Adult and Social Care Service Plan

2019-20

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1. ADULT AND SOCIAL CARE SERVICE OVERVIEW

Setting the Scene

This Service Plan has been developed and will be delivered during a time of continuing major change in public services. The new arrangements for integrated health and social care services went live on 1st April 2016. Services to offenders have been reorganised to be delivered locally through the new Community Justice Partnership which took effect from 1st April 2017. Partnership working is vital to the preventative agenda in health and care and the Community Empowerment Act 2015 makes it clear that Community Planning is the process by which public bodies must work together alongside natural communities to plan for, resource and provide services. This changing landscape is taking shape during a climate of very severe financial constraints with unprecedented pressures on the Local Authority budget alongside increasing demand arising from the growing and ageing population.

Midlothian Strategic Plan and Client Group Plans

It is now a legal requirement to produce a Strategic Plan for Health and Social Care. The local Health and Social Care Partnership is finalising its second such plan for the period 2019-22 and, given the commitment to integrated working, this document provides the basis for this Adult and Social Care Service Plan. This service plan will sit alongside a range of client group specific plans and plans for the development of our resources such as the local Care Home Plan and the Extra Care Housing Plan.

There are a number of key themes in the Strategic Plan which require us to place greater emphasis upon delivering services which promote the prevention agenda; address health inequalities; support people with long-term conditions; give priority to public protection; ensure coordinated care; and recognise the crucial role of unpaid carers. As part of our local reorganisation, services will be planned and delivered for i) older people and ii) for adults with disabilities, long term conditions and/ or ongoing health issues. The service plan has been written to reflect these new arrangements.

Consultation

There is a well-established programme of public, and staff, engagement including surveys and public engagement events. Over the past year we have undertaken a comprehensive programme of consultation in contributing to the development of the IJB Strategic Plan 2019-22 with, for example, over 1400 people responding to our written survey. Our mechanisms for consultation are detailed in Appendix D.

Equalities

The major new responsibility of the Integration Joint Board is to address Health Inequalities. This is being pursued in close collaboration with other Community Planning partners who agreed that addressing inequalities was its main objective during 2016-19 and this focus continues to be a priority in the Single Midlothian Plan.

Sustainability

The objective of integration is to ensure long term sustainability of health and care services in the face of growing demand, ageing and increasing population, and reducing finance. This will be achieved through a greater emphasis on prevention and recovery; through a more skilled and flexible workforce; through stronger working with local communities; through innovation and the application of technology; and by designing more cost effective ways of supporting people with very high levels of need.

2. KEY SUCCESSES IN 2018-19

a. The move towards more integrated health and care arrangements is evidenced in a range of joint plans including an Annual Delivery Plan, a Property and Housing Strategy, a Financial Strategy, an Annual Performance Report, and a Workforce Framework. These all help underpin a joint approach to the delivery of health and care services. More integrated management arrangements have been implemented at third tier level which will facilitate the delivery of more seamless frontline services.

b. There has been a continued emphasis on preventative services including local area coordination, day services and the Ageing Well programme. The Frailty Project being undertaken in partnership with GP Practices enables the identification of people at an earlier stage allowing early intervention and support alongside coordination and continuity of care.

c. There has been continued development of more intensive services to avoid hospital admission, support discharge and enable rehabilitation. Capacity in Highbank Intermediate Care, and Hospital at Home has increased while NHS rehabilitation beds are now provided locally in Midlothian Community Hospital. A Midlothian Flow Hub has been established in 2018 which will enable people to be discharged from Acute Hospitals to the most appropriate local service, in a more timeous and coordinated way.

d. The redesign of Learning Disability Services has continued with the development of a new local day service for young people. The extensive programme of care package reviews has continued with the aim of ensuring care arrangements are adjusted to take account of changing need, new policies and new approaches to delivering care. As of 2018 no one from Midlothian with a learning disability lives in a hospital setting.

e. The Carers Act (Scotland) 2016 has now been fully implemented with the provision of Adult Carer Support Plans including Emergency Care Plans. In response to the Act some changes have been made to the provision of respite care including a new investment of £30,000 in the Short Breaks Service.

f. The Mental Health Access Point and the Wellbeing Service, now rolled out to all GP Practices, have increased our capacity to respond proactively to people with complex lives and common mental health needs. Detailed planning and preparation has been undertaken for the new Dalkeith Recovery Hub which will provide more integrated services in Mental Health, Substance Misuse and Services for Offenders.

g. There has been some good progress in improving the quality of our services with positive care inspection grades received for Newbyres Care Home, Cowan Court, Cherry Road, Highbank and the SVQ Assessment Centre.

3. SERVICE CHALLENGES AHEAD

1. This coming year will continue to entail wide ranging transformation in both the organisation and delivery of health and social care services. To ensure a managed approach to these changes a Transformation Board, *Realistic Care Realistic Medicine*, has been established. Alongside the redesign of services there is a continuing need to support people to manage their own conditions more effectively, supporting a growing understanding of the need to change our expectation of health and care services.

2. Following the implementation of integrated management teams within the HSCP, the review and reshaping of social work fieldwork services will be completed. This will enable stronger joint working with health services. We will also consider how to build on the learning from the Penicuik Collaborative project (multi-disciplinary/multi-agency teams) in considering how to strengthen interagency working at locality level.

3. The move to the provision of a Recovery Hub during 2019 provides a great opportunity to strengthen services to people with mental health needs, substance misuse needs and people involved in the criminal justice system.

4. The changing demographics, a growing and ageing population, alongside a reducing financial envelope mean it is essential that we change the emphasis of service delivery towards prevention; recovery wherever possible; and care and treatment at home. These shifts have major implications in relation to workforce-recruitment, retention, skill mix and partnership working, as well as public expectations and historical models of care.

5. In relation to older people we know that there will be many more people who are frail, have dementia and/or are living longer with multiple long term conditions. We also know that isolation and loneliness are widespread and is detrimental to mental and physical wellbeing. We must focus more effort on working closely with natural communities to prevent and militate against the impact of people living on their own, who are restricted in their ability to have meaningful contact with others.

6. The financial constraints facing the Partnership mean it is critical that we continue to review and redesign how we provide services to people with complex care needs. Some packages of care are in excess of £250k per annum and approximately 35 service users account for over £5m of the community care annual budget. Following the opening of the 12 bedded unit in Penicuik for people with complex needs plans are being made to develop new shared housing models which will be critical in meeting this challenge, alongside implementing a more localised approach to the delivery of 'Positive Behavioural Support'.

7. The greatest challenge facing the service continues to be the provision of high quality Care at home services with the capacity to respond to assessed need. The continued shortfall puts a strain on the whole system including acute hospitals, reablement services and of course family/unpaid carers. It is also a service which requires a high level of investment yet with the financial pressures on the whole system there is a requirement to make savings of £400k through improved efficiency including reduced levels of sickness absence. It remains the highest risk to the Partnership and despite significant recent improvements; there is a need to consider alternative long-term arrangements to ensure sustainability.

4. SERVICE WIDE PRIORITIES

Locality Working: One of the key objectives of integration is to improve the delivery of more joined up care to service-users. This requires more effective working at a local level including stronger working at community level between social care, primary care and independent providers and more localised delivery of NHS Lothian services. We will learn the lessons from the Collaborative Leadership Programme in Penicuik and roll this out to other communities.

Wellbeing: The emphasis on prevention must be translated into services which support this approach. Reducing isolation; supporting people with common mental health problems; and easy access to advice on physical activity and healthy eating are all approaches which we must strengthen. The development of proactive responses to people identified as 'frail' will be one substantial initiative in reducing isolation and supporting people to be active. We will also work closely with the Sport and Leisure Service to promote the benefits of physical activity. In relation to mental wellbeing there are a number of relatively new services and work will be undertaken to ensure that these provide a coherent approach to addressing the wide spectrum of issues referred to as 'common mental health concerns'.

Health Inequalities: One of the main objectives of Integration has been to bring fresh energy and a new approach to addressing health inequalities. Whilst this is heavily dependent upon the broader Community Planning Partnership being able to address poverty and unemployment, social care services can play an important role in work with individuals and by targeting resources to areas/client groups particularly vulnerable. The development and implementation of a Diabetes Strategy and participation in the Lothian wide programme (hosted by Midlothian) "Improving the Cancer Journey" are two initiatives which will contribute to this priority.

Public Protection: Protecting people from any form of abuse remains a key responsibility of social work alongside an increasing role for health staff. We continually seek to strengthen practice through training, improved interagency working and systematic auditing.

Workforce planning and development: Ensuring the recruitment and retention of a skilled committed workforce is critical to the successful delivery of social care services. Work will continue on the Organisational Development Programme for Integration. We have established a Midlothian Council SVQ Centre and have collaborated with NHS Lothian to deliver SVQs for their new Modern Apprenticeship Healthcare Support staff (18 staff). There remains a continuing need to reduce the costs and impact on service delivery of staff absence rates.

Assessment and Care Management: There is a need to establish ways of working which provide more coordinated care; provide greater continuity of care; and supports the approach which anticipates changing needs through emergency planning and anticipatory care planning. Crucially we must enable a shift towards more "Realistic Care" given the very significant pressures there are on increasing demand and our workforce capacity. This will become a clear focus once the new fieldwork arrangements have been implemented.

Community Based Services: The need to continue our focus on shifting the balance of care is evidenced by continued severe pressures on acute hospitals and increasing reliance upon care homes. The planned investment in extra care housing will make a significant contribution to this aim.

5. SERVICE SPECIFIC PRIORITIES

OLDER PEOPLE

Reducing Avoidable Admissions and Unnecessary Delays in Acute Hospitals: This remains a key priority as there is considerable scope to improve the efficiency of the health and care system. We will continue to aim to reduce delayed discharge and work as efficiently and safely as we can towards the national target. Alongside this we will strengthen services to reduce the incidence of repeat emergency admissions through Midlothian Rapid response team, Midlothian Hospital at Home team and Midlothian Community Respiratory team. Early supported discharge will be managed throughout Flow Hub and supported by a new Discharge support team, who will focus older people's medicine and orthopaedics.

Promoting Wellbeing and Recovery: Longer term there is no doubt that we must enable people to stay well; recover from periods of ill health; and live well with Long Term Conditions. Strengthening responses to isolation and increasing our capacity to provide local rehabilitation including through Intermediate care will be vital.

Supporting People with Dementia: The single biggest impact of an ageing population is the increasing numbers of people with dementia which is set to double over the next 20 years. The establishment of a Single Dementia Team, the redesign of Newbyres, Service initiatives flowing from the 8 Pillars Dementia Demonstrator project, and reviewing our care home model to progress to a proactive multidisciplinary model, including physical and mental health and wellbeing, are all key actions to help respond to this growing need.

Care Homes: A Care Home strategy will be implemented and supported by a Care Home multidisciplinary team. This team will support all Care Homes to improve quality of care, and will work in partnership with providers to ensure a proactive model of care and support in in place. The team will also lead the development of comprehensive Anticipatory Care planning across all Care Homes.

Care at Home: The service will continue to improve efficiency and outcomes, and will look to further develop relationship with external providers to maximise capacity. The service will undergo a service redesign, looking to provide a more structured model, incorporating new roles to provide the team with opportunities to have a career in care. We will continue to develop our work in the establishment of Care Academies, as well as host an annual Faces of Care recruitment campaign with partners.

ADULTS

Supporting People with Long Term Conditions: There is a growing recognition that the national and local focus on the needs of older people has perhaps masked the needs of younger people living with long term conditions. We know this is more common for people living in relative poverty and is often associated with low level mental health problems. A range of initiatives including House of Care and the TCAT project (cancer) will help provide a more proactive approach.

Common Mental Health Problems: Services for people with acute mental health needs are well organised and effective in supporting people outwith hospital settings. The high level of people with common mental health needs such as anxiety, depression is reflected in 16% of the population being on medication as a result. Further work with the voluntary sector will be the main route to adopting a more proactive approach including for people with both mental health and substance misuse problems.

Reshaping Substance Misuse Services: The direction of travel is to give much more priority to supporting recovery through initiatives such as peer support.

Transforming Learning Disability Services: Community based services for people with learning disability can be very expensive for those people with complex needs. We will continue the transformation of local services including through the provision of redesigned day services and services offering positive behavioural support.

6. KEY ACTIONS FOR 2018-19

SERVICE WIDE

Health Inequalities

- Participate in the area targeting programme.
- Provide staff training on inequalities and poverty.
- Maintain and strengthen links with new local services e.g. Community Health Inequalities Team and the Thistle Project.
- Implement new approaches to preventing and addressing the needs of people with long term conditions including diabetes, cancer and COPD.

Assessment and Care Management

- Strengthen multiagency arrangements and more localised approaches involving the workforce in the Community Care Team.
- Continue to address waiting times for Occupational Therapy and Social Work.
- Establish sustainable ways of undertaking care package reviews.
- Contribute to future planning through anticipatory care planning, emergency care planning for unpaid carers and the 'Housing Solutions' approach.
- Arrange care packages in a way which maximises the capacity of families and communities and takes account of the public sector financial constraints.

Carers

- Seek to identify hidden carers in response to the national Health and Wellbeing Survey which highlighted a low level of satisfaction in Midlothian.
- Fully implement the structured and comprehensive approach to the provision of Adult Carer Support Plans including emergency planning for carers.
- Continue to evaluate how to respond to the needs of carers including access to respite care, peer group support, benefits advice and pressures from caring arising from also being in employment

Service Planning and Redesign based on Data and Public Feedback

- All planning groups will consider the outcome of the Joint Needs Assessment completed in 2019
- All planning groups and service managers will consider the outcome of the public engagement undertaken in 2018 and continue to stay close to service users in relation to their experience of services.

Technology

Midlothian HSCP have agreed to be a "Digital first" organisation, and will look to invest in Technology where this will add value to pathways of care. We will continue to work with Scottish Government TEC directorate to support redesign of local models of care for older people, as well as collaborate with Digital Health Institute on tests of change to integrate new products into the health and social care system. Midlothian will also focus on a data driven approach to service transformation, and will continue to invest in data systems and workforce.

As part of a broader approach to the application of technology in health and social care we will progress the following specific projects.

- Frailty - Identify at an earlier stage people who are frail in order to proactively provide support. This will focus on moderated to severe frailty, and will support the *Mid Med* test of change.

- Video consultations: AHP and Nursing teams will implement video consultation into patient pathways, ensuring safe and faster access to health and social care services.

- Development of an integrated service performance dashboard that will support operational decision making in times of pressure, will provide health and social care data in an integrated report, supporting teams to make decisions in a proactive, data driven way

- Data Visualisation - Explore creation of a social care data set to support business intelligence and therefore service planning.

- Analogue to Digital – Continue to progress preparation of a replacement plan for analogue telecare equipment which will become obsolete due to upgrade of national telecom structure by 2023.

OLDER PEOPLE

MERRIT

Review and redesign of Rapid Response pathways.

Invest in development of the COPD pathway including the COPD Advanced Physiotherapy service.

Review of the Hospital at Home model

Intermediate care

Review and implementations of refined intermediate care pathways to ensure that people access the service most appropriate to their needs.

Highbank

Upon approval from Council, planning has now commenced to re-provide Highbank Intermediate Care facility, with an estimated date for summer 2020.

Falls Strategy

Develop and implement a Falls Prevention Strategy.

Day Support

Review model of day support services to reduce isolation. This will include exploring how to increase the involvement of volunteers. This issue will link to the work being undertaken in Penicuik with housebound people and also to the *eFrailty* project.

Extra Care Housing

Prepare for the re-provision of special accommodation in Gore Avenue and develop more specific plans for the provision of extra care housing for older people in Dalkeith.

Care Homes

Review the current capacity and quality of local provision with a view to developing a local commissioning strategy in collaboration with neighbouring Authorities. Implement the Care Home strategy and continue to develop the model of care though our new Care Home team.

Care at Home

Finalise the review of Care at Home and establish new models of care that supports a sustainable approach to the delivery of care at home,. This should both generate efficiencies as well as improving quality and capacity.

Frailty

Work with Primary Care to provide a proactive approach to people identified by GPs as being frail, through the development of the e-frailty project.

ADULTS UNDER 65

MENTAL HEALTH

Midlothian Access Point

Expand Midlothian Access Point as the route into mental health services. Enhance social prescribing as an alternative to medication for people with common mental health issues. Alongside this we will test and evaluate the role of primary care mental health nurses initially in 4 GP practices.

Mental Health Rehabilitation

We will Implement and evaluate Wayfinder Grade 4 support and accommodation and rehabilitation pathway including hospital in patient and transitional Grade 3 support for people living in their own tenancy.

Employment Support

Embed an Individual Employment Support model within the Joint Mental Health team to support employment opportunities for people with mental health problems.

Recovery Hub

Implement a Recovery Hub for people with mental health and/or substance misuse needs.

Working with People in Crisis

Review and strengthen our support arrangements for people in crisis including those for whom the Police are the first line of response.

Trauma

Develop and implement a strategy to address the needs of people whose lives continue to be affected by earlier trauma.

LEARNING DISABILITY

Housing Options

Continue to develop the range of properties available to individuals with Learning Disabilities to ensure accommodation maximises independence and supports sustainable delivery of care needs

Challenging Behaviour Service

Implementation of a multi-disciplinary and multiagency framework to provide support to individuals that present with challenging behaviour

Day Services

Complete the review and redesign of day services reducing costs including transport.

Reviews

Continue the programme of reviews of all high packages of care and establish long term sustainable arrangements for reviews. Reduce the average length of time since last review

SUBSTANCE MISUSE

Substance Misuse Service Redesign

Reshape local services to reflect changes in funding and emerging National priorities. Ensuring the balance of spend within a balanced budget reflects commitment to prevention, treatment and recovery.

Recovery Networks and Peer Support

Adult and Social Care Service Plan 2018-19

Continue work of Peer Support Co-ordinator in embedding Peer Support provision in new Recovery Hub.

OFFENDERS

Health Inequalities

Work with the Communities Health Inequalities Team to help address the poorer health experienced by people who have offended.

Domestic Abuse

Improve staff awareness and responses to domestic abuse.

Rape

Strengthen our response to people who have been victims of rape including joint work with the specialist voluntary organisation.

LONG TERM CONDITIONS, DISABILITY & SENSORY IMPAIRMENT

Integrated Approaches

Develop integrated approaches across health and social care to the enhance support to individuals with Physical Disabilities / Long Term Conditions

Cancer

Plan how best to maintain a service to people with cancer following the cessation of the TCAT Project building on the new "Improving the Cancer Journey" programme being undertaken in collaboration with Macmillan.

Employment

Continue to work with the employability service and specialist employment agencies in sensory impairment, cancer etc.

Audiology

Fully implement plans for the local provision of audiology clinics and hearing aid repairs.

Sensory Impairment

Continue to expand and promote the services provided by Deaf Action and RNIB at a local level. Finalise the Midlothian British Sign Language plan and work towards the implementation of it.

Diabetes

A community planning focus on Diabetes prevention and management is underway, and will continue to focus on lifestyle and self-management, as well as support Midlothian to be a local authority who has an all-encompassing approach to health and wellbeing.

COPD

A continued approach to manage COPD is in development, as well as a locality wide plan for prevention, working with GPs and across agencies to provide a coordinated approach to care.

7. MANAGEMENT ARRANGEMENTS AND RESOURCES

New more integrated Health and Social Care Services management arrangements were put in place during 2018/19 and this will be followed by the implementation of the review of frontline services. Workforce Planning, Team Development and individual Team Planning will be key approaches to ensuring these new organisational arrangements lead to improved service delivery.

During 2018-19 there has been a range of activities undertaken which fall within the broad principles of self-evaluation whereby we have sought to look critically and with fresh eyes our effectiveness across a range of services. This has included the preparation for the new three year Strategic Plan based partially upon an updated Joint Needs Assessment and on the outcome of a comprehensive public and staff engagement programme. Staff in the partnership also participated in the *iMatter* programme which facilitates staff feedback in relation to organisational and team functioning.

At an individual service level the registered services have undertaken **self-assessments** in preparation of Care Inspectorate visits. We have also continued to critically review our approaches to workforce planning and to the allocation of resources through the Realistic Care Realistic Medicine Transformation Board.

As key elements of our transformation we have also undertaken specific **self-evaluation** exercises in areas such as Learning Disability Day Services; Care Homes and Care at Home. In preparation for the establishment of a Recovery Hub work has been undertaken to review our approach to the provision of services in mental health, substance misuse and criminal justice The addition of new funding from Scottish Government in all three areas has contributed to the value of this exercise.

Health and Social Care

Adult and Social Care - Delegated to MIJB

	Budget	
	2018/19	2019/20
SERVICE FUNCTION	**£**	**£**
Addictions	29,266	29,266
Assessment and Care Management	3,083,354	3,277,789
Criminal Justice	4,825	4,595
Learning Disability Services	12,500,339	12,818,988
Management and Administration	102,381	104,493
Meldap	192,383	209,778
Mental Health Services	790,266	790,266
Non Specific Groups	1,056,190	1,056,190
Older People	17,145,944	19,472,010
People with AIDS/HIV	(32,778)	(32,778)
Performance and Planning	587,942	608,254
Physical Disability Services	3,294,892	3,294,892
Public Protection	398,563	413,603
Service Management	293,627	308,729
Strategic Commissioning	278,709	295,997
NET EXPENDITURE	39,725,903	42,652,072
SUBJECTIVE ANALYSIS		
Employee Costs	16,845,595	17,746,381
Premises Costs	163,067	187,734
Transport Costs	1,390,115	1,392,716
Supplies and Services Costs	937,039	937,039
Third Party Payments	38,886,513	40,578,097
Transfer Payments	13,045	13,045
GROSS EXPENDITURE	58,235,374	60,855,012
INCOME	18,509,470	18,202,940
NET EXPENDITURE	39,725,903	42,652,072

Health and Social Care

Adult and Social Care - Non-Delegated

	Budget	
	2018/19	2019/20
SERVICE FUNCTION	**£**	**£**
Community Safety	777,886	686,227
NET EXPENDITURE	777,886	686,227
SUBJECTIVE ANALYSIS		
Employee Costs	291,514	230,713
Premises Costs	0	0
Transport Costs	3,500	3,500
Supplies and Services Costs	6,587	6,587
Third Party Payments	640,213	603,903
Transfer Payments	0	0
GROSS EXPENDITURE	941,814	844,703
INCOME	163,928	158,476
NET EXPENDITURE	777,886	686,227

8. PERFORMANCE MANAGEMENT

Performance is increasingly monitored and managed by the Health and Social Care Partnership and Integrated Joint Board to inform future service delivery. Performance is jointly managed across Adult Health and Social Care.

Service performance is reported in the quarterly performance reports and these reports can be found online at https://www.midlothian.gov.uk/downloads/download/90/service_plans

Midlothian Council along with Community Planning partners has integrated the Local Outcome Improvement Plan into a single document – the **Single Midlothian Plan** (SMP). This approach signals the significant shift towards the need to ensure that Community Planning is at the core of all Council activities.

Service Plans provide a link to the local outcomes contained within the commitments of the SMP, also any relevant legislation that is specific to the Service and to the strengths and improvement activities identified as part of self-evaluation. The SMP provides the framework and direction of travel for the Councils' Transformation Strategy.

The SMP outlines the public's, Council's and partners short, medium and long term priorities by reflecting the Council's priorities and partners contributions to the Single Outcome Agreement . The Midlothian Community Planning Partnership undertakes an annual data gathering exercise to produce the 4 Midlothian Profile. This is used as the starting point of the annual strategic assessment undertaken by the Community Planning Partnerships five thematic groups.

The **Midlothian Councils Balanced Scorecard** approach provides the Council with a strategic performance management tool which allows each service area to consider and contribute to core Council outcomes and priorities in terms of planning and performance management. The following shows the Balanced Scorecard perspectives that are applicable across the Councils Services. Those specifically relevant to Adult and Social Care are highlighted.

Customer/Stakeholder	**Financial Health**
▪ Improving outcomes for children, young people and their families ▪ **Ensuring Midlothian is a safe place to live, work and grow up in** ▪ **Creating opportunities for all and reducing inequalities** ▪ Growing the local economy and supporting businesses **Responding to growing demand for Housing and Adult Social Care Services**	▪ **Maintaining financial sustainability and maximising funding sources** ▪ **Making optimal use of available resources** ▪ **Reducing costs and eliminating waste**
Service Improvement	**Learning and Growth**
▪ **Improve Community engagement Strengthen partnerships** ▪ **Improve and align processes, Services and infrastructure** ▪ **Manage and reduce risk**	▪ **Develop employee knowledge, skills and abilities** ▪ **Improve engagement and collaboration** ▪ **Develop a high performance workforce**

2019/20									
Action	**Due Date**	**Performance Indicator**	**Target**	**Baseline**	**Previous Trend Data**	**Team**	**Managed By**	**Source**	**New indicator for 2018/19 yes/no**
Service Priority : Health Inequalities									
Support people with long term health conditions through the wellbeing service that has been introduced in all 12 GP practices	31.03.20	Number of people receiving the Wellbeing Service across all 12 GP practices.	data only	tbc	n/a	Health and Social Care Partnership	Mairi Simpson	HSCP data	yes
Reduce unnecessary admission to hospital by referral to the Community Health Inequalities Team	31.03.20	Number of referrals to Community Health Inequalities Team	data only	tbc	n/a	Health and Social Care Partnership	Mairi Simpson	HSCP data	yes
Service Priority: Assessment and Care Management									
Reduce the waiting times for occupational therapy and social work services.	31.03.20	Average wait time for occupational therapy services.	6 weeks	9 weeks Mar 2014	2015 - 2019	Adult & Social Care	Anthea Fraser	H & SC data	No
	31.03.20	Average wait time for social work services.	6 weeks	6 weeks Mar 2014	2015 - 2019	Adult & Social Care	Anthea Fraser	H & SC data	No
Continue to implement and monitor Self Directed Support	31.03.20	Improved reported outcomes by service users. (annual indicator)	data only	87% 2014/15	2014 - 2019	Adult & Social Care	Shelagh Swithenbank	H & SC data	No
	31.03.20	Increase % of people who feel they are participating more in activities of their choice. (annual indicator)	data only	57.3% 2014/15	2014 - 2019	Adult & Social Care	Graham Kilpatrick	H & SC data	No
	31.03.20	The proportion of people choosing SDS option 1.	data only	n/a	2015 - 2019	Adult & Social Care	Graham Kilpatrick	H & SC data	No
	31.03.20	The proportion of people choosing SDS option 2.	data only	n/a	2015 - 2019	Adult & Social Care	Graham Kilpatrick	H & SC data	No
	31.03.20	The proportion of people choosing SDS option 3.	data only	n/a	2015 - 2019	Adult & Social Care	Graham Kilpatrick	H & SC data	No
	31.03.20	The proportion of people choosing SDS option 4.	data only	n/a	2015 - 2019	Adult & Social Care	Graham Kilpatrick	H & SC data	No

Service Priority: Supporting Service Users Through the Use of Technology									
Implementation of an integrated health and social care dashboard to manage operational service delivery.	31.03.20	n/a	n/a	n/a	n/a	Health and Social Care Partnership	Matthew Curl	HSCP data	n/a
Support the development of improved informatics for MERRIT	31.03.20	n/a	n/a	n/a	n/a	Health and Social Care Partnership	Matthew Curl	HSCP data	n/a
Establish exemplar 'Attend Anywhere' video conferencing clinics where services are willing to adopt e.g. dietetics	31.03.20	Number of services utilising the 'Attend Anywhere' video conferencing platform	data only	n/a	n/a	Health and Social Care Partnership	Matthew Curl	HSCP data	n/a
Service Priority: Carers									
Work to achieve Carer positive employer status (level one)	31.03.20	n/a	n/a	n/a	n/a	Adult & Social Care	Shelagh Swithenbank	H & SC data	n/a
Promote and improve uptake of Adult Carer Support Plan	31.03.20	Number of carers receiving an adult carer support plan of their care needs by Adult Social Care.	data only	n/a	n/a	Adult & Social Care	Shelagh Swithenbank	H & SC data	No
		Number of carers receiving an adult carer support plan of their care needs by VOCAL.	data only	n/a	n/a	Adult & Social Care	Shelagh Swithenbank	VOCAL	Yes
Ensuring that support and services are in place to equip carers with the tools and skills to manage their caring role	31.03.20	Number of Carers receiving 1:1 support by VOCAL	data only	n/a	n/a	Adult & Social Care	Shelagh Swithenbank	VOCAL	yes
Develop the Midlothian Carer Strategy and Action Plan for 2019-22	31.03.20	n/a	n/a	n/a	n/a	Adult & Social Care	Shelagh Swithenbank	H & SC data	n/a

Service Priority: Older People									
Reduce unplanned admissions to hospital from care homes	31.03.20	Reduce number of unplanned admissions to hospital from a care home.	data only	n/a	n/a	Adult & Social Care	Anthea Fraser	HSCP data	yes
Investment in services that enable older people to avoid hospital admission or to return home from hospital as quickly as possible.	31.03.20	Number of individuals receiving support from the Hospital at Home and Rapid reponse team (Merritt)	data only	n/a	n/a	Adult & Social Care	Anthea Fraser	H & SC data	yes
		Reduce the number of people in hospital for last 6 months of their life.	tbc	2017/18	2014-2018	Health and Social Care Partnership	Jamie Megaw	HSCP data	yes
Support planning for the provision of intermediate care housing	31.03.20	n/a	n/a	n/a	n/a	Health and Social Care Partnership	Anthea Fraser	HSCP data	n/a
Ensure a continuous improvement approach with the Care at Home in-house services and partnership approach with external providers.	31.03.20	Number of indiviudals receiving care at home.	data only	n/a	n/a	Adult & Social Care	Anthea Fraser	H & SC data	no
	31.03.20	Number of people waiting for a package of care.	data only	n/a	n/a	Adult & Social Care	Anthea Fraser	H & SC data	no
	31.03.20	Reduce delayed discharge by 20%	data only	2017/18	n/a	Adult & Social Care	Jamie Megaw	HSCP data	No
Service Priority: Mental Health									
Enhance mental health services in Primary Care including the expansion of the Access Point.	31.03.20	Increase in the number of individuals accessing the Access Point	data only	tbc	tbc	Health and Social Care Partnership	Sheena Wight	HSCP data	yes
Evaluate the triage with Police Scotland and other emergency services	31.03.20	The number of people signposted or referred to the Joint Mental Health Team and Intensive Home Treatment Team	data only	tbc	tbc	Health and Social Care Partnership	Sheena Wight	HSCP data	**yes**
Implementation of the new specialist employment project for people with mental health issues.	31.03.20	Number of people in employment following intensive intervention.	6	n/a	n/a	Health and Social Care Partnership	Sheena Wight	HSCP data	**yes**

Establish partnership working to ensure effective implementaion of the Wayfinder Grade 4 model within the rehabiliation pathway.	31.03.20	n/a	n/a	n/a	n/a	Health and Social Care Partnership	Sheena Wight	HSCP data	n/a
Service Priority: Learning Disability									
Implementation of framework for providing positive behavioral support within in Midlothian.	31.03.20	Number of individuals with a PBS plan	data only	n/a	n/a	Adult & Social Care	Graham Kilpatrick	H & SC data	yes
Reduce the average length of time since last assessment or review of cases.	31.03.20	Average length of time since last assessment	data only	n/a	n/a	Adult & Social Care	Graham Kilpatrick	H & SC data	yes
Complete the review and redesign of day services reducing costs including transport.	31.03.20	n/a	n/a	n/a	n/a	Adult & Social Care	Graham Kilpatrick	H & SC data	n/a
Service Priority: Adults Substance Misuse									
Complete work with relevant service managers on core services for the Recovery Hub, which will bring together Mental Health, Substance Misuse and Criminal Justice Services, including third sector partners, together.	31.03.20	n/a	n/a	n/a	n/a	Adult & Social Care	Martin Bonnar	H & SC data	n/a
Continue work of Peer Support Co-ordinator in embedding Peer Support provision in new Recovery Hub, which will bring together Mental	31.03.20	n/a	n/a	n/a	n/a	Adult & Social Care	Martin Bonnar	H & SC data	n/a

Health, Substance Misuse and Criminal Justice Services, including third sector partners, together.									
Work with partners to enhance the complementary role partner services such as VOCAL and Children First in the Recovery Hub	31.03.20	n/a	n/a	n/a	n/a	Adult & Social Care	Martin Bonnar	H & SC data	n/a
Service Priority: Adults Offenders									
Continue interventions to non-Court mandated domestic abuse +A48:J50perpetrators referred through the Safe and Together approach.	31.03.20	Number of individuals through the Safe and Together approach	data only	n/a	n/a	Adult & Social Care	Margaret Brewer	H & SC data	yes
Continue to implement and expand the Spring Service provision in line with funding.	31.03.20	Increase numbers accessing SPRING service(cummulative)	data only	n/a	2016 - 2019	Adult & Social Care	Margaret Brewer	H & SC data	No
Continue to develop multi-agency arrangements to include violent offenders.	31.03.20	Monitor the number of violent offenders with MAPPA involvement.	data only	n/a	2016 - 2019	Adult & Social Care	Margaret Brewer	H & SC data	No
Service Priority: Adults with Long Term Conditions, Disability and Sensory Impairment									
Promote Weight Management Programmes to help address and prevent obesity and type 2 diabetes	31.03.20	Number of people who go through weight management triage	data only	n/a	n/a	Health and Social Care Partnership	Mairi Simpson	HSCP data	yes
Implementation of plans for delivering Audiology clinics in Midlothian Community Hospital.	31.03.20	n/a	n/a	n/a	n/a	Adult & Social Care	Jayne Lewis	H & SC data	n/a

Working with RNIB (Royal National Institute for the Blind) and Deaf Action to provide training	31.03.20	Number of training awareness sessions)	data only	n/a	n/a	Adult & Social Care	Jayne Lewis	H & SC data	n/a

Integrated Impact Assessment Form

Promoting Equality, Human Rights and Sustainability

Integrated Impact Assessment Form

Promoting Equality, Human Rights and Sustainability

Title of Policy/ Proposal	Adult and Social Care Service Plan
Completion Date	21-02-2019
Completed by	Alison White
Lead officer	Alison White

Type of Initiative:

Policy/Strategy ☐
Programme/Plan ☐ New or Proposed ■
Project ☐ Changing/Updated ■
Service ■ Review or existing ■
Function ☐
Other Statement of Intent……..

1. Briefly describe the policy/proposal you are assessing.

Set out a clear understanding of the purpose of the policy being developed or reviewed (e.g. objectives, aims) including the context within which it will operate.

The Adult & Social Care Annual Plan outlines the key challenges and planned developments in 'Community Care' and 'Criminal Justice'. It also seeks to measure the impact the service will have on users and carers through a suite of performance indicators; this entails setting targets for improvement in critical areas of activity.

2. What will change as a result of this policy?

High Relevance	**Yes/no**
The policy/ proposal has consequences for or affects people	Yes
The policy/proposal has potential to make a significant impact on equality	Yes
The policy/ proposal has the potential to make a significant impact on the economy and the delivery of economic outcomes	No
The policy/proposal is likely to have a significant environmental impact	No
Low Relevance	

The policy/proposal has little relevance to equality	No
The policy/proposal has negligible impact on the economy	Yes
The policy/proposal has no/ minimal impact on the environment	Yes
If you have identified low relevance please give a brief description of your reasoning here and send it to your Head of Service to record.	

3. Do I need to undertake a Combined Impact Assessment

Midlothian Integrated Joint Board (IJB) has a three-year strategic plan, which has an Integrated Impact Assessment (IIA). This plan clarifies the council's actions and responsibilities within the current year. There is significant transformation planned within the year to ensure financial targets are met and that services continue to meet needs and improve outcomes at an individual and community level. This includes the delivery of the recovery hub, improving services across Mental Health, Substance Misuse and Criminal Justice. There is also major work on redesigning how we support older people, particularly in relation to care at home.

If you have answered yes to high relevance above, please proceed to complete the Integrated Impact Assessment.

4. What information/data/ consultation have you used to inform the policy to date?

Evidence	**Comments: what does the evidence tell you?**
Data on populations in need	There is significant demographic increase both in terms of older people and in terms of younger people with complex and multiple disability.
Data on service uptake/access	We have seen increasing demand on services at a time of pressures in recruiting care staff.
Data on quality/outcomes	The service has a range of performance measures that ensure that we monitor access to service and outcomes because of these services. A quarterly quality improvement meeting addresses any areas of concerns and shares good practice.
Research/literature evidence	Practice is clearly linked to evidence, and ongoing learning and development opportunities are available for staff to ensure that they are aware of changes.
Service user experience information	This is monitored through surveys, regular consultation events and as part of individual reviews to ensure outcomes are being met.
Consultation and involvement findings	There is ongoing work to engage and consult through a variety of mechanisms.
Good practice guidelines	A range of bitesize training is available to ensure that staff are aware of good practice guidance. We ensure a practitioner led approach to implement service changes.

Other (please specify)	Significant work was undertaken to complete a needs assessment for the IJB which ensures clear local data to help shape service design and delivery.
Is any further information required? How will you gather this?	No

5. How does the policy meet the different needs of and impact on groups in the community?

	Comments – positive/ negative impact
Those vulnerable to falling into poverty • Unemployed • People on benefits • Single Parents and vulnerable families • Pensioners • Looked after children • Those leaving care settings (including children and young people and those with illness) • Homeless people • Carers (including young carers) • Those involved in the criminal justice system • Those living in the most deprived communities (bottom 20% SIMD areas) • People misusing services • People with low literacy/numeracy Others e.g. veterans, students	Due to the nature of the services included within this plan all listed categories have the potential to be impacted. This plan hopes to address areas of inequalities and improve outcomes for affected groups.
Geographical communities • Rural/ semi rural communities • Urban Communities • Coastal communities	All communities are served irrespective of geographical location

6. **Are there any other factors which will affect the way this policy impacts on the community or staff groups?**
   No

7. **Is any part of this policy/ service to be carried out wholly or partly by contractors?**

   If yes, how have you included equality and human rights considerations into the contract?

Around 63% of service delivery is provided by the private, voluntary and third sector. Issues of equality are addressed within contracts and at regular contract management meetings.

8. **Have you considered how you will communicate information about this policy or policy change to those affected e.g. to those with hearing loss, speech impairment or English as a second language?**

   The service has lead responsibility for sensory impairment and has developed the local strategy as a result of the See Hear national strategy. Awareness training has been developed for staff.

   Information published by Midlothian Council can be provided on request in many of the community languages and also in large print, Braille, audio tape or BSL. For more information, please contact the Equality , Diversity & Human Rights Officer on 0131 271 3658 or equalities@midlothian.gov.uk

9. **Please consider how your policy will impact on each of the following?**

Objectives	**Comments**
Equality and Human Rights	
Promotes / advances equality of opportunity e.g. improves access to and quality of services, status	This is central to the development of the service plan

Promotes good relations within and between people with protected characteristics and tackles harassment	The service works with the Public Protection team ensure that issues of harm are addressed.
Promotes participation, inclusion, dignity and self control over decisions	The approach to self directed support firmly embeds an outcomes focused inclusive approach to service design. Co-production is central to our approach.
Builds family support networks, resilience and community capacity	Vocal (a voluntary organisation that provides support to carers) are commissioned to ensure that we provide appropriate levels of support to family carers.
Reduces crime and fear of crime	The reducing reoffending agenda will tackle this area of work.
Promotes healthier lifestyles including • diet and nutrition, • sexual health, • substance misuse • Exercise and physical activity. • Lifeskills	Health inequalities are a central theme of the policy.
Environmental	
Reduce greenhouse gas (GHG) emissions in East Lothian (including carbon management)	The IJB has produced a climate change plan. There is no impact as a result of this plan.
Plan for future climate change	
Pollution: air/ water/ soil/ noise	
Protect coastal and inland waters	
Enhance biodiversity	

Encourage resource efficiency (energy, water, materials and minerals)	
Public Safety: Minimize waste generation/ infection control/ accidental injury /fire risk	
Reduce need to travel / promote sustainable forms or transport	
Improves the physical environment e.g. housing quality, public and green space	
Economic	
Maximises income and /or reduces income inequality	Improvements to the living wage for care workers will have an impact on individuals and the local economy. Through work on apprenticeships, we are supporting young people into employment; we also offer a range of student placement opportunities. We continue to explore how to support people back into employment e.g. new developments within Mental Health with Occupational Therapists taking a lead is one example of this. We also support learning opportunities which help people develop the skills to get back into work
Helps young people into positive destinations	
Supports local business	
Helps people to access jobs (both paid and unpaid)	
Improving literacy and numeracy	
Improves working conditions, including equal pay	
Improves local employment opportunities	

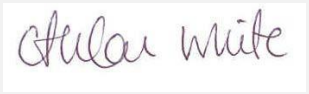
10. Is the policy a qualifying Policy, Programme or Strategy as defined by The Environmental Impact Assessment (Scotland) Act 2005?

No

11. Action Plan

Identified negative impact	Mitigating circumstances	Mitigating actions	Timeline	Responsible person
None identified				

12. Sign off by Head of Service/ NHS Project Lead



Name Alison White
Date 14 March 2018

How the partnership engages with the public

		General Public	Older People	Carers	Mental Health	Learning Disability	Physical Disability	Substance Misuse
Inform	Directory	• Communities • MC/IJB/NHS web	• Older People • Red Cross	• WeeBreaks	• Midspace	• Autismideas • Disabled Sport	• Disabled People • LCiL • Disabled Sport	• Meldap
	Newsletter	• IJB		• VOCAL			• Forward Mid	
	Online	• MC/NHS Facebook & Twitter • MVA email		• VOCAL Facebook		• Autism Facebook	• Forward Mid Facebook	• Meldap Facebook
Consult	Survey	• Health & Wellbeing • Citizen's Panel • Service Users (MC) • Census • Mid Profile (NRS) • NHS ISD • Patient Satisfaction		• Carers (MC) • Carer's Census • VOCAL		• CAT team		• Service Questionnaires
	Face to Face	• Hot Topics • Third Sector Summit • Collective Voice	• Annual event (MC) • MOPA	• Annual event (MC)	• Annual Event (Midlothian Voices) • Orchard Centre member's Group	• Health Fair • People First • ASD Expert Panel • LD Expert Panel • Provider Forum	• Disabled People's Assembly	
	Feedback	• Comments (MC web and phone) • External inspection				• Online - "What should we focus on next?"		• Facebook • Consultations • Emails to MELDAP
Collaborate	Public reps	• IJB	• Planning Group	• Planning Group • Carer's Action	• Planning Group • Quality Improvement	• Planning Group	• Planning Group	• MELDAP Commissioning + Performance Group
	Advocacy		• EARS		• CAPS • Midlothian Voices			• Peer Support
	User Groups	• One Dalkeith • Neighbourhood Planning • Community Council • People's Equality	• Bonnyrigg Seniors • Dalkeith Welfare • Gorebridge Forum • Ageing Well • Dementia Reference • Day Centres	• Dementia Group • Group (Grassy Riggs) • Coffee Morning (VOCAL) • D Café (Alzheimer Scotland)	• Orchard Centre • Recovery Café • Recovery College • Peer Support	• CAT hubs • Shared Lives • Supported Living • Day Centre • Artlink	• Access Panel • Peer Support • Café Connect • Deaf Action • RNIB	• Horizons Recovery Café • Peer Support Workers/Volunteers