2024/25

Annual Performance Report

East Lothian Integration Joint Board

Contents

Introduction

Welcome to this year's Annual Performance Report. In it you will read about our performance, including ways in which we have continued to develop health and social care services in East Lothian during 2024/25.

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

You will also see examples of how we have worked with third and independent sector colleagues and local community groups to support the health and wellbeing of East Lothian residents, developing new and innovative ways of responding to individual needs. The support of these groups has been crucial in delivering services in 2024/25, supporting the IJB to meet its strategic objectives.

This report covers a year in which the Integration Joint Board (IJB) continued to work within a challenging financial context. Over the year, services worked to deliver a programme of efficiency measures agreed by the IJB. This included a range of operational schemes along with a number of larger individual schemes related to service redesign.

The IJB recognises that, whilst financial recovery activity will continue to be necessary to balance budgets and to help ensure longer term sustainability, the safety and wellbeing of service users, patients and carers remains paramount. The challenge of balancing these factors was reflected in a report to the IJB by the Professional Leads[1] in December. The report highlighted concerns regarding the impact of the ongoing delivery of efficiencies on the ability of services to meet professional standards.

Projected overspends for future years, and ongoing financial uncertainty at a national level mean that the IJB will be faced with further difficult decisions in future years. We are committed to early and ongoing financial planning to ensure that our budget decisions are well informed and support the most effective and efficient use of resources.

Work began at the start of 2025 to review the current IJB Strategic Plan, with a view to agreeing an updated plan by the end of the year and covering the period up to 2030. Development of a revised IJB Strategic Plan will be based on extensive stakeholder engagement along with close consideration of the challenges and opportunities that are likely to be presented over the lifetime of the plan.

[1] Professional leads for Social Work, Allied Health Professionals and Nursing and the Clinical Director.

About this Report

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

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

An Annual Delivery Plan (ADP) is produced yearly outlining planned activity to support delivery of the IJB's strategic objectives for the coming year. Responsibility for delivery of activities detailed in the ADP is assigned to either Change Boards[2] or to specific HSCP Officers / Teams. The East Lothian Strategic Planning Group maintains oversight and monitors progress in relation to the ADP.

This Annual Performance Report describes how East Lothian Health and Social Care Partnership (ELHSCP) services have contributed to the delivery of the East Lothian IJB Strategic Objectives during 2024/25. The report's structure is based on the 7 strategic objectives, with a section dedicated to each of these.[3] There is also a section outlining performance in relation to National Integration Indicators and one on financial performance.

As noted above, work began at the start of 2025 to review and update the IJB Strategic Plan.

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

[2] Work took place during 2024/25 to review our Change Board structure with revisions resulting in the introduction of new 'Programme Boards' for 2025/26 – these build on the previous Change Board structures and will continue to evolve, including in response to the revised IJB Strategic Plan once it is place.

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

National Integration Indicators – How We Performed

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

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

Core Suite of National Indicators

(i) Scottish Health and Care Experience Survey (2023/24)

Nine of the national integration indicators are based on data from the biennial Scottish Health and Care Experience (HACE) survey. As the HACE survey results are only ever two years, they are not included them in this year's Annual Performance Report – the most recent HACE survey results were reported in 2023/24 and included in last year's IJB Annual Performance Report (which you can view here).

(ii) Operational Performance Indicators

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

It should be noted that, where indicated (indicators 12, 13, 14, 15 and 16), the figures given are for calendar year 2024. Calendar year 2024 is used as a proxy for 2024-25 due to the national data for 2024-25 being incomplete at the time of publication. We have done this following guidance from Public Health Scotland and to improve consistency between our report and other Health and Social Care Partnerships.

Overview of performance against indicators

Looking across the National Indicators, East Lothian's position improved or remained at around the same level for 7 out of 10 indicators. When compared to Scottish rates, East Lothian's position was better than average for 8 out of 10 indicators; in line with the average for one indicator and slightly poorer than average for one indicator – this was in relation to the percentage of adults with intensive care needed receiving care at home where East Lothian's rate was 1% lower than the national rate (noting that the was little variation on this across IJBs).

A decline in position can be seen in relation to the premature mortality rate for under 75 year olds (National Indicator 11), although East Lothian's level was still significantly below the Scottish average. A declining position is also evident in relation to delayed discharge for the over 75 age group (National Indicator 19), although again, East Lothian's position was positive in comparison to the Scottish level (activity to address delays and support hospital flow is covered fully at pages 21-22 below).

Comparison with the previous year is only possible for 5 of the Ministerial Steering Group (MSG) indicators. East Lothian's position improved in relation to three of these; declined slightly for the indicator related to A&E attendances; and declined more significantly in relation to delayed discharges.

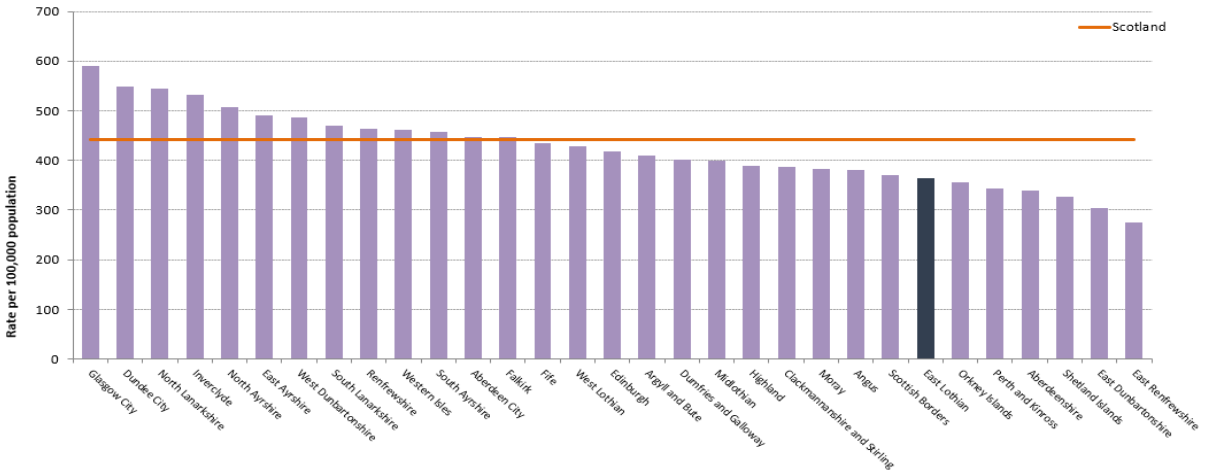
National Indicator 11 - Premature mortality rate for people aged under 75 per 100,000 persons (by calendar year)

	2018	2019	2020	2021	2022	2023
East Lothian	330	309	338	370	350	363
Scotland	430	424	455	463	441	442

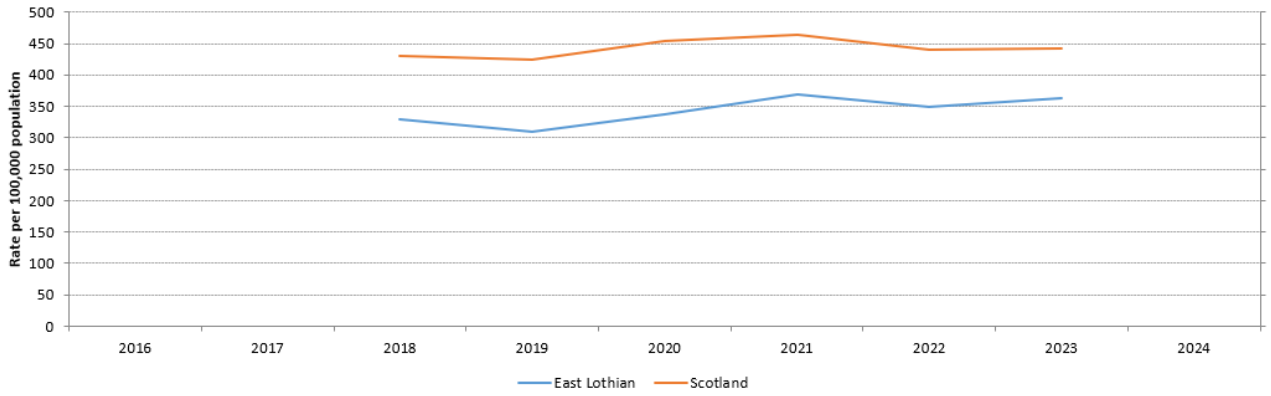
Figures showed that the premature mortality rate for people under 75 years of age increased for East Lothian during 2023, although this was still below the Scottish level.

Linked activity in Annual Performance Report – Activity across all IJB Strategic Objectives contributes to overall population health and wellbeing in East Lothian. Activity in relation to health inequalities is of specific relevance – **see pages 67–68.**

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

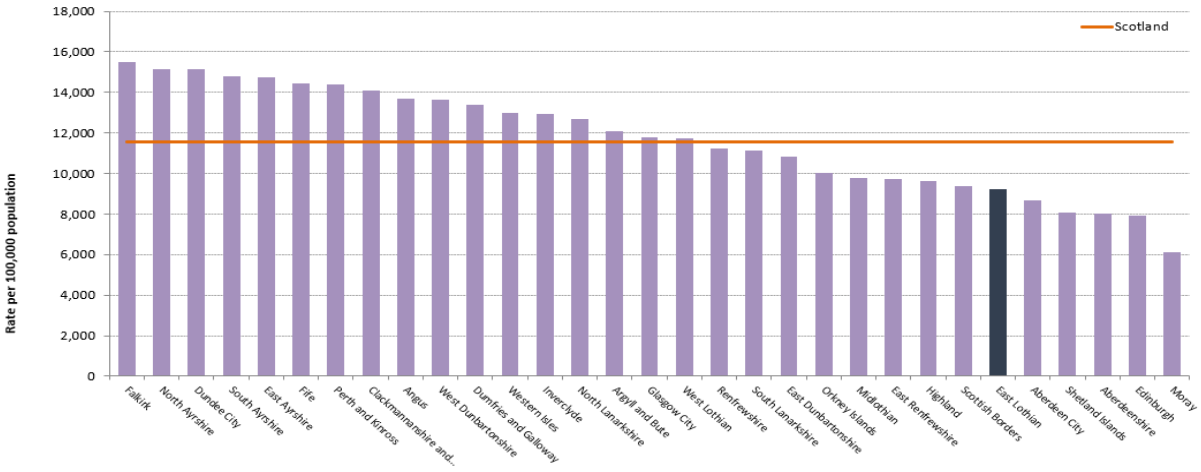


National Indicator 12 – Emergency admission rate for adults per 100,000 persons

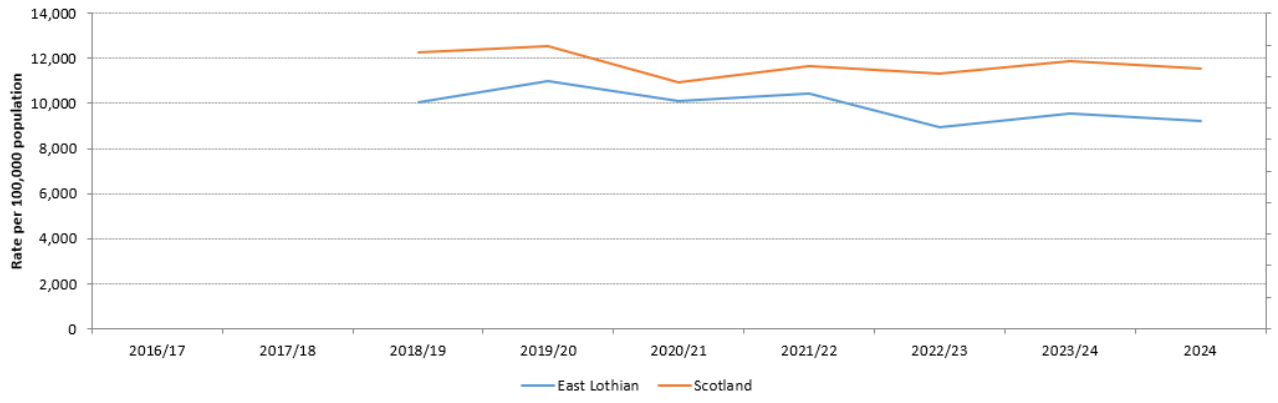
	2019/20	2020/21	2021/22	2022/23	2023/24	2024	East Lothian's emergency admission rate reduced in 2024 and continued to be lower than the Scottish rate.
East Lothian	10,978	10,091	10,442	8,939	9,545	9,204	
Scotland	12,532	10,965	11,645	11,318	11,859	11,559	

Linked activity in Annual Performance Report – Our services continue to take a multi-disciplinary approach to identifying and responding to individual need, planning care and support that helps to prevent avoidable hospital admission. Ongoing development of the East Lothian 'Home First' model and Single Point of Access will further strengthen our activity in this area - **see pages 21–25 and case study on page 47.**

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

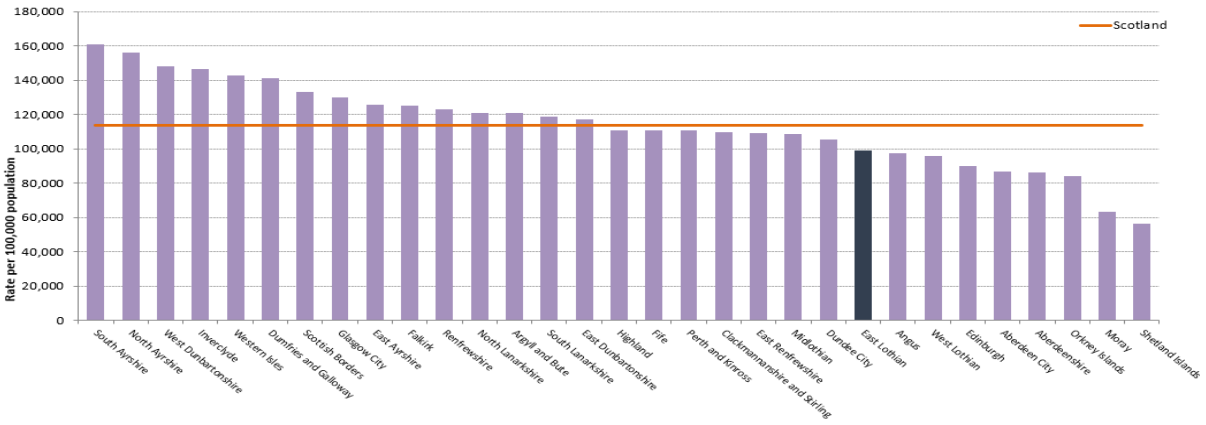


National Indicator 13 – Emergency bed day rates for adults (per 100,000 population)

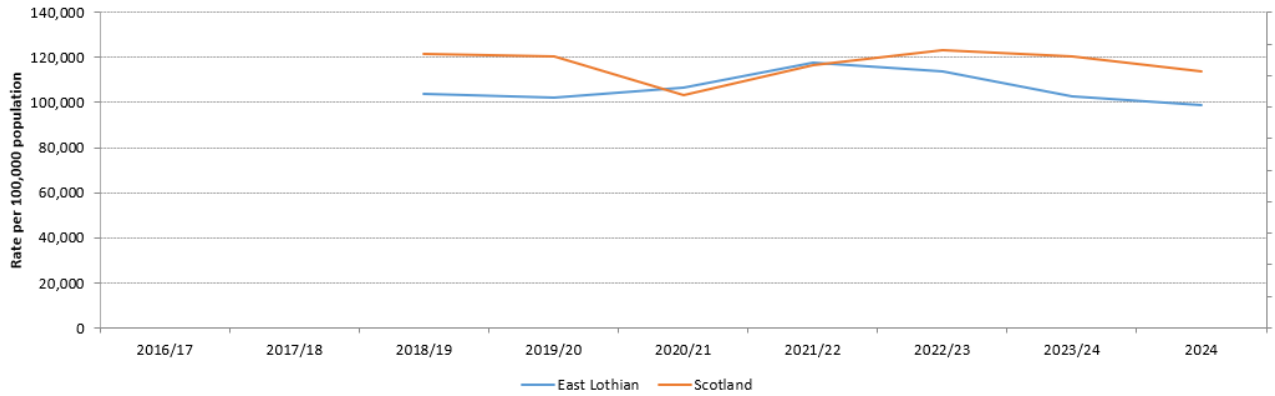
	2019/20	2020/21	2021/22	2022/23	2023/24	2024	The East Lothian emergency bed day rate reduced in 2024 and remained significantly below the Scottish rate.
East Lothian	102,101	106,657	117,489	113,986	103,044	98,923	
Scotland	120,677	103,433	116,389	123,061	120,407	113,627	

Linked activity in Annual Performance Report – Services continue to work on a multi-disciplinary basis to closely monitor East Lothian patients in hospital to help reduce the length of stay **see pages 21–25.**

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

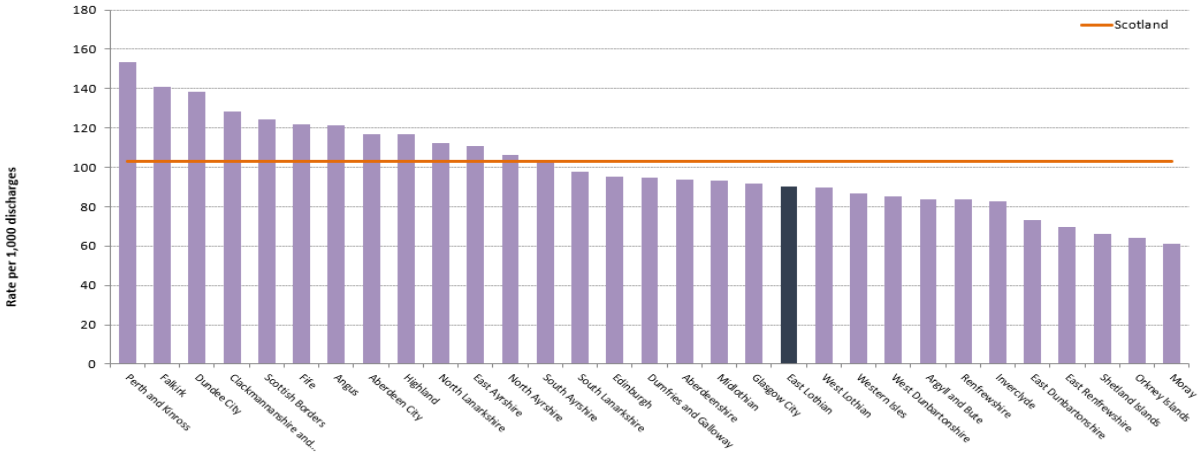


National Indicator 14 – Readmission to hospital within 28 days of discharge (rate per 1,000 discharges)

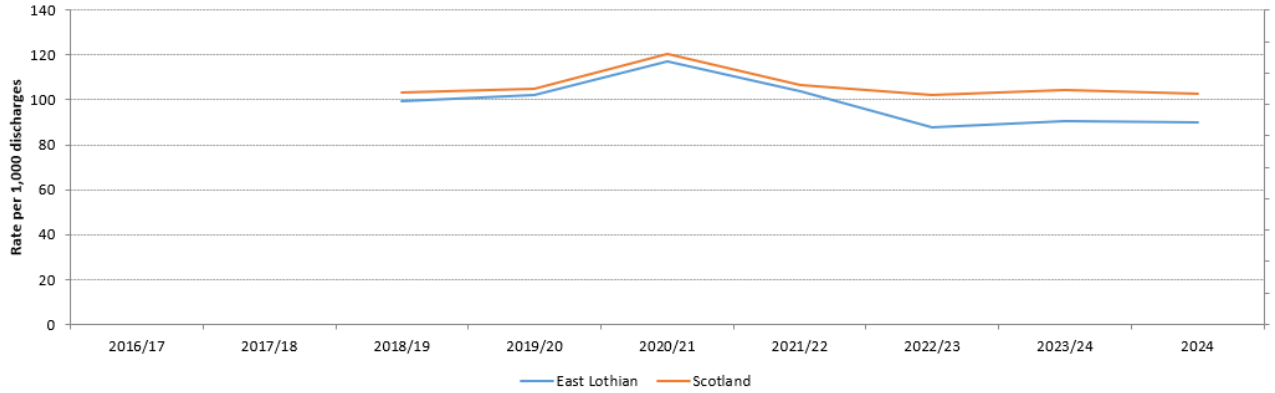
	2019/20	2020/21	2021/22	2022/23	2023/24	2024	The readmission rate for East Lothian improved slightly compared to the previous year and remained below the Scottish rate.
East Lothian	102	117	104	88	91	90	
Scotland	105	120	107	102	104	103	

Linked activity in Annual Performance Report – Our effective, multi-disciplinary approach to discharge planning helps to reduce readmission, as does the provision of appropriate care and support post-discharge, including through care at home services **see pages 21–25.** Services such as VCEL's Community First Service also play a key role **see pages 31-32.**

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

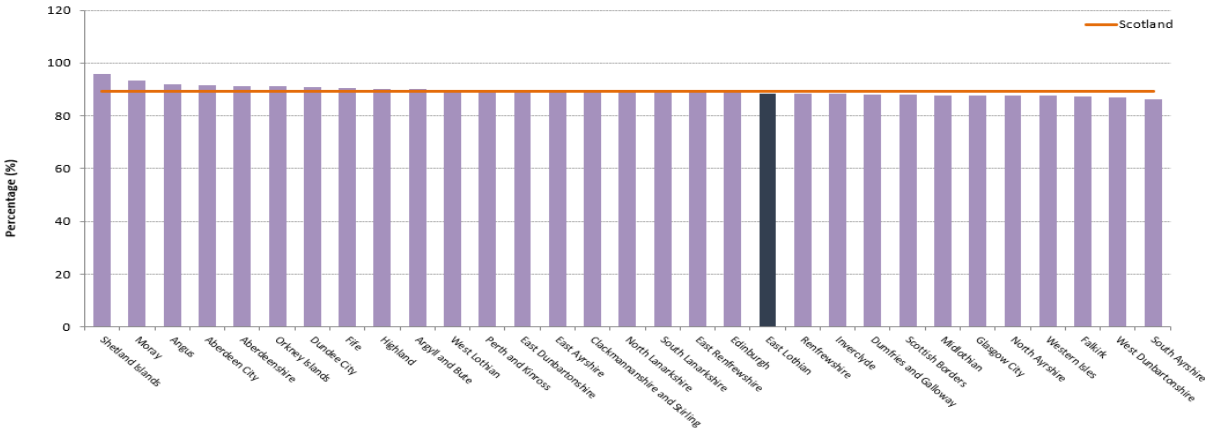


National Indicator 15 – Proportion of last 6 months of life spent at home or in a community setting

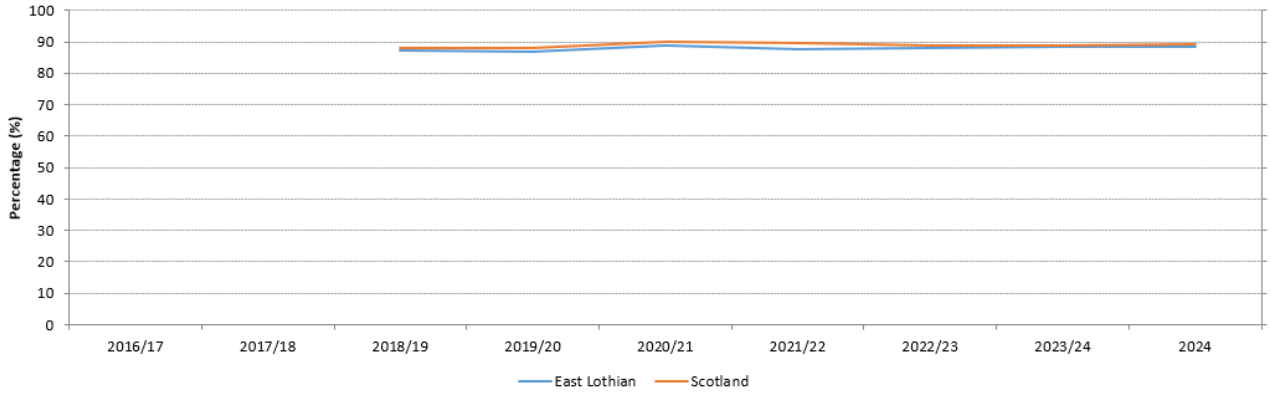
	2019/20	2020/21	2021/22	2022/23	2023/24	2024	
East Lothian	87%	89%	88%	88%	88%	89%	There was a small improvement in the percentage of last 6 months of life spent at home or in a community setting, with the East Lothian level now in line with the national average.
Scotland	88%	90%	90%	89%	89%	89%	

Linked activity in Annual Performance Report – We continued to develop our approach to providing palliative and end of life care aimed at providing choice whilst reducing the reliance on hospital admission **see page 55.**

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

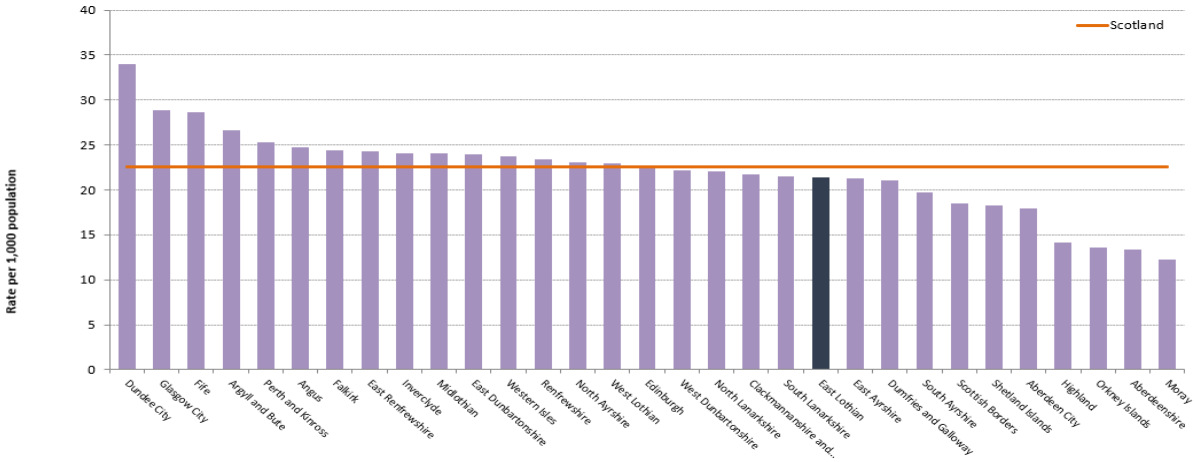


National Indicator 16 – Falls rate per 1,000 population aged 65+

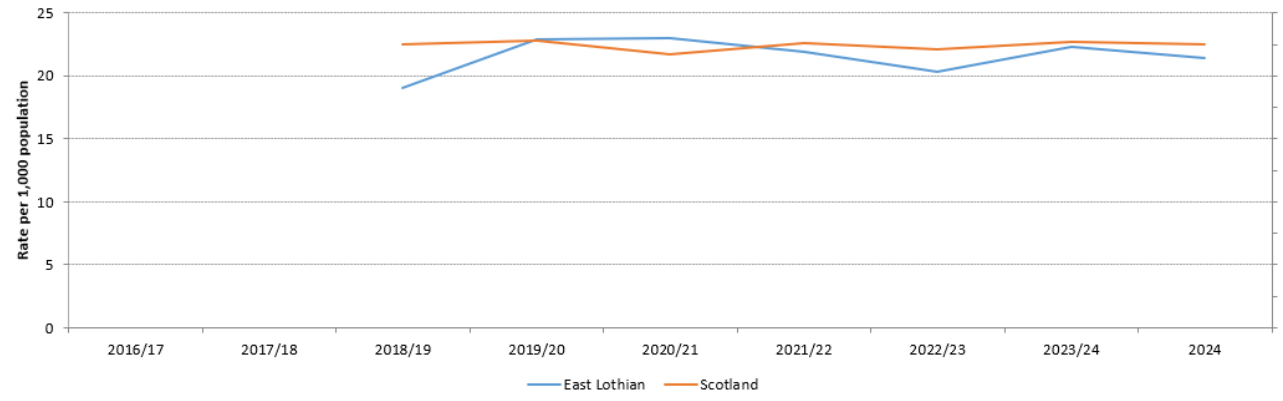
	2019/20	2020/21	2021/22	2022/23	2023/24	2024	There was a decrease in the falls rate for 2024, with the rate remaining below the Scottish rate.
East Lothian	23	23	22	20	22	21	
Scotland	23	22	23	22	23	23	

Linked activity in Annual Performance Report – Falls prevention and management continued to be a delivery priority during 2024/25 – **see page 38** for details of work carried out by our Fall's Service.

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

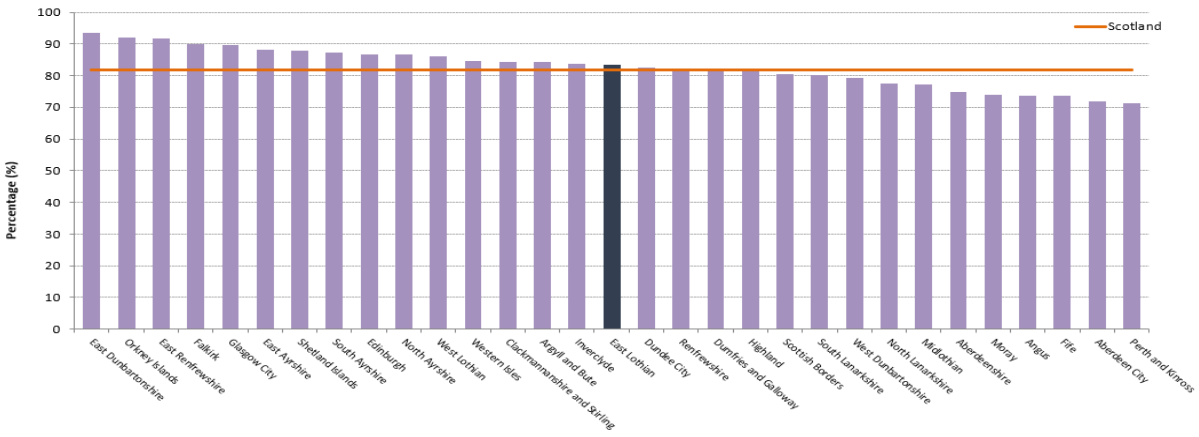


National Indicator 17 – Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

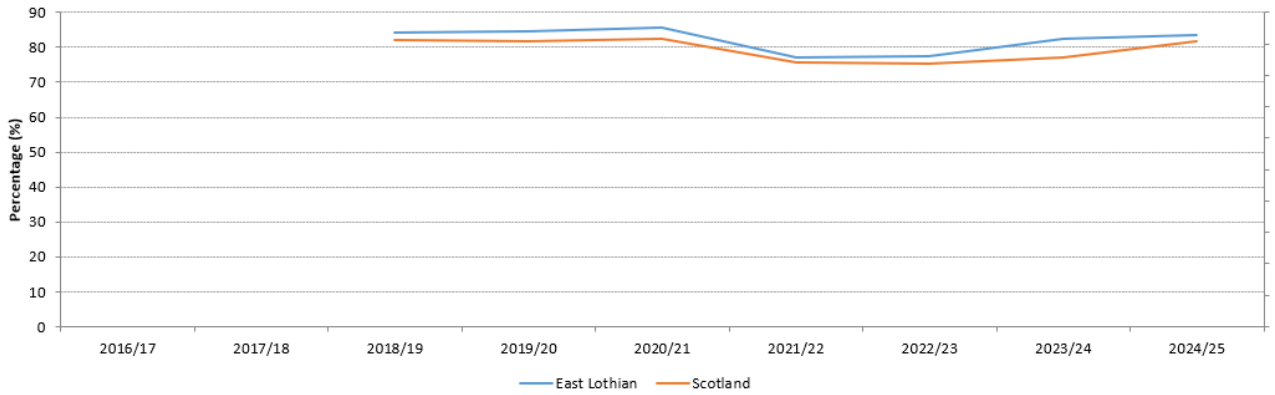
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	The proportion of East Lothian care services graded 'good' or better has been consistent over the past two years and slightly ahead of the national level.
East Lothian	85%	86%	77%	77%	83%	83%	
Scotland	82%	83%	76%	75%	77%	82%	

Linked activity in Annual Performance Report – Our Care Home Team provides clinical care and educational support across Care Homes. Support is also provided by our Planning and Performance Team and through Quality Improvement support – see **pages 26-29**.

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

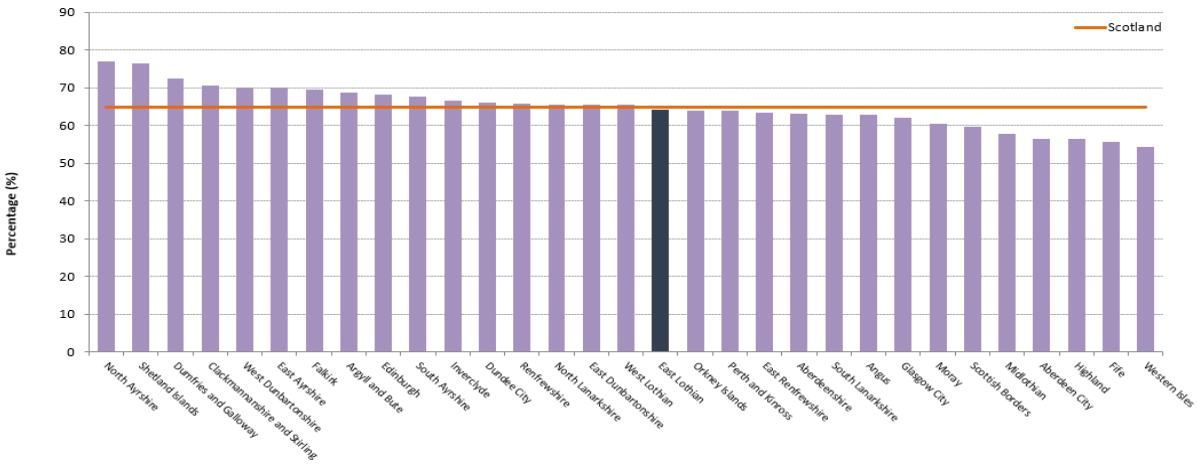


National Indicator 18 – Percentage of adults with intensive care needs receiving care at home

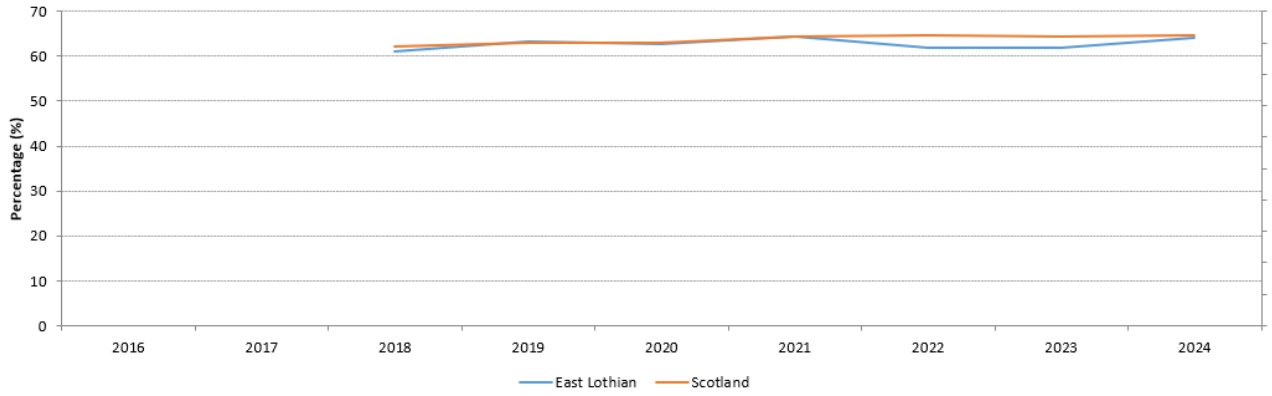
	2019	2020	2021	2022	2023	2024	
East Lothian	63%	63%	64%	62%	62%	64%	There was an increase in the % of adults with intensive care needs receiving care at home, with East Lothian moving closer to the Scottish rate.
Scotland	63%	63%	64%	65%	65%	65%	

Linked activity in Annual Performance Report – We continue to develop our services to support people to live at home or in a homely setting where possible. Work was carried out during 2024/25 to develop at Care at Home Strategy providing a roadmap for our ongoing development of services – **see pages 23-24.**

Scottish Comparison (East Lothian in black)



Time Series – East Lothian



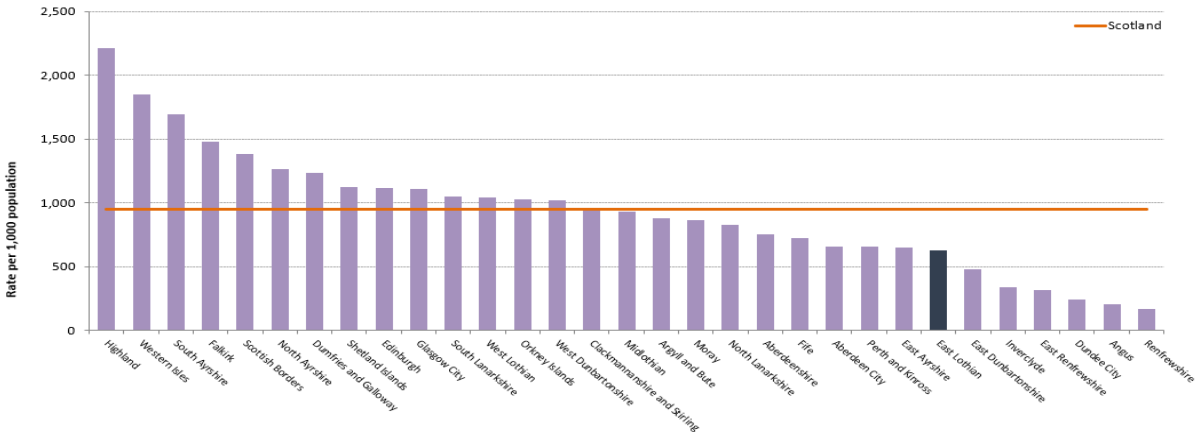
National Indicator 19 – Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	The number of bed days related to hospital delays for the over 75s increased significantly during 2024/25, while still remaining below the Scottish level.
East Lothian	327	258	153	194	224	626	
Scotland	774	484	748	883	867	952	

Linked activity in Annual Performance Report – Pressures across the health and social care system contributed to an increase in delays for East Lothian patients. This reflected the national picture resulting from continued high levels of demand combined with the impact of ongoing budget constraints and reductions in service capacity.

Activity to support hospital flow and minimise delays included continued close monitoring and management of East Lothian patients and the ongoing development of our Home First approach. Additional Scottish Government investment in the latter part of the year enabled us to increase capacity and further bolster this approach, including through a new Single Point of Access – **see pages 21-25.**

Scottish Comparison (East Lothian in black)



Time Series – East Lothian

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

- Indicator 10 - % of staff who say they would recommend their workplace as a good place to work.
- Indicators 20 - % of health and care resources spent on hospital stays where the patient was admitted in an emergency.
- Indicator 21 - % of people admitted to hospital from home during the year, who are discharged to a care home.
- Indicator 22 - % of people who are discharged from hospital within 72 hours of being ready.
- Indicator 23 - Expenditure on end of life care costs in last 6 months per death.

Ministerial Strategic Group (MSG) Indicators

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

Indicator	2019/20	2020/21	2021/22	2022/23	2023/24	2024	Commentary
1. Number of Emergency Admissions (18+)	9,028	8,267	8,489	7,586	8,341	**8,098**	Emergency admissions reduced from the previous year. **See pages 21-25**
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	67,652	67,239	73,569	77,144	71,629	**69,890**	Unscheduled hospital bed days reduced from the previous year. **See pages 21-25**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	2,900	6,725	7,141	7,250	7,047	**6,072**	Issue with data – comparison not valid at this point. **See pages 21-25**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	2,493	6,577	6,921	6,973	7,017	**6,072**	Issue with data – comparison not valid at this point. **See pages 21-25**

2iii. Number of Unscheduled Hospital Bed Days – Mental Health (18+)	14,001	12,632	13,271	13,654	13,030	**11,709**	The number of mental health unscheduled bed days reduced. **See pages 21-25**
3. New Accident and Emergency attendances (18+)	21,305	17,923	21,229	21,266	21,407	**21,485**	Accident and Emergency attendances were at a similar level to the previous year. **See pages 21-25**
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	4,506	3,878	2,672	3,251	3,638	**8,275**	The total bed days lost to delays increased significantly in 2024. **See pages 21-25**
5. Percentage of last six months of life spent in community setting	87.0%	88.7%	87.6%	87.9%	88.6%	-	Data not yet available via MSG data set, however, see National Indicator 15 above. **See page 55**
6. Percentage of the population at home – supported and unsupported (aged 65+)	96.8%	96.6%	96.6%	96.6%	96.9%	-	Data not yet available via MSG data set, however local data suggests no change from the previous year. **See pages 23-24**

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

Planning Older People's Services

Our Planning Older People's Services (POPS) work concluded with the publication of our final report and recommendations, which were approved at the Integration Joint Board at its February 2025 meeting. The final report provides an overarching summary of the engagement activity undertaken at each stage of the project, starting with the outcomes of the Community Hospitals and Care Home's Change Board in early 2023, to the feedback gathered from the 12-week public engagement and consultation period between September to December 2024.

The report made six specific recommendations for the Integration Joint Board to consider. All of which were agreed by the IJB.

Report Recommendations:

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

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

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

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

5) ELHSCP Officers to continue to collaborate with NHS Lothian Public Health, East Lothian Council Area Partnership Health and Wellbeing sub-groups, 3rd sector partners / interfaces and community

groups to explore and develop early intervention and prevention approaches that support IJB strategic priorities and deliver intermediate care and support.

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

The IJB have committed to progress the recommendations of the POPS project and partners across the Health and Social Care Partnership will now concentrate on ensuring that each recommendation is progressed with a number of the work streams being adopted as part of the newly established Programme Board structure.

We would like to take this opportunity, once again to offer our sincere thanks to everyone who has been involved in the Planning Older People's Service Project, especially our Independent Community Panel members. It would not have been possible to come to these conclusions and recommendations without your valuable input. We additionally look forward to working with the Independent Community Panel on an ongoing basis, building on the foundations that were achieved during the POPS project.

East Lothian Home First

Our services continued to develop and embed a 'Home First' approach during 2024/25, focusing on ensuring that people get the care and support they need to remain at home; reducing the need for hospital admissions, and enabling people to return home from hospital as soon as possible.

Home First is a national initiative based on a multi-disciplinary, collaborative approach to providing coordinated community based care. By working collaboratively, services are able to quickly identify the best option to meet each patient's needs and outcomes – recognising that a hospital bed should not be the default choice.

From an organisational perspective, a Home First approach helps to deliver a rapid response; supports patient flow; reduces length of stay and delayed discharge rates, improves patient experience; and ensures that hospital beds are allocated to those who need them most.

Home First recognises that assessment and rehabilitation does not always have to take place in a hospital bed and may be more appropriate and effective in a person's home environment. Prevention is also a key objective, through early assessment and planning so that appropriate support can be put in place to keep people at home and to maintain their independence.

Diagram 1 below shows the HSCP teams playing a role in the East Lothian Home First approach. Services provided by independent providers and community and third sector organisations are also key in providing support to people at home as part of this overall approach.

Diagram 1 – East Lothian Home First Approach

During the year, we continued to closely monitor and manage East Lothian patients in hospitals via our daily Activity Huddle. The Activity Huddle brings together staff from HSCP services, along with HSCP managers, and colleagues from acute hospital sites. Meetings are held online and provide a daily opportunity to review East Lothian patients across all Lothian hospitals, helping to deliver a pro-active, multidisciplinary approach to tracking and monitoring patients and planning their discharge home. We introduced use of FlowMap in early 2025 to further support this activity – this provides a platform for live patient tracking and communication, facilitating real-time updates and enabling timely decision-making.

We also continued to deliver our Care Home Huddle and introduced a new Care at Home Huddle to ensure efficient use of available Care at Home resources. All of our Huddles are chaired by members of the Core Management Team on a rotational basis, providing strong leadership and supporting rapid decision making and escalation when required.

Towards the end of 2024, the Scottish Government committed additional investment to support initiatives aimed at reducing delayed discharge and easing pressure on acute hospital inpatient beds. East Lothian was successful in securing funding to support the recruitment of additional staff across Care at Home, Rehabilitation, and Social Work teams, providing additional capacity and allowing delivery over 7 days a week.

Recruitment to the new posts took place in the latter part of 2024/25, as did work to establish a new professional Single Point of Access (SPOA). The new SPOA simplifies referral routes for health and social care; reduces delays and duplication; and supports a timely, effective, multi-disciplinary response.

Despite the range of activity described pressures across the system contributed to an increase in delays for East Lothian patients during the year (see page 15 above for related data). These pressures were felt across Scotland and were the result of ongoing growth in demand combined with the continued impact of ongoing budget constraints and reductions in service capacity.

The occupancy rate for acute hospital beds is also useful performance measure in relation to hospital flow providing a fuller picture when viewed alongside data on delays. East Lothian performed well in this respect during 2024/25, with occupancy levels within or below the allocated bed base throughout the year.

By the end of 2024/25, delayed discharges had reduced significantly from the higher levels seen earlier in the year, sitting at 15.6 delays per 100,000 population by April 2025 (comparing favourably to the Scottish Government target of 28.4 per 100,000 population).

Care at Home Services

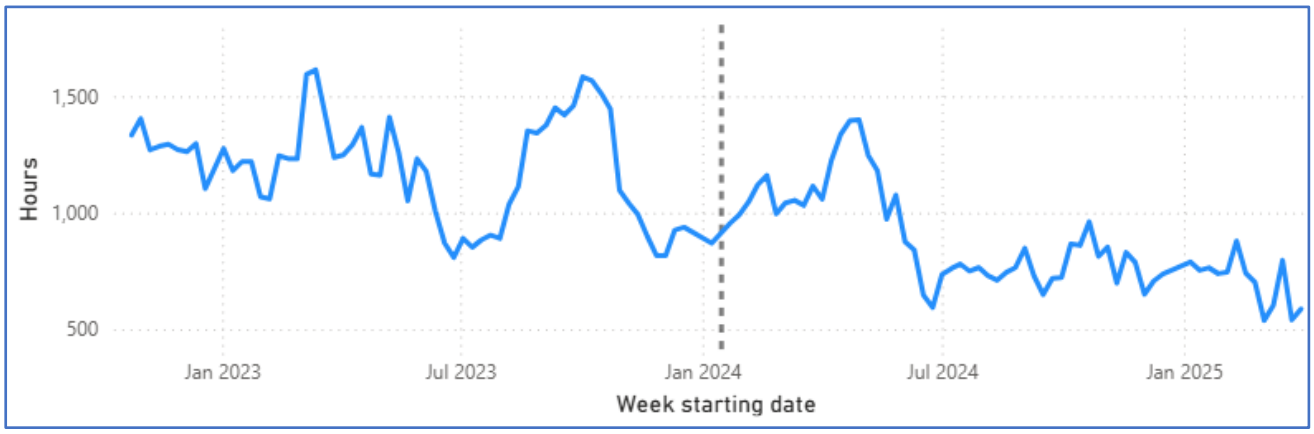
Care at Home services in East Lothian are delivered by a combination of HSCP managed services and services delivered by external providers. At the end of 2024/25, 84% of care at home hours were delivered by external providers and 16% by internal HSCP services.

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

Graph 1 below shows that the level fluctuated throughout the year, the number of hours of unmet need was lower at the end of 2024/25 compared to the start (reducing from 1,058 hours to 587) and lower than the previous year.

As described above further improvements were made in relation to the close monitoring and operational management of care at home resources, including through the introduction of a new Care at Home Huddle. The Care at Home Huddle brings together colleagues from across services to take a multi-disciplinary approach to the operational oversight of care at home delivery, including the matching of available resources to individual need.

Graph 1 – Hours of care at home to be provided – East Lothian (weekly)[4]



Care at Home 'Test of Change'

The Strategic Planning Group and Care at Home Change Board agreed to form a Locality Project Team in May 2024 to undertake a Test of Change programme.

The Test of Change took place during a 12-week period over winter 2024 and was based on a Community and Care Coordination approach. This included adopting strengths-based conversations

[4] Source - Whole System Pressures Dashboard – NSS / Public Health Scotland / Scottish Government

to identify people's needs and priorities, along with improvements to both hospital and community assessment. The approach also incorporated enhanced care coordination involving Allied Health Professionals, Adult Social Work, and Community First colleagues in identifying care and support, including considering alternative options to formal care services, with a particular focus on local support.

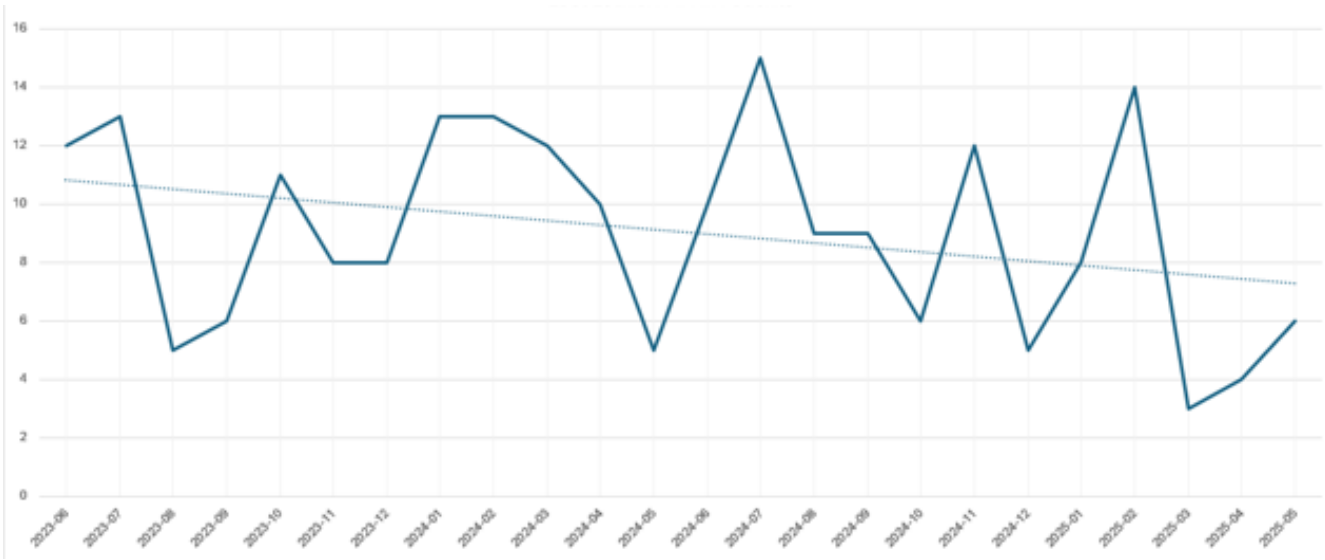
Evaluation of the initiative identified evidence that the approach had been successful in terms of improving outcomes for individuals; diverting people from care at home services or reducing the number of hours they needed; preventing hospital admission; supporting timely hospital discharge; and delivering financial savings.

A final report recommending that the approach taken by the Test Change be rolled out and adopted on a permanent basis has informed the development of a five-year Care at Home Strategy that will be considered by the IJB in autumn 2025.

Mental Health Inpatient Beds

Work continued throughout 2024/25 to reduce the number of East Lothian mental health inpatient bed days, with the ongoing ambition to work within our commissioned bed base[5] of 8 acute adult beds, 1 adult IPCU6 bed and 6 adult rehabilitation beds at the Royal Edinburgh Hospital. Whilst East Lothian inpatient bed use continues to vary throughout the year, as shown in Graph 2 below, the trendline demonstrates a gradual decrease in the average use of acute mental health beds.

Graph 2 – East Lothian Mental Health Inpatient Bed Use



[5] East Lothian IJB commissions NHS Lothian to deliver Mental Health inpatient services (beds).
[6] Intensive Psychiatric Care Unit.

Alongside the three times weekly local mental health "Activity Huddle", East Lothian teams participate in daily flow huddles within ELHSCP and REAS, to support hospital flow by reducing unnecessary admission and ensuring timely hospital discharge. The key focus is upon PDDs[7] and collaboration across services (for example, ICAT, Housing and Adult Social Work).

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

Commissioning

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

The approach we take to commissioning is important in terms of helping to ensure that commissioned services are provided in a way that reflects our vision and values and contribute to the delivery of our strategic objectives. Our strategy sets out our commissioning intentions and key market messages, including our commitment to an outcome focussed approach, and ethical commissioning that takes into accounts factors beyond price, including fair work, staff terms and conditions, trade union recognition, sustainability of services, equality, and environmental impact. Meanwhile, our Market Facilitation Statement aims to help the IJB, HSCP and service providers to plan future service delivery by setting out key pressures and summarising current supply and anticipated demand.

The current East Lothian HSCP Commissioning Strategy and associated Market Facilitation Statement run from 2022 to 2025 and as such are due to be updated to reflect the refreshed IJB strategic plan and priorities. The IJB strategic plan and priorities are currently being refreshed and once this concludes later in 2025, the strategy and statement will be reviewed and updated to ensure alignment.

Supporting Sustainable Care Home Provision

We continued to focus on a home first approach for people discharged from hospital, with the aim of increasing the proportion of people going home as opposed to be begin discharged to a care home placement. This approach helps to deliver the best outcomes for individuals and reflects a common desire for people to remain at homes for as long as possible. This also helps to ensure that care home

[7] PDD (Planned Date of Discharge) should be identified at the earliest possibly opportunity in a patent's hospital stay and should involve engaging with the patient, carer, and family to plan for when the person is likely to be discharged.

placements (especially those at national care home rate) remain available for people with the highest level of need, which is crucial to remain within budget.

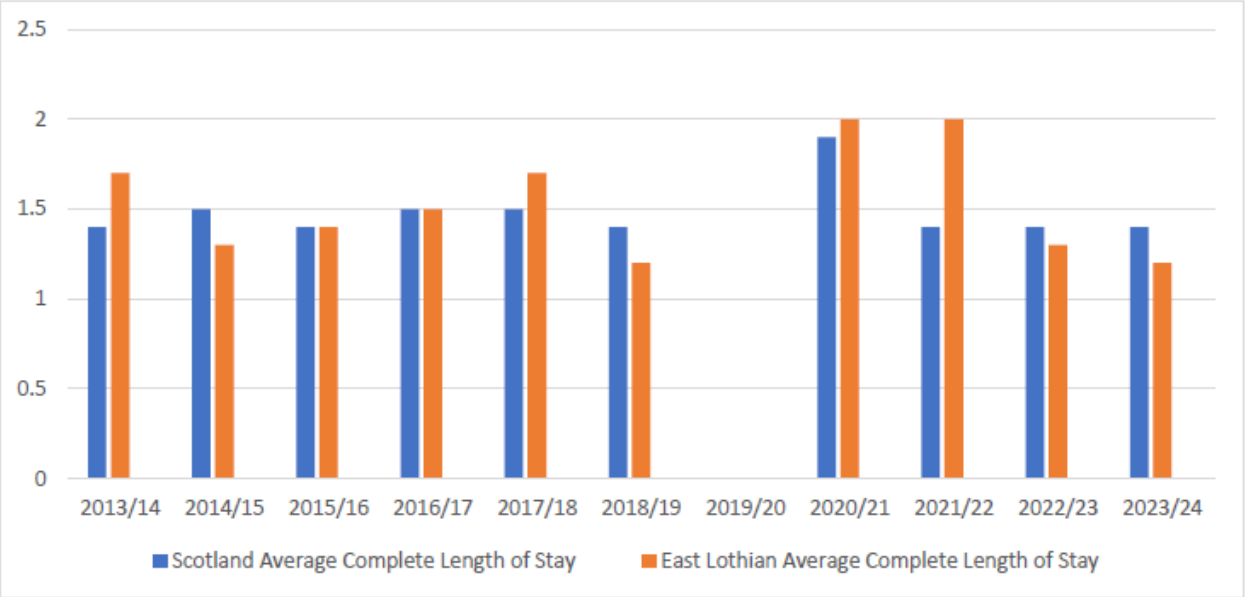
The Social Work Hospital Discharge Team grew in the last year with the addition of two posts (redeployed from a different team), increasing the team's capacity to plan complex discharge back home. This expanded Hospital Discharge Team, with strengthened supervisory management, brought enhanced skills and improved knowledge of community provisions, contributing to the team being able to support more people to return home.

Key elements supporting our responsive hospital discharge approach include:

- Maintaining strong links with the Patient Flow and Inreach teams as well as East Lothian Community Hospital (ELCH) ward staff, helping with early conversations.
- Early social work intervention through positive working relationships with ward staff, particularly in ELCH, e.g., attendance at key decision making meetings with families and at regular ward meetings. This also helps families consider alternatives to care home placements, where appropriate, at an earlier stage.
- Increased capacity to look at complex discharges home.
- Continued good working relationships with the care homes to help minimise care home vacancies – waiting lists maintained for each home and regular communication with managers.
- Links with adult social work team to prioritise care home admissions for those at risk of hospital admission from the community, balancing with the need to ensure patient flow out of the hospitals.
- Advice and guidance provided to hospital staff re social work processes, attending daily huddles and ensuring there is good communication between NHS / social work teams.
- Continuous focus on Home First and keeping assessments up to date as people progress through the hospital system with changing needs and circumstances.
- Participation in twice daily hospital huddles to ensure a joined-up approach with early intervention in hospital admissions.

The impact of work to support people to return to and remain in their own homes for as long as possible can be seen in the reduction in average length of time older people tend to live in care homes at the end of their lives.

Graph 3 - Average Length of Stay in Care Homes (Years)



As well as hospital discharge work, the team continued to work directly with individual care homes providing a social work service to residents. This included carrying out routine annual reviews, responding to incidents within care homes (for example, mediation to prevent placements breaking down or resolving financial disputes), and providing Adult Support and Protection for residents.

The Care Inspectorate inspects our care homes and care at home services to assess the quality of care. Inspection grades across East Lothian care homes improved over the course of 2024/25 with 8 out of 17 homes (47%) achieving grades of 5 or above in the 'Key Question – Wellbeing'. Additionally, East Lothian now has 5 homes on the National Care Home Contract receiving the enhanced quality award where services not only receive grades of 5 in Wellbeing but also achieve at least one other 5 in any other area inspected. At present no care homes are below a grade of 3 and there have been no Large Scale Investigations over the course of 2024/25.

Table 1 below shows grades reported for our internal care homes in 2024/25.

A new purpose-built care home was opened by Mansfield Care in Gateside Haddington, in March 2025 replacing the previous Hilton Lodge building in the town centre. This increased capacity from 22 beds to 60 beds and will provide care for both residential and nursing level clients.

The NHS Care Home Team have also continued to roll out their services, aiming to provide clinical care and educational support across all East Lothian Homes and are now working in both Lammermuir Nursing Home and the new Hilton Lodge at Gateside. Only one home remains to be covered by the team, and they are continuing to recruit to be able to further expand their services.

Table 1 - Care Inspectorate Grades:

6	Excellent	3	Adequate
5	Very Good	2	Weak
4	Good	1	Poor

Name of Establishment	Date of CI report	Wellbeing	Leadership	Staffing	Setting	Care & Support	Quality Award
Nursing Homes							
Astley House	03/09/2024	5	5	5	4	4	Yes
Drummohr	16/04/2025	4	4	4	4	4	
Fidra Nursing Home	17/03/2025	5	N/A	5	N/A	N/A	Yes
Haddington Care Home	28/11/2024	4	4	4	3	4	
Harbour House	22/05/2024	4	4	4	5	4	
Lammermuir House	24/04/2024	3	4	4	3	3	
Muirfield Nursing Home	17/09/2024	5	5	5	5	5	Yes
Tantallon House	18/04/2024	3	3	3	4	3	
Tranent Nursing Home	07/06/2024	4	4	4	4	3	
Tyneholm Stables	04/12/2024	4	4	4	4	4	
Hilton Lodge	16/01/2024	5	5	N/A	N/A	N/A	
Residential Homes							
Leuchie House	18/03/2025	6	N/A	5	N/A	N/A	
Carberry	14/01/2025	5	N/A	5	N/A	N/A	Yes
Florabank	04/05/2023	4	4	N/A	N/A	4	
St Anne's Care Home	13/12/2024	5	N/A	5	N/A	N/A	Yes
Linkfield	26/06/2024	4	N/A	4	N/A	N/A	
Crookston	22/01/2025	5	N/A	5	N/A	N/A	

Closure of Care Homes

The IJB made a decision in March 2024 to permanently close the Abbey Residential Home and Belhaven Nursing Home (manged by the HSCP). This was part of wider financial recovery programme and related to the age and condition of both buildings and the challenge this presented in terms of meeting care and safety standards for staff and residents.

Steering groups and project plans for both the Abbey and Blossom House care home closures were introduced at the start of the financial year and engagement and communication with staff, residents and families was key to planning and delivery.

The remaining care home residents had been successfully relocated to new placements by the end of summer 2024 and the sites were decommissioned and handed back to East Lothian Council (Abbey Care Home) and NHS Lothian (Blossom House).

Thirty-four residents were successfully moved onto alternative placements over the course of March to August 2024 and the sites were decommissioned and handed back to East Lothian Council (Abbey Care Home) and NHS Lothian (Blossom House).

Furniture and equipment from the homes was distributed among our private providers where possible. The HSCP received significant support from East Lothian Council Human Resource colleagues during the project with staff being given the opportunity to trial alternative placements in other departments and limiting the number of redundancies as a result.

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

We continue to develop and deliver innovative approaches to social care, working alongside communities and third sector partners and adopting a 'co-production' approach where possible. Some examples of activity during 2024/25 are included below.

Resource Coordinator Service

Our Resource Coordinator service continued to offer a valuable community based service for adults with a learning disability. The service aims to develop groups and opportunities linked to people's identified outcomes and assessments. In 2024/25, over 150 people accessed activities offered across the county based in a range of community buildings. Sessions included health and wellbeing, life skills and education.

Throughout the year, Resources Coordinators worked closely with community organisations to develop new opportunities. During 2024/25, this included working with Our Community Kitchen in Tranent and Haddington and opening up opportunities in relation to garden maintenance at Tynebank in Haddington.

People using the service were also supported to take part in a variety of college programmes at Edinburgh College's Milton Road Campus, with opportunities at Sighthill Campus also being explored. The achievements of participants was recognised with twenty-five people from East Lothian taking part in a graduation ceremony in June 2025.

Resource Coordinators also continue to link with community partners to gather information about what is available in communities and provide valuable signposting to individuals and professionals on local opportunities.

Neighbourhood Networks

Neighbourhood Networks support vulnerable adults many with learning disabilities, physical disabilities and mental health issues to live an active, healthy life, within their own homes and through their local communities. The aim of Neighbourhood Networks is for members to learn essential life skills; become more independent; benefit from peer support; and become less reliant on paid support.

Each Network has up to ten members who all live locally. At the moment there are five networks - Musselburgh, Musselburgh Transitions, Tranent, Dunbar/Haddington, and Dunbar/Haddington Transitions (the Transitions Networks support young people moving to adult services). At the end of

2024/25, Neighbourhood Networks were supporting 30 members, 4 associate members, and 4 independent members.

The service has carried out analysis of outcome achieved by member and identified significant progress across outcome areas – outcomes currently focused on include:

- Money Management
- Life Skills
- Digital Inclusion
- Health & Wellbeing
- Employment / Volunteering
- Community Participation
- Confidence & Self Esteem
- Independent Travel
- Friendships & Relationships

Feedback from members demonstrates the impact involvement can have:

> 'I want to say thank you, you have fair cheered me up. The group is great, and I feel like I'm getting back to my old self. I trusted staff very quickly and I find it hard to trust people. I'm feeling optimistic and I haven't felt that in a long time'.
>
> 'I have made great friends since joining Neighbourhood Networks. I feel that without NN my life would be totally different, and I would struggle with money and friendships. My confidence has grown greatly, and I am happy to take on new challenges'.

Due to funding reductions, Neighbour Networks have restructured their staff team and will make some changes to the delivery model, resulting in a slight reduction in the service's capacity going forward.

East Lothian Community First Service

Community First (delivered by VCEL with funding from East Lothian HSCP) provides support to people who are struggling with their health and wellbeing, helping them to access community services. It also provides support to people leaving hospital, as well as helping to prevent hospital admission / readmission.

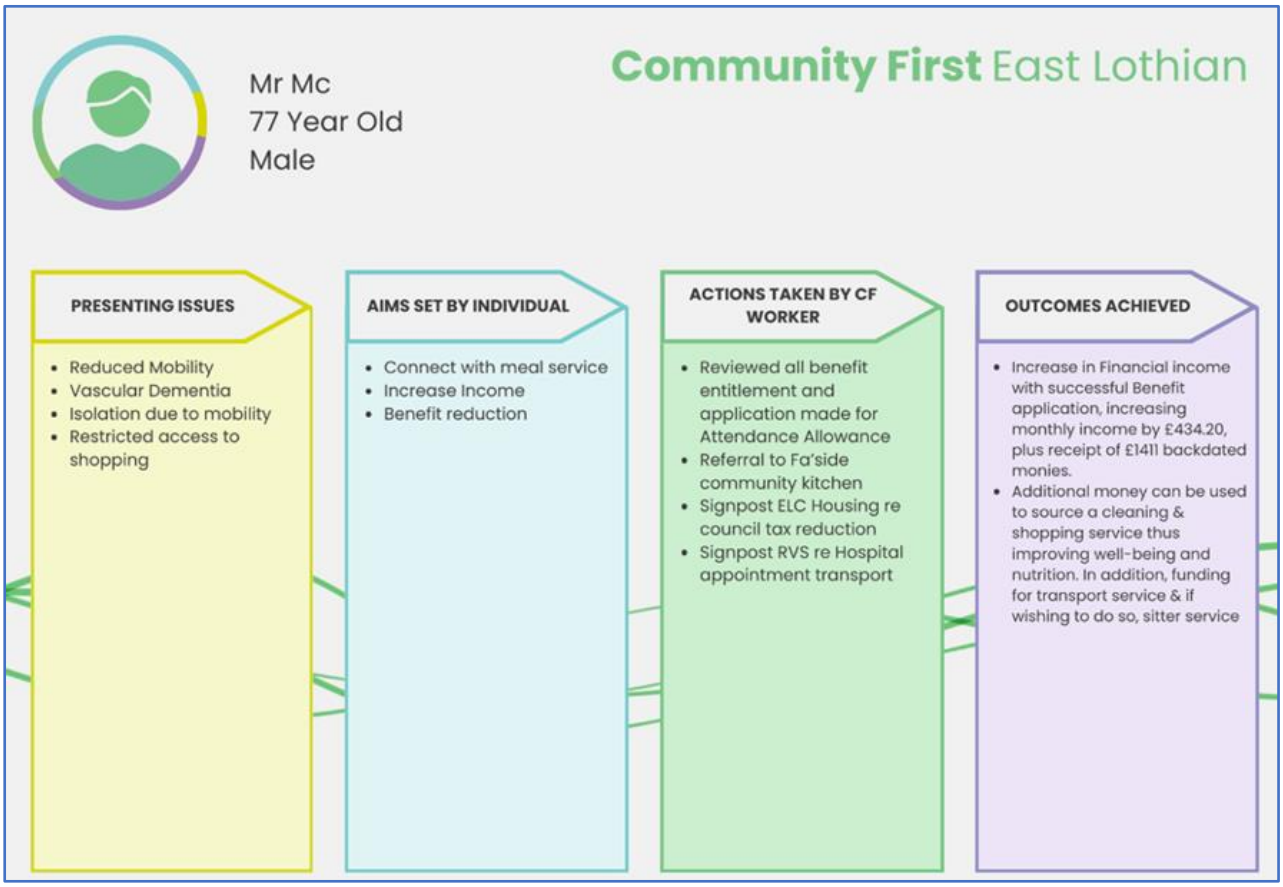
Community First is a trusted, relational, and proven early intervention model. It bridges the gap between communities and services, reduces crisis demand, and supports the vision of empowered, healthy, and resilient communities.

Community First aligns directly with the IJB Strategic Plan, and national frameworks such as the Health and Social Care Service Renewal, Population Health Framework, and the Prevention and Early Intervention agenda.

In response to feedback, the service lowered its age criteria from 35+ to 18+ during 2024/25. A total of 402 referrals were received across the year (up from 326 the previous year) and 355 individuals and 66 carers were supported by the service.

Through its activities, Community First contributed to preventing delayed discharges; avoiding carer breakdown; alleviating loneliness; and supporting independent living. The service has also helped people to navigate systems, make informed choices, and rebuild confidence. The service has a ripple effect, impacting positively not only individuals, but also on their families and communities.

Community First – Example of Impact



Musselburgh Meeting Centre – A Place To Be Me

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

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

DFEL continued to deliver the Musselburgh Meeting Centre over 2024/25 and have been exploring pathways to offering people support at an earlier stage. The introduction of a 3rd day has been offered to people referred but waiting for assessment and potential diagnosis. Research and lived experience suggest that supporting people living with dementia and care-partners helps them to adjust to the many changes dementia brings, improving quality of life and independence. The Meeting Centre if a flexible resource for care-partners and people living with dementia. Some care partners join sessions, others drop in for a cuppa or join events and celebrations. The Centre also hosts a carers-space facilitated by Open Arms Carers and a weekly friendship group for people who need less support but enjoy the many benefits of being with people in the same boat.

The development project also provides learning and experience to support Meeting Centres in other communities and exploring how we might deliver an integrated model of dementia meeting centre and day centre in Musselburgh.

Musselburgh Day Service for Older People

East Lothian IJB are due to make a decision on progressing with an integrated model of day centre and meeting centre for the Musselburgh, Wallyford and Whitecraig area. In October 2024, the IJB agreed to pause the development of a new Day Centre for Older People in this area due to the financial recovery programme. A further review and business case was presented to Strategic Planning Group in January 2025 and agreement was made to explore the development of an integrated model of Dementia Meeting Centre and Day Centre, noting that efficiencies from the integrated model will reduce the cost of the new service.

A key finding of the review was that there was a significant unintended consequence of the delay in Musselburgh Day Centre, affecting the delivery of the local Dementia Meeting Centre (for people with mild to moderate dementia). The Meeting Centre members needs are now too complex for them to manage, but there is no service pathway.

Key benefits of the integrated model would be - clearer pathway, better partnership working, better services for carers, community buy in, as well as financial efficiencies of moving to one provider through a reduction in management and other costs.

Participation and Engagement

During 2024/25, IJB supported the trialling of a new approach to community engagement focusing on:

- Building long-term, high-quality relationships with people in the community already well connected across the county in a variety of ways and through different organisations and forums.
- Foregrounding the voices of people with lived experience of a range of health and social care issues, services and interventions to better understand and show respect for these experiences.
- Taking a human-rights approach to enabling participation through meeting people's social, communication and access needs.

Good progress was made during the year, beginning with a series of sessions with a group of community members who had contributed greatly to the co-design of the Planning for Older Peoples Services project (see page 19 above). This included the group brainstorming ways to connect with people who have not engaged with health and social care planning previously to encourage them to participate in relation to topics that are important to them.

The approach continues to develop and will include the establishment of:

An Independent Community Panel (ICP) – a group of community members with lived experience of a range of health and social care issues (champions) who will use their community connections and skills to reach out to others with lived experience who do not feel ready to participate in this type of forums directly. ICP members will speak with IJB members / HSCP staff at senior level meetings and will participate in equality and fairness impact assessments; championing and communicating the concerns, suggestions and needs of the broader community.

A Lived Experience Network - A network of contacts that already work with the community in a direct capacity that can help the IJB / HSCP connect with lesser heard voices and with those experiencing barriers to accessing the things they need to thrive. The aim will be to meet community members in settings that they already visit or feel comfortable in order to learn about their lives. This will assist in providing a deeper sense of participants needs and priorities to inform the planning, commissioning, and codesign of health and social care services.

Strategic Objective 3 – Focus on prevention & early intervention

East Lothian Rehabilitation Service (ELRS)

East Lothian Rehabilitation Service (ELRS) delivers a wide range of services in East Lothian. More information on these services and their performance during 2024/25 can be found in the ELRS Annual Report (available on the East Lothian IJB web pages). The information below provides a summary of activity related to delivery priorities detailed under Strategic Objective 3 in the HSCP's Annual Delivery Plan. ELRS services also contribute the IJB's other Strategic Objectives, with reference to other ELRS activities throughout this report.

Technology Enabled Care

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

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

During 2024/25:

- There was a continued growth in referrals to the Telecare team and ongoing pressure on workload due to its role in supporting the analogue to digital transition.
- The number of people using the Telecare service increased slightly from 2,536 at the start of the year to 2,598 at the end.

Consumer technology[8] is transforming healthcare by supporting people to manage their health and live independently, aligning with Scotland's Digital Health and Care Strategy. To realise this potential, ELRS Consumer Technology Pathway aims to help people live independently, safely and stay connected through the use of accessible digital tools and everyday technology through upskilling staff and engaging public.

Since 2018, ELRS has built a consumer technology hub, initially led by a Specialist Occupational Therapist and later expanded to include a Specialist Physiotherapist and a team of digital champions. The service evolved from a specialist role into a multi-professional model, ensuring consumer technology is integrated across all assessments and care pathways.

[8] Consumer technology refers to digital tools and devices that people can use directly to manage, monitor or improve their health and wellbeing.

Key activities during 2024/25 included:

- Staff training and development in relation to technology enabled care and available solutions – delivered to ELRS staff and other colleagues across the HSCP. Over 100 staff took part in training during 2024/25.

- Public education and engagement – including drop-in clinics at the WellWynd Hub and pop-up events across East Lothian to raise awareness and promote self-management. 49 members of the public attended these over the year.

- One-to-one technology assessments – individual assessments provided at WellWynd or in people's homes – focused on complex needs and provide tailored recommendations. 91 interventions were completed in 2024/25.

Ongoing work will focus on expanding training across the HSCP; increasing public and professional engagement; growing the digital champion network; collaborating with universities and technology providers; and supporting ongoing development through Continuing Professional Development and leadership programmes.

Digital Platform – Access to a Better Life in East Lothian

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

In April 2024, ELRS transitioned the content of 'Access to a Better Life in East Lothian' (ABLE) to the East Lothian Council website (it had previously been hosted by ADL SmartCare). This decision followed a comprehensive evaluation of the platform's effectiveness, which identified low user engagement alongside increasing subscription costs. To ensure the sustainability of digital support for residents, ELRS redeveloped the platform's key features within a more streamlined and cost-effective framework.

Drawing on user feedback and lessons learned from the original platform, particular attention was paid to reducing the number of steps required to access core information— making the digital journey easier and more accessible for users with varying levels of digital confidence. The popular Smart Home resource, previously an interactive element within ABLE, was reimagined into a simplified model.

Ongoing user feedback is being sought through the existing patient engagement survey which is now hosted on the new ELRS website. This allows for continuous improvement with clinical services and for positive feedback to be fed back to the staff groups.

Analysis of use of the site during 2024/25 showed:

- 17,659 people had used the site, and there had been 21,339 views.
- Activity increased throughout the year with an average of 1,462 users visiting the site per month.

You can visit the digital platform here.

Falls Prevention & Management

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

The Falls Service's work covers three main strands:

- **1:1 input** – provided to patients that require 1:1 support due to a history of falls or having been identified as being at risk of falls or of having a fear of falling – patients are referred to the service by health professionals. 274 people were referred for 1:1 support during 2024/25.

- **'Steady On' falls prevention classes** – 14-week low level strength and balance classes delivered to groups in community settings. 97 people were referred to classes during 2024/25.

- **MOSIAC alerts** – responding to fall alerts from the Emergency Care Service (ECS) following a fall at home that required ECS support. Falls team carry out a home visit or telephone intervention. A total of 2,191 referrals were received this way during 2024/25.

Priorities for the 2025/26 financial year will be to continue the shift towards a preventative approach, with increased and sustained provision of Falls Prevention classes, as well further strengthening of collaboration with primary care services. Development of a vestibular service will also continue, with the view to establishing a referral pathway within East Lothian.

Mental Health & Wellbeing – Prevention & Early Intervention

Many people will experience issues with their mental health at some stage in their lives. For some, these issues will be more complex and require a higher level of treatment and support from mental health services. For others, issues may be less complex, and will benefit from early, lower-level interventions to support individuals to cope and to improve their own mental wellbeing. This section describes developments that took place during 2024/25 in relation to services providing a preventative / early intervention approach (wider mental health provision is covered in other parts of the report).

CWIC Mental Health

The CWIC (Care When it Counts) Mental Health service aims to promote a holistic, person-centred, and trauma-informed model of supported self-management to promote mental health and wellbeing and is staffed by a multi-disciplinary team of Mental Health Nurses and Mental Health Occupational Therapists. The team provides mental health assessment and offers brief intervention as required, for example, in relation mood and anxiety management. The services is closely linked in with GP Practices and Community Mental Health Services to ensure joined up pathways of care.

In preparation for the launch of the Mental Health Single Point of Contact in March 2025, the service embarked on an appointment resetting plan with a target of new appointments offered within 5 working days. This target was achieved in time for the launch date and continues to be the case.

The CWIC Mental Health service is important in the delivery of the new Mental Health Single Point of Contact (SPOC) (see page 39 below) in terms of its key objective of providing quick access. Prior to introduction of the SPOC, the team embarked on an appointment resetting plan and has been successful in offering new appointments within a 5-day target since the SPOC was launched.

Feedback from people accessing the service more recently has been very positive regarding the ease of accessibility and timely response.

Distress Brief Intervention (DBI)

Progress continued during 2024/25 with embedding the Distress Brief Intervention (DBI) service in East Lothian, offering accessible support to people in distress. People referred to the DBI service are seen quickly and provided with compassionate, problem-solving support, wellness, and distress management planning, supported connections and signposting. The aim is to reduce immediate distress for people and to empower them to develop the ability to manage future distress. The service is funded by East Lothian IJB and delivered by Penumbra.

People can be referred to the East Lothian DBI service by our IHTT (Intensive Home Treatment Team) and CWIC MH services, as well as newly established pathways through MHAS (the mental health out of hours service), Police Scotland, and the Scottish Ambulance Service.

To date, over 800 referrals have been made to the East Lothian DBI service, with an average of 50 referrals a month. Predominant presenting problems have been stress and anxiety; depression and low mood; and suicidal ideation. The most common contributory factors have included relationships; past adverse / traumatic life experiences; and life coping skills. Support is delivered by trained Mental Health and Wellbeing Practitioners during pre-scheduled appointments (either over the phone, by videocall or face-to-face at Penumbra's Musselburgh office) and lasts for a period of between 14 and 21 consecutive days.

Mental Health and Wellbeing Information

A Mental Health and Wellbeing Information Hub development working group has been established in collaboration with Public Health and involves a wide range of partners including mental health services, transport, connected communities, libraries and the third sector. The working group has been mapping current hub activity and planning to ensure all that all 6 locality areas have regular information hubs to enable communities to access the information they need. A whole person / whole family lens is being taken, as well as an early intervention and prevention approach to mental health and wellbeing.

EASTSPACE Digital Platform, run by Health in Mind, continues to provide information based on the 6 locality areas and organised by themes (for example, money advice, housing, mental health and wellbeing). We are looking to further develop this to include live capacity, wait times and to give us information about what information people are accessing the most.

A Mental Health Partners Group has been developed partnership with VCEL. This provides a forum for groups and organisations with both direct and indirect involvement in supporting mental health and wellbeing, with the purpose of increasing awareness of services and support avoidable and building collaborative working. The Partners Group now has around 100 partners signed up including NHS Lothian, East Lothian Council, Police Scotland, the Scottish Fire and Rescue Service, along with a wider range of third sector organisations. Members meet via TEAMS every 2 months to share information and discuss topics of shared interest (partners can book slots to share information / pose topics).

Looking ahead, the Mental Health Partners Group is planning a suicide prevention networking event in June 2025. This event will look at current provision as well as identifying what needs to be developed in relation to suicide prevention in East Lothian going forward.

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

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

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

HSCP primary care services continue to develop to improve patient experience and make efficient use of the funding and resources available. The following provides a description of development activity during 2024/25. You can find out more information about primary care services here.

Care When It Counts (CWIC)

The Care When it Counts (CWIC) service supports GP practices by offering same-day appointments with a team of clinical professionals.

With a growing population and increasing demand for healthcare in East Lothian, improving patient access to services is a key priority. A new model, CWIC Direct, offering direct telephone access to the CWIC service, was initially piloted at Inveresk Medical Practice (IMP), and expanded in December 2024 to include Harbours Medical Practice (HMP), Tranent Medical Practice (TMP), and Riverside Medical Practice (RMP). Early data from the 12-week pilot suggest this model can improve access, reduce strain on GP practices, and enhance patient experience.

Over the 56-day pilot period a total number of 6,161 calls were received and 70% of these were answered in less than 5 minutes (44% answered in less than 1 minute). This resulted in 7,631 appointments with 87% being carried out face to face and 13% by photo submissions or over the telephone. 26% of patients who called were signposted to other services (e.g. MSK, Mental Health, Pharmacy First, etc).

Practices raised concerns that patients in higher deprivation areas might face barriers travelling to Musselburgh. However, demographic data showed similar usage rates across deprivation quintiles, matching practice population profiles. This suggests CWIC Direct is accessible across socioeconomic group.

The overall sentiment of patient feedback was Positive (78%) with neutral/mixed (14%), and the main themes identified as speed of contact, staff care, and reliability driving strong endorsement.

CWIC Direct Pilot - Patient Feedback:

- Would you use CWIC Direct again instead of contacting your GP first? - 70% of respondents said 'yes', 27% were unsure, and only 3% said 'no'.
- Was it convenient to travel to Musselburgh? - 95% said they found it convenient.
- Do you want service to continue? - 84% said 'yes'.
- Likelihood to recommend the service or use again? - 93% said 'likely' or 'fairly likely'.

The CWIC Direct pilot showed promising results. The service managed a significant call volume, with the majority of patients receiving timely responses and face-to-face appointments. Patient satisfaction was high, with strong support for the model to continue.

The pilot suggested that CWIC Direct could be a sustainable and scalable model to improve patient access across East Lothian and may be used as a case study for wider implementation across NHS regions.

The CWIC multidisciplinary team has a strong improvement culture and a clear focus on providing high quality care. Their approach was recognised nationally with the team shortlisted for the final of Team of the Year in the National GP awards and a poster was also presented at the NHS Scotland event showcasing the pilot and improvement to patient access to the service.

Community Treatment and Care Service (CTACS)

The Community Treatment and Care Service (CTACS) is a nurse-led service delivering clinics across East Lothian. CTAC provides a range of services to patients of all ages in a treatment room setting.

During 2024/25, CTACS service improvements included the clinical development of its Band 6 nurses, supporting them to expand their roles by undertaking prescribing qualifications. This initiative will play a vital part in the ongoing development of CTACS by enabling the staff team to better respond to the needs of patients in a timely and effective manner. Whilst this is still in the early stages, progress so far has been encouraging, with the first Band 6 successfully completing their training during 2024/25.

Prescribing training and support is part of a broader service development strategy across our Primary Care Improvement Plan (PCIP) services. As a key component of our care model, we are empowering our PCIP services to take on more clinical responsibility and play a greater role in decision-making. This has clear benefits for our staff in terms of their professional development and support but also

reduces the need for patients to see their GP and means that patients receive treatment quicker, leading to better patient outcomes.

Pharmacotherapy Team

One of the key activities for the HSCP's Pharmacotherapy Team is the carrying out of polypharmacy reviews. These are in-depth reviews of complex medicines regimes which aim to improve safety and effectiveness of medicines, often in patients who live with multiple health conditions. The Planning for Older People's Services (POPS) engagement identified polypharmacy reviews as a priority in relation to services for older people going forward (see page 19 above).

Of our eleven pharmacists who work regularly in GP practices, seven are trained to deliver polypharmacy reviews. The main focus so far has been working collaboratively with the Care Home Team to carry out polypharmacy reviews for Care Home patients, however, a smaller number of reviews have been carried out for other patients. Each GP practice has a session each week which is set aside for the pharmacist conducting polypharmacy reviews, they can access advice from a Medicine of the Elderly consultant fortnightly and have robust peer review to discuss challenging cases.

Having gained experience of carrying out reviews for Care Home patients, the team is now looking to further expand with other patient groups, including:

- Patients attending Day Centres.
- Patients supported by Care at Home services.
- Patients with compliance aids.

There are significant challenges to the delivery of polypharmacy reviews related to:

- Increases in GP practice workload are being absorbed by the team leaving less time for polypharmacy reviews.
- The pool of pharmacists available is small.
- Limited availability of the senior pharmacist to train remaining team members.
- Securing a suitable clinical space to review patients.
- Competing demand with other work such as prescribing efficiencies.

However, options are being considered to improve staff availability to undertake further reviews.

Right Care, Right Place

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

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

During 2024-25 we continued to deliver a Primary Care Communication Plan aimed at raising awareness of the range of services available, providing information on how to access them, and encouraging people to contact these services directly rather than going to their GP first. This included further development of the Primary Care Health Services web content that had been launched the previous year.

East Lothian Community Hospital Outpatient and Day Services

East Lothian Community Hospital (ELCH) provides local inpatient care, as well as an ever-growing number of outpatient services and clinics, reflecting our Strategic Objective to provide care closer to home where possible.

The number of outpatients seen in OPD1 ELCH has grown from around 30,000 in the last years of Roodlands Hospital[9] to just over 57,000 appointments offered in 2024/25, with the DNA (Did Not Attend) rate sitting at 6.2%. This figure does not include the number of appointments accommodated at ELCH whilst the Princess Alexandra Eye Pavillion (PAEP), including the Dental Rooms was being refurbished where we offered 62 sessions per week to the Ophthalmology Service.

A further 5,093 patients attended the Endoscopy and Minor Procedure Unit (an increase from 4,637 the previous year), with a DNA rate of 6.6% down from the previous year's figure of 9.1%.

Across all out-patient services delivered at ELCH (Mental Health, CTAC, Vaccinations, Dentistry, Podiatry, etc.) the total number of attendances was 114,021 with a DNA rate of 6.0%, down from 6.6% the previous year.

Key developments for ELCH outpatient and day services during the year included:

- Escalating the number of nurse-led minor operations clinics at ELCH with 356 appointments attended in 2024/25, a slight increase from the previous year.

[9] The transfer of Roodlands Outpatient Department to the new East Lothian Community Hospital began in March 2018, with all other services moving to ELCH by the end of 2019.

- New clinics in OPD1 (Out Patient Department 1) - including an expansion of the Travel Immunisation Clinic from two to three days per week, a combined nurse led and consultant Parkinson's Clinic, a Multiple Sclerosis Clinic and Trauma Orthopaedic Clinic, incorporating a Physiotherapy Clinic.

- The continued expansion of both Dermatology and Ear Nose and Throat (ENT) Clinics.

- Training of a member of staff in OPD to deliver optical coherence tomography in the department. This has allowed delivery of an ophthalmology clinic at ELCH previously held in the Princess Alexandra Eye Pavillion.

- Increasing the capacity and use of the Endoscopy and Day Services Unit at ELCH. Developments this year included the hosting of Plastic Surgery lists previously only available in St John's Hospital. This helped to reduce waiting times and reduced travel for East Lothian residents.

- The provision of both gynaecological and urological diagnostic procedures, including trans perineal prostate biopsies which are now nurse led - a first in NHS Scotland.

- Training of staff in Endoscopy in the management of Central Vascular Access Devices (CVAD), as well as midlines, this has allowed the unit to deliver out-patient antibiotic therapy 5 days per week to local residents who previously would have to travel to the Western General Hospital. The management of CVADs as allowed us to work in association with the Edinburgh Cancer Centre to offer line management to oncology / haematology patients to provide care closer to home and reduce journeys into Edinburgh.

- Offering training courses at ELCH in both endoscopy and colonoscopy as well as endoscopic ultrasound procedures to trainees from across the UK. These courses are income generating for NHS Lothian and have helped to raise the profile of the hospital.

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

- Continuing to work with the Haematology Unit at the Edinburgh Cancer Centre to provide Intravenous (IV) therapy at ELCH as an alternative to travelling to the Western General. Endoscopy staff have trained to manage the haemochromatosis service and no longer require a nurse to travel from the WGH.

- Expanding the service to include older East Lothian residents who require treatment for anaemia via either blood transfusion or intravenous iron therapy.

Re-imagining Adult Social Work

We continued to develop and improve our Adult Social Work services during 2024/25, with services continuing to play a critical role in enabling people to live safely and independently, while responding to an increasingly complex landscape of demographic pressures, system demand, and workforce challenges.

At the heart of transformation is the way social work connects with people—not only as recipients of support, but as experts in their own lives. We continue to shift from a gatekeeping function to a partnership model with those we support, where social workers build strong, compassionate, and empowering relationships that enable people to have real choice and control and develop resilience.

Key developments during 2024/25

- Introduction of a unified assessment and care management pathway, reducing duplication and enabling smoother transitions between teams and services.
- Growth in Self-Directed Support (SDS) uptake, supported by learning and information sessions, targeted reviews, and strengthened SDS processes.
- Improved practice quality, through reflective supervision, peer audits, self-evaluation and shared learning events anchored in strengths-based, trauma-informed, and outcomes-driven approaches.
- Clearer performance oversight, including audit cycles on timeliness, recording quality, care planning standards, and compliance with statutory duties.

A major strand of transformation has been the implementation of a new operational screening procedure aligned to Home First principles and prevention of hospital admissions (see page 21 above). This procedure strengthens our ability to provide timely, proportionate responses at the point of referral, with a focus on early intervention, rapid stabilisation, and community-based alternatives to hospitalisation.

Screening is now delivered through our front-door/duty system, using a structured triage process and decision-making framework. Key features include:

- Screening decisions within 4 hours of referral, prioritising individuals at risk of deterioration, carer breakdown, or imminent admission.
- Clear escalation pathways into Home First and rapid access to re-ablement or community alternatives.
- Real-time recording using structured note templates to track interventions aimed at early support and admission avoidance.

Adult Social Work - Case Study

Sadie, an 84-year-old woman living alone in Dunbar[10], was referred to Adult Social Work Services through the Single Point of Access (SPOA) after her GP raised concerns about repeated falls, social isolation, and carer strain affecting her daughter, Anne. Although Sadie was not medically unwell, there was a high risk of unnecessary hospital admission due to her growing dependency, loneliness, and unsafe mobility within her home.

Intervention Pathway

1. Timely Screening and Early Decision-Making

Within 2 hours of referral, the duty social worker completed triage using the new Home First-aligned screening template. Sadie was prioritised for a same-day joint visit with the Community Frailty Nurse and Community Care Worker.

2. Integrated Assessment and Rapid Response

The strengths-based assessment identified Sadie's desire to remain at home, her fear of being a burden, and a recent deterioration in mobility due to lack of confidence following a fall. The assessment was co-produced with Sadie and her daughter, leading to an emergency OT referral and a Care Plan developed within 24 hours.

3. Use of Flexible Self Directed Support Option 2

Sadie was supported to access a blended care-at-home package using Self-Directed Support Option 2, enabling Anne to choose a local provider with whom Sadie felt comfortable. This offered continuity and enhanced trust. Digital sensors and a community alarm were installed through the TEC (Technology Enabled Care) team within 48 hours.

4. Community Connectors and Loneliness Reduction

A "social prescription" was arranged via a Community Link Worker, reconnecting Sadie with a local walking group and church lunch club. Transport was coordinated through our third-sector partners.

Outcomes Achieved

- No hospital admission occurred, despite two flagged risk indicators.
- A follow-up review at 6-weeks showed improved wellbeing, a reduction in falls, and stronger engagement with community networks.
- Sadie's daughter reported reduced carer stress and a more sustainable balance between caregiving and her employment.
- The Care Plan and Review were fully completed within the 28-day performance target.

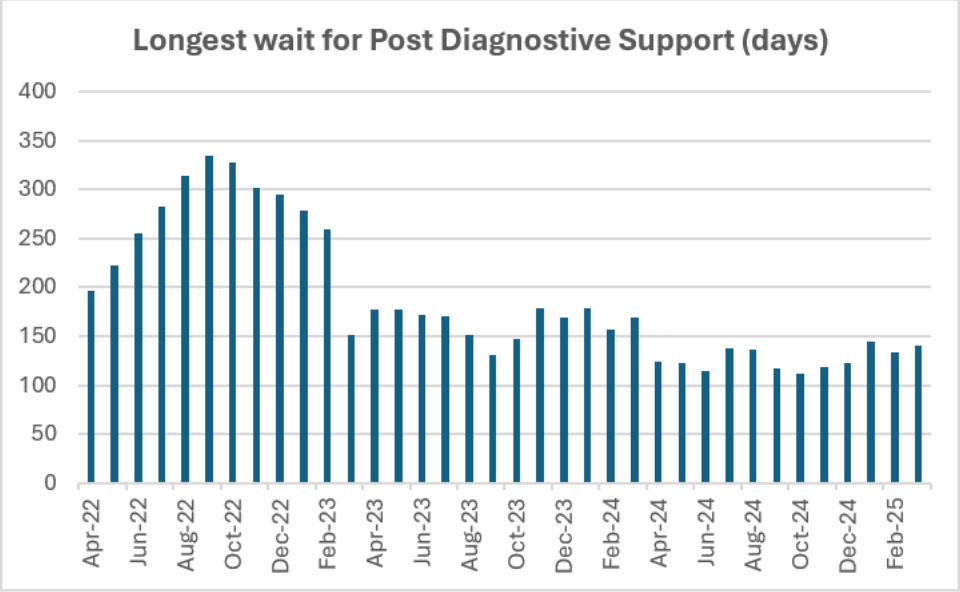
[10] Case studies are intended to illustrate how are services work in practice and are not related to real patients or service users.

Dementia

Post Diagnostic Support

Post Diagnostic Support is provided on behalf of ELHSCP by Alzheimer Scotland. This is offered for one year following a diagnosis dementia and uses their 5 Pillar Model. During PDS, people are offered advice and support to help them understand their condition and to signpost them to services they may find helpful. PDS can also assist with the development of a person-centred plan, as well as providing support for carers.

Alzheimer Scotland's 3.5 full time equivalent link workers continue to overperform against their contract terms and by December 2024 were providing a high of 197 people with PDS. The waiting list for the service as of March 2025 is currently at 60 people with the longest waiting time in 2024 at a period of 4.4 months.



Alzheimer Scotland have also introduced new Post Diagnostic Support groups for those on the waiting list to help increase uptake of PDS support. The groups ran for the first time in 2024 with the first session being held in Musselburgh. 29 people with dementia attended as well as 30 carers. The groups are designed to follow the 5-pillar model to demonstrate what is offered during the one-year formal support, and to introduce people to their link workers. To date 100% of people who attended the groups went on to sign up for formal PDS support. The groups also help to promote informal peer support among attendees.

Dementia Strategy

There has been progress in several key areas within the East Lothian Dementia Strategy and is shared with the ELHSCP Dementia Special Interest Group.

- Work is ongoing to finalise an improved dementia information resource which combines key contacts of local and national services to provide a guide to help people who are diagnosed with dementia and their carers. The resource will be tested with people with lived experience via the Musselburgh Meeting Centre and the Alzheimer Scotland Dementia Cafés before this is developed into an online version.

- Alzheimer Scotland has increased the number of dementia cafés in East Lothian to include an additional monthly café in Prestonpans.

- Day centres are continuing to develop outreach services to support carers of older people living in the community, including those with dementia.

- ELHSCP took part in the Re-think Dementia Campaign run by the Scottish Government and developed in Partnership with the National Dementia Lived Experience Panel. The campaign aimed to reduce stigma associated with dementia and encourage people to get a diagnosis. The government is currently evaluating the impact of the campaign.

- Ward 2 and 4 in East Lothian Community Hospital were accepted onto the Health Improvement Scotland Stress and Distress Improvement Programme with the wards working with HIS to develop an area for meaningful activity to reduce stress and distress in hospital wards. Learning from the programme will be rolled out to wider wards. A local East Lothian care home, Tyneholm Stables was also chosen to participate in the programme.

- Alzheimer Scotland have been working with ELHSCP and local GP practices around increasing access to future care plans for people with dementia. All those who receive Post Diagnostic Support will now be offered the chance to have key information from their plan logged on their GP records to provide emergency services and other professionals with this information in the event of a hospital admission. The aim is that a better understanding of the person's circumstances will help reduce stress and distress on admission.

- ELHSCP has held exploratory meetings with STAND in Fife (roving Meeting Centre model) and Alzheimer Scotland Community Connections model to understand good practice in other areas as part of the work to develop increased community activities for people with dementia in East Lothian.

Supporting Carers

East Lothians second local Carers Strategy was published in June 2023 and will help to guide activity in this area over the next three years. Highlights from the second year of implementation are summarised below, under each of the strategy outcomes. Full details of we said, we did update to the carers strategy action plane will be published here: carers strategy downloads

Outcome 1 - Carers are identified and can access support.

Both our adult and young carers services continue to identify new carers every year, Carers of East Lothian (CoEL) provide active support to over 1,500 carers every year (between 500 and 600 of these are new to CoEL each year). Our Young Carers Service continue to help young people identify as carers; new registrations have reached 270 in 2024/25 with over 700 young carers now registered with the service.

This year our Young Carers service introduced an ID card for young carers, ensuring they are recognised and valued as young carers as well as giving them access to local offers and discounts.

In 2024/25 we supported the pilot of a hospital based carer support worker to identify more carers of people in East Lothian Community Hospital and ensure they are meaningfully included in hospital discharge planning. This role has been highly valued by carers and staff, creating an independent party who can advocate for carers rights and facilitate communication between carers and hospital staff giving better outcomes for everyone. Funding has been agreed to continue this over the next two years.

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

An open tender was issues in January 2025 for providers to bid for the contract to provide adult carer support services across East Lothian for up to six years. Carers of East Lothian (CoEL) were again successful in securing this contract providing sustainability for carer advice, information and support services and providing the “one stop shop” carers have asked for.

We have worked to ensure information is available to carers at the time they need it and in a format they can access it, we continue to develop different ways of sharing information including; production of a carers rights video for carers rights day in November 2024, in person carer education sessions through Alzheimer’s Scotland Dementia cafes and education and wellbeing sessions for carers such as positive parenting and empowerment workshops.

Welfare rights advice is available to all carers, in the last 6 months 289 carers received welfare rights advice and a further 202 accessed CoEL’s benefits enquiry helpline. East Lothian Councils financial inclusion team can offer support where there are issues around access to benefits.

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

The revised Adult Carer Support Plan (ACSP) has been in use for over a year and with its introduction we have worked to ensure this is the basis for a good conversation focused on what matters most to the carer and what kind of support will make a difference to them.

Carers have access to a wide range of opportunities for peer support with groups in local areas and with specific focus, new groups in this year include; Men who care, Venturing Outs outdoor adventure group and MILANs carer support group for people from South East Asian Communities.

Carers have access to counselling through the carers centre and many wellbeing activities. They can access funding to support wellbeing through Time for Me or individual carer grants from the HSCP.

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

Access to breaks remains a priority with feedback from local carers and national reports highlighting that too few carers have access to the breaks they need to maintain their own health and wellbeing and achieve a balance between caring and other things that are important to them.

In 2024/'25 funding available for breaks through Carers of East Lothians (CoEL) Time for Me funding contribution was increased to £50,000 reflecting the need for this early and preventative support. CoEL launched as a Respitality partner in 2024 and even with being a small Local Authority area and starting in June East Lothian had the 4th highest number of Respitality breaks taken.

Carers Act funding continues to be invested in local organisations best placed to support breaks from caring, such as Day centres for older people, Leuchie's at Home service and through Volunteer Centre East Lothians Community First project.

East Lothian Councils Young Carers Service continue to extend and diversify the breaks available to young people with caring responsibilities adding; Fostering compassion, Karele equine therapy, Dukes art school and Yarrow cookery school.

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

The review of East Lothians Carers eligibility criteria highlighted the importance of being able to achieve a balance as a key outcome in supporting carers linking closely with access to breaks.

The focus in this year has been on carer awareness in employers, making more businesses carer aware and offering support to carers, promoting the Carer Positive awards and carers rights/ needs with our local employability supports. We have also been working with schools to increase understanding of competing demands on Young Carers time and supported Young Carers Action Day theme of "Give me a break". We celebrated Knox academy being recognised with the first We Care Awards in East Lothian

Outcome 6 – Carers and young carers are respected as Equal Partners, involved in planning and delivering care and support for those they care for, and their voices are heard and supported.

CoEL continue to deliver Think Carer training aimed at professionals supporting carers and are designing a bite size input suitable for team meetings to act as an introduction to the topic, we also promote NHS Education for Scotland Equal Partners in Care modules.

Local carers voices have been promoted through communication campaigns sharing carers stories and for example in our carers rights campaign video.

Carers voices are heard and represented through different networks such as the Carers programme board, the Mental Health Partners Group and the Children and Young Peoples forum and carers feedback has been meaningfully included in the HSCP impact assessment process.

Engagement with CoEL's carers panel and the Young Carers forum is ongoing to ensure carers voices are heard and central to planning locally.

Carers are included in planning for new models of support, for example in the Meeting Centre development project.

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

The HSCP have a communications plan and take opportunities to promote carer awareness through campaigning and information sharing.

The Carers Change Board continued to oversee developments around carer support and has an advisory role in agreeing use of the Carers Act budget allocation from Scottish Government. A number of local organisations and groups were funded in 2024/25 to expand local carer support in their communities including Dunbar Dementia Carers, MILAN, Thrive, Circle and Venturing Out.

Carers budget information.

The IJB receives funding, via East Lothian Council, from Scottish Government to support the implementation of the Carers Act. We routinely update the Change Board during the financial year on the funding, expenditure incurred to date and projected expenditure.

Funding increased over a 5 year period following the implementation of the Carers Act (Scotland) 2016 reaching £1.549 million in 2023/24.

Funding for 2024/25 remains the same with ELHSCP receiving £1.549 million with no expectation of any further increases.

Palliative and End-of-Life Care

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

During 2024/25:

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

- District Nursing and East Lothian Palliative Care Team worked together to support end of life care in people's homes where this was their wish.

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

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

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

- Two of our care homes are participating in the Marie Curie Project 'Achieving a Good Death in Care Homes' research into practice. Our Quality Improvement and Care Home Support Team are helping with this.

The Planning Older People's Services engagement programme and hurdle criteria exercise (see page 19 above) identified palliative and end of life care an area for further consideration during the next stage of the programme. It has been agreed to carry out a review and mapping of current provision to identify any gaps and / or opportunities for service development.

Strategic Objective 5 – Develop and embed integrated approaches and services

Integration and Multi-Disciplinary Working

We continued to develop integrated approaches to service delivery during 2024/25, with colleagues from across teams and disciplines working together to deliver more effective planning, assessment, and care.

There are examples of integrated, multi-disciplinary approaches throughout this Annual Report, reflecting the considerable progress made to date in relation to the integration of health and social care services in East Lothian.

Pathways

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

Review of access to Mental Health Services

Last year we reported on progress with the review of access to mental health services and described activity aimed at improving access and patient pathways. Progress continued during 2024/25, culminating in the launch of a new Mental Health Single Point of Contact (SPOC) in March 2025.

The introduction of the new East Lothian Mental Health SPOC reflects the following Scottish Government priorities of:

- Improving access to treatment;
- Prevention (preventing illness and proactively meeting needs);
- Achieving the highest attainable standard of physical / mental health;
- Getting it Right for Everyone;
- Strong redirection policies at the 'front door' (the first point of access).

The approach also helps with the management of workload and provide safer and quicker transitions to care, based on a model that is recovery and treatment focused.

The design of the SPOC pathway is based on the work of Kate Malcomess and the evidence based Care Aims approach – this embraces the following principles:

- A population-based approach that manages demand by managing the referral boundary and supporting public / workforce responsibility.

- An outcomes-centred approach, focusing on the reasons for intervention before the type or amount of input delivered.
- Provision of services that are high quality, value for money, and efficient, and which empower people and equip them to lead the process of achieving their personal outcomes.
- Promotion of self-help and personal responsibility.

The East Lothian SPOC model:

- Provides a clear approach to triage / referral decisions, helping to achieve the best possible outcomes for people asking for help from mental health services.
- Supports a strengths-based, outcomes focussed approach to assessment.
- Increases collaboration across the referral boundary and improves interagency, inter-disciplinary and transition relationships.
- Enables same day assessment, allowing a number of requests to be met at the point of referral through self-management approaches.
- Takes a Whole System approach to patient flow beyond 'bed-management' and 'risk assessment'.
- Efficiently manages patient flow and ensures patients receive the most appropriate level of care from the outset, reducing unnecessary escalation and hospital admission.

Early feedback from those contacting the SPOC has been positive, with people suggesting they were grateful to be listened to and for being able to get advice at their first point of request for help.

ADHD and ASD Assessment Pathways

The ADHD[11] pathway doubled its capacity for assessments during 2024/25 by assigning a full-time nurse in addition to the already established part time nurse assessors. It is anticipated that this additional capacity will result in an estimated 200 assessments being completed in the coming year. However, the current waiting list sits at around 1,200 patients, with 449 further patients added over the year. The pathway remains consultant led, with ongoing training to build a nurse led model over time. This service is continuously being reviewed through the Local and Pan Lothian working groups.

ASD[12] commissioned assessments were paused in 2023/24 due to a governance issue with assessment outcomes unable to be recorded in TRAK. As a result, the waiting list has grown to approximately 552 patients.

[11] Attention Deficit Hyperactivity Disorder.
[12] Autism Spectrum Disorder.

Older Adult Mental Health Services

Older Adult Mental Health Services continued to develop and deliver effective, streamlined mental health support for older adults. During 2024/25, activities included:

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

- Social Work attendance at Multi-Disciplinary Team meetings on a weekly basis, either in person or via Teams to improve the communication across the partnership.

- A weekly huddle involving all services providing support to care homes to help further develop joint working and information sharing, as well as providing an opportunity to benefit from input from the Care Inspectorate.

- Attendance of members of the team at the Care at Home Huddle weekly to enable joint working with ICAT (the Integrated Care Assessment Team) and care providers.

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

- Working with Meeting Centres Scotland, Dementia Cafes, Dementia Friendly East Lothian and other organisations to provide evidence to support continued funding to these organisations. Also providing staff support and information to carers and service users to improve community links with health and provide sign posting to other help and support, including befriending, during the current financial climate (see page 32 above).

- Delivering a memory assessment in either a clinic or in the patient's home linking in with the Post Diagnostic Support Service provided on a commissioned basis by Alzheimer Scotland. Alzheimer Scotland provide the five pillars model for those with mild to medium cognitive impairments. The Community Mental Health Team (CMHT) provides the 8 pillars model to those with moderate to severe cognitive impairments.

- The provision of mental health care to those residing in care homes and other 24-hour facilities has been challenging since losing all three nurses who were dedicated to these roles. As an intermediate measure, the Community Psychiatric Nurses from the Community Mental Health Team (CMHT) have been providing input where required. The potential development of an Advanced Nurse Practitioner and a Stress and Distress Practitioner to provide mental health support and advice in care homes is now being explored.

Meeting Housing Needs

Housing Contribution Statement

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

Further work took place over 2024-25 to develop a Housing Contribution Statement (HCS). Housing Contribution Statements are a statutory requirement and provide a bridge between the Local Housing Strategy and the IJB Strategic Plan. The HCS was developed by East Lothian Council's Housing Services, in partnership with HSCP colleagues and was agreed at the December 2024 meeting of the IJB – the full Statement can be viewed here.

The Housing, Health and Social Care Strategy Group will continue to help support partnership working at a strategic level across relevant Council and HSCP services and will play a key role in developing and overseeing activity related to the HCS.

Elder Street

Elder Street in Tranent is a 24/7 supported accommodation and rehabilitation resource for up to 6 people facing mental health challenges that are impacting on their day-to-day functioning. The provision focuses on offering between 6 and 18 months of supported accommodation as part of people's journey back to maximum independence. The service is provided by Penumbra, with inreach support from several external providers.

In October 2024, a pause on admissions was put in place due to significant water damage in the building along with associated health and safety risks. Repairs are ongoing with an anticipated completion date in August / September 2025. During this period the number of residents reduced to two and the service was adapted on a temporary basis to provide outreach. Staffing and contract price were reduced accordingly in agreement with all parties. A collaborative working group have used the pause to strengthen processes and pathways to maximise service quality and flow and a decision was made to make all flats single tenancies reducing capacity from 10 to 6 but in doing so avoiding complexities around sharing and therefore improving recovery journey and flow.

Learning Disability

The Learning Disability Social Work team continued to work closely with colleagues in East Lothian Council's housing department to ensure that our service users are appropriately matched to housing. Primarily this is focussed on identifying new housing stock that can be utilised under a core and cluster

model. Over this last year, a new core and cluster was established in Windygoul, Tranent supported by Carr Gomm.

Over the next year it is anticipated that we will establish another core and cluster in the Tranent area, service users have already been identified to move into these properties once a support provider has been identified.

The Social Work team send a representative to the Re-Housing Panel every month to contribute to discussions over whether service users should be awarded the full points available.

Transitions

Planning for young people's transition from child to adult services is already well established in East Lothian, with transition referrals made at an early stage and contact and multidisciplinary meetings taking place on a regular basis.

The Learning Disability team has been leading on the development of a Transitions Policy and Procedure document which is mostly complete and awaiting signing off from the appropriate governance groups before implementation. The document is anchored in the Principles of Good Transitions from the Scottish Transition Forum.

For 2024/25 the LD team had 10 referrals including 2 Looked After and Accommodated Children (LAAC), all transitions have planned support identified, outcomes are a mixture of centre-based support; respite; universal services and staying in school.

Ongoing work with partners in Education and Children's Services is planned to ensure a shared understanding of eligibility criteria. Eligibility criteria can differ in Adult Services from Children's Services and managing expectations is important to support a smooth transition and avoid disappointment.

For 2025/26 onwards it has been agreed that Adult Social Work Team will now take full ownership of transition referrals for young people without diagnosed learning disabilities.

Strategic Objective 6 – Keep people safe from harm

Adult Support and Protection

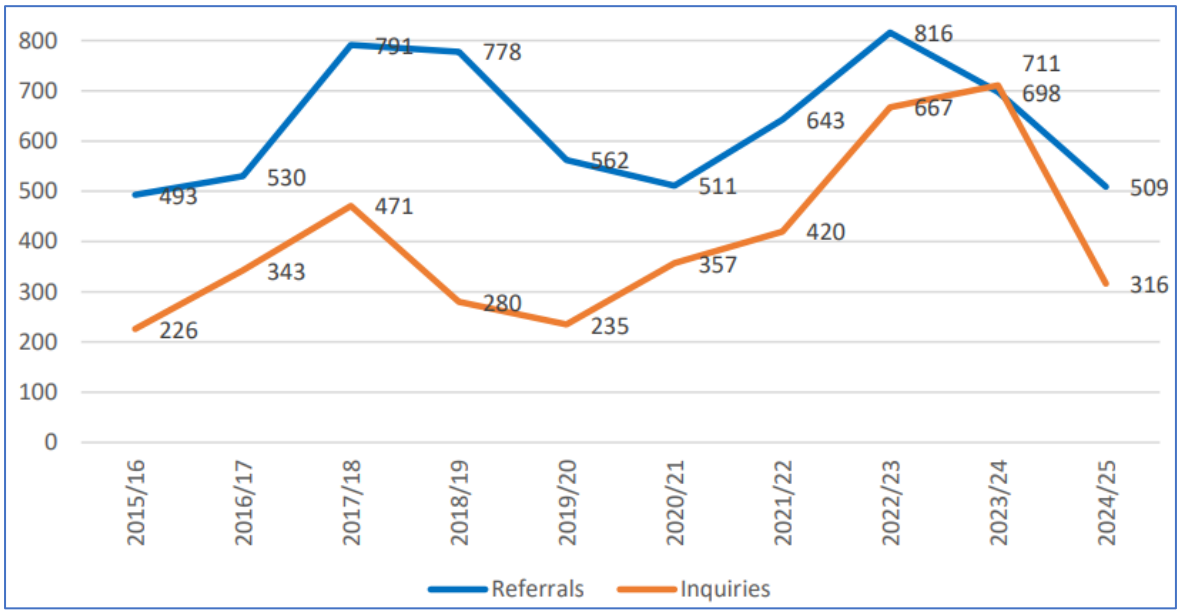
Detailed data in relation to the East Lothian and Mid Lothian Adult Support and Protection performance is reported in the EMPPC Annual Report which is available on the EMPPC website. Quarterly newsletters describing Public Protection activities and including articles on a range of related topics are also available on the website.

East Lothian Health and Social Care Partnership has robust internal quality assurance arrangements in place, with a quarterly Oversight Group meeting to review performance, audit findings, and emerging themes across Adult Social Work Services. The service has benefited this year from the appointment of a dedicated Adult Support and Protection Quality Assurance Lead roles who has laid down the foundation for future reporting, bringing consistency of approach and supporting Scottish Government and local reporting requirements. Reporting into both the Social Work Governance and Clinical and Care Governance Committee, the Quality Assurance Lead post has delegated accountability for ASP performance and improvement with operational oversight of all Adult Support and Protection activity, auditing, and data.

Activity levels

There were 509 referrals categorised as Adult Protection in East Lothian during 2024/25. During the year there was a routing of more Adult Support and Protection referrals to general Adult Social Work duty rather than an Adult Support and Protection inquiry, which we can see in both the reduction in inquiries and conversion rate returning to the levels seen in 2020/21 and 2021/22 (see Graph 5 below). Managerial oversight provided assurance that assessment and support needs were addressed although not progressed under Adult Support and Protection.

Graph 5 – East Lothian ASP referrals and inquiries by year



Key highlights during 2024/25 included:

- Enhancement of the ASP Management Screening Decision, a tool used to provide rationale, evidencing defensible decision making when downgrading an ASP Referral before moving through our Social Work Duty system.

- Continued audit activity with regular 'dip' audits; peer audits; focussed audits in relation to screening of police concerns; and cross-team audits. Finding of audits fed into continuous improvement cycle utilising an embedded SMART Audit System.

- Full implementation of the revised ASP Code of Practice.
- Strengthening the use of chronologies and SMART risk management plans.

- Expanded multi-agency audit activity using the Care Inspectorate tool used in joint inspection.

- Continued strong performance in timely inquiry completion.

- Initiation of Care Inspectorate-aligned ASP self-evaluation.

Looking ahead to 2025/26, we plan to:

- Continue alignment to minimum national dataset reporting requirement.

- Commence a comprehensive self-evaluation aligned with the Care Inspectorate's Quality Framework for ASP which will help us to critically reflect on our practices, systems, and impact. This self-evaluation is part of our commitment to continuous improvement and ensures we remain aligned with national expectations while being responsive to local needs and risks.

- As part of our continuing work on developing our approach to communications, we will engage with partner agencies and local communities in the coming year to promote Adult Support and Protection as everyone's responsibility.

Reducing Harm from Substance Use

MELD Contact Service

The MELD (Midlothian and East Lothian Drugs) Contact Service continues to provide information and advice regarding substance use. Acting as a first point of contact for people wishing to engage in recovery services, the Contact Service offers a brief assessment and triage on to appropriate services to meet the needs of the individual, including access to the East Lothian Substance Use Service (ELSUS) Same Day Access to Treatment clinic. The service currently operates from 9am to 9pm, Monday to Friday.

During 2024/25:

- There were 1,556 enquiries to the Contact Service; 270 of these were during the Out of Hours service (up from 1,286 and 159 the previous year).

- 66 people were directed to East Lothian Substance Use Service following a triage assessment (up from 25 the previous year).

- 52 people were directed to East Lothian Same Day Access Treatment Clinic.

- 376 people were triaged to MELD following assessment (up from 311 the previous year).

MELD is also commissioned to order, distribute, and report on Take Home Naloxone (THN) and Nyxoid Kits[13] and distributed 258 kits during 2024/25 (up from 258 kits the previous year).

Medication Assisted Treatment (MAT) Standards

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

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

The Scottish Government set a target for the full implementation of MAT Standards 1 to 5 by April 2023, followed by Standard 6-10 being fully implemented by April 2026. East Lothian HSCP has worked with Midlothian and East Lothian Drugs and Alcohol Partnership (MELDAP) to deliver a level of performance ahead of both target dates and have been assessed as green (fully implemented) for all ten standards. Activity related to implementation of the MAT Standards included:

- Same day access for assessment and treatment remains ongoing, with assessment slots available 5 days a week.

- Supporting people to make an informed choice about medication options and dosage in primary and secondary care settings. This has resulted in a continued steady uptake of Buvidal (long-acting buprenorphine). Currently over 50% of the MAT caseload is prescribed Buvidal and it remains a popular choice for those entering treatment.

[13] Naloxone is a medication that temporarily reverses the effects of opioid overdose and is available to anyone at risk of overdose. Naloxone is available in injectable form or as a intra-nasal spray (Nyxoid).

- Ensuring that people who have experienced a Near Fatal Overdose (NFO) are contacted within 24 to 72 hours after services have been notified and provided with harm reduction advice and support and encouragement to engage with treatment services. over 75% of people are contacted within 24hrs. This work has extended to directly screening Police VPD's and offering support where appropriate. These are also followed up within the 24-72hr timescale.

- Joint working with BBV team to promote the update of BBV testing/re-testing. This has involved staff training/case finding/drop in clinics.

- Low threshold cafes in Tranent and Prestonpans are now established as low threshold access to treatment.

- Three lived experience sessions have taken place to obtain the views of service users and funding is being sought to offer sessions on a more regular basis.

- Over 75% of the staff group are trained in delivering Tier 1 psychological interventions.

- Well established alcohol pathway offering pre detox planning / coping skills to promote self-management.

Case Study

Patient A[14] contacted the service after receiving information from a friend who was using the Assertive Outreach Service. They had a long term history of problematic substance use and were looking to access injecting equipment provision, as they were using both heroin and cocaine intravenously several times a day.

They had attended the Community Drug Problem Service years ago for a prescription of methadone but stated that they had no desire to engage with East Lothian Substance Use Service (EL SUS) for Medication Assisted Treatment (MAT), at that time, as they knew it would mean attending the pharmacy daily to have their medication supervised and felt this was stigmatising for them.

Patient A was resistant to accessing support from services as they felt this had not been helpful in the past. The Assertive Outreach Service began visiting Patient A on a weekly basis using the provision of injecting equipment as a way of engaging with them. Patient A also agreed to undertake Naloxone training and accepted a supply of Naloxone.

[14] Case studies are intended to illustrate how are services work in practice and are not related to real patients or service users.

The Assertive Outreach Service and Patient A spent time discussing safer injecting and other harm reduction measures during their appointments. After a period of time, Patient A agreed to testing for Blood Borne Viruses (BBV) and engaged well with the EL SUS BBV nurse.

As someone living on their own and using both heroin and cocaine intravenously daily patient A was at high risk of a drug related death. Through the weekly appointments, psychoeducation was provided and risks discussed. Patient A eventually agreed to phone the MELD Contact Service and ask for a same day access to treatment appointment for medication assisted treatment (MAT).

Patient A engaged with EL SUS and initially opted for methadone as their MAT choice, as they had been prescribed this in the past. They became stable on 100mg methadone and 30mg diazepam. Due to Patient A being stable on a MAT prescription, their use of heroin reduced significantly, they ceased intravenous use and converted to smoking heroin and stopped using cocaine.

Patient A's reduction in substance use meant his peer group changed as they had stopped mixing with a number of associates who also use substances, this resulted in Patient A felling isolated and his mood became low. Patient A was referred to Mid and East Drug Service (MELD) and was allocated a peer worker to support with reintegration back into the community.

During the months following the initiation of methadone Patient A struggled to completely cease their heroin use. Following discussion with their keyworker Patient A decided that they wanted to convert to Buvidal (long-acting buprenorphine) as they thought this would be a deterrent to using heroin. The pharmacological nature of Buvidal reduces the efficacy of any additional opiates used and can often be motivating factor for individuals as they get no benefit from using heroin on top of this medication.
To safely commence Buvidal, individuals need to be is a significant state of opiate withdrawal. As this can be difficult to achieve when converting from methadone, due to its long-acting nature, Patient A opted for an admission to the Ritson Clinic to undergo this conversion.

The Ritson admission was a success, and Patient A is now prescribed Buvidal. They report to have ceased heroin use, and this is evidenced by toxicology results. The focus moving forward is to support Patient A to find structure and meaningful activity.

Justice Social Work

The Justice Social Work Service Plan 2024-27 vision is to 'balance the risks and needs of people on the justice pathway to promote public safety and social parity' with outcomes and priorities for:

- Greater equality of opportunity
- Delivering engagement and interventions that address offending behaviour
- Promoting early intervention and prevention activities
- Offering robust community sentences that hold people to account for their offending behaviour and provide sentencers with alternatives to custody
- Through partnership arrangements support service user transitions into, through and out of the justice system to enable independence
- Work across disciplines to assess risk of serious harm delivering risk management strategies and plans that protect the public

Key service developments for 2024/25 included:

- The Big Pick – this project is run by those undertaking unpaid work in the community and has already donated over £3,000 to local charities.
- We were able to offer places on a Trauma Informed Report Writing course in line with the Scottish Government Transformational Change Programme 1 – to deliver person-centred and trauma-informed justice services.
- We commissioned a bespoke full day BASW-delivered course on Professional Curiosity, although there were mixed views form attendees the value and importance of 'just one more question' is recognised across the service
- Managing STP40 – following the ever growing prison population, East Lothian worked with partners across the Scottish Prison Service estate to manage the early release of prisoners at the 40% part of their custodial terms, rather than the previous 50%. Such releases will now all be at 40% unless the convictions are for domestic abuse or sexual offences.
- Caseload Management System – following on from the Setting the Bar Report and the implementation of an updated Supervision Policy, the service have devised and implemented a Caseload Management System. Its benefits in helping to identify areas of key strain and limited flex has been noted by team members and is used as and when required, rather than as a standardised bi-monthly or quarterly activity.
- In November 2024, the service completed their self-evaluation as part of the Care Inspectorate review of governance and assurance in Justice Social Work. This activity was supported by all team members with a collegiate response to performance activities across all aspects of the service.

Focus on Community Payback Work Team

In Spring 2024, the Community Payback Work Team Service began delivering on the 'Model for Practice' which aims to address key areas of need and deprivation by those required to undertake unpaid work in the community as part of a community sentence. The model has three key areas:

- Clothing poverty – by running monthly Big Picks the service is able to address some aspects of clothing poverty by giving local people the chance to buy clothing at significantly reduced rates and, where applicable, provide free shoes to children
- Transport poverty – by collecting, fixing and then donating bicycles to individuals and community groups, the service supports those with limited resource for travel and, by default, improves activity and wellbeing for those in receipt of a bicycle
- Food poverty – not only does some of the profit from the Big Pick get donated to foodbanks, but we are continuing to establish a network of developing unused ground to offer local residents and communities the chance to grow their own fruit and vegetables. This project is still in its infancy, but we are committed to increasing our reach across the county.

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

Strategic Objective 7 – Address health inequalities

The inclusion of Strategic Objective 7 in the IJB Strategic Plan reflects the IJB's recognition of the key role it plays in relation to reducing health inequalities[15] in East Lothian.

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

Developing Our Understanding of Health Inequalities

Work to develop a new Joint Strategic Needs Assessment[16] (JSNA) took place during 2024/25. Led by Public Health colleagues, the development of the JSNA has helped to further develop our understanding of health inequalities and contributing factors. The new JSNA will be a key document in informing the review and update of the IJB's Strategic Plan and will also continue to be a valuable resource in relation to the development of wider strategic planning activities.

You can view the current JSNA here.

IJB members took part in a Development Session during the year to enhance their understanding of equality and community engagement. The session focused on:

- IJB members specific role in assuring community engagement takes place at the right time; is of the right standard; and includes a broad range of community voices.

- The role of IJB members in ensuring compliance with equality legislation and public sector duties and helping them to consider how they carry out this role in practice.

The session included an interactive exercise looking an example court case brought against an IJB. This case ruled that an impact assessment and community engagement carried out by the IJB was unsatisfactory in terms of being carried out too late and not involving the right people. East Lothian IJB members found this exercise instructive, particularly in terms of them being able to identify missed opportunities where IJB members could have spoken up.

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

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

Equality and Fairness Impact Assessments

A new suite of Equality and Fairness Impact Assessment paperwork was developed during to 2024 in order to strengthen the approach to assessing the impact of policy development and decision making in terms of equality and fairness. The new documentation aims to:

- Present the impacts and recommendations identified during the assessment process to decision makers more succinctly, prioritising voices with lived experience.

- Provide a clear, accurate record of factors to be monitored over time to gauge impact during the implementation of decisions / policies.

- Present a more comprehensive impact assessment report suitable for community audiences, supporting their understanding of the equality and fairness impacts identified and how these were considered and reflected in the final decision or policy.

Equality Outcomes 2025-2029

The process of co-designing Equality Outcomes with the East Lothian community for the period 2025-2029 began late in 2024 with the new set of outcomes agreed upon in Spring 2025. These outcomes align strongly with the IJB Strategic Objectives and work actively towards supporting and achieving these through reducing barriers to access and participation, eliminating discrimination and embedding considerations of impacts on everyone in East Lothian (but especially the most vulnerable) in planning and commissioning.

The Equality Outcomes agreed for 2025-2029 are:

Outcome 1: Participation and Co-production - We will place human rights at the heart of our approach to community engagement.

Outcome 2: Dignity and Respect - Everyone is treated with dignity and respect.

Outcome 3: Anti-Racism - We will be an anti-racist organisation.

Outcome 4: Enabling Independence - We will encourage and enable independence.

Outcome 5: Addressing Health Inequalities - We aim to reduce health inequalities by addressing their root causes.

You can find out about some of the way in which we will achieve these outcomes here.

Our Financial Performance 2024/25

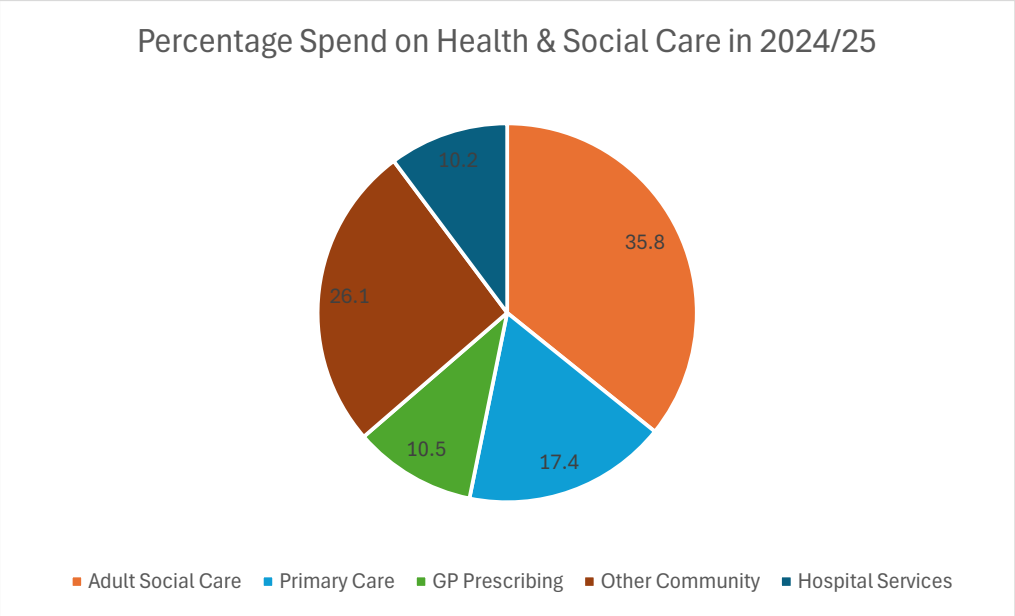
East Lothian Integration Joint Board is funded by financial allocations from its partners – East Lothian Council and NHS Lothian. These allocations include funding provided by the Scottish Government to local authorities to support the delivery of the Real Living Wage for the providers of adult social care. These funds make up the budgets that the IJB has available to deliver the functions (services) delegated to it by the partners. The operational management of the services is provided by the partners who also provide the financial information that informs the reported financial position for the IJB.

The IJB reported a break even position for 2024/25, however this was only achieved after receiving additional funds from NHS Lothian and East Lothian Council, and the use of the IJB's reserves.

IJB Budgets	Annual Budget £000's	Expenditure 2024/25 £000's	Variance £000's
Health - Core Services	116,937	120,584	(3,647)
Health - Hosted Services	19,044	18,764	280
Health - Set Aside Services	23,116	23,639	(523)
Adult Social Care	75,262	78,065	(2,803)
Position before Adjustments	**234,359**	**241,052**	**(6,693)**
Addition Funds from NHS Lothian	794		794
Addition Funds from East Lothian Council	2,803		2,803
Transfer from Reserves		(3,096)	3,096
Final 24/25 Position	**237,956**	**237,956**	**(0)**

The overspend reported reflects increased pressures relating to GP Prescribing, and significant pressures relating to demand for acute health services (at the Royal Infirmary of Edinburgh and the Western General Hospital), and pressures within social care services across East Lothian.

The chart below shows percentage of the IJB's funds that are spent on providing social care services, community health services, hospital based services, and the services provided by GPs and other Primary Care practitioners in East Lothian.



Reserves

At the start of the financial year the IJB held both earmarked reserves (funds held for specific purposes) and general reserves (funds used to support the management of financial risk) totalling c.£4.344m. The IJB received and used significant levels of earmarked reserves during the year. It also utilised the remaining general reserve balance resulting in closing earmarked reserves balance of £1.5m.

2025/26 Financial Outlook

The IJB's five year financial plan has been updated to reflect the most recent planning assumptions and financial projections. It is projecting a financial pressure of £4.2m for 2025/26 reflecting increased demand for services. As part of the budget setting paper approved by the IJB at its March 2024 meeting, a range of efficiency plans have been agreed which bring the 2025/26 position back into balance.

Appendix 1 – Ministerial Steering Group Indicators by East Lothian Localities

Indicator	Locality	2019/20	2020/21	2021/22	2022/23	2023/24	2024
1. Number of Emergency Admissions (18+)	EL **East**	3,260	2,932	3,162	2,787	3,041	2,960
1. Number of Emergency Admissions (18+)	EL **West**	5,770	5,332	5,320	4,792	5,300	5,138
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	EL **East**	26,742	24,773	29,600	28,782	27,825	27,548
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	EL **West**	40,799	42,084	43,640	48,242	43,804	42,342
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	EL **East**	576	2,153	3,099	3,243	3,212	2,602*
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	EL **West**	2,324	4,572	4,052	3,996	3,735	3,470*
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	EL **East**	523	2,131	3,028	3,248	3,282	2,602*
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	EL **West**	1,970	4,446	3,893	3,719	3,735	3,470*
2iii. Number of Unscheduled Hospital Bed Days – Mental Health (18+)	EL **East**	8,273	6,144	6,921	6,358	7,299	4,906*
2iii. Number of Unscheduled Hospital Bed Days – Mental Health6 (18+)	EL **West**	5,728	6,488	6,383	7,355	5,731	6,803*
3. New Accident and Emergency attendances (18+)	EL **East**	6,763	5,849	7,405	7,166	7,146	7,155
3. New Accident and Emergency attendances (18+)	EL **West**	14,542	12,074	13,821	14,100	14,261	14,330
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	EL **East**	2,469	1,615	1,040	1,277	1,347	3,099
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	EL **West**	2,241	2,294	1,601	1,912	2,227	4,958

* Figures for these indicators may be affected by data completeness.