Strategic Plan 2016-19

Summary

This document is a summarised version of the Strategic Plan.
As partners in joint health and social care integration, Midlothian Council and NHS Lothian have a statutory requirement to prepare a Strategic Plan.

Health and social care services are joining to form a new ‘Health and Social Care Partnership’. This change is happening across Scotland, not just in Midlothian.

The current way of delivering health and care services is no longer workable. This is due to (1) the changing needs of our society e.g. more older people. (2) the financial challenge – reduced funding. (3) the desire to improve health & wellbeing of Midlothian residents.

The services we are responsible for need to meet a set of nationally agreed health and well being outcomes. Our strategic plan explains how we will do this.
In Summary

The integration of health and social care is one of the Scottish Government’s top priorities and is designed to meet these needs.

The population in Midlothian is increasing and people are living longer, healthier lives. As society changes so do the health and care needs of our communities.

Midlothian Council and NHS Lothian are now working together as a Health and Social Care Partnership governed by the Midlothian Integration Joint Board (IJB).

The new partnership means working together, with joint responsibility and accountability, in helping achieve better outcomes for Midlothian’s people.

**MIDLOTHIAN HEALTH AND SOCIAL CARE VISION:**
People will lead longer and healthier lives by getting the right advice, care, and support, in the right place, at the right time.
Achieving Better Outcomes

**Our Priorities**

- Staying healthy and well
- Providing excellent quality care, treatment and support
- Engaged and supported workforce
- Efficient and effective use of resources
- Positive experience and treated with dignity
- Support to live in the community
- Improved quality of life
- Improved health and wellbeing
- Reduced health inequalities
- Getting the right services at the right time
- Safe from harm
- Support for carers

**NATIONAL HEALTH AND WELLBEING OUTCOMES**
Working Together for Better Outcomes

We’ve worked in partnership with and listened to communities, staff within health and social work and representatives of voluntary and independent organisations to develop the Strategic Plan. We will continue to do so to deliver the plan and continuously improve our services.
We need to work more closely with all our communities. Midlothian is small, both geographically and in population terms. Due to the practicalities of planning on a small scale we will establish two localities – one in the East and one in the West of Midlothian. (see map)
Services included in the Plan

Some examples of people who provide these services are:

- GPs
- Occupational Therapists
- Nurses
- Dentists
- Physiotherapists
- Pharmacists
- Care Home Staff
- Social Workers
- Dieticians
- Podiatrists
- Speech & Language Therapists

- Mental Health
- Physical Disability and Long Term Conditions
- Sensory Impairment
- Unscheduled Hospital Care
- Midlothian Community Hospital
- Services for unpaid carers
- Criminal Justice
- Substance Misuse
- Learning Disability
- Health Inequalities
- Dementia
- Primary Health Care
- Older People
- Housing
Planned Hospital In-Patient Services

Children’s Services such as education, and children and families social work

Other Council Services such as transport, leisure and libraries

We need to work together with all other services and partners to help tackle some of the big issues that affect our health and wellbeing.
The Plan

**House of Care**
The House of Care model is a way of working with people with long term conditions. It means helping people to make decisions and set their own goals. It means developing people’s skills and confidence to manage their own condition in their day to day life.

**Findiing employment**
For e.g. we will continue to fund Midlothian Training Services to provide employment support for people with mental health problems, substance misuse problems and learning disabilities. We will consider strengthening these types of services for other vulnerable groups.

**Reducing health inequalities**

- **Test “House of Care” in Newbattle and Penicuik**
- **Reduce health inequalities for people with disabilities**
- **Support people to find employment**
- **Increase dentist registration for older people**
- **Better address the health care needs of homeless people**
- **Target support to promote warmer homes**
- **Raise staff awareness of LGBT issues and needs of Veterans**
- **Work with Community Empowerment Development Worker**
- **Community Health Inequalities Team**

**Area Targeting**
This project involves lots of different organisations working with the community to improve people’s lives. The communities we will work with are Gorebridge, Woodburn and Mayfield and Easthouses.

**Community Empowerment Development Worker**
This worker is based in Mayfield and will work with community members to find ways to improve health. This is part of the Area Targeting project.
This will help to support GPs so they have more time.

More services at Midlothian Community Hospital.

We will transfer beds from Liberton Hospital to Midlothian Community Hospital.

Rehabilitation for older people

We are building a new health centre for Loanhead. We will extend the Medical Centre in Gorebridge and we plan to improve facilities in Penicuik, Danderhall and Newbattle medical centres.

Screening and tests
We will provide home-based blood pressure monitoring, target screening checks for people most at risk, and provide more tests at GP surgeries.

Better health screening and checks

Consider treating minor illnesses at the Community Hospital

Wider range of outpatient clinics at Community Hospital

Rehabilitation for older people at the Community Hospital

Ensure ambulance and A&E staff have the key information

Improve GP premises

More health care assistants

GP premises

This will help to support GPs so they have more time.

More health care assistants

Pharmacists working in GP practices

Advanced training for nurses

Better links between health and social work

Local health services

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Local health services
The Plan

Discharge Earlier
Providing increased support for discharge home earlier, including additional assessment of people’s needs at home and reducing length of stay in hospital.

Care at home and support to leave hospital

- Increase skills of nurses
- Supporting discharge earlier
- Single contact for hospital discharge hub to use
- Make hospital in-reach team stronger
- Increase the Reablement Service
- Assess need for overnight social care
- Strong link between GPs and consultants
- Prevent unnecessary hospital stays for people with dementia
- Enable people to die at home if they wish
- Promote Power of Attorney

Dying at home
We will set up a Palliative Care Steering Group to oversee the quality of care we provide and training for staff.

Power of Attorney
Encourage people to plan ahead so that families are able to legally make decisions on behalf of their relative and help people be discharged.

Hospital In-Reach
We will employ additional Community Care Assistant, fund Red Cross and pilot a District Nurse in the team.

Reablement helps people to regain skills and confidence.
The House of Care model is a way of working with people with long term conditions. It means helping people to make decisions and set their own goals. It means developing people’s skills and confidence to manage their own condition in their day to day life.

Support people to take part in activities and groups. They aim to help people to stay healthy and reduce isolation. Services have been extended to people aged under 65 with long term conditions, as well as older people and people with disabilities.

Macmillan Cancer Support – Transforming Care After Treatment programme
This aims to make sure people diagnosed with cancer are supported. People are assessed to find out what support they need. We will increase access to physical and social activity, healthy eating advice, and employment / benefits advice.

Occupational Therapy
At the moment people can get different Occupational Therapy support from social care and from health. Sometimes people are assessed twice and see different people for different things. We want to change this so the service is more joined up.

The Plan

Support for people with long term health conditions

Living Well Team – increased staff to support self-management
Take part in “Transforming Care After Treatment” for people with cancer
Test “House of Care” in Newbattle and Penicuik
More weight management courses for people at risk of developing diabetes

Look at providing rehabilitation for under 65s at Highbank

Improve ways to access Occupational Therapy
Work with voluntary sector to develop peer support

Local Area /Community Coordinators
Support people to take part in activities and groups. They aim to help people to stay healthy and reduce isolation. Services have been extended to people aged under 65 with long term conditions, as well as older people and people with disabilities.

Local Area Coordinators & Community Coordinators

Living Well Team

Transforming Care After Treatment programme

Work with voluntary sector to develop peer support

Local Area Coordinators & Community Coordinators
The House of Care model is a way of working with people with long term conditions. It means helping people to make decisions and set their own goals. It means developing people’s skills and confidence to manage their own condition in their day to day life.

Self-directed support gives people choice and control over the support they receive from social care. Some people can manage their support on their own, while others need help from friends and family, or a special organisation.

Support for people with physical disabilities

Rehabilitation for people aged under 65
Highbank Care Home provides short-term rehabilitation. For example for people who leave hospital and need to regain skills before they go home. We are looking at extending this service to people under 65. This will help people leave hospital sooner and will prevent some people from going to hospital.

Promoting Employment
Co-ordinate partnership working with Edinburgh College and others to develop and promote a resource pack to inform and support employers to recruit people with disabilities.

Promoting inclusion through local area coordination services

Make better plans with people about their future care

This is sometimes called anticipatory care planning

Promote inclusion through local area coordination services

Carry on implementing self-directed support

Take action to address health inequalities

Promoting employment opportunities

Look at providing rehabilitation for under 65s at Highbank

Work with voluntary sector to develop peer support

Test “House of Care” in Newbattle and Penicuik

Work with voluntary sector to provide advice about welfare reform

Improve ways to access Occupational Therapy and de-duplicate services

The Plan

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Improve ways to access Occupational Therapy and de-duplicate services
You can already get replacement hearing aide batteries at libraries. We are looking at how we can use libraries more, for example to get replacement tubes for hearing aides.

Audiology Clinics
At the moment audiology clinics take place at Lauriston Buildings in Edinburgh. We would like to provide audiology clinics in Midlothian and we are looking at how to do this.

Find out if audiology clinics can be provided in Midlothian

Develop a ‘See Hear’ action plan

Support for people with sensory impairment

Distribute information and equipment at libraries

Improve access to communication supports

British Sign Language App
Council staff have use of a tablet with contactScotland BSL app providing access to online interpreter.

Screening Tools
Five trained Sensory Champions will be trialing basic hearing and vision screening equipment in Council residential establishments, identifying the need for professional assessments where appropriate.

Promote the use of screening tools for sensory impairment

 Improve links with specialist organisations like Deaf Action

Increase staff awareness about sight and hearing loss

See Hear is a new national strategy to improve the lives of people with hearing and sight impairment.

The Plan

Support for people with sensory impairment

Improve access to communication supports
The Plan

Supporting people with learning disabilities

Day services, respite and short breaks
People’s needs are changing. We have reviewed and redesigned Cherry Road, and are reviewing other services to make sure they can support people with different needs and people of all ages.

Hidden sight and hearing problems
We have two sensory impairment champions in our learning disability services.

New housing unit
We are building a new housing unit for 12 people with very complex needs. This will be in Penicuik.

Better Plans
This includes Power of Attorney and Anticipatory Care Plans

Create a joint health and social care service

Develop local support for people with challenging behaviour

Build a housing unit for people with complex needs

Make better plans with people about what to do when they are ill

Encourage older people to be physically active

Provide more local day activities for younger people

Identify hidden sight and hearing problems

Carry on introducing self-directed support

Change day services, respite and short breaks

Make sure care packages are right for people
The Plan

Autism Spectrum Disorder action plan
The plan will include:
- Getting information and advice
- Accessing further education
- Getting a job
- Being involved in the community

Local action plan for Autistic Spectrum Disorder

Mental health and substance misuse needs of offenders

Employment support

Better links between mental health and substance misuse teams

Awareness raising campaigns to tackle stigma

Integrated Substance Misuse Service

New Royal Edinburgh Hospital opens 2016 – make sure Midlothian needs are met

Better access to psychological therapies and community support

Supporting mental wellbeing and addressing substance misuse

The needs of offenders
We will improve access to psychological therapies for offenders. We will invest in SPRING – a project that supports women at risk of offending.

Mental health and substance misuse
We will develop clear guidelines for working together and staff will attend each other’s team meetings. We will make sure people with substance misuse problems have quick access to mental health services.

Psychological support
There will be a new service to help people access support including psychological therapies. The team will work in different places across Midlothian and will be quick to access.

Preventing drug and alcohol problems
We will spend less on specialist treatment and more on prevention and early intervention. For example counselling, therapies, access to physical activity.
The Plan

Support for Older People

- Make plans with people in case their health gets worse
- Support people to be active and connected
- Prevent falls and accidents at home
- Redesign Day Hospital and Day Services
- Provide more specialist support to Care Homes
- Hospital at Home – people treated at home instead of hospital
- More “step down” beds for people leaving hospital
- More support for people leaving hospital
- Rehabilitation beds at Midlothian Community Hospital

Support and MERRIT

Reablement helps people to leave hospital and return home. The service will be increased. MERRIT also supports people to leave hospital or to stay at home. It will now open in the evenings and at weekends, as well as through the week.

Emergency Admissions

We are giving priority to developing services which reduce the need for older people to go into hospital.

Reduce isolation and ill-health

We will continue to fund Ageing Well, voluntary sector Day Services, Community Coordinator services and other voluntary services which help other people stay active and connected.

Preventing falls and accidents

We will prevent falls by offering more physiotherapy, exercise programmes and technology. We will work with the fire rescue service and housing providers to reduce accidents at home.
The Plan

**Anticipatory Care Plans**
This helps people plan for the future so they can manage better if their health changes.

**Dementia-friendly homes**
We will work with Commercial Services to carry out work to make homes dementia-friendly.

**Power of Attorney**
Encourage people to plan ahead so that families are able to legally make decisions on behalf of their relative and help people be discharged.

**Dementia Hub**
Establish a Dementia Hub to test how to use technology with users and carers.

**Support for people with dementia**

- Single dementia team – coordinated care
- More funding for support post-diagnosis
- Anticipatory care planning
- Family group conferencing
- Use more new technology
- Prevent unnecessary hospital stays for people with dementia
- Raise awareness about dementia
- Promote Power of Attorney
- Plan care before leaving hospital
- Reduce avoidable hospital admissions

**MERRIT and the Dementia Team**
will work together to do this.
Support for carers

- Short breaks for carers
  "Wee breaks" www.weebreak.org supports carers to have flexible breaks from caring. We may also need to invest in more respite care.

- Reaching carers from minority ethnic groups

- Minority ethnic carers
  We will support voluntary organisations to access language and interpreter services, and to provide ongoing support to carers from minority ethnic groups.

- Hospital Inreach Carer Support Worker

- Develop emergency plans

- Strengthen carer’s rights

- Identify hidden carers and make sure they are supported

- Use new technology to support carers

- Implement Self Directed Support for carers

- Continue welfare advice sessions for carers at the Carer Centre

- New technology
  An example of the new technology we could use is “Jointly” – a standalone app to support unpaid carers to communicate and coordinate shared care needs.

- Carer Rights
  There is new legislation that strengthens carer rights including the right to a carer support plan.
The Plan

Expand Telecare
Examples include:
1. Technology that helps people record information about their own health. This can be shared with staff if people choose. It can show if health is changing and if people are at risk.
2. "Just Checking" – technology that picks up on movement in a house and can provide peace of mind to carers.

Use telecare and smart technology more

Coordinate support to people living in new homeless unit

Better housing design so that people with dementia can live safely at home

Housing design and dementia
Examples of supporting better housing design:
- developing design guidance for builders
- training and resources for maintenance staff and families

Coordinate support to people with higher needs

Make Handyman Service sustainable

Handyman Service
This service will be continued. We will develop the service so that service users will pay for materials and an affordable charge for labour.

Build housing unit for 12 people with complex learning disabilities

Develop extra care housing in private sector

Redesign sheltered housing schemes

Sheltered Housing
We will work with Housing Associations to redesign some sheltered housing schemes so that they can support people with higher needs.

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Sheltered Housing
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This means supporting people to access community activities and resources like peer support or physical activities. We are looking at how we can do this better in GP surgeries, as well as funding services like the Community Coordinators.

"Signposting" This project involves lots of different organisations working with the community to improve people’s lives. The communities we will work with are Gorebridge, Woodburn and Mayfield and Easthouses.

Support the Area Targeting Project and Community Empowerment Worker

Employ a Communication Officer for Health and Social Care

Share information about services and community activities

Improve "signposting" to support

Public and Carer members on the Health and Social Care Joint Board

Public & Carer Members

A member of the public and a carer have been recruited as members of the Integration Joint Board. Their role is to make sure the Board takes the views of the public and carers into account.

Hot Topics Group

There will be 5 meetings every year to talk about key topics that affect a range of different people. Health and Social Care Managers will go to the meetings.

Support the Area Targeting Project and Community Empowerment Worker

Strengthen work with service user and carer groups to plan services

Hold meetings to discuss key topics hosted by local people

Stronger links with Neighbourhood Planning and Community Councils

Produce information in visual and easy read formats, including this plan

The Plan

Communication and community engagement

Area targeting project

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Progress & Next Steps

1. CONSULTATION
Open from 30th September to 25th November 2015

2. UPDATE
December 2015/January 2016
Using consultation feedback, the Strategic Plan was updated

3. REVIEW
Revised Plan to Strategic Planning Group for review 1 February 2016

4. APPROVAL
Approval by the Integration Joint Board (IJB) March 2016

5. ACTION
Implementation of the Strategic Plan 2016/2017

6. REVIEW
April 2017

the right care
the right support
the right time
Health inequalities

Mortality has also been decreasing across the area but differences remain between the East and West localities.

Of the Midlothian population has increased over the past 50 years, but differences of up to 12 years exist between the most affluent and most deprived areas.

Life expectancy

Under-75 Coronary Heart Disease mortality age-sex standardised rate per 100,000

Prevention through Early Intervention

Population need to be supported to make healthy informed decisions.

Promotes patient / person independence

Improves outcomes

Minimises avoidable service use

Midlothian want to move towards being proactive rather than reactive.

Prevention through healthy choices

to download Midlothian Strategic Plan, visit: www.midlothian.gov.uk/downloads/file/6012/strategic_plan
Aging Population

The population of Midlothian is changing

2037

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2037 Population Growth</th>
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<tbody>
<tr>
<td>0–15</td>
<td>+22%</td>
</tr>
<tr>
<td>16–64</td>
<td>+2%</td>
</tr>
<tr>
<td>65–74</td>
<td>+36%</td>
</tr>
<tr>
<td>75+</td>
<td>+112%</td>
</tr>
</tbody>
</table>

2012

<table>
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<tr>
<th>Age Group</th>
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</tr>
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<tbody>
<tr>
<td>0–15</td>
<td>20%</td>
</tr>
<tr>
<td>16–64</td>
<td>70%</td>
</tr>
<tr>
<td>65–74</td>
<td>8%</td>
</tr>
<tr>
<td>75+</td>
<td>2%</td>
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</tbody>
</table>

Significant growth in the 75+ population means people are living longer, however, this success potentially creates a rising demand for health and social care services.

Unpaid carers are also likely to be affected by the ageing population, often putting their own health at risk as they take on more responsibility as they become older.

Those living in deprived areas are at particular risk of ill-health and are likely to develop two or more conditions 10–15 years earlier than those living in affluent areas.

Those with multiple long-term conditions in deprived areas are more likely to have a coexisting mental health condition such as anxiety and depression.

Sustainability of Quality Services for People with Multiple Long-term conditions

Those with multiple long-term conditions in deprived areas are more likely to have a coexisting mental health condition such as anxiety and depression.
Changing Social Landscape

By 2037, one in three households will be occupied by someone living alone.

Living alone can often lead to social isolation—particularly if a rise in single-person households is a consequence of an ageing population.

Workforce Planning

Midlothian has an ageing workforce—in particular district nursing and home care services. We must also ensure we have effective recruitment and retention policies. In areas such as district nursing and home care we have an ageing staff group, whilst in social care services generally there is a need to improve our retention of staff as high turnover is wasteful of resources and disruptive to service users.

to download Midlothian Strategic Plan, visit: www.midlothian.gov.uk/downloads/file/6012/strategic_plan
The traditional service model for health and social care is untenable going forward.

In the future this will be supported by technology enabled care (TEC) which is intended to enhance and/or make the quality of care more efficient and accessible for people through the application of technology.

Example: How it’s working for CHD

High blood pressure is one of the major risk factors which can lead to CHD. It is also the second most common reason for attending a health centre to see a doctor or nurse.

A trial is currently being run by Scale-Up BP in NHS Lothian which seeks to improve accuracy of blood pressure readings, free up time for doctors and nurses and reduce costs...

...through supplying patients with blood pressure monitors which will prompt them to take regular readings and filter them back to their surgery via text. The patients will be told immediately whether their blood pressure is on target or whether they should contact their surgery.

The patients will also be given advice on how to control their blood pressure through healthy lifestyle choices.

This is a key example of technology, self-management and healthy informed decisions working together to improve outcomes and, if the trial is a success, the scheme will likely be rolled out beyond the NHS Lothian area.
We’d love to hear your thoughts and views on our plan:

Does the content make sense to you?  
Is there anything missing?  
Anything else you want to add?

We are happy to translate on request and provide information and publications in other formats, including Braille, tape or large print.

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