Midlothian
Health & Social Care
Partnership

Strategic Plan

2019 - 2022

Contents

Who we are

The Midlothian Health and Social Care Partnership is responsible for services that help you live well and get support when you need it. This includes all **community health and social care services for adults in Midlothian and some acute hospital-based services.**

Midlothian Health & Social Care Partnership

is responsible for

NHS Lothian

Unscheduled care in Hospitals (e.g. A&E, Minor Injuries, Acute wards)

Community Health Services (e.g. GPs, District Nurses, Dentists, Pharmacists, Mental Health services and the Community Hospital)

Health Visiting and School Nurses. (Most children's services remain the remit of the Getting it Right for Every Child Group)

Midlothian

Adult Health and Social Care (e.g. Social Work, Day Services, Care at Home, Allied Health Professionals)

Services for offenders to address the health and care needs that may be the root causes of offending. (Reducing offending remains the remit of the **Community Justice and Safety Partnership.)**

We also work in partnership with many voluntary and independent providers.

We are governed by the **Integration Joint Board** who are responsible for a budget of **£131million a year**.

Links between adult and children's services are important, but strategic planning for children's services remains the responsibility of the **Getting it Right for Every Midlothian Child** group.

Introduction

Living in a changing world

The delivery of Health and Social Care services has to change. Hospitals, GPs and Care at Home are struggling to manage the growing demand on their services. Change will take time and this plan explains what we will try to do to improve services for people in Midlothian over the next 3 years. This will mean developing new ways of working and also some difficult decisions will have to be made about services we may need to reshape, reduce or no longer provide. We want to make sure all changes are planned, transparent and made with the people who will affect them.

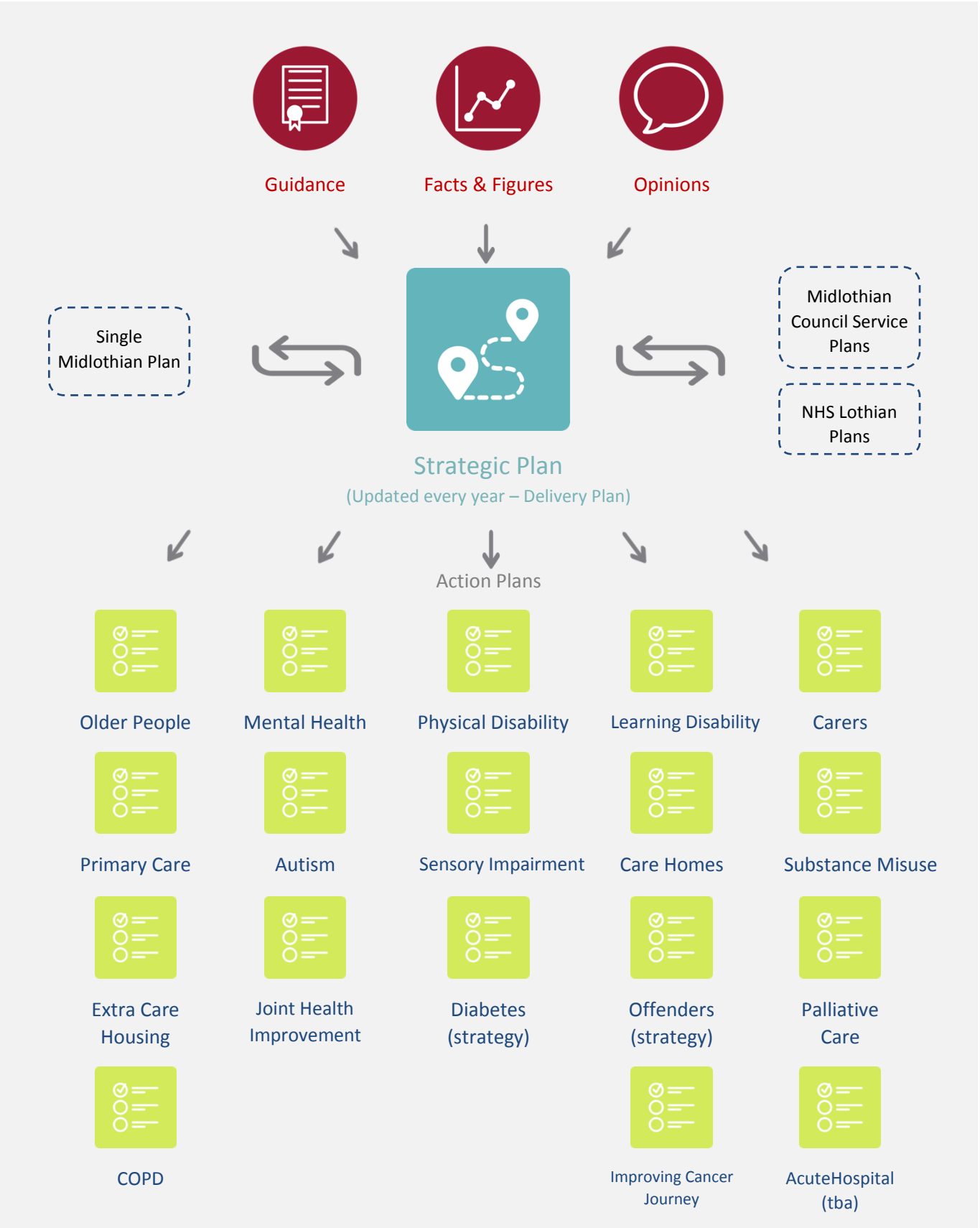
How we make decisions

We have based this plan on a number of different pieces of evidence:

- **Facts & Figures**
  We use data and predictions about who will use our services in the future. This includes information on matters such as birth and death rates, life expectancy, smoking rates and hospital use.
- **Views of the Public & Staff**
  We listen and act upon feedback about the services we provide in a variety of ways including:
  - **User groups** e.g. Forward Mid, CAM (Carers Action Midlothian), MOPA (Midlothian Older People's Assembly), People First, Access Panel, People's Equality Group, and Midlothian Voices.
  - **User and Carer representatives** on planning groups and the Integration Joint Board.
  - **Staff & Public consultations**
- **How well we are doing**
  We measure our performance to see what is working well and what can be improved by looking at:
  - **Our published annual performance report** including the National Health & Wellbeing Indicators
  - **Quarterly reports** providing detailed information across a range of services.
- **Local Policies & Strategies**
  - **Financial Strategy**
  - **Workforce Strategy**
  - **Property Strategy**
  - **Physical Activity Strategy**
  - **Food Strategy**

What happens now?

The actions outlined in this strategy will form the basis of more detailed plans for client groups and key services. They also form the basis of the Directions we give to the NHS and Midlothian Council.



Our Vision, Values & Challenges

Our Vision

Everyone in Midlothian will have the right advice, care and support; in the right place; at the right time to lead long and healthy lives.

By working with individuals and local communities we will support people to achieve these outcomes:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services contribute to reducing health inequalities.
- People who work in health and social care services are engaged with their work and improve information, support, care and treatment they provide.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Resources are used effectively and efficiently.
- People who provide unpaid care are supported to look after their health and wellbeing.
- People using health and social care services are safe from harm

Our Values

We will achieve this ambitious vision by changing the emphasis of our services, placing more importance and a greater proportion of our resources on our key values.

This will not be achieved overnight; changes in the way in which health and care services are delivered take time.

Prevention:

You should be supported to take more responsibility for your health and wellbeing. We want to deal with the causes rather than the consequences of ill health wherever possible.

Independence, Choice & Control:

You should be able to manage your condition + control your support. We will support you to live independently at home and promote the principles of independent living and equality.

Support the person not just the condition:

Your support/treatment should consider key issues affecting your life as well as supporting you to manage your condition.

Recovery:

You should be supported to recover good health and independence as far as possible.

Coordinated Care:

Everyone who provides your care should be working together.

Local:

Your support should be provided as close to your home as possible and you should only go to hospital if you really have to. Much of this support is provided by families, neighbours and your local community. We will work in partnership with unpaid carers, volunteers and communities.

Public Protection:

You should feel safe at home and in your community.

Equality:

You should not be disadvantaged due to your ability, ethnicity or caring responsibilities. We will do everything we can to reduce health inequalities and respect your dignity and human rights in the planning of health and social care.

Evidence based decisions:

Services will be commissioned based on identified need. We will listen to people who use our services, and the people who care for them, working together to develop the services that are right for them.

Quality:

We will provide the highest quality health and care services, with a very strong emphasis upon improving the quality of services, responding to user feedback and internal and external audit.

Our Challenges

A growing and ageing population

There are 90,090 people in Midlothian. We are the second smallest Local Authority in mainland Scotland but the fastest growing. 12,000 new houses will be built in the next 3 years. This will pose challenges for all our health and social care services whilst also changing the face of some of the local communities.

As people live for longer many more people will be living at home with frailty and/or dementia and/or multiple health conditions.

An increasing number of people live on their own, and for some this will bring a risk of isolation.

Higher Rates of Long-Term Conditions

Managing long-term conditions is one of the biggest challenges facing health care services worldwide, with 60% of all deaths attributable to them. Midlothian has a higher incidence than the national prevalence of cancer, diabetes, depression, hypertension, Chronic Obstructive Pulmonary Disease (COPD) and asthma. Older people are more susceptible to developing long-term conditions; most over 65s have two or more conditions and most over 75s have three or more conditions. (This is referred to as 'multiple morbidity').

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 2 or more conditions 10-15 years earlier than people living in affluent areas. It is estimated that people with long-term conditions are twice as likely to be admitted to hospital and have a longer length of stay accounting for 80% of all GP visits and for 60% of hospital admissions.

High rates of mental health needs

Many mental health problems are preventable, and almost all are treatable, so people can either fully recover or manage their conditions successfully and live fulfilling healthy lives as far as possible.

The incidence of mental health issues in Midlothian, while similar to the rest of Scotland, is a major concern for the Partnership. 19.7% of the population is on medication for anxiety, depression or psychosis. Living in poverty increases the likelihood of mental health problems but also mental health problems can lead to greater social exclusion and higher levels of poverty. People who have life-long mental illness are likely to die 15-20 years prematurely because of physical ill-health. The national Mental Health Strategy 2017-27 states that "Our guiding ambition for mental health is simple but, if realised, will change and save lives - that we must prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems".

Our services are under pressure

People place a high value on being able to access effective health services when they need them. People expect to receive high quality care services when these are needed whether as a result of age, disability or long term health conditions. Yet there are a number of pressures on our services.

Financial pressures

Financial pressures on public services are severe with the difficulties facing national health services never far from the attention of the media. Locally the Council continues to face severe reductions in its overall budget but has sought to protect social care budgets from the level of cuts required in other services. There is no doubt that we need to do things differently: the traditional approach to delivering health and care services is no longer financially sustainable.

Our projections are that unless significant changes are made to the way services are delivered Midlothian IJB will be overspent by £4m in 2021-22.

Workforce Pressures

Two of the main areas of concern to the public in recent times have been difficulties in accessing primary care and not always receiving care at home despite being assessed as in need of the service.

Recruitment and retention is a growing problem in health and social care. There is a shortage of GPs; a significant proportion of District Nurses are nearing retirement; while care at home providers find it difficult to attract and keep care at home workers despite measures such as the Living Wage and guaranteed hours. The aging population means these pressures will almost certainly increase. There is a clear need to plan ahead and find alternative solutions to ensure services are able to meet people's needs.

Family and other unpaid carers have always been vital to enabling older people and those with disability or longer term health conditions to manage their lives. It is essential that the increased emphasis on care at home does not put intolerable pressure on family carers; this is a risk if we fail to address the workforce challenges.

Acute hospitals

We must reduce avoidable admissions and enable people to be discharged as quickly as possible. We have some plans in place as described later but this will be a major focus over the next 3 years.

"Healthcare is often spoken of as a cost to the state and society rather than an investment that generates returns for the individual, communities and the nation. The NHS and public health services are not a burden on our finances – they help to build our future. Moreover, the good health of our nation is the bedrock of our happiness and prosperity"
(2018 Report by Chief Medical Officer England)

Inequality across Midlothian

Inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups.

Social determinants of health are the conditions in which we are born and in which we live and work. They can impact on our health and wellbeing and include:

Deprivation is the key determinant of these differences in people's health. Health and life expectancy both generally decline as deprivation increases. People affected by poverty and social disadvantage have poorer health and are more likely to die at a younger age than their neighbours with more resources. People also experience disadvantage through, gender, social position, ethnic origin, geography, age and disability.

The Scottish Index of Multiple Deprivation (SIMD) 2016 is the Scottish Government's tool for identifying places experiencing deprivation. It combines seven different aspects of deprivation: income; employment; health; education, skills and training; geographic access to services; crime; and housing. By identifying small areas where there are concentrations of multiple deprivation, policies and resources can be targeted at the places with greatest need. We are continuing to pay particular attention to the needs of people living in more deprived areas of Gorebridge, Mayfield and Woodburn.

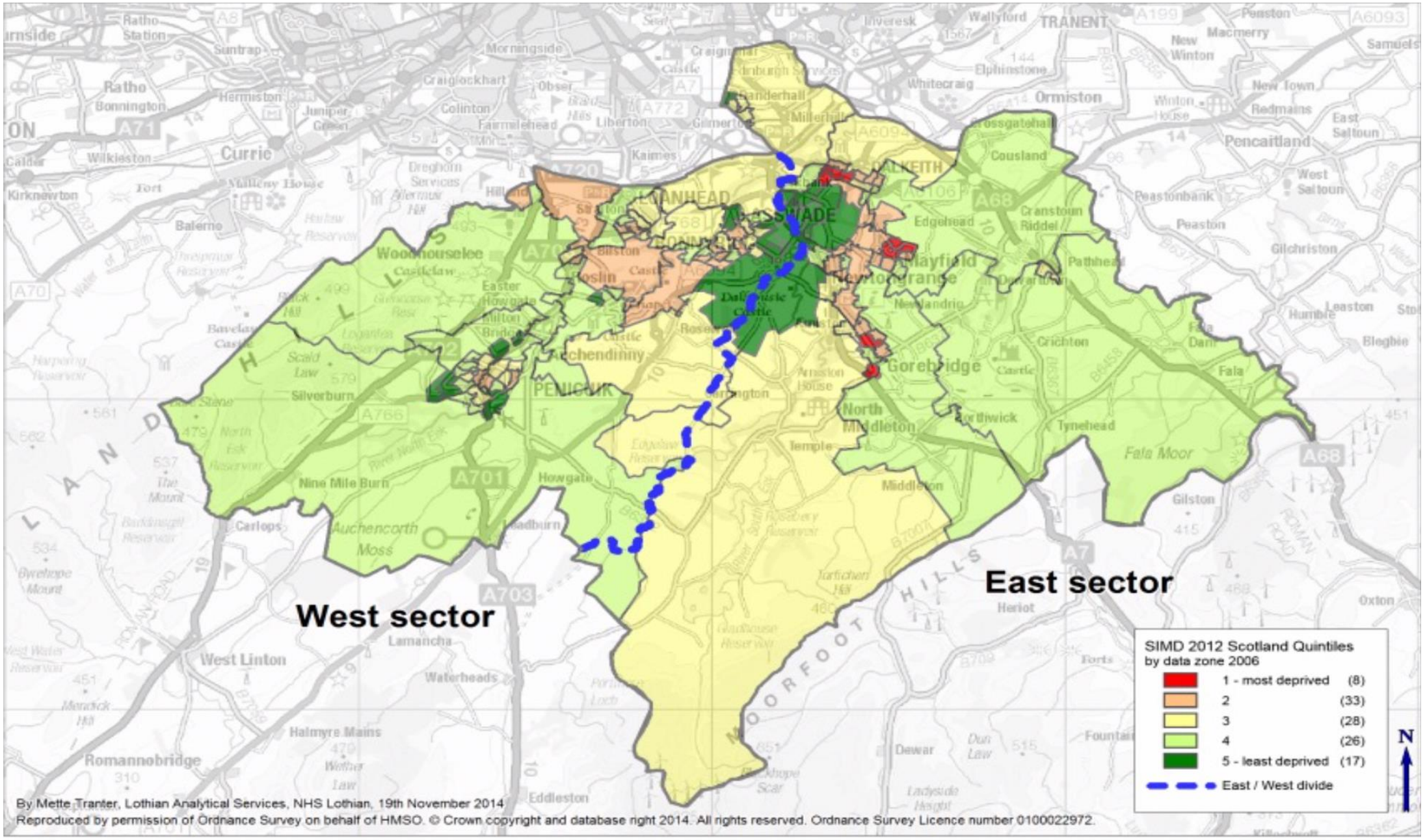
People living in some communities are more likely to be living in poorer health and to die younger with higher rates of cancer, stroke, diabetes and heart disease. People with disabilities are more likely to have lower educational achievements, higher rates of poverty and poorer health outcomes. Unpaid or family carers are more likely to have poorer health and there are at least 8,000 carers in Midlothian.

Working with Communities

Active, supportive communities are fundamental to a good quality of life for people vulnerable through age, illness or disability. It is important in addressing the harmful effects of social isolation which can lead to poorer physical and mental ill health and an increased risk of hospital or care home admission.
We have strong local communities in Midlothian and we must do more to harness the strengths they can bring to improving health and wellbeing. Voluntary organisations, volunteers, neighbours and extended families are all vital to helping people who are vulnerable to stay safe and well.

The law requires that each Health and Social Care Partnership must designate at least two 'localities' for planning purposes. Midlothian, as the smallest mainland authority operating as an IJB cannot plan, organise and commission services in two separate localities which do not reflect any recognisable sense of belonging. Instead we will focus our energies on developing stronger links with our natural communities as outlined later.

Figure 2.2: SIMD Datazone Quintiles by geography.



Long Term Conditions

Realistic Care, Realistic Medicine creates a more personalised approach to the delivery of health and social care

What matters to you rather than what is the matter with you

Managing long-term conditions is one of the biggest challenges facing health care services worldwide, with **60% of all deaths attributable to them**.

Midlothian has a higher than national average occurrence of cancer, COPD, diabetes, depression, hypertension and asthma.

In this plan we have highlighted the conditions that affect a significant number of people, however there are a wide range of other long term conditions for which we will continue to provide support. For example we will contribute to the Lothian implementation of national programmes such as the new out-patient care pathways for people diagnosed with coeliac disease, irritable bowel syndrome and inflammatory bowel disease.

Many people have more than one condition – this is known as Multiple Morbidity. Older people are more susceptible to developing long-term conditions; most over 65s have two or more conditions and most over 75s have three or more conditions.

Prevention

Many long term conditions are linked to lifestyle factors such as obesity and smoking. Much of our work will focus on supporting people to access support to achieve and maintain a healthy weight.

People told us that they wanted to maintain a healthy weight but wanted it to be easier to fit exercise into their lives. Some suggestions include:

- Exercise classes outside regular work hours
- Childcare facilities in gyms
- Better walking and cycling routes

Inequality

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.

People told us that some people face greater barriers to maintaining a healthy weight through a number of ways including:

- High cost of leisure centres
- Hard to find information if they can't access the internet
- Finding it hard to access groups without their own transport , especially after the loss of the taxicard

Mental Health

There is increasing recognition of the greater vulnerability to mental health problems for those living with long term health conditions.

Hospital Stays

It is estimated that people with long-term conditions are twice as likely to be admitted to hospital, have a longer length of stay and account for 80% of all GP visits and for 60% of hospital admissions.

Planning Ahead

We are placing more emphasis on supporting people to plan ahead as their conditions and circumstances change. This includes promoting the use of Power of Attorney, Anticipatory Care Plans and Emergency Plans for Carers.

Choice and Control

There is a growing view that people living with long term conditions should be supported to be more involved in decision-making, more in control of their own care and more confident about managing the impact of their conditions on their lives.

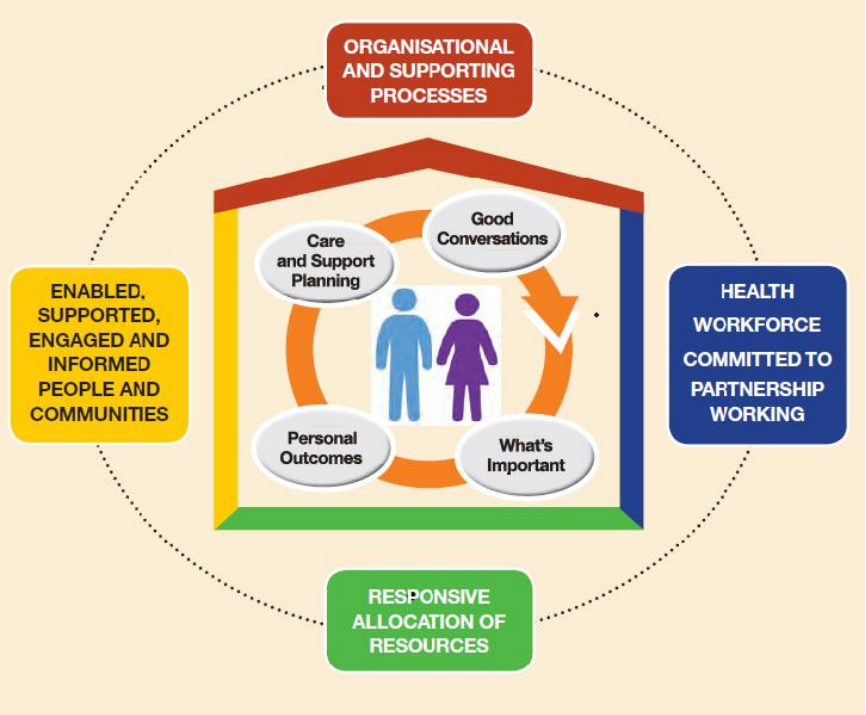
People felt that choice in support/treatment was limited. Reasons included:

- There is a limited choice of services available – this is mainly due to budgets and lack of staff.
- People don't get enough time to talk to professionals about what matters to them.
- There is a need to improve information provision – with a mix of online and offline especially 1:1 support.

Person Centred Approach

One of the models we use for delivering person-centred, integrated care is the House of Care. This creates space for people to have 'a good conversation' on what is important to them and helps them recover or live well with their health conditions.

Using the image of a house helps us to appreciate how all the parts need to be in place, equally strong and joined up for this approach to be successful.



Key Actions

Cancer

- Reduce rates of smoking, support people to maintain a healthy weight and improve screening rates.
- Explore ways to deliver treatments locally, in particular chemotherapy.
- Implement the new 'Improving Cancer Journey' to provide support to people after a diagnosis of cancer.

Respiratory Disease: COPD & Asthma

- Reduce rates of smoking and support people to maintain a healthy weight.
- Improve access to the Community Respiratory Team and work with the Scottish Ambulance Service to support people in a crisis.
- Strengthen partnership working with MERRIT, Marie Curie and Edinburgh Community Respiratory team.
- Support people through Pulmonary Rehabilitation Service and self-management.

Neurological Conditions

- Improve housing options to support people to live in their own homes.
- Work with the Astley Ainslie hospital to explore ways to deliver in-patient and out-patient services locally.
- Review demand for services in light of introduction of free personal care for under 65s.

Stroke

- Reduce rates of smoking and support people to maintain a healthy weight.
- Offer rehabilitation on discharge by working with community Allied Health Professionals in reablement services to set up a Discharge to Assess model to get more patients home earlier.
- Review our community based support by working with the Edinburgh Stroke Unit.

Heart Disease

- Reduce rates of smoking and supporting people to maintain a healthy weight.
- Review community based rehabilitation and support.

Diabetes and Obesity

- Support adults to maintain a healthy weight, especially those with pre-diabetes, e.g. through increased weight management services.
- Work in collaboratively with other Partnerships in south east region of Scotland to increase services to tackle type 2 diabetes.

Sensory Impairment

- Improve awareness and understanding of sensory impairment among staff.
- Detect vision and hearing loss early through clinics and checks.
- Provide services locally such as audiology maintenance clinics.

Palliative Care

- Strengthen choice and control through Anticipatory Care Plans, Power of Attorney arrangements and Adult Carer Support Plans.
- Improving services by training staff in care homes and consulting with families.
- Reintroducing the Palliative Link Nurse role.

Cancer

National/Local Guidance:

- Beating Cancer: Ambition and Action (2016)
- National Health and Care Delivery Plan (2017-18)
- Better Cancer Outcomes in Lothian – A Strategy for Cancer (2014 – 2020)

3,000

People live with cancer

Nearly one in two people will get cancer and advances in treatment mean that people live longer with cancer even if they are not 'cured'.

Well-being is more than clinical treatment. People affected by cancer have other concerns too and how we provide opportunities for these conversations is where we have focused our efforts. We have recently completed a successful pilot of the Transforming Care After Treatment programme to support people to live with the consequences of the diagnosis and treatment. People had time to talk and using a process called a 'Holistic Needs Assessment', we understood people's needs and practical issues such as work, family life and finances, as well as the impact treatment has in terms of fatigue, pain and coping emotionally. We will build on this learning to put in place more robust services for people with cancer as part of the Lothian Improving the Cancer Journey programme funded through Macmillan.

Services are currently delivered at the **Edinburgh Cancer Centre**, based at the Western General Hospital and to a lesser extent, the Royal Infirmary, with active follow up and support through Primary Care, Marie Curie Staff and the local community nursing service which provides care and support for people who are terminally ill.

The most common concerns for people who took part in the Transforming Care after Treatment Project were:

- Tired/exhausted or fatigued.
- Worry, fear or anxiety.
- Sleeping problems/nightmares.
- Exercise / activity.
- Memory / concentration.
- Sadness or depression.

"The biggest success of this project has been its ability to make us, as patients feel important and listened to.
The psychological effects have been immense"

514 people were diagnosed in 2016

Midlothian's cancer survival levels from all causes of cancer are **above the Scottish average.**

The gap between East and West Midlothian localities is narrowing. Those most vulnerable to health inequalities are often those less likely to participate in screening campaigns.

Most people requiring chemotherapy have to travel to the **Edinburgh Cancer Centre**.

Prevention & Early Intervention

- **Reduce smoking**:
  - Make smoking cessation support easier to access by offering it at pharmacies.
  - Work with local secondary schools to prevent young people starting to smoke.
  - Work with the Midlothian Stop Smoking Service.
- **Maximise people's income:**
  - Continue to fund the Macmillan Welfare Rights Post to offer benefits advice.
  - Improve uptake of the Vocational Rehabilitation service to support people stay in work.
- **Improve screening rates:**
  - Target hard to reach groups for cervical and bowel cancer (Detect Cancer Early).
  - Strengthen screening of bowel cancer for people with learning disabilities.
- **Support people to maintain a healthy weight:**
  - Increase weight management support - group and 1 to 1 support.
  - Improve information and access to healthy food options.
  - Work with GP practices on raising discussions around a healthy weight.
  - Work with Leisure Services to increase physical activity options for people with a long term condition.
  - Work with the Community Planning Partnership to ensure the built environment and the food environment support healthy choices.
  - Investigate a weight management programme for people with a learning disability.

Planned Support, Treatment & Recovery

- **Deliver treatments locally:**
  - Work with the Edinburgh Cancer Centre to explore, and if feasible, implement ways to deliver treatments locally in particular chemotherapy.
- **Providing non clinical support:**
  - Implement the Improving Cancer Journey programme funded by Macmillan.

Unplanned Support & Treatment

- **Promote awareness of specialist advice services such as the Cancer Treatment Helpline.**

Respiratory Conditions COPD & Asthma

National/Local Guidance:

- NICE Guidance
- British Thoracic Society: Guidelines (Asthma & COPD)
- NHS Lothian: Guideline
- Scottish Government: COPD best practice guide

2,700

People live with COPD

6,468

People live with asthma

Chronic Obstructive Pulmonary Disease (COPD) is a lung disease that causes coughs and breathlessness and increased sputum. We have a higher prevalence of COPD than the rest of Lothian.

Asthma is a long-term condition that affects the lungs. It causes swelling and narrowing of small tubes that carry air in and out of the lungs, causing coughing and shortness of breath.

We are working towards providing greater support within the community and have set up the **Community Respiratory Team** for people who have presented to A&E twice or more in a year because of their COPD. The team help them manage better at home if possible and avoid hospital admission. In the future this team will also accept referrals from GPs for people who attend hospital frequently for their COPD.

The Pulmonary Rehabilitation Programme is a Lothian Wide physiotherapy led service for anyone with chronic lung disease and provides an exercise based programme with a large educational and self management component within the community. This service has been streamlined and strengthened with additional staff. We are looking to increase the number of venues it is offered to increase availability.

The services used telehealthcare to increase access, availability and uptake, especially for those in rural and remote areas. This service has been expanded and now provides additional occupational therapy, nutritional screening and first line nutritional support.

Feedback from GPs and patients on the advanced physiotherapy service is positive, complementing the care pathway between secondary care and primary care with their close links to the ward. GPs appear satisfied with the input and feedback during acute exacerbations, and care plans for patients.

"I have learned how to deal with panics, I no longer phone the ambulance straight away, I take my nebuliser first and try to do my breathing exercises"

17.8% of people smoke. This is lower than the rest of Scotland (19.6%).

The number and prevalence of COPD has been **increasing** over the last decade. Midlothian ranks 11th highest out of the 31 HSCP for COPD prevalence.

There are more people living with COPD in our areas of deprivation.

Prevention & Early Intervention

- **Reduce smoking**:
  - Make smoking cessation support easier to access by offering it at pharmacies.
  - Work with local secondary schools to prevent young people starting to smoke.
  - Work with the Midlothian Stop Smoking Service.
- **Support people to maintain a healthy weight:**
  - Dietetic support where required, especially in relation to gaining or maintain weight.
  - Improve information on healthy eating and improving access to healthy food options.
- **Early identification of people with asthma and COPD, in particular those at high risk.**

Planned Support, Treatment & Recovery

- **Support people to self-manage, including access to psychosocial support.**
- **Support people with COPD to manage at home:**
  - Improve access to the Community Respiratory.
  - Expand the Community Respiratory Team to take referrals from GPs for frequent hospital attenders.

- **Strengthen partnership working with:**
  - Peer support group Breathe Easy.
  - Fatigue Anxiety Breathlessness class (FAB) at the Marie Curie Centre.
  - Midlothian Enhanced Rapid Response Team (physiotherapy, occupational therapy, community care support and Hospital at Home team).
  - Edinburgh Community Respiratory Team at the Royal Infirmary.

Unplanned Support & Treatment

- Support people to stay at home in a crisis:
  - Improve communication between the Scottish Ambulance Service and the Community Respiratory Team, to see if there is a way for the patients to be managed at home.
  - Improve communication with out of hours care services (Unscheduled Care) and the respiratory nurse specialist team at Edinburgh Royal Infirmary.

Neurological Conditions

5,300

People live with Neurological Conditions
(Based on national prevalence rates)

National/Local Guidance:

- The Neurological Care Improvement Plan (2014-17).
- Healthcare Improvement Scotland Standards (2019)

Neurological conditions include epilepsy, seizures, chronic headache and migraine, Parkinson's disease, multiple sclerosis, acquired brain injury, Huntington's disease, dystonia, functional neurological symptoms, cerebral palsy, motor neurone disease and muscular dystrophy. Common symptoms include dizziness, seizures, paralysis, headache and sensory symptoms.

Neurological conditions are the most common cause of serious disability in Scotland.

Most services for people with a neurological condition are coordinated at a Lothian level. There are Lothian wide nurse and care adviser specialists for the main neurological conditions.

There are plans to reprovision the **Astley Ainslie Hospital** in Edinburgh. This currently provides a range of services for people with neurological conditions. This will be an opportunity to increase our understanding of how neuro-rehabilitation services are used by Midlothian residents. The small prevalence rate for specific conditions makes it difficult to create a local response.

At present we do not have clear processes for engaging with service users with neurological conditions. We will consider the outcome of the national consultation being carried out in early 2019.

In addition we are putting in place a process for involving local service users in helping us plan services in light of the long term plan to replace the Astley Ainslie Hospital

There is a lack of good local data. It is estimated that 530 of the people with a neurological condition will be disabled by the condition.

Nationally it is estimated that 17% of GP consultations are for neurological symptoms.

Prevention & Early Intervention

- **Support people to live in their own home:**
  - Strengthen the partnership between the Occupational Therapy Service and the housing department to improve housing options.

Planned Support, Treatment & Recovery

- **Deliver treatments locally:**
  - Work with the Astley Ainslie hospital and people living with a neurological condition to explore, and if feasible, implement ways to deliver in-patient and out-patient services locally.
- **Improve care and support:**
  - Ensure services meet the new Healthcare Improvement Scotland Standards.
  - Review and strengthen the pathways for neurological conditions.
  - Review the approach to managing transitions from children's services.
  - Review demand for services in light of introduction of free personal care for under 65s.

Unplanned Support & Treatment

- Review emergency respite options.

Stroke

2,200

People are living with the effects of stroke

National/Local Guidance:

- SIGN Guideline 118 (2010)

A stroke occurs when the blood supply to part of the brain is compromised, often by a blood clot blocking an artery or a blood vessel rupturing, resulting in a bleed. The effects of a stroke may alter someone's ability to move, feel, think, communicate and function. There are hospital and community based stroke services that can support people to make the best possible recovery.

The risk of a stroke can be reduced through a healthy lifestyle:

- eating a healthy diet
- taking regular exercise
- drinking alcohol in moderation
- not smoking

Stroke is the third commonest cause of death and the most frequent cause of severe adult disability in Scotland. Approximately 20% of stroke patients die within 30 days and about 30% of survivors will be fully independent within three weeks, rising to nearly 50% by six months.

People mentioned wanting exercise to fit around their lifestyles. Suggestions included:

- Reducing the cost of leisure centres
- Having more classes/activities outwith working hours
- Providing childcare
- Improving walking and cycling routes

The raw prevalence rate for all types of stroke in is **2.43 per 100 patients admitted to hospital** . This is **higher** than the Scottish average

76 stroke patients were discharged to their own homes between 1 Nov 2017 and 31 October 2018. This is a **drop** on previous figures.

Midlothian has an increasing stroke mortality rate in contrast to NHS Lothian and Scotland.

Prevention & Early Intervention

- **Reduce smoking**:
  - Make smoking cessation support easier to access by offering it at pharmacies.
  - Work with local secondary schools to prevent young people starting to smoke.
  - Work with the Midlothian Stop Smoking Service.
- **Support people to maintain a healthy weight:**
  - Increase weight management support - group and 1 to 1 support.
  - Improve information and access to healthy food options.
  - Work with GP practices on raising discussions around a healthy weight.
  - Work with Leisure Services to increase physical activity options for people with a long term condition.
  - Work with the Community Planning Partnership to ensure the built environment and the food environment support healthy choices.
  - Investigate a weight management programme for people with a learning disability.

Planned Support, Treatment & Recovery

- **Offer rehabilitation on discharge:**
  - Working with community Allied Health Professionals in rehabilitation and rapid response services to set up a Discharge to Assess model to get more patients home earlier.
- **Review our community based support**:
  - Working with the Edinburgh Stroke Unit and local people.

Unplanned Support & Treatment

- **Improve the transition between the hospital and home:**
  - Involve patients and carers early in the rehabilitation process.
  - Involve patients, carers, primary care team, social services and allied health professionals in the pre-discharge process.
  - Ensure essential alterations to the patient's home are completed prior to discharge.

Heart disease

3,927

People live with Heart Disease

National/Local Guidance:

- **Heart Disease Improvement Plan** (2014).

Coronary heart disease happens when the heart's blood supply is blocked or interrupted by fatty substances in the coronary arteries. These arteries supply the heart muscle with oxygen-rich blood.

It is largely preventable. The main factors that increase the risk of developing Coronary Heart Disease are:

- Smoking
- High blood pressure and high blood cholesterol
- Diabetes
- Being physically inactive
- Being overweight or obese
- Family history of heart disease
- Ethnic background
- Sex - men are more likely to develop heart disease at an earlier age than women.
- Age - the older you are, the more likely you are to develop heart disease.

Although the number of people with coronary heart disease is decreasing in Scotland, it is still a leading cause of illness and mortality.

People mentioned wanting exercise to fit around their lifestyles. Suggestions included:

- Reducing the cost of leisure centres
- Having more classes/activities outwith working hours
- Providing childcare
- Improving walking and cycling routes

Many people were positive about the Cardiac Rehabilitation Services:

"It has allowed my wife to be part of the recovery period and encouraged us as a family to being much more healthier"

"Cardiac rehabilitation has helped me understand what a heart attack is and has supported me to think how I can help myself"

Early death from CHD varies across neighbourhoods. While there is a strong link between this and areas of deprivation (Dalkeith Gorebridge, Mayfield), particularly high rates are also seen in Newtongrange and Loanhead.

There has been a downward trend in both East and West Midlothian and the gap between the two localities is narrowing, however West locality shows consistently lower rates.

Prevention & Early Intervention

- **Reduce smoking**:
  - Make smoking cessation support easier to access by offering it at pharmacies.
  - Work with local secondary schools to prevent young people starting to smoke.
  - Work with the Midlothian Stop Smoking Service.
- **Support people to maintain a healthy weight by:**
  - Increase weight management support - group and 1 to 1 support.
  - Improve information and access to healthy food options.
  - Work with GP practices on raising discussions around a healthy weight.
  - Work with Leisure Services to increase physical activity options for people with a long term condition.
  - Work with the Community Planning Partnership to ensure the built environment and the food environment support healthy choices.
  - Investigate a weight management programme for people with a learning disability.
- **Investigate the high rates of Heart Disease in areas such as Newtongrange and Loanhead.**

Planned Support, Treatment & Recovery

- **Review our specialist community based rehabilitation support** (pan-Lothian service).
- **Support people to achieve and maintain a healthy weight after diagnosis:**
  - Improve access to weight management support.

Unplanned Support & Treatment

- **Work with local communities and the Midlothian Council community development workers to review access to community defibrillators.**

Type 2 Diabetes & Obesity

4,410

People have type 2 Diabetes

National/Local Guidance:

- A Healthier Future: Scotland's diet + healthy weight delivery plan.
- A Healthier Future: Type 2 Diabetes prevention, early detection and intervention framework.

Type 2 diabetes occurs when the body doesn't produce enough insulin, or the body's cells don't react to insulin. This means glucose stays in the blood and isn't used as fuel for energy. Both obesity and Type 2 Diabetes impact on a person's health, wellbeing, employment and engagement. Being overweight or obese is the main modifiable risk factor. A healthy diet and physical activity are important as are environmental, financial and social barriers.

Many incidences of type 2 diabetes can be prevented or its onset delayed. Diabetes care accounts for around 10% of all NHS expenditure. **If no changes are made to the way diabetes is treated by 2036, this will rise to around 17%**. This high level of investment emphasises the importance of preventing or reversing the condition.

People who live in more deprived areas tend to be most impacted. We need action that doesn't stigmatise people but supports them and recognises their experiences and challenges.

Midlothian Community Planning Partnership Board has agreed that Type 2 diabetes and weight management should be an objective of the Partnership. This commitment and leadership is necessary as a whole-system approach is required. Partners with an influence on services such as town planning, schools, colleges, workplaces, parks, licensing, homelessness, roads, adult learning, children's services, health, social care, private business and others have a role to play in this undertaking. A strategic, joined-up approach to what is a complex issue is required.

People mentioned wanting exercise to fit around their lifestyles. Suggestions included:

- Reducing the cost of leisure centres
- Having more classes/activities outwith working hours
- Providing childcare
- Improving walking and cycling routes

"Family illness (nephew with Type 2 Diabetes is now blind, on kidney dialysis and has had legs amputated) was "a wakeup call""

People living in more deprived areas are more likely to experience type 2 diabetes, regardless of age or gender.

More men than women have type 2 diabetes.

While type 2 diabetes is most prevalent in people over 65, more younger people are being diagnosed.

Prevention & Early Intervention

- **Support people to maintain a healthy weight:**
  - Increase weight management support - group and 1 to 1 support.
  - Improve information and access to healthy food options.
  - Work with GP practices on raising discussions around a healthy weight.
  - Work with Leisure Services to increase physical activity options for people with a long term condition.
  - Work with the Community Planning Partnership to ensure the built environment and the food environment support healthy choices.
  - Investigate a weight management programme for people with a learning disability.
- **Work with people who have pre-diabetes by:**
  - Increase access to weight management services.
  - Identify people with pre-diabetes and support them to avoid or delay the progression to type 2 diabetes.
  - Increase resources for early intervention through redirecting services currently used within the acute hospital.

Planned Support, Treatment & Recovery

- **Improve care and support:**
  - Work in collaboration with other Partnerships in south east region of Scotland to increase services to tackle type 2 diabetes.
  - Consult with people with lived experience and service providers.
- **Provide appropriate accommodation**
  - Work with housing to provide accommodation for people who are severely obese.

Unplanned Support & Treatment

- **Review admissions to hospital related to type 2 diabetes.**

Sensory Impairment

National/Local Guidance:

- British Sign Language (Scotland) Act 2015
- Midlothian British Sign Language Plan 2018-2024
- The Equality Act 2010
- See Hear Strategy 2014-24
- Midlothian See Hear Implementation Plan 2014-17

5,656

People have hearing loss
(Based on national prevalence rates)

1,922

People have sight loss
(Based on national prevalence rates)

The ability to communicate effectively is a major factor in people being able to live independently and feel included. Technology offers new opportunities to access support; for instance contactSCOTLAND is a live, online, video relay system which facilitates communication between British Sign Language (BSL) users and public bodies/third sector organisations. Locally, we plan to reflect the long term aim of the Scottish Government – "to make Scotland the best place in the world for BSL users to live, work and visit".

There is a need to improve diagnosis; for instance it is estimated that 50% of sight loss is preventable or treatable-and eye tests are free and readily accessible. Deteriorating sight amongst older people can result in injury from falls. Deteriorating hearing can make social interaction more difficult and increase isolation and yet people delay addressing the problem for many years. People with learning disabilities are 10 times more likely to have some degree of sight lost, again not always recognised. Sensory impairment can remain hidden for people who have had a stroke or live with dementia. It is therefore essential to raise awareness, knowledge and understanding of sensory impairment amongst both professionals and the wider population. Also key, is to make services easily accessible for those requiring them ie local provision.

People mentioned more local delivery of services would be good - particularly for hearing impaired – Audiology services
"The services are frustrating. Midlothian people feel separated from the service."

People also mentioned the need for awareness raising both for professionals and the wider community
"My GP was looking at my ears and she said your hearing is normal as now you have a hearing aid! That was unbelievable."

We do not have accurate information on the numbers of people with sight or hearing loss beyond the 2011 census

580 people are on the RNIB Blind Register. RNIB provided services to **151** people not on the register.

233 people are British Sign Language users (based on national prevalence rates)

Prevention & Early Intervention

- **Improve awareness and understanding of sensory impairment among staff:**
  - Work with RNIB (Royal National Institute for the Blind) and Deaf Action to provide training across public, private and third sector.
  - Create sensory champions to provide specialist knowledge in each service area.
- **Detect any vision or hearing loss early:**
  - Promote the importance of regular checks.
  - Provide hearing and vision checks to tackle hidden sensory loss e.g. in care homes.

Planned Support, Treatment & Recovery

- **Provide services locally:**
  - Continue to run and promote the hearing aid battery collection service, hearing aid battery pick up points and battery recycling in Midlothian libraries.
  - Develop the provision of local hearing aid maintenance clinics, utilising volunteers
  - Deliver audiology clinics in Midlothian Community Hospital.
  - Review peer support and if feasible create a group for people who lip read.
  - Promote the RNIB's service at the Eye Pavilion through Optometrists and GPs.

Unplanned Support & Treatment

- **Improve understanding of who can help in a crisis:**
  - Promote the leaflet 'Who to see instead of my GP' including high street optometrists as the first point of contact for eye related issues.

Palliative Care

National/Local Guidance:

- The Neurological Care Improvement Plan (2014-17).
- National Health and Social Care Delivery Plan (2016)
- Palliative and End of Life Care Partnership group Work plan
- Midlothian Palliative Care Action Plan (2019)
- Strategic Framework for Action on Palliative and End of Life Care (2015)

504

People are on palliative care registers

Palliative care aims 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.

While palliative care is provided in hospitals, care homes and hospices we know that, wherever possible, people prefer to receive care in their own homes. District Nurses, Home Carers and Marie Curie Nurses work alongside family carers to make this possible.

The national Health and Social Care Delivery Plan includes a requirement to double the end of life provision in the community by 2021 and reduce the numbers of people dying in hospital.

Midlothian Palliative Care Steering Group leads local developments and collaborates with the Lothian Palliative Care Managed Clinical Network.

People mentioned the importance of creating an end of life plan with the person receiving care, their carers and relatives.
"Any questions, concerns were answered… Our concerns were met"
"No conversation about religion "

People also mentioned the importance of being treated with dignity and respect by staff.
"Carers treated dad with dignity, discretion and respect"

Patients and carers expressed their preference to die in their place of residence

87.4% of people spent their last six months of life at home or in a community setting.

100% of people who took part in the Family Perception of Care Questionnaire 2018 in Newbyres Care Home said that overall they were satisfied with the end of life care that was given to their family member.

Prevention & Early Intervention

- **Strengthen people's choice and control over their palliative care:**
  - Complete Anticipatory Care Plans and Power of Attorney arrangements initially in all our care homes.
  - Complete Adult Carer Support Plans or Young Carer Statements, and provide information and advice on bereavement support services for carers.
  - Complete Emergency Plans for carers in the event that they are unable to provide care.

Planned Support, Treatment & Recovery

- **Improve services:**
  - Train staff to develop more skills in palliative care e.g. video conference training in care homes.
  - Introduce Palliative Care Champion role within each care home.
  - Consult with bereaved families at Newbyres Care Home, Midlothian Community Hospital, District Nursing Service and other care homes.
  - Establish links with the Improving Cancer Journey programme.
- **Provide bereavement support to people:**
  - Explore one to one and group support provided by Marie Curie staff.
  - Provide information on sources of support.
  - Extend programmes such as New Beginnings (a group programme for people who have experienced loss).
- **Re-introduce the Palliative Link Nurse role within our wards at the Community Hospital and within our District Nursing service.**

Unplanned Support & Treatment

- **Ensure carer involvement in discharge planning of cared-for person.**
- **Strengthen nursing support to care homes to reduce admissions to hospital.**
- **Strengthen Hospital at Home services if resources allow enabling people who are dying to remain at home.**

Service User Groups

Realistic Care, Realistic Medicine means putting the person receiving health and social care at the centre of decisions about their care.

The strong emphasis of this strategy is to encourage and enable all services to place a higher priority on person-centred approaches. In practice this means adopting a starting position that people using health and care services should be considered equal partners in planning and monitoring their care arrangements. This is based on the belief that people and their families are experts in what is important to them and how services can best support them. It is no longer a case of doing things to people but with them.

This approach challenges the way in which our services are organised. For many years we have structured services to reflect the main issues which impact on people's health and wellbeing. These include delivering services for people who are old, people who have mental health needs and people who have life-long disabilities**. In practice people do not fit neatly into these categories**. Older people may well be more likely to experience frailty or dementia but these conditions affect younger people as well. People with learning disabilities may also experience other disabilities such as physical disability or sight difficulties. While any of us may experience mental health difficulties at some point in our lives people who misuse substances or are involved in the criminal justice system are also more likely to have mental health needs.

We work hard to ensure that there are strong links between our services.

Both members of public and staff mentioned the benefits of joined up working including more efficient working and sharing information. They however mentioned challenges including:

- Finding information about available services
- Waiting lists and differing opening hours/contact details for specialist services making accessing holistic care difficult
- Needing more time to discuss a person's outcomes and choices - to ensure all appropriate services are involved.

We know there are risks involved as a result of the way we are structured. Indeed the Government produced guidance a number of years ago titled "Mind the Gaps" which highlighted the risk that people do not experience services which recognise the complexity of the issues they are facing:

> *"There is a large group of men and women in our society with a mixture of mental health problems and problems arising from alcohol and substance misuse. Many lead troubled lives, seeking help from individual services, both voluntary and statutory, from time to time. But the individual's experiences and service components do not generally run smoothly."*

Similarly we know that people with certain health conditions such as dementia or having had a stroke increases the likelihood of sensory impairment yet for many this remains a hidden problem. We are training some individuals in each service to act as 'Sensory Champions' to help reduce this risk.

We must organise our services in a way which enables the whole health and care system to operate smoothly. Older people's services ensure that when people need 24 hour care there are good quality care homes available. Learning Disability services ensure that staff are trained to respond to situations when people's behaviour becomes challenging. Effective services for people with mental health needs depend on staff with the right skills and experience to support them towards recovery.

Our challenge is how to combine a person-centred approach with also ensuring the right type of services and staff skills are available. This involves changing cultures, attitudes and skills across our services. A strong lead in this respect has been given by the Chief Medical Officer in Scotland in promoting Realistic Medicine.

'Realistic Medicine has become embedded far beyond the medical profession and in numerous contexts in Scotland, a "social movement" to some extent but also being deliberately written into NHSScotland health and social care policies, guidance documents, teaching and learning packages, information for patients, medical school curricula and the selection process for medical students.' (Practicing Realistic Medicine. Chief Medical Officer's Annual Report 2016-17)

Both members of public and staff mentioned the positive outcomes that can be achieved through person centered care but many people mentioned challenges to achieving this including:

- Feeling rushed when speaking to professionals about their support/treatment
- A lack of resources which can make offering choice and control hard.
- Difficulty with practicalities such as information, transport, flexibility of care workers and funding that make accessing support hard.

We have structured our plans according to established service user group categories and these are reflected in national policies including "Reshaping care for Older People"; "Mental Health Strategy 2017-27" and "The Keys to Life" (Scotland's Learning Disability Strategy). However we will work hard to ensure that these services work effectively together through training and through developments such as the establishment of a Recovery Hub designed to enable closer working between mental health, substance misuse and criminal justice services

Key Actions

Older People

- Identify frail people and provide early intervention using GP, health and social care data.
- Strengthen the Ageing Well project to help reduce isolation and promote activity.
- Strengthen systems to reduce numbers of people being delayed in hospital including a new discharge hub.
- Improve the care planning system both to simplify and to involve service users more fully.

Mental Health

- Reshape the rehabilitation pathway.
- Enhance mental health services in Primary Care including the expansion of the Access Point.
- Review the use of mental health older people's beds in the Community Hospital and look to enhance community based supports.
- Refresh the local suicide prevention plan.

Physical Disability

- Plan for the implementation of changes to the Welfare Benefits system in Scotland.
- Plan for the provision of free personal care for under 65s.
- Contribute to the re-provision of Astley Ainslie Hospital including strengthening community based services.
- Continue to strengthen the provision and accessibility of information about services and supports.

Learning Disability

- Commission new build housing for people with learning disability using clustered models supported by TEC.
- Implement a range of changes to the provision of day services including more local services and more age appropriate services.
- Develop community based services using Positive Behavioural Support for people with complex care needs.

Autism

- Introduce a local "Guide to Autism".
- Devise a mobile app to discover Midlothian through the eyes of people with complex needs.

Criminal Justice

- Providing people on Community Payback Orders with recognised qualifications through Unpaid Work staff becoming registered trainers.
- Supporting families through the Safe and Together service by working with perpetrators of domestic abuse.

Substance Misuse

- Improve services, especially for people with dual diagnosis of mental health and substance misuse, through the Recovery Hub.
- Increase the role in treatment and support services of people with lived experience.
- Increase employment opportunities for people in recovery by improving engagement in education, training and volunteering.

Older People(65+)

16,667

People are over 65

National/Local Guidance:

- Reshaping care for Older People (2011)
- Joint Strategy for Older People (2016 – 2019)

People are living longer and the majority of older people live without any formal support. Many make a very significant contribution as volunteers, helping local organisations, participating in local government, providing unpaid care or being supportive grandparents. However old age does not come alone; as we get older there is a greater likelihood of developing long term health conditions.

People over 85 are at a greater risk of living with dementia. There is likely to be 2,800 people with dementia in 20 years-which is double the number there are today. The main social care supports for older people who have dementia and/or who are frail are day care, care at home and care homes. Older people are also more vulnerable to sensory impairment. Older people can become isolated and often have to cope with bereavement of a loved one. Supporting older people to live well involves the contribution of a wide range of agencies.

People mentioned the difficulties they had accessing a GP. The older people's consultation event also noted an over reliance on GPs for advice or assistance including non-health matters.

"There was anger on the subject of GP appointments with some saying they are unable to get face to face appointments, even in an emergency."

Both public and staff mentioned issues with care at home – in particular the difficulty offering flexible care arrangements.

People mentioned the need for information to be easily accessible – in particular the importance of a person being able to provide information and advice.

18.5% of people are over 65. This is a smaller population in comparison to Scotland.

The largest percentage increase for population between 1997-2017 was seen in the over 75s (+46.5%). It is predicted to increase by a further 40.6% by 2026

The life expectancy at birth is **77**years for men and **81** years for women. This is above the Scottish average.

20% of people over 65 volunteer in the community.

Prevention & Early Intervention

- Use GP, Health and Social Care data to identify and contact people who would benefit from advice, guidance and support within their community.
- Develop a network of activities providing opportunities for people to make friends, be more active and more involved in their community.
- Invest in services that prevent admission to hospital or enables people to return home from hospital as quickly as possible.
- Support unpaid carers.
- Grow the Ageing Well project and provide opportunities in people's homes for people who are at risk from inactivity and social isolation.
- Raise awareness of the flu jab and offer greater access to flu jabs.
- Enable people, organisations and services to establish local activities and meaningful things-to-do of interest that help people's health and wellbeing.

Planned Support, Treatment & Recovery

- Access to dental care for people over 75yrs and to domiciliary dental care for people who are housebound are issues which need to be considered by services.
- Work in partnerships with GP practices to build social prescription opportunities.
- Widen the 'Reablement' approach across care at home provider workforce.
- Strengthen care co-ordination in the community for people with dementia.
- Use data intelligently to provide information, guidance and support that enables people to live in their own homes and as independently as possible for as long as possible.
- Improve our care assessments and care reviews by involving people more in their care plans and reducing unnecessary processes in the provision of care at home services.
- Improve older people's experience of care services by setting clear quality and performance targets that include the views of people using services and significant people in their life.
- Care Home Support Team to deliver training on Essentials in Psychological Care – Dementia (NES).

Unplanned Support & Treatment

- Strengthen our Midlothian Emergency Rapid Response Intervention Team (MERRIT) to better respond to falls and to provide a Hospital at Home Service.
- Reduce the length of time people are delayed in hospital when they are clinically well enough to return home.
- Reduce the number of unplanned hospital admissions through the work of the new Care Home Support Team.

Mental Health

17,470

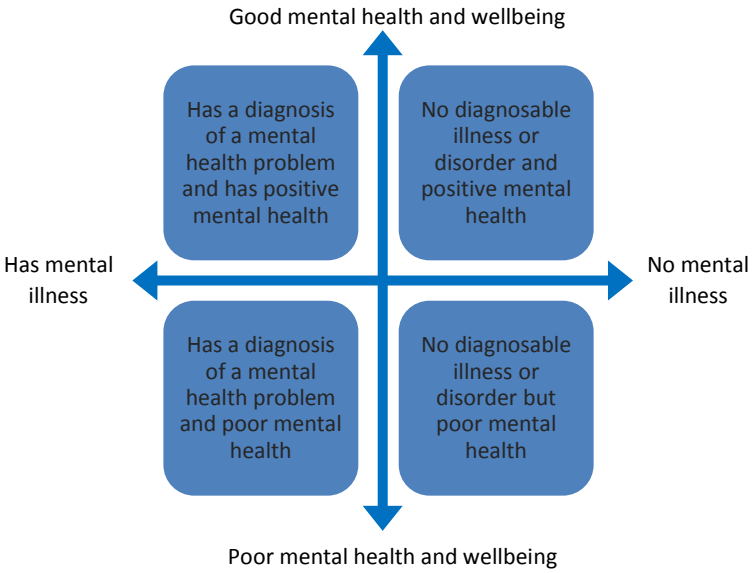
People are on medication for depression, anxiety and/or psychosis.

National/Local Guidance:

- National Mental Health Strategy (2017 – 2027)
- Every Life Matters Scotland's Suicide Action Plan (2018)
- Good Mental Health For All (2016)

One in four of us will experience mental health difficulties at some time in our life. We know that these are not experienced evenly across the population and inequalities are largely determined by social and economic factors. It is important to think about staying and being well when we are planning and delivering services and supports. We also need to think about what happens to people who do not always have good mental health.

We use this model as a basis for planning, developing and reviewing an integrated and inclusive response to Mental Health & Wellbeing, consistent with national and local strategies, based on identified local needs.



The Mental Health Strategy identifies 4 areas for action:

- prevention and early intervention,
- access to treatment + joined up accessible services,
- people's physical wellbeing
- rights information use and planning.

We will keep a focus on wellbeing and recovery, remembering individual's strengths and things that keep them well; employment; volunteering; peer support and utilising people's lived experience. We will also focus on life journeys and transitions such as child to adult services and adult to older age services.

There were several clear themes that came through in CAPS consultation events:

- It's hard to find information on what's available locally
- There is a need for more services for young people
- Transport is a barrier to accessing services.
- People value opportunities to come together face to face
- Joined up working is important.

19.7% of the population were prescribed drugs for depression, anxiety and/or psychosis in 2017. This is **increasing** and is higher for those living in the most deprived areas.

The number and rate of Midlothian patients with a psychiatric hospitalisation continues to be **lower** than the Scottish average.

Over the last 5 years there has been an average of 12.6 probably suicides per year, only a proportion of these have a diagnosed mental health diagnosis.

Prevention & Early Intervention

- Utilise mental health supports including computerised Cognitive Behavioural Therapy, and web based information.
- Ensure Midspace is up to date.
- Enhance community resources for social prescribing e.g. stress control.
- Focus on physical health of people with mental health problems - support access to existing community resources, physical activity, weight management, smoking cessation & screening.
- Refresh Midlothian's approach to Suicide Prevention in accordance with Every Life Matters.
- Interface with Midlothian Early Action Project for people between 5 and 25.
- Review practice for people with a first episode of psychosis and implement new guidance to help people recover and gain a good quality of life.

Planned Support, Treatment & Recovery

- Implement and evaluate *Wayfinder Grade 4 Support and Accommodation and rehabilitation pathway* for people living in their own tenancy.
- Review of mental health older people's beds at Midlothian Community Hospital and enhance community supports.
- Implement and evaluate Individual Placement Support model to support employment opportunities for people with mental health problems.
- Expand Midlothian Access Point and support developments in Primary Care (Action 15).
- Work in partnership to provide joined up and accessible services - particularly in relation to substance misuse.
- Review access to specialist mental health services for Midlothian residents and ensure services are provided as locally as possible.
- Improve access to psychological therapies through for example computerised cognitive behavioural therapy, increased staffing capacity, work with partners and other initiative.
- Provide paid peer support and develop peer support pathways.
- Review commissioned day supports and community activities.
- Ensure our requirement Royal Edinburgh Hospital beds is met - 1 low secure and 2 rehabilitation.
- Increase opportunities for psychological interventions for people over 65.
- Increase Occupational Therapy capacity within community mental health teams.
- In partnership with service users and collective advocacy group Midlothian Voices, review and remodel supports and services.

Unplanned Support & Treatment

- Continue triage with Police Scotland and other emergency services.
- Strengthening Crisis and Out of Hours Care including Intensive Home Treatment Team.
- Develop responses to distress - Distress Brief Interventions.
- Expand Midlothian Access Point and pathways in Primary Care.
- Develop local responses for people who frequently attend A&E.

Physical Disability

National/Local Guidance:

- A Fairer Scotland for Disabled People (2016).
- Physical Disability Planning Group Action Plan (2016 – 2019)
- Equalities Act 2010
- UN Convention on the Rights of Persons with Disabilities 2016

4,800

People between 16-64 have a physical impairment which affects their ability to undertake normal daily living tasks

The medical model defines a disabled person by their illness which requires to be managed by professionals. The social model however, states that the person is disabled, not by their impairment, but by barriers in society that make life harder e.g. attitudes or physical barriers such as inappropriate access to buildings. A disabled person is someone with a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. This includes people born with impairment, those who have suffered an injury and those whose disability has developed as a result of an illness

While Health and Social Care are key elements in supporting disabled people, we must work in partnership with Housing, Transport, other Council services and other public bodies, to ensure we remove the barriers which restrict and exclude disabled people. Disabled people can make a positive contribution, add talent, diversity and richness to our communities. Our job is to work together to remove the barriers. We need to ensure that all disabled people are supported to live and work in a place and in a way they choose.

Most people who received equipment were happy with it and that it increased their independence.

"The services I receive are essential to support me to continue to live independently but my dignity, control and choices must be respected"

370 specialist aids and major adaptation provisions were made between 2017- 2018 e.g. wet floor showers, stairlifts and ramps.

The number of people living with a physical disability is close to the Scottish average

4,517 people have a blue badge for parking.

1,200 people are registered wheelchair users

Prevention & Early Intervention

- Ensure front line staff are trained to identify the support needs of both people with a disability and their carers following diagnosis.
- Work with partners to improve information on and access to services and facilities that promote an active lifestyle for people with a disability.
- Work towards the provision of suitable respite facility in Midlothian for Disabled People under 65 years of age.
- Plan for the implementation of changes to the Welfare Benefits System which have been devolved.
- Plan and implement the arrangements for free personal care for people under 65 years.
- Work with Edinburgh College, Adult Learning staff and local employers to increase the number of people with a disability in further education and employment.
- Create an assembly of people with a disability in Midlothian following the success of the Older People's annual assembly.

Planned Support, Treatment & Recovery

- **Support people to live where they want:**
  - Support people to move to suitable housing.
  - Increase the availability of suitable housing.
- **Deliver treatments locally:**
  - Work with the Astley Ainslie hospital to explore, and if feasible, implement ways to deliver in-patient and out-patient services locally.
  - Consider results of a new approach to multidisciplinary working that was tested in Penicuik to support people who are housebound to develop in new areas.
  - Support people with long term health conditions through the Wellbeing Service.

Unplanned Support & Treatment

- **Improve access to medical treatments:**
  - Work with GPs Dentists, Pharmacists and Opticians to improve accessibility of premises and of information.

Learning Disability

1,772

People have a learning disability
(Based on national prevalence rates)

National/Local Guidance:

- Keys to Life (2013)
- Learning Disability and Redesign (2018)

The national strategy Keys to Life places an emphasis on human rights, tackling health inequality, and living an ordinary life with Individual, local solutions for people.

The prevalence rate is 5.8 per 1000. This is higher than the Scottish average (5.2), which may be due to the presence of a large learning disability hospital, St Joseph's, which closed in the late 1990s when residents moved to houses across the county. 40 to 50 of people have very Complex Care Needs and 628 receive social care services.

Key areas of service planning include

- addressing health inequalities such as obesity, sensory impairment and sexual health;
- providing support to older people with a learning disability;
- managing transitions from children's services including age-appropriate day services;
- supporting individuals with complex needs in the community and preventing hospital admissions and delivering positive behavioural support services locally.

More broadly the significant increase in funding of services to people with learning disability is not sustainable in light of the general financial position. This means we must review all care packages to determine if they remain appropriate, redesign day services and develop alternative housing models with a greater emphasis on shared support.

People mentioned 4 main areas of importance:

- **Housing** - There should be a better choice of housing which should be in the heart of communities and not segregated.
- **Feeling Safe** in their community is really important to people.
- **Staff** - Support staff should be well trained and know how to communicate. People want consistent support staff who know and listen to people.
- **Rights** - Support to take part in society and live an ordinary life. To be fully included in all areas of life and to be treated as equal citizens

Learning Disabilities is the highest area of spend based on client group and spend per head.

Approximately **66%** of adults with a learning disability live alone. This is higher than the Scottish average.

30 teenagers are known to Social Care who will need significant support over the next few years as they transition to adulthood.

Prevention & Early Intervention

- **Support people to stay healthy:**
  - Improve opportunities for health and social care practitioners to work together.
  - Run Health Fairs in 2019 and 2021 to bring together people with disabilities, service providers, and family and paid carers to inform health improvement activity.

Planned Support, Treatment & Recovery

- **Strengthen services:**
  - Review day services to determine the range and capacity of services required.
  - Redesign, develop and/or commission services:
    - For young people - with pathways between services, education, and employment.
    - For older people - based on maintaining friendships and keeping active.
    - For people with Dementia.
  - Tailor and personalise experiences to support adults with complex learning disabilities and adults with autism.
  - Discontinue the use of day services out with Midlothian unless there is a clear reason.
- **Support people to live in suitable accommodation:**
  - Build expertise across services to support people with complex needs to live ordinary lives.
  - Commission new build housing for people with a Learning Disability using clustered models, supported by Technology Enabled Care.

Unplanned Support & Treatment

- **Avoid inappropriate hospital admission:**
  - Develop robust community services incorporating Positive Behavioural Support to support people with complex needs in crisis.

Autism

National/Local Guidance:

- The Scottish Strategy for Autism 2018-2021
- Two Trumpets – Midlothian's Autism Strategy (2016)

918

People (adults and children) have autism

The Autism Strategy Group is a multi-agency and multi-disciplinary group that will oversee and sustain the collaborative efforts and collective knowledge of people with autism, families, and services that contributed to 'Two Trumpets', our Autism Strategy.

"Autism is a very complex condition, on a spectrum which encompasses all abilities from the highly articulate to others who need advocates to help express their needs. It is also life–long and, of course, as the person with autism ages their social and emotional needs change too. Many autistic people have their lives further complicated by mental health issues, learning disabilities and other challenges. When dealing with the day to day reality of autism the difficulties faced by autistic people and their families should not be underestimated; indeed at times they could hardly be over–stated." Two Trumpets Autism Strategy.

People mentioned there is a gap in health and social activity for women with autism.

They also felt that young people with Autism have limited opportunity to socialise outside of school.

We should build on the unique skills of Midlothian people with autism and complex needs discovering Midlothian through their eyes.

There is no reliable data on the prevalence of Asperger's Syndrome either nationally or locally due to variances in the definition.

32% of people with a diagnosis of autism also have a diagnosis of a learning disability.

The Midlothian prevalence of autism is consistent with that of Scotland.

Prevention & Early Intervention

- The ‘Guide to Autism Services’ will provide an accessible and easy way to find out about autism supports in Midlothian.

Planned Support, Treatment & Recovery

- Place Boardmaker in local libraries to allow people and their families to access the resources to create their own timelines and symbols, with support from experienced and trained staff.
- Local Area Coordinators will respond to highlighted gaps in health and social activity for people with Autism.
- Train all Midlothian Leisure coaches in Autism specific coaching.
- Devise a mobile app to discover Midlothian through the eyes of people with complex needs. A team of software engineers will help support workers or parents find activity which relates to people’s unique interests.

Unplanned Support & Treatment

- Identify sources of support during a crisis.

Community Justice

National/Local Guidance:

- Community Justice Outcomes, Performance and Improvement Framework (2016)
- Midlothian Community Justice Outcome Improvement Plan (2017-20)

4,500

Crimes and offences recorded by the police (2017/18)

People who offend, or are at risk of doing so are much more likely to experience multiple and complex health issues. Frequent re-offenders often have complex needs that relate to their social circumstances, a history of abuse, mental health and addiction problems. More generally there is a strong link between offending and alcohol and drug misuse.

The Recovery Hub will bring together partners from mental health, substance misuse and offenders services which will strengthen partnership working.

The Scottish Government is likely to extend the presumption against short sentences to under twelve months. This is positive as it could reduce reoffending but will create pressure on criminal justice social work.

People who had undertaken a Community Payback Order (CPO) felt they had helped the community, gained new skills and improved their attitude towards offending.

"I have learned new skills and done things I didn't know I was capable of"

Replies from a Community Justice Survey in 2017 showed people would like the unpaid work team to help less able/vulnerable people with gardening or landscaping for public places.

People also believed the work should involve talking to or providing for victims of crime.

Other ideas included helping people learn skills and a work ethic to help with future employability.

20% of all violent crimes had alcohol as a factor.

71% of offenders assessed by criminal justice social work had left school at the minimum leaving age. **70%** were unemployed

49% of offenders assess by criminal justice social work said they were or had been the victim of violence within their families.

Prevention & Early Intervention

- **Support people at risk of offending:**
  - Support women with complex needs through the Spring service.
  - Provide people on CPOs with recognised qualifications through training Unpaid Work staff as registered trainers in Health and Safety, First Aid, painting and decorating.
  - Offer holistic support to people in the Recovery Hub e.g. mental health, substance misuse and criminal justice.

Planned Support, Treatment & Recovery

- **Provide Peer support:**
  - Employ a peer support worker for women through the substance misuse service that women on the Spring service will be able to access.
  - Employ a peer support coordinator to ensure peer support is available across substance misuse, mental health and criminal justice services.
- **Provide specialised support:**
  - Support families through the Safe and Together service. Criminal Justice will pilot work with perpetrators on a voluntary basis.
  - Support people affected by domestic abuse through the Caledonian programme.
  - Support people convicted of sexual offending through the Moving Forward, Making Changes programme.
- **Improve access to services:**
  - Work together in the Recovery Hub for people who have overlapping mental health, substance misuse and offending issues.

Unplanned Support & Treatment

- **Support people due for release:**
  - Ensure health outcomes are met with a seamless prescriptions ‘through the gate’, registration with a GP and drug and alcohol treatment.
  - Enhance information sharing between the Scottish Prison Service and other partners.
- **Support people at point of arrest:**
  - Extend funding for Fresh Start –Arrest Referral which supports individuals being held in the custody suite at Dalkeith Police Station.

Substance Misuse

National/Local Guidance:

- Rights, Respect and Recovery (2018)
- Alcohol framework 2018: Preventing Harm

345

People have alcohol related hospital admissions (2016/17)

Alcohol misuse contributes to a wide range of health problems, deaths, hospital admissions, unintentional injuries and a range of diseases such as cancer.

The Midlothian rate of **530.6** per 100,000 hospital admissions is lower than the national rate of 685.2

Between 2012 and 2016 there was an average of **15.39** alcohol related deaths each year.

In 2017 there were **19** drug related deaths. The majority of these were men with a long history of chaotic drug use who were not in contact with treatment or recovery services at the time of their deaths.

There are strong links between substance misuse and other services including mental health and criminal justice. This has been recognised in the move to establish a Recovery Hub for these services including health, social care and voluntary organisations.

People mentioned the importance of early intervention to ensure children living with parents who have experience substance misuse are supported.

They mentioned the importance of including people with lived experience in treatment and support services, and the importance of improving engagement in education, training and volunteering.

People felt that it would be helpful to ensure individuals who have dropped out of treatment were supported to reengage.

Alcohol-related death rates in the neighbourhoods with the most off-sales outlets were **2.4 times higher** than in neighbourhoods with the least"

Heroin, cannabis and diazepam were the drugs most often reported to have been used in the month prior to assessment at the treatment service

The highest drug user prevalence rates for males aged 25 to 34 years (7.14%).

Older males (aged 55-64) are identified as having problem alcohol use more than any other age group.

Prevention & Early Intervention

- Work with partners to develop evidence based educational interventions for all children and young people.
- Focus on early intervention to ensure children living with parents who have experience of problematic substance use are safe and supported as part of the agenda to minimise the impact of Adverse Childhood Experiences.
- Increase the reach of the take-home Naloxone kits to those most at risk of overdose including those recently liberated from prison.

Planned Support, Treatment & Recovery

- Review local assets and needs to ensure appropriate responses to the most at risk populations.
- Increase the role in treatment and support services of people with lived experience including opportunities for peer volunteering, peer mentoring and employment.
- Through the Recovery Hub provide improved arrangements for dual diagnosis for people with problematic substance use and mental health diagnosis.
- Increase the range of treatment and recovery interventions available for individuals and their families delivered through the Recovery Hub.
- Develop assertive outreach approaches to engage harder to reach groups including those most at risk of overdose.
- Increase employment opportunities for people in recovery by improving engagement in education, training and volunteering.
- Ensure that the quality of service provided to children, young people, adults and families reflects the standards of care and support defined in the National Quality Principles.
- Work with partners to increase access to BBV testing and Hepatitis C treatment.

Unplanned Support & Treatment

- Develop interventions and pathways for individuals presenting at an emergency service such as A&E departments or social work centres.
- Ensure that there are systems in place to help individuals who have dropped out of treatment re-engage.

Resources

Realistic Care, Realistic Medicine recognises that a “one size fits all” approach to health and social care is not the most effective approach for either service users/patients or for Health and Care services

A sensible and practical idea of what can be achieved or expected.

Audit Scotland published their report "*Health and social care integration-Update on Progress*" in November 2018. They commented that Integration Authorities still have a lot of work to do to make sure that their use of resources matches their key priorities - **in particular how they intend to use their resources to make progress in providing sustainable, preventative and community based services.** Given the continuing pressure on public finances they pointed out that this planning would need to include how some existing services would have to cease or be reduced in scale.

In September 2018 we approved a 3 year Financial Strategy to describe how we intend to shift our use of resources in line with our vision and values.

Move from treating the causes rather than the consequences of ill health

Prevention is good for people and the utilisation of health and social care resources. Much preventative activity is delivered by partners within the broader Community Planning Partnership including employability support services, welfare rights, housing and leisure services.

The shift towards prevention will be greatly enhanced by enabling people to live in good quality housing suitable to their needs. Midlothian Council has an ambitious programme of house building which will support this objective. Alongside this we are continually exploring how best to harness new technology to increase the efficiency and effectiveness of our systems and to enable people to manage their health conditions and manage as independently as possible.

People told us they supported a move to supporting people to prevent illness as it could save money to spend on front line services. Suggestions included:

- Increasing support for isolated people through day centres and volunteers
- Supporting people to stay active, maintain a healthy weight by education, community health, food programmes and reducing the cost of leisure centres
- Regular Health MOTs or making it easier to access GPs to stop problems escalating,
- Making the environment more accessible
- Supporting self help.

Move from Hospital or Care Homes to Community Based Services

People wish to remain at home for as long as possible and only go into hospital if absolutely necessary. There is scope to provide more services in the community. We have committed to reduce occupied hospital bed days by 10% which would enable a significant transfer of resources to community services.

The health and social care system is entirely dependent on the daily contribution of thousands of family carers, friends and neighbours who support people in need whether as a result of age, ill-health, disability or isolation. The new Carers Act 2016 is the latest in a succession of policy and legislative measures introduced to ensure that carers are fully supported and recognised as equal partners in care.

People told us they valued the support they received at home but there were a number of challenges with this including:

- Availability of support workers to meet needs.
- The timing of assessment and care provision often takes too long and leads to people falling into crisis or needing long term care.
- The need to improve the working conditions for frontline staff.
- Support for unpaid carers.

Move from Treatment and Support to Recovery and Reablement

Emphasising recovery by providing more intensive support to enable people to recover as far as possible is reflected clearly in areas such as mental illness and substance misuse and a more proactive approach to rehabilitation is being adopted in areas such as stroke and in the delivery of care at home services.

People mentioned a variety of supports that helped them with recovery and reablement including:

- Peer support groups, Befriending, Volunteering, Local Area Coordinators. These helped people regain confidence and maintain social supports
- MERRIT and reablement were seen as positive resources but people mentioned a need to expand their services.
- Waiting lists for GPs and other services can make it hard to access support

Our resources are for the most part used to fund primary care, hospital services social care and services provided by voluntary and independent providers. Shifting our use of resources will require strong partnership working across these sectors of the Health and Social Care system.

Achieving significant changes in the way in which health and social care services are delivered will only succeed if we have the right skills and working conditions to enable the workforce to function in a way which reflects our key values and principles. We are now taking a longer term approach to planning our workforce requirements whilst also continuing to invest in training and development across the partnership.

Key Actions

Primary Care

- Expand workforce through pharmacists, physiotherapists, wellbeing workers and other disciplines.
- Increase capacity in GP practices.
- Implement the local Prescribing Action Plan.

Social Care

- Develop more joined up services e.g. the recovery hub; locality work and the learning disability team.
- Strengthen the approach to self-directed support.
- Fully implement new policies such as Fair Access to Care and new legislation including the Carers Act.

Hospitals

- Strengthen the pathway for people who present at acute hospital whose needs are more social in nature.
- Increase the role of Hospital at Home.
- Implement the new Discharge to Assess service.

Carers

- Full implementation of provision of Adult Carer Support Plans.
- Provision of respite care and short breaks.
- Improve identification of 'hidden carers'.

Workforce

- Enable all staff to work in a more person-centred way with a stronger focus on prevention and recovery.
- Develop and implement forward looking action plans for each service area.

Communities

- Develop a stronger locality based approach building on the work through the Penicuik Collaborative.
- Continue to have a focus upon the three areas of deprivation in Woodburn, Mayfield and Gorebridge.

Third Sector

- Explore the viability of establishing a Voluntary Sector Hub within health and social care.
- Continue to develop stronger working relationships both operationally and in relation to service redesign.

Housing & Property

- Investigate the options for the provision of a local care and repair service.
- Continue to promote a planned approach to ensuring people live in the most appropriate accommodation.
- Plan the development of a range of extra care housing schemes.

Technology enabled care

- Improve our use of health and social care data to understand and respond to the needs of the population.
- Introduce TEC systems to lessen the need to travel into hospital for clinics and appointments.
- Use technology to help people, particularly those with learning disability, feel safe and secure overnight.

Primary Care

National/Local Guidance:

- The GP Contract (2018)
- National Review of Primary Care Out of Hours Services (2015)

80

GPs

41

Nursing Staff

Primary care is the first point of contact with the NHS. Across our 12 practices GPs, Nurses and Reception Teams work together to provide care and support. Out of hours services via NHS 24 as well as Pharmacists, Opticians and Dentists are also all part of the primary care family.

Midlothian's population is growing and our workforce is changing. Nationally, 2018 saw a new General Medical Services Contract agreed in Scotland. This recognises that primary care is collaborative and that to safely manage work, how we use primary care is changing. The role of the GP as the 'Expert Medical Generalist' – someone who can help with a range of health issues- continues. But who else can help? Our reasons for contacting a practice are varied and we need to understand more about the other skilled professionals available and make sure that people see the most appropriate person.

Having a diverse team is becoming more familiar, such as Advanced Nurse Practitioners, Pharmacists and Advanced Physiotherapists and there are plans to introduce further roles, such as Primary Care Mental Health Nurses. The community nursing workforce is also changing, with specific training on clinical decision making and prescribing in place. All of this means that the GP is not necessarily the automatic choice. Widening the help available within primary care is a central part of our Improvement Plan to reduce waiting times and eliminate restricted lists. We value the expertise available, with staff able to safely offer care and meet the needs of a growing and ageing population, without necessarily having to see a GP. We have started to recruit staff with the right skills and who are working in a number of our GP practices already, and this will continue over the coming three years.

People can find accessing a GP hard. Common reasons include:

- Difficulties getting through on the phone
- No appointments outwith working hours
- Hard to book advance appointments

"Because of how difficult it is to see a GP, I have found it easier to wait until after business hours and phone NHS24. The phone is answered almost right away, a referral/appointment made and usually all completed within an hour, visit to out of hours included. Such a contrast to daytime hours where you can spend more than 100 attempts to get through for an appointment at the GPs and by the time you get through there is no availability"

600 000 appointments are offered every year

There are 12 G.P Practices. There are plans for the known pressure points - in the Shawfair development, South Bonnyrigg and Newbyres

£18m of the total £45m Community Health Partnership budget for NHS Services **is spent on prescribing**

20% of people (in Scotland) aged 75 years + are not registered with an NHS dentist.

Recruitment is a concern across General Practice and District Nursing.

Prevention & Early Intervention

- **Increase vaccinations**:
  - Transfer clinics from GP practices e.g. travel clinics and immunisations.

Planned Support, Treatment & Recovery

- **Train staff:**
  - Practice Managers and Reception Staff to signpost people to the right member of the Primary Care Team.
  - Nursing staff to become Advanced Nurse Practitioners.
  - Partnership pharmacists to become independent prescribers.
- **Expand the workforce:**
  - Increase the number of Wellbeing Practitioners to 12 GP practice.
  - Increase Advanced Physiotherapists from 3 practices to 12 GP practices.
  - Increase pharmacists and pharmacy technicians in GP practices.
  - Introduce mental health nurses in 4 GP practice.
- **Increase capacity:**
  - Open a new clinic at Newtongrange and plan for additional practices.
  - Provide financial support to GP practices for population growth.
  - Secure financial contributions from new housing developments.
- **Develop community treatment services for minor injuries.**
- **Use data to understand our population and plan services.**
- **Implement the Midlothian Prescribing Action Plan.**
- **Explore the viability of a community pain management service.**

Unplanned Support & Treatment

- **Strengthen Out of Hours services**:
  - Work in collaboration with NHS Lothian.
  - Reduce reliance on out of hours services by:
    - Improve Anticipatory Care Planning.
    - Expand the Access Point and introduce mental health nurses in GP practices.
    - Improve coordination of health and care services during evenings, overnight and at weekends.

Social Care Support

National/Local Guidance:

- Realistic Medicine
- Self Directed Support
- Fair Access to Care

2,000

People have a care package

We provide care packages for 2000 people. A further 900 people are in receipt of telecare alarm service only.

These services cost approximately £40m a year, either provided directly from the Council or from independent and voluntary sector providers funded by the Council.

The main services include:

- care homes for older people with 11 situated in Midlothian;
- care at home services;
- day support for people with learning disability and people with mental health needs;
- supported accommodation for people with learning disability.

Following the implementation of Self-Directed Support more people are exercising choice and control in relation to making arrangements for their care packages

Recent changes to the provision of social care services include the application of new policies such "Fair Allocation of Care" intended to ensure a more equitable allocation of services, and the implementation of the Carers Act

Both the public and staff mentioned a lack of resources that impacts on their ability to offer choice and control.

"homecare unable to provide suitable times due to demands. Not really a service to suit person but people need to fit service."

"We would like to give choices, but we don't' have the choices to give"

5,432 referrals were received by the Adult Social Care team in 2016/17

There are almost double the number of referrals for support for those aged 65+ compared to those under the age of 65.

Around **12,000** care at home visits are scheduled every week.

Between 2016-17 there was an almost **20% increase** in older people moving into a care home.

Prevention & Early Intervention

- **Reduce health inequalities:**
  - Increase staff understanding of inequalities;
  - Maximise income of vulnerable groups.

Planned Support, Treatment & Recovery

- **Improve choice and control:**
  - Expand service options to enable greater self-directed support.
- **Strengthen multi-agency working:**
  - Learning disability staff to offer coordinated support.
  - Locality working to link local health, social care and third sector organisations.
  - Open Recovery Hub to improve services for mental health, substance misuse and offending.
  - Improve links between Social Work and third sector organisations.
- **Extend the use of technology to support people at home.**
- **Strengthen the arrangements to regularly review care packages.**

Unplanned Support & Treatment

- **Explore viability of a joined up comprehensive out of hours service including social care.**

Hospitals

240

Hospital beds under control of the IJB across all hospitals

National/Local Guidance:

- Ministerial Strategic Group for Health and Community Care

There are a number of hospitals for patients in Midlothian.

- **Midlothian Community Hospital**: continuing care and rehabilitation for elderly patients, Physiotherapy and occupational therapy, Out-patient department, GP Out-of-Hours service, X Ray Department
- **Royal Edinburgh**: Beds for patients with acute psychiatric and mental health needs, learning disabilities, dementia, alcohol problems and young people's mental health.
- **Astley Ainslie**: Rehabilitation services for adults with acquired brain injury, stroke, orthopaedic injuries, limb amputation, and progressive neurological disorders. Community Services for chronic pain, cardiac rehabilitation and angina. The South-East Mobility and Rehabilitation Technology (SMART) Centre
- **Royal Infirmary Edinburgh**: - 24hr A&E department, Surgical, medical and maternity
- **Western General** Regional centre for cancer, neuroscience and infectious diseases
- **St John's**: -Plastic Surgery

The IJB is responsible for working with Acute Hospitals and the other Lothian IJBs to manage some inpatient services, particularly for people whose admission was unplanned –referred to as Unscheduled Care. **This costs £17m a year**. It is vital that they are only used for people who really need to be in hospital. Community services must provide alternative services where possible and ensure that people can be discharged as soon as they are fit to do so. Pressures on care at home services; care homes; and extra care housing have reduced our ability to achieve this.

The importance of reducing reliance upon acute hospitals is reflected in the Government's key performance indicators for Integration Authorities –all of them relate to hospitals including, crucially, the balance of spend which is intended to shift from institutional care to community based services.

"Local support provided from areas such as the Midlothian Community Hospital. This could be for sensory loss and appointments to neuro support, cancer treatment. The local access could make a big difference to people's lives."

Interventions to reduce the number and length of hospital stays include COPD, fraility, the Rapid Response Service (**1,397** emergency falls call outs (2017/18))and the Hospital at Home service (**2,751** 'virtual ward' bed days

A&**E attendance rates have increased and are above the Scottish average.** There are higher attendance rates from the East Locality. However the number of bed days occupied has reduced.

1 in 5 people are discharged within 3 days - most are delayed by **two weeks or more**. This is comparable to the Scottish average

Prevention & Early Intervention

- **Reduce preventable admissions**
  - Expand the Frailty project to identify people and provide proactive support.
  - Strengthen the falls prevention programme.
  - Improving uptake of flu vaccination.
  - Improve pathways for people whose needs are more social in nature e.g. access to homelessness services and the Health Inequalities Team.

Planned Support, Treatment & Recovery

- **Reduce delayed discharge rates by 20% by:**
  - Strengthen Care at Home, including overnight care.
  - Strengthen Hospital at Home.
  - Strengthen intermediate care in extra care housing.
  - Improve dementia care within care homes.
  - Promote the use of Power of Attorney.
  - Implement the Discharge to Assess service with elderly and orthopaedic wards.
  - Implement the local discharge hub arrangement.
- **Increase capacity for rehabilitation** in Midlothian Community Hospital.
- **Explore opportunities for specialist care and treatment to be delivered locally**, for example chemotherapy.
- **Improve use technology for consultations e.g. video links.**

Unplanned Support & Treatment

- **Reduce unnecessary admissions by:**
  - Expand the Community Respiratory Team.
  - Create a Care Home Support Team.
  - Strengthen community care for people with a diagnosis of Dementia.
  - Promote the appropriate use of A&E and community resources.
  - Maintain current level of A&E attendances.
- **Reduce emergency admissions to acute hospitals by 5%.**
- **Reduce occupied bed days for acute, geriatric and mental health patients by 10%**

Carers

National/Local Guidance:

- The Carers (Scotland) Act (2016)
- Midlothian Carer strategy and action plan (2017 – 2019)

9,000

People are carers
(Statistical estimate – based on 2011 census)

Unpaid carers fulfil wide-ranging, significant and valuable roles within our communities and economy; a role that statutory services cannot replicate. Within our communities there is an increasing number of people living with long-term health conditions, people are living longer, and mental wellbeing is a challenge for many. In addition, the re-design of health & social care services involves a cultural shift to support more people to be directly involved in their care and decisions that affect their health and wellbeing; promoting self-management of their conditions. We recognise that this shift relies on participation by patients, service-users and carers; and in many situations it is carers who take on this extra responsibility. It is vital that we recognise what carers do and the impact that their caring role can have on them. Services should offer support to carers and identify hidden carers. Individual and peer support; breaks from caring; advice with finances and their health and wellbeing; and future and emergency planning are issues which are key to contributing to carer support.

The Midlothian Carer's Strategy recognises and addresses issues faced by both young and adult carers. The Health & Social Care Partnership oversees services for adults, whilst Education and Children & Families Social Work services are the direct responsibility of Midlothian Council. The Carers Strategic Planning Group includes representatives from health and social care, VOCAL, organisations that provide carer support and from carers. .

People mentioned the importance of breaks from caring and the need for support to access these.

They also mentioned the challenges of living on a tight budget as a carer (relying on benefits), including transport issues and housing costs.

The impact of caring on carers own health and wellbeing, and relationships is also important – people mentioned the importance of access to carer support.

Unpaid carers contribute over £150million to the local health and care economy in labour terms

Less than half of carers say they have had time away from caring in the past year. More than a third say that they have never had time away

Carers who access support reported that the most common type of service was practical support including transport

32% of carers feel supported to continue in their caring role. This is below the Scottish average (37%)

Prevention & Early Intervention

- Improve early identification of carers.
- Improve uptake of Adult Carer Support Plans.
- Enable carers to have breaks from caring.
- Support carers to improve their financial wellbeing through specialist advice services.
- Work with local employers to improve carer awareness and links to Carer Positive schemes.
- Provide vaccinations and health checks to carers.

Planned Support, Treatment & Recovery

- Fund services to provide information and advice for carers.
- Provide training to staff to support carers to plan ahead e.g. emergency plans and suitable housing options.
- Provide practical training to carers to equip carers with the tools and skills to manage their caring role.

Unplanned Support & Treatment

- Strengthen links between Social Care and Primary Care.
- Ensure emergency respite care is available.

Workforce

691

Staff in Adult Social Care

484

Staff in NHS Lothian (Midlothian)

National/Local Guidance:

- Integration Joint Board Workforce Planning Framework 2017

Our workforce is our most valuable asset. In this environment of transformational change, where new models of integrated working and new forms of commissioning are evident, investment in building strong values, strong effective working relationships, a shared culture, the right skills and knowledge and providing clear career pathways are all key elements of workforce planning.

Developing our culture of working closely together across all service sectors will result in better use of resources and improved experiences for people requiring services.

Our changing communities need a workforce to be flexible and responsive. To do so we need to work closely with our communities in a way which maximises and develops their talent and capacity as well.

We need continuous investment in our Workforce to ensure that we have the right skill, knowledge and experience to support good outcomes.

People felt that the lack of staff was having a profound effect by:

- Increasing waiting times for support at home which could lead to people ending up in crisis.
- Lack of ability to offer choice and control over packages of care
- Frustration over inability to access a GP.

Both staff and public felt more should be done to support frontline care staff with suggestions including:

- Increasing pay (by diverting it from managers)
- Bringing care staff back 'in house'
- Allowing care staff more time with their patients.

Over **75%** of the workforce is female.

The highest proportion of the workforce have been in their job for **less than 2 years**

The largest percentage of the workforce fall within the age range **45-60**

We have known recruitment pressures in Care at Home, General Practice and District Nursing

Prevention & Early Intervention

- Expand services that focus on prevention e.g. the wellbeing service and community health inequalities team.
- Strengthen joint work with other services such as leisure services and libraries.
- Increase staff knowledge of their role in prevention and early identification e.g.
    - Become more person-centred.
    - Identify and addressing health inequalities.
    - Support people to recover.
    - Prevent ill health, or avoidable deterioration.

Planned Support, Treatment & Recovery

- Create a robust Care at Home service.
- Strengthen joint working across Mental Health, Criminal Justice and Substance Misuse teams in the Recovery Hub.
- Complete workforce action plans for all service areas.
- Strengthen workforce development and training for all staff.
- Invest in the SVQ Assessment centre to ensure frontline Care staff have the right knowledge and qualification and have invested in supporting Modern Apprentice.
- Invest in our Team Leaders through a Team Development programme
- Provide good induction to new staff.
- Create oppoprtunities for school students in Foundation Apprenticeships, as part of encouraging a pathway for a career in care.

Unplanned Support & Treatment

- Implement the new GP contract including developing multi-disciplinary Primary Care teams.
- Reduce reliance on bank and agency staff.
- Improve retention of care at home staff to reduce delayed discharge.
- Develop stronger joined up out of hours services.

Communities

National/Local Guidance:

- Community Empowerment (Scotland) Act 2015

24

Peer support groups

There are strong local communities and we must do more to harness the strengths they can bring to improving health and wellbeing. This will include establishing more effective communication channels and demonstrating a stronger commitment to working with voluntary organisations functioning in those localities. There are also related challenges for our local health and care services in finding ways to work more closely with volunteers and unpaid carers, recognising that they, more so than formal public services, are critical to the health and wellbeing of the population. Midlothian is small geographically and in population terms however there are two localities, East and West Midlothian for planning and commissioning purposes. This reflects the requirement in the Public Bodies Act to designate a minimum of two localities.

A successful project in Penicuik, supported by national government, explored how to strengthen local joint working. We will now consider how best to replicate this multidisciplinary approach in other communities in Midlothian.

We will seek to strengthen our links with local communities through both Community Councils and Neighbourhood Planning Groups. Person centred care and support requires work across the Community Planning Partnership with services such as leisure, adult learning, transport and support for domestic abuse survivors.

People felt that investing in communities might help save money through prevention. Suggestions included:

- Healthy eating ideas in libraries
- Befriending schemes for people who are socially isolated
- Local groups and activities
- Increased community sport – in particular for the young and elderly
- Improving the accessibility of local buildings

”I would put more money into community health, food programmes, and support services of many kinds”

Around **29%** of adults are involved in formal volunteering.

13 data zones are within the most deprived 20% data zones in Scotland**.**

88% of people feel connected to friends and family

Prevention & Early Intervention

- **Target services to areas of deprivation including Dalkeith/Woodburn, Mayfield and Gorebridge.**
- **Increase use of social media to engage in conversations with our community.**

Planned Support, Treatment & Recovery

- **Engage community members, including people with lived experience, in service planning and review at a local level:**
  - Continue to test and where appropriate expand local approaches such as the Penicuik Collaborative that brought together GPs, nurses, OTs, third sector organisations and day centres.
  - Explore meetings with Neighbourhood Planning Groups and Community Councils.
- **Provide advice, support and funding for peer support groups.**

Unplanned Support & Treatment

- **Participate in the Care for People Group - to enable communities to become more resilient in dealing with adverse circumstances, such as severe weather, power cuts and other risks that they have identified.**

Third Sector

National/Local Guidance:

- The Community Empowerment Act (2015)

40

Number of organisations we have contracts with

A requirement of Integration is that the Third Sector be fully involved in the planning and design of health and social care services as well as playing a central role in the delivery of services. A shift towards prevention and self-management is critical for the long-term sustainability of health and social care and third sector organisations have considerable expertise in promoting healthy lifestyles and enabling peer support. Their contribution cannot be overstated-they provide opportunities for physical activity, companionship and the pursuit of hobbies such as music or crafts. There 700 such organisations in Midlothian and some of these are able to attract additional funding from Trusts, Lottery funding etc. Midlothian Voluntary Action act as an umbrella body providing support and advice.

Third Sector Organisations also play a major role in providing a service user voice.

Third sector organisations participate in local joint planning groups, the Integrated Joint Board and the Strategic Planning Group.

In order to strengthen joint working with the Third Sector a programme of quarterly summits now take place. These provide an opportunity for voluntary organisations to contribute their experience and understanding of the needs of communities to the redesign of services.

People mentioned the need for better joint working – e.g. managing risk, flexible and longer term commissioning, collaboration in service redesign, involvement of communities in budget decisions and sharing information.

They also suggested improvements could be made with services including care at home, out of hours services and better use of technology for self-management

They mentioned the need to invest in low cost – high impact services as prevention is critical

The Health and Social Care Partnership has contracts with approximately 40 organisations

These contracts costs £14million a year. This is a third of the total Adult Social Care budget.

These organisations employ around 340 staff and have many volunteers.

Prevention & Early Intervention

- Address isolation through day services. local area coordination and befriending.
- Support physical activity through group activities - walking etc.

Planned Support, Treatment & Recovery

- **Enable self-management:**
  - Provide individual advice, support and peer support e.g. for people with sensory impairment and unpaid carers.
  - Provide support following diagnosis of health conditions including dementia, cancer and frailty.
  - Provide day time support and activities for people with learning disabilities and those with mental health needs.
  - Promote recovery for people with substance misuse issues and those with mental health needs.
- **Strengthen joint working:**
  - Continue close working in areas such as MERRIT, the Joint Dementia Team, GP Practices and Cherry Road Day Centre.
  - Continue co-location of staff such as Deaf Action, RNIB, VOCAL and Red Cross who have a regular presence in the social work offices.
  - Run workshops with the third sector and partnership staff to generate new ideas.
  - Develop a hub with shared premises for third sector organisations, if possible.
- **Improve access to community buildings to enable affordable informal support and reduce public expenditure.**

Unplanned Support & Treatment

- Provide support following discharge from hospital.
- Provide day time support in response to crisis for carers.

Housing & Property

National/Local Guidance:

- Housing (Scotland) Act 2001
- - Local Housing Strategy 2019
- - Midlothian's Strategic Housing Investment Plan
- - Midlothian's Rapid Rehousing Transition Plan
- - Joint Housing Delivery Plan for Scotland, 2015

370

Number of major adaptations and specialist equipment provision (2017/18)

Midlothian is the fastest growing Council area in Scotland and this places pressure on public services. Nevertheless the investment in good housing for all sectors of society contributes to improved health and wellbeing. The Council's new housing programme commits to the provision of additional extra care housing and housing for people with special needs including learning disability and mental health.

There is a waiting list of over 100 people for Extra Care Housing and over 450 for Retirement Housing.

Housing and Occupational Therapy work together to ensure a best practice approach to the provision and management of adaptations in Council tenancies, making best use of existing adapted properties, identifying housing solutions for people with complex or changing needs, identifying specific geographical areas of need for specialist housing and consulting on new build housing projects such as Extra Care and wheelchair accessible accommodation.

While Homelessness is not a delegated function to the IJB many people experiencing homelessness may also experience health and wellbeing challenges such as mental health, substance misuse or involvement in offending. Closer collaboration between Housing and Health and Care Services will enable a stronger approach to addressing homelessness and the health inequalities which arise.

Most people in receipt of equipment were happy with the support and it made a difference to their independence

There is a concern that timing of assessment, adaptation and housing moves take too long which leads to people falling into crisis. Occupational Therapy and adaptations could promote independence and to prevent further need.

Joint working with OT and Housing was raised as very important as many people felt there was a lack of suitable accommodation.

"The shower and other equipment provided has made a great difference to me living independent the whole process was carried out quickly and with me in mind thank you."

Council housing stock has been increasing. In 2017 there were **6,812** with plans to build another 1,000.

457 people were recorded as homeless (2016/17). This is 63 less than in the previous year.

The requirement for adaptations has increased significantly. This includes major adaptation works in owner occupied homes as well as council, Registered Social Landlord and private rented tenancies.

Prevention & Early Intervention

- Support people to access advice to avoid homelessness.
- 'Support to Move' guide offers a series of hints and tips for both professionals and their clients and families at each stage of moving house.
- Develop a Housing Options brochure providing details of Amenity, Retirement, Wheelchair, Sheltered, Very Sheltered and Extra Care facilities.
- Investigate 'Support to Move' Service.
- Roll out training for staff on Housing Solutions to support staff to have earlier conversations about housing - focusing on staff who are often the first point of contact such as podiatrists and practice nurses.

Planned Support, Treatment & Recovery

- **Extra Care Housing -**
  - Twelve fully wheelchair accessible bungalow units including 1 unit for intermediate care in Gorebridge. Estimated completion spring/summer 2021.
  - Forty flats and 8 bungalows including 1 unit for intermediate care in Dalkeith. Estimated completion early 2021.
  - Health & Social Care to work with Housing to identify other areas of need.
  - Identify existing properties for remodelling, particularly in areas where 'new build' opportunities are restricted.
- **Intermediate Care Housing** - Flat identified at Cowan Court and further provision will be included in each of the extra care housing sites. The aim is to have 4-5 in Midlothian.
- **New House building** sites will include an increasing number of wheelchair accessible and bariatric accommodation and accommodation with ground floor bedrooms.
- **Investigate viability of a Care & Repair service.**
- **Health & Social Care Occupational Therapy and Housing Partnership to create adaptation policy to support people with complex needs to consider all potential housing solutions**.
- **Work with house builders and planning officers to ensure local communities benefit from developer contributions (section 75).**
- **Explore digital solutions when designing new houses and facilities.**

Unplanned Support & Treatment

- Support people in homeless accommodation to access housing, health, social care, welfare rights and other support.

Technology Enabled Care

1,700

Number of Midcare alarms

National/Local Guidance:

- Scotland's Digital Health and Social Care Strategy (2018)

The traditional service model for health and social care will not be able to cope with the financial pressures and the ageing population. We must find new ways of supporting people and enabling them to stay well that are sustainable. Increasingly this will include redesigning services to embed and incorporate the right technologies to support new care models. This approach is in line with the wider impact of new technology in our day to day lives.

It is not simply about the right 'kit' but how the right care can be supported by technology. For example the delivery of better care can be facilitated by helping family members share information about the person for whom they are caring with one another as well as with health and social care staff; a simple smartphone or computer can support this but fundamentally the focus is supporting good communication

"Technology is neither good nor bad, it's what you do with that makes the difference" Marc Benioff Salesforce.

"Increased use of equipment/technology would help the current care situation"

"Provide equipment to facilitate independence rather than a Package of Care."

Dietitians continue to offer **Health Call** as part of the care they provide when treating malnutrition with oral nutritional supplements. Over 100 patients have used the system and provided very positive comments on how easy it is to use and that it is convenient.

8,500 people in Midlothian are estimated to be living with frailty – the Electronic Frailty Index is a tool to identify frailty across the population.

100 people have been involved in the community malnutrition service

5 GP practices are involved in the Scale-Up Blood Pressure project

Prevention & Early Intervention

- Provide early support and anticipatory care plans to people identified as frail using the eFrailty Index assessment within GP practice computer programmes.
- Provide easily accessible information to the public and local services.
- Use technology to monitor activity to explore risk of falls.

Planned Support, Treatment & Recovery

- **Support people to manage their long term conditions by**:
  - Providing shared overnight support to people with learning disabilities.
  - Supporting people to monitor biometrics through Surgery Pods – in 6 practices/7 locations.
  - Training staff in care homes through videoconferencing.
- **Replace existing analogue telecoms infrastructure with a digital one.**
- **Promote self-help in the mental health field such as the use of computerised cognitive behavioural therapy.**
- **Improve understanding of services by:**
  - Connecting health and social care data to help us understand the needs of the population and the effectiveness of services.
  - Sharing information between health and social care to enable more joined up care.

Unplanned Support & Treatment

- Develop telehealth assessment/review by unscheduled GP care services in care homes with a pilot project planned with Drummond Grange care home.

Appendix – Housing Contribution Statement

Housing's Contribution to Health and Social Care Integration in Midlothian

1. The role of the local housing sector in the governance arrangements for the integration of health & social care

1. The Chief Officer of the Integrated Joint Board is also managerially responsible for the Council's Housing Service. Through this role he is able to ensure that housing issues are recognised and addressed within the context of the Integrated Joint Board.

2. The Strategic Planning Group is able to establish strong links with housing through representation from both the RSL Sector and the Council's Housing Service.

3. Both the Chief Officer and the Chair of the IJB are members of the Community Planning Board and through this are able to influence decisions relating to housing as it relates to the objectives of the Integrated Joint Board.

2. Overview of the shared evidence base and key issues identified in relation to housing needs and the link with health & social care needs

The Housing Need and Demand Assessment (HNDA2) provides a robust evidence base for housing and sets out the total additional future housing estimate over a 20 year period within the six South East of Scotland (SESPlan) Local Authorities - City of Edinburgh, East Lothian, South Fife, Midlothian, the Scottish Borders and West Lothian. The HNDA2 informs the development of the Local Housing Strategy (LHS) and the SESPlan Development Plans (DPs) by providing accurate and reliable data enabling local authorities to develop long term strategic and robust views of housing need and demand. This includes households requiring specialist housing provision.

A shortage of housing and need for significant increases in the supply of housing is an issue for all local authority areas within the SESplan region.

Specifically, section 7.1 of the HNDA2 assesses the need and demand for specialist housing provision across the SESPlan area. It identifies three broad categories of housing need, covering six types of housing or housing related provision, to support independent living for as long as possible and enable people to live well and with dignity. Examples of specialist provision are shown in the table below:

Specialist Housing Provision – Categories of Need and Types of Housing	
Category of Housing Need	**Type of Housing Provision**
Property needs	Accessible and adapted housing
	Wheelchair housing
	Non-permanent housing e.g. for students, migrant workers, asylum seekers, refugees
Care and support needs	Supported provision e.g. care homes, sheltered housing, hostels and refuges
	Care / support services for independent living
Locational or land needs	Site provision e.g. sites / pitches for Gypsies / Travellers and sites for Travelling Show-people

Key Housing Points

Between 2001 -2011, the change in household numbers across the SESplan was 47,334 (9.3%) compared to 2,116 (6.0%) for Midlothian over the same period.
Between 2012 and 2037 the number of households is projected to increase for the SESplan area from 559,838 in 2012 to 700,389 in 2037, representing a 20% increase in households. For Midlothian, the number of households is projected to increase from 35,540 in 2016 to 43,312 in 2037, representing a 22% increase in households. This has significant implications for housing.

Older People

The health implications of an ageing population are likely to impact considerably upon housing and housing related services. From 2001 to 2011, the population aged 65 to 79 increased by 12.7% in Midlothian compared to 8.5% across the SESplan area. The population aged 80+ increased by 23.2% in Midlothian compared to 20.1% across the SESplan area during the same period.

For the period 2014 – 2039 it is projected that the percentage of people aged 75 and over in Midlothian will increase by 106%. This projection shows a rise from 6,566 people in 2014 to 13,542 by 2039.

Physical Disability and Long Term Illness

The Scottish House Condition Survey (SHCS) findings for 2014-2016 show that:

- 41% of households in Midlothian contain one or more long term sick or disabled persons.
- 53% of households where one or more of the members are long term sick or disabled are resident in social housing, 38% are in owner-occupied properties.
- Households containing pensioners comprised the highest percentage of households containing one or more long term sick or disabled (60%), followed by households with adults only with 40% and Families with 27%.
- 8% of households where one or more of the members are receiving care services are in social housing, 4% are in owner-occupied housing. Pensioners, with 12%, have the highest percentage of households where one or more of the members are receiving care services.

Disabled People

In Midlothian 15% of dwellings have some form of adaptation. In social housing this percentage rises to 30% whilst 9% of owner occupied housing have had an adaptation. When looking at household types it should be noted that 28% of pensioner households have had an adaptation carried out compared to 7% of family households and 13% of adult only households.

Homelessness

There are over 1,000 homeless households in Midlothian. In 2017/2018, 485 households were assessed as homeless in Midlothian. It is worth noting that the total number of Midlothian Council housing allocations in 2017/2018 was 313 (this figure includes lets to homeless households, those with health problems, the overcrowded etc). This means the demand for accommodation far exceeds the supply of affordable housing.

3. Shared outcomes and service priorities linking the Strategic Commissioning Plan and Local Housing Strategy

Midlothian Local Housing Strategy
The Local Housing Strategy sets out the key housing issues to be addressed across all tenures in Midlothian, and also sets the strategy for addressing homelessness, housing support, fuel poverty and energy efficiency/climate change.
The Local Housing Strategy's strategic vision for housing in Midlothian is that:

"All households in Midlothian will be able to access housing that is affordable and of good quality in sustainable communities."

Development of the next Local Housing Strategy, covering the period 2019 – 2024 is currently underway. Key actions of the next Local Housing Strategy are likely to relate to the following housing issues:

- The supply of new housing
- Addressing homelessness.
- Housing quality.
- Health and housing
- Energy efficiency and fuel poverty

4. Overview of the housing related challenges going forward and improvements required

Key housing related challenges are closely related to the main challenges identified within the Strategic Plan 2018 – 2022. These are:

1. More people who are frail or have dementia are living for longer at home
2. People are living longer with multiple long term conditions
3. There has been little progress in reducing health inequalities
4. Our services are under pressure

More people who are frail or have dementia are living for longer at home

Most older people wish to remain living independently in their own home and housing providers in Midlothian are able to support this in several ways. Resourcing adaptations to housing is vital to ensure this as is providing suitable housing options for households who are unsuitably housed.

There are various existing sheltered housing and retirement housing complexes in Midlothian. There is also some amenity and wheelchair housing and many homes have been adapted to meet the needs of older people.

Extra Care Housing is also provided for older people. This is more suited for older people with higher care needs and developing accommodation of this type is an important housing option which will reduce the reliance on hospital and care home provision**.** There are currently 2 Extra Care Housing facilities in Midlothian. Midlothian Council manage a 32 flat facility at Cowan Court Penicuik (28x1

bed and 4x2 bed). This was built in 2013, and is fully wheelchair accessible throughout and includes 1 x Intermediate care flat. All care and housing support provided by on-site staff and opt in meals service available for tenants 7 days per week.

There is also a development of 35 extra care flats managed by Trust Housing Association at Hawthorn Gardens, Loanhead. Originally built as sheltered accommodation, the service was remodelled to Extra Care in 2013. All care and support is provided by Trust's on-site staff team. Meals are provided as standard and included in the standard charges to tenants. Midlothian Council's Housing section have 100% nomination rights to all vacancies which arise and manage the waiting list for this facility as part of the nomination agreement.

Both Bield and Castlerock Edinvar Housing Associations have previously been engaged in discussion with Midlothian Council re the option to remodel specific identified sheltered complexes to Extra Care, however both have withdrawn from this process and have deregistered all their facilities to 'retirement' status (definition of 'retirement' being accommodation for people over the age of 60 with part time Housing Manager on site). This means that there is no longer any Sheltered Housing provision in Midlothian. Viewpoint Housing Association currently provide 'very sheltered' accommodation at their Glenesk House site, Avenue Road Eskbank

People are living longer with multiple Long Term Conditions

In Midlothian, 18% of the population are reported to have a limiting long term physical or mental health condition (12,744 people). Long term conditions are illnesses which require ongoing medical care, limit what a person can do and have a clear diagnosis.

In Midlothian, 42 adults are identified as having a learning disability and complex needs. A further 21 people are younger people who also have complex needs and are likely to need specialist housing provision now or in the near future. Health & Social Care and Housing recognise the need for a more proactive approach to providing sustainable and good quality housing for people with a Learning Disability in Midlothian as demand for housing increases and pressure on services grows. The pressures arise from a number of factors including population growth, an emerging generation of young people with new and more complex needs, and older people who are currently living with a relative or carer.

The two key elements of any successful support package are a suitably adapted environment alongside specialist support, and this can be difficult to coordinate without the right housing options. For people with the most complex needs the preferred model of support is provided within a core and cluster model, with flexibility built in to respond to changing needs. This type of model allows for flexibility to be built into care packages for people who typically would have their support provided on a 1:1 or 2:1 basis giving options to improve effectiveness and efficiency of Supported Living Services, including in relation to use of sleepovers.

For people with a more moderate Learning Disability any clustering arrangements can be more dispersed and often delivered within more mainstream housing within any given locality.

To meet this need Midlothian Council has developed Teviot Court in Penicuik, a housing development which meets the specific needs of households with a learning disability and complex care needs. Following this Housing continues to work alongside Health & Social Care's Learning Disability colleagues to identify specific sites under the New Build programme suitable for consideration for purpose build Learning Disability accommodation, and are specifically looking at

a development of around 12 units in Bonnyrigg. Housing will also continue to work in partnership with the Learning Disabilities team to identify and allocate mainstream properties to clients in cases where this type of accommodation meets required need.

Midlothian Council and other Registered Social Landlords have also adapted existing housing stock to meet the specific needs of householders with Long Term Conditions.

The need for specialist provision is likely to increase as the number of people with Long Term Conditions continues to rise.

There has been little progress in reducing Health Inequalities

It is very important that low income groups have access to good quality affordable housing in the community that they belong too. For many disadvantaged groups access to affordable housing will help to address health inequalities. Poor housing can lead to a range of health problems and lack of affordable housing will lead to some households being more at risk of poverty. While there has been significant investment in new housing in Midlothian with 3,102 additional affordable homes built in the past decade the number of households requiring new housing is projected to increase.

In addition, it is recognised that people living in the most deprived communities are more likely to have poorer physical and mental health throughout their lives. In addition, it is likely that in the most deprived areas, Midlothian Council and other Registered Social Landlords will have a significant number of tenants in these areas. Therefore, housing providers can play an important role in addressing health inequalities in areas of deprivation in particular. Actions to effectively address health inequalities include:

- Identifying and engaging with disadvantaged groups who are likely to experience health inequalities in their lives.
- Investment in new, good quality homes in the private sector and social rented sector.
- Preventing at risk households from becoming homeless and ensuring that homeless households are able to access settled accommodation which meets their needs.
- Empowering communities by, for example, working in a co productive way to achieve common goals to give people a greater say in how services are delivered in their area.
- Support local initiatives to increase training and employment opportunities.
- Providing welfare benefits advice
- Reducing the number of households living in fuel poverty by improving the energy efficiency of properties, sourcing cheaper energy options and providing support and advice services for those in fuel poverty or at risk of fuel poverty.

Our services are under pressure

It is acknowledged that financial pressures on the health service are severe and there are ways to ensure that housing services can assist in addressing some of these pressures. Housing and housing support providers can play a positive role in preventing hospital admissions and reducing the length of time that people stay in hospital. Approaches which could ease pressures on the NHS could be:

- Ensuring adaptations are progressed quickly to reduce the length of hospital stays.
- Ensuring that there is a supply of suitable adapted temporary accommodation which can be made available to reduce the length of hospital stays.
- Ensuring that new housing is suitable for easy to undertake and cost effective adaptations or reduce the costs involved, such as barrier free entry into houses.

- Providing housing support services to ensure that vulnerable households are supported to sustain their tenancies and are equipped with life skills to avoid acute medical services, such as emergency hospital admission for substance misuse.

A review of the 2012/13 major adaptation works illustrates a significant rate of spend in the private sector, with 47.8% of all spend on adaptations in owner occupied and private rented sectors identified as necessary works for older people. This is in comparison to 27.5% spent on Council tenancies and remaining 24.8% on Registered Social Landlord (RSL) tenancies. More up to date spend information, broken down by tenure is not available.

- Private sector (owners & private rented) 47.8%
- Council tenancies 27.5%
- Registered Social Landlord tenancies 24.8%

Table 1 and 2 shows the level of adaptations being undertaken in council housing and in the private sector in Midlothian in recent years. In terms of council housing, wet floor shower rooms and ramping were the most commonly required adaptations carried out.

Table 1: Council Housing Adaptations in Midlothian 2013/14-2016/17

	2013/14		2014/15		2015/16		2016/17		
	Spend	**No**	**Spend**	**No**	**Spend**	**No**	**Spend**	**No**	**Total**
Wet floor shower	£341,675	57	£367,701	63	£194,656	34	£50,427	8	162
Level access shower	£220,350	37	£0	0	£17,905	3	£6,052	1	41
Access ramp	£25,908	9	£0	0	£23,040	6	£6,202	3	18
Bathroom adaptation	£0	0	£0	0	£32,230	5	£12,215	2	7
Other	£0	0	£0	0	£6,885	2	£8,173	1	3
Total	£587,933	103	£367,701	63	£274,716	50	£83,068	15	231
	Total Spend £1,313,419				**Total Adaptations**			**231**	

Note: Other includes adaptation works to bedroom, electrical works – data for 2016/17 only covers si months of 2016/17 which is why figures are lower in this year.

Table 2, below, shows the level of investment, total number and types of adaptation works on housing in the private sector namely owner occupied and PRS housing between 2014/15 and 2016/17. Of the 257 adaptations that were completed during this period, the most types of works were level access showers (150) and Stairlifts (79). These works accounted for over 90% (£1.03 million) of the total £1.221 million adaptation budget during this period. Of the total private sector adaptation budget, 85% were to owner occupied housing compared with the remainder to households who rented privately.

Table 2: Private Sector Adaptations in Midlothian- 2013/14-2016/17

Private Works Type	**Total - 2014/15**			**Total - 2015/16**			**Total - 2016/17**		
	Spend	No	**%**	**Spend**	No	**%**	**Spend**	No	**%**
Level access shower	£307,995	60	64%	£248,861	46	55%	£268,772	44	55%
Bathroom adaptation	£0	0	0%	£10,952	2	2%	£64,723	5	6%
Access ramp	£14,451	4	4%	£1,646	1	1%	£8,421	3	4%
Stairlift	£71,448	27	29%	£77,886	31	37%	£58,911	21	26%
Other	£8,386	3	3%	£8,326	3	4%	£70,961	7	9%
Total	**£402,281**	**94**	**100%**	**£347,671**	**83**	**100%**	**£471,788**	**80**	**100%**

5. Housing-related actions which contribute to Health and Social Care Outcomes in Midlothian

New Housing Development

Midlothian's Local Plan provides a sufficient land supply to meet local needs, and all new housing being developed will meet modern building regulations which are designed to better meet particular needs. For example new build housing will have level access to ground floor accommodation and improved circulation spaces within homes.

Midlothian's Strategic Housing Investment Plan 2019/20 – 2023/24 has identified sites for the development of up to 2,202 new affordable homes during this period. These are being developed by the Council and other local Registered Social Landlords. A total of 239 specialist provision homes have been identified which is 11% of the total. However, a much higher number of homes than this is likely to be suitable for those with impaired mobility but not requiring specific adaptations.

- 81 homes are being planned as extra care housing
- 104 homes are being planned as amenity housing
- 12 homes are being planned for complex care needs
- 5 wheelchair houses are being planned
- 4 homes are being planned for bariatric accommodation
- 34 homes with level access shower rooms are being planned

Current Extra Care Housing Projects in Midlothian

Gore Avenue, Gorebridge (Midlothian Council)

- 12 fully wheelchair accessible bungalow units (10 x 1 bed and 2 x 2 bed) to be built.
- 2 x 2 bed units will be suitable for individuals with bariatric needs (weighing more than 25 stone).
- Care provision and housing support will be provided by a dedicated on site team of staff.
- Estimated completion summer 2021.

Newmills Road, Dalkeith (Midlothian Council)

- 40 flats and 8 bungalows to be built.
- Will include 2 bariatric bungalows.
- All care and housing support will be provided by a dedicated on site team of staff.
- Estimated completion 2021.

Glenesk House, Eskbank (Viewpoint Housing Association)

- 30 extra care flats are proposed for development within the grounds of Glenesk House, Eskbank.
- Estimated completion autumn 2020.

Existing Midlothian Council Housing Stock

- Housing are currently working in partnership with Health & Social Care to identify properties potentially suitable for remodelling to core and cluster extra care housing.

Other Sites

- Health & Social Care are working with Housing to identify further areas for developing extra care housing.

Housing / Occupational Therapist Partnership

Health and Social Care staff meet with housing representatives on a quarterly basis to review the need for specialist provision and consider further provision where required in order to address emerging needs.

Current Areas of Work:

- New adaptation policy drafted by Health and social care occupational therapists in partnership with Housing Services.
- Improved partnership working and regular communication between Housing and Health & Social Care to identify suitable clients with priority for previously adapted properties.
- Regular communication between Housing and Health & Social Care to identify possible housing solutions for specific identified cases with complex needs.
- Ongoing input to the Housing New Build Plan – next phases of New Build sites will include an increased proportion of wheelchair accessible accommodation, ground floor accommodation with facilities such as level access showers, bariatric accommodation.

- Four staff from Health and Social Care and Housing are now qualified as trainers to run Housing Solutions training which is supported by iHub. The training is aimed at supporting all staff across health, housing and social care to have earlier conversations about housing and trying to prevent these discussions occurring too late.

Homelessness and Rapid Rehousing Transition Plan

Midlothian Council's 5 year Rapid Rehousing Transition Plan (RRTP) details the authority's plans to provide short and long term solutions to end homelessness and rough sleeping. It notes that there are over 1,000 homeless households in Midlothian and it can take many years for these households to access permanent housing. The Plan was submitted to the Scottish Government in December 2018 and will take a housing led approach towards rehousing people who have experienced homelessness; making sure they reach a settled housing option as quickly as possible. The Plan will also detail the approach intended to rapidly rehouse those with multiple and complex needs. Housing first is one model which will provide intensive support to individuals with the most complex needs by providing the individual with a tenancy and intensive support at the outset of their homeless application.

It is likely that existing strategic planning groups and structures will develop and review the Rapid Rehousing Transition Plan to ensure the correct resources collaborate towards early intervention and preventing negative outcomes and the demand for costly crisis services. In particular, housing staff will work in partnership with health and social care teams to implement the Health and Homelessness Action plan which is focused on ensuring that the health and wellbeing needs of this vulnerable group are being addressed. It will also support ways of working which can help prevent homelessness and ensure those with the most complex needs are able to access appropriate support for their needs.

Funding for fuel poverty and energy efficiency

There are various funding streams which support improved energy of housing stock, and which contribute to the reduction in fuel poverty. Whilst landlords and owners can be proactive in improving the energy efficiency of housing, the Scottish Government also funds several programmes which help improve energy efficiency or support households at risk of fuel poverty. The Home Energy Efficiency Programmes for Scotland: Area Based Schemes are designed and delivered by local authorities, targeting fuel poor areas, to provide energy efficiency measures to a large number of Scottish households while delivering emission savings and helping to reduce fuel poverty.

The Scottish Government's 'Warmer Homes Scotland Scheme' is specifically for vulnerable owner occupiers and tenants of private landlords who can access help to make their homes more energy efficient and reduce fuel bills.

The Energy Saving Trust manages delivery of the other Home Energy Efficiency Programmes for Scotland through the Home Energy Scotland hotline on behalf of the Scottish Government in partnership with a range of advice providers and the energy companies. They offer energy efficiency advice, information on low cost energy tariffs, and advice on income maximisation, as well as a wide range of energy efficiency measures.

Midlothian residents also currently benefit from a funding grant from the Big Lottery Fund. The environmental charity Changeworks will deliver the 'Canny Tenants' project until 2020 in Midlothian and the Scottish Borders in partnership with Eildon Housing Association, Melville Housing Association and Midlothian Council. Thanks to a £494,180 grant from the Big Lottery Fund, the project aims to bring about positive change for local people in the greatest need. This includes people who are in debt as well as older people and those who have been homeless or in the care system. A wide range of support is available ranging from home visits and budget management training, to help with using heating more efficiently and advice on cutting down on food waste

Intermediate Care Housing

Housing now work with Health and Social Care to provide intermediate care/ temporary accommodation for individuals who require:

- To await permanent offer of suitable housing from Midlothian Council;
- To await completion of adaptations / repairs / provision of specialist equipment in their existing property;
- To await provision of appropriate care package / support services at home;
- To provide a period of ongoing intermediate care and rehabilitation where other intermediate care facilities are assessed as inappropriate for the needs of the individual;
- To enable a period of assessment re an individual's level of care and support needs, and suitability for Extra Care Housing or other types of accommodation.

Further intermediate care flat provision has been will be included on future extra care housing sites, however work continues between Housing and H&SC to identify other potential properties throughout Midlothian which could be used for this same purpose. The aim is to ultimately have 4-5 in the area located in Dalkeith, Bonnyrigg, Penicuik, Gorebridge and Newtongrange, however

other areas will also be considered depending upon the suitability of any identified property.

Support To Move

- 'Support To Move – A guide for people in Midlothian' has now been published in conjunction between Health & Social Care and Housing and offers a series of hints and tips for both professionals and their clients and families at each stage of moving house, from deciding whether or not they want to move or stay, choosing the house that's right for them, right through to planning and making the move. The guide is available on the Midlothian Council website and in all Midlothian Libraries.
- Work ongoing to develop a separate Housing Options brochure providing details of Amenity, Retirement, Wheelchair, Sheltered, Very Sheltered and Extra Care facilities in Midlothian.
- Support to Move Service – initial discussion has taken place around the viability of a Support to Move Service in Midlothian. One of the biggest challenges when encouraging people to

consider a move to more suitable accommodation is simply the prospect of the planning, organising and actually moving itself.

Care & Repair Services

The principal objective of Care & Repair services operating in Scotland is to offer independent advice and assistance on adaptations, repairs and improvements to owners and private tenants who are over the age of 60 and provide the following core services.

- Information and advice on property related issues
- Major adaptations and repairs – assistance with identifying repairs and improvements, preparing specifications, obtaining quotes, and monitoring works
- Handyperson services – assisting with straightforward small repairs
- Small repairs service – assistance with small repairs that require more specialist skills and knowledge.

Midlothian currently has no Handyman or Care & Repair service and indeed is the only Local Authority in Scotland not have any such service.

Summary of key housing-related actions between 2019 and 2022

- Develop 1,000 new council houses in Midlothian, taking account of housing need and demographic changes.
- Develop at least 81 extra-care homes in Midlothian by 2022.
- Develop at least 101 new amenity houses in Midlothian by 2022.
- Develop 4 bariatric properties in Midlothian by 2022.
- Develop 12 units for households with learning disability and or complex care needs by 2022.
- Develop an increased number of new homes with adaptations for specialist provision by 2022.
- Support homeless households accessing housing first tenancies (approximately 15 per annum) for those households with complex needs.
- Continue to support improved health and wellbeing outcomes for homeless households by implementing the Health and Homeless Action Plan
- Increase the number of households accessing energy saving or fuel poverty advice and assistance schemes.
- Undertake feasibility study of delivering Care and Repair Services in Midlothian.
- Undertaken feasibility study of providing a Support to Move Service to provide advice and assistance to help households move to more appropriate housing.
- Deliver further Housing Solutions training sessions to Health and Social Care staff and other partner organisations.
- Increase the number of intermediate care properties by using 6 Midlothian Council properties for intermediate care.
- Ensure a reduction in major adaptations due to improved targeting of adaptations in appropriate housing.

COMMUNICATING CLEARLY

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

如有需要我們樂意提供翻譯本，和其他版本的資訊與刊物，包括盲人點字、錄音帶或大字體。

Zapewnimy tłumaczenie na żądanie oraz dostarczymy informacje i publikacje w innych formatach, w tym Braillem, na kasecie magnetofonowej lub dużym drukiem.

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Körler icin kabartma yazilar, kaset ve büyük nüshalar da dahil olmak üzere, istenilen bilgileri saglamak ve tercüme etmekten memnuniyet duyariz.

اگر آپ چاہیں تو ہم خوشی سے آپ کو ترجمہ فراہم کر سکتے ہیں اور معلومات اور دستاویزات دیگر شکلوں میں مثلاً بریل (نابینا افراد کے لیے اُبھرے ہوئے حروف کی لکھائی) میں، ٹیپ پر یا بڑے حروف کی لکھائی میں فراہم کر سکتے ہیں۔

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