East Lothian
Health & Social Care
Partnership

Care at home Strategy 2025 – 2030

CONTENTS

1. FOREWORD

There must be a systematic change to the way care at home is provided if we are to continue to meet people's care at home needs. There are a lot of fantastic people doing excellent work every day in all parts of East Lothian but the system cannot cope with current demands for care at home.

The vital role that unpaid carers play needs particular attention to ensure they are able to continue to provide support and so support the Care at Home sector. As well as support from community providers and the third sector to support people to stay well in their own homes. Something has to change quickly.

Doing more of the same is therefore not an option

The system for providing care at home is complex and ever-changing, involving people, their carers and a multitude of agencies.

We know that staying in their own homes and communities is vitally important to people with health and social care needs and it makes economic sense to sustain this. Lasting improvements can only be achieved when those who need the support, or directly provide it, are equal partners in deciding how services are put together and delivered. Citizens and families need to do as much as they can for themselves, with front-line professionals supporting people to manage their own risks and take more responsibility for their own wellbeing.

If we are to achieve the ambition of supporting people in their own homes or a homely setting and avoid more costly responses, resources need to be re-directed from more acute forms of care and treatment and into the community setting. But the system must be set up to support this shift. We have a number of examples of how delivering care earlier or in a different way has supported the care at home sector, but that alone will not deliver sustainable solutions to meet new demands.

A systematic change is required. All sources of community-based support, including suitable housing, should be aligned to maximise their impact and avoid duplication. East Lothian IJB are in an ideal position as they direct integrated health and social care services across East Lothian to look at all available resources and use data and research to help inform priorities for investment whilst managing an ever-increasing financial pressure.

2. EXECUTIVE SUMMARY

People in East Lothian want to live in their own homes, and when needed receive good quality care and support to stay independent and well. Engagement shows that people want flexible, consistent support that focusses on their personal wellbeing outcomes. Families, carers and communities are the foundation of care and support at home. As demand for care increases, we need to make changes to address some real challenges. This will need to include new ways of designing care at home and making sure services are properly resourced.

> **Care at home makes sure that as many people as possible are supported in their own homes.**
>
> **The care at home service can touch on all aspects of your daily life in your own home**
>
> - Care Inspectorate

Our vision for change

ELHSCP will work with the community, the independent care sector and the HSCP's to improve the delivery of care at home services. We will improve our assessments of need to ensure it is holistic and focussed on outcomes and not an assessment for a care at home service.

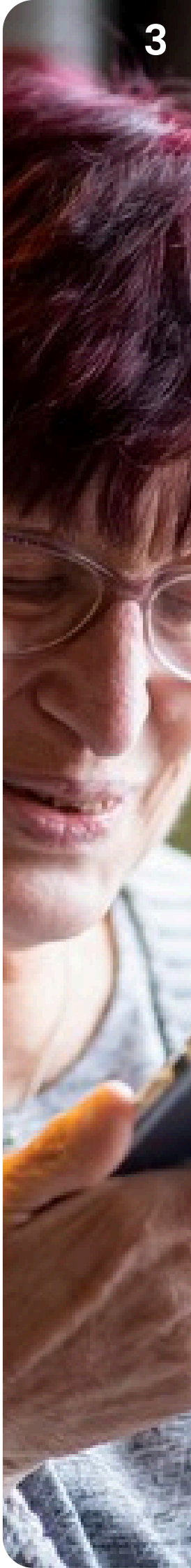
To make this happen, we need to:

1. Make sure people who need care and support, and carers, are equal partners who can use their skills and experiences to help make decisions and provide support and care in a sustainable way.

2. Care at home needs to be built around communities. We need to support carers to continue caring, and communities to offer support. ELHSCP needs to harness the strength of the communities and use the support of all services available to ensure wellbeing outcomes are met.

3. Care at home needs to support personal outcomes and support from elsewhere to meet different needs. The assessment of need and the subsequent meeting of those agreed needs and outcomes must be clear and various resources available to meet those needs, not just a reliance on Care at Home. The response needs to be co-ordinated around the individual so all services whether statutory, third sector or from family and friends are able to work together to provide the best outcomes for the individual.

4. Make sure the workforce has the knowledge, skills and values to provide care at home The workforce is critical; they need to be valued, reliable, competent and confident.



3. INTRODUCTION

People in East Lothian want to live in their own homes and communities with the support they need, when they need it. This is even when they have complex health, care and support needs.

Care at Home is a service that supports people to live at home. It is provided by organisations who are regulated by the Care Inspectorate but also by individuals who are employed through a Direct Payment/Option 1 under Self Directed Support.

However, Care at Home is not able to support all the people who have been assessed as having health and social care needs.

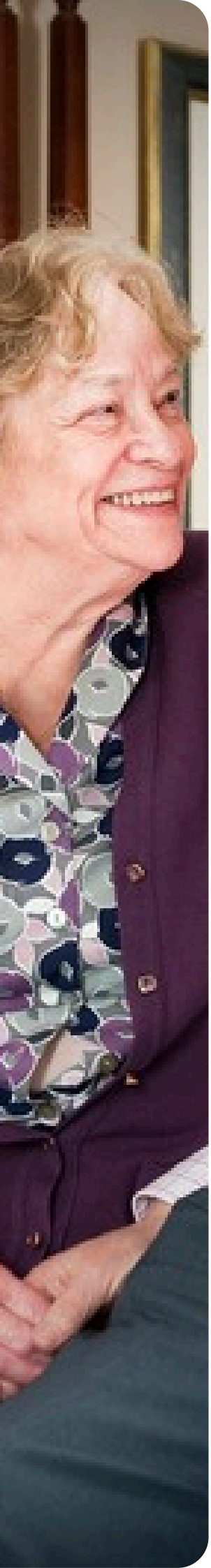
The Care at Home market is therefore heavily supported by:

- **Unpaid carers**
- **Community supports such as day centres for older people and community day support for adults with Learning Disability, Mental Health or physical disabilities.**
- **Volunteers**
- **Health Services**

Effective Care at Home makes it possible for people to stay in their own homes for longer, preventing early admissions to care homes, reduces hospital admissions and ensures timely discharge from a hospital setting.

Care at Home needs to be reliable, consistent, flexible and promote independence at all times.

This strategy draws on the work presented by Cap Gemini's analysis of Care at Home in East Lothian completed in 2023 and the delivery of a pilot project '**The Locality Model**' delivered over a 12 week period from November 2024 to February 2025. Plus, the data gathered from the delivery of Care at Home services across East Lothian.



There are a number of challenges in delivering Care at Home across Scotland, and East Lothian is not unique in trying to address these challenges. What is evident from the consultation and from the data is that Care at Home is only one part of the whole Health and Social Care System and in order to deliver a safe and effective Care at Home service we must take a whole system approach.

- Focus on what is important to the individual who requires support. Committing to strength based conversations with people.

- Recognise the importance of unpaid carers, in providing support but also in supporting them in their care giving role.

- Supporting assessment of need to take a holistic community approach to accessing support – 'Care at Home' must not be the default.

- Focus of early intervention, reducing and delaying the need for a care at home service.

All whilst reflecting relevant legislation and adhering to Health and Social Care Standards.

4. THE CASE FOR CHANGE

4.1 The Current Picture

Demographics

East Lothian witnessed the largest growth in population of all Scottish local authorities in the **11 years from 2011 to 2022** (based on 2022 census figures). Projections forecast further high levels of growth in the East Lothian population over the **next 20 years**. An increase in the proportion of the population within the older age cohorts is also projected.

The projected population growth will further add to the pressure on health and social care services. The increase in the older population is particularly significant given that **76% of people** in receipt of health and social care services in Scotland are aged **65** or over [1].

Historic Growth - Key Points

- East Lothian population grew by **24.6%** from 2001 to 2022 - the highest rate of growth in Scotland.
- In 2022, **9.8%** of the East Lothian population was **75+**, higher than the Scottish level of **9%**.
- The Scottish Government's funding allocation **did not increase** to reflect population growth over this period (East Lothian's grant for 2023/24 was the **third lowest per head** of population for Scotland).

[1] Integration Joint Boards' Finance and performance 2024 | Audit Scotland

Projected Growth – Key Points

- It is projected that East Lothian's population will have grown by **15.08%** between 2018 and 2043. This will bring the population to an estimated **121,743 by 2043** (from 105,790 in 2018).

- The number of people aged **75+** is projected to almost double to **18,338 by 2043** (a 94% increase from 9,437 in 2018).

- The number of people in the **65 to 74** age group is set to increase by **22.76% to 14,404** (from 11,733).

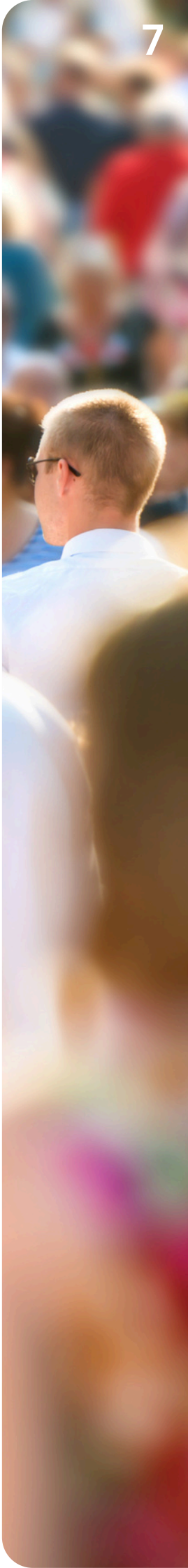
- The projected increase is **higher** than the Scottish rate in both of the older age cohorts (the Scottish increase is estimated at 70.6% for the 75+ age group and 7.6% for the 65 to 74 age group).

- The position for people being supported with Learning and Physical Disabilities has remained **relatively static**, however the level of **complexity of support required has increased**. This is seen particularly for people with Learning Disabilities who with improved health and social care are living longer.

4.2 Care at Home Demand

A review of Care at Home services in 2022/23 showed that demand in the preceding 4 years had remained relatively stable and that the pressures faced (at the time of reporting) were not due to increases in demand, but the result of instability in the external providers market, due mainly to smaller providers closing down as they were no longer financial viable and transformation work to support a more community based approach to support.

Although demographic change had not appeared to be impacting on demand at this point, it was noted that this was likely to bring significant challenges going forward. The report included modelling of several different scenarios reflecting both demographic change and cost pressures.



- Whilst the total number of Care at Home service users had been relatively stable over the period studied, a reduction in service user numbers was evident from March 2020 at a rate of around -2.59% per annum.

- Although the number of service users had decreased, there was no significant change in the number of hours provided. This was the result of an increase in the number of hours required by the under 65 cohort as a result of increasing level and complexity of need for individuals within this group.

- The number of people receiving Care at Home support from an external provider decreased from the outbreak of the pandemic (at a rate of 5% per annum), with in-house provision having to increase to offset this loss. The number of hours delivered by external providers decreased by 13% over the period studied (2022- 2023).

- The increased reliance on internal Care at Home services, provided at a higher unit cost along with inflationary pressures, resulted in a **significant increase** in the cost of providing Care at Home services over the period looked at **24%** of the total cost in 2022/23 draft outturn was in relation in-house services, a rise of **12%** compared to the 2018/19 outturn.

4.2.1 Required Capacity for Care at Home

Based on current practice, Care at Home data and predicted future demand, we require to fund a further 2100 hours of Care at Home services. Developments as detailed in this Strategy will support a more robust and sustainable requirement for Care at Home services, which would also better align the financial position of the IJB.

Further work within the HSCP is required to establish the demand for a Care at Home hospital discharge service with a primary focus on rehab and hospital discharge and the requirement for ongoing support within the community, which supports both the prevention agenda as well as the ongoing demand for services.

4.3 Workforce

Care at Home relies on a stable workforce, who feel **valued** with the right skills, knowledge and opportunity for training and career development. However, **financial pressures** have led to lower rates of pay and high staff turnover within the independent sector. Despite the dedication of many staff and the **exceptional lengths** staff go to, to deliver support often working alone in the community it is a role which struggles to **earn the status it deserves.**

With regards to internal Care at Home services there have been improvements in retention of staff over the last year. Internal NHS services has seen an increase in staff numbers and investment through Unscheduled Care funding. This has increased overall internal Care at Home services to around **3,400 hrs per week.** (April 2025).

East Lothian HSCP has a detailed Workforce Strategy and Action Plan 2025-2028, which details the work to support the internal Care at Home services and other workforce which support the HSCP services including allied health professional's social work, nursing staff etc.

4.4 Carers

The impact that unpaid carers have on supporting the health and social care system is substantial. It is estimated that the financial value to health and social care from unpaid carers in Scotland is approximately **£15.9 billion per year**. From the 2022 [2] carers census the number of unpaid carers in East Lothian was **13,147.**

> **"With Scotland's population ageing and more people living longer with multiple health conditions, and at the same time, our health and social care systems struggling to meet demand, we expect to see more carers providing intense caring roles of over 35 hours per week. [3]"**

It is essential ELHSCP is able to support these carers in their caring role.

Providing a break from caring on a regular basis and also providing Care at Home for the cared for person are ways of ensuring carers can continue in their carers role.

[2] Carers Census 2022-23 Scotland
[3] Valuing Carers Scotland Report

4.5 Financial Position

The current budget for all Care at Home services within East Lothian Council is **£21,746,000** per annum. However, the forecasted spend for 2024-25 is **£25,409,000**. This results in an end of year financial gap of **£3.6 million**. This equates to approximately **3000hrs per week of unfunded care**.

This is in addition to the people who have been assessed as requiring Care at Home and remain on a waiting list.

4.5.1 Unscheduled Care Funding (NHS) March 2025

Funding	Total Care Staff	Approx Care Hours Per Week
£1,686,000	37.8 WTE	900 hrs

Scottish Government provided funding via NHS Lothian, which ELHSCP used to recruit staff to support hospital discharge, including supporting 'Enhanced Discharge to Assess' (ED2A). Once the support to discharge is stable then the proposal is to support the unmet need within the community.

Although it is recognised that increasing Care at Home does and will support the system, it is a short-term fix as demand will again outstrip capacity. It is therefore important that we continue to look at alternatives to Care at Home and improvements in the initial conversations staff have with people requiring HSC services. In addition, improved communication between all 'support services' involved in someone's life is critical.

5. WHY CHANGE IS NEEDED

East Lothian needs a consistent approach to Care at Home. It must be built around individuals, families, carers and communities.

ELHSCP's Strategic Plan 2022-25 [4] draws on the "Framework for Community Health and Social Care Integrated Services", highlighting its core components, namely:

Promoting healthy, independent living by supporting people to:

- Adopt an assets-based approach.
- Manage their own conditions.
- Connect with their communities.
- Live independently at home or in a homely setting.

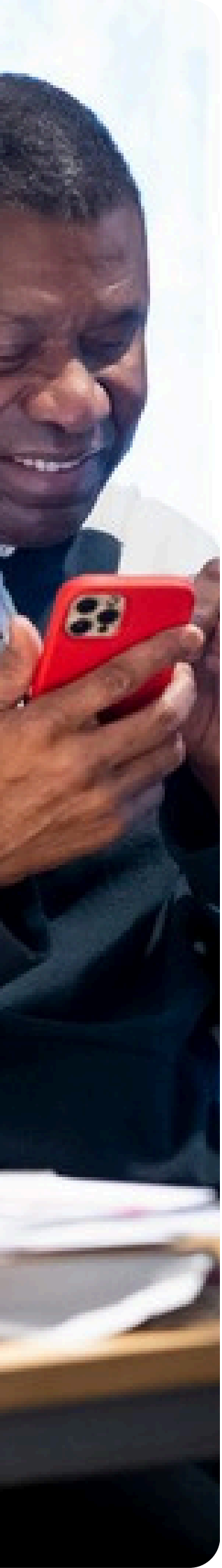
Making services more accessible and responsive by developing:

- First Point of Contact.
- Anticipatory Care Planning.
- Reablement within all services.
- Short-term, targeted interventions to meet more complex need.

Improving outcomes by working more effectively to deliver:

- Fully integrated community teams.
- Teams aligned to General Practice.
- Seamless working with acute care.
- Enhanced care in care homes and supported accommodation.

[4] East Lothian Strategic Plan 2022-2025



The approach to Care at Home needs to better reflect ELHSCP's Strategic Plan, to better reflect the outcomes the service should deliver, and to create a viable service model for the future.

This change will need to impact:

1. **The assessment,** particularly the initial conversation with individuals and their existing support networks.

2. **Community engagement,** developing more capacity in the community.

3. **Care coordination**, engaging all people involved in someone's care to know who to talk to and exploring how to find a better way to supporting people, which focuses on all available support not just Care at Home.

4. **Commissioning,** paying the fair amount for care, creating greater room for innovation in care delivery, developing a care economy that is viable for the long term. Commissioning a range of services to meet need and not just different care providers delivering the same service.

5. **Tech-enabled care,** to use technology in the right way and for the right people, reducing the need for short visits and reducing risk.

6. KEY ACTIONS

1. Assessments

Care at Home and how it is delivered is still in the most part, decided by an initial assessment of need. These assessments are carried out in someone's own home or in hospital if the individual is requiring support at home prior to being able to leave hospital.

The assessments can be carried out by a number of different professionals, including Occupational Therapists, Nurses, Social Work or Social Care staff. The assessments are multidisciplinary and will include feedback from other health professional such as GP's as well as unpaid carers and providers of support.

The assessment process needs to focus on the outcome requirements for the individual and should not be an assessment for a service. The assessment should, start from a point of 'strength based conversation', where family, friends and communities are considered as part of the assessment. The importance of all these factors has in supporting a persons outcomes needs to be considered and the use of Care at Home should form only one part of the overall support and meet the more complex, high level needs of an individual. This holistic approach to assessments results in outcomes being achieved.

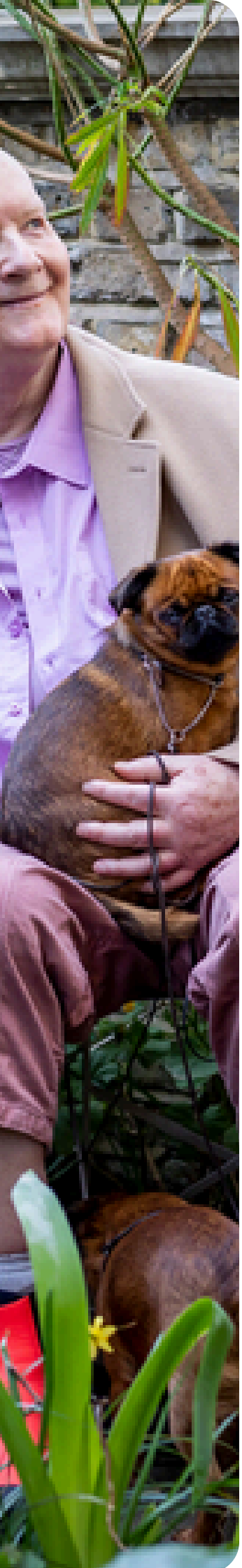
As important as how the assessment is carried out is when it is carried out. Most notably assessments are requested and provided in times of crisis- at the point of hospital discharge, after a fall at home etc. This is why it is important that initial assessments are reviewed soon after the crisis assessment and support has been put in place.

The review needs to be able to measure if the outcomes for the induvial are being met as a result of the support being given, and the support remains at all times in line with Health and Social Care Standards. The assessment and review outcomes as well as the cost of the service should all be clear to the individual in receipt of these services.

It is well recognised that the longer support is in place the more dependent an individual can become. This is especially true around Care at Home that is given immediately after a crisis intervention. Having a rehab focus to Care at Home support ensures that individuals are given the right support at the right time and do not become 'deconditioned' and require more support for a longer period of time [5].

Strengths based conversations, focusing on what matters to the individual should be embedded across all Health and Social Care engagement with individuals to maximise the evidence-based benefits across the system. This will contribute to reshaping statutory service and community enablers in achieving prevention, rehabilitation and self-management around health and social care needs.

[5] Relationship between hospitalisation and functional and cognitive impairment



2. Community Development

A key area to improve the delivery of Care at Home is to ensure there are adequate and robust community supports to complement and enhance the delivery of Care at Home service. The idea of 'community assets' is detailed in works by Prof. John L. McKnight and Cormac Russell who have researched how building an Asset-Based Community Development system can provide the right conditions to help support people in their own homes and communities. The resources they identify are as follows [6];

A- Contributions of residents: The gifts, skills and passions and knowledge of residents, which are contributed towards the collective wellbeing of their community.

B - Associations are clubs, groups, and networks of unpaid citizens, who create the vision and implement the actions required to make their vision, visible, and of consequence.

C - Local institutions: The nature of an institution that is community oriented is that it acts as a resource toward community wellbeing and aims to be supportive, not directive. The goal of such supportive institutions is to enable citizenship and interdependence at the centre of community life. Supportive institutions consider citizens to be the primary inventors of community wellbeing in a democracy, and see their role as cheering on that inventiveness and serving while walking backwards.

D - Local Places: Small, local, bounded places, that people relate to as their shared place: neighbourhood, village, town and so on, provide an optimal threshold within which these resources, can be brought into right relationship with each other to become connected and mobilized. As well as providing an ideal context for gift exchange, hospitality and revealing abundance, local bounded places are replete with all manner of practical resources that are essential to community life.

[6] Asset Based Community Development

E – Exchange: In the non-monetary world, there are three forms of exchange: 1) the exchange of intangibles, 2) the exchange of tangibles, and 3) use of alternative currencies. In the commercial world 4) there is a fourth form of exchange in the shape of money.

F – Stories: Local culture, or 'the community way' often finds expression within stories of the people and the 'ways' they have learned through time to survive and thrive within their home places. Hence the sixth resource that enables shared visioning and productivity are community stories.

Within East Lothian we have a strong third sector and vibrant communities. The challenge is to be able to access and support the communities which will in turn support Health and Social Care services.

3. Care Coordination

Highlighted during a number of engagements, with communities, users of health and social services as well as staff who deliver the services, is the need for a joined up approach to the delivery of all services, and a single point of contact to support navigation through the Health and Social System.

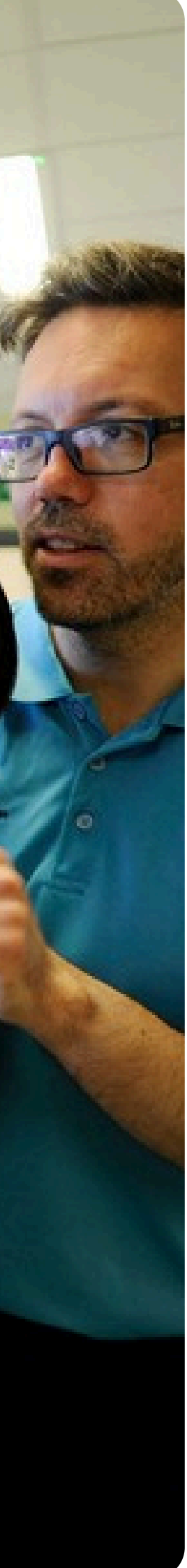
Care co-ordination offers this approach and along with increasing community capacity supports the move away from Care at Home being used to deliver all outcomes. It also allows services both statutory and those delivered by the independent and voluntary sector to work in a more integrated way.

Engaging with all the people involved in someone's care, knowing who to talk to and when is key to exploring a better more sustainable way to support people.

A care coordination model would focus on a Locality Model and support all the individuals in that local and would have a multi-disciplinary approach involving;

- Social Work Staff
- Allied Health Professionals
- Community Nursing
- Community Supports
- Care at Home Supports

This approach would allow a focussed holistic approach on each individual which removes the emphasis on, ongoing Care at Home and looks at alternatives to a care at home service where possible.



4. Commissioning

The current market in 2025 for Care at Home is split by 30% internal services (ELC and NHS services) and **70%** external services for people over 65 yrs. Under 65's are supported **97%** by external providers and **3%** by the internal service.

The balance between internal services and external is important to manage. The 'pull' of staff to what can be seen as better paid Council and NHS posts can cause instability in the care market. The care market is finite, and it is long recognised to have reached saturation point. It is also established that the base cost of Care at Home delivery is almost **30%** higher for internally delivered services.

Since 2020 ELHSCP have increased the delivery of internal services by around 20%. This was in response to a failing external market and a recognition that the cost of managing a high number of providers with a small number of hours was unsustainable for both provider and the HSCP.

Although procurement processes follow a strict ethical commissioning process which allow for certain stipulation to providers to adhere to fair working practices within in East Lothian including paying staff the Real Living Wage, the majority of providers employ staff on 'task based' salary. This means although paid at least the Living Wage, staff are paid only when delivering care. This results in a perverse incentive to continue to deliver care even if the outcome has been met. This increases people's dependency on care and puts further strain on the limited care at home resource.

The Fair Work Framework outlines key themes of: Effective Voice, Opportunity, Security, Fulfilment and Respect, which further forms an evidence base that change actions in commissioning can positively impact on workforce development. Fair Work Framework

Consideration for collaborative style approaches to Care at Home commissioning can support providers to respond collaboratively to population needs, alongside a locality focused care co-coordination system model.

4.1 Capitation / block contracts

Provision of block contracts or a 'Capitated' model whereby Providers are contracted on a geographical location and funded to deliver support to a certain number of individuals and therefore it is based on the person rather the hours required, can help to improve providers terms and conditions of employment. However, the HSCP would need to ensure its assessments and reviews were outcome focused. Without this focus on outcomes rather than hours, the contracting for and delivery of care remains on a time and task bases.

East Lothian will aim to have Care at Home capacity reflective of actual population need at any one time enabling the right amount of support at the right time which also supports the avoidance of hospital admissions and prevents delays to hospital discharge.

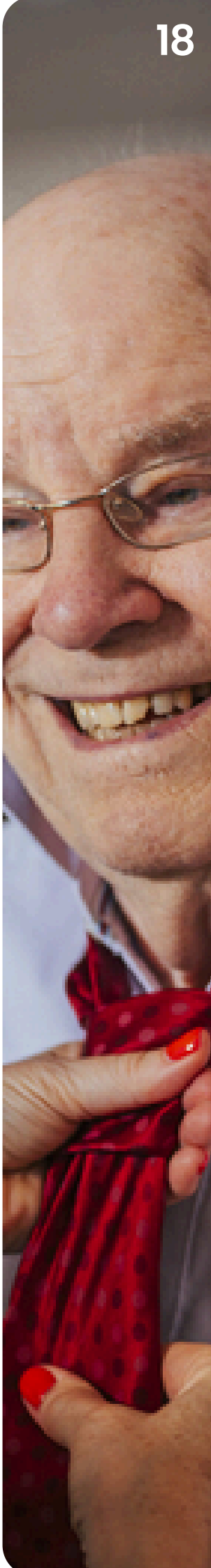
East Lothian are keen to move towards an outcome-based capitated budget for providers and note the following pro's and cons.

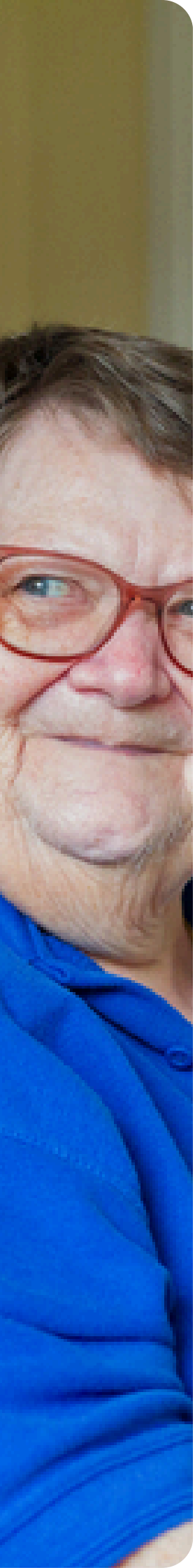
Pros

- As a capitated payment is not linked to how much care is provided, providers have the flexibility to spend money on services they think will secure the best outcome for the service users.
- The potential for more integrated care and evidence that professionals work more closely together when working under a capitated budget.
- Evaluations of programmes elsewhere show they are more cost-effective than other payment systems.

Cons

- Providers are paid regardless of what they deliver - enabling them to provide as little care as possible to minimise costs.
- They do not necessarily take into account changes in levels of demand.
- Services delivered by different organisations require significant capabilities on the provider side - e.g. coordination between primary and secondary care.





4.2 Provider Capacity

Provider size is crucial to the delivery of external provision. New providers coming into the area are most at risk of collapse if they deliver fewer than 500hrs per week. The HSCP is unable to pay above the average rate for Care at Home provision which in 2025/26 is £23.81 per hour. An hourly rate which is only sustainable for medium (500 hrs- 1500 hrs per week) providers. As the organisation grows there appears to be a critical position where providers need to move to around 2500 hrs to become sustainable at an affordable rate for the HSCP. Capacity within East Lothian including the internal services means there are around 4 main providers mainly providing to people under 65. These 4 providers account for 80-90% of the external market. Therefore, new providers who can often provide care immediately but ultimately not sustainably come into the market for short periods of time. It is important that ELHSCP control the market ensuring providers are supported to become sustainable and procured to allow for improved terms and conditions of employment for external provision.

To support providers, the HSCP will work to reduce the amount of travel time associated with the delivery of the Care at Home services. Rural areas will be supported by the Internal service who have better access to transport and can access electric and non electric vehicles so cost is not passed onto the care worker nor is an additional expensive for a provider who may not have sufficient contracted hours to fund a vehicle.

Care packages will be clustered to ensure providers are not crossing over each to provide services. This may mean service users experience a change in provider and communication around these changes will be key.

4.3 Option 1 (Direct Payment) / Option 2.

These purchase options under the Social Care (Self-directed Support) (Scotland) Act 2013, are to allow people to purchase alternative support that the HSCP is unable to provide. The legislation is in place to give people who have assessed care needs more choice and control over the support they receive. However, in practice these options are often used to purchase care that is not immediately available through Option 3 and allows individuals to pay additionally to secure a normally smaller more expensive care at home provider.

The options are often seen as the last resort, to be used if ELHSCP have been unable to source an option 3 provider. As we secure the option 3 market, we should see the number of Self Directed Support options 1 and 2 reducing and those who do choose those options do so to make an active choice to purchase support that is not available via option 3, that will offer them more control and choice around how their care is delivered, rather than to bypass a waiting list for Care at Home.

Actions include adopting system wide change in conversation at the time of assessment, to focus on what matters to the individual and can be supported by Self Directed Support Improvement Planning.

5. Tech-enabled care

As care at home is challenged by increasing demand, underfunding and the lack of an appropriately skilled workforce, technology in it's many forms is seen as way to address some of these issues.

It will be important to invest in both staff training and public education into the use of technology in the right way and for the right people to reduce the need for short visits and reducing risk of leaving people with no support if the use of Technology in care is to be successful.

We will look to consider two aspects of technology in relation to Care at Home:

- The technology that is available to support providers to deliver care in the most effective and efficient way - for example reducing travel time for care staff, improving lone working, being able to record visit times etc.

- The use of technology to reduce the need for a care at home service, or to improve the delivery of the support to an individual such as Robotics, sensors, tracking and monitoring, home testing and increasingly the exploration of Artificial Intelligence.

There is a Digital and Data Programme Board within East Lothian that will take forward workstreams around both Telecare and Digital solution.