- Person Centred Care-

PREVENTION

RECOVERY

EMPLOYMENT

SAFE

CO-PRODUCTION

TECHNOLOGY

**Midlothian Joint Needs Assessment**

V1.6

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**Thanks to all who have contributed to this document**

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Electronic Reading Note: Though they look like standard text, all graphs, tables, figures and section references are cross referenced hyperlinks. Clicking on them will take you to the link - pressing Alt+Left Arrow should take you back.
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1 Welcome

1.1 Narrative Guide

Welcome to the first Joint Strategic Needs Assessment for Midlothian’s Health and Social Care Partnership, which has been produced to support the new Strategic Plan for Midlothian. This Joint Strategic Needs Assessment uses a variety of expert opinion, routinely available data and comparison with other areas, to build up a picture of the health issues affecting the Midlothian population. The Needs Assessment has been developed in conjunction with the Strategic Plan for Midlothian, helping to ensure our health and social care services are designed to meet the current and future needs of the population.

Needs assessments can sound rather mysterious, but at their core they are simply a way of using information to describe the health and wellbeing of a population. Through the collation of information and expert opinion the Needs Assessment identifies key health and care priorities and helps to focus commissioning in areas where people are experiencing poorer health outcomes. Circumstances change over time and this Needs Assessment will need to be repeated to ensure our Strategic Plans in the future are also able respond to emerging health and care issues and so that we can review the impact of our actions.

We are fortunate in Scotland to have very rich data sources but there are still significant gaps. Where gaps have been encountered we have used nationally available data to describe trends and evolving health risks. We will work with other national and local agencies to strengthen the information gathering process in future years.

This is a lengthy report, created with input from many different people and we are grateful for all of their efforts identifying and analysing information from a variety of different sources.
1.2  Emerging Key Themes Summary

We have identified five key themes/messages emerging from the Joint Strategic Needs Assessment. These themes provide an overview of the issues facing Midlothian both now and in the immediate future. We would encourage you to read the more detailed information contained in each section of the report in order to gain an in-depth understanding of these summary themes.

Health Inequalities

Over the past 50 years health and life expectancy have improved overall, however, there remain stark differences in health as a result of poverty and social disadvantage. Life expectancy can vary by up to 12 years across different parts of Midlothian. Though ‘All Cause Mortality Rates’ (see section 6.2: Mortality) for the population of Midlothian as a whole demonstrate a consistent downward trend, this hides a variation in disease specific mortality in the east and west localities into which Midlothian has been divided under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 (see section 3: Localities).

The Scottish Index of Multiple Deprivation (SIMD) is a tool for identifying those places in Scotland suffering from deprivation. SIMD divides Scotland into small areas called data zones each containing around 350 households. In SIMD 2012, eight Midlothian datazones are amongst the most deprived 20% areas in Scotland. Around 7% (5,908) of the population of Midlothian lives in these zones and they are all in the East locality.

It is also useful to consider the datazones just outwith the most deprived 20% and in this case the spread is geographically wider including Loanhead, Penicuik, Rosewell. Despite years of effort trying to reduce health inequalities, there remain significant differences in population health. Tackling health inequalities is important, challenging and requires co-ordinated partnership working.

Prevention

The central challenge for health and social care services is promoting upstream work to prevent disadvantage and ill-health from occurring in the first place. This involves influencing wider Government agencies, which may well have competing priorities to address. Finding ways to address inequalities can feel overwhelming at times. However, there are opportunities to work differently with the creation of this new Health and Social Care Partnership.

We need to make it easier for people to make healthy choices, so they can avoid obesity and the health conditions associated with it: type 2 diabetes; cardiovascular disease; hypertension; and stroke (see sections 5.2.4: Healthy Weight). Eating well and leading a physically active lifestyle are evidence based methods for supporting reduced incidence of these chronic conditions.

Smoking cessation, reducing harmful alcohol intake, drug use, falls, and teenage pregnancy are other areas to continue preventative input (see section 5: Behavioural Determinants of Health – Lifestyle Factors and section 6.16: Sexual Health and Blood-Borne Viruses).

Midlothian’s Integrated Joint Board (IJB) needs to continue the transformation from reactive to proactive care for the population it serves. We need to support people to remain in their own
homes or a homely setting for longer and reduce inappropriate use of acute health and care services through co-productive partnership working and better information sharing to plan care.

Understanding how to respond to the needs identified in this document by adjusting investment in services towards prevention, rather than reaction, will be a key challenge for Midlothian.

**Sustainability of Quality Services for People with Multiple Long-term Conditions/Multimorbidity**

**Current Model: “Do for”**

Midlothian faces a significant challenge in managing services which remain sustainable against population figures rising consistently ahead of projections and a constrained financial climate. We know that population projections have consistently underestimated future population growth. We need to strengthen planning links with housing to ensure services are commissioned at the correct scale and that housing stock remains appropriate to population health and care needs (see section 4.5: Housing).

Many people live with more than one illness and this is described as multimorbidity. Managing long-term condition’s is one of the biggest challenges facing health care service worldwide, with 60% of all deaths attributable to them (see section 6.3.3: Living with Illness). People living in areas of multiple deprivation are at particular risk of ill-health. They are also likely to develop two or more conditions 10-15 years earlier than people living in affluent areas. Given an aging population, managing long-term conditions represents a significant challenge.

The heart of the Scottish Government’s strategic narrative towards achieving the 2020 “Triple Win” (see section 8.1: Knowledge Gaps) is achieving the transition from a ‘do to/do for’ health and social care system to one of Co-production. More than just working together, co-production refers to multiple stakeholders building and sustaining assets (material and non-material) as resources to maintain health and wellbeing.

Continuing and strengthening service delivery working fully with patients and their carers will be essential to the IJB meeting the needs identified in this document.

**Future Model: “Co-production”**

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Aging

The Midlothian population age profile is changing. The population in Midlothian is rising faster than predicted. Currently we have above average populations of children (0-15), older working adults (45-59) and retired people (within the 60-74 age bracket) when compared to the average for Scotland; there is a comparatively lower proportion in the oldest grouping (75 years +). Midlothian therefore has a larger proportion of the population with the greatest demand for public services and this is likely to remain so in the medium term (see section 2: Demographics).

By 2035, the proportion of the population (at 2011 Census levels) aged 75 years or more is predicted to more than double. Huge growth projected in the pensionable ages and especially the 75+ age group (see section 2.3.1: Age Projections) is a success story; more people are living longer! Nevertheless, this success comes with resource implications for health and care services because of rising demand for health and care services with increasing age.

Though we do not know the exact number of unpaid careers in Midlothian, their contribution is striking (see section 6.15: Carers). Sources indicate that as carers get older they take on more responsibility. We know that carers often de-prioritise their own health. This can lead to requests for crisis support.

The IJB must ensure that services continue to adapt and develop to meet the changing needs of the population and incorporate new technologies to facilitate supported self-care, working with carers and supporting service delivery.

Changing Social Landscape

A growing population needs houses to live in. Between 2012 and 2037 the number of households in Midlothian is projected to increase by 7,773 to 43,312 (see section 2.3.2: Households). Currently Midlothian has a slightly lower percentage of the population living in single-person households than other parts of the country. However, like most parts of Scotland, by 2037 Midlothian is predicted to see a rise in the proportion of people living in single-person households. The change predicted is the same as for other parts of Lothian and Scotland but we are starting from a lower baseline. By 2037 therefore, we’ll still have fewer single-person households than other areas (though will have experienced a significant rise from 2012). In fact one in three households will be occupied by someone living alone.

There is a growing understanding of the impact of loneliness on our physical and mental health. Isolation is an objective status; loneliness is a subjective experience (see section 6.10: Loneliness and Social Isolation). In light of the recognised health impacts, if the increase in single-person households is a consequence of an aging population living in the community, ensuring this population does not experience these states will be crucial. Finding ways to help people stay socially engaged will be a key challenge in the future as lifestyle changes continue.
1.3 Trend Data Visual Summary
Graph 1.1: Growth of the 65-74 and 75+ Populations (2002-2013) in East and West Localities of Midlothian
Graph 2.3: Reduction in Coronary Heart Disease Mortality in East and West Localities of Midlothian
Graph 4.5: Rising Chronic Obstructive Pulmonary Disease (COPD) Admissions to Hospital from East and West Localities of Midlothian
Graph 6.7: Comparative Alcohol Related Hospital Admissions (HAs) and Mortality from East and West Localities of Midlothian
2 Demographics

2.1 Map and Geographic Summary

Figure 2.1: Map of Midlothian

The geography of Midlothian is defined by Edinburgh’s southern boundary, the Pentland Hills in the west and the Moorfoot Hills of the Scottish Borders in the south. The overarching Local Authority in Midlothian is comprised of 16 Community Councils/Neighbourhood Planning Areas (Figure 2.1). Most of Midlothian’s population (~85,000) resides in or around the main towns of Penicuik, Bonnyrigg, Loanhead, Dalkeith, Mayfield and Gorebridge. The southern half of the authority is predominantly rural. Midlothian Council’s population projections indicate a predicted growth in population from 81,156 in 2010 to 95,490 in 2020, continuing to grow up to 2024 to a predicted level of 99,136.¹

¹ Single Outcome Agreement – Midlothian (2012 – onwards)
2.2 Population Now

Midlothian’s population was recorded as 83,187 at the 2011 census\(^2\), an increase of 817 on the General Register Office for Scotland (GROS) 2011 estimate of 82,370 and 2.8% above the 2001 census record.\(^3\)

In between the censuses the population is estimated annually by the GROS. The most recent mid-year figures (mid-2014) estimate the population of Midlothian to be 86,210 - an increase of 3,023 (or 3.6%) on the 2011 census figure.

2.2.1 Age Profile

Graph 2.1 illustrates the age profile of the population, taken from the 2011 census record. Compared with the rest of Scotland, Midlothian has above average populations of children, the older element of the working population and retired people. Conversely, the proportion of the population of working age is slightly lower than the average for Scotland. Midlothian has a comparatively lower proportion of its population in the oldest (75+) age grouping. Midlothian therefore has a larger proportion of the population with the greatest demand for public services and this is likely to remain so in the medium term.

Graph 2.1: Comparison of Populations of Midlothian and Scotland by Age

Data source: 2011 Census \url{http://www.scotlandcensus.gov.uk}

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\(^2\) \url{http://www.scotlandcensus.gov.uk/ods-web/area.html} - Accessed 20/7/15
\(^3\) The 2011 Census provides a record of the population living in Midlothian on census day (27 March 2011). It is considered a more accurate measure of population details than the estimates developed from the previous 2001 census and has been used as far as possible.
2.2.2  Gender

Graph 2.2 shows the population of Midlothian by fifteen year age bands and reveals:
- Higher numbers resident in Midlothian between the ages of 30 and 59.
- The female proportion of the population increases with age. This pattern is unchanged from the previous profile. Concerns about the implications for pensioner poverty remain therefore as, historically, women have smaller retirement pensions.

Graph 2.2: Recorded Population of Midlothian by Age Group and Gender - 2011 Census Record

![Graph showing population by age and gender](http://www.scotlandscensus.gov.uk)

2.2.3  Ethnicity

The 2011 census asked about ethnic identity and provides the most recent view of the ethnic make up of the population. At that time less than 1.8% of Midlothian’s population belonged to a Minority Ethnic Community (Table 2.1). This compares with 4% of the Scottish population overall. Although the Midlothian figure has doubled from 0.9% in 2001 the Scottish equivalent has also doubled from 2.0%.

Table 2.1: Population of Minority Ethnic Communities in Midlothian

<table>
<thead>
<tr>
<th>Ethnic Minorities (all ages)</th>
<th>% of Postal Population (2011 Census)</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Locality</td>
<td>635</td>
<td>39,154</td>
</tr>
<tr>
<td>West Locality</td>
<td>837</td>
<td>44,014</td>
</tr>
<tr>
<td>Midlothian</td>
<td>1,472</td>
<td>83,168</td>
</tr>
</tbody>
</table>


(Note: The Midlothian population total Table 2.1 is lower than that reported in section 2.2 by 19. This is likely due to postcode boundary discrepancies)
2.3 Projected Population

Population projections are statistical predictions of the growth or decline in aspects of the population; age, sex, migration etc. All such models have limiting assumptions in their development. The extent to which they are relied upon must reflect the validity of these assumptions. Caution must be exercised when using population projections for planning purposes.


In Graph 2.3, please notice that:

- While it is not of itself useful to compare the current and previous projections quantitatively, the divergence between the 2004 and 2012 projections should signal caution in the extent to which they are relied upon without other information being used.
- The 2012 projection predicts a population of 90,000 by 2023, a 7.9% increase on the 2011 census measure of 83,400 and a significant increase in the future demand for services.
- The actual population of Midlothian as measured at the 2011 census already exceeds the 2010 projection by 2.2%.
- These projections are based upon statistical trends and do not take account of information such as the scale of housing land committed and described in the Midlothian local plan.
- There is now a mid 2013 estimate of 90,090 for the projected population in 2037.

The National Records of Scotland (NRS) 2012 population projection predicts a 17.63% increase over its trajectory, 6% more than the 2010 projection. The total population of Scotland is expected to rise by 8.8%. NHS boards are expected to see similar rises in population under this projection and the population served by NHS Lothian is predicted to rise by 23%, the largest rise predicted for any Scottish health board.

2.3.1 Age Projections

Graph 2.4 shows an increase in all age groups across the population. The predicted increases are much greater as the population ages and the proportion of the current population aged 75 or more...
is predicted to more than double by 2035. This is the result of reduced premature mortality. In order to lend this analysis some context and define the relative size of the age groups over time this projection has been applied to the age profile of the 2011 census in Graph 2.5.

Graph 2.4: Projected Percentage Population Change to 2037 (2012 Estimate Base Figure)

Graph 2.5: Projected Population Change to 2037 (2012 Estimate Base Figure)

Looking at the changes in the population of Midlothian in this way it is clear that number of people aged 75+ will be the sub-group with the largest change.

N.B: The analysis assumes that the pensionable age group is 60-75 for both male and female.
2.3.2 Households
Between 2012 and 2037, the number of households in Midlothian is projected to increase by 7,773 from 35,540 to 43,312. Unlike other areas, Midlothian does not see a huge increase in the number of single person households (Table 2.2).

Table 2.2: Household Person Occupancy 2012 and projected 2037

<table>
<thead>
<tr>
<th>Council area</th>
<th>1 adult</th>
<th>1 adult, 1+ children</th>
<th>2 adults</th>
<th>2+ adults, 1+ children</th>
<th>3+ adults</th>
<th>1 adult</th>
<th>1 adult, 1+ children</th>
<th>2 adults</th>
<th>2+ adults, 1+ children</th>
<th>3+ adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
<td>28%</td>
<td>7%</td>
<td>33%</td>
<td>22%</td>
<td>10%</td>
<td>33%</td>
<td>8%</td>
<td>34%</td>
<td>19%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Data source: courtesy of NHS Lothian Analytical Services: September 2014

2.3.3 Birth and Death Rate Trends
Midlothian’s population is growing. An increasing birth rate, declining death rate and a net migration inflow all have a part to play. Successive population projections have underestimated this, possibly due to projections being trend-based population estimates and not taking account of the large scale house-building which has taken place since. It is worth noting that population projections/estimates don’t necessarily take all local changes into account.

Graph 2.6 illustrates the number of births registered for Midlothian between 2003 and 2013; in 2013 there were 1,016 births, 490 males and 526 females, a 4.2% decrease on the 2012 birth rate. The birth rate was 12.0 per 1,000 head of population in 2013, higher than the average for Scotland (10.5 per 1,000 head of population). Midlothian’s birth rate is still showing signs of increase, moving away from the Scottish average.

Graph 2.6: Birth Rate per 1,000 population in Midlothian & Scotland 2002-2013

The death rate for Midlothian in 2012 was 9.77 per 1,000 head of population (based on 2012 mid-year population estimates). The death rate was lower than the average figure for Scotland at 10.34
per 1,000 head of population. Midlothian’s death rate is consistently lower than the Scottish average (Graph 2.7). In percentage terms, Midlothian has more births than deaths, so in terms of natural change the population should be expanding. Updated figures now show there were 818 deaths in 2013.

Graph 2.7: Death rate per 1,000 population in Midlothian & Scotland 2002-2012

2.3.4 Migration

Migration is the most difficult component of population change to estimate as, unlike births and deaths, there is no comprehensive system for the registration of moves to or from the rest of the world, nor for moves within the UK. Official estimates of migration are therefore based on survey data and the best proxy data available.4

Three key sources for this are5:

- The National Health Service Central Register (NHSCR) is used to calculate moves between NHS Board areas within the UK. It is also used to distribute estimates of international migration to NHS Board areas in Scotland.
- Community Health Index (CHI) is used to estimate migration at Council area and below.
- International Passenger Survey (IPS) provides information on moves into and out of Scotland with an origin or destination of outside the UK.

Midlothian’s population has shown an increase due to migration in the six years to 2011-12. This inflow has itself increased fivefold in that time with the bulk of the increase due to migration from elsewhere in Scotland (Graph 2.8). Migration information from within Scotland migration is derived from registrations at GP practices through the Community Health Index (CHI) number.

Graph 2.8: Migration Flows for Midlothian 2006/7 to 2012/13

![Graph 2.8](image-url)

Latest figures show that the 16 to 29 year olds age group accounted for the largest in-migrants and out-migrants (Graph 2.9).

Graph 2.9: Migration, in, out, and net, Midlothian, annual average 2011-13*

![Graph 2.9](image-url)

*Migration figures are based on a 3-year average and include migration within Scotland, between Scotland and the rest of the UK, and between Scotland and overseas. They do not include asylum seekers and armed forces movements.
2.4 Dependency Ratios

Within a population, the ratio of ‘dependents’ (those aged 0-15 and 65+) to ‘working age’ individuals (those aged 16-64) is called the population dependency ratio; the higher the dependency ratio the smaller the size of the ‘working age’ population in comparison to ‘dependents’. For example a dependency ratio of 50% equates to one ‘dependent’ person for every two ‘working age’ people, a dependency ratio of 75% equates to three ‘dependent’ people for every four ‘working age’ people.

While this can be a useful indication of the age structure of the population now and projected into the future, it is also a crude measure. The ratio does not take into account factors such as employment rates and retirement ages. It also relies on future predictions of mortality, fertility and net migration (predictions vary). Table 2.3 and Graph 2.10 show calculated dependency ratios for Midlothian in comparison with Scotland using the most recent population projection data.

Table 2.3: ‘Dependents’, ‘Working Age’ and Dependency Ratios in Midlothian and Nationally 2012-2037

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2012</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
<th>2037</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 16</td>
<td>15,935</td>
<td>16,228</td>
<td>17,226</td>
<td>17,977</td>
<td>18,792</td>
<td>19,405</td>
</tr>
<tr>
<td>65+</td>
<td>14,705</td>
<td>16,933</td>
<td>18,887</td>
<td>21,048</td>
<td>23,183</td>
<td>24,781</td>
</tr>
<tr>
<td>Total Dependents</td>
<td>30,640</td>
<td>33,161</td>
<td>36,113</td>
<td>39,025</td>
<td>41,975</td>
<td>44,186</td>
</tr>
<tr>
<td>16-64 (&quot;working age&quot;)</td>
<td>53,600</td>
<td>53,827</td>
<td>54,028</td>
<td>54,284</td>
<td>54,339</td>
<td>54,904</td>
</tr>
<tr>
<td>Scotland</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 16</td>
<td>914,671</td>
<td>919,318</td>
<td>954,473</td>
<td>965,641</td>
<td>973,237</td>
<td>964,964</td>
</tr>
<tr>
<td>65+</td>
<td>925,751</td>
<td>1,023,425</td>
<td>1,124,204</td>
<td>1,251,168</td>
<td>1,383,138</td>
<td>1,473,158</td>
</tr>
<tr>
<td>Total Dependents</td>
<td>1,840,422</td>
<td>1,942,770</td>
<td>2,078,677</td>
<td>2,216,809</td>
<td>2,356,375</td>
<td>2,438,122</td>
</tr>
<tr>
<td>16-64 (&quot;working age&quot;)</td>
<td>3,473,178</td>
<td>3,464,227</td>
<td>3,440,911</td>
<td>3,409,083</td>
<td>3,357,148</td>
<td>3,342,249</td>
</tr>
</tbody>
</table>

| Dependency Ratio Midlothian | 57.2% | 61.6% | 66.8% | 71.9% | 77.2% | 80.5% |
| Dependency Ratio Scotland   | 53.0% | 56.1% | 60.4% | 65.0% | 70.2% | 72.9% |

Data source: [http://www.isdscotland.org/Products-and-Services/GPD-Support/Population/Projections/](http://www.isdscotland.org/Products-and-Services/GPD-Support/Population/Projections/)
The dependency ratio in Midlothian is projected to increase over the next two decades and to be consistently higher than that of Scotland as a whole. The main reason for this is an expected large increase in the “dependent” population aged 65+.

“The implications of an ageing population, and a worsening dependency ratio, are wide-ranging and complex. They include potential increased demands on public services (particularly from increased numbers of older people, although some of these pressures may be off-set by reduced demands for services from a smaller under 16 population, i.e. for education), and potential reduced tax revenues (unless older people work longer, a trend evident since 2002) to fund this increased demand as a result of fewer (or proportionately fewer) people aged 16 and over in employment.”

Estimating potential increased demand on public services is important in forward planning.

2.5 Socioeconomic Deprivation

The Scottish Index of Multiple Deprivation (SIMD) 2012 (as published on 18 December 2012) is: “the Scottish Government’s official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects of deprivation, combining them into a single index. It divides Scotland into 6,505 small areas called datazones, each containing around 350 households. The Index provides a relative ranking for each datazone, from 1 (most deprived) to 6,505 (least deprived). By identifying small areas where there are concentrations of multiple deprivation, the SIMD can be used to target policies and resources at the places with greatest need. The terms ‘deprivation’ and ‘poverty’ are sometimes used interchangeably. However, in this context, deprivation is defined more widely as the range of problems that arise due to lack of resources or opportunities, covering health, safety, education, employment, housing and access to services, as well as financial aspects. The

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**SIMD uses data relating to multiple aspects of life in order to gain the fullest possible picture of deprivation across Scotland. Seven different aspects are identified – the seven SIMD domains – and data from these domains are combined to produce the index**

The SIMD is calculated using 7 domains. The individual domain scores are calculated and combined to create the overall SIMD. The overall SIMD is a weighted sum of the seven domain scores. Different domains are given different weights (Table 2.4).

**Table 2.4: SIMD – Domains and associated weightings**

<table>
<thead>
<tr>
<th>Domain</th>
<th>2012 Weight</th>
<th>% of overall SIMD 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>12</td>
<td>28%</td>
</tr>
<tr>
<td>Income</td>
<td>12</td>
<td>28%</td>
</tr>
<tr>
<td>Health</td>
<td>6</td>
<td>14%</td>
</tr>
<tr>
<td>Education, Skills and Training</td>
<td>6</td>
<td>14%</td>
</tr>
<tr>
<td>Geographic Access to services</td>
<td>4</td>
<td>9%</td>
</tr>
<tr>
<td>Crime</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Housing</td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>


Information on the SIMD can be found on the Scottish Government’s website at [http://www.scotland.gov.uk/Topics/Statistics/SIMD](http://www.scotland.gov.uk/Topics/Statistics/SIMD)

It should be noted that:
- The SIMD identifies areas NOT individuals
- Not everybody living in a deprived area is deprived and not all deprived people live in deprived areas
- Rankings are relative not absolute
- SIMD measures deprivation and not affluence
- Financial poverty is treated as just one aspect of deprivation

The use of SIMD information varies but a number of organisations (including statutory agencies) use particular cut offs, such as ‘most deprived 15%’, to target funding or resources
In SIMD 2012, 8 datazones in Midlothian were within the most deprived 20% datazones in Scotland (Figure 2.2):

- 2 datazones in the most deprived 5-10% datazones, in central Dalkeith and Woodburn. The most deprived data zone in Midlothian is in Woodburn (a rank of 585)
- 1 datazone in the most deprived 10-15% (in Mayfield)
- 5 datazones in the most deprived 15-20% (one each in Dalkeith, Mayfield and Easthouses and two in Gorebridge)

Although the Scottish Government primarily targets those datazones in the most deprived 15% (or sometimes 20%) it is useful to know about the datazones that are just outwith the most deprived 20%.

Whilst all the datazones in the most deprived 20% were concentrated in Dalkeith/Woodburn, Mayfield/Easthouses and Gorebridge, the datazones in the most deprived 20-30% were spread more widely including also parts of Loanhead, Penicuik and Rosewell.

Compared to other parts of Lothian, Midlothian has the lowest number of people living in the least deprived SIMD quintiles as a proportion of local population. Midlothian is also home to the second smallest share of the most deprived people (Graph 2.11 & Table 2.5)
Graph 2.11: SIMD Quintiles

Table 2.5: Population by SIMD Quintiles Data Table

<table>
<thead>
<tr>
<th>2012/13</th>
<th>All Residents</th>
<th>Residents 75+ years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Most deprived</td>
<td>Least deprived</td>
</tr>
<tr>
<td>SIMD Quintile</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>SIMD Q1</td>
<td>16,858</td>
<td>25,872</td>
</tr>
<tr>
<td>SIMD Q2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIMD Q3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIMD Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIMD Q5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian (East Locality)</td>
<td>12,863</td>
<td>12,580</td>
</tr>
<tr>
<td>Midlothian (West Locality)</td>
<td>3,995</td>
<td>13,292</td>
</tr>
<tr>
<td>Lothian</td>
<td>91,823</td>
<td>159,316</td>
</tr>
<tr>
<td>Scotland</td>
<td>992,973</td>
<td>1,017,549</td>
</tr>
</tbody>
</table>

Data source: courtesy of NHS Lothian Analytical Services: September 2014
3 Localities

3.1 Requirements

“Public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve. We must prioritise expenditure on public services which prevent negative outcomes from arising. And our whole system of public services – public, third and private sectors – must become more efficient by reducing duplication and sharing services wherever possible. Experience tells us that all institutions and structures resist change, especially radical change. However, the scale of the challenges ahead is such that a comprehensive public service reform process must now be initiated, involving all stakeholders.”

”. . . effective services must be designed with and for people and communities – not delivered ‘top down’ for administrative convenience”


Community Health Partnerships have been criticised for a lack of opportunity for communities and a range of professionals to take an active role in, and provide leadership for, local planning of service provision. The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health and Social Care Partnerships to identify at least two localities and to include representatives from these localities in the strategic planning group. A locality is defined in the Act as a smaller area within the borders of an Integration Authority. The purpose of localities is to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the Integration Authority’s strategic commissioning plan – localities must have real influence on how resources are spent in their area.

The principles by which the Localities will operate were defined in 2012 via 2 workshops:

1. They are co-produced with local communities, users of services and their unpaid carers.
2. They are an integral part of their Health and Social Care Partnership and will be held to account for the delivery of local priorities.
3. They are based on trust and parity of respect between all partners.
4. They are multidisciplinary and multi-sector.
5. They have common purpose through an agreed scope and local outcomes for the population.
6. There is a clear understanding of the measurable outcomes for both services and service users that will be delivered by multi-disciplinary teams.
7. They have a level of devolved financial and operational responsibility within the Health and Social Care Partnership to make decisions on the use of resources and service delivery for their communities.
8. They make a central contribution to the development and delivery of the joint strategic commissioning plans.
9. They will have a focus on creating health and tackling inequalities through service planning, co-production, support for self-management and asset-based approaches.
10. They embody non-competitive direct engagement in the commissioning of support and services.

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8 http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

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3.2 Midlothian’s Approach – East & West

Locality areas should be based on clusters of GP practices and should relate to natural local communities in ways that make sense to the people living and working in them. Their size will vary, but will need to feel ‘right’ to people living and working in the area: large enough to offer sufficient scope for service improvement, but small enough to feel local and ‘real’. Midlothian is small geographically and in population terms and due to the practicalities and implications of commissioning on small scales, the impact of a localities based approach was discussed with Scottish Government. The requirement for at least two localities was upheld and subsequent analysis of the services, pressures and geography across Midlothian resulted in determining a pragmatic East/West split (Table 3.1 & Figure 3.1).

Table 3.1: Midlothian Neighbourhood Districts by East/West Split

<table>
<thead>
<tr>
<th>Locality</th>
<th>Neighbourhood Area</th>
<th>Population</th>
<th>% Over 75s</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>Penicuik &amp; District</td>
<td>13,948</td>
<td>7.2%</td>
</tr>
<tr>
<td></td>
<td>Howgate</td>
<td>854</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roslin / Bilston</td>
<td>3,185</td>
<td>8.5%</td>
</tr>
<tr>
<td></td>
<td>Damhead</td>
<td>624</td>
<td>6.6%</td>
</tr>
<tr>
<td></td>
<td>Loanhead &amp; District</td>
<td>5,508</td>
<td>8.5%</td>
</tr>
<tr>
<td></td>
<td>Bonnyrigg / Lasswade</td>
<td>11,538</td>
<td>7.3%</td>
</tr>
<tr>
<td></td>
<td>Poltonhall &amp; District</td>
<td>6,046</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rosewell &amp; District</td>
<td>1,500</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td><strong>Total Population</strong></td>
<td><strong>43,167</strong></td>
<td><strong>7.40%</strong></td>
</tr>
</tbody>
</table>

| East     | Dalkeith & District        | 8,800      | 7.7%       |
|          | Eskbank / Newbattle        | 5,634      |            |
|          | Danderhall & District      | 3,636      |            |
|          | Mayfield / Easthouses      | 7,577      |            |
|          | Newtonrange                | 4,931      |            |
|          | Gorebridge & District      | 6,197      | 7%         |
|          | Moorfoot                   | 596        |            |
|          | Tynewater                  | 1,924      | 8.4%       |
|          | **Total Population**       | **39,295** | **7.18%**  |


(Note striking contrast is found in East Midlothian in the geographic area per person ranging from a five-a-side pitch in Newtonrange to 18 football pitches in Moorfoot)

Comprised of smaller Neighbourhood Areas, each locality has a different health and social care profile (described throughout this document) and distinctive characteristics. A significant difference in East Midlothian is the presence of three areas of multiple deprivation (parts of Gorebridge, Mayfield and, Woodburn [Dalkeith & District]); in total there are 8 data zones in most deprived 20% areas in Scotland. In these areas the life expectancy can be significantly (up to 12 years) less than for people residing in more affluent areas of Midlothian. Although ‘All Cause Mortality rates’ for the population of Midlothian as a whole demonstrates a consistent downward trend, this hides variation in disease specific mortality in East and West localities.
Figure 3.1: Midlothian Neighbourhood Planning Areas by East/West Split
4 Determinants of Health and Health Inequalities

Figure 4.1: The Determinants of Health

4.1 A Picture of Health Inequalities in Midlothian

4.1.1 Overview
Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups.\(^9\)

People living in Midlothian who are affected by poverty and social disadvantage have poorer health outcomes than their neighbours with more resources and better life chances. We know that people experiencing deprivation are more likely to die at a younger age and that they are more likely to suffer ill-health. There is now a substantial evidence base, describing the poorer health outcomes experienced by people across the social gradient. This was eloquently described by Sir Michael Marmot in his report ‘Fair-society, Healthy-lives’\(^10\), which set out clear policy areas for action. Other people also experience disadvantage and these too need careful consideration by services; broadly these can be grouped together as issues of low income, gender, social position, ethnic origin, geography, age and disability. However, despite years of effort trying to reduce health inequalities there remain significant differences in population health. In part this is because addressing disadvantage needs concerted efforts across agencies outside health and social care. This is difficult to do and requires long-term commitment. It is also difficult for services to easily identify individual people who are experiencing deprivation.

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\(^9\)World Health Organisation [Available at: http://www.who.int/hia/about/glos/en/index1.html]
4.1.2 Measurement
The main method used to describe geographical areas in Scotland which are most affected by deprivation is the government based tool the Scottish Index of Multiple Deprivation (SIMD)\(^{11}\). This tool identifies small areas with high levels of deprivation, allowing services to then consider how best to respond to these areas of need and is described in this needs assessment in more detail under section 2.6.

While the SMID is very useful it does not identify all people who are facing disadvantage and who are affected by health inequalities. Deprivation in Midlothian can be ‘hidden’ to this method of analysis. Individual people experiencing poverty may live in a relatively affluent and well provided for area. The challenge remains to accurately identify everyone who will benefit from support.

A range of indicators have been identified by the Scottish Public Health Observatory for every local authority area in Scotland. This provides us with some insights into how the health of the population is changing and also a means of monitoring some of the drivers of disadvantage in the population.

4.1.3 Future
The central challenge for health and social care services is promoting upstream work to prevent disadvantage from occurring in the first place. This involves influencing wider Government agencies, which may well have competing priorities to address. Finding ways to address inequalities can feel overwhelming at times. However, there are opportunities to work differently with the creation of the new Health and Social Care partnerships. This will be discussed further in our Strategic Plan.

4.2 Socioeconomic Deprivation Causes Health Inequalities
Health inequalities are influenced by a wide range of factors including\(^{12}\):

- Access to education
- Employment
- Good housing
- Equitable access to healthcare
- Individuals’ circumstances and behaviours – such as their diet, how much they drink, smoke or exercise and income levels
- Wider national and global issues

Midlothian contains stark differences in socio-economic deprivation cheek by jowl. The inequalities can be illustrated using nearby areas defined by Scottish Public Health Observatory (Gorebridge, Pathead and Rural East Midlothian, and Eskbank) as reference examples compared to Midlothian as a whole:

- Gorebridge has a higher level of income deprivation and working age population claiming benefits. The population in this area also has higher hospitalisation rates for COPD,

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\(^{11}\) The SIMD uses data relating to multiple aspects of life in order to gain the fullest possible picture of deprivation across Scotland. Seven different aspects are identified - the seven SIMD domains - and data from these domains are combined to produce the index. [What is the SIMD? | SIMD](http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf)

emergency admissions in the over 65s. All comparators score significantly worse than the Midlothian values.

- Four miles east in Pathhead and Rural East and Midlothian the economic comparators are nearly the mirror opposite of Gorebridge.
- Four miles north in Eskbank, all economic and health indictors used to describe Gorebridge are significantly better.

Over the past 50 years health and life expectancy have improved overall however health inequalities remain entrenched. Deprivation is the key determinant of health inequalities as health and life expectancy both generally decline as deprivation levels increase. The Long Term Monitoring of Health Inequalities report\textsuperscript{13}, which shows absolute and relative differences for a number of conditions and indicators in Scotland, also shows significant gaps between deprived groups and the rest of the population.

Tackling health inequalities is therefore important, challenging and requires co-ordinated partnership working.

4.3 Qualifications
The 2011 census showed that Midlothian has the fewest people in Lothian with degree level qualifications while also having the highest percentage of people, compared with other Lothian local authorities (but similar to Scotland), with no qualifications whatsoever (Graph 4.1).

Graph 4.1: Qualifications for people aged 16 and over

Low educational attainment also drives inequalities – especially where this is linked to unemployment. In most Western countries, lifestyle factors such as smoking, drinking to excess and


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overweight/obesity only explain about a third of differences in health outcomes. Most of the remaining differences are a result of the combination of wider social factors. Education supports individuals to get a job and reduces levels of poverty. It also acts along with other determinants of health (housing, income, transport, work employment, access to healthcare); enabling individuals to better protect their own health, of their families and also through the community to improve the wider physical environment.

4.4 Employment

Currently, Midlothian’s largest employers remain the public sector: Midlothian Council with 3,351 employees; NHS Lothian (526); and Police Scotland (approx 346). The largest private sector employers are Arthur McKay, Tesco, Mactaggart Scott and Dobbies.

The percentage of the working age population in employment in Midlothian decreased from 74.0% to 73.0% for the period July 2013 – June 2014. However, employment levels remain above the Scottish and GB figures for June 2014 at 71.8% and 71.9% respectively.

Table 4.1: Midlothian Based Employment by Occupation Jun 2012-13

<table>
<thead>
<tr>
<th>SOC 2010 Group number &amp; Occupational Title</th>
<th>Midlothian Numbers</th>
<th>Midlothian %</th>
<th>Scotland Numbers</th>
<th>Scotland %</th>
<th>Great Britain Numbers</th>
<th>Great Britain %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Managers &amp; Senior Officials</td>
<td>3,200</td>
<td>2,800</td>
<td>7.7</td>
<td>7.2</td>
<td>8.3</td>
<td>8.6</td>
</tr>
<tr>
<td>2. Professional Occupations</td>
<td>6,400</td>
<td>5,800</td>
<td>15.5</td>
<td>14.9</td>
<td>19.0</td>
<td>19.9</td>
</tr>
<tr>
<td>3. Associate professional &amp; technical</td>
<td>5,500</td>
<td>5,200</td>
<td>13.3</td>
<td>13.2</td>
<td>12.9</td>
<td>13.0</td>
</tr>
<tr>
<td>4. Administrative &amp; secretarial</td>
<td>5,500</td>
<td>4,400</td>
<td>13.4</td>
<td>11.2</td>
<td>10.9</td>
<td>11.0</td>
</tr>
<tr>
<td>5. Skilled trades occupations</td>
<td>4,900</td>
<td>5,400</td>
<td>12.0</td>
<td>13.7</td>
<td>11.4</td>
<td>11.1</td>
</tr>
<tr>
<td>6. Personal service occupations</td>
<td>5,100</td>
<td>4,300</td>
<td>12.3</td>
<td>11.0</td>
<td>9.8</td>
<td>9.0</td>
</tr>
<tr>
<td>7. Sales &amp; customer service occupations</td>
<td>3,700</td>
<td>3,500</td>
<td>9.0</td>
<td>9.0</td>
<td>9.2</td>
<td>9.0</td>
</tr>
<tr>
<td>8. Process plant &amp; machine operatives</td>
<td>2,000</td>
<td>2,200</td>
<td>4.9</td>
<td>5.5</td>
<td>6.6</td>
<td>6.4</td>
</tr>
<tr>
<td>9. Elementary occupations</td>
<td>4,800</td>
<td>5,300</td>
<td>11.6</td>
<td>13.4</td>
<td>11.5</td>
<td>11.3</td>
</tr>
<tr>
<td>Total</td>
<td>41,100</td>
<td>38,900</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data source: ONS annual population survey. Notes: Numbers and percentage are for those 16+; % is a proportion of all persons in employment.

Table 4.1 shows that, during 2012-13 there has been a decrease (2,200) in the number of people being employed in Midlothian across many occupational areas, however, there have been increases

14 Oxford Handbook of Public Health Practice ; Oxford University Press, 2006
in the Skilled Trade, Process Plant and Machine Operatives and Elementary occupations. In comparison with the GB and Scottish figures Midlothian is under-represented in groups 1 and 2.

4.4.1 Income
There has been a persistent though declining deficit between the wages earned in Midlothian businesses and those earned by Midlothian residents (Graph 4.2). This could indicate a shift towards increased residency in Midlothian however it could also suggest that Midlothian’s residents do not have the skills and qualifications to compete for the highest paid jobs available from Midlothian’s employers. Improvements in the educational attainment suggest that this is getting better but Midlothian’s success in attracting science based industries may mean that even more must be done to ensure this keeps reducing. Efforts must be made to ensure residents’ wages are rising to meet the Midlothian Employee median earnings as this is a major factor in perpetuating health inequalities.

Graph 4.2: Comparison of Median Gross Weekly Earnings Midlothian for Employees & Residents 2008-14

Data source: NOMIS

4.5 Housing
The newly formed Health and Social Care Partnership does not include any responsibility or power over housing. The essential role that housing plays in wellbeing and enablement is acutely recognised however and the partnership and housing department have ensured that strong links have been formed between them.

The 2020 vision seeks to treat people “at home or in a homely setting”. If this is to be achieved the Health and Social Care partnership and Housing must continue to work increasingly closely to respond robustly to the needs of the population with regard for the local housing stock. Though

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15 Midlothian Profile 2014
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new build housing will meet current standards, much of the housing stock is 1950 houses, less suited to meet increasing home based needs without adaptation.

There is great potential to develop our partnership by working to deliver a ‘First Through The Door’ approach for needs awareness and onwards referral to enhance joined up working and maximise efficiencies for patient centred care. This approach is in line with national initiatives such as Building Safer Communities and the Adapting for Change pilot.

4.5.1 Adaptations to Housing Stock for Residents to Remain at Home
Suitable housing has long been regarded as vital in supporting people who are frail or have some form of disability, to live successfully in the community. Staying at home is a viable option for most of us as we age depending on our home’s location, accessibility, size, energy efficiency and proximity to local amenities. Midlothian Council continues to build new housing ensuring that some priority is given to the needs of older people, most recently through the construction of Cowan Court extra-care housing in Penicuik. We are also working with Housing Associations to redesign some sheltered housing schemes (there are 310 apartments in 11 schemes) to enable people with higher levels of need to be supported.

We need to consider how our housing models will drive our care aspirations especially with regard to dementia friendly and learning disabled appropriate environments.

4.5.1.1 Number
The requirement for adaptations is increasing; the number has doubled in the last 4 years. A review of the 2013/14 major adaptation works illustrates a significant rate of installation in the private sector, with 47.1% of all adaptations in owner occupied and private rented sectors identified as necessary works for older people, compared with 42.4% in Council tenancies and remaining 10.5% on Registered Social Landlord (RSL) tenancies. The extent of work is incorporated in Table 4.2 (for older people only) according to their tenure.

Projections for future adaptations suggest significant increases in the number of adaptations and the level of investment required, indicating the total number of adaptations will increase from 247 in 2013/14 to 463 in 2017/18. The need for adaptations will be monitored annually as there has been some recent fluctuations in the demand for adaptations and projections have not taken into account the investment in certain housing types, such as Extra Care Housing and reuse of existing adaptations within the housing stock. If this projection is realised a considerable increase in the level of investment would be required in order to carry these adaptations. This could have a significant impact on future rents charged by social landlords and the capacity of existing resources to meet this need.\(^\text{16}\)

Table 4.2: Actual 2013-15 and Projected 2015/18 Housing Adaptations by Tenure (Older People)

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Council Housing Stock</th>
<th>Private Housing Stock</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>117</td>
<td>130</td>
<td>247</td>
</tr>
<tr>
<td>2014/15</td>
<td>137</td>
<td>152</td>
<td>289</td>
</tr>
<tr>
<td>2015/16</td>
<td>160</td>
<td>178</td>
<td>338</td>
</tr>
<tr>
<td>2016/17</td>
<td>187</td>
<td>208</td>
<td>396</td>
</tr>
<tr>
<td>2017/18</td>
<td>219</td>
<td>244</td>
<td>463</td>
</tr>
</tbody>
</table>

Data Source:

The latest Scottish Household Condition Survey figures for adaptations are shown in Table 4.3. It shows that, by number, the majority of housing stock is post 1945, about 60% more houses have been adapted than flats, around twice as many flats require adaptations compared to housing and owner occupied and social housing adaptations are broadly on a par. Of those restricted by their dwelling: ownership to social housing is a 2:1 ratio, they are over 7.5 times more likely to live in a house than a flat, and the largest group are pensioners.

Table 4.3: Midlothian Adaptations

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th>Pre-1945</th>
<th>Post-1945</th>
<th>House</th>
<th>Flat</th>
<th>1 or 2</th>
<th>3+</th>
<th>Owner-occupied</th>
<th>Social Housing</th>
<th>Private Rented</th>
<th>Families</th>
<th>Pensioners</th>
<th>Adult Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Households (000s)</td>
<td>36</td>
<td>29</td>
<td>7</td>
<td>29</td>
<td>6</td>
<td>14</td>
<td>22</td>
<td>24</td>
<td>10</td>
<td>2</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>% of LA</td>
<td>23%</td>
<td>18%</td>
<td>22%</td>
<td>16%</td>
<td>47%</td>
<td>30%</td>
<td>16%</td>
<td>17%</td>
<td>38%</td>
<td>*</td>
<td>14%</td>
<td>35%</td>
<td>18%</td>
</tr>
<tr>
<td>% of Dwellings requiring Adaptations</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>5%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>*</td>
<td>1%</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>% Dwellings containing a Long Term Sick or Disabled individual who is restricted by the dwelling</td>
<td>7%</td>
<td>11%</td>
<td>7%</td>
<td>8%</td>
<td>5%</td>
<td>10%</td>
<td>6%</td>
<td>7%</td>
<td>7%</td>
<td>*</td>
<td>3%</td>
<td>12%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Note: % figures rounded to 1 s.f.

Data source: Scottish Household Condition Survey – Local Authority Analyses (2011-2013)

4.5.1.2 Cost and Prevailing Type

The cost to meet adaptations varies depending on tenure:

- Owner Occupier/Private let: 80% or 100% home improvements grants are available via Environmental health from Scottish Government
- Registered Social Landlords: Money allocated from Scottish Government
- Council Properties: Health and Social Care contribute to a percentage
Significant investment in property is required annually to ensure households with mobility needs are able to remain in their own home. Table 4.4 shows investment during 2012/13 in terms of adaptations to council housing and private sector housing.

### Table 4.4: Council Housing and Private Sector Housing Adaptations 2012/13

<table>
<thead>
<tr>
<th>Year</th>
<th>Council</th>
<th>Private Sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£454,593</td>
<td>£410,653</td>
<td>£865,193</td>
</tr>
</tbody>
</table>

Data source: Midlothian Council Internal Data

The ‘Top 9’ major adaptations currently undertaken by Midlothian are shown in Table 4.5 along with associated costs. Additionally, the council funds a range of smaller adaptations to assist people to live safely in their own home.

### Table 4.5: Midlothian ‘Top 9’ Adaptations Costs

<table>
<thead>
<tr>
<th>Adaptations</th>
<th>Installation Cost</th>
<th>Service Costs (ex. VAT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wet Floor Shower</td>
<td>£4,000 - £5,000</td>
<td>n/a</td>
</tr>
<tr>
<td>Straight Stairlift</td>
<td>£600 - £1,800</td>
<td>£31 -54</td>
</tr>
<tr>
<td>Curved</td>
<td>£3,000 - £5,000</td>
<td>£31 -54</td>
</tr>
<tr>
<td>Ramps</td>
<td>£1,500 - £8,000</td>
<td>n/a</td>
</tr>
<tr>
<td>Closomat Toilets</td>
<td>£2,500 - £3,800</td>
<td>£135</td>
</tr>
<tr>
<td>Ceiling Track Hoists</td>
<td>£2,000 - £4,000</td>
<td>£96 (total for twice yearly)</td>
</tr>
<tr>
<td>Automatic Door Openers</td>
<td>£1,500 - £3,000</td>
<td>n/a</td>
</tr>
<tr>
<td>Through Floor Lifts</td>
<td>£8,500-14,000</td>
<td>£39-43</td>
</tr>
<tr>
<td>Step Lifts</td>
<td>£8,000 - £11,000</td>
<td>£39-43</td>
</tr>
</tbody>
</table>

Data source: Midlothian Council Internal Data

### 4.5.2 Homelessness

Poor health is not only a consequence of homelessness but can also help to precipitate it. The NHS Inequalities Strategy states: “Homeless people suffer substantially poorer physical and mental health than the rest of the population. Health starts to deteriorate within two weeks of homelessness.”

More generally there is a greater risk of premature death and morbidity amongst the homeless population than amongst the population at large.

On 21\textsuperscript{st} November 2012 the Scottish Parliament voted to approve the Homelessness (Abolition of Priority Need Test) (Scotland) Order 2012. This established a homelessness commitment that from the end of 2012 all those assessed as unintentionally homeless by local authorities will be entitled to settled accommodation as a legal right. Nationally figures have shown that an approach which focuses on prevention is working in that fewer people are reaching the point of homelessness.\footnote{http://www.ccpscotland.org/hseu/resources/2012-homelessness-target/- accessed 29\textsuperscript{th} June 2015}

This has increased the number of households Midlothian Council provides assistance to overall despite a decrease in households presenting as homeless (Graph 4.3)
Midlothian Council has undertaken a variety of actions to address homelessness and ensure it could meet the Homeless 2012 target (see Midlothian Council Strategic Housing Investment Plan 2013/14 – 2017/18 [p.17]).

“It can be more difficult for homeless people to sustain continuity of care, to meet appointments made a long time in advance, or to participate in health improvement and health promotion activities, such as healthy eating and physical activity. Maintaining contact with key workers such as the family GP, social workers, dentists and lawyers can be difficult if the household is accommodated temporarily some distance away from such support networks. Research suggests that flexibility in health services for homeless people results in high levels of satisfaction”\(^{19}\). The Health & Social Care Partnership must therefore strengthen collaborative working including Housing. The recent publication of Restoring the Public Health response to Homelessness in Scotland\(^{20}\) should offer additional support for further development in this area.

### 4.6 Fuel Poverty

Fuel is essential to maintaining a comfortable environment throughout the year, especially during the colder winter weather. Again if more of the population are to be maintained at home then ensuring that homes are adequately heated will be an essential requirement. The global economic downturn has been a challenge to Midlothian and fuel poverty has been a real consequence. Latest figures from the Scottish Household Condition Survey show that pensioners are the largest group affected for both fuel poverty and extreme fuel poverty (Table 4.6). Owner-occupied tenants of 3+ bedrooms, houses are greatest in absolute number but nearly half of social housing tenants are recorded as experiencing fuel poverty.


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### Table 4.6: Midlothian Fuel Poverty

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Fuel Poverty by Dwelling Characteristics</th>
<th>Fuel Poverty by Household Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age of Dwelling</td>
<td>House or Flat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-1945</td>
</tr>
<tr>
<td>Number of Households (000s)</td>
<td>Total</td>
<td>36</td>
</tr>
<tr>
<td>% of LA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Fuel Poor Households:</td>
<td>31%</td>
<td>45%</td>
</tr>
<tr>
<td>% of Households Extreme Fuel Poor</td>
<td>8%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Note: % figures rounded to 1 s.f.

Data source: Scottish Household Condition Survey – Local Authority Analyses (2011-2013)
5  Behavioural Determinants of Health – Lifestyle Factors

5.1  Smoking
Smoking is strongly associated with a number of long-term conditions including Chronic Obstructive Pulmonary Disease (COPD), as well as lung cancer. Promotion of smoking cessation is therefore a crucial step in our ability to improve the health of the Midlothian population.

5.1.1  Smoking Prevalence
It is estimated that approximately 18,500 people in Midlothian are smokers. Data from the Scottish Public Health Observatory suggests 27% of the population are active smokers, compared to 21.9% in Scotland overall.\footnote{Data courtesy of NHS Lothian Analytical Services: September 2014}

“Smoking prevalence amongst the Midlothian adult population (25.4%) for combined survey years 2012/2013 was not significantly different from the Scottish average (23.0%), with both sexes and each age grouping being not significantly different from their respective Scottish averages. The adult smoking prevalence has been around 25% over time; however, in 2007/2008 combined surveys, it increased to 28%.”\footnote{ScotPHO Tobacco Profiles Second Release (January 2015) available \url{http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool} - Accessed 24 April 2015.}

“Midlothian had a significantly higher (worse) percentage of women smoking during pregnancy when compared with the Scottish average (26.1% and 20.1%, respectively) for the 3-year combined period 2010-2012. This has increased since the early 2000s when the prevalence was around 17%, but, since 2010, has stabilised around 26%. There is evidence of under-reporting by women of their smoking behaviour at the booking appointment (see the latest ISD births report). This issue is being addressed, and has improved in recent years. This may have had an effect on prevalence levels and therefore trend data.

Following the Scotland trend, the percentage of women smoking during pregnancy in Midlothian increases as the level of deprivation increases. However, the highest percentage is in the second most deprived area (33.1%). Those living in the most deprived areas are approximately 3 times more likely to smoke during pregnancy than those in the least deprived areas (Graph 5.1).

Additionally, significantly fewer pregnant women made a quit attempt (19.3%) with the help of NHS smoking cessation services compared with the Scottish average (23.5%).

Post-partum smoking rates were significantly higher in Midlothian when compared with the Scottish average (21% vs. 17%, respectively) for financial year period 2010/11-2012/13. However, since financial year 2009/10, the rate of post-partum smoking has remained constant.”
Graph 5.1: Percentage of women smoking during pregnancy by SIMD quintiles in Scotland

5.1.3 Smoking Related Mortality

“There were around 3,300 smoking attributable hospital admissions per 100,000 of the population in Midlothian for the combined 3-year period 2011-2013. This was significantly higher (worse) than the Scottish average at approx 3,150 per 100,000 population; however, this may reflect the high recording of diagnostic information in hospital systems. The rate of smoking attributable deaths per 100,000 was not significantly different to the Scottish average (360 vs. 325, respectively).

Over the same time period, the COPD incidence rate per 100,000 in Midlothian was significantly higher (worse) than the Scottish average (444 vs. 391, respectively, however, please note coding comment above). The number of deaths per 100,000 from COPD was not significantly different from the Scottish average (86 vs. 78, respectively). Over time, the rate has dropped to its current level (78) from 128 in 2003-2005 combined years.

Lung cancer registrations per 100,000 population for the combined 3-year period 2010-2012 were not significantly different from the Scottish average (135 vs. 133, respectively), and have been decreasing since 2008-2010. The rate of lung cancer deaths per 100,000 population for 2011-2013 combined years was not significantly different from the Scottish average (114 vs. 107 respectively), with rates showing a decrease over the last decade, from a high of 152 in 2004-2006.”

5.1.4 Smoking Cessation Services

The proportion of successful quit attempts among the smoking population in Midlothian is very similar to that of the Scottish population (3.9% of all smokers in Scotland and Midlothian successfully quit according to data from the Scottish Health Survey).

“There were 1,874 quit attempts made with the help of NHS smoking cessation services in 2013. This was a 3.8% increase on 2012, where there were 1,805 quit attempts. This was contrary to the trend seen at the Scotland level where for the first time in recent years there has been a decrease, which could be partly explained by the rise in use of electronic cigarettes (a 13% reduction is seen at Scotland level).

The number of quit attempts made with an NHS smoking cessation service in 2013, as a % of total estimated adult smoking population (SHoS, 2012) was significantly higher (better) than the Scottish average (10.8% vs. 10.1, respectively). The same was true for the successful one month self-reported quits (4.1% vs. 3.8%, respectively), again as a % of total estimated adult smoking population (SHoS, 2012).

Quit rates (the percentage of self-reported quits, as based on all quit attempts set through a smoking cessation service) at three (9.0%) and twelve months (3.9%) after quit date were significantly lower (worse) than the Scottish average (11.2% and 5.6%, respectively); however, at one month they were not significantly different from the Scottish average.

The one month quit rates in all deprivation quintiles were not significantly different compared with the Scottish average. The quit rate was 38.2% in the most deprived group compared with 45.2% in the least deprived group (Graph 5.2).

Dispensing of smoking cessation products in Midlothian for financial year 2013/14 was significantly higher (better) than the Scottish average (6 daily doses per 1,000 population vs. 5 daily doses per 1,000 population). There has been a consistent increase in the number of smoking cessation products dispensed each financial year since 2007/08. However, over the last 2 financial years (2012/13-2013/14), the number of products dispensed has been falling.”

<table>
<thead>
<tr>
<th>Our Key Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Action should be taken to ensure all health professionals address smoking in all care settings and refer to smoke free Lothian.</td>
</tr>
<tr>
<td>• Improve reach into target communities, with use of NHS and Council media services, Midlothian Area Resources Co-ordination for Hardship (MARCH)</td>
</tr>
<tr>
<td>• Continue to strengthen links with community groups/third sector providers.</td>
</tr>
<tr>
<td>• Awareness of 2035 targets has to be raised (see Section 5.1.5: Tobacco Prevention); communities need to be involved in this.</td>
</tr>
<tr>
<td>• Campaigns to raise awareness of Stop Smoking Services, as well as encourage smokers to quit (e.g. ex-smokers 5K run). This includes promoting national campaigns such as &quot;Stoptober&quot;.</td>
</tr>
</tbody>
</table>

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26 SHoS – Scottish Household Survey

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5.1.5 Tobacco Prevention

In 2013 the Scottish Government set a target to make Scotland smoke-free by 2034\(^{27}\). In setting this target the modelling assumes the prevalence of smoking among young people age 15 years will reduce by 2.5% every two years until a floor of 2% is reached. The rate of 15 year olds in Midlothian who smoke in 2013 was 6% which is 3% below the Scottish average\(^{28}\). Whilst encouraging, the downward trend among younger adolescents is overshadowed by the rapidly accelerating year on year increase in the rate of smoking among young people ages 16-24 years, where the average nationally is around 24% (and even higher within certain categories of young people such as those unemployed or in low-paid employment)\(^{29}\). Consequently, reducing the prevalence of youth smoking to achieve the overall national target will require sustained action by agencies across all sectors.

In line with Scottish Government tobacco control strategy, priority actions required in Midlothian in future are:

- Rigorous enforcement of tobacco sales laws, including tackling under-age purchases and proxy sales
- Implementation of smoke-free policies across Midlothian Council and NHS properties and surrounding grounds
- Review and improve tobacco education in secondary schools (across all years S1-S6), Community Learning and Development (CLD) establishments and youth-work services
- Review and improve implementation of smoke-free policies within schools, CLD establishments and youth-work services
- In keeping with Getting It Right For Every Child (GIRFEC) principles, services should proactively support parents/carers to protect children from second-hand smoke


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\(^{27}\) Scottish Government 2013, Creating A Tobacco-Free Generation: A Tobacco Control Strategy for Scotland

\(^{28}\) NHS National Services Scotland 2013, Scottish Adolescent Lifestyle and Substance Use Survey

\(^{29}\) ScotPHO 2009, Young Adult Smokers in Scotland
5.2 Misuse of Drugs and Alcohol

The issue of substance misuse can be an emotive one; there is a tendency to consider the problem as one which is self-inflicted and not fully appreciate the difficulties people have in dealing with their dependency. The impact of substance misuse is also not just on the individual but on their family and wider society.

5.2.1 Drugs

Table 5.1 and Table 5.2 reveal that while Midlothian had comparatively lower rate of new clients in 2011-12 compared to NHS Lothian and Scotland as a whole, Midlothian also currently faces a considerable challenge with respect to drug abuse among young people between the ages of 20 and 29 where the rate of new clients is considerably higher than the rate experienced in both Lothian and Scotland-wide. In other age groups the rate appears to be lower than that in Lothian and Scotland.

Table 5.1: New Patients/Clients Attending Drug Treatment Services (Numbers & Standardised Rate/100,000 Population for Midlothian & Scotland)

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
<td>127</td>
<td>145</td>
<td>143</td>
<td>145</td>
<td>141</td>
</tr>
<tr>
<td>Lothian</td>
<td>2,190</td>
<td>2,280</td>
<td>1,973</td>
<td>1,977</td>
<td>1,893</td>
</tr>
<tr>
<td>Scotland</td>
<td>13,120</td>
<td>12,345</td>
<td>11,665</td>
<td>11,696</td>
<td>11,380</td>
</tr>
<tr>
<td>Midlothian EASR</td>
<td>199</td>
<td>219</td>
<td>215</td>
<td>220</td>
<td>203</td>
</tr>
<tr>
<td>Lothian EASR</td>
<td>253</td>
<td>261</td>
<td>225</td>
<td>223</td>
<td>211</td>
</tr>
<tr>
<td>Scotland EASR</td>
<td>270</td>
<td>253</td>
<td>238</td>
<td>238</td>
<td>230</td>
</tr>
</tbody>
</table>


Table 5.2: New Clients/Patients at Drug Treatment Services by Age Group 2010-11 (Numbers and Standardised Rates/100,000 Population)

<table>
<thead>
<tr>
<th></th>
<th>All Ages</th>
<th>Under 20</th>
<th>20 - 24</th>
<th>25 - 29</th>
<th>30 - 34</th>
<th>35 - 39</th>
<th>40 yrs+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
<td>141</td>
<td>6</td>
<td>26</td>
<td>36</td>
<td>30</td>
<td>25</td>
<td>18</td>
</tr>
<tr>
<td>Lothian</td>
<td>1,889</td>
<td>145</td>
<td>259</td>
<td>367</td>
<td>386</td>
<td>347</td>
<td>385</td>
</tr>
<tr>
<td>Scotland</td>
<td>11,363</td>
<td>757</td>
<td>1,457</td>
<td>2,143</td>
<td>2,555</td>
<td>1,972</td>
<td>2,479</td>
</tr>
<tr>
<td>Midlothian EASR</td>
<td>203</td>
<td>28</td>
<td>489</td>
<td>764</td>
<td>720</td>
<td>525</td>
<td>47</td>
</tr>
<tr>
<td>Lothian EASR</td>
<td>211</td>
<td>72</td>
<td>385</td>
<td>505</td>
<td>598</td>
<td>601</td>
<td>101</td>
</tr>
<tr>
<td>Scotland EASR</td>
<td>230</td>
<td>58</td>
<td>397</td>
<td>598</td>
<td>793</td>
<td>613</td>
<td>104</td>
</tr>
</tbody>
</table>


Scottish Public Health Observatory (ScotPHO) drugs data is complied for Mid- and East Lothian jointly. A selection of the latest figures relevant to the joint needs assessment is shown in Table 5.3. Locally it has been determined that there are approximately 570 regular drug users in Midlothian.\(^{30}\)

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\(^{30}\) Midlothian Strategic Issues Paper
### Table 5.3: Drugs profile (Mid and East Lothian Alcohol & Drug Partnership)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Period</th>
<th>Number</th>
<th>Measure</th>
<th>Measure Type</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Drug-related hospital stays(^A)</td>
<td>2013</td>
<td>188</td>
<td>112.1</td>
<td>sr3</td>
<td>124.6</td>
</tr>
<tr>
<td></td>
<td>Drug-related mortality</td>
<td>2013</td>
<td>16</td>
<td>9.3</td>
<td>sr3</td>
<td>10</td>
</tr>
<tr>
<td>Prevalence</td>
<td>Population prevalence of problem drug use</td>
<td>2012</td>
<td>1800</td>
<td>1.5</td>
<td>%</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Male prevalence of problem drug use</td>
<td>2012</td>
<td>1270</td>
<td>2.2</td>
<td>%</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>Female prevalence of problem drug use</td>
<td>2012</td>
<td>530</td>
<td>0.9</td>
<td>%</td>
<td>1</td>
</tr>
<tr>
<td>Services</td>
<td>Drug treatment waiting times(^B)</td>
<td>2013</td>
<td>2</td>
<td>0.5(^C)</td>
<td>%</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Data source: [https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do](https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do)

A: The ESP2013 has been used to calculate the rate for this indicator. Please see Appendix I of the technical report for further details.
B: Indicator based on Health Board boundaries prior to April 2014.
C: Percentage of clients waiting for more than 3 weeks between referral to a specialist drug and alcohol service and start of treatment (HEAT Target)

**Measure Type Key:**

- % = percent
- sr3 = age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

The number of drugs related deaths in Midlothian is low and has been relatively stable over the past 6 years (partial figures shown Table 5.4).

### Table 5.4: Drug-related deaths - Midlothian (relating to cases eligible for review by the Edinburgh & Lothian DRD Case Review Group)

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian</td>
<td>84</td>
<td>79</td>
</tr>
<tr>
<td>Midlothian</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Data source: [Drug-related Deaths 2013 Edinburgh and Lothians. Edinburgh And Lothian Drug-related Death Case Review Group](http://www.drdlothian.org.uk/AboutDrugRelatedDeaths/Pages/Definition.aspx)

#### 5.2.2 New Psychoactive Substances (NPS)

“NPS are substances designed to produce the same or similar effects, to drugs such as cocaine and ecstasy, but are structurally different enough to avoid being controlled under the Misuse of Drugs Act. NPS cannot be sold for human consumption so they are often sold as bath salts, research..."
chemicals, plant food or advertised as ‘not for human consumption’ to get round the law”\textsuperscript{32}. Being able to buy and sell these substances under these circumstances leads people to use the highly misleading term ‘legal highs’ as products sold can contain legal substances, illegal substances or even a mixture of both. The term ‘legal’ often leads people falsely to believe that these substances are safer than illicit drugs.

“Significant intelligence gaps remain as to the full extent of NPS use in Midlothian and the harm it is creating within our local communities.

Information suggests that NPS are being used by males and females, of all ages 13-60 years in most areas of Midlothian. Various types of NPS are being used with varying methods of administration (including smoking, snorting, swallowing and injecting).

Professionals report a wide range of side effects and health implications from using NPS both short and long term.”\textsuperscript{33}

Purchases from retail shops are the most popular sources while the amount of online buying is difficult to ascertain. On 8th April 2015 the UK government passed a Temporary Class Drug Order prohibiting the sale and distribution of ethylphenidate which subsequently came into force on 10th April 2015 and will be effective for up to 12 months. The Order is effective for five compounds related to methylphenidate (a class B drug). Temporary Class Drug Orders focus on supply and anyone caught will be subject to penalties of up to 14 years in prison and an unlimited fine, in accordance with the Misuse of Drugs Act 1971.

5.2.3 Alcohol

Alcohol enjoys enormous popularity and special significance in Scottish society. It is used for relaxation, socialisation and celebration. While there is not a single drinking culture in Scotland we are, as a nation, drinking too much. 50% of men and 30% of women regularly drink over the sensible drinking guidelines\textsuperscript{34}. Alcohol misuse is associated with many long-term health risks including: high blood pressure, stroke, obesity, cancer, and dementia\textsuperscript{35}. Additionally, alcohol misuse can lead to a wide range of health social harms (Table 5.5).

In the most recent five years for which data is available (2005-2009), there were 46 deaths in males in Midlothian where the underlying cause of death was an alcohol-related diagnosis and 21 deaths in females\textsuperscript{36}. For males, the average age-standardised death rate over this period was 20.7 deaths per 100,000 population, which compares favourably with the average Scotland rate of 35.3 deaths. The average female age-standardised rate is also less than the Scotland rate, at 8.6 deaths per 100,000 population, compared with 15.6 per 100,000 for Scotland.

Scottish Public Health Observatory (ScotPHO) alcohol data is complied for Mid- and East Lothian jointly. A selection of the latest figures relevant to the joint needs assessment is shown in Table 5.5.

\textsuperscript{32} Know the Score. [Available at]: http://knowthescore.info/drugs-a-z/legal-highs#accordion-1 – Accessed on 24\textsuperscript{th} April 2015
\textsuperscript{33} Yuill, L. Single Focus Drug and Alcohol Misuse Group – New Psychoactive Substances – Current Picture in Midlothian (2014)
\textsuperscript{34} Men: 3-4 units per day, but not every day. Women: 2-3 units per day, but not every day
\textsuperscript{35} CHOICES. http://www.nhs.uk/Conditions/Alcohol-misuse/Pages/Risks.aspx - accessed July 2015
\textsuperscript{36} www.alcoholinformation.isdscotland.org – Accessed June 2015
### Table 5.5: Partial Alcohol profile (Mid and East Lothian Alcohol & Drug Partnership)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Period</th>
<th>Number</th>
<th>Measure</th>
<th>Measure Type</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Alcohol-related hospital stays</td>
<td>2013</td>
<td>889</td>
<td>488.6</td>
<td>sr3</td>
<td>696.9</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related mortality</td>
<td>2013</td>
<td>25</td>
<td>13.4</td>
<td>sr3</td>
<td>21.4</td>
</tr>
<tr>
<td>Community Safety</td>
<td>Serious assault&lt;sup&gt;A&lt;/sup&gt;</td>
<td>2012</td>
<td>89</td>
<td>4.8</td>
<td>rt1</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>Common assault&lt;sup&gt;A&lt;/sup&gt;</td>
<td>2012</td>
<td>1439</td>
<td>77.7</td>
<td>rt1</td>
<td>102.5</td>
</tr>
<tr>
<td></td>
<td>Vandalism&lt;sup&gt;A&lt;/sup&gt;</td>
<td>2012</td>
<td>1722</td>
<td>93</td>
<td>rt1</td>
<td>100.3</td>
</tr>
<tr>
<td></td>
<td>Breach of the Peace&lt;sup&gt;A&lt;/sup&gt;</td>
<td>2012</td>
<td>655</td>
<td>35.4</td>
<td>rt1</td>
<td>46.8</td>
</tr>
<tr>
<td>Environment</td>
<td>% people perceiving rowdy behaviour very/fairly common in their neighbourhood</td>
<td>2013</td>
<td>44</td>
<td>9.2</td>
<td>%</td>
<td>12.6</td>
</tr>
<tr>
<td></td>
<td>Premise licences in force - On trade</td>
<td>2013</td>
<td>339</td>
<td>23.2</td>
<td>rt2</td>
<td>26.6</td>
</tr>
<tr>
<td></td>
<td>Premise licences in force - Off trade</td>
<td>2013</td>
<td>150</td>
<td>10.3</td>
<td>rt2</td>
<td>11.4</td>
</tr>
<tr>
<td></td>
<td>Premise licences in force - Total</td>
<td>2013</td>
<td>489</td>
<td>33.5</td>
<td>rt2</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Personal licences in force</td>
<td>2013</td>
<td>1628</td>
<td>111.6</td>
<td>rt2</td>
<td>123.5</td>
</tr>
<tr>
<td>Services</td>
<td>Alcohol treatment waiting times</td>
<td>2013</td>
<td>8</td>
<td>1.8</td>
<td>%</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Data source: [https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do](https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do)

**Measure Type Key:**
- % = percent
- sr3 = age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report
- rt1 = Crude rate per 10,000 population
- rt2 = Crude rate per 10,000 population aged 18+
- rt3 = Crude rate per 10,000 aged less than 18 years

#### 5.2.3.1 Alcohol Consumption

Eleven datazones in Midlothian were identified in an Ipsos MORI survey<sup>37</sup> as having significantly higher than average levels of alcohol consumption, eight as significantly higher than average levels of hazardous consumption (above recommended levels) and three with significantly higher than average levels of harmful consumption (35+ units/week for women and 50+units/week for men). These areas are in Dalkeith, Lasswade, Roslin and Penicuik. The areas showing hazardous consumption are among the least deprived 10% of datazones in Scotland whilst those showing the

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harmful consumption were among the most deprived 20%. This data came from a self-reporting survey and so needs to be treated with caution.

5.2.3.2 Primary Care

A key approach in promoting a healthier drinking culture which supports informed decision making and positive health behaviour change relating to alcohol consumption is the use of Alcohol Brief Interventions (ABIs). An ABI can be described as “a short, evidence-based, structured conversation about alcohol consumption with a patient/client that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.”

“Research has shown that ABIs delivered in primary care settings result in around one in eight patients adopting healthier drinking habits (Anderson et al 2005). This compares favourably with smokers offered nicotine patches to stop smoking, where figures show that one in twenty gives up the habit. The beneficial effects of an ABI can persist for up to two years and sometimes longer.

The spirit in which the intervention is offered is collaborative and non-confrontational and seeks to increase knowledge, allowing patients to make informed personal choices about their alcohol consumption and health-related issues.”

Graph 5.3 shows the number of ABIs offered through primary care (not including the Keep Well programme) in Midlothian between 2011/12 and 2014/15.

Data source: NHS Lothian Annual Reports available at [http://www.nhslothian.scot.nhs.uk/Services/A-Z/HealthPromotionService/Alcohol/Pages/KeyDocuments.aspx](http://www.nhslothian.scot.nhs.uk/Services/A-Z/HealthPromotionService/Alcohol/Pages/KeyDocuments.aspx)


Note: The increase shown in 2013/14 is difficult to explain and should be interpreted with caution. The 2013/14 spike may well be an artefact caused by challenges posed by data collection.

5.2.3.3 Acute Care

Table 5.6 shows that the number of alcohol related admissions in Midlothian, Lothian and Scotland show steady decline. Table 5.7 shows that there are comparatively fewer alcohol-related general acute hospital admissions in Midlothian than in Lothian and Scotland, when taking account of the population structure. Alcohol related hospital stays are significantly lower for Midlothian compared with Scotland\(^{40}\).

Table 5.6: General Acute Inpatient Admissions with Alcohol-Related Hospital Discharges with Alcohol Related Diagnosis in Any Position

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
<td>570</td>
<td>508</td>
<td>449</td>
<td>478</td>
<td>421</td>
<td>439</td>
</tr>
<tr>
<td>Lothian</td>
<td>6,378</td>
<td>5,744</td>
<td>4,936</td>
<td>5,240</td>
<td>5,245</td>
<td>5,016</td>
</tr>
<tr>
<td>Scotland</td>
<td>43,054</td>
<td>41,980</td>
<td>39,344</td>
<td>38,825</td>
<td>38,924</td>
<td>38,776</td>
</tr>
</tbody>
</table>


Table 5.7: General Acute Inpatient Admissions with Alcohol-Related Hospital Discharges with Alcohol-Related Diagnosis in Any Position (Age Standardised Rates*) Per 100,000 of Population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
<td>690</td>
<td>591</td>
<td>533</td>
<td>556</td>
<td>506</td>
<td>528</td>
</tr>
<tr>
<td>Lothian</td>
<td>755</td>
<td>669</td>
<td>567</td>
<td>595</td>
<td>629</td>
<td>601</td>
</tr>
<tr>
<td>Scotland</td>
<td>788</td>
<td>763</td>
<td>710</td>
<td>695</td>
<td>735</td>
<td>732</td>
</tr>
</tbody>
</table>


5.2.4 Healthy Weight

In common with other countries in the developed world Scotland faces a significant challenge from rising levels of obesity. Maintaining a healthy weight is important. For adults, the body mass index (BMI) is used to calculate whether a person is underweight, a healthy weight, overweight or obese for their height. BMI allows for natural variations in body shape, giving a healthy weight range for a particular height. The calculation divides the adult’s weight in kilograms by their height in metres squared. Adults are classed as overweight if their BMI is 25 to less than 30, obese if their BMI is 30 to less than 40 and morbidly obese if their BMI is 40 or more.

“Since 1995 there has been a significant increase in the proportion of adults aged 16 to 64 categorised as obese (from 17.2% in 1995 to 25.6% in 2013), although the level has remained fairly constant since 2008. Over the same period, the proportion who were overweight or obese increased from 52.4% to 62.6%, again showing some stability in recent years\(^{41}\)” (Graph 5.4).
In 2012\textsuperscript{42}:

- 64\% of the adult Scottish population was classified as overweight or obese (BMI>25)
- 27\% of adults are classed as obese (BMI>30).
- 30\% of children are at risk of overweight or obesity.

Graph 5.4: Prevalence of overweight and obesity in men and women (aged 16-64), 1995-2013 (Scotland)

Recent Lothian figures (2008-2011) are in keeping with national trends and suggest that 61\% of the adult population is overweight or obese and 27\% are obese. Women are more likely to be obese (27\% to 25\% men) whereas men are more likely to be overweight (40\% to 30\% women).

The UK Foresight report\textsuperscript{43} into obesity suggests that by 2025, prevalence of obesity among adults will be 47\% for men and 36\% for women. Based on 2011 census population estimates, this equate to 18,833 men and 15,522 women. The same report projects that only 10\% of men and 22\% of women will be in the normal weight range (BMI 20-25) in 2025.

Obesity has serious health implications. People who are obese and people who are overweight are at high risk from serious chronic diseases which can lead to premature death or reduced quality of life. These include type 2 diabetes, cardiovascular disease, hypertension and stroke, and some forms of cancer.

It can also be harmful to have a low body weight and this can be a result of either an eating disorder or long term illness. We have not looked at this in detail as part of this Needs Assessment however specialist services are available to support people. Additionally, low birth rate is a risk for poor health outcomes. Low birth weight can be caused by mothers smoking during pregnancy as well as other medical problems. This has not been looked at in detail either as the focus of this Needs Assessment is on adult health and care services.

\textsuperscript{42}http://www.nhslothian.scot.nhs.uk/OurOrganisation/OurHealthOurCareOurFuture/SupportingDocuments/OurHealthOurCareOurFuture/Appendix%201%20-%20population%20and%20disease%20projections.pdf


Midlothian Joint Needs Assessment Draft v1.6 (Sept/Oct 2015). Editor Matthew.Curl@midlothian.gov.uk
5.2.5 Diet and Nutrition

“A lack of fruit and vegetables in people’s diet has been shown to be a risk factor in a range of serious health problems, such as heart disease, cancer, type II diabetes, hypertension and obesity. The World Health Organisation (WHO) recommends adults eat at least five varied portions - where a portion is defined as 80g - of fruit and vegetables a day.

Scotland’s unhealthy diet is widely cited as a factor in its poor health record. Previous research has shown that children and young people in Scotland follow a diet that falls short of national recommendations and is less healthy than that of children in other European countries.

The proportion of adults consuming at least 5-a-day, the recommended daily intake, has remained stable since 2003 (Graph 5.5). In 2012, 22% of adults ate at least five portions in the 24 hours prior to interview, similar to the level in 2003 (21%). The percentage of men consuming at least 5-a-day ranged between 19% and 22% in the decade 2003-2013 but in no clear direction. Over this same period, the figure for women meeting the target ranged between 21% and 25%, with a slight increase detectable up until 2009, followed by a small decrease thereafter.”

Graph 5.5: Prevalence of adults who consume five or more portions of fruit and vegetables a day (Scotland)

5.2.6 Physical Activity and Exercise

“The health benefits of a physically active lifestyle are well documented and there is abundant evidence that regular activity is related to a reduced incidence of chronic conditions of particular concern in Scotland, such as cardiovascular disease, obesity, and type 2 diabetes. Physical activity is also associated with better health and cognitive function among older people, and can reduce the risk of falls in those with mobility problems. In 2008, the World Health Organisation (WHO) estimated that 3.2 million deaths per year could be attributed to low physical activity levels.

In 2013, 64% of adults aged 16 and over met the current moderate/vigorous physical activity (MVPA) guideline. The figure in 201244 was 62% (Graph 5.6).

Men were significantly more likely to meet the MVPA guideline than women (71% compared to 58%). The gap was widest among the youngest and oldest age groups: 88% of men aged 16-24 met the guideline, compared with 70% of women of the same age; and 36% of men aged 75 or above met the guideline, compared with 19% of women.

Between 2012 and 2013, the proportion of men meeting the guideline increased significantly from 67% to 71%. Adherence to the guideline did not change for women between 2012 and 2013 (58% in both years).

Graph 5.6: Proportion of adults meeting physical activity recommendations (Scotland)

It will be important to continue to promote healthy lifestyle choices. Nationally only 4% of the adult population in 2013 knew the current guideline on physical activity:

- Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
- Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.
- Adults should also undertake physical activity to improve muscle strength on at least two days a week.
- All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.


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45 Year corrected from the quoted reference from 2013 to match graph illustration point.
46 http://www.gov.scot/Topics/Statistics/Browse/Health/TrendPhysicalActivity
6 Health Status

6.1 Life Expectancy

Life Expectancy (LE) is an estimate of the number of years a newborn child would live if it was to experience the current mortality rate for all of its life. It is one of the simplest ways we can look at changes in population health over time. It does not take into account whether people are living in good health; for that we have to look at other sources. The life expectancy at birth in Midlothian in 2010-12 for both sexes is slightly above the Scottish average (Table 6.1).

Looking at the records since 1998, the overall trend is an improvement in LE for both sexes. Note however that when looked at in detail some areas of Midlothian will have lower life expectancies than this.

Table 6.1: Life Expectancy in Midlothian (and Scotland), NHS Lothian and Scotland

<table>
<thead>
<tr>
<th></th>
<th>2008-10</th>
<th>2010-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian: Female, at birth</td>
<td>81.4 (80.4)</td>
<td>81.26 (80.83)</td>
</tr>
<tr>
<td>Midlothian: Male, at birth</td>
<td>76.6 (75.8)</td>
<td>77.59 (76.61)</td>
</tr>
</tbody>
</table>

Data source: GROS – [www.gro-scotland.gov.uk](http://www.gro-scotland.gov.uk)

Healthy Life Expectancy (HLE) is the average number of years that a newborn can expect to live in “full health”. It is calculated to adjust LE for the amount of time spent in ill health. The difference between LE and HLE shows number of years spent in poor health. HLE is a key summary measure of a population’s health.48

Graph 6.1 and Graph 6.2 present male and female life expectancy and healthy life expectancy at birth (in years) for the five year period 1999 to 2003. Females in Midlothian had a longer life expectancy than males though it was equal to the Scottish national average.

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Graph 6.1: Male Life Expectancy and Healthy Life Expectancy at Birth for Midlothian and Scotland (1999-2003) [‘Not Healthy’ years also shown explicitly]

Data Source: [http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/community-health-partnerships](http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/community-health-partnerships)

Graph 6.2: Female Life Expectancy and Healthy Life Expectancy at Birth for Midlothian and Scotland (1999-2003) [‘Not Healthy’ years also shown explicitly]

Data Source: [http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/community-health-partnerships](http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/community-health-partnerships)

**Key Point:** Although the HLE for males and females in Midlothian is close to the Scottish average, we should not be complacent about this. The Scottish Public Health Observatory notes that Scotland has one of the lowest Life Expectancies in Western Europe. In other words, we need to keep working to improve the health of our population.
6.2 Mortality

6.2.1 All Ages

6.2.1.1 All Cause
The number of deaths observed in Midlothian was analysed in 3 year rolling averages between 2006/8 (2,430) and 2011/13 (2,420 deaths). There was very little change in the total number of deaths across Midlothian over this time period.

Absolute numbers of deaths don’t allow us to make easy comparisons. The data were standardised to adjust for changes in age and sex of the Midlothian population. This shows a noticeable downward trend in mortality rates over the whole time period (Graph 6.3).

This trend is apparent in both the East and West localities; the decline has been slightly steeper in West Midlothian over recent years. It is important to recognise that since both localities are relatively small, there will be some random variation in death rates (even when aggregated up to a 3 yearly figure).

Graph 6.3: All Cause Mortality

![Graph 6.3: All Cause Mortality](image)

Data source: courtesy of NHS Lothian Analytical Services: September 2014

Key point: There has been a steady decline in all cause mortality in both East and West Midlothian between 2006/8 and 2011/13

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49 Data courtesy of NHS Lothian Analytical Services: September 2014
Midlothian Joint Needs Assessment Draft v1.6 (Sept/Oct 2015). Editor Matthew.Curl@midlothian.gov.uk
6.2.1.2  Coronary Heart Disease
A similar pattern is seen with mortality rates for coronary heart disease, standardised by age and sex (see Appendix 1 – Additional Graphs and Tables: Graph 9.1).

**Key point:** There has been a steady decline in all Coronary Heart Disease mortality in both East and West Midlothian between 2006/8 and 2011/13

6.2.1.3  Stroke
A similar pattern of decline in mortality is seen for stroke related deaths (see Appendix 1 – Additional Graphs and Tables: Graph 9.3)
6.2.2 Early Ages (<75)

6.2.2.1 All Cause
Deaths under the age of 75 years are described as ‘early’ and analysed separately. In 2006/8 there were 865 deaths in Midlothian, in 2011/13 there were 924. Since there are smaller numbers of deaths in this age group it is reasonable to expect some additional variation in mortality rates over time. West Midlothian has consistently had lower death rates than the rest of Lothian or indeed Scotland. East Midlothian has shown a more variable picture, closer to the average for Lothian, but with some suggestion of a reduction in mortality rates over time (Graph 6.4).

Graph 6.4: Early (<75) All Cause Mortality

Data source: courtesy of NHS Lothian Analytical Services: September 2014

Key point: West Midlothian has had consistently lower all cause mortality rates for people aged <75 years between 2006/8 and 2011/13. East Midlothian has shown a more variable picture, but with some suggestion of a reduction over time.

6.2.2.2 Coronary Heart Disease
We examined the mortality rates in those under 75 years of age by specific cause of death. The standardised mortality rates for cardiovascular disease show a downward trend in both East and West Midlothian but again with the West locality showing consistently lower mortality than other parts of Lothian as well as Scotland (see Appendix 1 – Additional Graphs and Tables: Graph 9.2).

Key point: The standardised mortality rates for cardiovascular disease show a downward trend in both East and West Midlothian for people aged <75 years between 2006/8 and 2011/13.

6.2.2.3 Stroke
Very similar downward trends are seen with stroke mortality in the under 75 age group (see Appendix 1 – Additional Graphs and Tables: Graph 9.4).
6.2.3 Alcohol

Alcohol mortality involves much smaller numbers making interpretation difficult (there were between 32-40 deaths in Midlothian in each 3 year period between 2006/8 to 2011/13). There does appear to be an upward trend in the age standardised rates in West Midlothian although still below that of both Lothian more widely and Scotland (Graph 6.5).

Graph 6.5: All Alcohol Mortality

A similar picture is seen when we analysed deaths caused by liver cirrhosis (again very small numbers, between 23-34 across the whole of Midlothian in each 3 year period) [Graph 6.6]. Liver cirrhosis is strongly associated with harmful consumption of alcohol.

Graph 6.6: All Liver Cirrhosis Mortality

Data source: courtesy of NHS Lothian Analytical Services: September 2014
Key point: There appears to be an upward trend in the age standardised rates in both localities, a little more marked in West Midlothian. In both localities the age-standardised rates remain below that of both Lothian and Scotland. The standardised mortality rates for all alcohol related mortality and liver cirrhosis are based on relatively small numbers of cases.

6.2.4 Cancer
We analysed the total number of cancer deaths, again standardising by age and sex as before. Overall there were between 682-710 deaths from all cancers in each 3 yearly grouping across Midlothian (Graph 6.7).

Graph 6.7: All Cancer Mortality

![All Cancer Mortality Graph]

Data source: courtesy of NHS Lothian Analytical Services: September 2014

We also looked in more detail at mortality rates for breast, lung and colorectal cancers (see Appendix 1 – Additional Graphs and Tables: Graph 9.5, Graph 9.6, Graph 9.7). As before the deaths were aggregated into 3 yearly groupings. Lung cancer deaths were between 196-215 per 3 yearly grouping; Colorectal between 62-69; Breast between 29-46. With smaller numbers there will be more background variation in the standardised rates, even when these are aggregated into three yearly groupings and caution must be used interpreting. Overall, deaths from breast cancer are most affected by smaller numbers in the analysis. Looking at the overall picture, mortality from breast cancer in both East and West localities has generally been close to that of the Scottish average.

Key Point: East Midlothian has higher mortality levels from all causes of cancer than West Midlothian locality. However, there has been a convincing downward trend in deaths from cancer in East Midlothian over the period of analysis. This downward trend is also seen in deaths from lung cancer and deaths from colorectal cancer. Deaths from lung cancer in East Midlothian remain above the Scottish average.
### 6.2.5 Suicide

Changes to coding in 2011 mean that the number of deaths coded as suicide have increased.\(^{50}\) This means that it can difficult to compare trends before and after 2011 because different diagnostic categories have been included. The Scottish Public Health Observatory (ScotPHO) does provide comparable figures\(^{51}\) however (see Appendix 1 – Additional Graphs and Tables: Graph 9.8 & Table 9.1).

NHS Lothian issues reports on suicide rates annually and this is broken down by sex at individual local authority level. Suicide is a leading cause of death among those aged under 35 years although the absolute number of cases each year is fairly small (between 24-45 deaths in each 3 year grouping in Midlothian between 2006/8 and 2011/13).

Overall, suicide rates in East and West Midlothian remain close to the national average (Graph 6.8). Of course, each death can affect many people and discussion of the overall figures from a statistical point of view can seem very impersonal.

Monitoring will continue on an annual basis allowing us to establish whether the apparent increase in mortality rates can be solely accounted for by the recent coding changes.

**Key point:** There has been an apparent increase in the standardised mortality rates from suicide in East and West Midlothian in recent years. Changes in coding of deaths will have contributed in part to this rise. Further monitoring will be necessary before any definitive conclusion can be drawn.

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\(^{50}\) The National Records of Scotland (NRS) made a change to the way deaths are classified in 2011. The change was made to match World Health Organization (WHO) updates to codes. This has resulted in some deaths previously coded under ‘mental and behavioural disorders’ now being classed as ‘self-poisoning of undetermined intent’ and therefore included in the suicide figures.

6.2.6 Crude All Cause Mortality and Scottish Index of Multiple Deprivation

There is a well understood relationship between people living in areas affected by socioeconomic deprivation and greater levels of ill-health. We have looked at crude mortality rates by quintile of deprivation (Graph 6.9). The snap-shot below is interesting, the NHS Lothian pattern is what we would expect to see, with higher levels of mortality among those resident in the most deprived quintile. East Midlothian looks very unusual. This pattern has emerged because the population of people living in the least deprived fifth of the population in East Midlothian is very, very small. This means that a small number of deaths in the denominator population will significantly increase the crude mortality rate. (See Section 2.5: Socioeconomic Deprivation – Table 2.5 for additional reference data)

Graph 6.9: Crude All Cause Mortality and SIMD
6.3 Living and Dying Well in Midlothian

6.3.1 Palliative Care

NHS Lothian describes palliative care as aiming to “… improve the quality of life of patients and their families facing the problems associated with any life-limiting illness, through the prevention and relief of suffering by means of early identification and careful assessment and treatment of pain and other problems, physical, psychosocial or spiritual.”

Specifically, palliative care:

- provides relief from pain and other distressing symptoms
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient’s illness and in their own bereavement
- uses a team approach to address the needs of patients and their families
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- is relevant all through the course of an illness, in combination with many other treatments that are intended to prolong life, such as chemotherapy, radiotherapy, surgery, medication or renal replacement therapy.

The Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee outlined the following definition of palliative care, which usefully emphasises the progressive component of illness, and the co-ordination of care.

“Palliative care is active total care offered to a patient with a progressive illness and their family when it is recognised that the illness is no longer curable, in order to concentrate on the quality of life and the alleviation of distressing symptoms within the framework of a co-ordinated service. Palliative care neither hastens nor postpones death; it provides a relief from pain and other distressing symptoms and integrates the psychological and spiritual aspects of care. In addition it offers a support system to help during the patient’s illness and in bereavement. ‘Family’ is used as a general term to cover closely-attached individuals, whatever their legal status.”

Across NHS Lothian, patients and carers have expressed their preference to be cared for in the place where they live, for as long as possible. Where possible, many would also prefer to die in their place of residence. Although place of death is not regarded as the single most important factor indicating quality of palliative and end of life care, where appropriate, seeking to support someone to remain at home or in a community setting can be an indicator of meeting this expressed need. Figures for the percentage of the last six months of life spent at home or in a community setting are collected by ISD (Information Services Division) through the Quality Outcome Measures. Table 6.2

---

52 http://www.nhslothian.scot.nhs.uk/Services/A-Z/PalliativeCare/Pages/default.aspx - accessed 15/7/15
shows performance against this measure from 2008 – 2013, during which time Midlothian remained in the top 10 performing CHPs.

Table 6.2: Percentage of last six months of life spent at home or in a community (Financial Year ending 31st March)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian Community Health Partnership</td>
<td>92.0%</td>
<td>92.3%</td>
<td>92.7%</td>
<td>92.9%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Rank</td>
<td>9th</td>
<td>8th</td>
<td>6th</td>
<td>7th</td>
<td>9th</td>
</tr>
<tr>
<td>Scotland</td>
<td>90.4%</td>
<td>90.5%</td>
<td>90.7%</td>
<td>91.1%</td>
<td>91.2%</td>
</tr>
</tbody>
</table>

Data source: [http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/](http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/)

As part of the discussions informing our strategic plan a workshop was held with local lead officers. The following key need was identified:

<table>
<thead>
<tr>
<th>Our Key Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Establish a Midlothian Palliative Care Group (currently Lothian wide and a Mid-East partnership)</td>
</tr>
</tbody>
</table>

### 6.3.2 Anticipatory Care Planning

Anticipatory care, as an approach, was pioneered in the 1960s. Anticipatory Care Plans (ACPs) generally involve the early identification of patients who are at high risk, for example, of particular diseases or clinical conditions, by reviewing medical records or by addressing such needs with patients opportunistically during routine consultations or other patient-instigated contacts with the practice.56

In Midlothian good outcomes for older people with an anticipatory care plan include being supported at home, safely and securely and for as long as possible, having high quality palliative and end of life care.57 Patients enrolled in the Midlothian Anticipatory Care Service (MACS) showed a very high satisfaction in the service. Patients were asked for their views on a variety of issues including getting support when they needed it, how the service had helped them and what difference it had made to their life. The most important part of the evaluation related to the choice and involvement patients had in their own support, and the relationship they had with the staff. The results demonstrated a high level of satisfaction with the service and an increase in patients’ ability and confidence to self manage.58

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58 [http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/Patient%20evaluation%20poster_EMACS.pdf](http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/Patient%20evaluation%20poster_EMACS.pdf)
6.3.2.1  ACPs and the GP Contract

Anticipatory care was introduced nationally, as part of the GP contract in 2013/2014, broadly covering a cohort of patients with a medium to high risk of an unscheduled care event, such as an emergency admission, in the coming year. The ACP is to include a medication review and a review of medical and care needs, summarised in the Key Information summary.59

6.3.2.2  Key Information Summary

The Key Information Summary (KIS) is an extension to the existing Emergency Care Summary (ECS) system. It is designed to support patients who have long term conditions and/or who have anticipatory care plans in place. In Midlothian it is estimated that around 5% of GP practice populations will have a KIS. Information is shared with patient consent and KIS and is available for all ECS users in NHS24, Out of Hours (OOH) organisations, Accident and Emergency departments and the Scottish Ambulance Service.60

KIS contains Special information from the GP practice and also:
- Patient demographics and details of staff involved in care
- Current situation, including main diagnosis and current issues
- Carer and support details
- Information and recommended action for OOH clinicians

6.3.3  Living with Illness

Many people live with more than one illness and this is described as multimorbidity. The term means two or more illnesses or diseases occurring in one individual at the same time.

A recent study of patient data from 314 medical practices in Scotland (covering around one third of the national population) found that 42.2% of all patients had one or more morbidities.61 Graph 6.10 shows that multimorbidity is common and that most patients with a long-term condition experience a multi-morbidity

Long-term conditions prevalence is higher in older people. Most over 65s have two or more conditions and most over 75s have three or more conditions. People living in areas of multiple deprivation are at particular risk with, for example, a much greater likelihood of early death from heart failure. They are also likely to develop two or more conditions 10-15 years earlier than people living in affluent areas. There is a link between socioeconomic stress, premature ageing and deprivation – although the causal factors are not entirely clear.62 (See Section 4: Determinants of Health and Health Inequalities for more detailed health inequalities information).

Given an aging population, managing long terms conditions represents a significant challenge. Healthcare systems are still largely configured for individual diseases rather than multimorbidity.63

60  http://www.nisg.scot.nhs.uk/why-nisg/our-services/project-management/key-information-summary-kis
62  http://ije.oxfordjournals.org/content/38/5/1297.full - accessed 14/7/15
63  National Institute for Health and Care Excellence (NICE are currently consulting on clinical assessment and management of multimorbidity. The anticipated publication date is September 2016. (https://www.nice.org.uk/guidance/development/gid-cgwave0704)
Graph 6.10: Number of chronic disorders by age group

6.4 Self-Reported Health Status

Although a person’s judgement about their own health is highly subjective, studies have shown that people’s perceptions of their own health can be good predictors of future health care use and of mortality rates.\textsuperscript{64, 65}

Table 6.3: Self Assessment of Health Status

<table>
<thead>
<tr>
<th>Percentage of people whose health was:</th>
<th>Good</th>
<th>Fairly Good</th>
<th>Not Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilston</td>
<td>82.0%</td>
<td>11.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Bonnyrigg</td>
<td>84.4%</td>
<td>11.1%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Dalkeith</td>
<td>81.7%</td>
<td>12.8%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Danderhall</td>
<td>80.2%</td>
<td>13.4%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Gorebridge</td>
<td>81.3%</td>
<td>12.5%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Loanhead</td>
<td>80.8%</td>
<td>12.9%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Mayfield</td>
<td>80.7%</td>
<td>13.3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Pathhead</td>
<td>82.6%</td>
<td>12.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Penicuik</td>
<td>85.1%</td>
<td>11.1%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Rosewell</td>
<td>82.5%</td>
<td>11.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Roslin</td>
<td>84.3%</td>
<td>11.9%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Midlothian</td>
<td>82.9%</td>
<td>12.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Scotland</td>
<td>82.2%</td>
<td>12.2%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>


As can be seen in Table 6.3, at the time of the last census over 82% of Midlothian’s overall population rated itself to be in good health. This is in line with the Scottish average of 82.2%. Penicuik rated itself as the healthiest ward, with only 3.8% of residents deeming themselves to be in poor health. This compares with 5.6% of people in Scotland overall. Danderhall and Bilston residents considered themselves to be in the poorest health with 6.4% in both places considering themselves to be in poor health.

Table 6.4 is an extract of the Scottish Health Survey for 2012 included for comparison.

Table 6.4: Adults in NHS Lothian Self-Assessing Their Own Health Status as ‘Very Good’ or ‘Good’

<table>
<thead>
<tr>
<th></th>
<th>Very good</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
<td>52.90%</td>
<td>30.00%</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>56.14%</td>
<td>28.88%</td>
</tr>
<tr>
<td>Scotland</td>
<td>52.47%</td>
<td>29.74%</td>
</tr>
</tbody>
</table>


\textsuperscript{64} Idler, E. L. & Benyami, Y. (1997). Self- Rated health and Mortality; A review of Twenty-Seven Community Studies. Journal of Health and Social Behaviour, 38, 1


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6.5 Long-Term Conditions

In essence, long-term conditions (LTCs) are illnesses which require ongoing medical care, limit what a person can do for a year or more and have a clear diagnosis (e.g. coronary heart disease, diabetes). However, this definition also includes many conditions which, although long-term and life-limiting in some cases, can, also be acute or easily managed in other people (e.g. back pain, skin disorders). Just to confuse matters further, sometimes these types of illnesses can be described as ‘chronic diseases’. All analysis of long-term conditions should be interpreted according to the definition used.\(^{66}\)

Better treatment and earlier diagnosis means that more people are living for longer with conditions such as cancer. However, an increasing ageing population with multiple conditions puts pressure on key health and social care services.

Although many people with a long-term condition look after their day-to-day symptoms without support from health or social care services, others do need ongoing support from our services. There are a small number of patients with very complex needs who need support from multiple services for prolonged periods of time. Managing long-term conditions is one of the biggest challenges facing health care services worldwide, with 60% of all deaths attributable to them\(^{67}\).

6.5.1 Quality Outcomes Framework (QoF)

General Practices record information about some long-term conditions as part of the nationally agreed quality outcomes framework. This provides a snap-shot of the total number of patients with particular conditions, or risk factors (Table 6.5). There are limitations to this data; no patient identifiable information is included to compile the prevalence figures. That means we are unable to break down the numbers into age groups or by sex.

An increasing concern for health services is the rising number of people living with diabetes. It is known that at least 3,533 people live with the condition in Midlothian; the majority are over 60 years old and there is a higher rate in areas of multiple deprivation. The reason for the increasing numbers of people with diabetes is in part due to population ageing; diabetes is more common as people get older. It is also a success story, as more people with diabetes are surviving for longer with diabetes because of better treatments to control their blood sugar levels. There has also been an increase in the number of people with type 1 diabetes over recent decades, the reasons for which remain uncertain.

Table 6.5: Number of patient and raw prevalence rates for selected long-term conditions: QoF12/13

<table>
<thead>
<tr>
<th></th>
<th>Number of patients with Diabetes</th>
<th>Raw Prevalence (Diabetes)</th>
<th>Number of Patients with Dementia</th>
<th>Raw Prevalence (Dementia)</th>
<th>Number of Patients with COPD</th>
<th>Raw Prevalence (COPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian CHP</td>
<td>4,173</td>
<td>4.76</td>
<td>766</td>
<td>0.87</td>
<td>1,942</td>
<td>2.21</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>33,173</td>
<td>3.88</td>
<td>6,285</td>
<td>0.74</td>
<td>14,317</td>
<td>1.68</td>
</tr>
<tr>
<td>Scotland</td>
<td>252,599</td>
<td>4.6</td>
<td>41,655</td>
<td>0.76</td>
<td>115,974</td>
<td>2.11</td>
</tr>
</tbody>
</table>

Data source: courtesy of NHS Lothian Analytical Services: September 2014


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**Key point:** Midlothian has relatively high numbers of patients with each of the selected long-term conditions. This is likely to reflect the older population resident in Midlothian in comparison to other areas. Diabetes, COPD and dementia are all diagnosed more often among older age groups.

**Our Key Needs:**
- Increase supported self management
- Improve access to information and communication
- Consider our access points to facilitate early intervention/prevention approaches
- Promote rehab and recovery focus
- Recognise and align services to multi-morbidity
6.6 Sensory Impairment

We do not have accurate information on the numbers of people with sight or hearing loss in Midlothian. Graph 6.11 and Graph 6.12 show self-reports across Midlothian against the national and regional average from the 2011 Census results (a total of 1,922 people reported a visual impairment in Midlothian). Given the broad nature of the census questions, the responses provide no breakdown within either category in terms of degree of impairment. The average percentage of people affected by either impairment in Midlothian is close to the average across Scotland.

An additional data source is the RNIB (Royal National Institute of Blind People) Blind Register. Currently 580 Midlothian residents are registered (284 as blind; 296 as partially sighted). The register is voluntary with some opting out—RNIB report they have provided services to 151 Midlothian residents who are not on the register. There is no robust system for updating the register following the death of a registrant.

Nationally it is estimated that 1 in 6 of the population have a hearing loss while significant sight loss is estimated to affect 1 in 30 of the population. Older people are most likely to experience some degree of hearing loss and the vast majority of those with sight loss are in the older age range. Sensory impairment can remain hidden for people who have had a stroke or live with dementia. People with learning disabilities are 10 times more likely to have some degree of sight lost, again not always recognised.

There is a need to improve diagnosis, increase awareness amongst care staff and make aids to communication more available. In 2006, a new NHS eye examination was introduced and free comprehensive eye examinations were extended to all in Scotland. Approximately 35% of the Lothian population received an eye test during the year 2012/13. Optometrists/ophthalmic medical practitioners should now be promoted as the first point of contact for patients with eye related problems but this is not widely known resulting in many unnecessary GP consultations.

Our Key Needs:
- Accurately identify individuals with sensory impairment within the population and quantify needs.
- Address Health Inequalities and co-morbidities in: Elderly; Physical Disabilities; Learning Disabilities; Dementia; and Frail populations
- Develop a local Sensory Impairment Strategy
- Improve access to services, information and technology

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Graph 6.11: Percentage of Midlothian’s population (by town) reporting deafness or partial hearing loss

Graph 6.12: Percentage of Midlothian’s population (by town) reporting blindness or partial sight loss

6.7 Physical Disabilities

There are in the region of 4,800 people between the ages of 16-64 in Midlothian who have a physical impairment which affects their ability to undertake normal daily living tasks. This includes people born with impairment, those who have suffered an injury and those whose disability has developed as a result of an illness. Gathering information about the numbers of people with different types of disability is difficult. There are some national data sources but these use a variety of definitions. At the last census, 6.9% of Midlothian residents identified themselves as living with a physical disability that had lasted or was expected to last 12 months. This is very close to the Scottish average of 6.7%.

Number of environmental adaptations is increasing as we are maintaining people in their own home. This improves quality of life for the individual as well as being an example of a worthwhile preventative intervention.

Forward Mid, the Midlothian Disabled People Forum is about to launch its latest updated version of its Directory, providing extensive information on local services and supports. However, ensuring people have good, up to date, accessible information available remains a constant challenge.

The Midlothian Physical Disabilities Strategy is coming to an end in 2015. Outcomes are currently being reviewed. These will inform Midlothian’s response to the needs of this population for the next three year plan.

There is a difference between impairment (a state of being) and disability (a consequence of an environment). Equity of access to education, employment, appropriate housing, financial support as well as to being an active member of a local community, all have an impact on health and wellbeing. Consequently our response to physical impairment has a large impact on a person’s life and future levels of dependency on Health and Social Care services. We need to increase our understanding in this area.

Our Key Needs:

- Need to increase understanding in this area through detailed gap analysis inc.:
  - Create a dataset
  - Refine definition of the currently a broad term and how it links to long-term conditions.
  - Does delineating developmental from acquired provide improved support?
- To focus on addressing health and social care inequalities
- Need to consider the impact of housing and adapted environments
- Enhance access to information
- Influence other agencies to ensure inclusion in society for wellbeing

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70 A useful summary of different data sources is provided by the Scottish Public Health Observatory (http://www.scotpho.org.uk/health-wellbeing-and-disease/disability/introduction)
71 Data source: 2011 Census – www.scotlandscensus.gov.uk
6.8 Learning Disabilities

Midlothian has a proportionately large and growing learning disability population. Using the prevalence figures from 'The Keys to Life' the National Learning Disability Strategy (2013), we would estimate that there are 1,695 people with a Learning Disability in Midlothian in 2013. Of these, the Council knows of 596 people with a Learning Disability who use Adult Health and Social Care services (Table 6.6). Approximately 40 people in Midlothian have particularly complex needs.

Table 6.6: Adults with a learning disability known to Midlothian in 2013 by SIMD quintile

<table>
<thead>
<tr>
<th>SIMD Quintiles</th>
<th>Low</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Not Known</th>
<th>Adults known per 1,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>596</td>
<td>95</td>
<td>152</td>
<td>167</td>
<td>96</td>
<td>40</td>
<td>8.7</td>
</tr>
</tbody>
</table>

† Calculated using 2013 mid-year population estimates
Data source: GROS – www.gro-scotland.gov.uk

The research suggests that the learning disability population using services will increase by between 1.2 to 5.1% year-on-year dependent upon, amongst other factors, the eligibility criteria for access to services. The growth in the number of people with a Learning Disability known to Midlothian Council from 2012 to 2013 alone was 565 to 596 or 5.5%.

More young people with complex needs are surviving into adulthood and better health care has helped increase life expectancy significantly. The result has been particular growth in demand for services from young people with complex needs and people with a learning disability who are developing the complications of older age, including dementia. We must therefore strengthen both our transition process from child to adult services and develop our services to ensure the needs of an older population are met.

Improvements in health outcomes for people with a learning disability have not been anywhere near as significant as those for the general population; health inequalities remain significant.

**Our Key Needs:**
- Development of Services for Older People with a Learning Disability
- Develop responsive services for people with Learning Disability and Complex Needs related to Profound and Multiple Learning Disability, Autism Spectrum Disorder and Mental Health Issues.
- Flexible and modernised Day Opportunities
- A wider range of Short Break Services
- Tackling Health Inequalities faced by People with a Learning Disability
- Enhance joint working arrangements between statutory Learning Disability Services

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72 One of the contributors to this is likely to have been the presence of a large learning disability hospital, St Joseph's, which closed in the late 1990s when residents moved to houses located across Midlothian.

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6.9 Autism

We estimate that there are 748 people in Midlothian with some form of autism. Midlothian Community Care Services know about 62 people with autism and Midlothian Children’s Services know of 226 young people. Many adults with Asperger’s syndrome do not seek social care or health service support, but have a higher likelihood of remaining unemployed, and of mental health issues.

The transition to adulthood is a particularly important time in enabling people with some form of autism move on to successful employment and independence if at all possible. Only 62 people are known to adult services, the vast majority of these also having a learning disability. While many people not known to services find ways of managing their condition successfully and leading normal lives, there is a growing view that diagnosis is helpful in assisting the individual and their families manage their condition more effectively. People can feel quite isolated accompanied by feelings of anxiety or depression and we need to develop ways of providing effective support.

The needs of people with Autism are as varied as the people who have the condition but they are likely to exert a significant pressure on our systems and budgets over the coming years as incidence increases and diagnosis improves. A small number of people draw our most expensive packages of care, of up to and over £200,000 in several cases, mainly being young men with Autism, a Learning Disability and Complex and Challenging Behaviours. There is scope to manage cost by getting things right for young people early on in life.

Our Key Needs:
- Raise awareness of autism through training and provision of accurate and useful information
- Improve early assessment and diagnosis
- Get person centred support right quickly following diagnosis
- Plan early for transition and change
- Develop a clear pathway of care for people with autism
- Supporting employment prospects and opportunities for individuals with a diagnosis of autism
6.10 Loneliness and Social Isolation

Though often considered together, it is important to draw a distinction between these two issues:\(^73\):

- **Social Isolation** is an objective status and can be defined by the quantity of social relationships and contacts
- **Loneliness** is a subjective experience (a negative emotion) associated with a perceived gap in the quality and quantity of relationships that we have and of those we want.

The effects of social and emotional loneliness on physical and mental health and wellbeing are extensive. There is a growing understanding of the impact of loneliness on our physical and mental health including:\(^74\):

- Can cause physical harm equivalent to the effect of smoking 15 cigarettes a day and has a greater impact on mortality than current public health priorities such as obesity, alcohol consumption or a sedentary lifestyle\(^75\)
- Strong association with depression\(^76,\)\(^77\) and in older people a greater risk of developing dementia\(^78\), specifically Alzheimer’s disease\(^79,\)\(^80\)

Given these finding addressing the causes and consequences of loneliness is increasingly important. Midlothian needs to determine a strategy in this area.

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\(^80\) Valtorta N and Hanratty B (2012) Loneliness, isolation and the health of older adults: Do we need a research agenda? Journal of the Royal Society of Medicine, 105, 518-522
6.11 Oral Health

Tooth decay and gum disease are two of the most common diseases in the world; together with mouth cancer these diseases continue to present major public health challenges. As with other health problems these diseases affect those from more disadvantaged sections of the population. This burden may be further increased in more disadvantaged sections of the community where the ‘inverse care law’ operates. Unlike children, data on adult oral health is fairly limited. Key priorities include:

- **Improving registration and participation rates.** In April 2010 non-time limited registration was introduced to promote a more stable relationship between dentist and patient. This has led to a steady increase in registration rates, therefore another marker that indicates accessibility of primary dental care services is used, ‘participation’, which is a measure of patient attendance at an NHS dental practice for registration or treatment within the last 2 years.
- **Out of hours care-** reduce unregistered patients attending for pain, encourage registration and routine attendance.
- **Improve access to dental care for vulnerable groups** – continue to work towards the outcomes in the oral health priority strategy and roll out the ‘Caring for Smiles’ programme.
- **Oral cancer-** prevention- encourage dental teams to use every opportunity to ask about smoking status, promote stop smoking services and deliver brief intervention on alcohol. Encourage a holistic and common risk approach.

There is good access to an NHS dentist for people living in Midlothian and 84.4% of adults are registered with a dentist (Scotland=87.1% in March 2015). There is a dental strategy for Lothian but it is out of date and a new one will be developed during 2015.

Older people and children under 3 are less likely to see a dentist in Midlothian compared to the rest of the population in Midlothian and with other areas in Scotland. Table 6.7 shows this and describes the strategic ambition of the Midlothian IJB for primary care dentistry in 2015/16 and 2016/17:

**Table 6.7: Midlothian Dental summary**

<table>
<thead>
<tr>
<th>Age</th>
<th>Midlothian: % registered</th>
<th>Scotland: % registered</th>
<th>Best in Scotland mainland</th>
<th>Midlothian Strategic Ambition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 3</td>
<td>46.8%</td>
<td>47.6%</td>
<td>57.0% (Inverclyde)</td>
<td>Increase registration rate for children under three years older with a dentist so they can receive the benefits of the national Childsmile prevention programme.</td>
</tr>
<tr>
<td>65 - 74</td>
<td>75.3%</td>
<td>77.1%</td>
<td>86.3% (North Ayrshire)</td>
<td>Increase registration rate for older people</td>
</tr>
<tr>
<td>75+</td>
<td>69.2%</td>
<td>73.3%</td>
<td>78.7% (North Ayrshire)</td>
<td>Improve access to a dentist for people who are housebound or live in a care home and provide training to care staff using the Caring for Smiles and other training packages for vulnerable groups (Life Smile)</td>
</tr>
</tbody>
</table>

Data source: https://isdscotland.scot.nhs.uk/Health-Topics/Dental-Care/Publications/2015-06-16/Table_1_Registrations_trend.xlsx?16:03:26

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Midlothian Joint Needs Assessment Draft v1.6 (Sept/Oct 2015). Editor Matthew.Curl@midlothian.gov.uk
6.12 Mental Health and Well Being

Mental health and many common mental health disorders are shaped to a great extent by the social, economic, and physical environments in which people live. People with mental health problems still face significant inequalities for example, those with severe and enduring mental health problems die on average 15-20 years younger compared to the population as a whole.\(^81\)

Mental illness includes a wide range of conditions; one in four of us will experience such illness at some point in our lives.

Mental health problems account for almost one quarter of ill health and the prevalence is rising. The World Health Organisation predicts that depression will be the second most common health condition worldwide by 2020.

At the last census, 4.2% of Midlothian residents\(^82\) identified themselves as living with a mental health condition that had lasted or was expected to last 12 months\(^83\). Scotland wide statistics demonstrate that women and those living in deprived communities are significantly more likely to have a possible mental health problem. A higher proportion of mental health admissions are from deprived areas highlighting the link to socioeconomic health inequalities. It is very important that we promote positive mental wellbeing and that we seek support when required to reduce the need for medical assistance. Mental health is everyone’s business and all public services have a role to play in working with communities, families and individuals to improve mental health outcomes.

Bereavement, social isolation, loss of employment and debt can make us more vulnerable in terms of our mental wellbeing. The most common response is to seek medical help. In Midlothian 16.4% population are currently prescribed drugs for depression, anxiety and psychosis, i.e. 13,509 (the Scottish average is 16.2%)\(^84\). N.B. A notable proportion of drugs classed as antidepressants are prescribed at low dose for conditions other than depression.

The statistics for Midlothian patients with a psychiatric hospitalisation has traditionally been significantly lower than the Scottish average, however recently the impact of New Psychoactive Substances appears to be impacting on the number of admissions and the lengths of stay. In 2013 there were 107 Midlothian patients admitted to the Royal Edinburgh Hospital (8.9 per month).

The vast majority of people with mental health problems do not require a formal care package. There are a number of providers and sources of support that can be approached and ensuring these are accessible is important.

In 2013, a report by CAPS Independent Advocacy\(^85\) highlighted:

What’s most important to people

Having places to go to, things to do and people to see came out as most important. People want safe places to go where they can get support from their peers, attend a variety of groups and activities,

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\(^{82}\) 3,494 people based on the recorded population of 83,200 (see section 2.2: Population Now)

\(^{83}\) Data source: 2011 Census – www.scotlandcensus.gov.uk

\(^{84}\) Data source: ISD prescribing, http://www.isdscotland.org/Health-Topics/Prescribing-and-medicines/

\(^{85}\) “Things to do, places to go, people to see- What is most important to people who use mental health services in Midlothian”. A Report by CAPS Independent Advocacy, May 2013
and get one-to-one support from people who understand mental health. Knowing where to go and having good information and advice about what is available is also important.

What’s missing or needed?

People want easy access to help and support without having to be put on a waiting list. They also want more choice in services available. Information about community resources is needed so people know what is available. People want the activities and groups to be offered in the area they live. They want more activities, groups and drop-ins as well as a drop-in for younger people. Well informed GPs that are able to listen to people and understand mental health is something that there needs to be more of.

Our Key Needs:

- Recovery and rehabilitation focus
- Access to services
- Tackle stigma and discrimination
- Tackle inequalities
6.13 Dementia

Dementia predominantly affects older people, as age is a risk factor. In Midlothian 31% of people over the age of 85 years estimated to be affected. Younger people can also develop dementia however (approximately 50 in Midlothian). The figures below (Table 6.8) are calculated using the 2010 population projections from the Scottish Government and General Register Office for Scotland applying the relevant dementia prevalence rate averages extracted from the Alzheimer’s Scotland website. These figures shows that the predicted number of people living with dementia in Midlothian will nearly double (from 1,475 to 2,832) by 2035. Part of this increase will be due to diagnosing dementia in cases where it is currently undiagnosed. People with dementia are also very likely to have other long term conditions affecting their health.

There are particular concerns about the experience of people with dementia admitted to acute hospitals where they are likely to stay significantly longer than a patient without dementia of the same age and physical condition.

Table 6.8: Dementia Prevalence Projections for Midlothian

<table>
<thead>
<tr>
<th>Age band</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
<th>2035</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>195</td>
<td>232</td>
<td>246</td>
<td>251</td>
<td>275</td>
<td>285</td>
<td>46.2</td>
</tr>
<tr>
<td>75-84</td>
<td>515</td>
<td>583</td>
<td>662</td>
<td>811</td>
<td>868</td>
<td>909</td>
<td>76.5</td>
</tr>
<tr>
<td>85+</td>
<td>573</td>
<td>660</td>
<td>815</td>
<td>1018</td>
<td>1255</td>
<td>1638</td>
<td>185.9</td>
</tr>
<tr>
<td>Total</td>
<td>1283</td>
<td>1475</td>
<td>1723</td>
<td>2080</td>
<td>2398</td>
<td>2832</td>
<td>120.7</td>
</tr>
</tbody>
</table>

Data source: GROS – [www.gro-scotland.gov.uk](http://www.gro-scotland.gov.uk)
6.14 Falls and Bone Health

30% of the 65+ population and 50% of those over 80 fall each year. This equates to an estimated 73,943 falls across Lothian\(^{86}\). Falls are the most common cause of accidental death in those aged 75+ and of accidental injury in older people generally. Falls cause 85% of deaths due to home accidents in those over 65 years and 1 million non-fatal accidents each year in the UK. About 6% of falls in those over 65 result in a fracture, including 1% being of the hip. Having fallen is the most common reason for older people to attend A&E and for being admitted to hospital.

20,635 bed days were utilised in 2010 as a direct result of acute admissions in the 65+ population with a falls related fractured hip (neck of femur) across NHS Lothian. Approximately 50% of older people who fracture their hip are never functional walkers again and 20% will die within six months. The lifetime risk of fracture in males is approximately half that of females.

The economic cost to the NHS and local government associated with the management of unintentional falls is considerable, about half of which is associated with inpatient fracture management and almost as much with long term care provision. The major determinant of this cost is hospital length of stay for which there is considerable national variation, suggesting scope for improvement.

There is a strong evidence base for interventions to prevent falling. The evidence shows that risk assessment and multi-factorial intervention programmes can achieve a substantial reduction (6-30%) in the incidence of falls among Older People. Effective interventions are relatively simple and much can be achieved by redesign and coordination of existing services. In addition, fracture risk can be reduced by targeting effective, evidence based drug treatments to patients with osteoporosis.

In 2013, Midlothian officially launched its falls service for uninjured fallers. The service has been promoted widely and has successfully established effective Falls Pathways with NHS 24, The Scottish Ambulance Service, Fire and Rescue Service (Bariatric/Fallen Uninjured Person) and Police Scotland. The pathways are providing appropriate referrals to the Falls Service and ensure that precious emergency service resources are appropriately triaged. The service offers follow-up support and assessment of a range of falls risk factors to mitigate future risk where possible and the consequences of a fall where not. The result is better patient care.

The Midlothian Uninjured Falls Service shows sustained service growth over its first two calendar years, driven by significant public awareness raising. Month-by month figures however demonstrate marked variation (reasons for the September 2013 and May 2014 dips are not known). The Male:Female ratio remains nominally at 40:60 (indicative of the population profile – females enjoy longer life expectancy). Graph 6.13 shows uninjured fallers by age group and clearly shows that the major service trends and growth is driven by the 75+ age group.

Given the risks from and consequences of a fall on an individual’s mortality and morbidity, this is area requiring sustained focus.

\(^{86}\) 2009 population figures
The number of falls resulting in emergency admissions to patients over 75 years of age is presented below (Table 6.9). It is worth noting that this summary information records the number of episodes, rather than a headcount of the number of patients who are falling. Further analysis would be necessary to explore whether recent increases are the result of a small number of ‘frequent fallers’ or an increase in the absolute numbers of people falling.

Table 6.8: Number of Emergency Admissions for Patients over 75 in Midlothian

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian – East Locality</td>
<td>105</td>
<td>87</td>
<td>93</td>
<td>96</td>
<td>122</td>
</tr>
<tr>
<td>Midlothian – West Locality</td>
<td>94</td>
<td>113</td>
<td>129</td>
<td>111</td>
<td>141</td>
</tr>
<tr>
<td>Midlothian</td>
<td>199</td>
<td>200</td>
<td>222</td>
<td>207</td>
<td>263</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>1,980</td>
<td>2,027</td>
<td>2,099</td>
<td>2,142</td>
<td>2,314</td>
</tr>
<tr>
<td>Scotland</td>
<td>12,447</td>
<td>12,592</td>
<td>13,101</td>
<td>13,355</td>
<td>14,346</td>
</tr>
</tbody>
</table>

Crude Rate for Patients 75+ who had at least One Fall Emergency Admission (2008/09 - 2013/14) data can be seen in appendix 1 – Graph 9.9.
Our Key Needs:

- Develop our local falls strategy and intervention options.
- Continue to provide and embed falls assessment within all multidisciplinary teams.
- Provide and promote information, education and appropriate exercise opportunities to the pre-falling population.
- Target joining data from health and social care regarding falls.
- Communicate a clear message that falls are not an inevitable consequence of ageing and that much can be done to reduce the risk of falls and restore independence and quality of life following a fall.
6.15 Carers
It is hard to know how many carers there are in Midlothian as estimates vary from 10%\(^87\) (~8,300) to 17%\(^88\) (14,000) possibly as a consequence of difference in the way the question was asked (self reported vs. discussion).

The majority of carers providing help or care within the home provide care to a parent. This is closely followed by care to other relatives including spouses, children and siblings. We recognise that many carers are able to manage without any formal assistance and are happy to do so. We also recognise however, that many carers remain hidden including young carers and carers from minority ethnic groups. Based on our concerns regarding robust identification of carers in Midlothian, we believe our hidden carers potentially represent a significant unmet need. We are already targeting resources to try to identify and support carers\(^89\).

At the 2011 Census 2,173 people reported providing more than 50 hours care per week (Table 6.10). Using the data in Table 6.10, unpaid carers contribute in excess of an estimated £150million to the local health and care economy in labour terms\(^90\). The national importance attached to supporting carers is reflected in a range of policy documents both historic and current. These policy documents contain a number of common themes including statutory agencies working with carers as partners in providing care; shifting the balance of care towards preventative support; and enabling and encouraging self-directed care.

6.15.1 Carers’ Inequalities

6.15.1.1 Health
Carers often de-prioritise their needs leading to unnecessary stress and delay accessing support and/or medical treatment. Results from the 2013/14 Health and Care Experience Survey indicate that one third of carers who responded indicated that their caring role had negatively impacted on their health and wellbeing (Graph 6.14). Nationally 12.1% of carers undertaking an unpaid caring role reported that they were ‘not in good health’. Carers are twice as likely to experience ill health and 70% of carers hide this\(^91\). Sources indicate that as carers get older they take on more caring responsibility exacerbating their health and wellbeing inequalities. The 68% of carers providing care to people not living with them reported that they did not access any external support. Carers who access support reported that the most common type of service utilised was practical support including transport (22% of carers).

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\(^87\) The 2011 Census indicated that approximately 10% of the population in Midlothian (~8300 people) are carers.

\(^88\) The 2008 National Household Survey suggested there were as many as 14,000 family carers (approximately 17% of the population).

\(^89\) New carers support bill – 2015 to identify carer’s needs and support them. Carers (Scotland) Bill: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/86987.aspx

\(^90\) Calculated using hourly rate of £14.40 for 52 weeks of the year on a mid-point in the care hours bracket except 50hrs. Calculation: [(4689\*10)+(70\*27)+(667\*42)+(2173\*50)]*52*£14.40

6.15.1.2 Socioeconomic

Across Scotland the largest proportion of households with a carer (28%) are in the 20% most deprived data zones in the Scottish Index of Multiple Deprivation. This is a particular issue in Midlothian where following economic downturn some parts of Midlothian have seen increasing levels of deprivation. Deprivation is most prevalent in the communities of Gorebridge, Mayfield & Easthouses and Woodburn. There are also smaller pockets of deprivation within many other of Midlothian’s communities. In the 2006 Scottish Household Survey 30% of carers of working age are not in employment and those who cared away from the home were more likely to be in employment than those who cared in the home.

6.15.2 Co-production and Partnership

Supporting carers is vital; they provide the bulk of care to older people and those with disabilities. Intensive caring can result in carers being twice as likely to experience ill-health as non carers; up to 70% of carers will hide the fact that their health is suffering. As well as providing support we need to ensure a proactive approach to promoting their good health. This includes access to flu jags and more general health checks; VOCAL are working with local GPs to assess what further steps are possible.

Evidence both locally and nationally shows that maintaining their own health and wellbeing within the caring role continues to be one of the biggest issues for unpaid carers. The following evidence is taken from the analysis by VOCAL of data covering 390 carers over a period of 9 months (October 2010 to June 2011). This focuses on what carers fed back about what had supported them to maintain or improve their health and wellbeing within the caring role. These findings have been reinforced in subsequent years.

- Recognition and acknowledgement of the caring role, and an opportunity to talk about and reflect on the impact of the caring role on their life (carer conversation/assessment)
- Access to breaks from the caring role
- Accessing support for themselves as a carer, including counselling, peer support and training
- Support with accessing benefits and planning for the future e.g. Power of Attorney
- Improved knowledge and understanding of the condition of the person they are supporting
- Increased knowledge and understanding of the support available
- Increased support and services for the cared for person

These reflect the priorities within Caring Together – The Carers Strategy for Scotland and the Midlothian Carers Strategy, which include identification of carers, carers assessments/support plans, short breaks and access to carer support.

**Our Key Needs:**

- Accurately identify carers within the population.
- Understand the actual needs of the carers and the individuals being cared as impact varies according to more than hours provided.
- Reduce health and wellbeing inequalities for carers.
- Link carers needs to unscheduled care planning so that carer support is included in care of patient.
- Look at our whole carers strategy so we can ‘start a conversation’.
Graph 6.14: Health and Social Care Experience Survey Responses re. Caring Responsibilities

**CARING RESPONSIBILITIES**

- Carers have a good balance between caring and other things in their life: 27% Very Positive, 41% Positive, 21% Neutral, 10% Negative
- Carers are still able to spend enough time with people they want to spend time: 26% Very Positive, 46% Positive, 15% Neutral, 12% Negative
- Caring has had a negative impact on carers' health and wellbeing: 15% Very Positive, 29% Positive, 23% Neutral, 33% Negative
- Carers have a say in the services provided for the person they look after: 14% Very Positive, 34% Positive, 31% Neutral, 21% Negative
- Services are well coordinated for the people carers look after: 14% Very Positive, 39% Positive, 26% Neutral, 22% Negative
- Carers feel supported to continue caring: 13% Very Positive, 34% Positive, 32% Neutral, 21% Negative
Table 6.10: Provision of Unpaid Care in Midlothian by Age and Gender (Orange cells = highest value in corresponding category)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>All people</th>
<th>Provides no unpaid care</th>
<th>Provide Care</th>
<th>% of care given</th>
<th>Provides 1 to 19 hours unpaid care a week</th>
<th>% of carer whole</th>
<th>Provides 20 to 34 hours unpaid care a week</th>
<th>% of carer whole</th>
<th>Provides 35 to 49 hours unpaid care a week</th>
<th>% of carer whole</th>
<th>Provides 50 or more hours unpaid care a week</th>
<th>% of carer whole</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Total</td>
<td>83187</td>
<td>74949</td>
<td>8238</td>
<td>10%</td>
<td>4689</td>
<td>57%</td>
<td>709</td>
<td>9%</td>
<td>667</td>
<td>8%</td>
<td>2173</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>0 to 15</td>
<td>15603</td>
<td>15423</td>
<td>180</td>
<td>1%</td>
<td>151</td>
<td>2%</td>
<td>16</td>
<td>0%</td>
<td>5</td>
<td>0%</td>
<td>8</td>
<td>0%</td>
</tr>
<tr>
<td>Males</td>
<td>16 to 24</td>
<td>9165</td>
<td>8543</td>
<td>387</td>
<td>4%</td>
<td>247</td>
<td>3%</td>
<td>41</td>
<td>0%</td>
<td>54</td>
<td>1%</td>
<td>45</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>25 to 34</td>
<td>18229</td>
<td>15842</td>
<td>2387</td>
<td>13%</td>
<td>1414</td>
<td>17%</td>
<td>219</td>
<td>3%</td>
<td>223</td>
<td>3%</td>
<td>531</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>50 to 64</td>
<td>17357</td>
<td>14275</td>
<td>3082</td>
<td>18%</td>
<td>1936</td>
<td>24%</td>
<td>268</td>
<td>3%</td>
<td>206</td>
<td>3%</td>
<td>672</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>65 and over</td>
<td>13903</td>
<td>12372</td>
<td>1531</td>
<td>11%</td>
<td>599</td>
<td>7%</td>
<td>107</td>
<td>1%</td>
<td>102</td>
<td>1%</td>
<td>723</td>
<td>9%</td>
</tr>
<tr>
<td>Females</td>
<td>Total</td>
<td>43116</td>
<td>38172</td>
<td>4944</td>
<td>11%</td>
<td>2802</td>
<td>34%</td>
<td>463</td>
<td>6%</td>
<td>363</td>
<td>4%</td>
<td>1316</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>0 to 15</td>
<td>7704</td>
<td>7606</td>
<td>98</td>
<td>1%</td>
<td>80</td>
<td>1%</td>
<td>10</td>
<td>0%</td>
<td>4</td>
<td>0%</td>
<td>4</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>16 to 24</td>
<td>4381</td>
<td>4164</td>
<td>217</td>
<td>5%</td>
<td>132</td>
<td>2%</td>
<td>25</td>
<td>0%</td>
<td>32</td>
<td>0%</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>25 to 34</td>
<td>4771</td>
<td>4339</td>
<td>432</td>
<td>9%</td>
<td>221</td>
<td>3%</td>
<td>36</td>
<td>0%</td>
<td>36</td>
<td>0%</td>
<td>139</td>
<td>2%</td>
</tr>
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<td></td>
<td>35 to 49</td>
<td>9497</td>
<td>8025</td>
<td>1472</td>
<td>15%</td>
<td>869</td>
<td>11%</td>
<td>150</td>
<td>2%</td>
<td>103</td>
<td>1%</td>
<td>350</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>50 to 64</td>
<td>8967</td>
<td>7076</td>
<td>1891</td>
<td>21%</td>
<td>1190</td>
<td>14%</td>
<td>184</td>
<td>2%</td>
<td>125</td>
<td>2%</td>
<td>392</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>65 and over</td>
<td>7796</td>
<td>6962</td>
<td>834</td>
<td>11%</td>
<td>310</td>
<td>4%</td>
<td>58</td>
<td>1%</td>
<td>63</td>
<td>1%</td>
<td>403</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Nation Records of Scotland | Scotland’s Census 2011 - National Records of Scotland | Table DC3103SC - Provision of unpaid care by sex by age | All people. Crown copyright 2014
6.16 Sexual Health and Blood-Borne Viruses

6.16.1 Teenage Pregnancy

In recent years there has been an encouraging national trend showing a reduction in teenage pregnancy rates; across Lothian this trend has been closely matched (Graph 6.15). A key priority across Lothian has been to reduce the number of unintended teenage pregnancies in order to reduce the number of young women leaving full time education for this reason before the age of 18. This is linked to the overall strategic vision for children and young peoples’ health—that every child should have the best start in life and grow up being healthy, confident and resilient[92].

There is a slightly different picture in Midlothian however (see Appendix 1 – Additional Graphs and Tables: Graph 9.10, Graph 9.11, Graph 9.12 for more detailed graphs). Though the overall trend during the period shown is a reduction, the rates remain much higher than Lothian and Scotland as a whole. The pregnancy rate for the under 16s has converged with the Scotland figure over the past 3 years, but the rates for under 18s and under 20s are slightly higher in Midlothian compared to the national figure[93]. It is not clear why this is the case and further work will be required to understand this locally.

Graph 6.15: Teenage (Under 20) Pregnancies (rate per 1,000) for Midlothian, Lothian and Scotland per calendar year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Midlothian &lt;20</th>
<th>Lothian &lt;20</th>
<th>Scotland &lt;20</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>64.9</td>
<td>57.1</td>
<td>55.8</td>
</tr>
<tr>
<td>2005</td>
<td>65.8</td>
<td>58.9</td>
<td>56.9</td>
</tr>
<tr>
<td>2006</td>
<td>56.0</td>
<td>56.1</td>
<td>57.6</td>
</tr>
<tr>
<td>2007</td>
<td>62.5</td>
<td>57.1</td>
<td>57.7</td>
</tr>
<tr>
<td>2008</td>
<td>64.9</td>
<td>54.1</td>
<td>54.6</td>
</tr>
<tr>
<td>2009</td>
<td>69.0</td>
<td>49.6</td>
<td>51.3</td>
</tr>
<tr>
<td>2010</td>
<td>67.0</td>
<td>45.8</td>
<td>48.5</td>
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<tr>
<td>2011</td>
<td>60.1</td>
<td>45.6</td>
<td>43.8</td>
</tr>
<tr>
<td>2012</td>
<td>53.6</td>
<td>39.8</td>
<td>41.6</td>
</tr>
<tr>
<td>2013</td>
<td>59.8</td>
<td>39.8</td>
<td>37.7</td>
</tr>
</tbody>
</table>

Note: Under 20 - Includes all pregnancies in women aged under 20. The rate is calculated using the female population aged 15-19.

Data source: http://www.isdscotland.org/Health-Topics/Sexual-Health/Publications/data-tables.asp?id=1431#1431


[93] It’s worth noting when analysing that the figures for under 20s are by single calendar year while the under 16 and under 18 rates show a 3 year rolling aggregate.
6.16.2 Hepatitis C and HIV

There is a variety of Blood Borne Viruses (BBV) of which Hepatitis C and HIV have the most serious long term implications. There is no vaccine for either illness. There is no cure for HIV. For Hepatitis C there is a treatment which leads to sustained viral clearance in the majority of patients.

Health Protection Scotland publishes BBV data by Health Board but not by Local Authority. During calendar year 2014, 322 cases were newly identified as hepatitis C antibody positive in Lothian. The majority of these are likely to have been infected some years ago. This compares with an average of 203 in the years 2002-2009.

Since testing became available in the late 1980s there have been 5234 persons reported as hepatitis C antibody positive in Lothian (to 31st Dec 2014) of whom approximately 81% are still alive.

The number of new cases of HIV infection in Lothian has been falling since 2005 and in 2014 totalled 90. However, the prevalence of people with HIV is increasing due to decreased deaths, due to antiretroviral therapies and due to new cases being diagnosed. At 31 March 2015 there were an estimated 1,575 people living with HIV in Lothian, up from just over 1,000 in January 2010. There are around 5,800 people living in Lothian with HIV or Hepatitis C infection. Further planning work is required to estimate the numbers now and in the next five to ten years living in Midlothian who are likely to require Health and Social Care services.
7 Our Services

7.1 Workforce Planning Overview

Delivery of our services depends on a range of people (e.g. staff, volunteers, members of the public) and requires a level of workforce capacity and capability. Provision of Health & Social Care services is very staff intensive. More than 3000 people are employed in Adult Social Care across statutory, private and independent services and the Midlothian compliment of NHS staff number more than 520 (see section 4.4: Employment).

Across Midlothian, as in other areas of Scotland, in both statutory Health & Social Care and the independent Social Care sector, to varying degrees, we face a number of common workforce challenges e.g.:

- Ensuring the right skill mix in the workforce
- Managing vacancies
- Sickness absence
- Changing Roles
- Issues around low role value
- Succession planning for an aging workforce and a lack of youth in number
- Recruitment
- Turnover
- Disparity in terms and conditions
- Constrained financial operating environment

Our workforce age profiles (Graph 7.1 & Graph 7.2) indicate that our workforce lacks younger staff members in sufficient number to replace those leaving through natural wastage and other processes towards the upper limit of the age range. Thus we face challenges of experience and skills loss through retirement.

Skills Development Scotland have reported that in Edinburgh, Fife and the Lothians, the greatest employment increases in the coming decade are expected to come from Health & Social care. However, it is widely recognised that the traditional care delivery model for Health & Social Care services in Scotland is untenable going forward. The pressures from population demographics and a constrained financial climate require us to consider our Workforce Development response – how transformational change and modernisation be wrought throughout our services. We are not seeking simply to maintain the status quo! As service delivery priorities shift away from crisis acute care towards preventative work in the community and continue to promote self-efficacy and co-production, the needs profile for staff changes. The strategic plan seeks to set service priorities and this will inform the foundation upon with workforce development process will be aligned to. In essence, we face an immediate challenge to our workforce but the response is still developing, informed by strategic analysis.

Key areas or work we have underway:

- Review of Occupational therapy Services
- Planning a more robust approach to recruitment and retention of Social Care workforce

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95 Skills Development Scotland (2014). Regional Skills Assessment Edinburgh & Lothians. [Available at: https://www.skillsdevelopmentscotland.co.uk/media/1272696/SDS_RSA_Edinburgh_and_Lothians_Dig.pdf]
Graph 7.1: Headcount and Whole Time Equivalent (WTE) Number of Adult & Social Care staff by Age Distribution

Graph 7.2: NHS Midlothian Staff JobFamily by Age Distribution

Data source: Midlothian Council - Workforce Planning Data

Data source: NHS Lothian – Workforce Planning data
7.2 Primary Care
The following section describes our understanding in relation to GPs, Community Pharmacy and Community Nursing.

7.2.1 GP

7.2.1.1 Numbers and Pressures
Only headcount figures are routinely available for general practitioners working in Scotland and thus Midlothian also (Table 7.1 and Graph 7.3). This means we are unable to describe the total amount of doctor-time available within Midlothian. The number of GP’s working in Midlothian has increased slightly between 2008/9 and 2012/13. Working practices are changing over time, with increasing numbers of younger GPs choosing to work less than full-time hours. We are currently unable to use routine data to monitor the impact of these changing working practices.

Table 7.1: Number of General Practitioners in post 2008-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Midlothian CHP</th>
<th>NHS Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>86</td>
<td>782</td>
</tr>
<tr>
<td>2007</td>
<td>85</td>
<td>787</td>
</tr>
<tr>
<td>2008</td>
<td>90</td>
<td>815</td>
</tr>
<tr>
<td>2009</td>
<td>95</td>
<td>827</td>
</tr>
<tr>
<td>2010</td>
<td>89</td>
<td>821</td>
</tr>
<tr>
<td>2011</td>
<td>90</td>
<td>842</td>
</tr>
<tr>
<td>2012</td>
<td>91</td>
<td>838</td>
</tr>
</tbody>
</table>

Data source: courtesy of NHS Lothian Analytical Services: September 2014

Graph 7.3: Rate per 10,000 Population of Headcount Number of All GPs in Post by CHP 2006-2012

The demand for GP appointments is high and it is estimated that about 0.5 million appointments are offered each year with GPs seeing approximately 10% of the Practice population every week. As a result some practices have struggled to meet the standard of offering telephone advice or an appointment within 48 hours.
7.2.1.2 Prescribing Costs

In NHS Scotland, medication is by far the most common form of medical intervention. Four out of five people aged over 75 years take a prescription medicine and 36 per cent are taking four or more. However, it is suggested that up to 50 per cent of drugs are not taken as prescribed, many drugs in common use can cause problems and, that adverse reactions to medicines are implicated in 5 - 17 per cent of hospital admissions. £15m of the total £45m Community Health Partnership budget for NHS Services in Midlothian is spent on prescribing. Considerable effort is being made to reduce these costs safely whilst encouraging patient self management of symptoms where appropriate and generally encouraging healthy lifestyles. Additionally, we have developed some alternatives such as “healthy reading” and exercise referral schemes.

Using the costing methodology NHS Lothian and other health boards apply, in 2014/15 Midlothian’s average GP prescribing cost per patient in 2014/15 was £182 against a Scotland average of £180. Spending in Midlothian is growing faster than the rest of Lothian and Scotland.

7.2.1.3 Access to Services

There are 12 G.P. Practices in Midlothian operating from 10 premises. A number of these premises are good quality and modern, the latest being Dalkeith Health Centre. However, a number of GP practices in Midlothian have outgrown, or are likely to, the capacity of their premises and plans are being developed to address the main pressure points - in Newbyres, Penicuik, Danderhall and Loanhead. This position will remain under continual review with the Midlothian population set to grow by 5.5% between 2010-20 alongside the continuing trend of treating people at home rather than in hospital.

The National Health and Care Experience Survey asks peoples’ experiences of their GP practice and out-of-hours services, and their outcomes from NHS treatments. The 2013/14 survey (most recent) was widened to include other areas of care and help provided by local authorities and other organisations to support the national outcomes for health and wellbeing proposed under The Public Bodies (Joint Working) (Scotland) Bill.

In this survey Scottish practices performed highly with very high average scores for patient satisfaction across many parameters. Performance results, particularly with regard to average scores for access in this survey for Midlothian Community Health Partnership, were somewhat disappointing however. In general smaller practices seem to have fared better than larger ones; the reasons for this are unclear. Midlothian performance has dropped in comparison to the Scottish average since the last survey at which time Midlothian performance was very close to the Scottish Average, again there are no clear apparent reasons for this.

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97 Co-morbidity and repeat admission to hospital for adverse drug reactions in older adults: retrospective cohort study M Zhang et al BMJ 2009;338:a275
98 NHS Lothian CHP Prescribing Finance Report – March 2015
100 Clinical Director’s Report 2/10/14. Midlothian Community Health Partnership Sub Committee
7.2.2 Community Pharmacy

There are twenty pharmacies in Midlothian, most of which open until 6pm; two of which open until 10pm; and one opens on a Sunday. Within Midlothian, pharmacies are located in the areas of greater population density, the more dense the population the higher number of pharmacies there are. Medication is vital in helping people recover and keeping people well. (Figure 7.1)

The new community pharmacy contract aims to use the skills and knowledge of pharmacists better ensuring that all patients have access to support in the management of their medicines as well as providing a minor ailment service for advice on such conditions as hay fever, athletes foot and cold sores.

Figure 7.1: Map showing GP Practices and Pharmacies in Midlothian CHP

7.2.3 Nursing

There is a similar difficulty with the information available about the number of practice nurses as there is for GPs (Section 7.1.1.1). The only routine data source available to us is the NHS Scotland National Primary Care Workforce Planning Survey in 2007. Only 74% of practices completed the survey and again, only headcount information is available. Data from the survey is available but likely to be out of date and of limited value so not included in this summary.

Headcount and Whole Time Equivalent (WTE) information is available for community nurses, but only at NHS Lothian level at present. The total numbers of community nurses and WTE working have both increased in the last year (Graph 7.4). This information is available from the Information and Statistics Division of NHS Scotland.
Key point: There is limited routinely information available to describe the primary care workforce. This is not currently broken down to locality level. Available information suggests little change in the number of GP’s working in Midlothian and an increase in the number of community nurses working in Lothian overall.
7.3 Hospitals

There is scope to undertake a lot more analytical work in relation to Midlothian’s use of hospitals through existing and developing resources produced by Information Services Division (ISD) [see section 8.3 - Maximising Resources] and NHS Lothian Analytical Services. This work will continue throughout 2016/17. At this time, we can describe the following:

7.3.1 Unscheduled care

Unplanned admissions from Midlothian accounted for between 10-11% of all unplanned admissions in Lothian between 2008/9 and 2012/13. In summary charts showing only the number of admissions from all Lothian areas, the Midlothian line can be overlooked because it appears to be so low in comparison to Edinburgh. It is interesting to see that over time, focusing on admission rates, rather than absolute numbers, in Midlothian there is a changing picture, with a gradual increase in unplanned admissions. The cost of unplanned admissions to hospitals is very high; nationally it accounts for a third of the total budget on health and social care for older people. For many people admission is essential. However by providing immediate responses to emergencies the local Rapid Response Service has helped avoid some 500 admissions a year.

Graph 7.5: Crude Rates per 100,000 Population by Lothian CHP/Lothian Total: 2008/9-2012/13

Table 7.2: Total number of unplanned admissions by Locality

<table>
<thead>
<tr>
<th>Year</th>
<th>East Midlothian</th>
<th>West Midlothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>3,547</td>
<td>3,546</td>
</tr>
<tr>
<td>2009/10</td>
<td>3,403</td>
<td>3,729</td>
</tr>
<tr>
<td>2010/11</td>
<td>3,649</td>
<td>3,694</td>
</tr>
<tr>
<td>2011/12</td>
<td>3,987</td>
<td>3,830</td>
</tr>
<tr>
<td>2012/13</td>
<td>3,923</td>
<td>4,174</td>
</tr>
</tbody>
</table>

Data source: courtesy of NHS Lothian Analytical Services: September 2014
The overall crude admission rates (Graph 7.5 & Table 7.2) have been analysed by locality and split by SIMD quintile. There is a well recognised pattern of higher admission rates associated with deprivation and this can be seen in both East (Graph 7.6) and West Midlothian (Graph 7.7).

**Graph 7.6: Crude Rates per 100,000 Population by SIMD Quintile (East Area of Midlothian) 2008/9-2012/13**

**Key point:** There has been a gradual increase in the number of unplanned admissions from Midlothian (both East and West Localities) over recent years. Admission rates are higher among patients who are resident in areas of higher deprivation.

**Graph 7.7: Crude Rates per 100,000 Population by SIMD Quintile (West Area of Midlothian) 2008/9-2012/13**
7.3.2 A&E

A&E attendances from Midlothian residents accounted for between 10-11% of A&E attendances Lothian between 2008/9 and 2014/15. A&E attendance rates have been increasing over a number of years (Graph 7.8). Overall crude rate per 1000,000 residents A&E attendance by Midlothian residents has remained higher than for NHS Lothian as a whole. There is a consistent trend for higher attendance rates of A&E attendance from the East Locality of Midlothian in comparison to the west; this is likely to reflect the higher levels of socioeconomic deprivation in the East Locality. Further analysis would be necessary to take account of the demographic differences between East and West Locality to allow more complete understanding.

Though one must be cautious drawing links between higher A&E rates and higher unscheduled care, attendance at A&E represents the ‘Front Door’ of the hospital system. Though many attendances require the services of a 27/4 Consultant lead service, attendance at an A&E for reasons which primary care services are able to manage can lead to an admission that could have been preventable.

Spending on emergency service provision is likely to remain largely unchanged as a result of the new partnership – this service must remain a universal access point. Scope for change exists however in how patients flow to and through A&E to support the Shifting the Balance of Care agenda.

Graph 7.8: A&E Attendances - Crude Rate per 100,000 Residents
7.3.3 Mental Health
Midlothian has seen very significant changes in the approach to treating and supporting people with acute mental health problems. Provision for acute inpatient services for adults was transferred from Rosslynlee Hospital to Edinburgh in 2007 and health, social work and voluntary services in the community were strengthened. As a result fewer people are admitted to hospital (seventh lowest rate in Scotland) and spend less time there when admission is necessary. However, recently the impact of New Psychoactive Substances appears to be affecting the number of admissions and the lengths of stay. In 2013 there were 107 Midlothian patients admitted to the Royal Edinburgh Hospital (8.9 per month).

The in-patient facilities in the Royal Edinburgh Hospital are in phased re-development with purpose-built facilities for mental health care. This will ensure that the needs of Midlothian’s patients continue to be fully met in the new facilities due to open in 2016. The nominal inpatient bed complement for Midlothian will be eight.

7.3.4 Delayed Discharges
Delayed discharges of patients in Midlothian have been well controlled, consistently meeting the national target. A new target of people being delayed in hospital no more than two weeks comes into force in 2015. However, in advance of this, increased attention is being paid to supporting people to return home as soon as they are ready to do so. This is being achieved by Midlothian staff working in the Acute Hospitals working alongside hospital staff in an in-reach model.

7.3.5 Utilisation of MCH
Midlothian Community Hospital opened in 2010. It is a valued resource providing care for people who are very ill or are in the advanced stages of dementia and providing inpatient assessment of older people with acute mental health needs. We believe there is considerable scope to develop the use of the hospital by providing more clinics and day treatment locally, benefitting Midlothian patients whilst reducing pressures on Acute Hospitals. There are a growing range of clinics and services available in the community hospital, however further significant development would require investment by reducing expenditure elsewhere.
7.4 Tele-services

7.4.1 Digital Healthcare
Our Health and Social Care systems are becoming increasingly dependent on digital infrastructures and Information & Communications Technology (ICT). Digital advances such as analytics, mobility, social media and smart embedded devices are being deployed to change customer relationships, internal processes, and value propositions through all industries.

In health and social care ‘going digital’ represents a paradigm shift from previous work practices, thought processes, co-operation and models of efficiency refinement to very new and different way of thinking. At national level, there is alignment of strategic action to drive this new agenda forward. Digital health and care services will seek to network data, people and education and a variety of projects are in progress to achieve this (e.g. Clinical Portal Development, Knowledge into Action, Scottish Wide Area Network [SWAN], Living it Up).

Key developments from eHealth and integration are changing our resource status but we need to foster the required cultural change by encouraging skills development and a willingness to embrace the change in practice.

7.4.2 Telecare
Telecare has received Scottish Government development support since 2006. It is currently widely regarded as an effective way of supporting patients/clients and their families/carers. It offers reassurance where there was little or none previously and a sustainable solution to supporting people to remain at home for longer in complex care situations. Over recent years, Midcare (Midlothian Council’s telecare service), has increased telecare deployment and experienced needs led growth. Midcare currently provides a service to about 1,700 clients in Midlothian with the majority service user group being Older People. Midcare is only partially funded from core budget and remains dependent on short term funding (Change Fund and Integrated Care Fund). There is therefore a need to review the support of this service and strengthen provision to other service user groups (i.e. Learning Disabilities, Mental Health etc).

7.4.3 Telehealth
Midlothian currently has very limited activity in Telehealth. In recent years Midlothian has been involved in telehealth monitoring of patients with Chronic Obstructive Pulmonary Disease (COPD). Monitoring has now stopped as research evaluating the NHS Lothian trial of COPD monitoring found it failed to prevent hospital admission when compared to our local care to guideline standard and was slightly more costly. Different models of GP access are being explored however. Newbattle Practice offers a Total Telephone Triage Model (TTT) for consultations as an alternative method of general practice delivery and Strathesk Medical Practice are in the process of implementing a TTT system.

Midlothian needs to remain open to developments in this area as it is expected to be a growth area. A key NHS Lothian project is home blood pressure (BP) monitoring where there is good evidence that “supported self management by telemonitoring is an effective method for achieving clinically
important reductions in blood pressure in patients with uncontrolled hypertension in primary care settings”.

7.4.4 Videoconferencing

In the digital age there is a need to rethink the way traditional services are organised and offered using technology to shrink distances and model new methods of working, videoconferencing offers a solution. Two current examples in Midlothian are:

- Pulmonary rehabilitation classes via telerehabilitation using NHSScotland’s national videoconferencing service to connect a hub site to spoke sites and allows the resources to be stretched further.
- Care home multi-disciplinary team education development project to support the training needs of care home staff.

Though the numbers supported are currently small, the opportunities are numerous and nationally this is expected to be a growth area. The social care side of the partnership needs to develop the necessary IT links to enable integration and widespread use of the NHS National videoconferencing service.

7.4.5 Technology Enabled Care (TEC)

Technology Enabled Care (TEC) is an emerging term associated with telehealthcare service planning. In this context TEC is defined as “being where the quality of care in home or community setting is either enhanced and/or made more efficient through the application of technology as an integral part of the care process”. Telehealthcare enables the flow of health and care information relevant to supporting shared decision making and increases shared awareness (knowledge enhancement) to mediate improved co-productive outcomes. The process of forming the new partnership offers an opportunity to embed a renewed focus on technology.

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102 McKINSTRY, B; HANLEY, J; WILD, S; PAGLIARI, C; PATerson, M; LEWIS, S; et al. Telemonitoring based service redesign for the management of uncontrolled hypertension: multicentre randomised controlled trial BMJ 2013; 346 :f3030
103 TEC Letter 03/09/14 from JIT
104 Including, but not limited to, the use of telecare, telehealth and mobile health & wellbeing.
8 Information Gaps and Future Work

8.1 Knowledge Gaps
The Joint Needs Assessment and Strategic Planning processes have been a valuable opportunity to scrutinise our corporate knowledge network - what we know and how we know it. In many areas we have strong activity data; in some areas we need to strengthen our efforts; a few will never yield to full quantification. In part this is because the dimensions we wish to measure are complex and our tools too simple (what is the definition and measure of community resilience for example?). We are not alone in grappling with these issues, this is a global problem. Other reasons include the different delivery models and data cultures inherent to health and social care respectively and because policy and strategy can re-classify need. The result is a need to work flexibly with certainty and uncertainty using best judgement informed by close partnerships with strong communication channels. Though national and local work is ongoing to ameliorate discrete data sets, capture more and offer a ‘bigger picture’ view, the reality is that both the data and the capability to interpret and use it effectively will develop incrementally. Numbers of people being treated is however only a surrogate measure of need. We need to move to an Outcomes focus to determine if needs have been met.

Figure 8.1 offers a helpful mental framework for considering how the themed areas identified in Table 8.1 will contribute towards our ‘bigger picture’; the reader is invited to make their judgement regarding placement of the table items. The framework blends NHS Scotland’s ‘Triple Win’\(^{106}\) and Midlothian’s Community Planning Partnership aims to generate a true Partnership Vision.

These are just some of the areas that have been identified for the new Health & Social Care Partnership to consider. We must be vigilant against becoming data rich and remaining information poor however and only collect data that which will add to our understanding of population health needs.

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Figure 8.1: Partnership Pillars

Table 8.1: Themed Areas Identified Requiring Further Work

<table>
<thead>
<tr>
<th>System-wide Issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Usage</td>
<td>Is there a direct link between eliminating delayed discharges and a rising re-admission rate?</td>
</tr>
<tr>
<td>Acute Admissions</td>
<td>Not regarding acute admissions as a single entity (i.e. 24hr inappropriate admissions vs. the need for an individual to be in hospital)</td>
</tr>
<tr>
<td>Data</td>
<td>Articulating national datasets at Midlothian level (including localities)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Delivery</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
<td>Consider service delivery definitions in relation to lived experience</td>
</tr>
<tr>
<td></td>
<td>e.g. what and where is the distinction between physical disability and long-term condition. How and why does it matter?</td>
</tr>
<tr>
<td>Multimorbidity</td>
<td>How can we develop our care delivery models</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic Specific</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory Impairment</td>
<td>Quantify Unmet Needs</td>
</tr>
<tr>
<td>Physical Disabilities</td>
<td>Quantify Unmet Needs</td>
</tr>
<tr>
<td>Autism</td>
<td>Quantify Unmet Needs</td>
</tr>
<tr>
<td>Loneliness and Social Isolation</td>
<td>Consider health impacts on quality of life.</td>
</tr>
</tbody>
</table>
8.2 Outcomes Focus

Making a difference in people’s lives is a central tenet of the Public Bodies (Joint Working) (Scotland) Act 2014. With this comes a shift in the “focus of performance management improvement into the achievement of individual personal outcomes for those receiving support and care, and their carers”\(^\text{107}\). Outcomes and not activity will become increasingly important to articulate. To assist this nine national health and wellbeing outcomes have been created, the new Health & Social Care partnership will have to ensure these are meaningful to Midlothian.

**Outcome 1**: People are able to look after and improve their own health and wellbeing and live in good health for longer

**Outcome 2**: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

**Outcome 3**: People who use health and social care services have positive experiences of those services, and have their dignity respected

**Outcome 4**: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

**Outcome 5**: Health and social care services contribute to reducing health inequalities

**Outcome 6**: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

**Outcome 7**: People using health and social care services are safe from harm

**Outcome 8**: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

**Outcome 9**: Resources are used effectively and efficiently in the provision of health and social care services

Source: [The Scottish Government](http://www.gov.scot/Resource/0047/00470219.pdf)

Work is ongoing to develop a Performance Framework to allow Midlothian to meet the requirements incumbent upon it. This will require continued support and refinement as we seek to incorporate more Patient Reported Outcome Measures (PROMs).

8.3 Maximising Resources

8.3.1 Integrated Resource Framework (IRF)
The Integrated Resource Framework produced by Information Services Division (ISD) Scotland provides an overview of health and social care resource used by local populations and IRF supports an understanding of historical service patterns as a basis for strategic planning of services.

IRF data analysis includes:

- Total expenditure across health and social care sectors for each health and social care partnership, to understand the resource use in their population.
- An anonymous individual level costing system for healthcare activity; a much more in depth approach to understanding costs.
- Combined information with local authority expenditure to build an accurate picture of joint health and social care spending.

8.3.2 IRF Information Available at an Individual Level
IRF also provides information at an individual level. This means that, rather than just looking at activity across traditional budget lines, partnerships can review services across populations. This has allowed partnerships to review:

- Disease specific groups such as diabetes or dementia.
- Demographic groups (e.g. older adults and deprived households).
- Practice or geographical population (e.g. community planning partnerships).


Individual level linked information has also been used by partnerships to create a picture of how people move from one service to another. Understanding these service utilisation pathways is crucial in determining the needs of the local population and developing new integrated approaches to care delivery that leads to better outcomes with greater efficiency.

The linked dataset currently contains all record level activity plus costs for the following service areas:

- Inpatients - episode level
- Day cases - episode level
- Outpatient - Consultant new attendances only - DNAs included
- A & E attendances
- GP Prescribing - Number of prescribed items
- Deaths - dates and cause of death if applicable (NRS death records)

Where applicable, activity contains additional variables available on datasets centrally held by ISD. These include diagnoses, procedure codes, admission type, specialty and significant facility. Each activity item also contains patient demographics such as age, sex, deprivation quintile (SIMD), post code and location of treatment.
All current IRF analysis will be incorporated into the Health and Social Care Data Integration and Intelligence Project analytical platform.\(^{108}\)

### 8.3.3 Health and Social Care Data Integration and Intelligence Project (HSCDIIP)

The aim of HSCDIIP is to link client and patient level data from their contacts with NHS Scotland and Local Authority services. One of the main work streams is to produce a range of analytical outputs, which are based on expenditure and activity for each Scottish Integrated Care Partnership. The outputs are designed to support and enable decision making and to inform the strategic planning process, by providing integrated information for commissioning work and to help identify the current and future health and social care needs of their population. This information has been used to build interactive dashboards using the data visualisation tool Tableau.

**Information available via dashboards**

The following dashboards are available via the HSCDIIP project:

- High level mapping of health and social care expenditure; 2010/11 - 2013/14
- Hospital inpatient & daycase activity and expenditure; 2013/14
- High Resource Individuals (HRI); 2012/13
- Delayed discharges; 2012/13

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9 Appendices
9.1 Appendix 1 – Additional Graphs and Tables

Graph 9.1: All CHD Mortality

Graph 9.2: Early (<75s) CHD Mortality

Data source: courtesy of NHS Lothian Analytical Services: September 2014
Graph 9.3: All Stroke Mortality

Graph 9.4: Early (<75s) Stroke Mortality
Graph 9.5: All Breast Cancer Mortality

All Breast Cancer Mortality
Midlothian Locality, NHS Lothian and Scotland

- East Locality
- West Locality
- Midlothian CHP
- NHS Lothian
- Scotland

Data source: courtesy of NHS Lothian Analytical Services; September 2014

Graph 9.6: All Lung Cancer Mortality

All Lung Cancer Mortality
Midlothian Locality, NHS Lothian and Scotland

- East Locality
- West Locality
- Midlothian CHP
- NHS Lothian
- Scotland

Data source: courtesy of NHS Lothian Analytical Services; September 2014
Graph 9.7: All Colorectal Cancer Mortality

Data source: courtesy of NHS Lothian Analytical Services; September 2014

Graph 9.8: Suicide Rates in Midlothian

Data Source: http://www.scotpho.org.uk/downloads/suicide/Suicide_LA_Overview_2014_Final.xls
Table 9.1: Suicide Rates in Midlothian

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 5-year</td>
<td></td>
<td>All Persons</td>
<td>47</td>
<td>53</td>
<td>56</td>
<td>67</td>
<td>53</td>
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* 2009-13 analysis uses old coding rules for each year to allow consistent comparisons over time


Graph 9.9: Crude Rate for Patients 75+ who had at least One Fall Emergency Admission (2008/09 - 2013/14) per 10,000 Population for Midlothian Area/CHP, NHS Lothian and Scotland by year of discharge

Data Source: National Records of Scotland (NRS, formerly known as GRO) Mid-Year Population Estimates

Note - East/West areas of Midlothian is based on multi-member wards. They are defined as follows:
- East Area: Dalkeith, Midlothian East, Midlothian South.
- West Area: Bonnyrigg, Midlothian West, Penicuik.

**Key point:** Crude rates of patients admitted because of a falling have varied considerably between 2008/9 and 2012/13 in both East and West Midlothian. Overall, it appears that there is an increasing trend, but further analysis would be needed to establish whether this is as a result of a few individuals falling frequently or whether a larger number of individuals are affected. (Scottish Ambulance protocols could also have had an effect).
Graph 9.10: Teenage (Under 16) Pregnancies (rate per 1,000) for Midlothian and Scotland per calendar year.


Note: Under 16 - Includes all pregnancies in women aged under 20. The rate is calculated using the female population aged 13-15.

Graph 9.11: Teenage (Under 18) Pregnancies (rate per 1,000) for Midlothian and Scotland per calendar year


Note: Under 18 - Includes all pregnancies in women aged under 20. The rate is calculated using the female population aged 15-17.
Graph 9.12: Teenage (Under 20) Pregnancies (rate per 1,000) for Midlothian and Scotland per calendar year


Note: Under 20 - Includes all pregnancies in women aged under 20. The rate is calculated using the female population aged 15-19.
9.2 Appendix 2 – Data Sources – Dr. Joy Tomlinson – July 2015

Data availability

The Joint Strategic Needs Assessment used routinely available data sources to identify key health issues affecting the Midlothian population. As localities are newly defined geographical entities, not previously considered by key data providers, this poses challenges for us. Many national data sources are currently unable to provide information at locality level and this will limit our ability to tailor commissioning of services for the two Midlothian locality areas.

The table below summarises the information used in our Joint Strategic Needs Assessment, where the data is owned and whether it may be available by locality in future.

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<td>Sensory Impairment</td>
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