCH, with plans to roll out to the Ridge in Dunbar. ○ Mental Health Services relocated from Musselburgh Primary Care Centre to the Substance Use Services at the Esk Centre (May 2024) improving accessibility of MH specialist input for SUS patients, and vice versa. ○ Introduction of new Access Pathway / Single Point of Contact will also support improved access.
Option 51: We should develop and build upon existing volunteering schemes within communities (e.g., volunteer transport schemes, Gifford Community Volunteers, First Responder Groups, befrienders, buddy	Community Strategic Planning and Commissioning Officer, ELHSCP	Option 51 is closely aligned with the development of a locality-based care co-ordination model. The whole system approach and development of this model will incorporate the enhanced use and development of volunteering schemes in collaboration with	IJB annual delivery plan 2024-25: • **1.2.1** – Ongoing consolidation and development of range of Intermediate Care Services: ○ Continued review and development of interim care services (including care at home pilot – see below). ○ Further development and expansion of Home Care / Hospital to Home integrated service to create additional capacity, fully utilising One Plan, and reviews process – ongoing.

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systems, food delivery / meal share, telephone support and check in, end of life support). This may help with social isolation, building community spirit, transport difficulties, mental health and poverty. Could be particularly useful in more rural locations and new housing developments.		Volunteer Centre East Lothian (VCEL) and other third sector partners.	○ Enhanced Discharge to Assess project commenced in February 2024 bringing together Discharge to Assess (D2A) therapists, Emergency Care Service (ECS), and Care Capacity and Flow Team to facilitate discharges with initial care needs. Regular reporting on a monthly basis. • **1.2.2** – Delivery of programme to review and redesign Care at Home service provision: ○ Presentation of recommendations to SPG / IJB regarding a Test of Change Flexible Locality Model – May 2024. ○ Project Team formed to develop and implement the Flexible Locality Model. ○ Delivery of Test of Change project in Tranent from October (will run through to June 2025). ○ Care at Home Strategy to be developed in 2025.
Option 49: ELHSCP should explore and develop an outreach service in collaboration with Day Centres. Service could potentially support carers, care at home provision and those at end of life.	Day Centres Strategic Planning and Commissioning Officer, ELHSCP	ELHSCP has developed excellent relationships with day centres over the last few years and additional funding has been allocated, via Carers Act funding, for centres to explore models of outreach support in their local communities. Service hours and staff registration mean centres are not best placed to take on traditional care at home tasks, but they offer great opportunities for social support, breaks for carers, and to people who may not want or are not able to access building-based services, which could include people nearing end of life. Out of nine centres, eight now offer community-based support that complements their building-based service. Link officers will continue to work with centres to encourage development of their outreach	IJB annual delivery plan 2024-25: • **2.2.3** – Support the development of new (Dementia) Meeting Centres (focus on Musselburgh with proposals for satellites): ○ Development work is continuing to support other local areas to develop 'satellites' – led by Dementia Friendly East Lothian. ○ In Musselburgh, this will be delivered as two half days and one brain health hub session at the Hollies from November 2024. Referral pathways to be developed. ○ Development in Prestonpans looked initially positive but not progressed, Alzheimer Scotland D'Café developing in this area. ○ Partners coming together to support development of satellite in Haddington, session with Scottish Meeting Centre Network took place in November 2024. • **4.5.5** – Increase choice and availability of community-based support, for example through new meeting centres and extension of services offered by day centres for older people: ○ Most day centres have established models of community outreach support, ELHSCP Planning & Performance continue to support where this is not the case. ○ Commissioning of Musselburgh Day Centre paused as part of financial recovery process. Existing provider offering limited support to some members from Musselburgh area.

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		model. Any pilot of locality-based services as suggested under option 18 will include the day centre and exploration of their role within the locality approach.	
Option 56: Day Centre provision should be extended to evenings and weekends.	Day Centres Service Manager for Planning and Performance, ELHSCP	Nine Day Centres were successful in being awarded a contract for day centre provision for Monday to Friday in January 2024. Evenings and weekends were not included in the requirements due to lack of demand and insufficient HSCP funds. A recent needs analysis highlighted the complexity of the work undertaken in centres; increased costs and financial pressures for all centres as they are operating both centre and outreach (worsened by substantial increases in utilities and food costs); the impact of significant gaps in care at home provision; and major gaps in the availability of replacement care, for carers and cared for people across all geographical areas. To date, demand has been limited for centre-based support in evenings and weekends. One day centre is trialling services for weekends as an outreach activity. There is clear evidence from the engagement from the carer's strategy and the outreach work from day centres that replacement care and sitter-based services are a priority.	IJB annual delivery plan 2024-25: • **2.2.3** – Support the development of new (Dementia) Meeting Centres (focus on Musselburgh with proposals for satellites): o Development work is continuing to support other local areas to develop 'satellites' – led by Dementia Friendly East Lothian. o In Musselburgh, this will be delivered as two half days and one brain health hub session at the Hollies from November 2024. Referral pathways to be developed. o Development in Prestonpans looked initially positive but not progressed, Alzheimer Scotland D'Café developing in this area. o Partners coming together to support development of satellite in Haddington, session with Scottish Meeting Centre Network took place in November 2024. • **4.5.5** – Increase choice and availability of community-based support, for example through new meeting centres and extension of services offered by day centres for older people: o Most day centres have established models of community outreach support, ELHSCP Planning & Performance continue to support where this is not the case. o Commissioning of Musselburgh Day Centre paused as part of financial recovery process. Existing provider offering limited support to some members from Musselburgh area.

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Option 47: We should develop an awareness raising campaign and training programme in relation to dementia, including training for hospital staff, care home staff, day centre staff, carers, and other identified groups.	Dementia Strategic Planning & Commissioning Officer, ELHSCP	The content of this option forms a key part of the new Dementia Strategy and will involve collaboration across several teams, including, the NHS Care Home Team Education and Support, ELCHASE, the Quality Improvement Team and Planning and Performance dementia lead.	IJB annual delivery plan 2024-25: • **4.4.1** – Development and implementation of Dementia Strategy – Development of Implementation Plan delayed until IJB budget decisions made.
Option 59: In the spirit of people remaining within their own home / community for as long as possible, there should be sufficient dementia services within the community to achieve this.	Dementia Strategic Planning & Commissioning Officer, ELHSCP	Through delivery and implementation of our Dementia Strategy, increased development and investment in intermediate care and the strategic priority to enable older people to stay closer to home, in their own home or in a homely setting we are already well placed in terms of this option.	IJB annual delivery plan 2024-25: • **2.2.3** – Support the development of new (Dementia) Meeting Centres (focus on Musselburgh with proposals for satellites): ○ Development work is continuing to support other local areas to develop 'satellites' – led by Dementia Friendly East Lothian. ○ In Musselburgh, this will be delivered as two half days and one brain health hub session at the Hollies from November 2024. Referral pathways to be developed. ○ Development in Prestonpans looked initially positive but not progressed, Alzheimer Scotland D'Café developing in this area. ○ Partners coming together to support development of satellite in Haddington, session with Scottish Meeting Centre Network took place in November 2024. • **4.4.1** – Development and implementation of Dementia Strategy – Development of Implementation Plan delayed until IJB budget decisions made. • **4.4.3** – Tender of the Post Diagnostic Support (PDS) Contract to continue the 5 Pillar Model: ○ Monitoring of Post Diagnostic Support (PDS) 5 pillar model continues quarterly. Service is currently overdelivering in terms of the Specification (currently supporting 196 people which is over the required 175). ○ 6 weekly PDS groups began in May 2024 supporting 29 people on the PDS waiting list. Further group planned for winter 2024. ○ Review of the 5 Pillar model is underway by the provider using the Health Improvement Scotland Quality Improvement

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			Framework. Plans for development of the 8 Pillar Model delayed until the IJB financial decisions have been made.
Option 7: ELHSCP should raise awareness of Future Care Planning (previously known as Anticipatory Care Planning) and ensure that it is embedded within health and social care practice.	ELHSCP Strategy, Operations, Staffing Senior Communications Adviser, ELHSCP	ELHSCP is taking inspiration and best practice advice from the recent roll out of Anticipatory Care Planning within Edinburgh HSCP. Activity was summarised as follows. As ELHSCP are actively raising awareness of and using Future Care Planning this option was considered a work in progress.	IJB annual delivery plan 2024-25: • **1.7.1** – Continue to monitor quality and support improvement activity within care home provision: ○ Ongoing delivery and further development of the Care Home Huddle to support a multi-agency approach to monitoring care home quality and supporting improvement work. ○ Charging within local authority care homes has been reviewed to bring in line with CRAG (Charging for Residential Accommodation Guide) ○ Continue to deliver range of Quality Improvement (QI) activities, to include - falls and frailty support; pain management; embedding of HOPE workbook (spiritual care plan); and delivering My Health, My Care, My Home framework (future care planning).
Option 40: A review of working relationships and lines of communication should be undertaken between health and social care services. Particular focus on GP practices to Care Homes; Oak Tree Ward (ELCH) to Care Homes; Occupational Therapy to Care Homes; Hospital discharge planning to Care Homes; Hospital at Home to GP practices; District Nurses to GP practices; Hospital discharge to Social Work.	ELHSCP Strategy, Operations, Staffing General Manager for Acute and Ongoing Care, ELHSCP	• The Chief Nurse currently chairs a professional leads meeting, including GPs and Clinical Nurse Managers across ELHSCP, that meets on a bi-monthly basis. At their next meeting, a discussion about internal integration communications opportunities will be added to the agenda. • In addition, a District Nursing Review is already taking place, which includes a specific focus on developing media and communication strategies. This review incorporates representatives from acute, Allied Health Professionals, GPs and wider NHS Lothian links. The	IJB annual delivery plan 2024-25: • **1.5.1** – Support the development of General Practice Cluster work to improve the quality of primary care services in East Lothian – Work currently paused due to Cluster Quality Lead vacancy; recruitment underway (October 2024). • **4.2.2** – Further development of role ELCH plays in relation to teaching, training and staff development: ○ Ongoing development of teaching / training by the Endoscopy and Day Service Unit at ELCH.

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		review is scheduled to conclude in October 2024. • The learnings from this District Nurse review, will feed into the above-mentioned wider discussion about cross-service integration communication practices and how communication and working relationships can be enhanced between health and social care services.	
Option 42: There are often long-delays in recruitment processes when it comes to employing new staff within ELC/ELHSCP care homes (and other services) often resulting in candidates accepting jobs elsewhere in the meantime. ELHSCP should work in collaboration with ELC Human Resources to review the process and attempt to streamline.	ELHSCP Strategy, Operations, Staffing Organisational and Workforce Development Manager, ELHSCP	Confirmed that unfortunately due to the sensitivity of the posts and the current budget situation, there is no opportunity to streamline our current recruitment processes. There is a requirement for additional scrutiny and checks to ensure that we remain within budget and that the staff recruited pass the required pre-employment checks.	No further action as per previous update.
Option 66: We should review existing flow centre processes and infrastructure to ensure that staff are sufficiently trained to challenge and discuss all relevant care pathways and options.	ELHSCP Strategy, Operations, Staffing Head of Operations, ELHSCP	A Flow Centre Navigation Programme Board is currently in place across NHS Lothian, with a detailed work programme that covers the following key workstreams: • Develop workforce model with associated resources. • Clinical pathways review board for pathway development and monitoring.	IJB annual delivery plan 2024-25: • **1.3.1** – Delivery of approaches / activity to reduce admissions and support timely hospital discharge / hospital flow: o Ongoing delivery / development of multidisciplinary ICAT approach. o Ongoing delivery of Daily Flow Huddle. o Introduction of Care at Home Huddle. o Embedding of East Lothian multi-disciplinary team (MDT) in Royal Infirmary of Edinburgh (RIE), providing Physiotherapy and Occupational Therapy assessment and MDT case management.

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		• Communication and engagement. • Scope opportunities and plan future service delivery.	○ Continuation of East Lothian Inreach model for a further 12 months with funding from ELHSCP, following ongoing positive evaluation. ○ Completion of a programme of 'Ward Workshops' for ELCH Wards – focusing on multi-disciplinary approaches, implementation of Discharge Without Delay principles, etc. ○ Ward Development Plans developed on the back of Ward Workshop sessions. ○ Activity to further develop the use of data to inform operational delivery and decision making – ongoing. • **5.2** – Pathway reviews / improvements: ○ 5.2.1 Review patient pathways for Hospital Based Complex Clinical Care (HBCCC) and access to Ward 1. ○ 5.2.2 Deliver ongoing programme to review access to adult mental health services across primary care and adult community mental health services. ○ 5.2.3 Carry out a review of Older Adult Mental Health (OAMH) services. ○ 5.2.5 Provide clear public and patient information to help people to get to the right primary care service. ○ 5.2.6 Strengthen opportunities for direct access to PCIP (Primary Care Improvement Plan) services to reduce the need to contact general practice first.
Option 76: We should adopt more collaborative commissioning approaches with community groups, taking account of elements of gender responsive budgeting and human rights.	ELHSCP Strategy, Operations, Staffing General Manager for Planning and Performance, ELHSCP	ELHSCP currently has a collaborative approach to commissioning, which is reflected in our overarching Commissioning Strategy and Market Facilitation Statement. In addition, Integrated Impact Assessments are completed on any new policy development or service change. This includes commissioning services to meet strategic objectives, which ensure we address any potential	Being taken forward through review and delivery of ELHSCP Commissioning Strategy, ELHSCP Market Facilitation Statement and ELHSCP Participation and Engagement Strategy.

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		inequalities arising from our commissioning practices. It would be prudent for ELHSCP to continue to review and take appropriate action to ensure it remains engaged with community groups when commissioning services. Communication and engagement strategies need to be developed in service (re)design and when commissioning services. It is important that these engagement strategies are effective in their delivery and ensure a balanced and wide-ranging voice is considered and represented.	
Option 92: Staffing and workforce development should be better organised, advertised and facilitated at an ELHSCP level. This includes development of career pathways, training / development opportunities, reviewing job titles / roles to ensure they are reflective, and expectations are clear.	ELHSCP Strategy, Operations, Staffing Organisational and Workforce Development Manager, ELHSCP	The ELHSCP Workforce Development Team have developed career pathways and training opportunities where appropriate. When teams require further training or advice regarding job reviews, this is provided when requested and is monitored within the Workforce Plan and Workforce Steering Group. Work is ongoing with appropriate review and monitoring processes in place.	Being taken forward through review and delivery of ELHSCP Workforce Development Plan.
Option 98: We should explore cluster geriatricians / senior clinicians being made available for queries related to the increasing number of older people being cared for	ELHSCP Strategy, Operations, Staffing Clinical Director, ELHSCP	Currently there is a single geriatric consultant in East Lothian who provides informal e-mail advice to GPs and primary care colleagues. It is acknowledged there are not robust systems in place for recording this advice on TRAK,	IJB annual delivery plan 2024-25: • **4.5.5** – Increase choice and availability of community-based support, for example through new meeting centres and extension of services offered by day centres for older people: ○ Most day centres have established models of community outreach support, ELHSCP Planning & Performance continue to support where this is not the case.

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within their own homes and the community.		ensuring timeous response, ensuring messages are not lost in other email traffic, holiday cover, etc. Professionals can also seek advice from the Hospital at Home team in urgent scenarios where the aim is to avoid admission. To address this development of an 'advice-only' geriatric referral pathway via SCI Gateway (electronic web-based referrals portal used for all GP referrals) is being explored, which would make the process more robust, responsive, and accessible and would be auditable from a secondary care perspective. Following review this option was deemed to be in progress and incorporated within existing workstreams.	○ Commissioning of Musselburgh Day Centre paused as part of financial recovery process. Existing provider offering limited support to some members from Musselburgh area.
Option 101: The remit and role of the Care Broker Team should be developed and expanded. Some Social Work functions could be transferred, achieving better promotion and oversight of SDS, and a central point of contact for queries.	ELHSCP Strategy, Operations, Staffing General Manager for Adult Social Work, ELHSCP	Scoping and development work is being taken forward by the Adult Social Work Service Manager as part of the ongoing Self-Directed Support (SDS) improvement project. Once initial scoping and development has been completed a paper will be prepared for presentation to the SDS improvement working group.	IJB annual delivery plan 2024-25: • **4.3.3** – Implementation of Self-Directed Support (SDS) Improvement Plan: ○ Progress has been made around direct payments and supporting documents and processes. ○ Information / training sessions have been delivered. ○ Quality Assurance Manager now in post to support progress in relation to the improvement plan. ○ SDS lead continues to attend and engage with Social Work Scotland Community of Practice. ○ Temperature check undertaken in relation to updated SDS standards. ○ Replacement Care Policy completed, and processes updated to support this.

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			○ Website information regarding SDS has been updated. ○ Outcome based training is planned. • **4.3.4** – Development of Community Brokerage model: ○ Implementation based on equivalent budget by the end of 2024. ○ Scoping in relation to model design to take place during quarter 4 of 2024/25. ○ Test of Change model implementation and evaluation from first quarter of 2025/26. ○ Full roll out of model thereafter dependent on evaluation findings.
Option 72: NHS Lothian set-aside funding arrangements should be reviewed with a view to some funding being returned to local authority areas based on performance. Where local service improvements lead to reduced acute demand, this should be reflected from a funding perspective.	Finance and Investment Chief Officer, ELHSCP	The IJB's Set Aside funding represents functions (services) that NHS Lothian (the Health Board) has delegated to the IJB related to services delivered by NHS Lothian on its Acute Hospital sites (largely the Royal Infirmary Edinburgh and Western General Hospital). For 2024/25, the IJB has a total budget of £188.6m, of which the Set Aside budget is £18.7m. The IJB, through its Strategic plan may direct changes to the delivery of these services and therefore may move the funding resource from the Set Aside budget (the Acute Hospital services) to another part of the IJB's budget. It is for the IJB to then decide which delivery partner (either the local authority or the Health Board) would receive such funding in line with the Strategic Plan. The Set Aside budget is currently overspent and the IJB is working with its partners to bring this budget back into balance.	
Option 39: An audit of hospital readmissions should be completed to consider whether or not the pressure applied to get individuals discharged from hospital at pace is having a negative impact on their outcomes. Currently, appropriate discharge planning is not happening, information sharing is limited, and equipment is not put in place quick enough.	Hospitals Head of Operations, ELHSCP	Based on the available nationally comparable data, East Lothian performs relatively well on the 28-day readmission rate, with 84. 49 readmissions per 1,000 discharges compared to a national average of 101.7. The audit and ongoing review of hospital readmissions is already embedded within existing practice and performance reporting	IJB annual delivery plan 2024-25: • **1.3.1** – Delivery of approaches / activity to reduce admissions and support timely hospital discharge / hospital flow: ○ Ongoing delivery / development of multidisciplinary ICAT approach. ○ Ongoing delivery of Daily Flow Huddle. ○ Introduction of Care at Home Huddle. ○ Embedding of East Lothian multi-disciplinary team (MDT) in Royal Infirmary of Edinburgh (RIE), providing Physiotherapy and Occupational Therapy assessment and MDT case management. ○ Continuation of East Lothian Inreach model for a further 12 months with funding from ELHSCP, following ongoing positive evaluation.

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
			○ Completion of a programme of 'Ward Workshops' for ELCH Wards – focusing on multi-disciplinary approaches, implementation of Discharge Without Delay principles, etc. ○ Ward Development Plans developed on the back of Ward Workshop sessions. ○ Activity to further develop the use of data to inform operational delivery and decision making – ongoing.
Option 65: Direct GP access to ELCH beds should be explored and simplified where appropriate (e.g., overnight monitoring, tests, supervision of medication, nurse led care, short term rehab / stabilisation).	Hospitals Clinical Director, ELHSCP	Provision of direct access to palliative care beds has been developed and implemented over the past six months. There is currently no direct access to hospital beds at East Lothian Community Hospital out with the palliative care route. Future work will be undertaken to improve and formalise the referral process and raise GP awareness of the option of direct admission for palliative care. Direct admission to ELCH for more acute presentations would be complex and challenging to ensure safe care pathways. We are considering ways to optimise communication between GPs, hospital at home, medicine for the elderly and ICAT (Integrated Care and Assessment Team) to improve outcomes for patients and avoid admission to acute hospital wherever possible. Ongoing discussions are taking place between the Clinical Director, ICAT Service Manager and the Clinical Lead for Medicine to the Elderly. Pursuing direct GP admissions to	IJB annual delivery plan 2024-25: • **1.3.1** – Delivery of approaches / activity to reduce admissions and support timely hospital discharge / hospital flow: ○ Ongoing delivery / development of multidisciplinary ICAT approach. ○ Ongoing delivery of Daily Flow Huddle. ○ Introduction of Care at Home Huddle. ○ Embedding of East Lothian multi-disciplinary team (MDT) in Royal Infirmary of Edinburgh (RIE), providing Physiotherapy and Occupational Therapy assessment and MDT case management. ○ Continuation of East Lothian Inreach model for a further 12 months with funding from ELHSCP, following ongoing positive evaluation. ○ Completion of a programme of 'Ward Workshops' for ELCH Wards – focusing on multi-disciplinary approaches, implementation of Discharge Without Delay principles, etc. ○ Ward Development Plans developed on the back of Ward Workshop sessions. ○ Activity to further develop the use of data to inform operational delivery and decision making – ongoing. • **5.2.1** – Review patient pathways for Hospital Based Complex Clinical Care (HBCCC) and access to Ward 1: ○ Pathway has been rolled out to Ward 2 at ELCH. ○ Work is underway to look at the current provision of palliative care in Ward 1, including an analysis of the data (this is part of a wider discussion in relation to palliative care).

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
		ELCH would incur some significant risks and therefore alternative processes to address these scenarios are being considered.	
Option 71: Edington and/or Belhaven sites should be redeveloped as larger ELHSCP / Local Authority-run sites. Consideration to be given to protected step-up and step-down provision, palliative care, care home beds, community respite and community hub approach.	Hospitals General Manager for Acute and Ongoing Care, ELHSCP	The Scottish Government has confirmed that there is no capital funding to build new facilities and our NHS Lothian and East Lothian Council partners have also confirmed that these sites cannot be developed as ELHSCP / Local Authority run sites as no funding is available to support this.	Discussions are ongoing between community groups, partner organisations and providers to explore potential options and local solutions.
Option 1: ELHSCP should collaborate with partner organisations (e.g., Connected Communities, Libraries, Enjoy Leisure, VCEL, Education and Children's Services, Neighbourhood Networks, Penumbra etc) to develop robust programme of activities for older people to tackle social isolation, mobility, fuel poverty, health and wellbeing. Could this be incorporated into a more focussed social prescribing approach**.**	Partnership Development General Manager for Planning and Performance, ELHSCP	The HSCP has several collaborative actions already in place to address the issues contained within this option, with a particular focus on social isolation and we work closely with third sector, East Lothian Council and NHS Lothian to ensure work is co-ordinated and there is no duplication. Some areas, such as poverty are led by the Council, while others, such as the Community Link Workers service is led by the HSCP. We continue to work with partner organisations to develop a focused approach to social prescribing, which also sits with NHS Lothian partners. On all these themes, a joined-up approach which is well publicised and easily accessed is key to success. Further work on co-ordination of the communication,	IJB annual delivery plan 2024-25: • **1.2.1** – Ongoing consolidation and development of range of Intermediate Care Services: ○ Continued review and development of interim care services (including care at home pilot – see below). ○ Further development and expansion of Home Care / Hospital to Home integrated service to create additional capacity, fully utilising One Plan, and reviews process – ongoing. ○ Enhanced Discharge to Assess project commenced in February 2024 bringing together Discharge to Assess (D2A) therapists, Emergency Care Service (ECS), and Care Capacity and Flow Team to facilitate discharges with initial care needs. Regular reporting on a monthly basis. • **1.4.1** – Development and implementation of Commissioning Strategy: ○ Review and update of the current Commissioning Strategy and Market Facilitation Statement currently paused pending outcome of the IJB financial planning process. ○ Review and update of both documents anticipated mid-2025. ○ Other activity related to commissioning includes a phased move of Care at Home Framework Providers to the Scotland Excel Framework.

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
		engagement and publicity of this work is necessary, as although services are available in several areas, it appears from the Planning Older People's Services engagement that these are not well known.	• **2.2.2** – Further develop engagement with Area Partnership Health and Wellbeing subgroups: ○ Ongoing development of links and involvement of HSCP Strategy Officers in Local Area Partnership Health and Wellbeing Sub Groups.
Option 4: We should develop links with East Lothian schools and Queen Margaret University to encourage volunteering opportunities (two way), intergenerational links / older friends' scheme, awareness raising, and career development related to the older people agenda. Particular opportunity to establish links between local schools and care homes.	Partnership Development Organisational and Workforce Development Manager, ELHSCP	ELHSCP Workforce Development Team is actively reaching out to Universities and Colleges across Edinburgh and the Lothian's, and High Schools within East Lothian. The team regularly attends recruitment events to share career development opportunities, which include volunteering and locum positions. These sessions and engagement are monitored for impact within the Workforce Plan and Workforce Steering Group.	Being taken forward through delivery of ELHSCP Workforce Development Plan.
Option 5: ELHSCP, in collaboration with partner organisations, should develop and hold a health and social care career day to increase awareness of providers, training / job opportunities, career pathways and community benefits. Ideal opportunity to work in collaboration with Queen Margaret University and existing health and social care providers.	Partnership Development Organisational and Workforce Development Manager, ELHSCP	ELHSCP have committed to holding regular recruitment events within the East Lothian Community Hospital, with the first event in September 2023, which was specifically aimed at nursing vacancies. The latest event, in February 2024, included all teams from across the HSCP. Now that these events have been established, we will work with and invite other partner organisations to participate.	Being taken forward through delivery of ELHSCP Workforce Development Plan.
Option 28: ELHSCP should collaborate with East Lothian	Partnership Development	The HSCP already link in with Housing Strategy and Planning	IJB annual delivery plan 2024-25:

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
Council planning department and Care Home providers to inform and influence future developments. ELHSCP should share information and data on demographics, inequity of access, geographic spread of existing homes and local needs. Future developments should take into consideration community connections, co-location with other services, local provision of health and social care services (e.g., GP) and their capacity.	Strategic Planning and Commissioning Officer, ELHSCP	partners via the established Housing and Health and Social Care Strategic Group. The purpose of this group is to maintain strategic links and partnership working across HSCP, Public Health, Planning and Housing services as respective plans/strategies are developed and carried forward. This group will also oversee the development and strategic delivery of the Housing Contribution Statement. Data and demographics related to care home provision has and will continue to be shared with Planning partners via this group.	• **1.7.1** – Continue to monitor quality and support improvement activity within care home provision: ○ Ongoing delivery and further development of the Care Home Huddle to support a multi-agency approach to monitoring care home quality and supporting improvement work. ○ Charging within local authority care homes has been reviewed to bring in line with CRAG (Charging for Residential Accommodation Guide) ○ Continue to deliver range of Quality Improvement (QI) activities, to include - falls and frailty support; pain management; embedding of HOPE workbook (spiritual care plan); and delivering My Health, My Care, My Home framework (future care planning). • **1.7.2** – Develop approach to ensure that the best use is made of available care home capacity by effectively matching provision to need: ○ Progress continues to be made with the development of an agile Social Work Hospital Discharge Team. This aims to support early assessment and care package design, helping identify alternatives to care home admission. ○ A social work senior practitioner and an additional social worker have been moved from the main adult social work team to support the model. ○ Management scrutiny of care home referrals taking place through a resource panel to ensure care home places filled by those with the highest level of need. ○ Hospital admissions being tracked to identify any that could have been prevented and to reduce the risk of readmission once people discharged home.
Option 44: ELHSCP should work in closer collaboration with Education partners to establish stronger links between care homes, hospitals, older people, and young people. Examples	Partnership Development Organisational and Workforce Development Manager, ELHSCP	The Workforce Development Team have strong links with the Employability Teams within all East Lothian High Schools, attending various events, liaising with careers advisors, and providing mock interview opportunities. This	Being taken forward through delivery of ELHSCP Workforce Development Plan.

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
could include work placements for older children, career development and information, play sessions for younger children, reading clubs and outreach opportunities for care home residents to visit schools to mentor / buddy or vice versa.		ensures that there is an awareness of health and social care opportunities within East Lothian including apprenticeships.	
Option 90: ELHSCP should review and update their engagement and communications and workforce development plans taking in to consideration the following: 1) building stronger and sustainable relationships with ongoing ELC engagements and developments (e.g. Place, Poverty, Local Development Plan, Local Housing Strategy, Planning Department); 2) Working with Education Department and local institutions (e.g. Queen Margaret University, Edinburgh College) to promote health and social care career opportunities, pathways and work placements / experience; 3) Collaboration with ELC Human Resources.	Partnership Development Senior Communications Adviser, ELHSCP	Engagement Plans: The HSCP equalities and engagement officer works closely with ELC engagements and developments, sharing feedback, observations, and comments from our activity with relevant ELC departments and vice-versa. In recent months ELC has taken a more strategic approach to its public engagement consultations, with enhanced inter-departmental scheduling of public surveys, to consolidate and share findings wherever possible. ELHSCP is actively involved in this process and ELC are currently developing their Participation and Engagement Strategy with input from a multi-service sub-group in order to co-ordinate future engagement and consultations. Promoting career opportunities: ELHSCP's Workforce Development Team is actively reaching out to Universities and Colleges across Edinburgh and the Lothians,	Being taken forward through delivery of ELHSCP Workforce Development Plan and ELHSCP Participation and Engagement Strategy.

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
		attending recruitment events, and sharing career development opportunities. Similarly, the workforce team have proactive engagements with each of the East Lothian High Schools attending various events, liaising with careers advisors, providing mock interview opportunities to ensure that there is an awareness of health and social care career opportunities within East Lothian including apprenticeships. Collaboration with East Lothian Council Human Resources: ELHSCP work with East Lothian Council Human Resources daily, providing updates on recruitment opportunities, engaging in staff discussions, placements, and ongoing personnel concerns.	
Option 91: ELHSCP should collaborate with NHS Lothian Public Health Partnership and Place Team to review DNA (did not attend) data for East Lothian residents and consider potential service improvements.	Partnership Development Strategic Planning and Commissioning Officer, ELHSCP	The NHS Lothian Public Health Intelligence Team have undertaken a piece of work to review Did Not Attend (DNA) data across Edinburgh and the Lothian's and initial findings have now been shared with ELHSCP. An initial review of the findings suggests that East Lothian's DNA rate is relatively in line with neighbouring authorities. Colleagues within NHS Lothian's Public Health Intelligence Team will continue to update and work on the DNA data set with further	There has been no update to this data to date, but discussions have taken place between the HSCP Strategic Planning and Commissioning Officer and the Population Health Project Managers for East Lothian. NHS Lothian's Public Health Intelligence Team will continue to update and work on the DNA data set with further findings and information shared in due course.

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
		findings and information shared in due course.	
Option 103: We should explore opportunities to link in with the Fire Service and their fire safety checks in terms of assessing frailty, adaptations and equipment.	Partnership Development General Manager for Access and Rehabilitation, ELHSCP	The HSCP and Scottish Fire and Rescue Service have a well-established partnership working relationship linking on a variety of matters including fire safety checks, hoarding and adult support and protection. Further opportunities for partnership working will be explored as part of business as usual.	No further action as part of business as usual.

Option 38: ELHSCP should review all referral pathways and patient / family journeys through the health and social care system in order to identify gaps, improve and streamline processes and ensure that they remain outcomes-focused, and person-centred at all times.	Pathways and Referral Routes
	
	Head of Operations, ELHSCP
		Currently there are a high number of pathways across the health and social care system including unscheduled care, scheduled care, diagnostic, inpatient, day case, outpatient, cancer, admitted, non-admitted etc. that can and do support patients and their families. Many of these have been reviewed by multi-disciplinary teams or are part of wider pieces of ongoing improvement work (for example the Unscheduled Care Programme Board).
		
		It is acknowledged that streamlining processes would benefit patients and their families and would help with supporting financially sustainable services, however this option in its current form is unlikely to be a deliverable
			IJB annual delivery plan 2024-25:
			• **5.2** – Pathway reviews / improvements:
			  ○ 5.2.1 Review patient pathways for Hospital Based Complex Clinical Care (HBCCC) and access to Ward 1.
			  ○ 5.2.2 Deliver ongoing programme to review access to adult mental health services across primary care and adult community mental health services.
			  ○ 5.2.3 Carry out a review of Older Adult Mental Health (OAMH) services.
			  ○ 5.2.5 Provide clear public and patient information to help people to get to the right primary care service.
			  ○ 5.2.6 Strengthen opportunities for direct access to PCIP (Primary Care Improvement Plan) services to reduce the need to contact general practice first.

Option	Theme and Lead	Original Assessment (July 2024)	Update as per IJB mid-year update
		piece of work. Reviewing all referral pathways would be extremely resource intensive and very time consuming.	
Option 86: We should review the existing community alarm system and processes in order to ensure they are fit for purpose, flexible to needs and making use of technological developments.	Technology General Manager for Access and Rehabilitation, ELHSCP	The analogue to digital project is the main priority for the telecare team. There is a desire to look at proactive technology but currently there is not the capacity or focus to take this forward. In terms of reviewing the current telecare service, there are plans underway to scope working more in line with Occupational Therapist teams for closer working and clinical governance. There is also potential scope for the telecare team to utilise Mosaic in line with East Lothian Occupational Therapy and Social Work. A service review was completed in 2023 but further scoping and modelling is required to ensure the team has capacity and resilience to grow and develop to continue to support the Health and Social Care Partnership with its use of technology enabled care to provide quality care for East Lothians Older population.	
Option 94: When referrals are being made for secondary care services and appointments being planned, travel distance and accessibility should be considered for the older person. This system should be reviewed, streamlined and improved.	Transport Equalities and Engagement Officer, ELHSCP	Contact has been made with NHS Lothian's Equalities Lead, to raise this option and related engagement feedback from an equalities and Fairer Scotland Duty perspective. Plans are in place for both parties (ELHSCP and NHS Lothian) equalities officers to meet and discuss this matter further.	Once the Health and Social Care Partnership's new Equalities and Engagement Officer is embedded in post they will revisit this option with their NHS Lothian counterpart (anticipated in early 2025).

Options that were not identified as priorities following the Options Appraisal (September 2024)

Option	Theme and Lead	Update
Option 58: We should commission and structure health and social care services in a way that moves away from the older people / generational / geriatric model. People are living longer, long-term health conditions are not exclusive to 65+, care homes are generally not appropriate for younger people, mental health services for 65+ are limited, many people die before the 65+ mark etc. We need to develop more intergenerational services for East Lothian residents throughout people's lifespan.	ELHSCP Strategy, Operations, Staffing Strategic Planning and Commissioning Officer, ELHSCP	IJB annual delivery plan 2024-25: • **1.4.1** – Development and implementation of Commissioning Strategy. • **Strategic Objective 3 – focus on prevention and early intervention.** As previously noted a wholesale change to the generational approach to medicine and social care is not something that is achievable locally as our approach and structure largely mirror systems within the NHS, national policy, legislation and funding arrangements. The existing IJB priorities, ELHSCP Commissioning Strategy and Market Facilitation Statement focus more on care closer to home, intermediate care provision and outcome led care planning that places the person's individual needs, rights, and preferences above questions of affordability. Whilst developments and person-centred planning must be seen within the wider financial context it is key that assessments are the product of a full understanding of the individual's needs in the first instance rather than a decision-making process fuelled by financial limitations and structural bias from the outset. When the current strategy and statement are revisited in mid-2025 this option and its implications will be considered further, particularly from a throughout the lifespan and prevention perspective.
Option 104: Transport links to key health and social care sites should be reviewed and developed in collaboration with ELC colleagues and existing service providers. Consideration should be given to commissioning services or developing volunteer initiatives. Wider transport considerations related to the provision of intermediate care should also be reviewed and developed. Good practice should be explored nationally	Transport Chief Officer, ELHSCP	Although transport is not a delegated function to the IJB and responsibility primarily sits with East Lothian Council, the HSCP does recognise its importance and the challenges surrounding access to and from Health and Social Care services. Equality of access to services, rurality, centralised services, travel times and isolation have all been key themes throughout the Planning Older People's Services project and implementing any meaningful change is severely affected by the IJB's limited financial envelope. Transport and access to services, particular for those with protected characteristics, will continue to form part of Integrated Impact Assessments in future and our partnership working with Connected Communities and Area Partnerships.
Option 100: We should explore the potential for using day centres as a respite opportunity for unpaid carers further	Day Centres	IJB annual delivery plan 2024-25: • **4.5.4** – Develop plans for the provision of residential respite with proposed introduction of 'the right to a break':

Option	Theme and Lead	Update
	Service Manager, Planning and Performance, ELHSCP	○ Short breaks discussions have been managed through the Carers Change Board (rather than through the establishment of a Working Group). ○ Additional funding allocated to 'Time for me' small grants process delivered by Carers of East Lothian to support carers to access breaks. ○ Respite bed contract extended until March 2026. ○ Early discussions with another provider around potential to develop bespoke respite service for older people. ○ Short Breaks Hub development planned following work on overall replacement care budget and culture change. ○ Short breaks discussions have been managed through the Carers Change Board (rather than through the establishment of a Working Group). ○ Additional funding allocated to 'Time for me' small grants process delivered by Carers of East Lothian to support carers to access breaks. ○ Respite bed contract extended until March 2026. ○ Early discussions with another provider around potential to develop bespoke respite service for older people. ○ Short Breaks Hub development planned following work on overall replacement care budget and culture change. • **4.5.5** – Increase choice and availability of community-based support, for example through new meeting centres and extension of services offered by day centres for older people: ○ Most day centres have established models of community outreach support, ELHSCP Planning & Performance continue to support where this is not the case. ○ Commissioning of Musselburgh Day Centre paused as part of financial recovery process. Existing provider offering limited support to some members from Musselburgh area. • **4.5.6** – Continue to develop the Hardgate respite service for people with profound and multiple learning disabilities: ○ Hardgate has been developed to include an overnight nursing element to support clients transitioned from children's services that have complex physical care needs. ○ Work ongoing with financial accountant to separate Hardgate budget from Tynebank budget to clarify operating costs.
Option 57: We should review and develop provision of services to people living with young onset dementia. Care homes, day centres and a variety of other core services are not tailored to meet people's individual needs	Dementia Strategic Planning and Commissioning Officer, ELHSCP	IJB annual delivery plan 2024-25: • **2.2.3** – Support the development of (Dementia) Meeting Centres (focus on Musselburgh with proposals for satellites): ○ Development work is continuing to support other local areas to develop 'satellites' – led by Dementia Friendly East Lothian. ○ In Musselburgh, this will be delivered as two half days and one brain health hub session at the Hollies from November 2024. Referral pathways to be developed

Option	Theme and Lead	Update
		○ Development in Prestonpans looked initially positive but not progressed, Alzheimer Scotland D'Café developing in this area. ○ Partners coming together to support development of satellite in Haddington, session with Scottish Meeting Centre Network took place in November 2024. • **4.4.1** – Development and implementation of Dementia Strategy: ○ Development of Implementation Plan delayed until IJB budget decisions made. • **4.5.5** – Increase choice and availability of community-based support, for example through new meeting centres and extension of services offered by day centres for older people: ○ Most day centres have established models of community outreach support, ELHSCP Planning & Performance continue to support where this is not the case. ○ Commissioning of Musselburgh Day Centre paused as part of financial recovery process. Existing provider offering limited support to some members from Musselburgh area. While a gap in services has been identified for people with young onset dementia through the work on the East Lothian Dementia Strategy, we need to bear in mind that development of these services must be proportionate to the needs of people with dementia in East Lothian as a whole. In 2022 there were estimated to be a total of 2,104 people with dementia of which only 3.4% were under the age of 65.
Option 6: Lunch clubs or some form of outreach service surrounding meal prep / delivery for the most socially isolated and vulnerable should be introduced across East Lothian.	Community Service Manager, Planning and Performance, ELHSCP	IJB annual delivery plan 2024-25: • **4.5.5** – Increase choice and availability of community-based support, for example through new meeting centres and extension of services offered by day centres for older people: ○ Most day centres have established models of community outreach support, ELHSCP Planning & Performance continue to support where this is not the case. ○ Commissioning of Musselburgh Day Centre paused as part of financial recovery process. Existing provider offering limited support to some members from Musselburgh area. There are a number of lunch clubs and community-based kitchens in East Lothian who provide food with social interaction and the opportunity for meaningful activity. There are variety of different models (e.g. Pencaitland Lunch Club, the Hollies, Our Community Kitchen etc). These models go beyond the provision of food: where they are most effective they are community led and provide social interaction/connection, meaningful activity and healthy food. For example, Haddington OCK now has a garden which encourages people with complex needs to help develop and grow vegetables for the kitchen. Core requirements are a venue, relevant food hygiene qualifications and some level of staff and volunteers. Most clubs, especially in rural areas, also offer some form of transport to and from the venue, which increases the cost.
Option 84: We should invest in additional outreach services with	Intermediate Care	IJB annual delivery plan 2024-25: • **1.2.1** – Ongoing consolidation and development of range of Intermediate Care Services:

Option	Theme and Lead	Update
appropriate transport to facilitate - like a roaming heart failure nurse, respiratory nurse, antibiotic nurse etc.	Service Manager, Planning and Performance, ELHSCP	○ Continued review and development of interim care services (including care at home pilot – see below). ○ Further development and expansion of Home Care / Hospital to Home integrated service to create additional capacity, fully utilising One Plan, and reviews process – ongoing. ○ Enhanced Discharge to Assess project commenced in February 2024 bringing together Discharge to Assess (D2A) therapists, Emergency Care Service (ECS), and Care Capacity and Flow Team to facilitate discharges with initial care needs. Regular reporting on a monthly basis. • **1.2.2** – Delivery of programme to review and redesign Care at Home service provision: ○ Presentation of recommendations to SPG / IJB regarding a Test of Change Flexible Locality Model – May 2024. ○ Project Team formed to develop and implement the Flexible Locality Model. ○ Delivery of Test of Change project in Tranent from October (will run through to June 2025). ○ Care at Home Strategy to be developed in 2025. • **4.5.5** – Increase choice and availability of community-based support, for example through new meeting centres and extension of services offered by day centres for older people: ○ Most day centres have established models of community outreach support, ELHSCP Planning & Performance continue to support where this is not the case. ○ Commissioning of Musselburgh Day Centre paused as part of financial recovery process. Existing provider offering limited support to some members from Musselburgh area.
Option 53: We should look for opportunities to engage with the Leg Club Movement, which is a global initiative, designed to care for people suffering from or at risk of chronic leg disease within a social model of care.	Intermediate Care Service Manager, Planning and Performance, ELHSCP	IJB annual delivery plan 2024-25: • **1.2.1** – Ongoing consolidation and development of range of Intermediate Care Services: ○ Continued review and development of interim care services (including care at home pilot – see below). ○ Further development and expansion of Home Care / Hospital to Home integrated service to create additional capacity, fully utilising One Plan, and reviews process – ongoing. ○ Enhanced Discharge to Assess project commenced in February 2024 bringing together Discharge to Assess (D2A) therapists, Emergency Care Service (ECS), and Care Capacity and Flow Team to facilitate discharges with initial care needs. Regular reporting on a monthly basis.
Option 37: We should develop a 24-hour helpline / single point of contact for providers, professionals and service users to provide guidance, assistance, advice regarding placement breakdowns, hospital admissions /	ELHSCP Strategy, Operations, Staffing Senior Communications Adviser, ELHSCP	IJB annual delivery plan 2024-25: • **5.2.5** – Provide clear public and patient information to help people to get to the right primary care service: ○ Ongoing work with communications team to ensure people are aware of range of primary care services and how and when to access them.

Option	Theme and Lead	Update
discharge, out of hours support and a full-service directory.		Suggested next steps: • Continue to develop ELHSCP website for each ELHSCP service, indicating pathways to services and direct contact details. • Request each service / department to identify Single Point of Contact telephone number / email address which can made publicly available. • Where potential to link services: ELRS / Primary Care / Social Work – scope potential to develop single point of contact telephone phone line which can link to connected services, within existing provision. • Consider creation of printed ELHSCP directory of primary contact numbers to be made available for public distribution.

Option 93: We should develop a specific East Lothian minor injuries service to complement existing central provision (for example, services Minor Injuries services in Edinburgh). Full Options development and appraisal would be required.	Minor Injuries
	
	Head of Operations, ELHSCP
		IJB annual delivery plan 2024-25:
		• **1.3.1** – Delivery of approaches / activity to reduce admissions and support timely hospital discharge / hospital flow:
		  ○ Ongoing delivery / development of multidisciplinary ICAT approach.
		  ○ Ongoing delivery of Daily Flow Huddle.
		  ○ Introduction of Care at Home Huddle.
		  ○ Embedding of East Lothian multi-disciplinary team (MDT) in Royal Infirmary of Edinburgh (RIE), providing Physiotherapy and Occupational Therapy assessment and MDT case management.
		  ○ Continuation of East Lothian Inreach model for a further 12 months with funding from ELHSCP, following ongoing positive evaluation.
		  ○ Completion of a programme of 'Ward Workshops' for ELCH Wards – focusing on multi-disciplinary approaches, implementation of Discharge Without Delay principles, etc.
		  ○ Ward Development Plans developed on the back of Ward Workshop sessions.
		  ○ Activity to further develop the use of data to inform operational delivery and decision making – ongoing.
		• **4.2.1** – Ongoing development and enhancement of outpatient and day services at ELCH:
		  ○ Development of outpatient services at ELCH has continued.
		  ○ Additional services now being delivered include:
		  ▪ Chronic anaemia service (blood & iron infusion).
		  ▪ Outpatient IV antibiotic (moved from Western and delivered by HSCP staff).
		  ▪ Use of space within the Outpatient Department has been reviewed to ensure better utilisation of clinical space. This has allowed ELCH to accommodate clinics temporarily relocated from Edinburgh Eye Pavilion (November 2024).