

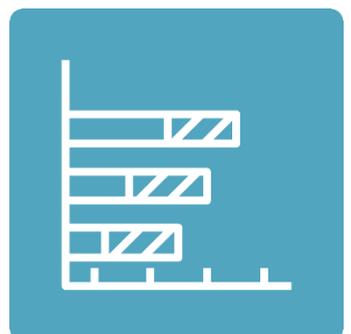
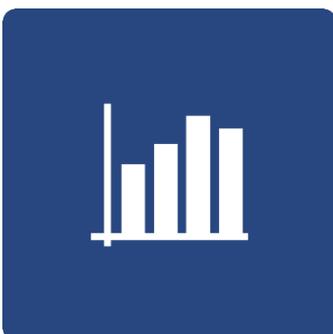


**Midlothian  
Health & Social Care  
Partnership**

# Joint Needs Assessment

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2019



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# Introduction

A key requirement of the in the Public Bodies (Joint Working) (Scotland) Act 2014 is that each integration authority must produce a strategic plan that:

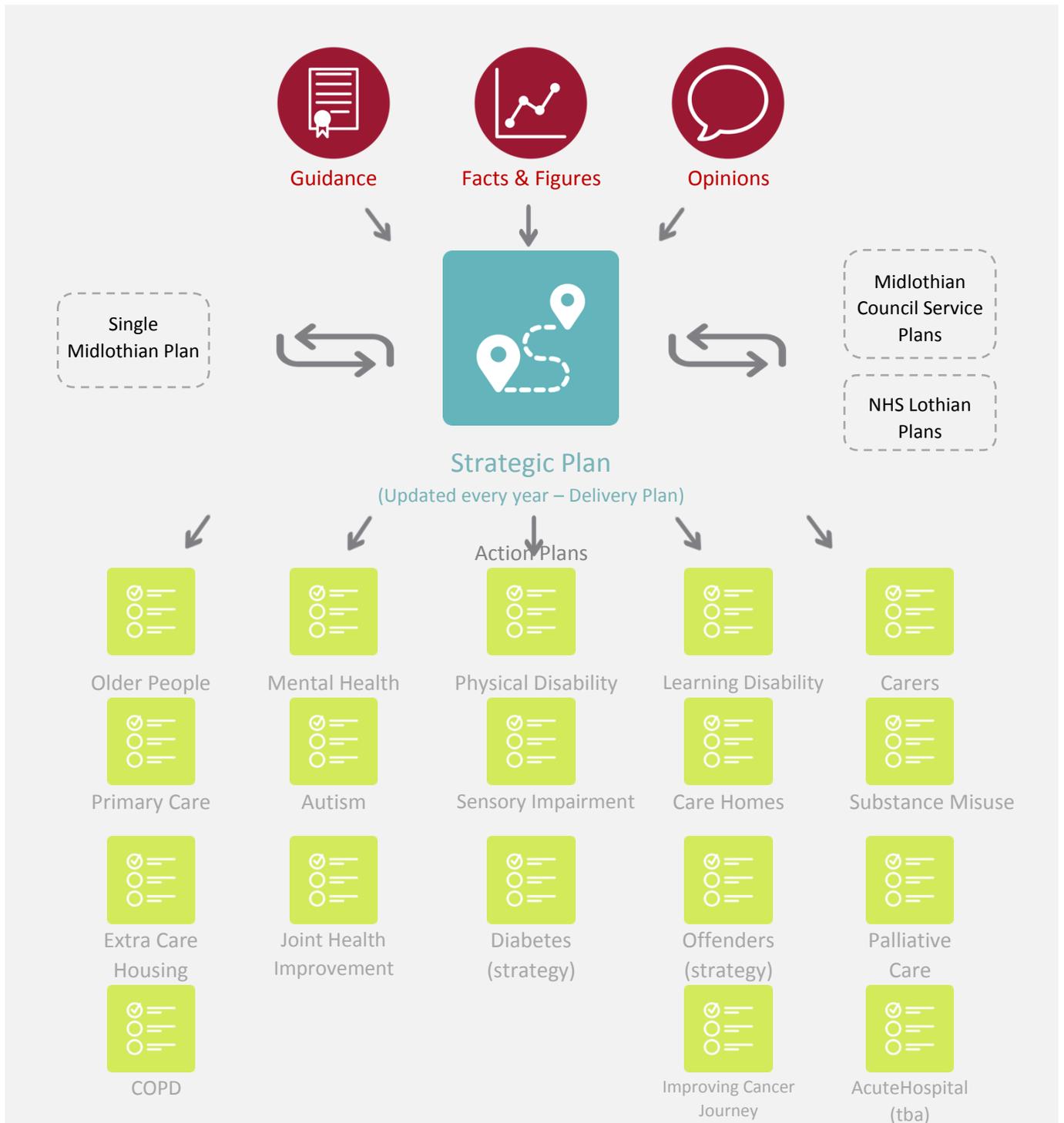
- explains how the integration authority intends to achieve a set of outcomes known as the national health and wellbeing outcomes
- divides the local authority area for which the integration authority is responsible into at least two localities
- sets out how the functions and services that the integration authority is responsible for will be delivered and how the related budget will be used

In order to ensure a robust and informed strategic plan each Integration Authority should oversee the production of Joint Strategic Needs Assessments (JSNAs).

The purpose of a Joint Needs Assessment is to assess and forecast the health and wellbeing needs of the adult population. It identifies key health and care priorities and helps to focus commissioning in order to improve the physical and mental health and wellbeing of individuals and communities. The Midlothian Health and Social Care Partnership's Joint Strategic Needs Assessment has been built from a variety of expert opinion, routinely available data and comparison with Scotland and the areas covered by NHS Lothian. It has been developed to inform the Strategic Plan for Midlothian, helping to ensure our health and social care services are designed in a planned, evidence based and transparent way to meet the current and future needs of the population.

# What happens now?

The information outlined in this Joint Strategic Needs Assessment will inform the Strategic Plan and detailed plans for client groups and key services. It will also inform the directions we give to the NHS and Midlothian Council



# Inequalities

People in our most deprived communities are more likely to die younger from every common cause of death. This makes inequalities a crosscutting theme and the reduction of inequalities a crosscutting goal for all service areas; as such it sits at the beginning of Midlothian Health and Social Care Partnership's JSNA.

**Inequalities** are the unfair and avoidable differences in people's health and wellbeing across social groups and between different population groups<sup>1</sup>. 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 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 outcomes, are more likely to die younger and are more likely to suffer ill-health 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. Rankings are relative not absolute. By identifying small areas where there are concentrations of multiple deprivation, policies and resources can be targeted at the places with greatest need.

The SIMD identifies areas NOT individuals. Not everybody living in a deprived area is deprived and not all deprived people live in deprived areas. The SIMD uses data relating to seven aspects of life. It measures deprivation and not affluence. Financial poverty is treated as just one aspect of deprivation. 13 datazones in Midlothian were within the most deprived 20% datazones in Scotland:

- 1 datazone in the most deprived 5% - in Dalkeith.
- 1 datazone in the most deprived 5-10% - in Dalkeith
- 5 datazones in the most deprived 10-15% - in Straiton, Dalkeith, North Gorebridge and two in Mayfield
- 6 datazones in the most deprived 15-20% - in Bonnyrigg South, Mayfield, Easthouses, 2 in Gorebridge & Middleton

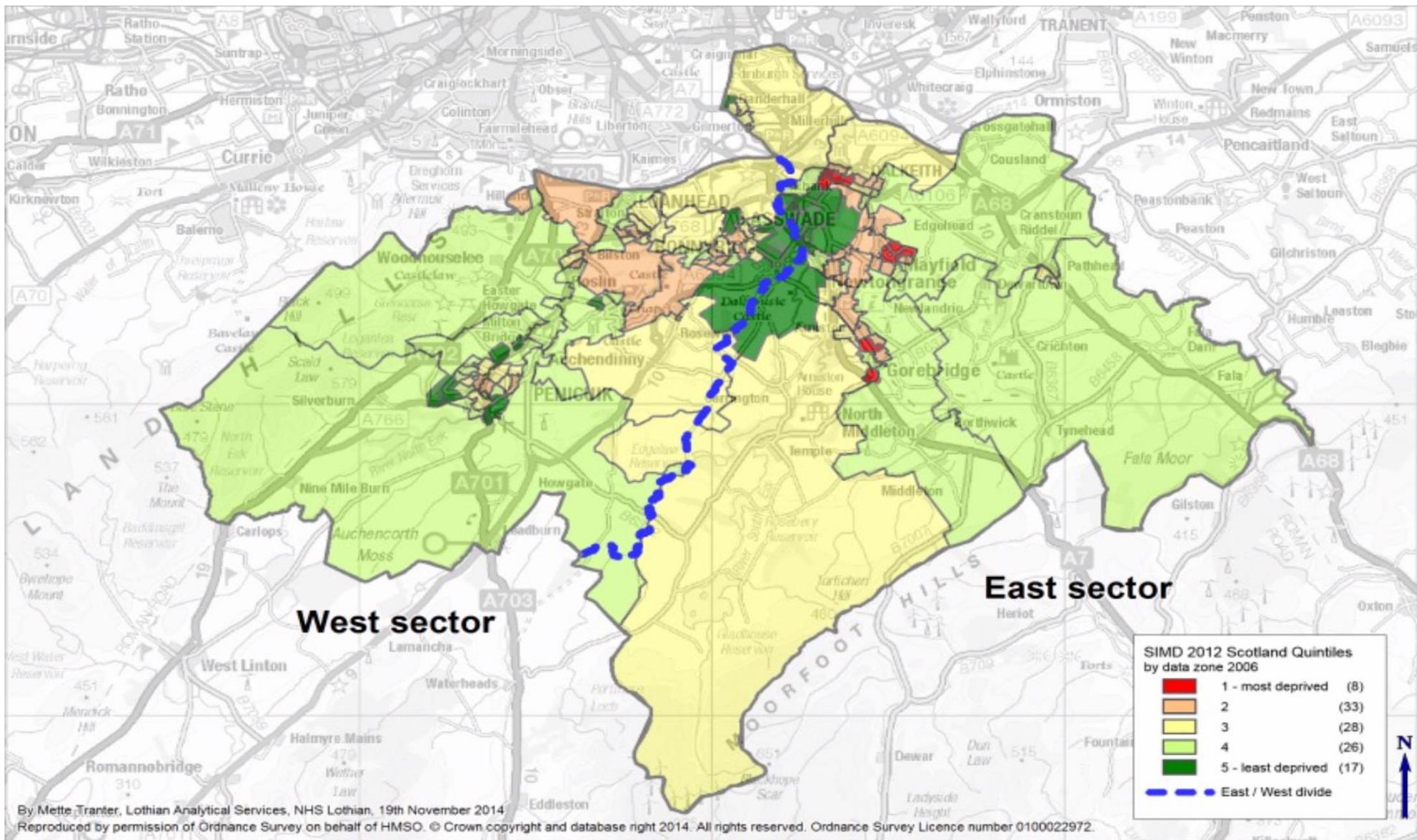
Whilst all areas in the most deprived 20% were around Dalkeith, Mayfield, Easthouses and Gorebridge, areas in the most deprived 20-30% were spread more widely including Thornybank, Penicuik and Newtongrange.

TABLE 1. POPULATION BY 2016 SIMD QUINTILES, LOTHIAN AREAS

|              | Most deprived ----- Least deprived |           |           |           |           | Total     |
|--------------|------------------------------------|-----------|-----------|-----------|-----------|-----------|
|              | 1                                  | 2         | 3         | 4         | 5         |           |
| East Lothian | 3,735                              | 26,592    | 22,902    | 28,242    | 20,579    | 102,050   |
| Edinburgh    | 65,318                             | 71,825    | 71,462    | 76,160    | 207,915   | 492,680   |
| Midlothian   | 8,803                              | 31,045    | 17,829    | 15,191    | 13,342    | 86,210    |
| West Lothian | 28,466                             | 48,466    | 36,393    | 30,804    | 33,021    | 177,150   |
| Lothian      | 106,322                            | 177,928   | 148,586   | 150,397   | 274,857   | 858,090   |
| Scotland     | 1,049,314                          | 1,046,173 | 1,067,682 | 1,080,177 | 1,104,254 | 5,347,600 |

Data source: *Scottish Index of Multiple Deprivation* [Accessed Aug. 2018]

FIGURE 1. SIMD DATA ZONE QUINTILES BY GEOGRAPHY



By Mette Tranter, Lothian Analytical Services, NHS Lothian, 19th November 2014

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Some health inequalities in Midlothian in areas affected by social disadvantage:

| Early death due to <b>coronary heart disease</b> <sup>2</sup> : | Hospital stay for a <b>preventable reason</b> <sup>3</sup> : | Difference in <b>Life expectancy</b> <sup>4</sup> : | Prescription for <b>anxiety/ depression</b> <sup>5</sup> : | <b>Children living in poverty</b> <sup>6</sup> : |
|---|--|---|--|--|
| X23 higher  | 15-20% more likely   | 7 years shorter                                     | 9% higher  | 22.5%  |

Scottish data:

| Women with a <b>learning disability</b>           | Average age of death for a <b>Homeless male</b> <sup>7</sup> | Average age of death for a <b>Homeless female</b> | Poverty rate after housing costs for <b>person with a disability</b> <sup>8</sup> |
|---|--|---|---|
| Around 25% attend cervical screening <sup>9</sup> | 47 compared to 77 in general population                      | 43 compared to 81 in general population           | 24% compared to 16% of people in a family without a disability                    |

### Implications.

When planning or reviewing services it is important to consider how inequalities:

- (i) May impact how a person accesses and benefits from services. Are services resourced and delivered at a scale and intensity that is proportionate to the degree of need? Services should be adapted to ensure that they are available according to need.
- (ii) Can be reduced through strategic decisions regarding services.

### Points to consider when planning services in Midlothian:

- **Available data – e.g. SIMD, age, gender, ethnicity, and other relevant data.**

Is the service as accessible to those living in disadvantaged areas as it is to those with more affluence? Are all genders benefitting? Are people with a disability accessing services or improving health outcomes? Is the age profile appropriate? Are people of different ethnicities engaged?

- **Prevention**

Prevention has the potential to reduce the problem of high demands, squeezed resources and reducing health inequalities by reducing avoidable health and social problems (so called 'failure demand').

- **Building Community Capacity/Co- production**

Communities of place or of interest can help to tackle inequality and develop new solutions. Facilitating community members to work in partnership with public service providers can result in improved service design and delivery. A shift towards self-management support can also empower people and communities.

- **Universal delivery of services – with fewer (or no) price, accessibility, discrimination or stigma barriers.**

Additional efforts are required to ensure equality of access to services e.g. attitudinal, language, information and physical barriers to healthcare (e.g. people from minority ethnic or LGBTI (Lesbian, Gay, Bisexual, Transgender or Intersex) population groups or people living with poverty, disability or mental health problems).

### Approaches that should be avoided:

The types of interventions that are less likely to be effective in reducing health inequalities are those which require individuals to opt-in (e.g. mass-media campaigns) and those which involve significant price barriers (e.g. travel or participation costs for health classes), or where access is limited by location or layout of properties or attitudes of staff. While focussing on areas of deprivation is appropriate it should not be exclusive as at least 40% of people who experience deprivation do not live in the areas defined as deprived according to SIMD data.

Addressing disadvantage needs concerted efforts across agencies outside health and social care to work the unequal distribution of income, power and wealth. This distribution can lead to poverty and marginalisation of individuals and groups. This requires national action on policy, taxation and other strategic decisions.

# Demographics

# Population

## Total Population

90,090 people live in Midlothian

## Projected Population

Population projections are estimates of the growth or decline in the number and characteristics of people living in an area. They take into account things like the local birth rate and how many people are coming to live in the area or leaving it each year.

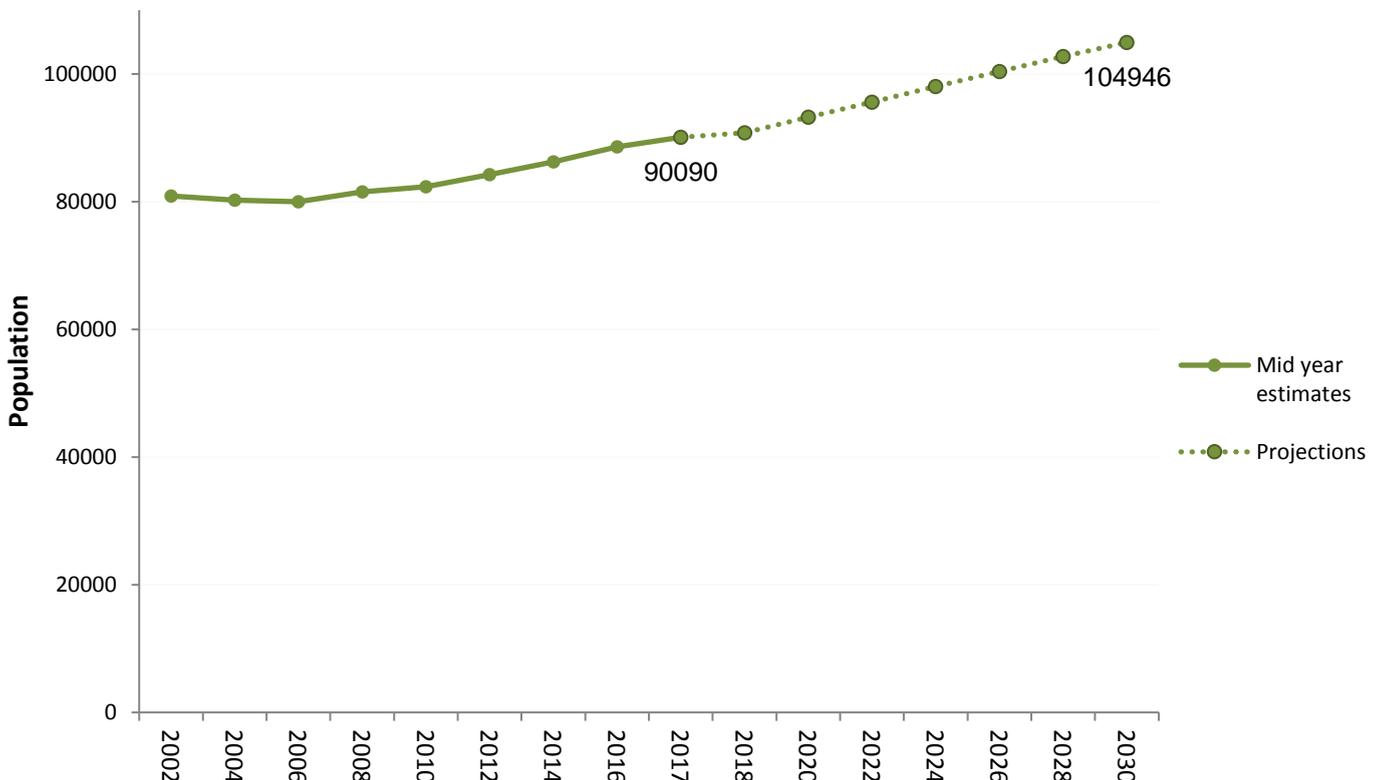
The Midlothian population has been growing. The 2016 projection predicts a population of 100,000 by 2026, a 20% increase on the 2011 census population of 83,400.

The largest percentage increase will be in those aged 75 and over.

Midlothian's population has shown an increase due to migration in the six years to 2015/16. This in-flow has increased fourfold in that time, with the bulk of the increase due to migration from elsewhere in Scotland.

By 2037, the number of households in Midlothian is projected to increase to **43,312**. In 2015 there were **37,069** households.

FIGURE 2. POPULATION PROJECTIONS (2016 BASED) WITH MID-YEAR ESTIMATE POPULATION (2002-2017)



Data source: [National Records of Scotland](#) [Accessed Aug. 2018].

## Birth & Death rates

The birth rate is the total number of live births every year per 1000 population.

The Midlothian birth rate is **12**. This is above the Scottish rate and has been steady for the last three years (2015-17) while Scotland's rate has declined to 9.7.

There were **1,107 births in 2017**.

The death rate is the total number of deaths every year per 1000 population per year.

The Midlothian death rate is **9.8** (2017) This is lower than the Scottish rate of 10.7.

There were **885 deaths in 2017**.

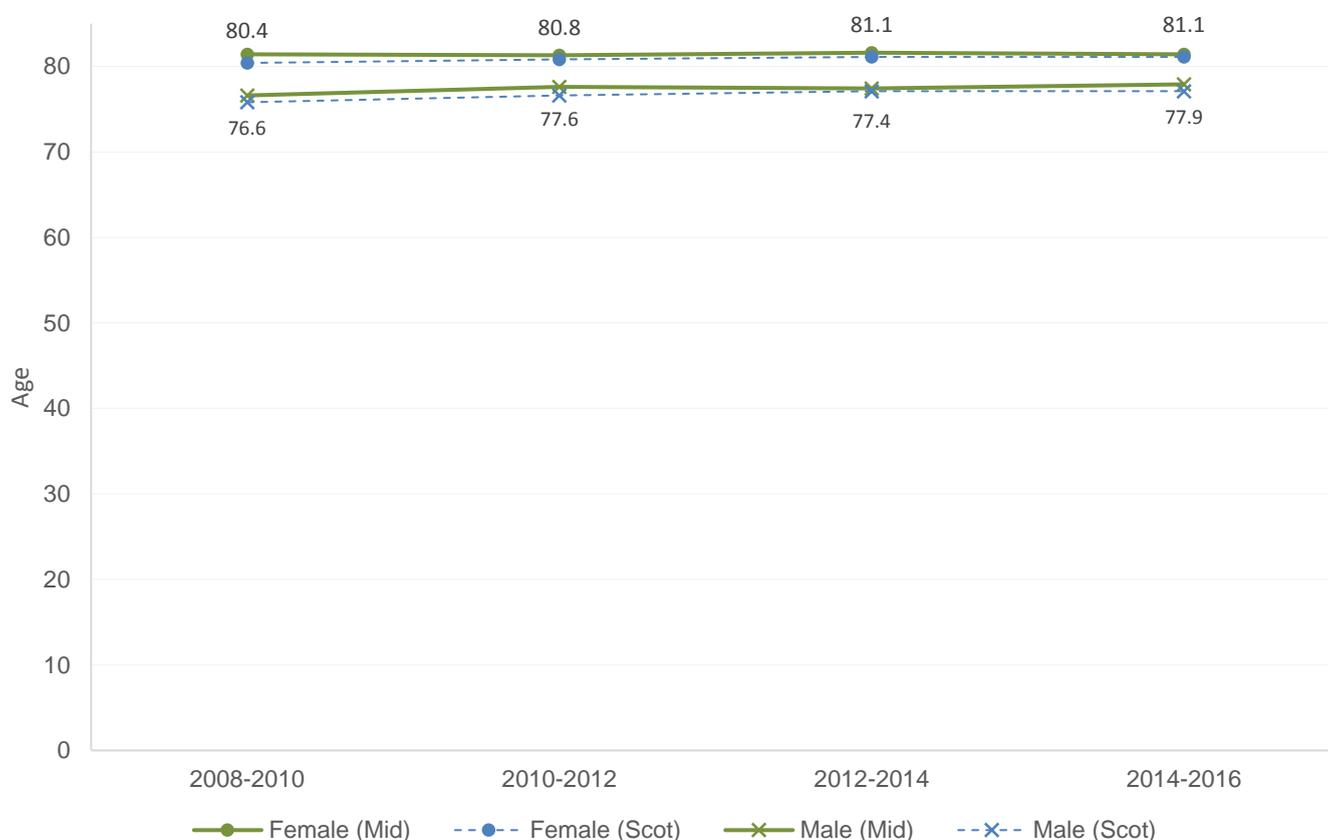
## Life Expectancy

Life Expectancy is an estimate of the number of years a newborn child would live if it was to experience the current mortality rate for all of its life. Scotland has one of the lowest life expectancies in Western Europe<sup>10</sup>

The life expectancy at birth in Midlothian is slightly above the Scottish average (2014/16) and **is improving**. Women live longer than men, both overall and in good health. However there are stark differences in health as a result of poverty and social disadvantage. Life expectancy can vary by up to 12 years across different parts of Midlothian.

More young people with complex needs are surviving into adulthood and better health care has helped increase their life expectancy significantly.

FIGURE 3. LIFE EXPECTANCY IN MIDLOTHIAN (AND SCOTLAND)



Data source: *National Records of Scotland* [Accessed Sept 2018].

Healthy Life Expectancy is the average number of years that a newborn can expect to live in “full health”. It is a key summary measure of a population’s health<sup>11</sup>.

FIGURE 4. MALE LIFE AND HEALTHY LIFE EXPECTANCY

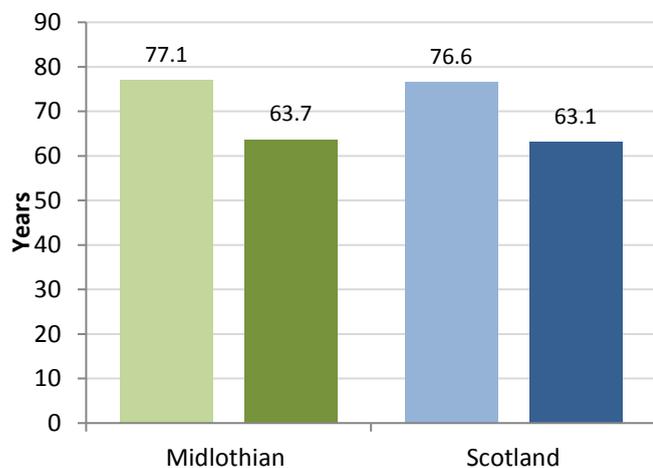
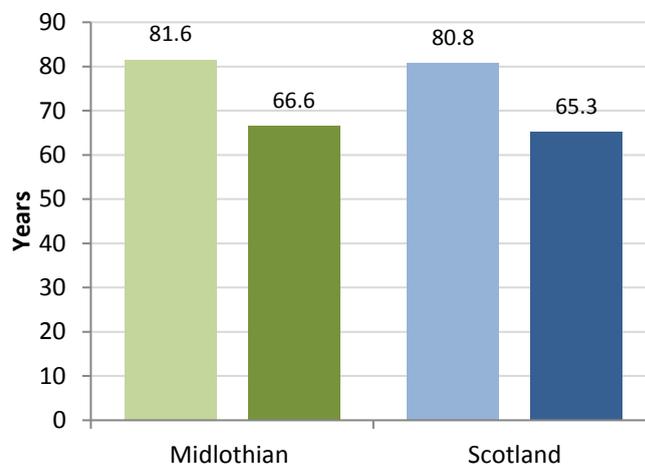


FIGURE 5. MALE LIFE AND HEALTHY LIFE EXPECTANCY



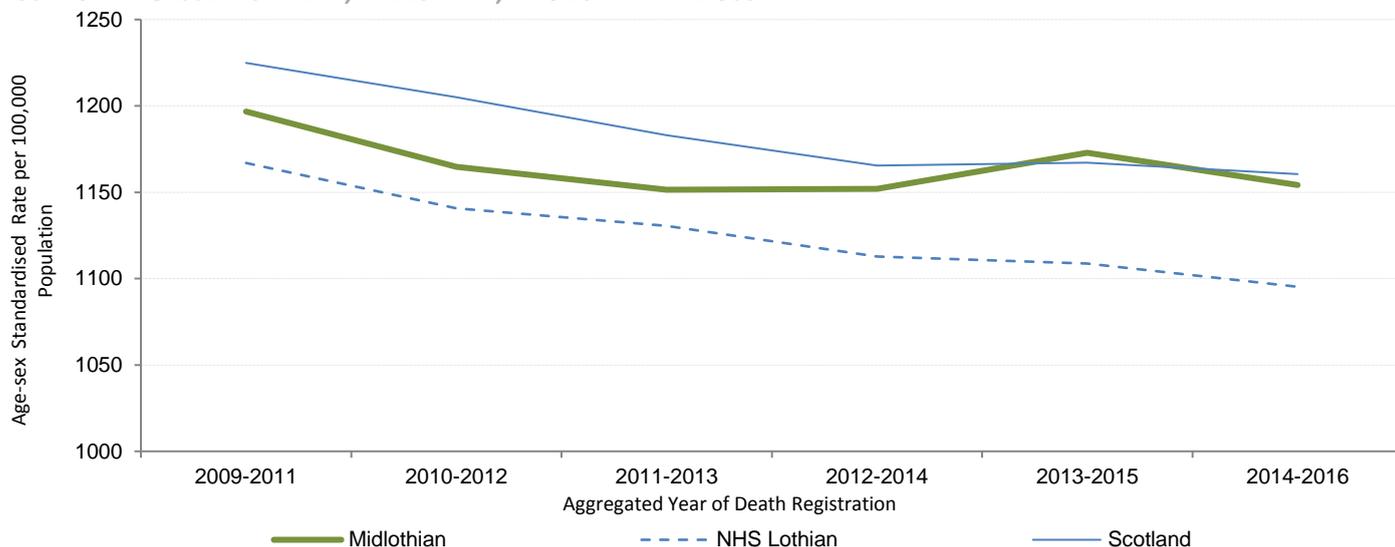
Data source: [Scottish Public Health Observatory](#) [Accessed Aug. 2018].

More people are living longer and with a longer period of their life in poorer health resulting in a likely increase in health and social care needs.

# Mortality

Mortality rates are the number of deaths observed over a specified time period. These are best compared as rates per 100,000 population, standardised to take account of differences in the structure of the population so that we are comparing like with like. For instance an area might have a lower death rate simply because the proportion of younger people living there is higher than another area.

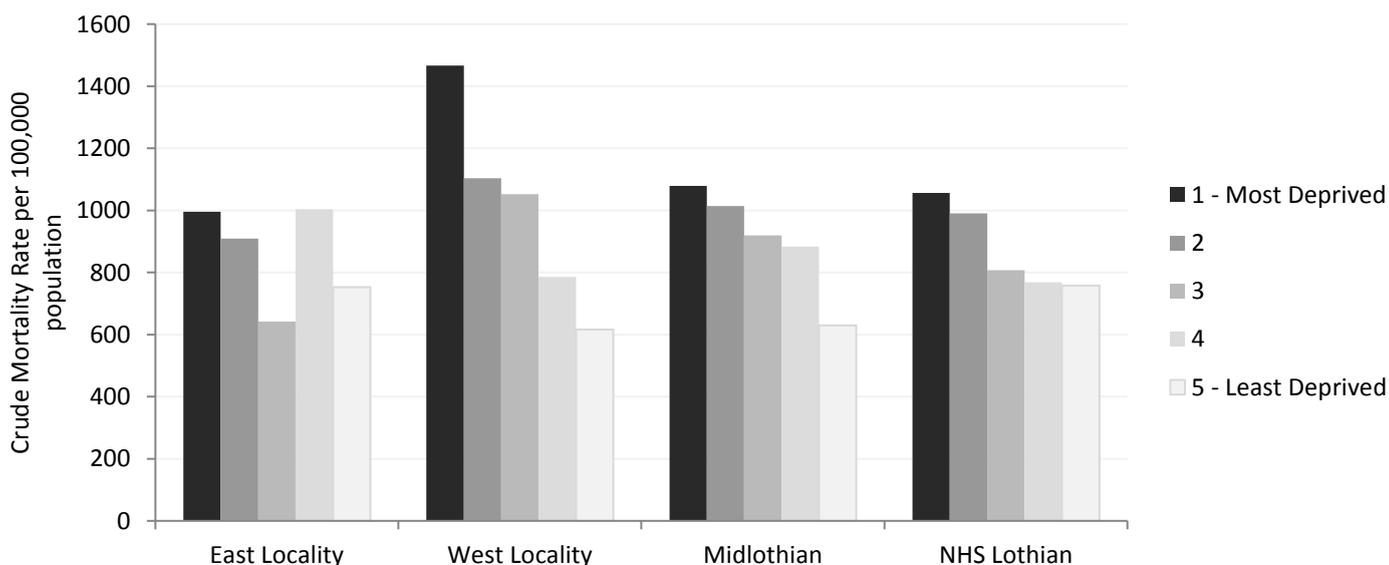
FIGURE 6. ALL CAUSE MORTALITY, MIDLOTHIAN, NHS LoTHIAN AND SCOTLAND



Data source: *National Records of Scotland* [Accessed Aug. 2018].

There is a relationship between the relative socioeconomic deprivation of an area and the mortality rate.

FIGURE 7. ALL CAUSE MORTALITY BY SIMD, CRUDE RATE PER 100,000 POPULATION, 2016

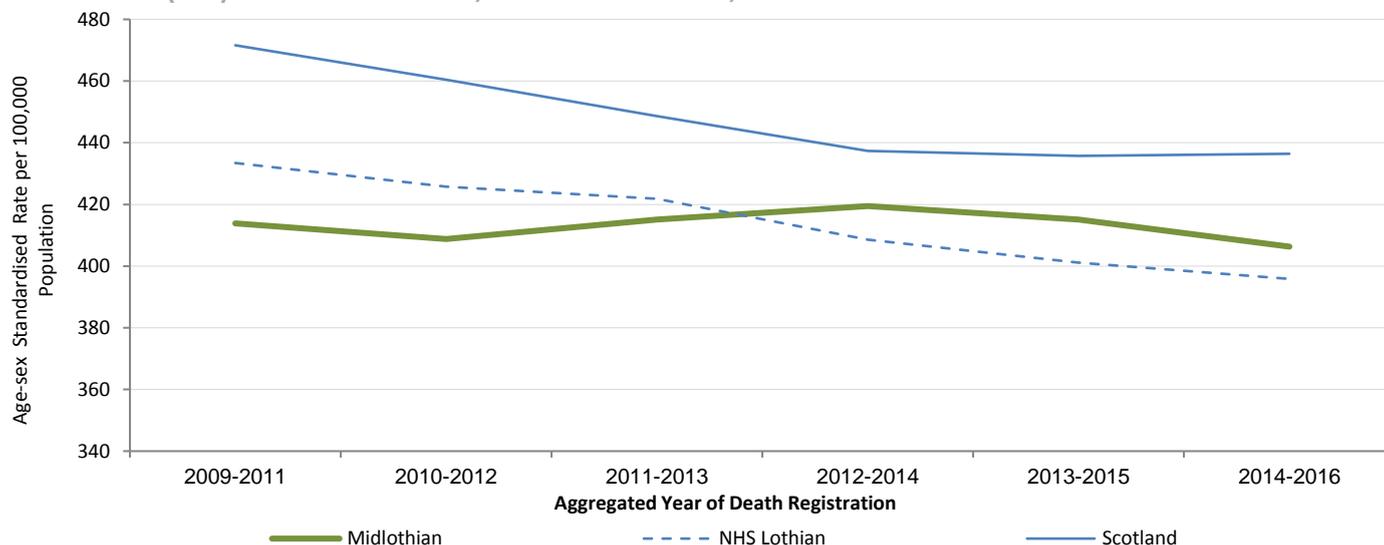


Data source: *National Records of Scotland* [Accessed Aug. 2018].

## Early deaths (premature mortality)

Early mortality rates are the number of deaths of people under 75 observed over a specified time period. These are a subset of the overall death rate. These are best compared as rates per 100,000 population, standardised to take account of differences in the structure of the populations being compared.

FIGURE 8. EARLY (<75) ALL CAUSE MORTALITY, MIDLOTHIAN LOCALITY, NHS Lothian AND SCOTLAND



Data source: *National Records of Scotland* [Accessed Aug. 2018].

In 2009/11 there were **890** early deaths in Midlothian, in 2014/16 there were **960**. Since there are smaller numbers of deaths in this age group it is reasonable to expect some variation in mortality rates between years.

While the death rate (all ages) is lowering in Midlothian, action across a range of fronts is required to maintain and improve this. Early mortality rates have remained fairly stable from 2009/11 to 2014/16. Midlothian rates lie below Scotland early mortality rates which is encouraging but requires further preventative action to improve this further.

## Ethnicity

Ethnicity is "the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race"<sup>12</sup>. It is a concept that can change and is normally user defined.

The 2011 census provides the most recent view of the ethnic make-up of the population. **1.8%** of the population belonged to a Minority Ethnic Community. This compared with **4%** of the Scottish population. For both Midlothian and Scotland these figures are double those of the 2001 census. Population by country of birth is another way to analyse the make-up of Midlothian.

TABLE 2. ESTIMATED POPULATION BY COUNTRY OF BIRTH (EU AND NON-EU COUNTRIES) - YEAR ENDING JUNE 2018

|            | Total     | UK Born   | CI +/- | Non-UK Born | CI +/- | EU      | CI +/- | Non-EU  | CI +/- |
|------------|-----------|-----------|--------|-------------|--------|---------|--------|---------|--------|
| Scotland   | 5,319,000 | 4,859,000 | 83,000 | 460,000     | 25,000 | 228,000 | 18,000 | 232,000 | 18,000 |
| Midlothian | 88,000    | 82,000    | 8,000  | 6,000       | 2,000  | 3,000   | 2,000  | 2,000   | 1,000  |

Data source: *National Records of Scotland* [Accessed: Dec. 2018].

**Gypsy/Traveller Families:** Whitecraig has a caravan site with **20 pitches** managed by East Lothian Council on behalf of both authorities. There are also Gypsy/Traveller families in settled accommodation. **72 people** (0.09% of the population) identify as Gypsy/ Traveller compared to 0.08% in Scotland.<sup>13</sup>

**Hate incidents** motivated by race, particularly against adults, accounted for the majority of hate incidents recorded within Midlothian. Point of sale, neighbour disputes and crimes against police officers continue to represent the majority of hate crime incidents across Midlothian<sup>14</sup>.

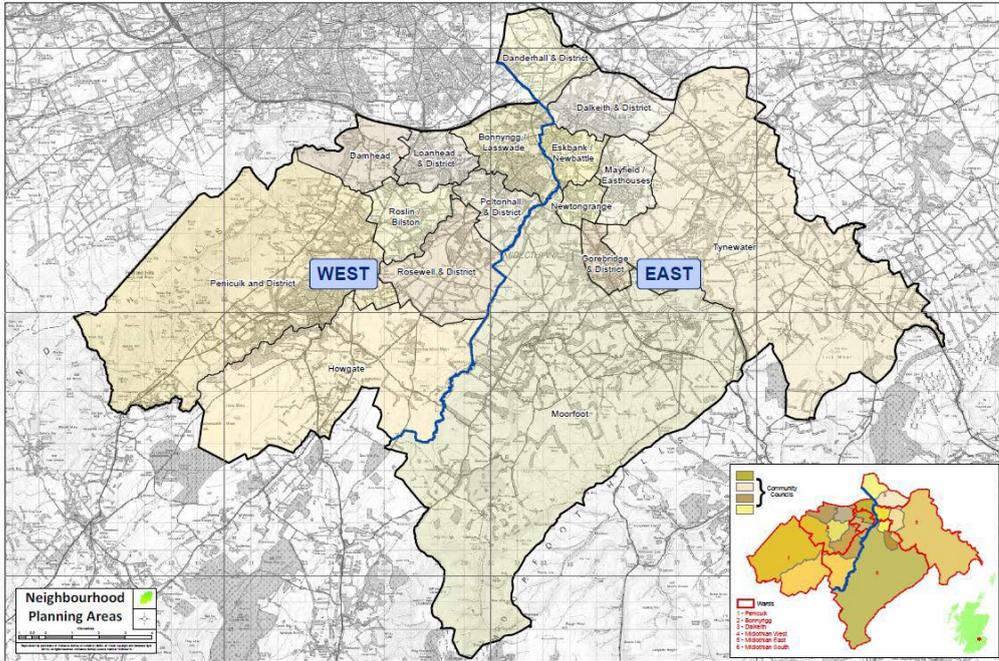
**Health and ethnicity** - The relationship between ethnicity and health is complex and is compounded by the socioeconomic profile of ethnic minority groups. Proportionately, much higher numbers of some groups (e.g. Chinese, Indian, Pakistani) live in much less disadvantaged circumstances in Scotland compared with the rest of Britain. While overall levels of population health, such as life expectancy, are better among many non-White ethnic minority groups in Scotland compared with the White Scottish population, this hides a 'highly complicated set of varying risks of particular diseases among different groups.'

- Most ethnic groups reported better health than the 'White: Scottish' ethnic group;
- Across most ethnic groups, older men reported better health than older women. Older Indian, Pakistani and Bangladeshi women reported poor health, and worse health than older men in these groups;
- Gypsy/Travellers had the worst health, reporting twice the 'White: Scottish' rate of 'health problem or disability' and over three and a half times the 'White: Scottish' rate of 'poor general health';
- 'White: Polish' people under 65 reported good health, whereas those aged 65+ reported poor health<sup>15</sup>
- A lower risk of cancer among many groups compared with White Scots,
- A similar (and in some cases, greater) risk of stroke among many groups compared with White Scots
- A greater risk of heart disease and diabetes for people with Pakistani origin compared to White Scots
- A greater risk of diabetes for people in the Indian population compared to White Scots
- A lower risk of many diseases for Chinese men and women
- For many conditions (e.g. respiratory, mental health related, gastrointestinal), the relationships are complex, with no clear patterns across ethnic minority groups emerging<sup>16</sup>.

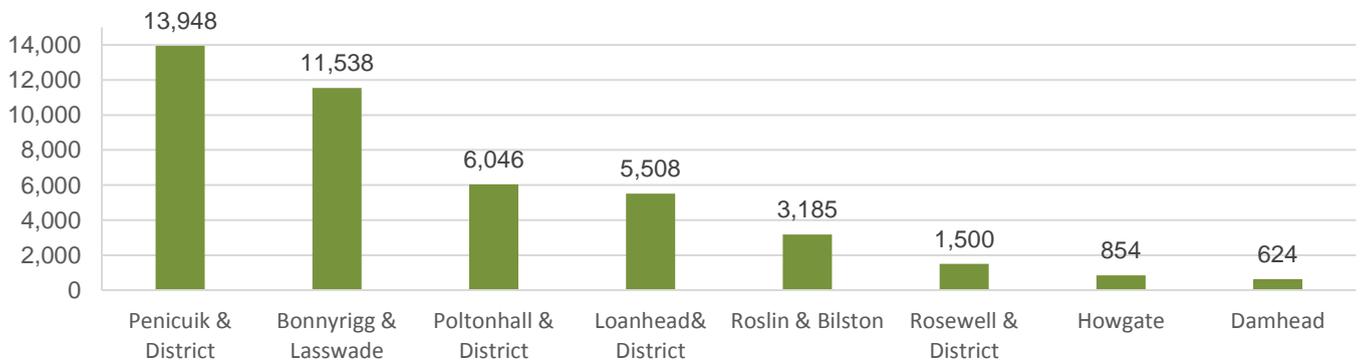
# Localities

Due to the practicalities and implications of planning and commissioning on a small scale we operate on an East-West approach to the establishment of two localities.

There are 8 data zones in the most deprived 20% areas. There are **3 areas of multiple deprivation – all in EAST Midlothian. They include areas of Gorebridge, Mayfield and Woodburn [Dalkeith & District]];**

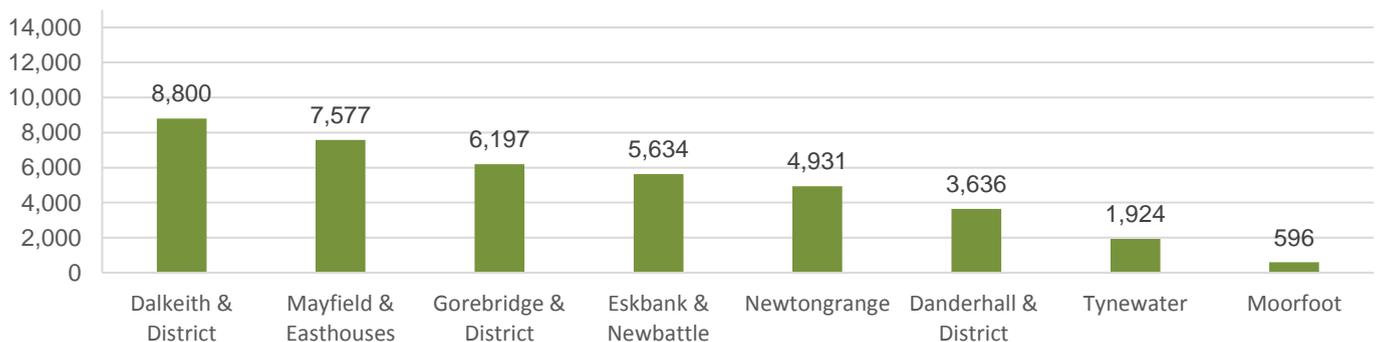


**West - Total population 43,167** (Population density - 292.1 pop/km3)



Data source: *Scottish Census 2011* [Accessed Dec 2018].

**East - Total Population 39,295** (Population density - 189.4 pop/km3)



Data source: *Scottish Census 2011* [Accessed Dec 2018].

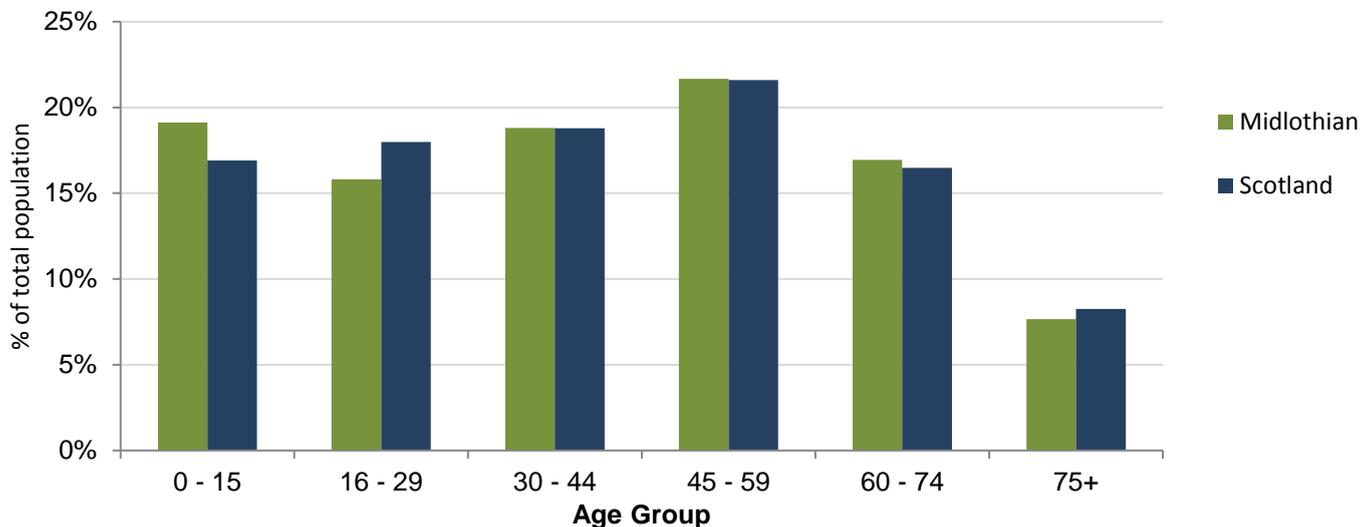
The Partnership aims to improve the design and delivery of health and social care services within Midlothian's natural communities recognising that the designation of East and West localities does not reflect any recognisable sense of belonging or indeed formal organisation of services. Data is available on some of the key health and care needs of our communities through for example *Scotpho* down to 22 intermediate data zones. However, as the Partnership becomes more sophisticated in its approach to analysing the needs of local communities, more detailed data gathering and analysis will be undertaken through existing health and social care systems.

There are strong local communities in Midlothian and we must harness the strengths they can bring to improving health and wellbeing by establishing effective communication channels and working with voluntary organisations, volunteers and unpaid carers in those areas, recognising that they, rather than formal public services are critical to the health and wellbeing of the Midlothian population.

## Age

Compared with the rest of Scotland, Midlothian has above average populations of children, the older element of the working population and retired people and below average populations of over 75s and young adults.

FIGURE 9. POPULATIONS OF MIDLOTHIAN AND SCOTLAND BY AGE (2017)

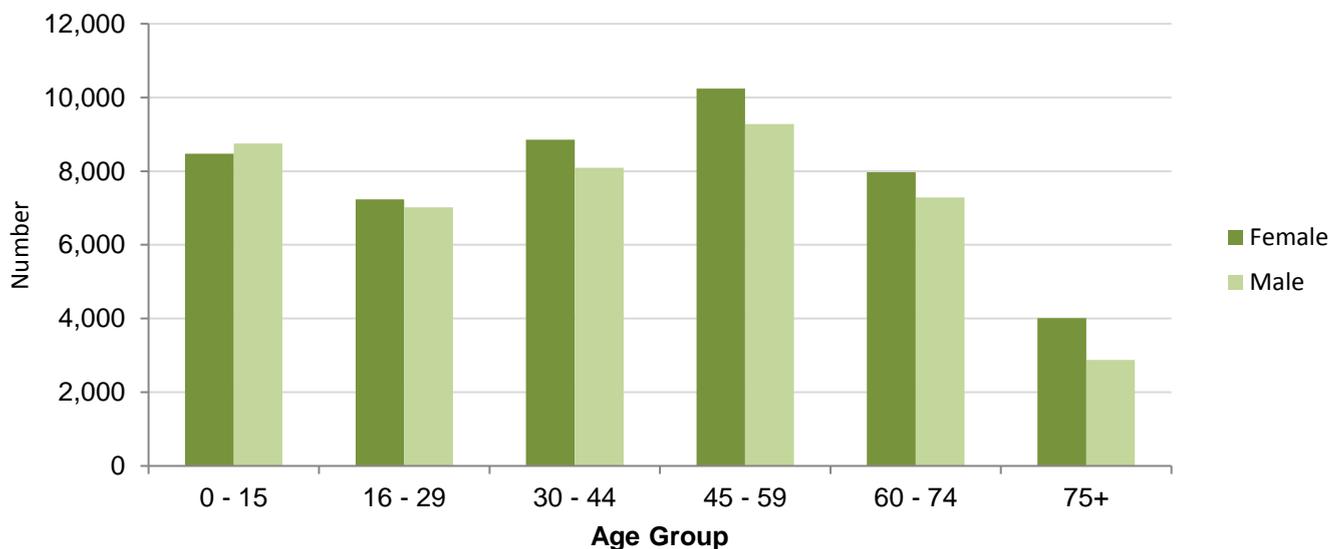


Data source: *National Records of Scotland* [Accessed: Aug. 2018]

## Gender

The female proportion of the population increases with age. This has implications for pensioner poverty as, historically, women have smaller retirement pensions.

FIGURE 10. POPULATION OF MIDLOTHIAN BY AGE AND GENDER (2017)



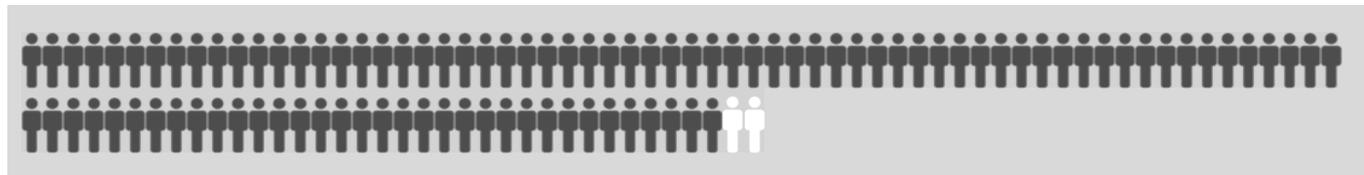
Data source: *National Records of Scotland* [Accessed: Aug. 2018]

We do not have reliable local figures for Trans and other gender identities. The Scottish Government does not currently have a recommended survey question to collect information about gender identity.

## Sexual Orientation

Sexual Orientation is a combination of emotional, romantic, sexual or affectionate attraction or feelings towards another person. It is about a person's identity. There is no reliable recent local information on sexual orientation for the Midlothian population. Extensive data is only available at a Scotland level.<sup>17</sup>

FIGURE 11. POPULATION OF SCOTLAND BY SEXUAL ORIENTATION(2017)



**2%** of the Scottish population identify as lesbian, gay bisexual or other.

Data source: Scottish Government (2017) *Sexual Orientation in Scotland 2017 A Summary of the Evidence Base*.

Compared to heterosexual adults, LGBTI adults were more likely to be younger; be single; live in large urban areas; live in deprived areas; report bad general health; smoke; be unemployed; and have a degree.

There has been a reduction in the percentage of people saying that 'sexual relations between two adults of the same sex' are 'wrong', and an increase in the percentage saying they are 'not wrong at all'. Despite this research findings show that this group continues to face discrimination.

**20%** of people had experienced a hate crime or incident due to their sexual orientation and/or gender identity in the last 12 month. **80%** of these said they didn't report this to the police<sup>18</sup>

# Prevention & early intervention

(factors that affect our health and wellbeing)

# Education and Qualifications

A person's level of education is an important influence on health and has a major role in shaping health and wellbeing over a lifetime. Education has a wide impact on health and wellbeing in terms of developing values, emotional intelligence, self-esteem and social functioning skills and should not just be focused on formal qualifications. There are also specific issues such as the much lower levels of literacy found among people who have convictions compared to the general population.

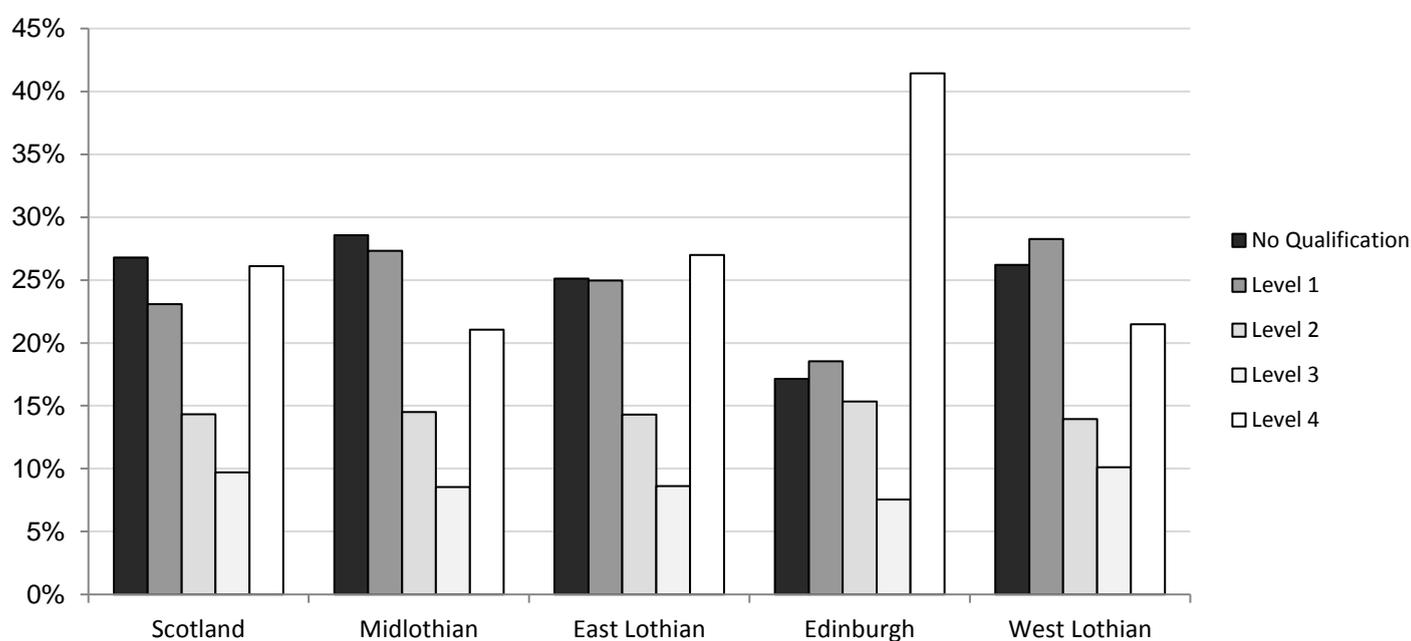
Qualifications are records of achievement awarded on the successful completion of a course of training or passing an examination. The census uses the following descriptors:

- Level 1 - SVQ 1 or 2 (standard grades and similar)
- Level 2 - SVQ 3 (Highers, advanced higher)
- Level 3 - SVQ 4 (HNC & HND)
- Level 4 - SVQ 5 (undergraduate and postgraduate degrees and professional qualifications)

## Adult qualifications:

There is still a lower proportion of people in Midlothian with HNDs, degrees, or degree-level qualifications than in Scotland overall. A lower proportion of Midlothian residents of working age achieve qualifications at SVQ3 and above than people in Scotland as a whole. The 2011 census showed that, in comparison to the rest of the Lothians Midlothian has the **fewest people with degree level qualifications** (level 4) and the **highest percentage of people with no qualifications**.

FIGURE 12. QUALIFICATIONS FOR PEOPLE AGED 16 AND OVER IN SCOTLAND & THE LOTHIAN PARTNERSHIPS



Data source: *Scottish Census 2011* [Accessed Dec 2018].

## Educational Attainment and Destination of School Leavers:

**93.9%** (835 pupils) of school leavers enter a positive destination e.g. training, employment, volunteering and further and higher education. This is higher than the national average and has increased from 78.4% in 2008/09.

### Higher education

The percentage of Midlothian leavers going into higher education over the last six years has dropped by **2.9%**, which is lower than the national average which has increased by 3.7%. In the last year, three schools have increased their proportions, while three have decreased

### Adult Literacy

The Midlothian Council Lifelong Learning & Employability ALN Service worked with **236** adults in the year 2016/17 (higher levels of women attended programmes than men).

**188** instances of ESOL (English Speakers of Other Languages) learning took place. The most common first language of people attending these courses was Polish.

### Further Education:

Total Midlothian student enrolments in 2016/17 at all colleges serving Midlothian was **3,160**. The highest disability in Edinburgh College in Midlothian is Dyslexia, with 38% of students who have a disability being dyslexic. Unseen disabilities such as diabetes, and undisclosed disabilities account for 33% of all other forms of disability.

**25.2%** of Midlothian school leavers go on to further education - lower than the national average (26.3%).<sup>19</sup>

## Employment & Income

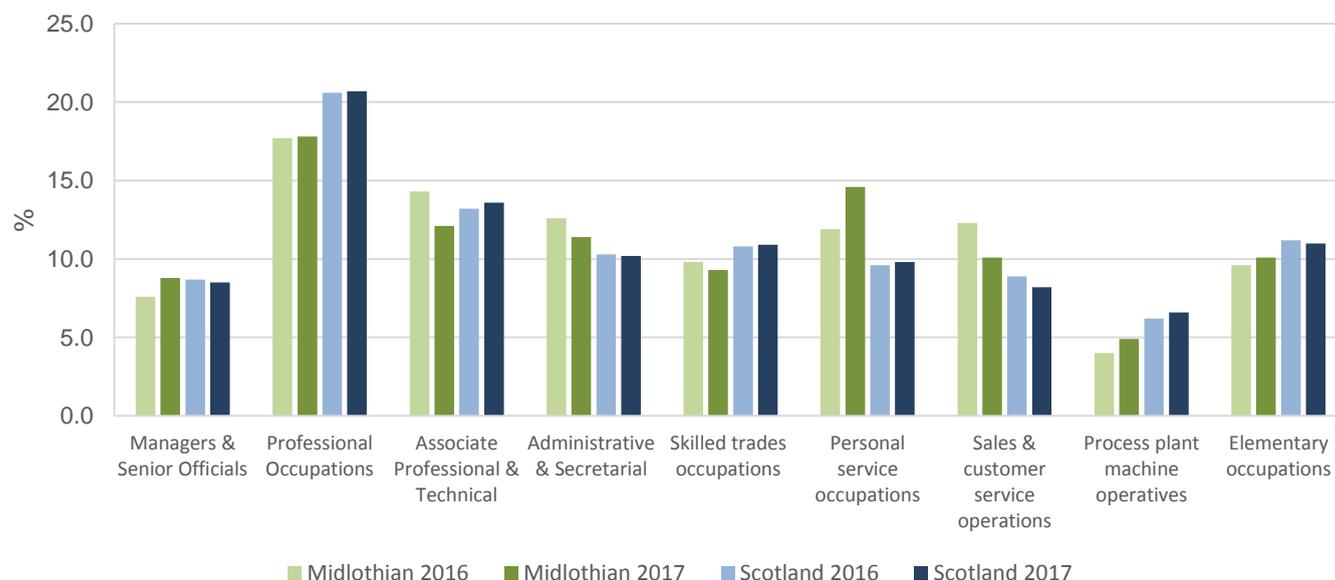
Income, and the lack of it can affect people's health in a number of different ways

- **Material:** Money buys goods and services that improve health. The more money families have, the better the goods and opportunities they can buy.
- **Psychosocial:** Managing on a low income is stressful. Comparing oneself to others and feeling at the bottom of the social ladder can be distressing, which can lead to biochemical changes in the body causing ill health.
- **Behavioural:** For various reasons, people on low incomes are more likely to adopt unhealthy behaviours – smoking and drinking, for example – while those on higher incomes are more able to afford healthier lifestyles.
- **Reverse causation (poor health leads to low income):** Health may affect income by preventing people from taking paid employment. Childhood health may also affect educational outcomes, limiting job opportunities and potential earnings<sup>20</sup>.

The availability and the nature of employment also affects people's health. In the past being involved in mining has had a considerable legacy, while more recently sedentary office work is also having an effect.

Half of all people in Scotland living in poverty live in a working household.

FIGURE 13. EMPLOYMENT BY OCCUPATION FOR MIDLOTHIAN RESIDENTS



Data source: *ONS Annual Population Survey*. [Accessed Sept 2018].

**Working Population:** The economically active population was 45,700 which is 80.9% of total working age population in 2017. This is an increase from 2016 (78.8%) and 2015 (78.5%). The Scottish rate is 81.25% (2018). For disabled people the national rate drops to 45.4%. The Scottish Government have set an ambition to half the pay gap by 2038<sup>21</sup>

**Earnings:** Workers in Midlothian (by place of residence) consistently earn less than the Scottish median earnings per week. Midlothian full time employed residents in 2017 earned on average £540.60 per week. This compares to the Scottish equivalent of £547.70, (a gap of £7.10) and UK of £552.70. This gap has closed from £29.70 in 2015, and £29.00 in 2016.

**Women's earnings:** Female full time workers in Midlothian (by place of residence) earned on averages £22.30 less than the overall Midlothian full time employee average figure in 2017, £11.90 less in 2015, and £13.00 less in 2016.

**Employment:** Between 2015 and 2016, there was an increase in the number of Midlothian residents in employment from 29,000 to **30,000**, 10,000 of which are part time. 2017 data is not available. Job Density (rate of jobs to applicants) remains below the Scottish average figures - 0.65 Midlothian to 0.8 Scotland and 0.84 UK.

**Benefits:** There were approximately **3500** Midlothian residents to be transferred over to Personal Independence Payments. Of the existing DLA claimants in Midlothian, it is expected that around 50% of working age claimants will lose some or all of their disability benefits by the end of 2018/19. Many unpaid carers of working-age disabled people who lose eligibility for DLA/PIP will no longer qualify for carer's allowance.

As of November 2018, **1,483** households in Midlothian had an active Universal Credit Claim<sup>22</sup>. Universal Credit replaces the following benefits into one monthly payment (or twice a month in Scotland if selected) Child Tax Credit, Housing Benefit, Income Support, Income-based Jobseeker's Allowance (JSA), Income-based Employment and Support Allowance (ESA) & Working Tax Credits. The Department of Work and Pensions call these legacy benefits. Many people are still on legacy benefits and will remain on these until they have a change of circumstance that would require them to claim Universal Credit. Since the introduction of Universal Credit levels of housing debt due to public and private sector landlords have climbed significantly, with £1.47million due to the Council by November 2017 (£1,283,124 for mainstream properties and £189,098 for temporary accommodation). The roll out also saw increased demand for Discretionary Housing Payments (DHP) with £828,492 being paid in 2016/17 and £966,368 paid and committed in 2017/18 as at 31 October 2017. The Scottish Welfare Fund, (SWF) saw a 20% increase in Crisis grant applications in the 7 month period to 31 October 2017 compared with the same period last year.<sup>23</sup>

Employment is important for health, but it needs to be 'good' employment that pays well so that people can sustain a reasonable standard of living. Policies that increase the number of working-age adults in sustainable, paid employment that protects their physical and mental health would make an important contribution to improving health outcomes.

In-work poverty should also remain a cause for concern.

Benefits are also important for maintaining people's income and therefore health when they are vulnerable or for other reasons. Therefore continued provision of benefits advice is essential.

Work with major employment sectors in Midlothian to improve the quality of employment.

# Housing

Housing plays a key role in the health and well-being of individuals. Where we live can promote our health if it is:

- affordable and provides a stable and secure base
- a place where we feel safe and comfortable
- able to provide for all the household's requirements
- connected to community, work and services<sup>24</sup>.

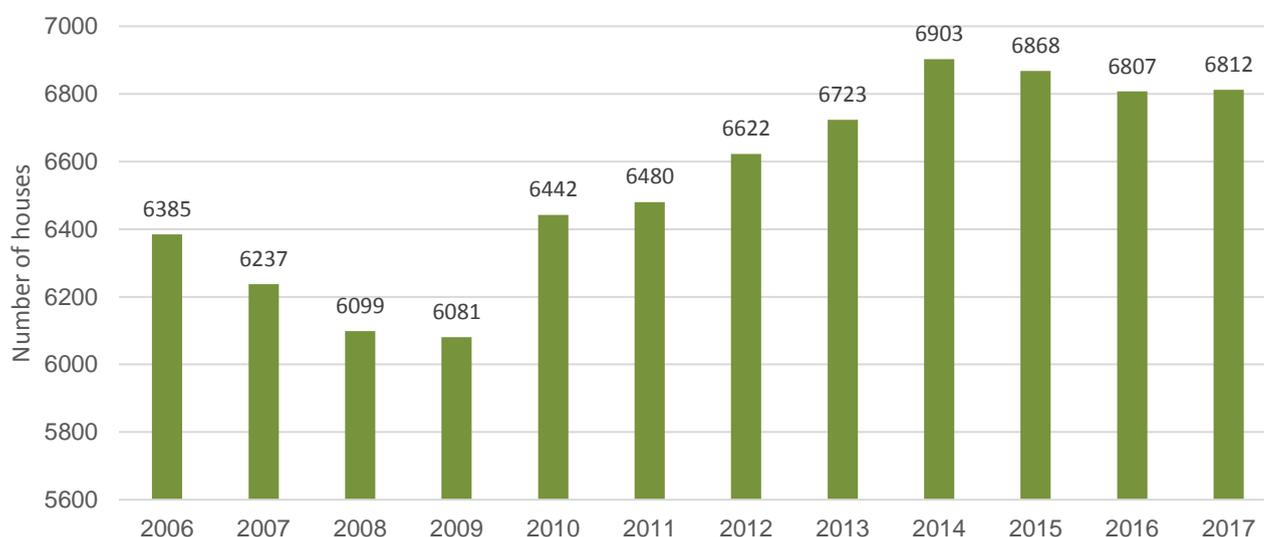
## Housing: availability and suitability

Good-quality housing is critical to health, it can reduce and delay demand for NHS and social care services and allows patients to go home when they are clinically fit to do so. Those living in more deprived areas or on lower incomes are more likely to experience housing with the potential to impact adversely on health, such as overcrowding, dampness, and fuel poverty. All affordable rented housing needs to meet the Scottish Housing Quality Standard. All stock is being improved to this standard.

Suitable housing has long been regarded as vital in supporting people who are frail or have some form of disability, to live well in the community. Staying at home is a viable option for most of us as we age, but may depend on our home's location, accessibility, size, energy efficiency and proximity to local amenities. **91%** of people believe their housing is currently suitable to their needs. **50%** of Health and Social Care workers agree with this statement.<sup>25</sup>

The number of households is projected to increase from **35,540** in 2016 to **43,312** in 2037<sup>26</sup>. This represents a 22% increase in households. Midlothian's Strategic Housing Investment Plan 2019 – 2024 has identified sites for the development of up to **2,202** new affordable homes. These are being developed by the Council and other local Registered Social Landlords.

FIGURE 14. LEVEL OF COUNCIL HOUSING STOCK



Data source: Community Planning. (2017). *Midlothian Moving Forward Community Planning for Midlothian*.

Legislation in 2016 ended the 'right to buy' sales of council houses which will avoid further depletions in the level of social rented stock in Midlothian. Council housing stock has been increasing. In 2017 there were 6,812 with plans to build another 1,000 council homes<sup>27</sup>.

Midlothian Council continues to build new housing ensuring that the needs of older people and people with a disability are considered. There is also work with Housing Associations/RSLs to redesign some accommodation to enable people with higher levels of need to be supported.

The Scottish House Condition Survey (2014-2016) shows:

- **41%** of households contain one or more long term sick or disabled persons.
  - **53%** of which are social housing, **38%** are owner-occupied properties.
  - **60%** contained pensioners,
  - **40%** had adults only, **27%** had families.

## Equipment and Adaptations

Significant investment is required in adaptations and equipment to promote independence and enable people to stay in their own home. The Adult Social Care Team process most requests for major housing adaptations.

The most common adaptations were **wet floor showers and ramps** in council houses and **wet floor showers and stairlifts** in the private sector (owner occupied and privately rented) between 2014 and 2017. These accounted for over 90% (£1.03 million) of the total £1.221 million Private Sector Housing Grant budget<sup>28</sup>.

Social landlords receive grants directly from the Scottish Government for adaptations. Information available shows adaptations to **showers and baths** accounted for the majority of all social landlord adaptations between 2013 and 18<sup>29</sup>.

The requirement for adaptations to support people to stay in their own homes is increasing. **15%** of dwellings have some form of adaptation. For social housing this rises to **30%**. **28%** of pensioner households have an adaptation compared to **7%** of family households and **13%** of adult only households<sup>30</sup>.

### Minor adaptations:

There were **693 minor adaptations** made to houses (council houses and private sector) as a result of both health and social care requests in 2016/17<sup>31</sup>. This includes **internal/external rails, grab rails and banisters**. The number rose to **761** with a cost of £118,000 in 2017/18 compared to £89,000 in 2016/17. Information for social landlords shows that **external and internal safety rails** were by far the most common minor adaptations between 2013/14 and 2017/18<sup>32</sup>.

### Major adaptations

There were around **480** requests to Adult Social Care for specialist equipment over £250 and major adaptations in 2017 and 2018. Around **370** of these resulted in a provision being made (equipment and/or adaptation)<sup>33</sup>. For major adaptations alone, **385** were completed between 2014 and 2017 for council and private sector properties<sup>34</sup>.

### Equipment

We spent **£869,773** on equipment through the Joint Equipment Store which is a shared resource between Midlothian, East Lothian and Edinburgh (2017/18)<sup>35</sup>. Common pieces of equipment include **walking aides, pressure care, commodes, chair and bed raisers, reclining chairs, hospital beds, bathing equipment and specialist equipment**.

Most people in receipt of equipment felt it made a difference to their independence and were pleased with the provision<sup>36</sup>. Staff also recognised the value of Occupational Therapy to promote independence and prevent deterioration, noting the importance of earlier intervention. Joint working with Occupational Therapy and housing was raised as an important issue to support appropriate housing<sup>37</sup>.

## Existing Additional Needs Housing Provision

Extra Care Housing is suited to older people (over 60) with higher care needs. There are onsite staff teams who provide support. Meals are also available onsite. There are **2 Extra Care Housing facilities**:

- Cowan Court (Penicuik) - **32** flats (1 intermediate care). Managed by Midlothian Council. **68** people are on the waiting list for a 1 bed flat, **5** are waiting for a 2 bed flat (2018).
- Hawthorn Gardens (Loanhead) - 35 flats. Managed by Trust Housing Association. **41** people are on the waiting list

**There is 1 'Very Sheltered' housing facility** providing accommodation with staff onsite and meals for those over 60.

- Glenesk House (Eskbank) – **35** flats. Managed by Viewpoint Housing Association. This is under development. **38** people are on the waiting list.

Sheltered housing is no longer available. Previous sheltered complexes have deregistered their facilities to retirement status.

**Retirement housing** provides accommodation with a part time manager onsite for those over 60. There are **9 retirement housing facilities**. The waiting lists vary from **78** applicants for Crystallmount in Dalkeith (Castlerock Edinvar HA) to **39** for Emily Court Gorebridge (Bield HA) (2018). More than 50% of the applicants on these waiting lists meet the criteria for Extra Care Housing, and while a number of these applicants can also be found on the waiting lists for Cowan Court and/or Hawthorn Gardens, the majority are not. The most common reason is that they do not wish to move to Penicuik or Loanhead. Many would prefer to stay in their local area and compromise on accommodation that does not perhaps best suit their long term care needs.

For adults who have a learning disability and complex needs the preferred model of support is core and cluster. This allows for flexibility to be built into support. For people with a more moderate Learning Disability clustering arrangements are more dispersed and often delivered within more mainstream housing within any given locality.

**Teviot Court** provides accommodation for **12** adults with a learning disability and complex needs in Penicuik.

## New Additional Need Housing Provision

A total of **239 specialist provision homes** have been identified for development by the Council and other local Registered Social Landlords as part of Midlothian's Strategic Housing Investment Plan 2019-2024<sup>38</sup>. This includes:

- 81 extra care housing homes
- 104 amenity housing homes
- 12 homes to meet complex care needs
- 5 wheelchair accessible homes
- 4 bariatric homes
- 33 homes with level access shower rooms

Most 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.

Demand for housing with support is high. If we are committed to tackling health inequalities there needs to be attention on housing. Where health and housing have come together, the focus has often been around keeping people independent and at home, and on supporting discharge from hospital. This is important but the Health & Social Care Partnership needs to take advantage of the contribution housing can make to maximise the health of local populations across the life-course. Housing has the potential to reduce or reinforce health inequalities. We need to consider how our housing models will drive our care aspirations especially with regard to dementia friendly, younger people with a physical disability, people with a learning disability and supporting people to maintain connections with their community.

## Homelessness

*Homelessness means* not having a home. You are *homeless* if you have nowhere to stay and are living on the streets or if you are: staying with friends or family, staying in temporary accommodation provided by the local authority, a hostel or B&B.<sup>39</sup> In Midlothian there is very little rough sleeping but there are over 1000 homeless households, mainly living in temporary accommodation<sup>40</sup>. People assessed as homeless are likely to be among the most deprived. Health outcomes and homelessness are known to be related<sup>41</sup>:

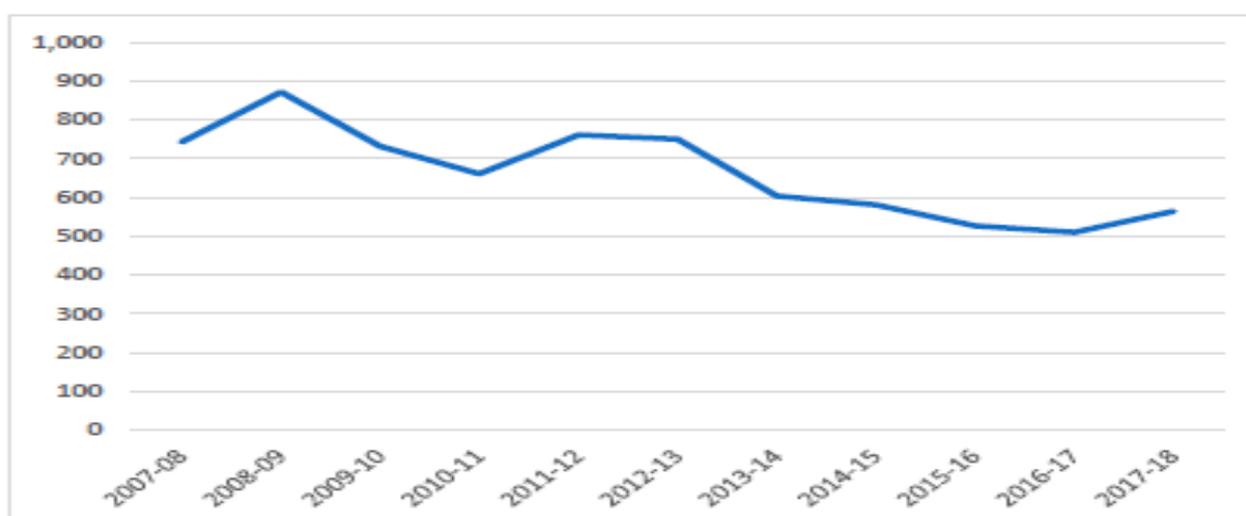
- Homeless people are among the most vulnerable and socially excluded in our society and often find it difficult to access the help they need.
- Homeless people have higher rates of premature mortality than the rest of the population, especially from suicide and unintentional injuries, and an increased prevalence of a range of infectious diseases, mental disorders, and substance misuse. Homeless people typically attend the emergency department more often than non-homeless people.
- Other studies have shown that homeless populations experience extreme health inequities across a wide range of health conditions, with the relative effect of exclusion being greater in female individuals than in male individuals.

TABLE 3. REASONS FOR HOMELESSNESS, 2012 – 2017

|   | Percentage |
|---|------------|
| Asked to leave  | 33%        |
| Dispute within household: violent or abusive                                | 22%        |
| Dispute within household / relationship breakdown: non-violent              | 15%        |
| Other action by landlord resulting in the termination of the tenancy        | 9%         |
| Other reason for leaving accommodation / household                          | 6%         |
| Other reason for loss of accommodation                                      | 3%         |
| Termination of tenancy / mortgage due to rent arrears / default on payments | 3%         |
| Discharge from prison / hospital / care / other institution                 | 2%         |
| Forced division and sale of matrimonial home                                | 2%         |
| Overcrowding  | 2%         |
| Loss of service / tied accommodation  | 1%         |
| Harassment  | 1%         |
| Fleeing non-domestic violence   | 1%         |
| Applicant terminated secure accommodation                                   | 1%         |

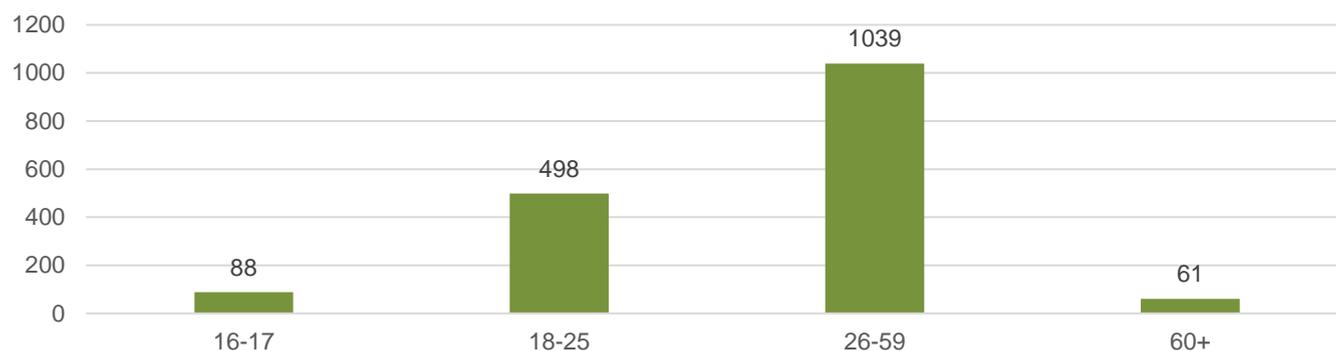
Data source: Midlothian Council. *Rapid Rehousing Transition Plan 2019/20 – 2023/24*.

FIGURE 15. NUMBER OF HOMELESS APPLICATIONS (2007 – 2018)



Data source: Midlothian Council. *Rapid Rehousing Transition Plan 2019/20 – 2023/24*.

FIGURE 16. HOMELESS APPLICATIONS BY AGE GROUP 2016 – 2018



Data source: Community Planning. (2017). *Midlothian Moving Forward Community Planning for Midlothian*.

Reductions in homeless presentations are attributable to Midlothian Council's approach to homeless prevention for those at risk of becoming homeless.

Youth homelessness continues to be a major problem in Scotland as well as in Midlothian which is detrimental to those in significant need.

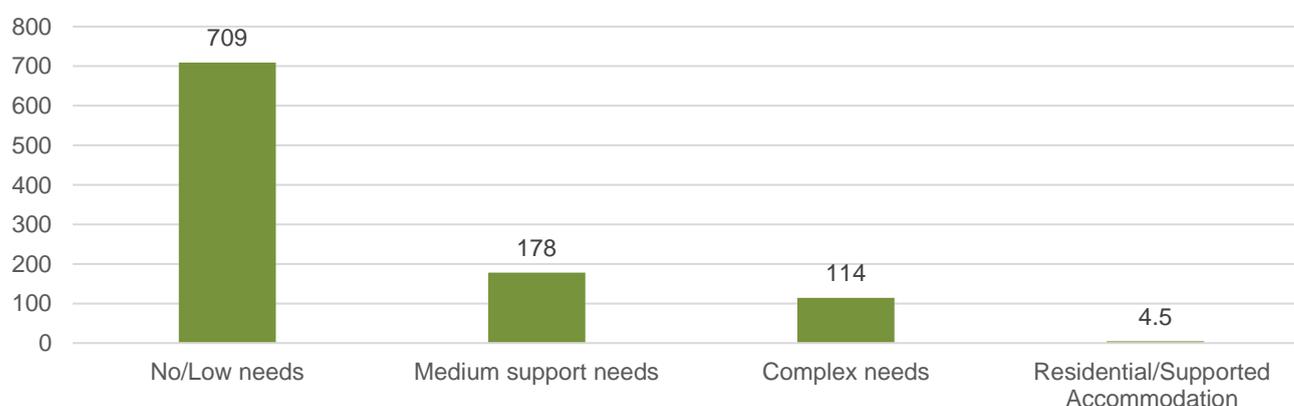
People in hostel accommodation valued the CHIT nurse visiting their unit and supporting them with health issues<sup>42</sup>

Due to the limited supply of new housing, homeless households spend a significant amount of time in temporary accommodation until they can be permanently housed. Midlothian Council reported the longest average number of weeks to close a homeless case in Scotland, with an average time of 105 weeks to close a case<sup>43</sup>. The average time across Scotland was 34 weeks. The shortest average time to close a homeless case in Scotland was 17 weeks. The main reason for this length of time is a lack of supply of social rented lets to accommodate homeless households.

Support needs of homeless households can be classified into 4 groups:

- **No/Low Support needs** – easily move into mainstream, settled housing with no need for specific support other than signposting/low level housing management support.
- **Medium support needs** – e.g. visiting housing support or multi-professional wrap-around support to enable people to live independently in mainstream housing.
- **Complex needs** – e.g. severe and multiple disadvantage or complex needs who would benefit from intensive wrap-around support and a housing first approach to re-housing
- **Residential/Supported Accommodation** – independent living is not appropriate due to safety, risk to self or others, choice and for whom shared and supported accommodation is the preferred housing option.

FIGURE 17. SUPPORT NEEDS OF HOMELESS HOUSEHOLDS (NOV 2018)



Data source: Midlothian Council. *Rapid Rehousing Transition Plan 2019/20 – 2023/24*.

Services need to support homeless people and families. The specific needs of those with multiple co-morbidities should be considered, for example those with co-existing substance misuse and mental health difficulties.

Health & Social Care Partnership can contribute to the prevention of homelessness by working with partners to support those with complex needs around their health and wider social care needs.

Health & social care services need to link to income maximisation and housing services in order to provide effective care and support.

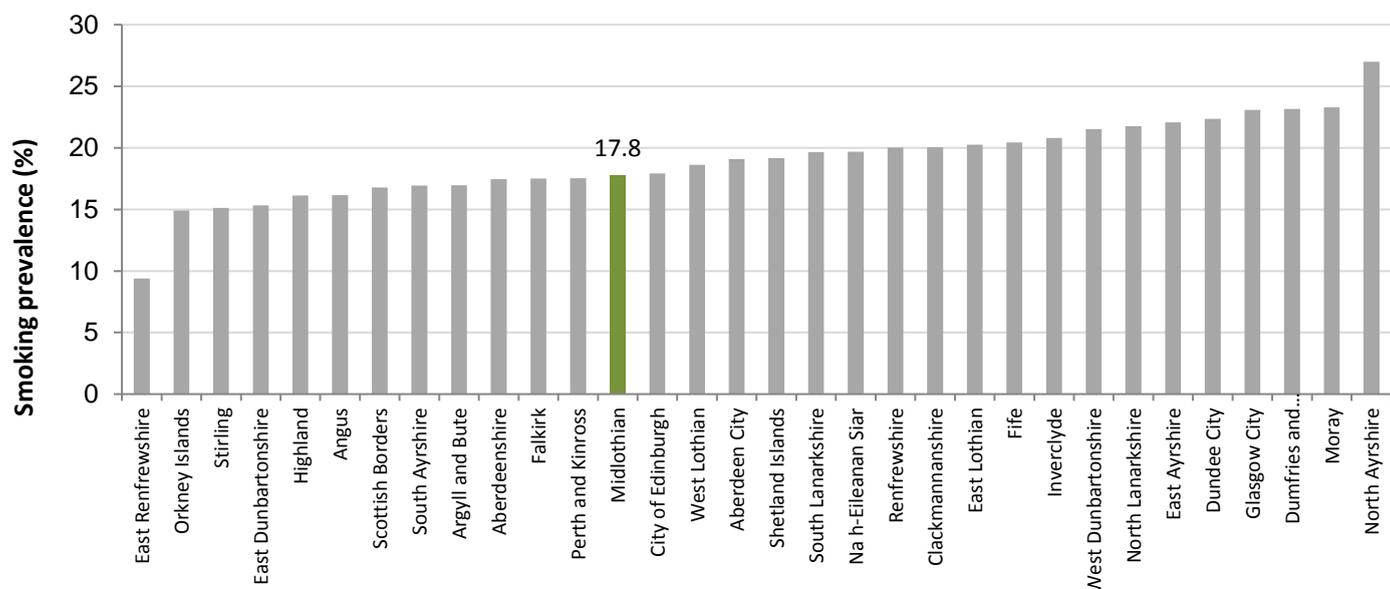
There is a role for preventative and early identification support to people in homeless accommodation. Universal and specialist services should be tailored to ensure reach, acceptability and positive outcomes, for example innovative approaches to support people to undertake screening. How we evaluate the impact of services and support for homeless people requires consideration.

# Lifestyle Factors

## Smoking

**Smoking prevalence** is the number of people who smoke tobacco in an area at a point in time. It is estimated from asking “Do you smoke cigarettes nowadays?” in three different annual household surveys.

FIGURE 18. SMOKING PREVALENCE FOR AGE 16+, BY LOCAL AUTHORITIES IN SCOTLAND (2016)



Data source: *Scottish Survey Core Questions* [Accessed Sept. 2018]

**17,500** (17.8%) people are smokers (2016/17), this is lower than 19.6% in Scotland overall<sup>44</sup>

TABLE 4. ESTIMATED PREVALENCE OF CIGARETTE SMOKING IN MIDLOTHIAN & ESTIMATED NUMBER OF ADULT SMOKERS

|                  | 2012 - 13   |                     | 2014 - 15   |                     | 2016        |                     |
|------------------|-------------|---------------------|-------------|---------------------|-------------|---------------------|
|                  |             | Confidence Interval |             | Confidence Interval |             | Confidence Interval |
| Prevalence       | 22.2 (23.3) | 18.1 -26.3          | 23.7 (20.9) | 19.1 -26.3          | 17.8 (19.6) | 12.9 - 22.6         |
| Mid year Pop 16+ | 68,481      |                     | 69,811      |                     | 71,726      |                     |
| No. of smokers   | 15,203      |                     | 16,545      |                     | 12,767      |                     |

Data source: *Scottish Survey Core Questions* [Accessed Sept. 2018]

**Smoking in Pregnancy:**

**14.6%** of women smoke during pregnancy in Midlothian which is slightly higher than the Scottish average of 14.4%<sup>45</sup>. Midlothian used to have a higher rate than Scotland but this gap has now reduced. Note that there is evidence of under-reporting by women of their smoking behaviour at the booking appointment but this issue is being addressed, and has improved in recent years. This may have had an effect on prevalence levels and therefore trend data.

Following the Scotland trend, the percentage of women smoking during pregnancy in Midlothian increases as the level of deprivation increases with the highest percentage in the most deprived category (30%). Those living in the most deprived areas are approximately 6 times more likely to smoke during pregnancy than those in the least deprived areas.

Additionally, significantly fewer pregnant women made a quit attempt in Lothian (4 week quit rate: 18.1%, 12 week quit rate: 11.0%) with the help of NHS smoking cessation services compared with the Scottish average (4 week quit rate: 31.7%, 12 week quit rate: 19.9%).

**Deaths and illness related to smoking:**

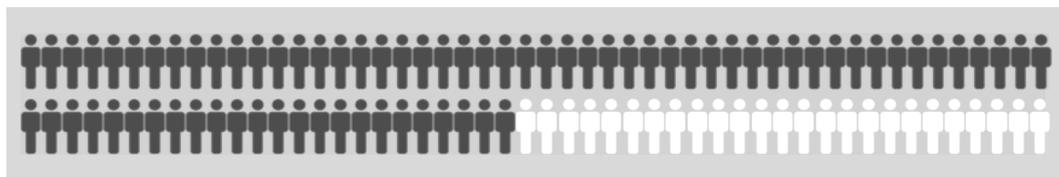
There were around 3,400 smoking attributable hospital admissions per 100,000 of the population in Midlothian for the combined 3-year period 2012-2014<sup>46</sup>. This was higher than the Scottish average (3,150 per 100,000 population). Contrasting with the Scottish average, this rate has been increasing since the 2008-2010 period, and has remained above the Scottish average since 2010-2012.

Two of the main health implications of smoking are COPD (see also COPD section) and lung cancer (see also Cancer section). Over the last decade the COPD incidence rate per 100,000 in Midlothian has improved such that the Midlothian rate (189) in the combined two year period of 2014/15 – 2016/17 is only slightly above the Scotland rate (180)<sup>47</sup>. The number of deaths from COPD in 2014-2016 per 100,000 is not significantly different from the Scottish average (77 vs. 93, respectively) but it is important to note that Midlothian rates have been increasing over time since 2011-2013 whereas Scotland has been falling.

Lung cancer remains the most common cancer overall in Scotland for both sexes combined, with 5,045 cases diagnosed in 2016. This accounted for 16.1% of all cancers in Scotland<sup>48</sup>. However, in both Scotland and Midlothian, rates of lung cancer registrations per 100,000 of the population have been decreasing since the period 2012-2014. Lung cancer deaths for 2014-2016 were also not significantly different from the Scottish average, with a decrease for Midlothian since 2012-2014.

## Diet and Nutrition

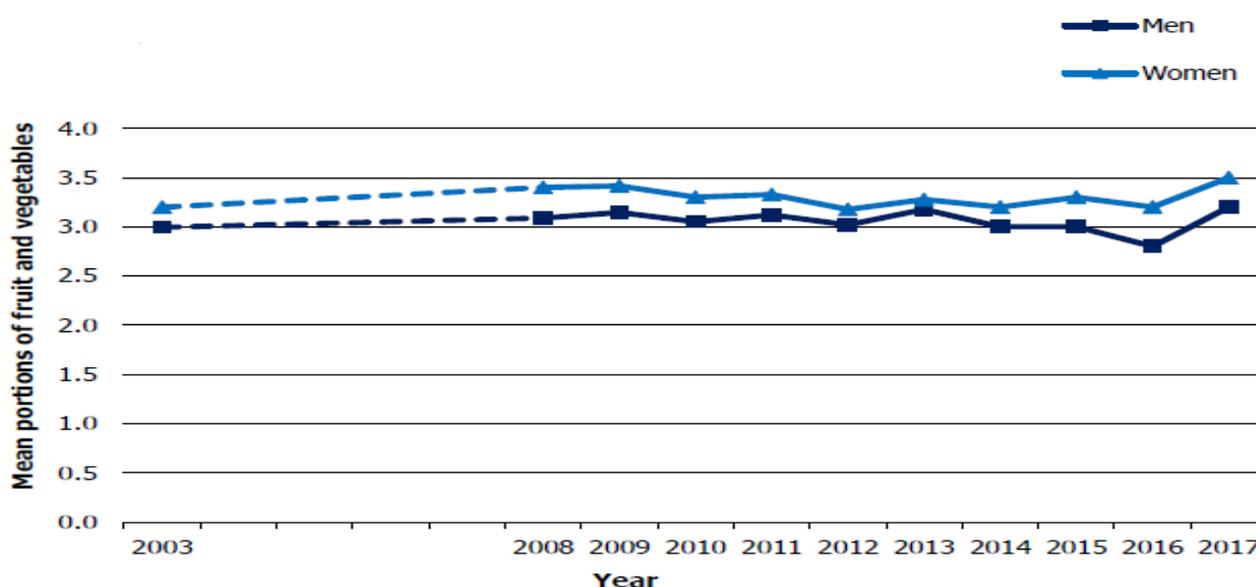
The World Health Organisation recommends adults eat at least five varied portions (80g per portion) of fruit and vegetables a day. The figures below are self-reported and it is not possible to verify them.



**29% of people** report that they eat at least 5 portions a day<sup>49</sup>. This proportion has remained relatively stable since 2003 and is higher than the Scottish average (24%)<sup>50</sup>.

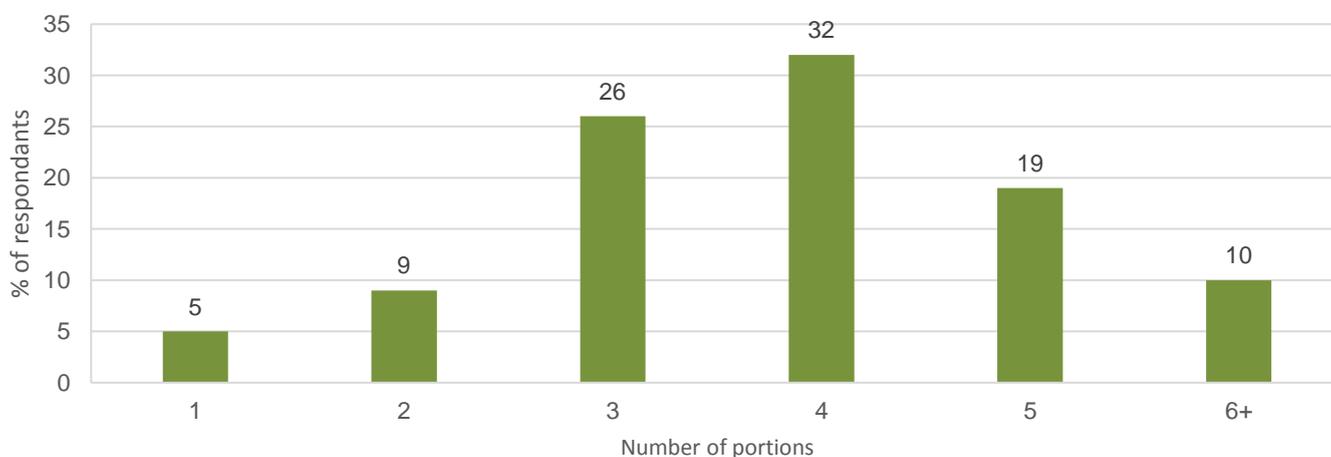
**24% of men** and **27% of women** eat the required portions in Lothian, similar to Scottish figures of (20% men, 22% women).

FIGURE 19. PREVALENCE OF ADULTS WHO CONSUME FIVE OR MORE PORTIONS OF FRUIT AND VEGETABLES A DAY (SCOTLAND)



Data source: Scottish Government. (2018). *The Scottish Health Survey 2017 edition* [Accessed Jan. 2019].

FIGURE 20. HOW MANY PORTIONS OF FRUIT AND VEGETABLES DID YOU EAT YESTERDAY? MIDLOTHIAN



Data source: Midlothian Community Planning Partnership. *Citizens' Panel - Winter 2017/18 Questionnaire*.

## Food insecurity

Food insecurity is the inability to acquire or consume an adequate quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.

The 2017 Scottish Health Survey asked 3 questions about food insecurity in the last 12 months. There was a significant association between area deprivation and food insecurity.

- **Percentage of people worried about running out of food due to a lack of money or resources:** **18%** of people in the most deprived areas compared with **3%** of people in the least deprived areas. The pattern was similar for men (19% to 3%) and women (17% to 4%).
- **Percentage of people who have eaten less than they should due to a lack of money or resources:** **15%** of people in the most deprived areas compared with **3%** of people in the least deprived areas. This pattern was similar for men (15% to 3%) and women (14% to 3%).
- **Percentage of people who had run out of food:** **10%** of people in the most deprived areas compared to **1%** in the least deprived areas. This pattern was similar for both men (11% to 1%) and women (9% to 1%).

The 2017-2018 Midlothian Citizen's Panel also asked a question about food insecurity in the last 12 months:

- Percentage of people who had to miss a meal because they cannot afford to buy the food they need. 2% of people had to miss a meal. This is down from 3% in 2017

Efforts to tackle inequalities in health outcomes will be seriously hampered by ongoing issues of food insecurity

A lack of fruit and vegetables in people's diet is a risk factor in a health problems such as heart disease, cancer, type II diabetes, hypertension and obesity. It is second only to smoking as a risk factor for early death.

Scotland's diet and alcohol intake is widely cited as a factor in its poor health. It is estimated that about a third of cases of cancer and cardiovascular disease could be prevented by changes in diet, both through improvements in nutritional content and overall reductions in body mass. Options such as decreasing access and availability of unhealthy options and increasing access, availability and affordability of healthy options should be considered.

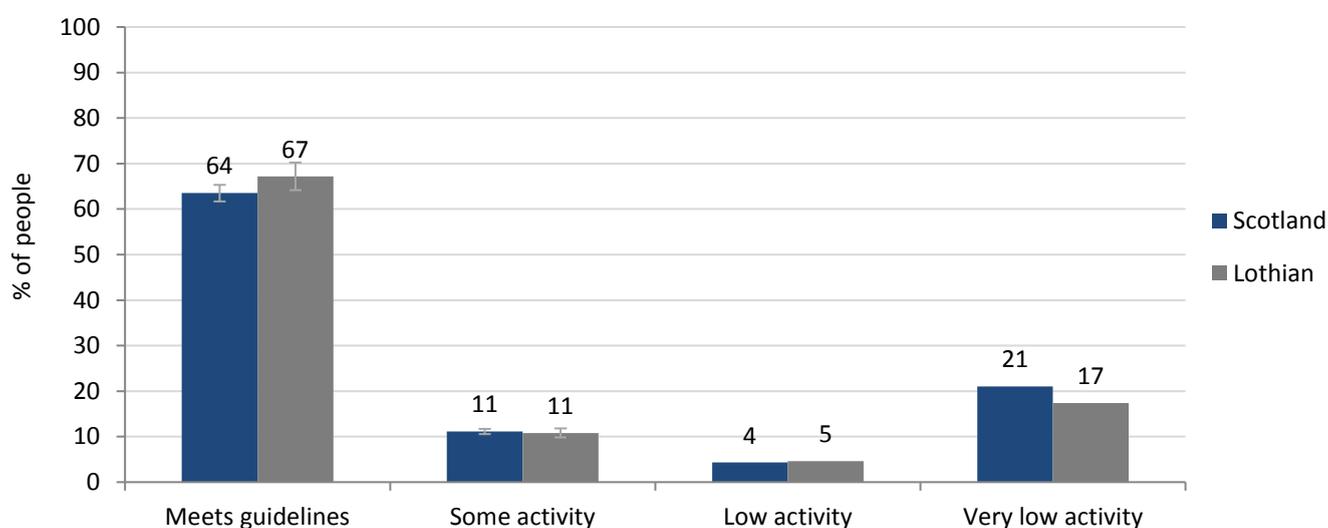
## Physical Activity and Exercise

Physical activity is measured using the Chief Medical Officers adult physical activity guidelines (per week):

- **Moderate/vigorous physical activity:** at least 150 minutes of moderately intensive physical activity or 75 minutes vigorous activity or an equivalent combination of both.
- **Some activity:** 60-149 minutes of moderate activity or 30-74 minutes of vigorous activity or an equivalent combination of these.
- **Low activity:** 30-59 minutes of moderate activity or 15-29 minutes of vigorous activity or an equivalent combination of these.
- **Very low activity:** Less than 30 minutes of moderate activity or less than 15 minutes of vigorous activity or an equivalent combination of these.

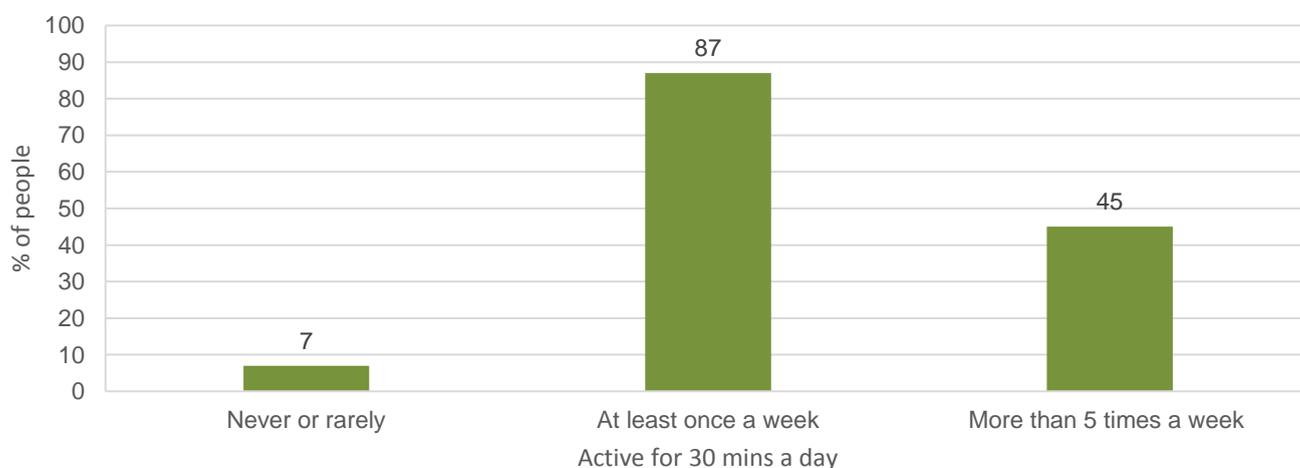
The figures below are self-reported and it is not possible to verify them.

FIGURE 21. PROPORTION OF ADULTS MEETING PHYSICAL ACTIVITY RECOMMENDATIONS (LOTHIAN)



Data source: Scottish Government. (2018). *The Scottish Health Survey 2017 edition* [Accessed Nov. 2018].

FIGURE 22. PROPORTION OF ADULTS BEING ACTIVE FOR AT LEAST 30 MINS A DAY (MIDLOTHIAN)



Data source: Midlothian Community Planning Partnership. *Citizens' Panel – Winter 2017/18 Questionnaire*.

The proportion of adults reporting that they are active for at least 30 minutes per day has increased rapidly from 2016 when only 1% of respondents said that they were active at this level and 2017 (36%). Walking (88%) and housework, gardening or window cleaning (70%) were the most cited physical activities by respondents. Gym activities (19%), work related activity (16%) and cycling (16%) were the next most popular.

Unfair and avoidable differences in the amount of activity a person is able to do still exist:

- increased walking is reducing inequalities but differences still exist, particularly for disabled people
- excluding school-based activity such as PE, the inequality in sports participation by deprivation in children is widening
- retirement and the transition from primary to secondary school are key moments to influence physical activity in old age and children respectively.<sup>51</sup>

It cannot be overstated how important physical activity is for our health. Inactivity is challenging smoking as a major cause of avoidable ill health. The health benefits of a physically active lifestyle are well documented and there is abundant evidence that regular activity is related to a reduced incidence of chronic conditions of particular concern in Scotland, such as cardiovascular disease, obesity, and type 2 diabetes.

## Healthy Weight

Maintaining a healthy weight is important. For adults, the body mass index (BMI) is used to calculate whether a person is underweight, a healthy weight, overweight or obese for their height. Adults are classed as overweight if their BMI is 25 to less than 30, obese if their BMI is 30 to less than 40 and morbidly obese if their BMI is 40 or more.

People who are overweight are at higher risk from serious diseases which can lead to premature death or reduced quality of life such as type 2 diabetes, cardiovascular disease, hypertension and stroke, and some forms of cancer.

People who have a low body weight (as a result of either an eating disorder or long term illness such as COPD) are also at risk. Low birth weight is a risk for poor health outcomes. Low birth weight can be caused by mothers smoking during pregnancy as well as other medical problems.

FIGURE 23. PREVALENCE OF OVERWEIGHT ADULTS

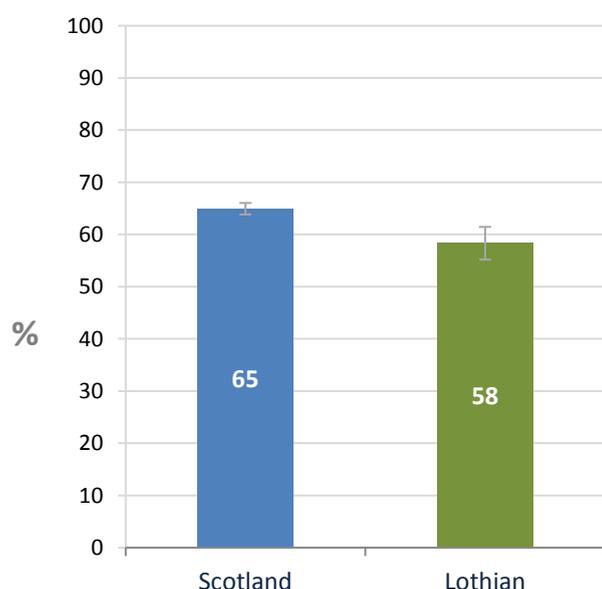
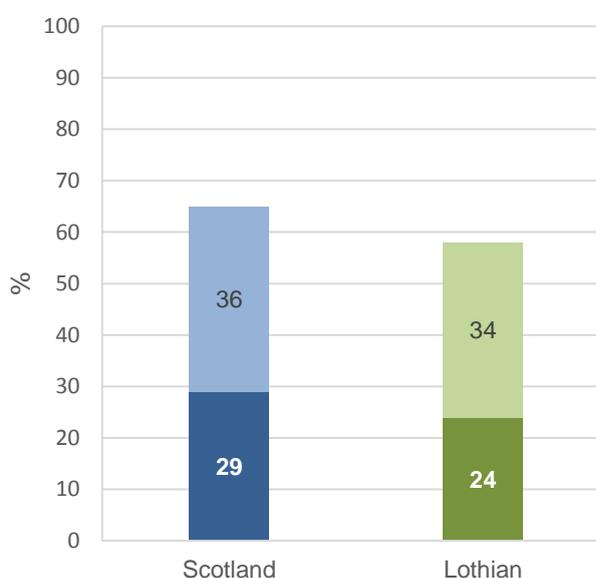


FIGURE 24. PROPORTION OF ADULTS (16+) WHO ARE OBESE (LIGHT COLOUR) OR OVERWEIGHT (DARK COLOUR) (2017)



Data source: Scottish Government. (2018). *The Scottish Health Survey Results for Local Areas 2014/2015/2016/2017; September 2018* [Accessed Oct. 2018].

In Scotland the prevalence of people who are overweight is the same among women and men. Men aged 65-74 years and women aged 45-54 years were most likely to be obese than other age groups.

Historically, there was an increase between 2003 and 2008, where prevalence of overweight (including obesity) rose from 62% to 65%. Rates have stabilised since<sup>52</sup>.

Although we don't have accurate data for on obesity we do know that cases of diabetes linked to obesity have risen significantly. We also know that services in Midlothian have had to invest in the provision of bariatric equipment and housing for people who are morbidly obese. Demand for treatment and support for people with obesity and linked conditions has gone up and will continue to do so unless we do a wide range of actions across the board.

In line with our prevention agenda services need to be promoting healthy weight at every opportunity. All services across the HSCP should be preparing for an increased number of people who are obese and overweight.

It's imperative to tackle the 'obesogenic environment' – the range of factors that influence what we eat and how much we are active.

## Oral Health

Oral health and general health are linked. Smoking, diet, alcohol use and income all have a strong influence and poor oral health can be largely prevented. The oral health of Scotland's primary school aged children has been improving<sup>53</sup>. However, for older generations there is still the legacy of poor dental hygiene and diet and there is no annual survey for adults at a Midlothian level.

TABLE 5. POPULATION TO DENTIST RATIO, BY NHS BOARD AND COUNCIL AREA (2018)

| Lothian Health Board | East Lothian | City of Edinburgh | West Lothian | Midlothian |
|----------------------|--------------|-------------------|--------------|------------|
| 1:1801               | 1:1906       | 1:1624            | 1:2238       | 1:2145     |

Data source: *NHS Internal Data - Dental list* (Accessed – Nov. 2018).

Note: ratios are calculated using mid-2016 population estimates for council areas.

Where dentists work in more than one practice they have only been counted once. Therefore some figures at council level may over or underestimate the ratio. It is also assumed that dentists will work a whole time equivalent in the NHS.

Data on the split between NHS and private treatment is not available at a practitioner level.

Adult oral health in Scotland has improved. **The number of people reporting no natural teeth has reduced<sup>54</sup>**. On the other hand 11% of adults reported they had experienced dental pain in the past year, 27% felt they needed treatment and 25% had noticed bleeding from their gums occasionally or often.

In the same survey 72% of adults in Scotland reported they had visited the dentist in the past year but 23% reported significant difficulties in accessing dental care which included physical access issues, cost of treatment and travel and difficulty in getting appropriate appointments.

**One in five of the population of Scotland aged 75 years or more are not registered with an NHS dentist<sup>55</sup>**

Overall access to dental services is not seen as a major issue. However, domiciliary provision is an issue for many. Older people or those who are housebound may be unable to access dental services easily. Provision for care homes is also an issue to address. There could be more focus to free up capacity by shifting care and treatment to those at most risk i.e. by those at low risk of disease visiting dentists less frequently.

## Falls

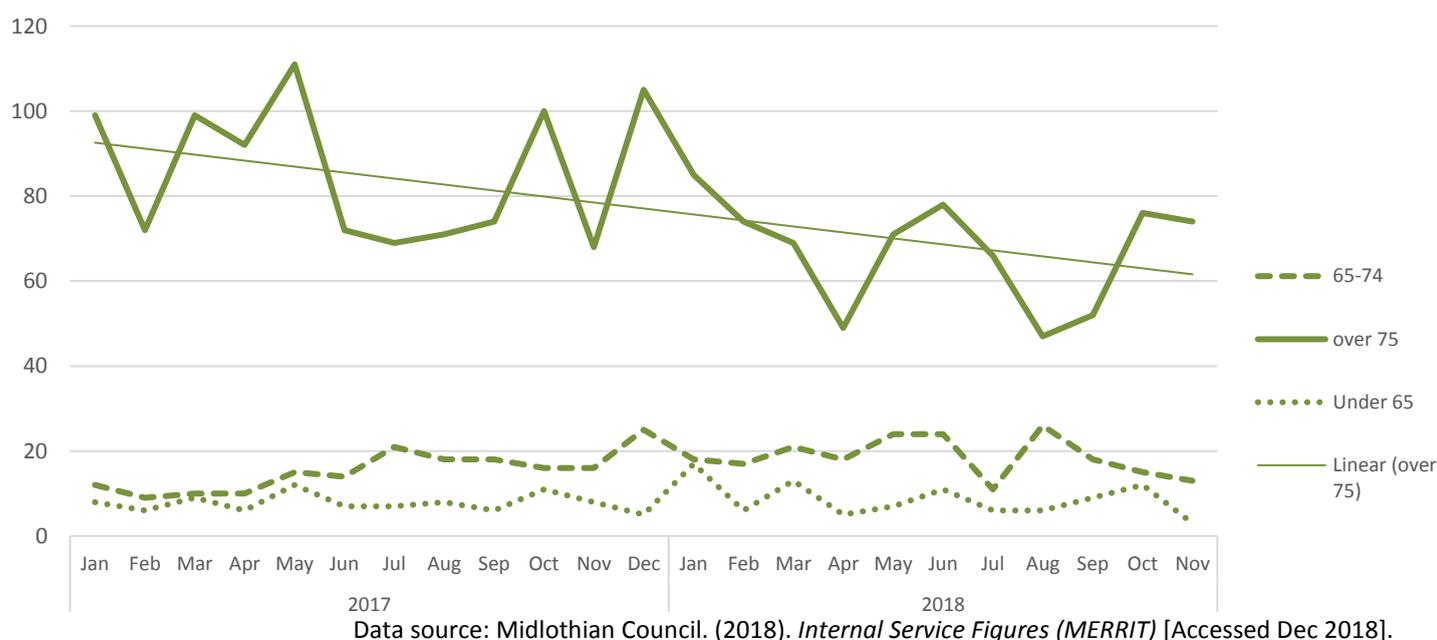
Falls among older people are a major concern. The cost associated with falls is considerable – both for inpatient fracture management and long term care provision. This is set to rise as our population ages. Falls have an impact on a person's independence and quality of life, and the repercussions for family and friends.

The risks associated with not taking action to reduce falls is significant<sup>56</sup>. Risk assessments and multi-factorial intervention programmes can achieve a substantial reduction (<30%) in the incidence of falls among older people. Many falls and fractures can be prevented by services and organisations working in partnership with the person and their carers. Falls prevention and management is not the preserve of one profession, service or organisation. The consequences of a fall cut across all agencies, all of whom can be part of the solution.

A fall is a symptom, not a diagnosis. It can be a marker for the onset of frailty, the first indication of a new or worsening health problem and/or can represent a tipping point in a person's life, triggering a downward decline in independence. However, falls are not an inevitable consequence of old age.

The male:female ratio remains nominally at 40:60 ( indicative of the population profile) for the Midlothian Uninjured Falls Service.

FIGURE 25. FALL CALL-OUTS BY MERRIT BY AGE GROUP (2017 – 2018)



The number of falls resulting in emergency admissions to hospital for patients over 75 years of age is below. It is worth noting that this summary information records the number of episodes, rather than a headcount of the number of patients who are falling. Further analysis would be necessary to explore whether recent increases are the result of a small number of 'frequent fallers' or an increase in the absolute numbers of people falling.

TABLE 6. NUMBER OF EMERGENCY ADMISSIONS FOR PATIENTS OVER 75 IN MIDLOTHIAN

| Area              | 2013/14       | 2014/15       | 2015/16       | 2016/17       | 2017/18       |
|-------------------|---------------|---------------|---------------|---------------|---------------|
| Midlothian - East | 137           | 120           | 103           | 112           | 120           |
| Midlothian - West | 142           | 144           | 143           | 124           | 131           |
| <b>Midlothian</b> | <b>279</b>    | <b>264</b>    | <b>246</b>    | <b>236</b>    | <b>251</b>    |
| NHS Lothian       | 2,379         | 2,329         | 2,279         | 2,303         | 2,387         |
| <b>Scotland</b>   | <b>14,707</b> | <b>15,157</b> | <b>15,576</b> | <b>16,136</b> | <b>16,040</b> |

Data source: Data source: *ISD Scotland* [Accessed Dec.2018].

## Loneliness & Social Isolation

Though often considered together, it is important to draw a distinction between social isolation and loneliness:

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

There is no 'typical profile' of someone at risk of social isolation or loneliness and patterns are not equally distributed across the population.

We know that social isolation and loneliness can contribute to poor health and wellbeing and conversely, people with poor physical and/or mental health may become more isolated due to the barriers their conditions present. Loneliness increases the likelihood of mortality by 26%<sup>57</sup>

Scottish Government has identified loneliness and isolation as a major health threat to Scotland's population. Previously initiatives have focussed on the needs of the elderly and their informal carers. It is now recognised through the growing body of evidence that these issues affect and are impinging at all life stages

**88%** of people feel connected to friends and family<sup>58</sup>

It is not possible to provide prevalence data on social isolation as there is no agreed set of indicators in Scotland. However, data routinely collected through Scottish surveys indicate that:

- **Social contact** – 6% of adults had contact with family, friends or neighbours less than once or twice a week<sup>59</sup>
- **Social support** – 14% had fewer than three people they could turn to for comfort and support in a personal crisis<sup>60</sup>
- **Neighbourhood contact** – in 2013, 18% had limited regular social contact in their neighbourhood<sup>61</sup>
- **Community involvement** – nearly three quarters (73%) felt not very much/not at all involved in the local community<sup>62</sup>
- **Social trust** – half of people in Scotland felt that 'most people can be trusted' (50%), while a similar proportion (48%) felt that '[you] can't be too careful in dealing with people'<sup>63</sup>
- **Social participation** – over a quarter (27%) of people in Scotland have volunteered<sup>64</sup> and 46% have been involved in some form of community action to help improve their local area<sup>65</sup>
- Where trend data are available over time, these figures are relatively stable, showing no major changes in levels of social isolation in Scotland over recent years.

Although rates of loneliness vary with age and gender, there is some evidence to suggest that adults in midlife and the 'oldest old'† are at increased risk. The effect of loneliness and isolation on mortality is comparable to the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking<sup>66</sup>. Loneliness is associated with an increased risk of developing coronary heart disease and stroke<sup>67</sup>. It puts individuals at greater risk of cognitive decline<sup>68</sup> and lonely individuals are more prone to depression<sup>69</sup>. Carers UK suggests that eight out of 10 carers feel lonely or isolated.

Academic research is clear that preventing and alleviating loneliness is vital to enabling older people to remain as independent as possible. Lonely individuals are more likely to:

- Visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term care<sup>70</sup>
- Undergo early entry into residential or nursing care<sup>71</sup>
- Use accident and emergency services independent of chronic illness.<sup>72</sup>

While there is limited data at a local level there is enough national data to evidence that loneliness is a significant issue which has a serious adverse impact on health and wellbeing. It is an emerging area of focus which is ripe for investment in preventative approaches and early intervention. The third sector has an important role to play in tackling social isolation and loneliness.

Based on the available data, those who are socio-economically disadvantaged and those experiencing poor physical and mental health are at particular risk, as are adults who are living alone, widowed or separated. Older people and those with disabilities are identified as client groups who need particular support.

The planning system has a vital role to play in delivering high-quality places, and delivering high-quality buildings, infrastructure and spaces in the right locations helps provide choice over where to live and style of home, choice as to how to access amenities and services and the choice to live more active, engaged, independent and healthy lifestyles. Accessible transport is also vital to people being able to meet face to face and stay socially active, particular for those in rural areas or later in life. Access to digital technology for people is also an area to explore in building social connections. Technology provides new and innovative opportunities to support people who may be isolated.

# Long term Conditions

# Cancer

Cancer is the name given to a collection of related diseases where some of the body’s cells begin to divide without stopping and spread into surrounding tissues. There are more than 200 different types of cancer.

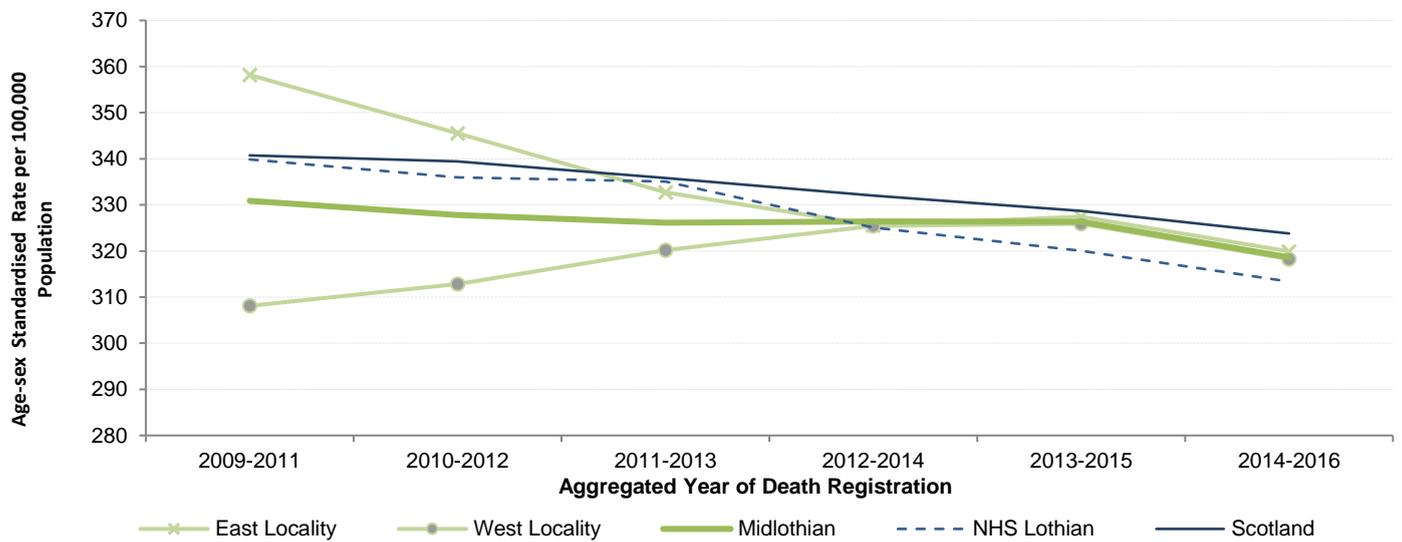
**1 in 2 people** in the UK will get cancer in their lifetime. Trends predict that the number of people diagnosed with cancer is likely to rise. This is due to our ageing population as life expectancy increases. Older people with cancer are likely to also have another long term condition(s).

Over the last twenty years, the majority of cancers have shown improvement in survival rates five years post-diagnosis.

Cancer continues to be a national clinical priority for the Scottish Government

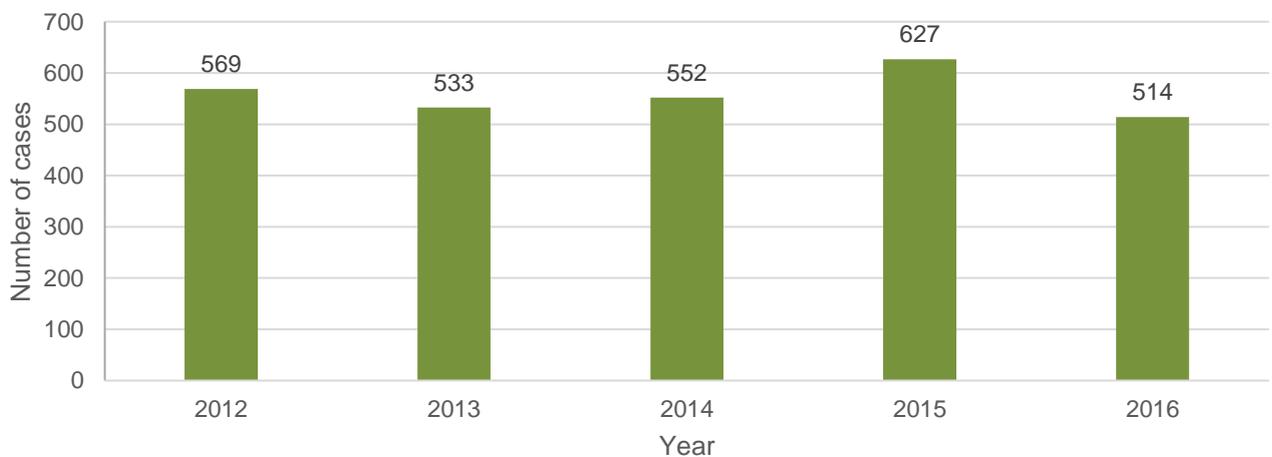
**Between 680 and 740 deaths** from all cancers in each 3 yearly grouping (2009 - 2016)

FIGURE 26. ALL AGE CANCER MORTALITY RATES, MIDLOTHIAN LOCALITY, NHS Lothian AND SCOTLAND



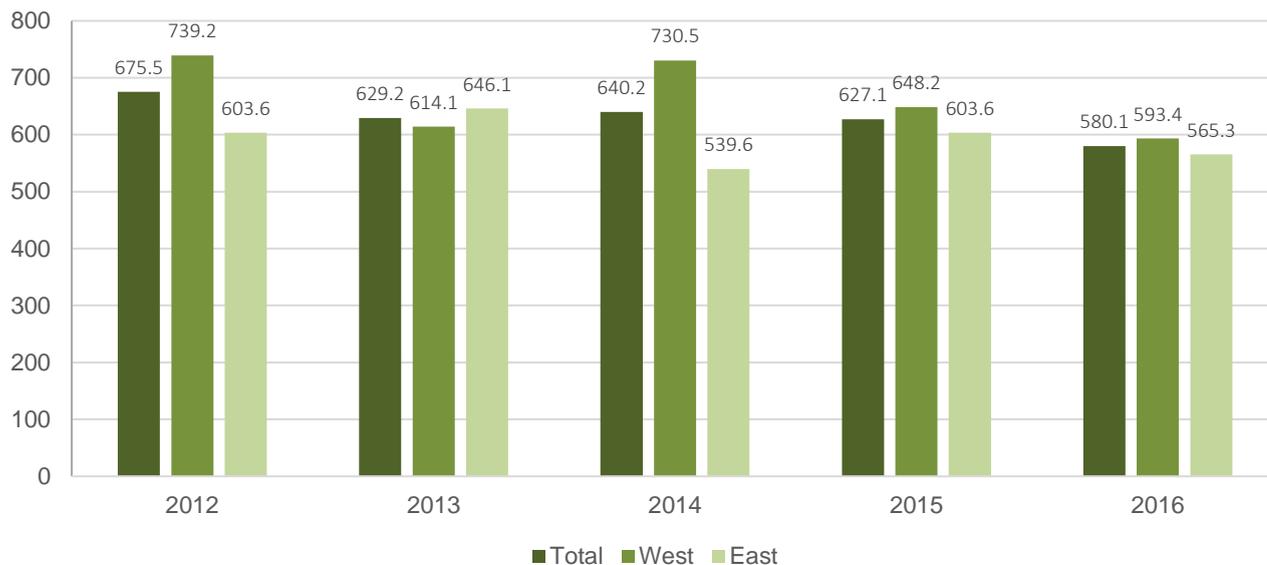
Data source: *National Records of Scotland*. [Accessed Aug 2018].

FIGURE 27. NUMBER OF CASES DIAGNOSED PER ANNUM



Data source: *Scottish Public Health Observatory*. (2016). [Accessed Aug. 2018].

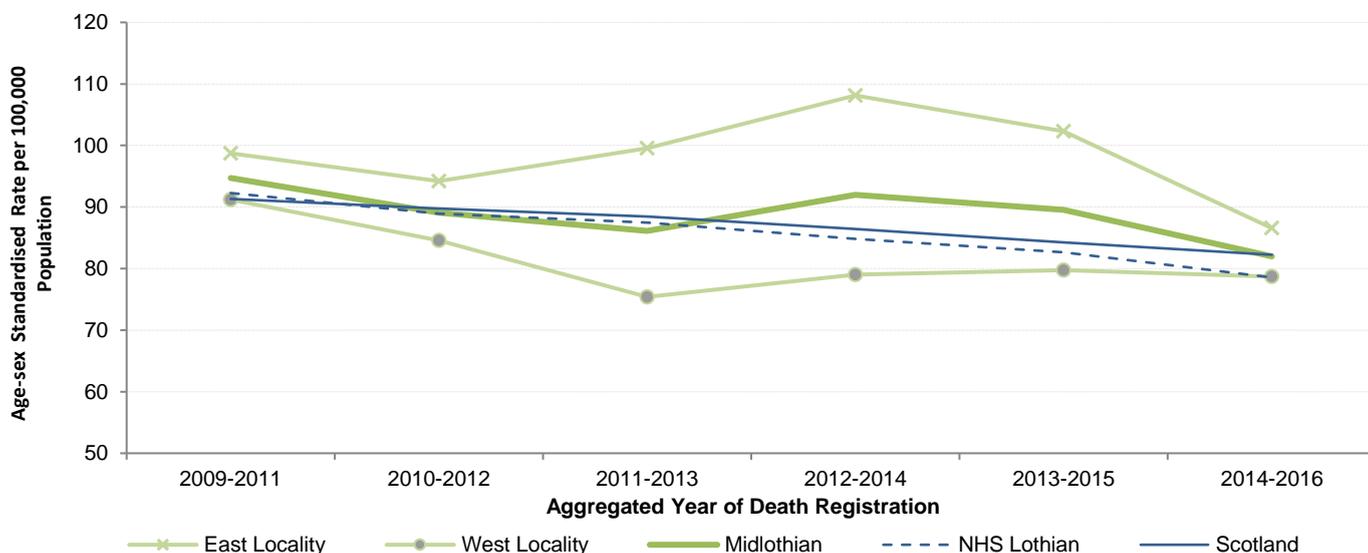
FIGURE 28. GRAPH CRUDE RATE OF CASES DIAGNOSED PER ANNUM (PER 100,000 PERSONS AT RISK)



Data source: *Scottish Public Health Observatory*. (2016). [Accessed Aug. 2018].

**All cancer** - East Midlothian has historically had higher mortality levels cancer than West Midlothian; however there has been a downward trend in deaths in East Midlothian and an increase in deaths in West locality so the figures are now very similar, and are below the Scotland average.

FIGURE 29. ALL AGE LUNG CANCER MORTALITY, MIDLOTHIAN LOCALITY, NHS LOTHIAN AND SCOTLAND



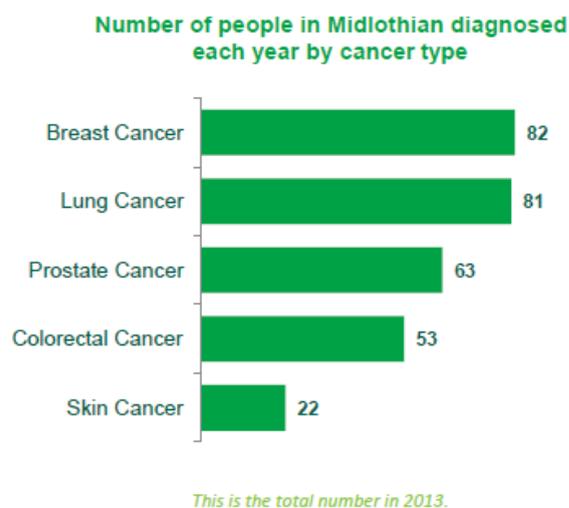
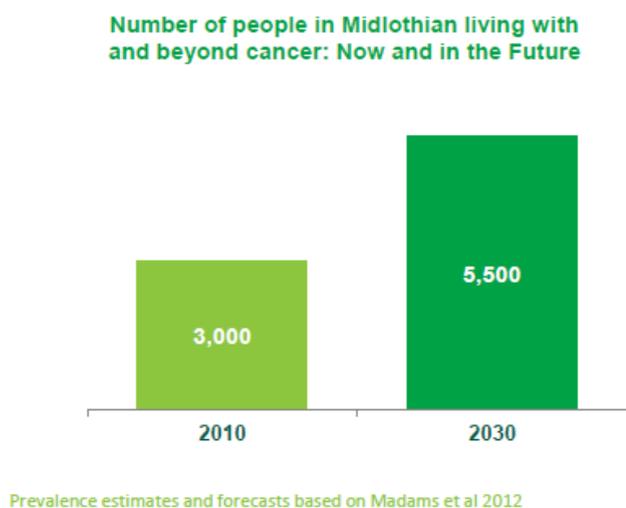
Data source: *National Records of Scotland*. [Accessed Aug 2018].

**Lung cancer** – there has been a downward trend in deaths with a wide range between East and West Midlothian. Deaths in East Midlothian remain above the Scottish average. The Midlothian rate closely follows the Lothian and Scotland averages

**Colorectal cancer** – there has been an increase in deaths and is now in line with Scotland and NHS Lothian.

**Breast cancer** - in both East and West localities has been close to that of the Scottish average;

FIGURE 30. NUMBER OF PEOPLE LIVING WITH CANCER

DATA SOURCE: **MACMILLAN CANCER STATISTICS**

For some cancers there is a link to lifestyle and to deprivation. Access to physical activity and support to eat a healthy diet will impact on cancer rates.

People who have experienced cancer should be offered emotional and practical support. This includes a financial assessment and support if required.

At present most people from Midlothian requiring chemotherapy treatment have to travel to Western General Hospital.

The impact of cancer on carers and family members should be considered; emotional, financial and practical implications.

Those most at vulnerable to health inequalities are often those less likely to participate in universal screening campaigns, such as the bowel screening programme. Increased efforts are required by to support people to participate, for example people who have a learning disability and people experiencing poverty. This requires a multi-agency response.

# Respiratory Conditions

## COPD (Chronic Obstructive Pulmonary Disease) and Asthma

Respiratory conditions are those which affect the airways and other structures of the lung.

Asthma is a long term common lung condition which affects the airways and impacts breathing. There are **6468** people living with asthma. The prevalence rate is **6.81** (per 100 patients). The Scottish rate is **6.39**. There is an increasing trend in asthma rates<sup>73</sup>.

COPD is an umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, and refractory (non-reversible) asthma. It is characterized by increasing breathlessness. COPD is a progressive and (currently) incurable disease, but with the right diagnosis and treatment, there are many things that can be done to manage COPD and breathe better. People can live for many years with COPD with a good quality of life.

Around **2,700** people live with COPD<sup>74</sup>. The number and prevalence of COPD has been increasing over the last decade.

Midlothian ranks **11th highest** out of the 31 HSCPs for COPD prevalence, has the **highest prevalence rate among the Lothian HSCPs, and a higher prevalence rate than the Scotland average**<sup>75</sup>.

People affected by poverty and social disadvantage have poorer health outcomes than their neighbours with more resources. COPD prevalence data indicates there are a higher number of people living with COPD in areas where people are more likely to experience disadvantage. (141 people per 100,000 in Eskbank and 404 per 100,000 in Newtongrange.)

Midlothian has a Community Respiratory Team which has made significant improvements to the management of COPD and to reducing unnecessary hospital admissions for people with COPD. It was recognised as a key development in Midlothian and evidence shows it is reducing cost and improving the management of COPD.

COPD is a significant health burden for the population of Midlothian. Work by the Community Respiratory Team has evidenced opportunities to improve the way we support people with COPD. A whole system approach is required to reducing COPD prevalence involve preventative and early identification activity.

# Neurological Conditions

Neurological conditions, disorders and syndromes affect the brain, spinal cord, nerves and muscles. Examples include Multiple Sclerosis, Parkinson's disease, Huntington's disease, Motor Neurone Disease, epilepsy, seizures, chronic headache and migraine, acquired brain injury, dystonia, functional neurological symptoms, cerebral palsy and muscular dystrophy. Neurological conditions are the most common cause of serious disability in Scotland.

There is no reliable data on the number of people with a neurological condition and most services are co-ordinated at a Lothian level. A purely statistical estimates suggests there are **5,300** people with a condition, **530** of whom will be disabled by the condition. Around **17%** of GP consultations are for neurological symptoms.<sup>76</sup>

The **Astley Ainslie hospital** in Edinburgh provides neuro-rehabilitation services and there are Lothian wide nurse and care adviser specialists for the main neurological conditions. At present data is not available on the Midlothian use of Astley Ainslie services, however there are plans to re-provision the hospital. This will be an opportunity to increase our understanding of how neuro-rehabilitation services are used by Midlothian residents. There is no local respite facilities for adults with a neurological conditions, Leuchie House in North Berwick in the closest specialist resource.

## MS

**209 per 100,000** – Scottish prevalence rate - this would suggest **188 people have MS in Midlothian**.

Scotland has one of the highest rates of MS in the world compared to a worldwide prevalence rate of 25<sup>77</sup>.

**The proportion of women being diagnosed with MS is increasing** - between two and three women have been diagnosed with MS for every man with the condition.<sup>78</sup>

## Parkinson's

**1 in every 375** adults – Scottish rate. This would suggest **240 people have Parkinson's in Midlothian**.

People with Parkinson's have a particularly high risk of hospital admission and are 6x more likely to develop dementia as people of the same age without the condition<sup>79</sup> Nationally numbers are continuing to rise for both MS and Parkinson's Disease. This is linked to people living longer with these conditions.

## Huntington's Disease

**16 people in every 100,000** – Scottish rate. This would suggest **14 people have Huntington's Disease in Midlothian**<sup>80</sup>. The Scottish Huntington's Association (SHA) reported a 55% increase in diagnoses between 2012 and 2015.

## Motor Neurone Disease

**2.4 per 100,000** – Scottish standardised incidence of people being diagnosed.(7.3 per 100,000 for people over 80) –

This would suggest **2 people have Motor Neurone Disease in Midlothian**

In Scotland incidence rates are higher than reported elsewhere and survival rates are lower. The median survival time for motor neurone disease in Scotland is 25 months.

The small prevalence rates make it difficult to create a local response for individual conditions. There is also a lack of good local data on neurological conditions.

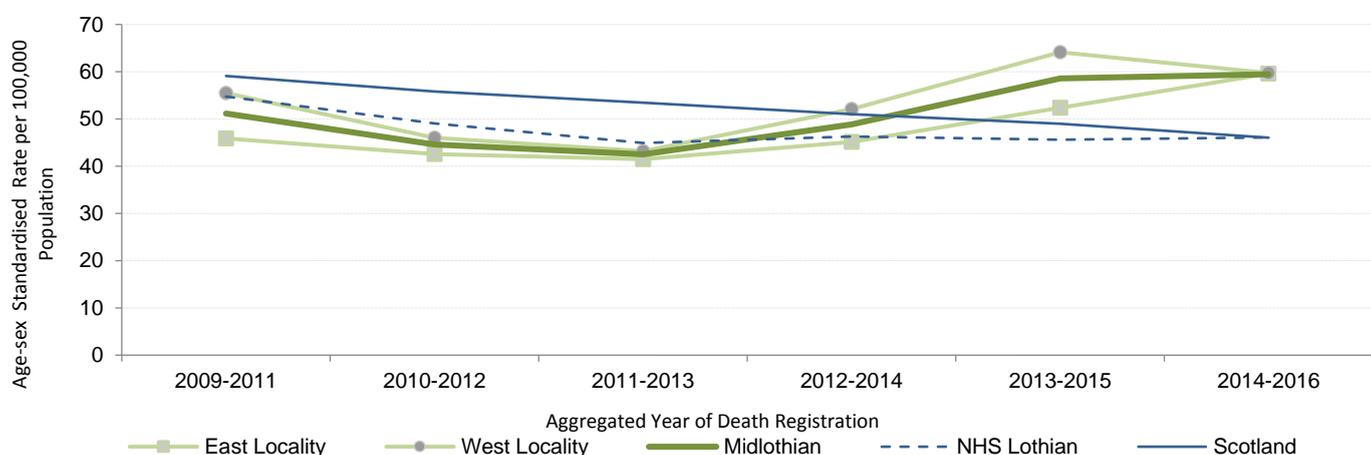
# Stroke

A stroke occurs when the blood supply to part of the brain is compromised, often by a blood clot blocking an artery or a ruptured blood vessel. The effects of a stroke may alter someone's ability to move, feel, think, communicate and function. Hospital and community based stroke services support people to make the best possible recovery. High quality acute care following a stroke is important as is rehabilitation and self-management support on return home.

The risk of a stroke can be reduced through a healthy lifestyle such as eating a healthy diet, taking regular exercise, drinking alcohol in moderation and not smoking. Certain conditions increase the risk of having a stroke, including high blood pressure, high cholesterol, irregular heart beat and diabetes.

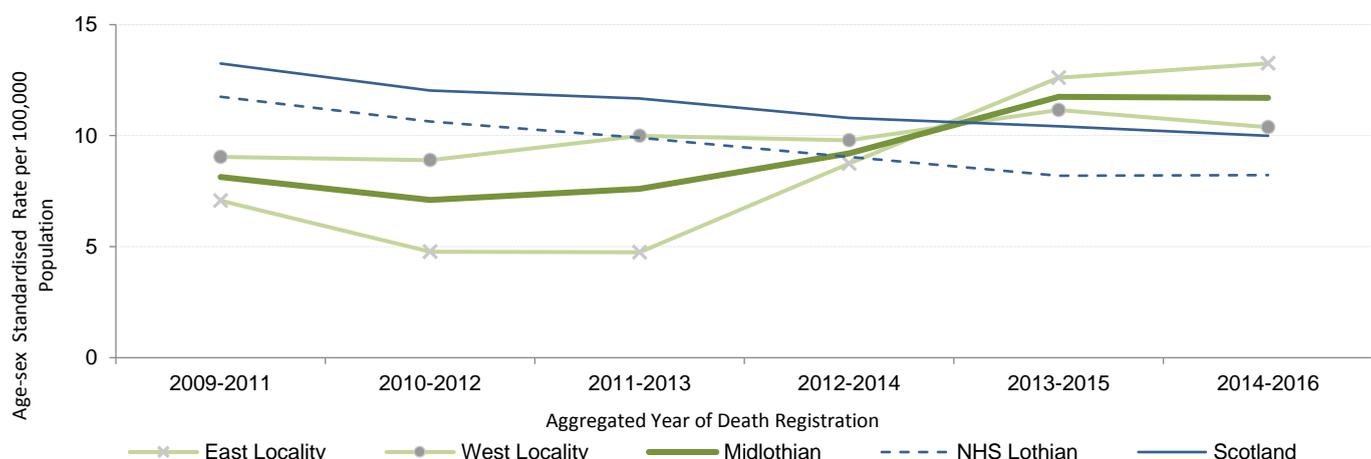
The raw prevalence rate (the number of people registered at one particular point in time) for stroke/TIA is **2.43 per 100 patients<sup>81</sup> which equates to around 2,200 people**. This is above the Scottish average prevalence rate (2.20). **76 patients** were discharged to their own homes after admission to hospital for a stroke/TIA (Nov 2017 -Oct 2018). This is a drop on previous figures.

FIGURE 31. ALL AGE STROKE MORTALITY, MIDLOTHIAN LOCALITY, NHS Lothian AND SCOTLAND



Data source: *National Records of Scotland*. [Accessed Aug 2018].

FIGURE 32. EARLY (<75) STROKE MORTALITY, MIDLOTHIAN LOCALITY, NHS Lothian AND SCOTLAND



Data source: *National Records of Scotland*. [Accessed Aug 2018].

While the numbers are very small, similar trends are seen with mortality rates in the under 75 age group as with all ages, with an increasing rate in Midlothian contrary to NHS Lothian and Scotland in recent years. Work needs to be done to look at the high mortality and lower discharge rates post stroke.

# Coronary Heart Disease

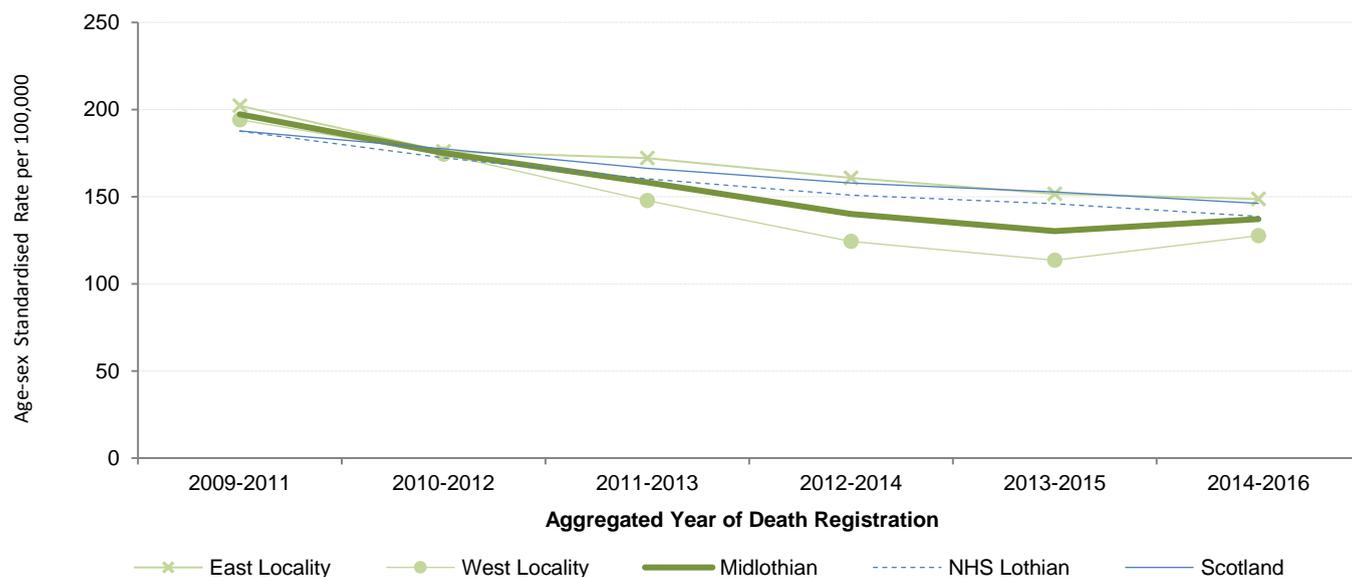
Coronary heart disease happens when the heart's blood supply is interrupted by a build-up of fatty substances that narrow the coronary arteries that supply the heart with oxygen-rich blood. Coronary heart disease is largely preventable and the main factors that can increase the risk of developing it are:

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

**3,927** people are living with Coronary Heart Disease. The prevalence rate is **4.30 per 100 patients**<sup>82</sup>.

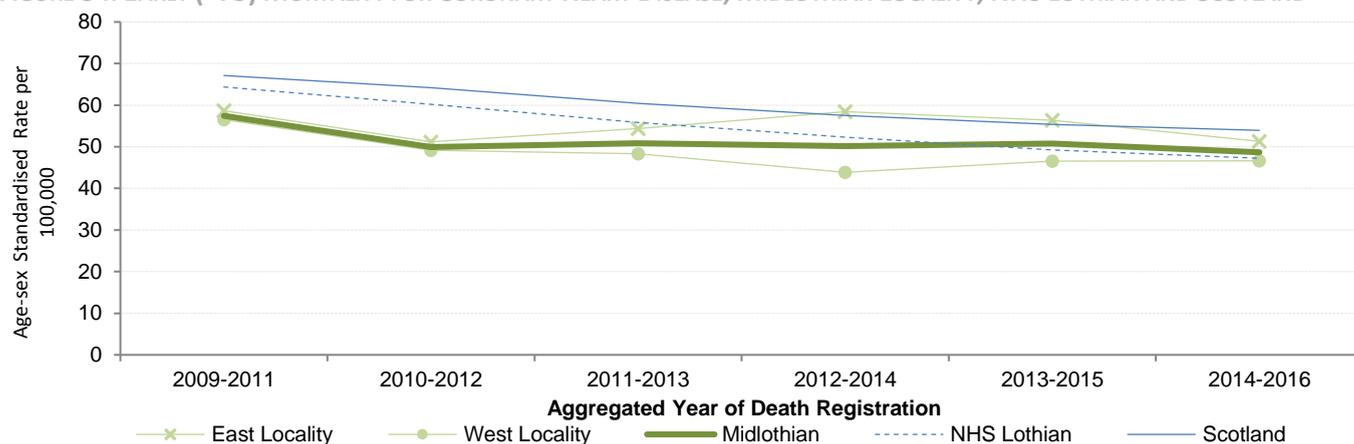
Nationally chances of surviving for 30 days after being admitted to hospital as an emergency after your first heart attack has increased from 86% to nearly 93%. There has been a downward trend in deaths over the last 10 years, in particular for those less than 75 years old. However this has not been at the pace of decline in neighbouring northern European countries. It is still a leading cause of death and a major public health problem in Scotland.

**FIGURE 33. ALL AGE MORTALITY FOR CORONARY HEART DISEASE, MIDLOTHIAN LOCALITY, NHS Lothian AND SCOTLAND**



Data source: *National Records of Scotland*. [Accessed Aug 2018].

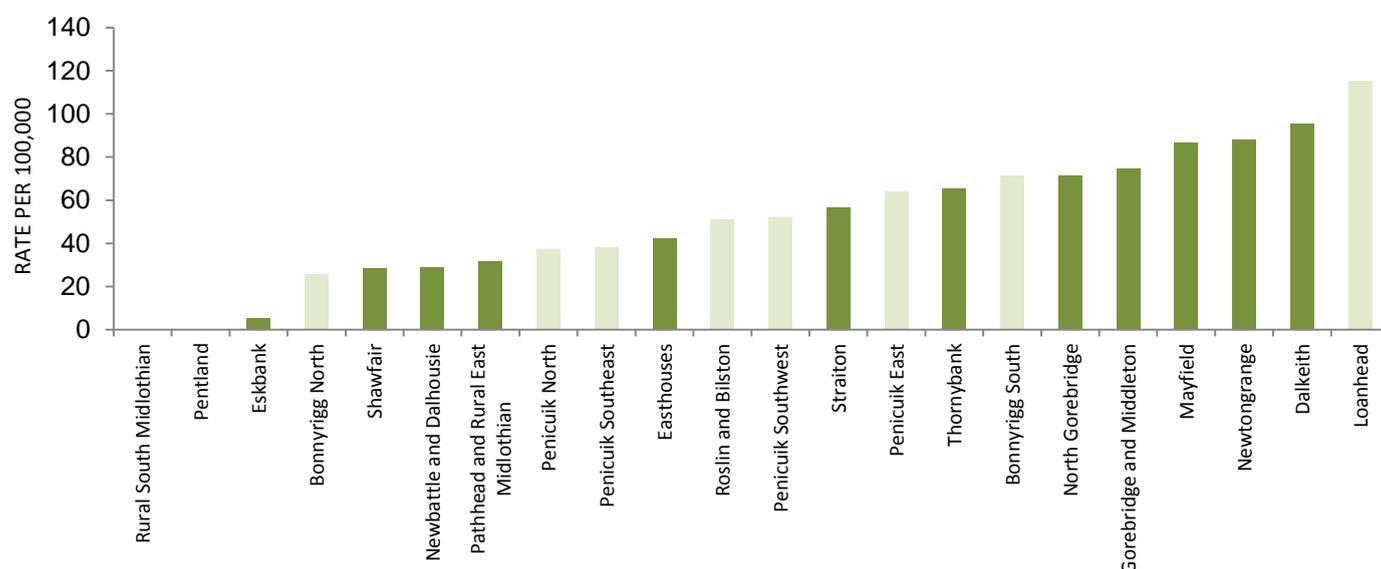
FIGURE 34. EARLY (<75) MORTALITY FOR CORONARY HEART DISEASE, MIDLOTHIAN LOCALITY, NHS Lothian AND SCOTLAND



Data source: *National Records of Scotland*. [Accessed Aug 2018].

FIGURE 35. EARLY (<75) DEATHS FOR CORONARY HEART DISEASE, MIDLOTHIAN LOCALITIES (2014-16 3YR AGGREGATE)

WEST = LIGHT GREEN, EAST = DARK GREEN



Data source: *Scottish Public Health Observatory* [Accessed: Oct. 2018].

The standardised mortality rates for Coronary Heart Disease in those under 75 between 2009/11 and 2014/16 show a downward trend in both East and West Midlothian. However the West locality shows consistently lower mortality than other parts of Lothian as well as Scotland (see Appendix 1 – Additional Graphs and Tables: Graph 9.2).

Coronary heart disease is largely preventable and varies between areas of greater or less material deprivation. Interventions should recognise the links to poverty, the unequal spread across Midlothian, opportunities for preventative work and links to good universal services across health and council. Early death from CHD varies across areas. Rates are generally linked to deprivation and health inequalities. Nationally there was a reduction in mortality in all the deprivation quintiles between 2006-2015. There was a larger decrease in least deprived quintiles than the most deprived. This implies a widening of relative inequalities.

People who are sedentary have about twice the risk of developing or dying from Coronary Heart Disease, compared to active people 37% of deaths from Coronary Heart Disease are attributable to physical inactivity; this is second only to raised blood cholesterol.<sup>1</sup> Access to physical activity programmes for people with heart disease, or at risk of heart disease, is important and should be a core element of any prevention or treatment programme.

# Diabetes & Obesity

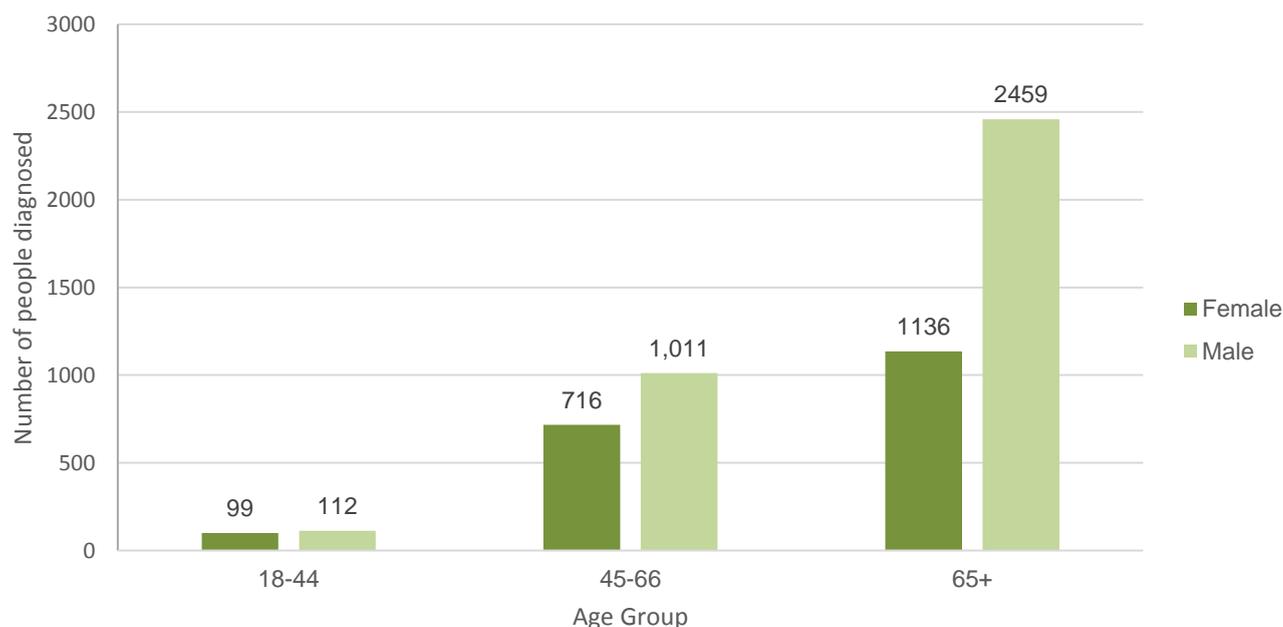
**Type 2 diabetes is a condition** that causes the level of sugar (glucose) in the blood to become too high. It develops when the body doesn't use or produce insulin properly. **Pre-diabetes** ('pre-diagnosis' of diabetes) provides a warning sign. It is when the blood sugar level is higher than normal, but is not high enough to be considered diabetes. It is possible for people with pre-diabetes to avoid or delay the onset of type 2 diabetes.

Long-term complications of type 2 diabetes include damage to eyes, heart, kidneys, nerves and feet. Approximately 80% of diabetes complications are preventable or can be significantly delayed through early detection, good care and access to appropriate self-management tools and resources. Type 2 diabetes can go into remission in some instances.

Being overweight or obese is the main modifiable risk factor for type 2 diabetes. In England, obese adults are five times more likely to be diagnosed with diabetes than adults of a healthy weight<sup>83</sup>. Currently 90% of adults with type 2 diabetes are overweight or obese. Prevention of type 2 diabetes, and the avoidance of complications in those with the condition would be extremely cost-effective & greatly improve quality of life.

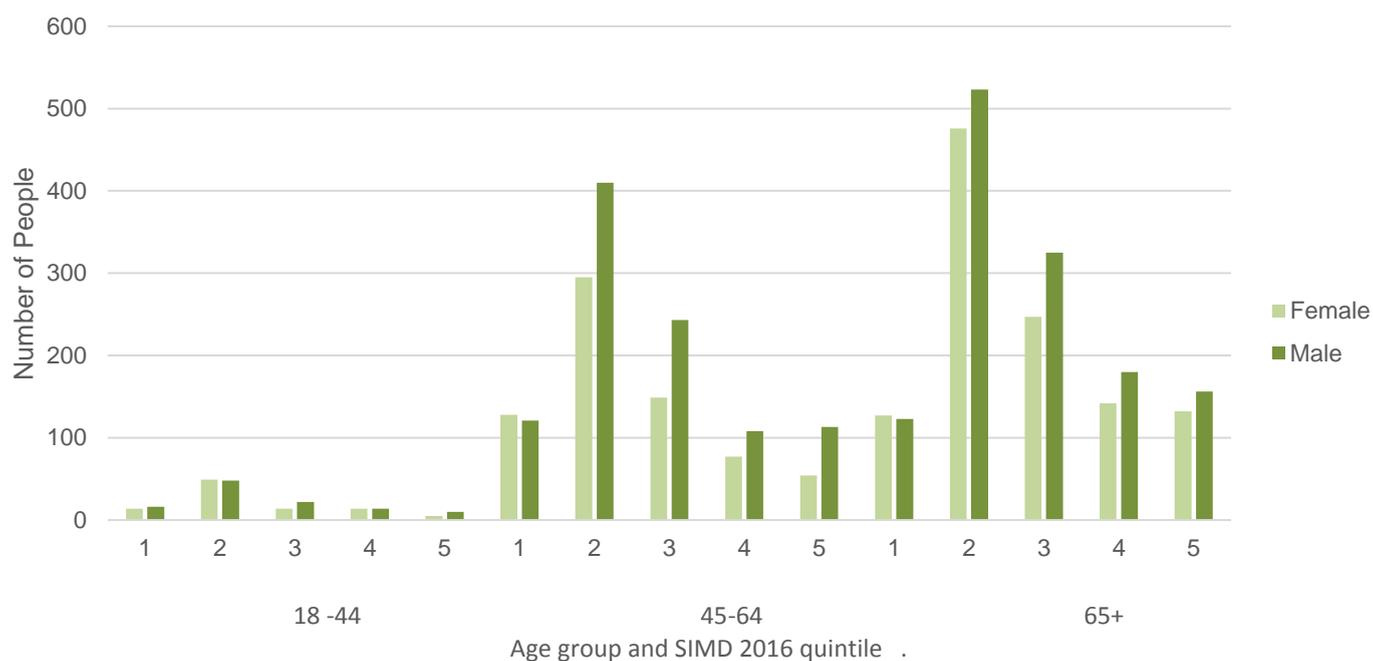
Diabetes care accounts for around **10% of all NHS expenditure**. If no changes are made to the way diabetes is treated by 2035/2036, this will rise to around 17% of NHS expenditure<sup>84</sup>.

**FIGURE 36. NUMBER OF PEOPLE JULY 2017 DIAGNOSED WITH TYPE 2 DIABETES, BY AGE GROUP AND GENDER (2017)**



Data source: *SCI Diabetes* [Accessed July 2018].

**FIGURE 37. NUMBER AND RATE PER 1,000 POPULATION MIDLOTHIAN RESIDENTS DIAGNOSED WITH TYPE 2 DIABETES, BY AGE GROUP, GENDER & DEPRIVATION**



Data source: *SCI Diabetes* [Accessed July 2018].

Those in SIMD quintiles 1 and 2 (more deprived) are more likely to experience type 2 diabetes. While type 2 diabetes is most prevalent in older people, more younger people are being diagnosed.

Services should recognise the links to poverty and the unequal spread across Midlothian.

Interventions that reduce poverty or the impact of poverty on individuals and families could impact on health and disease, including type 2 diabetes.

Access to healthy food and improved physical activity levels for all Midlothian residents will impact on rates of type 2 diabetes, coronary heart disease, stroke, depression fertility levels, obesity and other conditions.

Access to physical activity programmes for people with or at risk of developing type 2 diabetes, is important and should be a core element of any prevention or treatment programme.

Weight management support is important; it can reduce the number of people developing type 2 diabetes and can put the condition in remission.

People who have a diagnosis of pre-diabetes can avoid the onset of type 2 diabetes, primarily with weight management, physical activity and healthy eating support whilst recognising the links to poverty and deprivation.

# Sensory Impairment

Sensory impairment is the common term used to describe Deafness, blindness, visual impairment, hearing impairment and Deafblindness.

Nationally it is estimated that 1 in 6 of the population<sup>85</sup> have a hearing loss while significant sight loss is estimated to affect 1 in 30 of the population<sup>86</sup>. We do not have accurate information on the numbers of people with sight or hearing loss in Midlothian. Given the broad nature of the census questions, the responses provide no breakdown within either category in terms of degree of impairment. The average percentage of people affected by either impairment in Midlothian is close to the average across Scotland.

Older people are most likely to experience some degree of hearing loss and the vast majority of those with sight loss are in the older age range. Between 40 to 50% of older adults with visually impairing eye disease limited their activities due to a fear of falling<sup>87</sup>. It was noted that this protective strategy puts seniors at potential risk for social isolation and disability. 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.

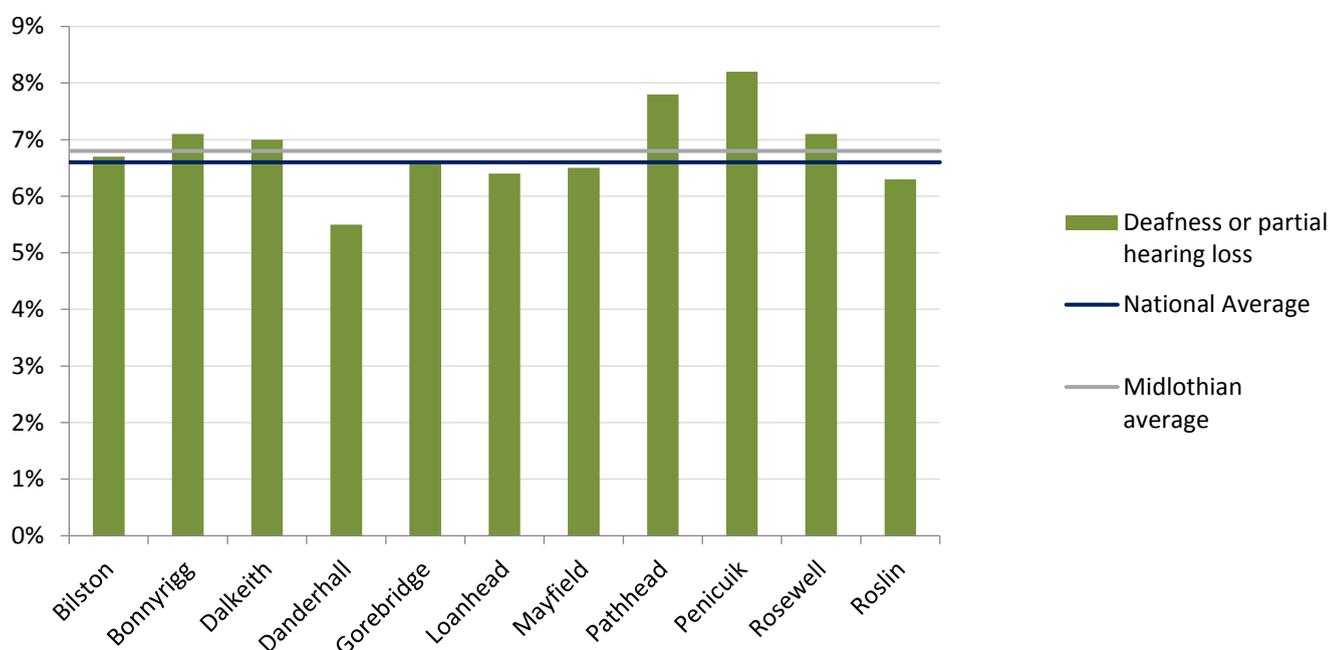
Hearing impaired adults with untreated hearing loss were more likely to report depression, anxiety, and paranoia and were less likely to participate in organized social activities, compared to those who wear hearing aids.

## Hearing Loss

**233** people are British Sign Language users

**5,656** people reported a hearing impairment

FIGURE 38. PERCENTAGE OF MIDLOTHIAN'S POPULATION (BY TOWN) REPORTING DEAFNESS OR PARTIAL HEARING LOSS



Data source: [National Records of Scotland](#) [Accessed Dec 2018].

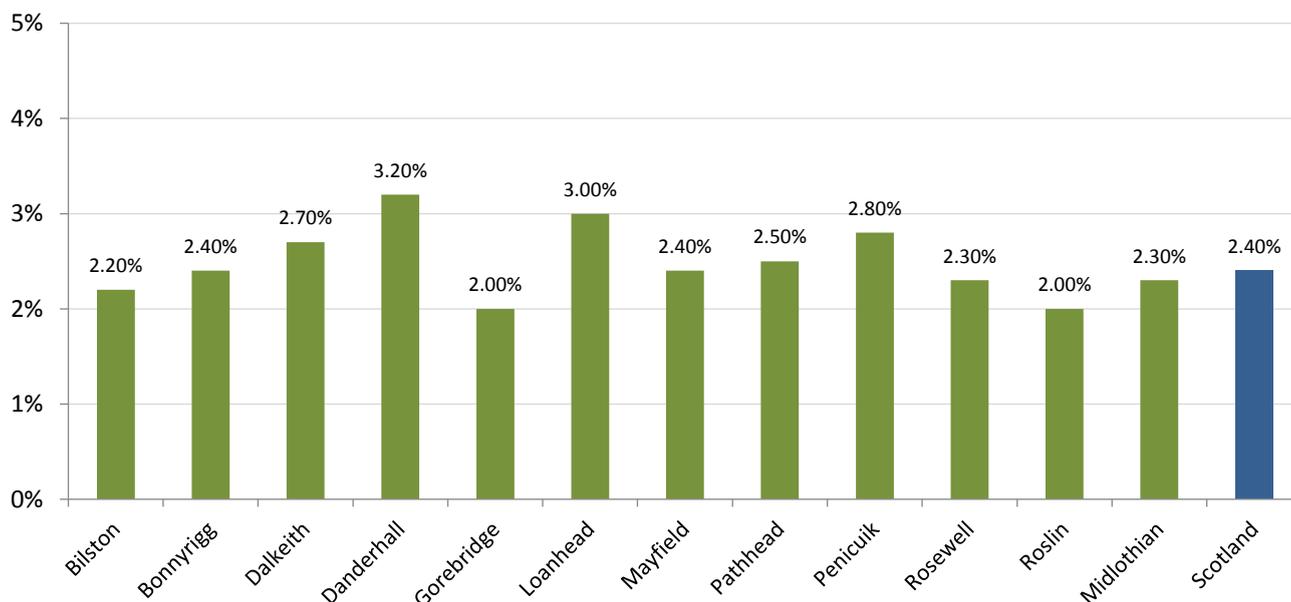
## Visual Impairment

43% of the Lothian population received an eye test during the year 2017/18.

**580** people are on the Royal National Institute of blind People Blind Register (284 as severely sight impaired; 296 as sight impaired). RNIB have provided services to 151 residents not on the register.

**1,922 people** reported a visual impairment

FIGURE 39. PERCENTAGE OF MIDLOTHIAN'S POPULATION (BY TOWN) REPORTING BLINDNESS OR PARTIAL SIGHT LOSS



Data source: *National Records of Scotland* [Accessed Dec 2018].

There is a need to improve diagnosis, increase awareness amongst care staff and make aids to communication more available.

An accurate measure of the number of people with sensory impairment their level of need is required.

Continued social support may be an effective buffer against the consequences of vision loss and the negative effects of stress caused by visual impairment.

Stigma that can further worsen social isolation and can deter people from accessing support.

# Palliative Care

Palliative care is the care, treatment and support someone receives when they have a life limiting illness. It aims to improve the quality of life of patients and their families, through the prevention and relief of suffering. It involves the early identification and careful assessment and treatment of pain and other problems, physical, psychosocial or spiritual. Palliative care can involve hospitals, hospices, GP practices and community teams. When people are in receipt of palliative care in the community it is normally co-ordinated by the District Nurses.

In February 2019 there were **504** people registered with their GP as being in receipt of palliative care<sup>88</sup>. 51 people were in receipt of specialist palliative nursing care from the Marie Curie<sup>89</sup>. Patients and carers express their preference to be cared for in the place where they live, for as long as possible. Where possible, many would also prefer to die in their place of residence<sup>90</sup>. There is no national and systematic data recorded on a person's preferred place of care at end of life and so the percentage of last six months spent at home or in a community setting is measured.

TABLE 7. PERCENTAGE OF LAST SIX MONTHS OF LIFE SPENT AT HOME OR IN A COMMUNITY (FINANCIAL YEAR ENDING 31ST MARCH)

|   | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---------|---------|---------|---------|---------|
| Midlothian Community Health Partnership | 84.8    | 85.6    | 84.6    | 85.6    | 87.4    |
| Scotland                                | 86.0    | 86.2    | 86.7    | 87.0    | 87.9    |

Data source: *Scottish Public Health Observatory* [Accessed Jan. 2019].

The increase from 2013 to 2018 roughly equals an extra five days on average spent at home or in a community setting. The difference between Midlothian and the Scottish average was around 1 day in 2017/18.

**100%** of family members of people who were receiving palliative care, in a care setting, felt that their family member's pain was eased to the greatest extent possible. **100%** also agreed that their family member was treated with dignity. **90%** felt they were informed by staff when they thought death was near and of those **90%**, all felt welcomed by staff to stay with their family member. Some people felt they were not involved by staff in the planning of care (20%) and some people felt that chaplaincy services were not at hand for their family (20% strongly disagreed and 20% neutral) or that they were not asked about the rites and rituals of their family (20% strongly disagreed and 10% neutral). Overall, **100%** agreed that they were satisfied with the end of life care that was given to their family member. It is important to note that in line with the small numbers of people in receipt of palliative care this questionnaire involved small numbers.<sup>91</sup>

Analysis of Scottish level data suggests the percentage of the last six months of life spent at home or in a community setting for those living in the most deprived areas is the same as those living in the least deprived areas.

The percentage of those in the youngest age group that spent their last 6 months at home or in the community was slightly higher than the percentage in the oldest age group; 92% in the 0-54 age group compared to 87% for those aged 85+. This may reflect the different causes of death in these age groups<sup>92</sup>.

Gaps in palliative and end of life care can result in a poor experience for individuals and have a lasting negative impact on their family and carers. This can also result in poor staff experience, inappropriate hospital admission and people dying somewhere other than their preferred place. The Perception of Care Questionnaire has shown that there are some gaps in quality which can be addressed locally such as involving families in care planning and in supporting people to explore and meet their spiritual needs.

# Sexual Health & Blood Borne Viruses

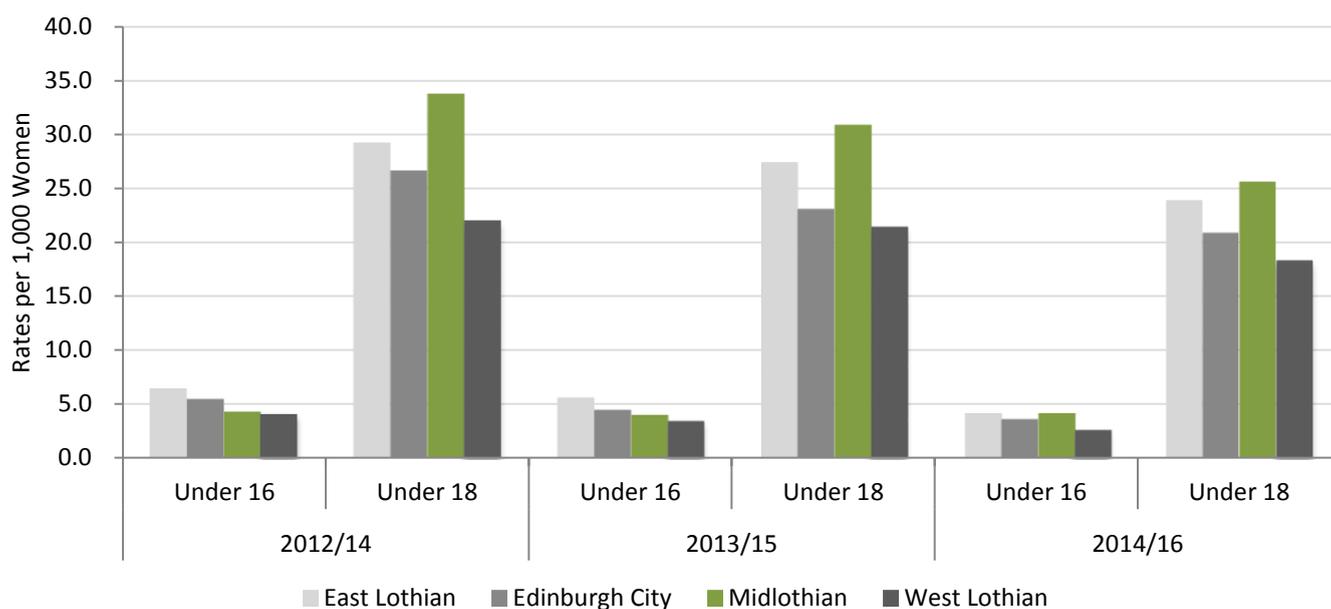
## Sexual Health

Sexual health is a broad area including the treatment of infections, the prevention of unintended pregnancies and the promotion of positive sexual relationships and wellbeing. Nationally emerging issues include coercion, harm and social media. There is also an ongoing need to recognise and address sexual exploitation and harm.

There is little local data on sexual health relating to the adult population. There has been a particular focus on teenage pregnancy. Most of this work is done by the GIRFEMC (services for children and young people). A priority has been to reduce the number of unintended teenage pregnancies to reduce the number of young women leaving full time education for this reason before the age of 18. This is linked to the overall strategic vision that every child should have the best start in life and grow up being healthy, confident and resilient.

Under 20 teenage pregnancy rates in Scotland and Lothian have continued to decline from the most recent peak of **57.7/1000** women (2007) to **31.6/1000** (2016). Lothian has mirrored this trend. However, the under 16 and under 18 pregnancy rates within NHS Lothian over three year rolling periods, and rates for **under 18 pregnancy in Midlothian have been persistently higher** than the other 3 local authority areas. The reasons for this are multifactorial but certainly high rates of deprivation in Midlothian are likely to make a contribution.

FIGURE 40. TEENAGE PREGNANCIES (RATE PER 1,000) FOR LOTHIAN LOCAL AUTHORITY (THREE YEAR COMBINED FOR <16 AND <18)



Data source: *Information Services Division*. [Accessed Sept 2018]

Note: This includes all pregnancies in women aged under 18. The rate is calculated using the female population aged 15-17 for 3 year periods.

A key intervention to prevent teenage pregnancy is contraception, and rates of contraception provision in primary care are persistently higher in Midlothian compared to national rates and the other three local authority areas. It is a policy objective to increase the proportion of women accessing termination services prior to nine weeks in order to increase the number of women able to have an early medical termination. In 2018, NHS Lothian have lead the way in Scotland by being the first board to offer home misoprostol for early medical abortion, which improves the experience of care for patients and reduces the number of unnecessary appointments.

## Blood Borne Viruses - Hepatitis C and HIV

Blood-borne viruses are viruses that some people carry in their blood and can be spread from one person to another. There are a variety of viruses of which Hepatitis C and HIV have the most serious long term implications. For Hepatitis C there is a new treatment which requires eight to twelve weeks of oral therapy, with very few side effects, that leads to sustained viral clearance in the majority of patients. People with HIV are now able to lead near normal lives with appropriate medication.

Health Protection Scotland publishes data by Health Board<sup>93</sup>

### Hepatitis C

**235 people** were newly identified as hepatitis C antibody positive in Lothian (during 2017), and 259 Lothian patients started treatment for hepatitis C; this includes 53 prisoners. The majority of these are likely to have been infected some years ago, but there is evidence of ongoing transmission in Lothian, particularly among people who use drugs.

Since testing became available in the late 1980s there have been **5,814 persons** reported as hepatitis C antibody positive in Lothian (to 31st Dec 2017) and it is estimated there 3,251 people with treated and untreated chronic hepatitis C in Lothian.

The UK Government is signed up to the WHO target to eliminate hepatitis C as a public health problem by 2030. However the Scottish strategy may seek elimination prior to this date.

### HIV

**1,465** people live with HIV in Lothian (Dec 2017), up from just over 1,000 in January 2010.

The number of new cases of HIV infection in Lothian has been falling since 2005<sup>94</sup> and in 2017 totalled **99**. However, the prevalence of people with HIV is increasing due to decreased deaths, antiretroviral therapies and new cases being diagnosed.

A new and highly effective form of HIV prevention, Pre Exposure Prophylaxis for HIV (PrEP), has been provided in Lothian since July 2017. It is expected that this will reduce incidence of HIV infection among men who have sex with men in Lothian.

There are **around 6,110** people living in Lothian with HIV or Hepatitis C infection.

Work has been undertaken to look at the health and care implications of the ageing HIV cohort. We also hope to have some local authority specific data on target numbers of HCV for elimination so HCV per se will not be a requirement for long term care in future, although drug and alcohol issues will remain for some.

# Service User Groups

# Older People (65+)

There are **16,667** people aged 65 and over. People are living longer and the majority of older people live without any formal support.

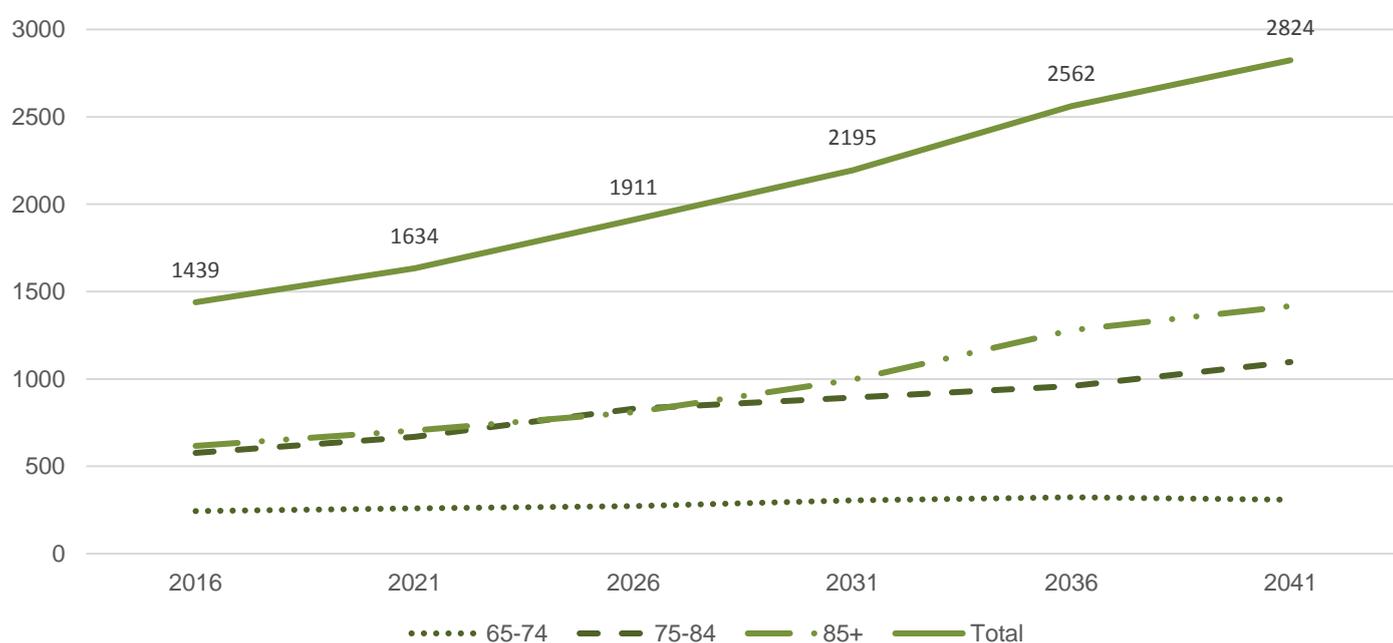
## Dementia

Dementia is a syndrome associated with an ongoing decline of the brain and its abilities. Common symptoms are memory loss, difficulty with thinking and understanding, decreased language skills and judgement. Alzheimer's disease is the most common type, other types include vascular dementia, dementia with Lewy bodies and frontotemporal dementia.

Age is a risk factor. It is slightly more common in women than in men which is to be expected with women living on average longer than men.

**31%** of people aged over the age of 85 are living with a diagnosis of dementia. This compares to around 50 people below the age of 65. The figures below are calculated using the 2016 population projections from the National Records of Scotland and applying the dementia prevalence rate averages from Alzheimer's Scotland<sup>95</sup>. The number of people living with dementia in will **nearly double** (from 1,475 to 2,824) by 2041. The improved identification of the signs and symptoms of dementia is predicted to lead to increased numbers of diagnosis. People with dementia are also very likely to have other long term conditions affecting their health.

FIGURE 41. DEMENTIA PREVALENCE PROJECTIONS



Data source: [National Records of Scotland](#). [Accessed Nov. 2018].

HEAT targets were introduced in April 2013 for people newly diagnosed with dementia to receive a minimum of 1 year's post diagnostic support. Data for this is only available at a NHS Lothian level. It shows that an estimated **40%** of people newly diagnosed with dementia were referred to post diagnostic support in 2015/6. This is slightly below the national average of 42%. Of those referred in NHS Lothian 76% received the support. These figures represent an increase on the previous year's figures of 25% diagnosed and 72% receiving support.

There have not been many large scale studies into the links between dementia and health inequalities, however it is known that health inequalities persist into old age and that many of the risk factors for dementia are associated with socio-economic disparities.

There is a higher rate of Dementia diagnosis in the learning disability community and onset tends to happen at a younger age. Up to 75% of people with Down's Syndrome over the age of 50 years of age develop dementia.<sup>96</sup>

Race does not affect prevalence rates for most types of dementia with the exception of early on-set (presenting before 65 years) and vascular dementia which have been found to be more prevalent in the black and ethnic minority community.

Having a diagnosis of dementia and being admitted to an acute hospital can have a significant impact on a person's health and behaviour and lead to extended stays in hospital. Preventing unnecessary hospital admission for people living with dementia is important for the person and for services.

The significant predicted increase in the number of people diagnosed with dementia has implications for local service design and delivery. While improvements have been made in percentage of people being referred for and receiving post diagnostic support the data shows further work is needed both locally and nationally which also needs to take into account the projected prevalence increase.

The changing picture of dementia among the learning disability community also has implications for community learning disability teams and hospital based services.

# Frailty

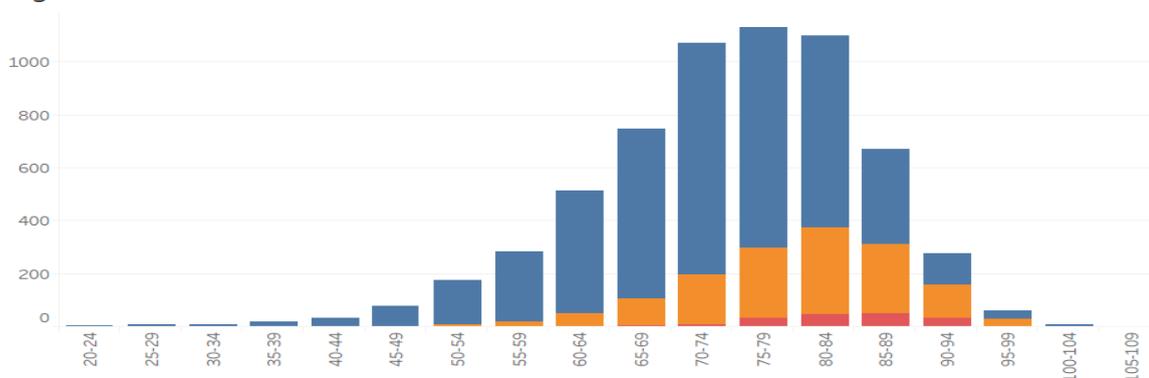
Frailty is commonly divided into mild, moderate and severe. There are a number of diagnostic instruments that involve looking at various factors such as diseases, symptoms and signs, and disabilities to assess the degree of a person’s frailty. It is common (25-50% of people over 80 years), progressive (5 to 15 years), involves episodic deteriorations (delirium; falls; immobility) has many preventable components and will impact on a person’s quality of life.

Frailty Index counts “deficits”. A deficit is a thing that is wrong with you (symptom, sign, disease or disability). A frailty Index is the proportion of deficits accumulated over time. Zero deficits from list of 50 means the frailty index is zero. Ten deficits from list of 50 means the frailty index is 10/50 or 0.20. Frailty Index based on deficit accumulation is closely related to risk of death. “The more things that are wrong with you, the more likely you are to be frail”

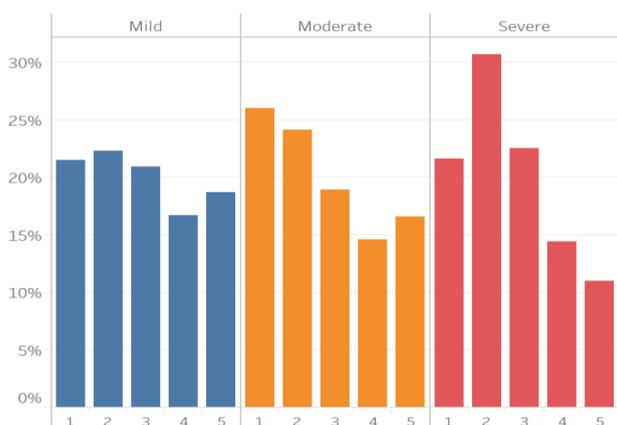
FIGURE 42. AVERAGE YEARLY SERVICE USAGE

|                         | Mild         | Moderate     | Severe     |
|-------------------------|--------------|--------------|------------|
| <b>Total</b>            | <b>4,581</b> | <b>1,378</b> | <b>195</b> |
| Age                     | 72           | 79           | 83         |
| GP Contacts             | 10           | 14           | 18         |
| Practice nurse contacts | 4            | 5            | 4          |
| Different BNF sections  | 9            | 12           | 15         |
| Outpatient appointments | 5            | 6            | 8          |
| Days in Hospital        | 2.1          | 7.2          | 14.3       |

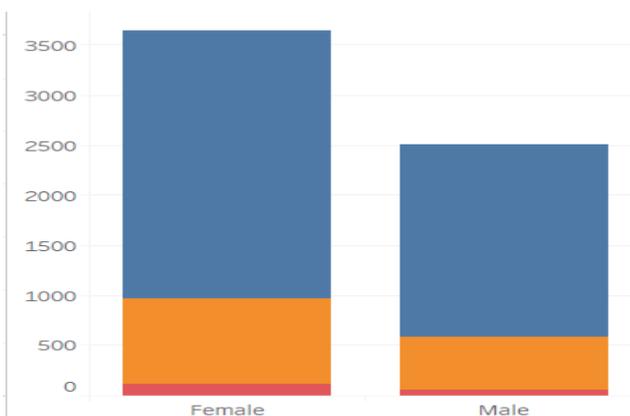
Age distribution



SIMD



Gender

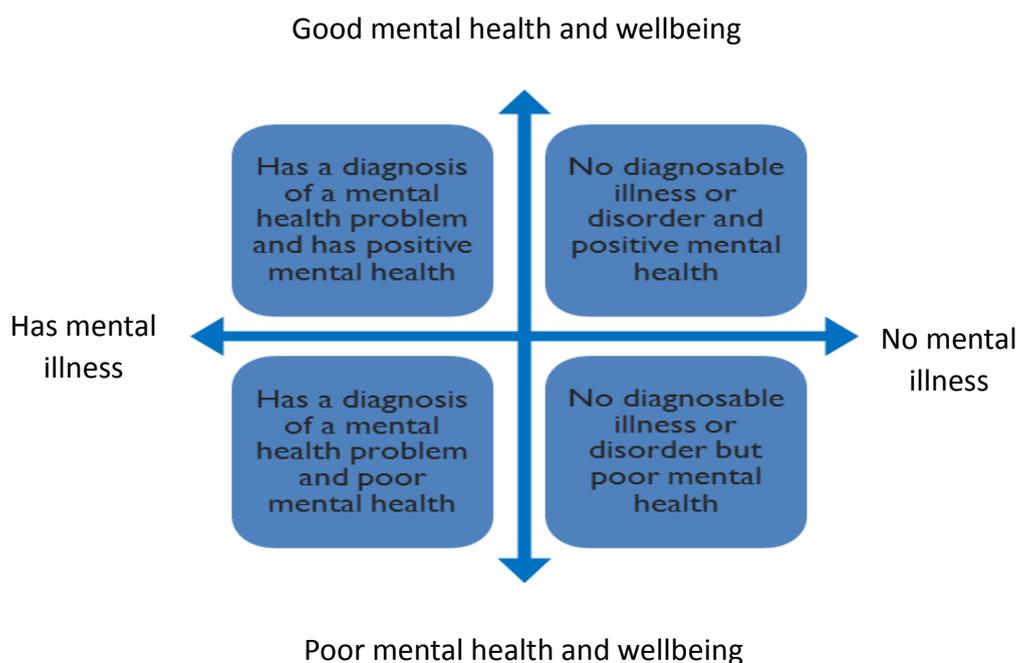


Data source: Midlothian Health and Social Care Partnership. (2018). Electronic Frailty Index

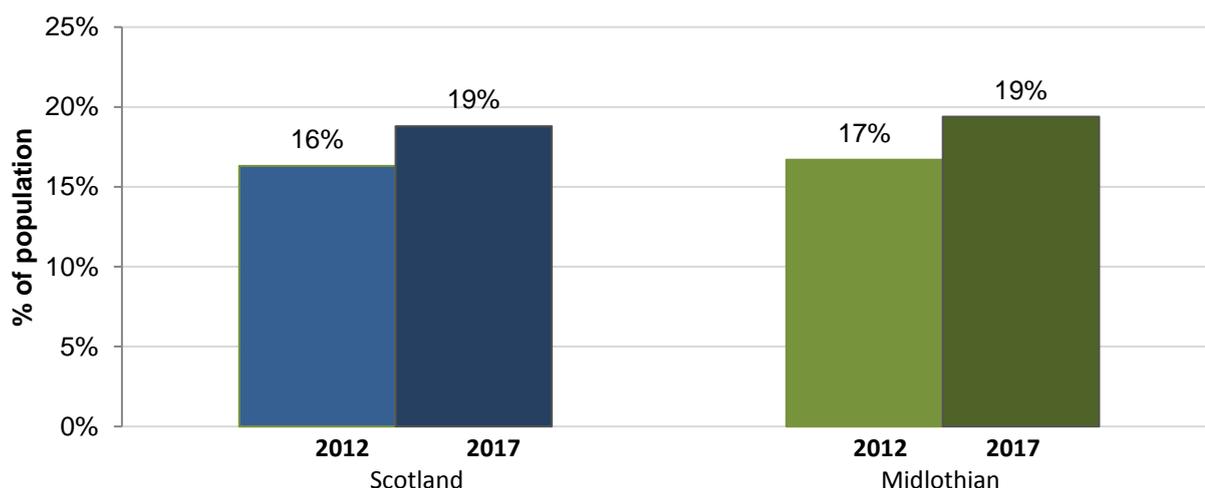
# Mental Health

Mental health is described by WHO as ‘... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.’

The diagram below is a way to think about our mental health and wellbeing, the continuum shows the relationship between wellbeing and poor mental health, mental illness and wellbeing<sup>97</sup>.



**FIGURE 43. PERCENTAGE OF THE POPULATION PRESCRIBED DRUGS FOR DEPRESSION, ANXIETY AND/ OR PSYCHOSIS, MIDLOTHIAN AND SCOTLAND, 2012-2017**



Data source: *Information Services Division*. [Accessed July 2018].

**4.2%** of people identified themselves as living with a mental health condition that had lasted or was expected to last 12 months<sup>98</sup>. In the 2018 Health and Social Care Survey **23%** of all respondents answered ‘no’ to the question ‘Do you have good mental wellbeing’ and **62%** of staff responded that they did not feel Services make it easy for people to sustain good mental health<sup>99</sup>.

**17,470** people (**19.7%** of the population), were prescribed drugs for depression, anxiety and/ or psychosis (2017). This has increased from 14.6% in 2010. The proportion of the Scottish population prescribed has also increased since 2010. For the most deprived SIMD (1) in Midlothian this rises to **26%**.

There were **106<sup>100</sup>** acute admissions to mental health specialties (2017). Note a person may have had more than one admission. The number and rate of Midlothian patients with a psychiatric hospitalisation continues to be lower than the Scottish average.

Themes identified by Midlothian Voices<sup>1</sup> include: a need for information on what is available to support mental health locally, more services for young people's mental health and wellbeing and continued efforts around communication and joined up working between services.

Scotland wide statistics demonstrate that women and those living in deprived communities are significantly more likely to have been identified as having a mental health problem. A higher proportion of mental health admissions are from deprived areas highlighting the link to socioeconomic health inequalities.

The high number of people prescribed medication for depression and anxiety suggests a strong need to look at alternatives including social prescribing and community supports.

It would be beneficial to expand our available data to capture acute mental health admissions whereby the person has been admitted to a non-psychiatric bed.

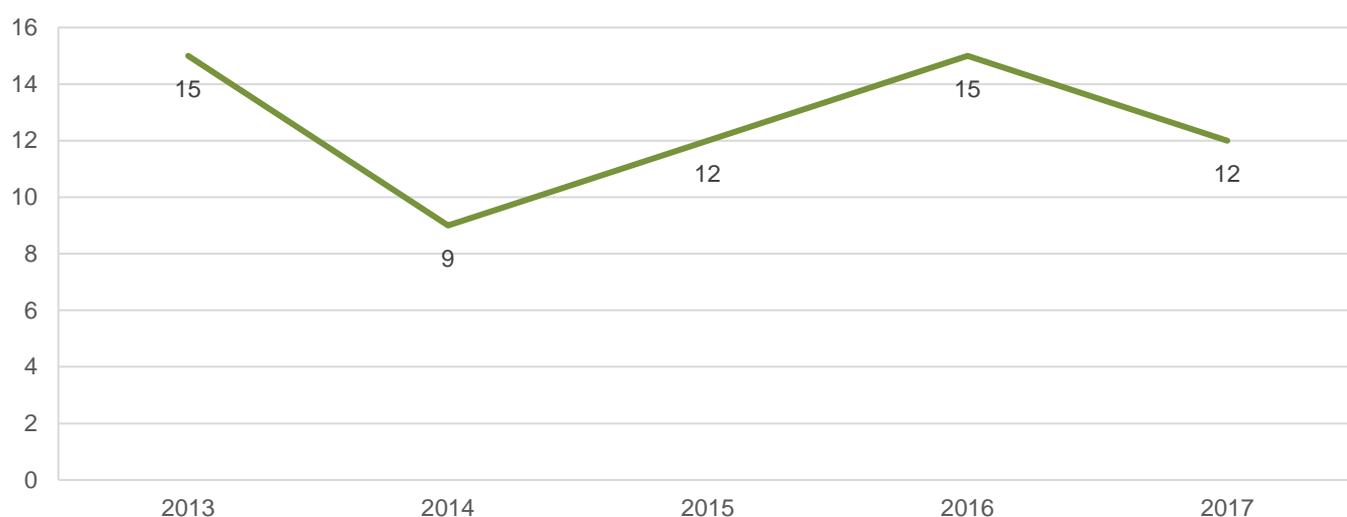
Given the high prevalence of mental health problems there is a need for a mental health focus across all services on wellbeing and recovery.

## Suicide

The reasons for suicide are complex and multi-factorial; they are best understood in the context of each person's individual life and life circumstances. Suicide may be defined as intentionally killing oneself.

The figures in Scotland are a combination of two groups of causes of death; intentional self harm and events of undetermined intent. For some deaths it is straightforward to determine the intention of the deceased. For other types of death it is not. The convention in Scotland has been to include both types so that all suicides are captured. At a Midlothian level the number of events are quite small and therefore subject to quite wide fluctuation year to year so it is often better to combine years into 5 year blocks.

FIGURE 44. NUMBER OF SUICIDES IN MIDLOTHIAN RESIDENTS, 2013-2017



Data source: *National Records Scotland*. (2017). [Accessed July 2018].

Over the last five years there have been an average of **12.6 probable suicides** a year. This is above Scotland and Lothian. The Scottish average rate was 13.5 per 100,000 while Lothian was 13.8 and Midlothian was rate 14.9.

Compared to ten years ago there has been a **7% decrease** in the rate. This is similar to Lothian but not as impressive as the decrease for Scotland (18%). However this hides substantial change between men and women.

- **Men** – Midlothian has seen a **4% increase**. This is higher than Scotland and Lothian rates - Scotland has decreased by 19%, and Lothian decreased by 4%.

The ScotSID report found that the bulk of deaths are men in their middle years with a strong emphasis on social isolation and economic inequality. Most people were in employment. A large minority had mental health and other needs but were not in contact with healthcare services.

- **Women** - Midlothian has seen a **35% decrease**. This is below Scotland and Lothian.

In terms of deprivation the **more deprived intermediate zones in Midlothian tended to have a higher rate of suicide** This is similar to national figures<sup>101</sup>

It is important to tackle the stigma associated with poor mental health to encourage the take up of health and social services. Responses need to look at and take into account the reported difference between men and woman. It also suggests a focus on early diagnosis and intervention is required, including looking at common mental health issues and depression in particular.

Suicide prevention should be part of a much wider improvement in public mental health and wellbeing and actions to address the underlying causes of poor mental health.

# Physical Disability

A physical disability is a limitation on a person's physical functioning, mobility, dexterity or stamina. There is a difference between impairment (a state of being) and disability (a consequence of an environment).

Equity of access to education, employment, appropriate housing, and financial support as well as to being an active member of a local community, all have an impact on health and wellbeing.

Around **4,800** people between the ages of 16-64 have a physical impairment which affects their ability to undertake normal daily living tasks<sup>102</sup>. This includes people born with impairment, those who have suffered an injury and those whose disability has developed as a result of an illness.

There are some national data sources on physical disability but these use a variety of definitions.

**6.9%** people identified themselves as living with a physical disability that had lasted or was expected to last at least 12 months<sup>103</sup>. This was very close to the Scottish average of 6.7%<sup>104</sup>.

**3,860** adults (18 and over) known to the Adults and Social Care team have physical disability recorded as their primary care group (2018)<sup>105</sup>.

**4,517** people have a blue badge<sup>106</sup>.

**1,200** people are recorded as wheelchair users<sup>107</sup>

As medical interventions become more sophisticated and the ageing population increases we can assume that the number of people with a physical disability will rise. It can further be assumed that people will continue to want to live in their own homes for as long as possible, requiring ongoing investment in adapted and accessible housing. In order to support people to live as full a life as possible it is also necessary to work toward reducing and removing barriers to education and employment (see Education and Employment sections).

# Learning Disability

People with a Learning Disability have a significant, lifelong, condition that started before adulthood, which affected their development, and means they need help to understand information; learn skills; and cope independently. The Learning Disability population in Midlothian is growing as are the complexities of their needs. It is necessary to develop health and social care responses which appropriately respond to these.

**1,722** people have a Learning Disability (a statistical estimate). There is a wide variation in reported rate, particularly for people with a mild learning disability.

**628** adults with a Learning Disability are known to Social Care service in Midlothian<sup>108</sup> **40-50** of whom have complex needs. The latter figures are the group that are most likely to make use of Health and Social Care services.

Midlothian has a higher prevalence rate of adults with a Learning Disability known to Social Care (**5.8 per 1,000**) in comparison to the Scottish average (5.2) (2018)<sup>109</sup>. This is related to the closure of several local hospital facilities in the 90s. Learning disabilities is the highest area of spend in Midlothian based on client group and spend per head.

**30 teenagers** (14-18 year olds) have been identified as having significant support needs and who are transitioning between children and adult services (2018)<sup>110</sup>.

**113 pupils** are on the Saltersgate school roll (Primary and Secondary). This includes some pupils in St. David's High School who as of August 2019 will not be part of Saltersgate. As a result 2019/2020 there will be a slightly lower register of 100 pupils. These are a group of young people who will likely meet the criteria for support from Adults Services when transitioning into adulthood.

Approximately **two thirds of adults with a learning disability live alone**. This is much higher than the Scottish average which is just over a half. **A fifth live with 3 or more other adults with a learning disability and less than 1 in ten adults are estimated to live with a family member**<sup>111</sup>. The high number of adults with a learning disability living alone in Midlothian might warrant some exploration including consideration of the theme of loneliness.

As a population, people with learning disabilities are experiencing increased life expectancy. Older adults are proportionally the largest and fastest growing group in the learning disabled population and more young people are surviving into adulthood. As life expectancy has increased, more people with learning disabilities are experiencing multi-morbidities and increased complexity in their health and social care needs.<sup>1</sup>

# Autism spectrum disorders

Autism is a lifelong developmental disorder that affects people differently with some individuals being able to live independently with others needing very specialist support. People who have autism experience problems with:

- Communication – both verbal and non-verbal,
- Reciprocal social interaction,
- Restrictive, repetitive and stereotypical routines of behaviour.

**918 people (adults and children)** have Autism<sup>112</sup>. This is **1.4% of the population**. This figure is consistent with the estimated prevalence of autism in Scotland.

**301** of these individuals also have a Learning Disability (32%) again consistent with Scotland. This information is currently not available for adults only. The people who have a diagnosis of Autism 68% but do not have an associated learning disability are less likely to be known to services or identified by services as having Autism

There is no reliable data on the prevalence of Asperger's Syndrome either nationally or locally due to variances in the definition.<sup>113</sup>

Autism is more **prevalent amongst males than females** with sex ratios typically ranging from around 2.5 – 6.0: 1<sup>114</sup>.

Nationally it is recorded that there is a high frequency of mental health problems experienced across the autism spectrum, particularly in relation to the prevalence of anxiety and depression<sup>115</sup>. Other common conditions which are known to concur with ASD, include epilepsy, attention deficit, hyperactivity disorder (ADHD), schizophrenia, obsessive compulsive disorder (OCD) and Tourette's Syndrome.

Where people are known it would be beneficial to build a better understanding of numbers and needs including the exploration of areas such as mental health.

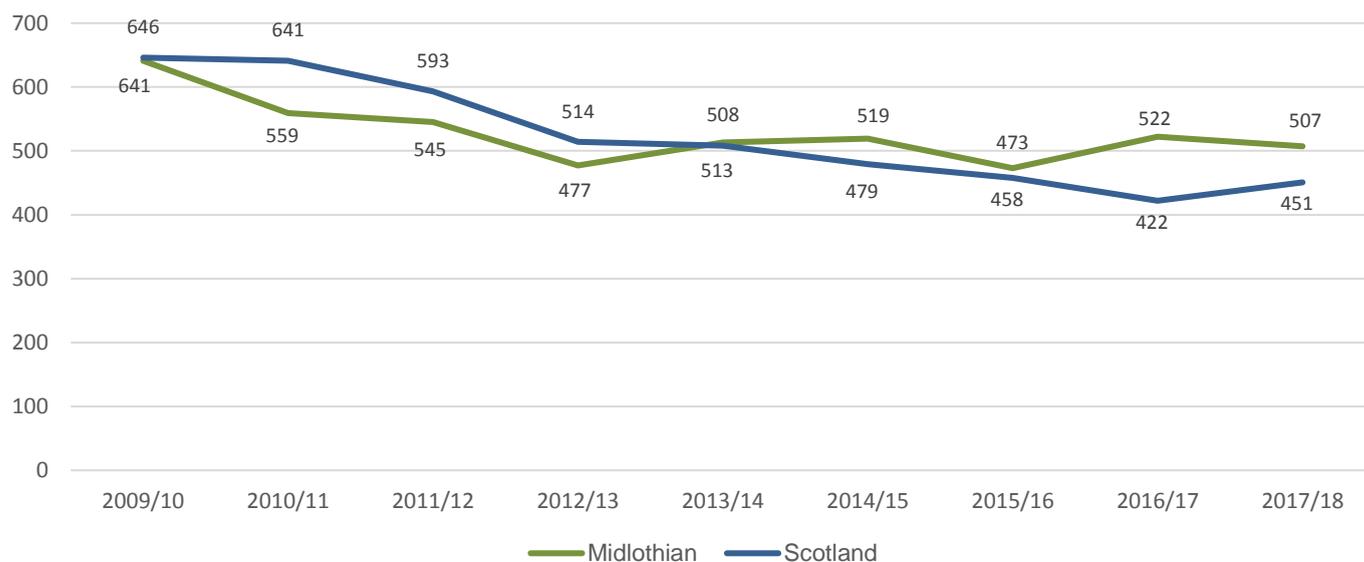
# Community Justice

Community Justice is the prevention and reduction of offending by addressing the underlying causes. It is concerned with the safe and effective management and support of those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all citizens.

Certain agencies have a statutory duty to be involved in Community Justice Partnerships:

- Scottish Ministers
- Police Scotland
- Health Boards
- The Scottish Courts and Tribunal Service
- The Procurator Fiscal Service
- The Scottish Fire and Rescue Service,
- Integration Joint Boards
- Skills Development Scotland
- Local Authorities

FIGURE 45. NUMBER AND RATE PER 10,000 POPULATION OF ALL CRIMES AND OFFENCES RECORDED BY THE POLICE



Data source: [Statistics.gov.scot](https://www.statistics.gov.scot) [Accessed Jan. 2019].

Data from Police Scotland (2017):

- **A fifth of all violent crime or anti-social behaviour** were tagged as having alcohol as a factor – a rate of 59 crimes per 10,000 population. It is expected that the true extent is far greater than reported.
- On average **2 calls each** weekend from members of the public reporting young people under the influence of alcohol. Eskbank has the highest rate of alcohol aggravated youth calls, at 521 calls per 10,000 population, followed by Dalkeith with a rate of 516 calls.
- A significant correlation between dishonesty crime and the roll-out of Universal Credit in Midlothian.

Data from criminal justice social work (clients interviewed at pre-sentence stage in 2016/17)

- **a third reported alcohol as a contributory factor** to the offence, and over a **third of clients charged with dishonesty crime reported drug misuse as a contributory factor**

Data from assessments carried out by Criminal Justice Social Work (January 2012 - January 2013):

- **65%** of individuals assessed had, had an alcohol problem at some point in their lives with **34%** describing themselves as having a current alcohol problem.
- **60%** of individuals had had a drug problem at some point in their lives with **31%** saying they had a current drug problem.
- **71%** had left school at the minimum leaving age and **70%** were unemployed at the time of the assessment.
- Where a current alcohol or drug problem was identified this had led to offending behaviour in **100%** of cases, had affected marital/family relationships in **82%** of cases and education/employment in **50%** of cases.
- **53%** reported current financial problems, **49%** said they were or had been the victim of violence within their families and **40%** said they had low self-esteem.
- **75%** of individuals were assessed as having problem-solving deficits.
- **58%** were assessed as having anger management issues.

Research shows that re-integration into families and communities, access to accommodation, employment, health and support services, are critical to support desistance.

Offending behaviour has strong links to areas of health and social need. Alcohol and drug use, mental health and reducing trauma were 3 of the 4 key areas identified by NHS Scotland Inequality briefing in relation to community justice (Aug 2017). There is a high correlation between being in prison and income inequality, social mobility, teenage births, mental illness and high levels of obesity.

Scottish data also shows a strong relationship between gender and community Justice. Males accounted for 83 per cent of all people convicted in 2016/17 but represented a higher proportion of all custodial sentences (92 per cent) totalling 11,656 men. By contrast women accounted for 17 per cent of people convicted compared to a lower proportion for custodial sentences (8 per cent of custodial sentences)<sup>116</sup>. Males also have higher reconviction rates and a higher average number of reconvictions per offender than females<sup>117</sup>.

Any attempts to reduce offending and reoffending as part of the Community Justice agenda require a multidisciplinary and community approach to issues such as inequality, adverse childhood experiences, trauma, lack of opportunity, poor physical and mental health issues and difficulties with accessing education and employment, and substance misuse.

The LSCMI tool can offer very rich data about those who come into contact with Criminal Justice social work. The data from the tool is currently not analysed routinely and consideration should be given to what data it can offer us to maximise the effectiveness of resources in the coming years.

# Substance Misuse

## Problem Drug Use

Problem drug use is the, 'problematic use of opiates (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use'<sup>118</sup>

Due to the illicit nature of drugs misuse it is difficult to say how many people have problems with drugs. Data is collected for people attending a treatment service usually for addiction to an opiate (e.g. heroin) and/or benzodiazepine (e.g. valium).

**920** problematic drug users in Midlothian - **690** males and **230** (33%) females<sup>119</sup>. The proportion of female users is slightly higher than the national figure of 29% and women's needs need to be taken into account when designing and delivering services to ensure they feel able to access available supports.

The highest prevalence rates for males aged 25 to 34 years were observed in Midlothian (7.14%), Inverclyde (6.83%) and Shetland Islands (6.83%<sup>120</sup>).

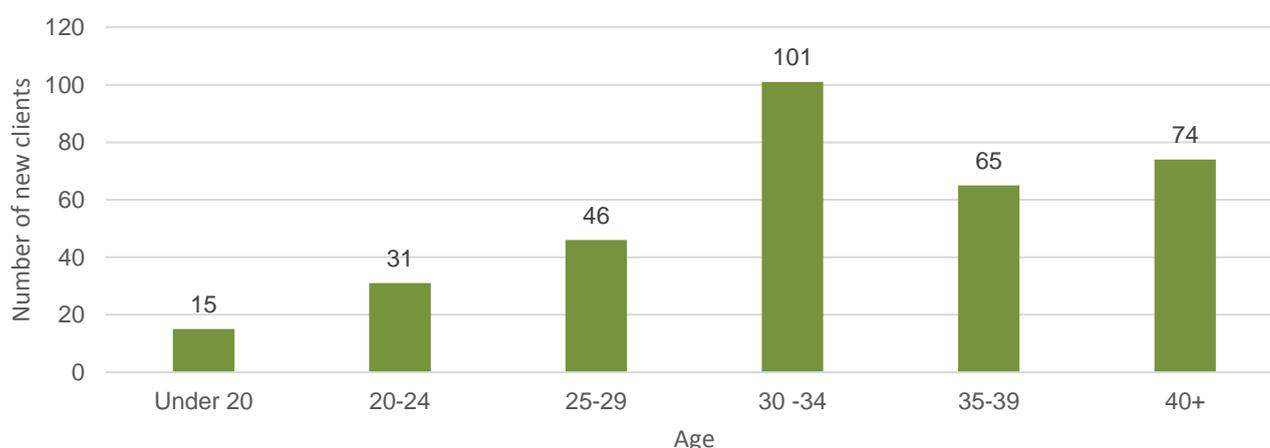
Characteristics of populations most at risk are<sup>121</sup>:

- Single, unemployed white Scottish men in their early 40s
- History of long term poly-substance use
- History of alcohol use
- Multiple co-morbidities
- History of mental illness
- History on non-fatal overdose
- Lived alone, died alone.

Since the introduction of the Psychoactive Substances Act in May 2016 Midlothian services and partners report little use of NPS. It is difficult to gauge the level of internet sales of NPS and other illicit substances.

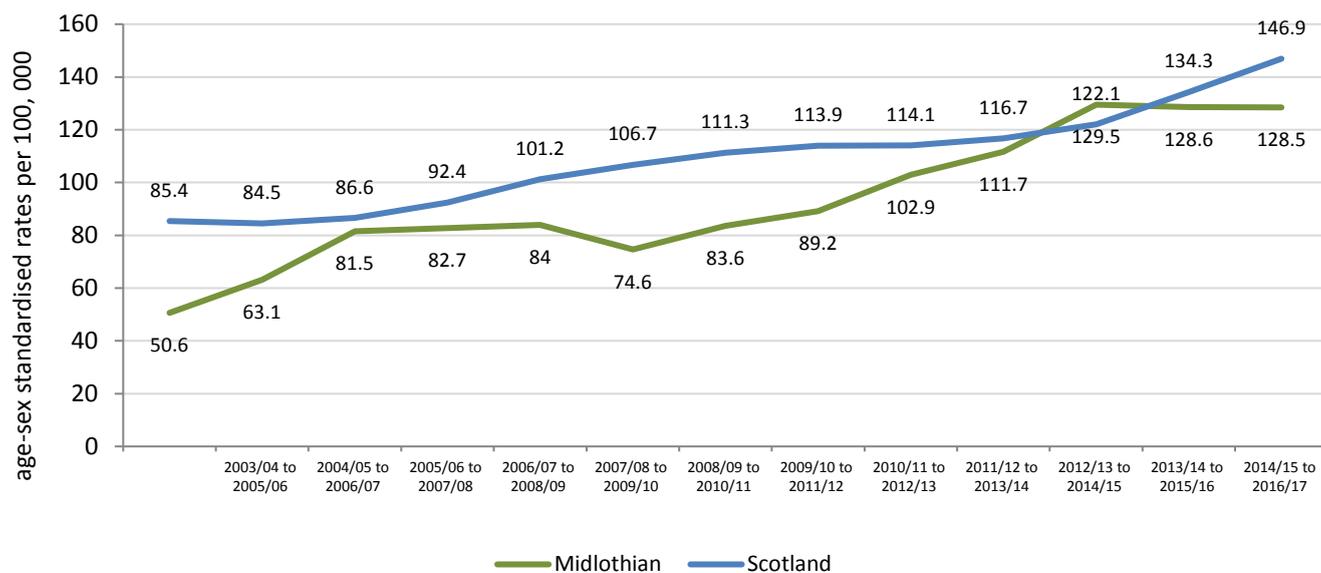
Heroin, cannabis and diazepam were most often reported to have been used in the month prior to assessment.

**FIGURE 46. NUMBER OF NEW CLIENTS SEEKING SUPPORT TO DEAL WITH THEIR SUBSTANCE USE (2016-17) TOTAL = 332**



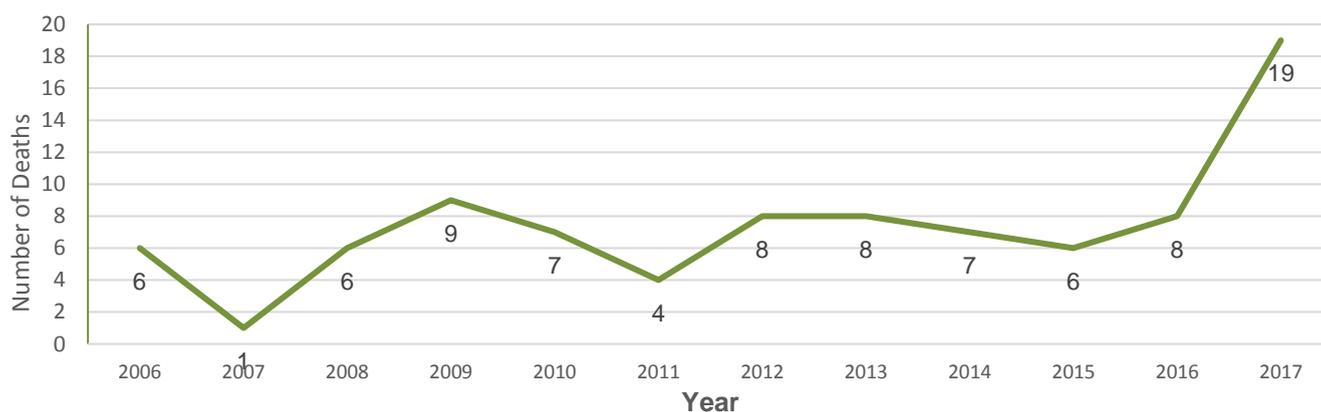
Data source: *Midlothian Internal Data (Substance Misuse Service)*. [Accessed Nov. 2018].

FIGURE 47. DRUG-RELATED HOSPITAL STAYS, 3-YEAR AGGREGATES, MIDLOTHIAN AND SCOTLAND



Data source: *Scottish Public Health Observatory* [Accessed Oct. 2018].

FIGURE 48. DRUG RELATED DEATHS IN MIDLOTHIAN (2006 – 2017)



Data source: *National Records of Scotland*. [Accessed Oct. 2018].

In 2017 there were **19 drug related deaths** (14 males and 5 females), the highest figure ever recorded and more the double the 2016 figure<sup>122</sup>. Of these deaths 15 were classified as accidental poisoning and 4 as intentional self-poisoning. Any opiate or opioid was noted as the drug present in 15 of the deaths.

Conclusions about trends cannot be drawn from this. Comparably in Scotland drug related deaths have increased over the last 4 years from 600 to more than 900. The five year average was 4 for 2003-2007 and 10 for 2013-2017.

We have an ageing population of drug users who are more likely to be frail and experience multi morbidity requiring increased health and social care support. Services need to target those most at risk of drug related deaths, these are a harder to reach and retain client group.

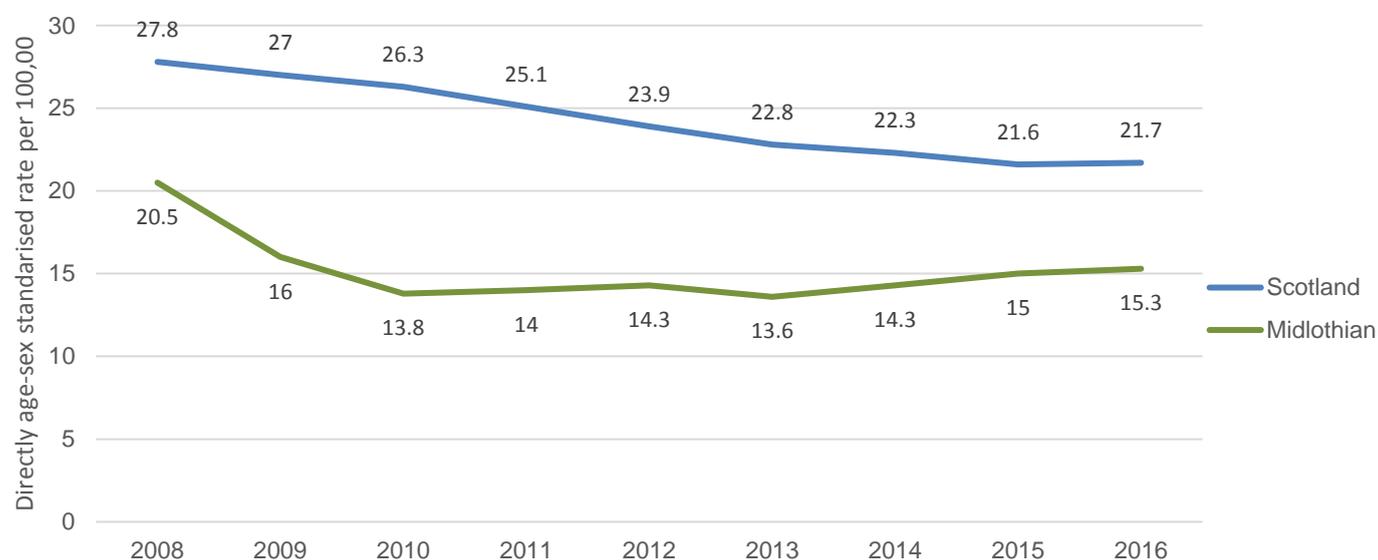
## Alcohol Related Harm

Alcohol use and misuse contributes to preventable illnesses and death such as a range of cancers, fertility problems, nervous system issues, liver disease and cirrhosis. It is also linked to a crime, anti-social behaviour, child neglect and violence against women and girls.

**Alcohol related deaths:** 17 alcohol related deaths (2016) with a five-year average of 17 (2012-2016). The average age-standardised death rate for the five-year aggregate 2012-2016 was 15 deaths per 100,000 population, which is similar to the average Scotland rate of 21.7.

Nationally statistics are collected on a narrow definition of alcohol related deaths – as those coded to a direct alcohol related cause such as alcoholic cirrhosis. They do not include deaths due to diseases for which alcohol is a risk factor (such as cancer). However, studies suggest that the number of deaths where alcohol was a contributory or risk factor is much larger. The use of this narrower definition ensures that it is easily collectable to demonstrate any trends.

FIGURE 49. DEATHS FROM ALCOHOL CONDITIONS (ROLLING 5 YEAR AVERAGE)



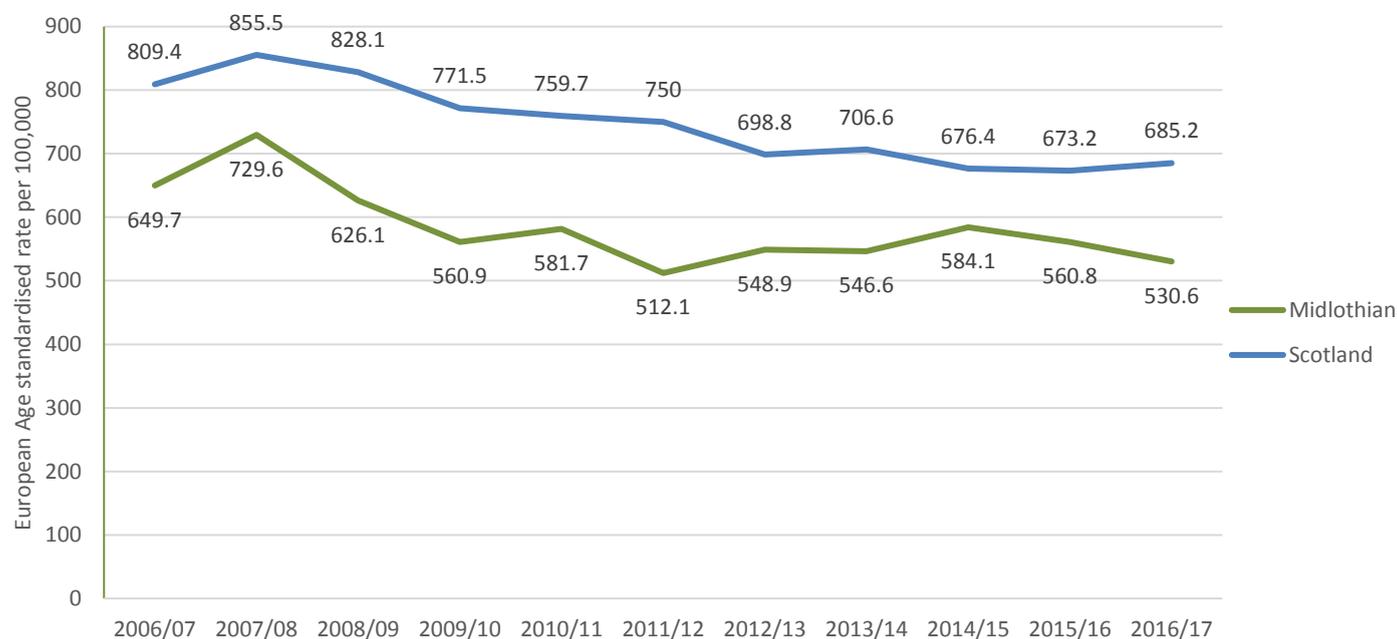
Data source: *Scottish Public Health Observatory*. [Accessed Oct. 2018].

Ten localities are above the Midlothian average for alcohol related deaths including:

- **Newtongrange** (average rate of 45.6 deaths per 100,000 population),
- **Loanhead** (28.41),
- **Thornybank** (26.98),
- **Penicuik Southwest** (26.76),
- **Bonnyrigg North** (25.53) and
- **North Gorebridge** (25.40).
- Dalkeith (19.88),
- Mayfield (19.35),
- Penicuik Southeast (18.61)
- Gorebridge
- Middleton (17.86)

**Alcohol related hospital stays** are the number of general acute inpatient and day case stays with a diagnosis of alcohol misuse in any position: **345** patients had alcohol related hospital admissions (2016/2017).

**FIGURE 50. GENERAL ACUTE INPATIENT AND DAY CASE STAYS WITH AN ALCOHOL-RELATED DIAGNOSIS IN ANY POSITION**



**Data source:** *Scottish Public Health Observatory*. [Accessed Oct. 2018]

Ten of Midlothian's localities sit above the Midlothian average for alcohol related hospital stays including:

- **Dalkeith** (rate of 1444 admissions per 100,000 population)
- **North Gorebridge** (865)
- **Newtongrange** (780)
- Straiton (719)
- Loanhead (701)
- Thornybank (694)
- Pentland (677)
- Penicuik Southeast (657)
- Penicuik East (577)
- Pathead and Rural East Midlothian (555).

“In Midlothian, a statistically significant relationship was found between alcohol outlet availability and alcohol-related deaths: neighbourhoods with more places to buy alcohol had higher alcohol-related death rates. Alcohol-related death rates in the neighbourhoods with the most off-sales outlets were 2.4 times higher than in neighbourhoods with the least”<sup>123</sup>

It is reasonable to assume based on national data that alcohol related harm is most acutely felt in Midlothian's most deprived communities.

While the data for Midlothian is better than the national picture there are challenges in tackling alcohol consumption, particularly for older males aged 55-64 in some of Midlothian's most deprived communities.

# Support & Resources

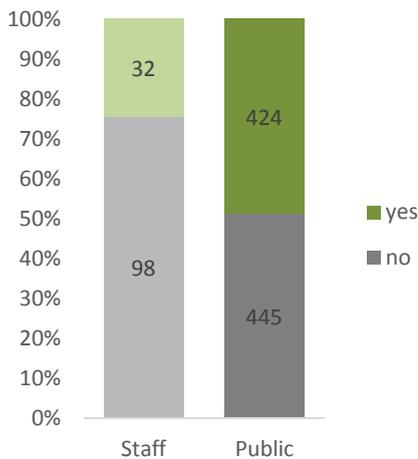
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# Support and Treatment

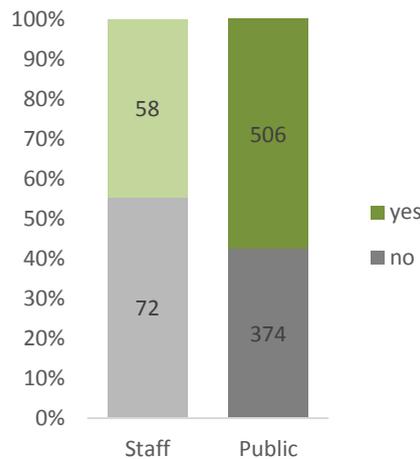
There are several measures in place to seek the views of patients/service users. The National Health and Care Experience Survey is sent to a random sample of around 5% of the population. 1977 people from Midlothian responded to the 2017/18 Survey. In preparation for the 2019 Strategic Plan the Health and Social Care Partnership carried out a consultation in which 1,600 people took part (1410 members of the public and 192 staff members). These two surveys provide a general impression of people’s overall experience of health and social care services.

FIGURE 51. STRATEGIC PLAN CONSULTATION FINDINGS

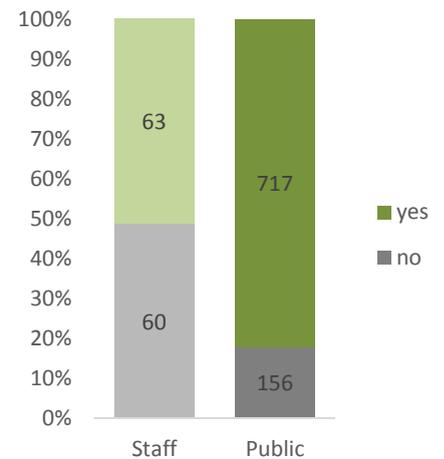
Is it easy to get support/treatment quickly?



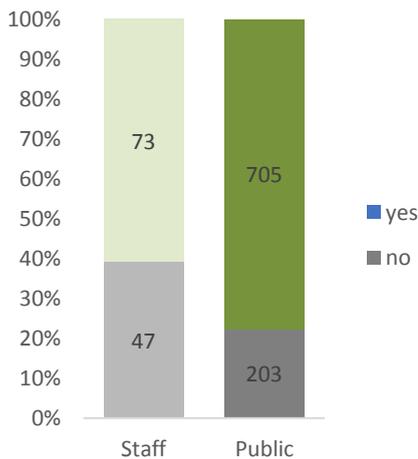
Is it easy to get support/treatment locally?



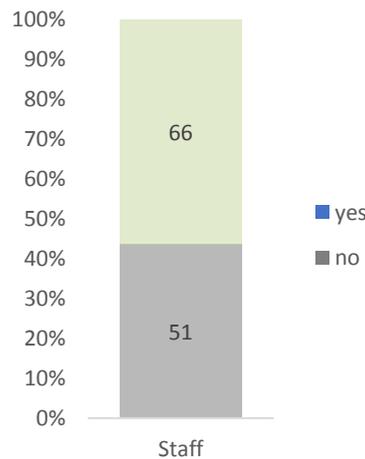
Do you feel you can control or change your support/treatment?



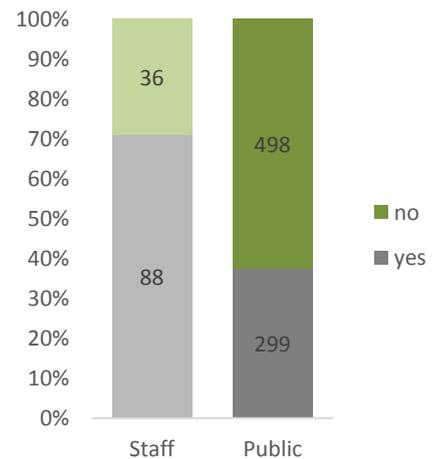
Do you feel your feedback will help change services?



Do you feel your feedback as a member of staff helps shape services?

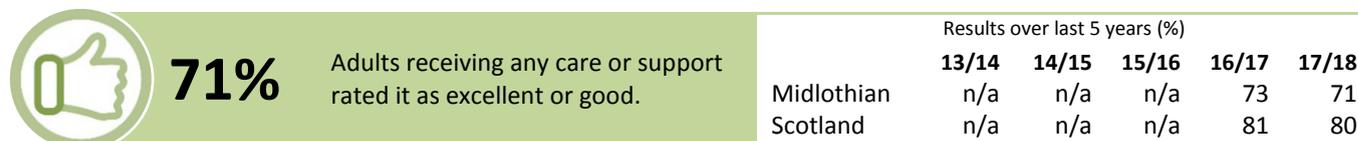
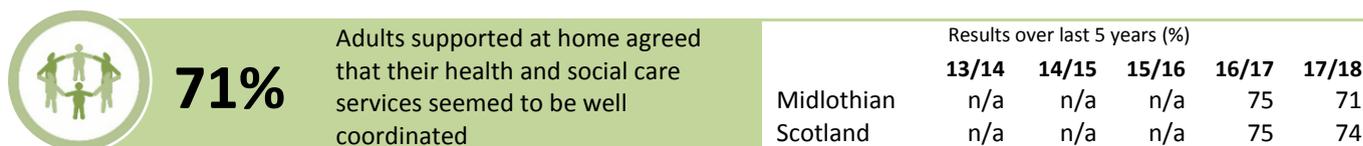


Has your support/treatment helped you recover?  
(Does the support/treatment we provide help people recover?)



Data source: Midlothian Health and Social Care. (2019). *Strategic Plan Consultation*.

FIGURE 52. NATIONAL HEALTH AND CARE EXPERIENCE SURVEY 2017/18



Data source: *National Health and Care Experience Survey*. (2018).

The overall results from the National Health and Care Experience survey suggest a decline in patient/service user experience compared to the previous year. This general trend is mirrored in the Scottish results. As the first Health and Social Care Consultation it is not possible to compare results with previous findings.

# Primary Care

## GPs

There are **12** G.P. Practices in Midlothian operating from 10 premises. A number of these premises are good quality and modern, the latest being Loanhead Medical Centre.

Several have, or are likely to outgrow the capacity of their premises. One additional clinic has been opened in Newtongrange and plans are being developed to address the other main pressure points - in the Shawfair development, South Bonnyrigg and Newbyres. This will increase capacity by between 7,300 and 8,300 patients or between 9% and 11% of the existing total practice list number in Midlothian.

We are unable to describe the total amount of doctor time as only headcount figures are available. Demand for GP appointments is high. The average number of consultations is **6 per person per year** (increased from 3.7) and **600 000 appointments** are offered every year. National figures suggest that **1 in 10 people visit their GP practice on a weekly basis**.

Between **84.6% to 98.9% people can access a GP within 48 hours or advance booking to an appropriate member of the GP team**. NHS Lothian and Scotland rates are (93%).

The National Health and Care Experience Survey asks people's experiences of their GP practice and out-of-hours services, and their outcomes from NHS treatments. **76%** of people said they had a positive experience of the care provided by their GP practice. This is lower than the previous year and is lower than the Scottish. There are no clear reasons for this.<sup>124</sup> In general smaller practices seem to have fared better than larger ones.

The new GP Contract was agreed in May 2018, it will 'refocus' the GP role to help them become 'expert medical generalists'. For local practice, this means that the primary care team will change to include a wider range of health professionals, such as Physiotherapists and Mental Health Nurses as well as exiting team members such as Practice Nurses taking on wider responsibilities. Having a broader range of skills and expertise will help patients see the most appropriate person who can help them. These plans are also designed to allow GPs the time and space for people with more complicated health conditions. 71% people are aware of alternative services to the GP which can be used when they are unwell. Most people said they knew about these because of word of mouth.<sup>125</sup>

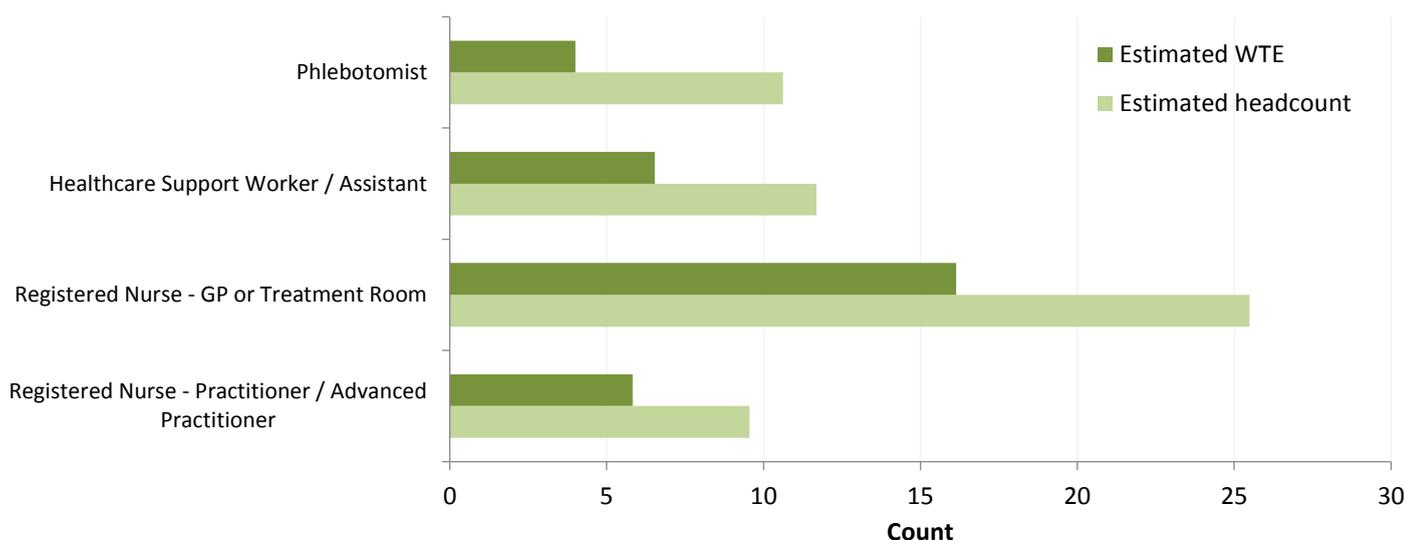
The growth of the population alongside recruitment, retention and changing work patterns have implications for the delivery of GP services. Specific pressure points have been identified and ways to address this need to be progressed.

## Nursing

The majority of nurses working in Midlothian are employed by NHS Lothian working in Community services and teams (District Nursing, Hospital at Home, Mental Health, Substance Misuse); Treatment rooms based within GP Practices; Midlothian Community Hospital wards; and in a care home for older people owned by the Partnership. Additionally Nurses are employed directly by General Practices and privately e.g. in care homes.

The NHS Scotland National Primary Care Workforce Planning Survey (2017), shows the breakdown of nursing and phlebotomy staff within GP practices.

**FIGURE 53. HEADCOUNT AND WHOLE TIME EQUIVALENT OF NURSING STAFF IN MIDLOTHIAN GP PRACTICES BY DESIGNATION, 2017**

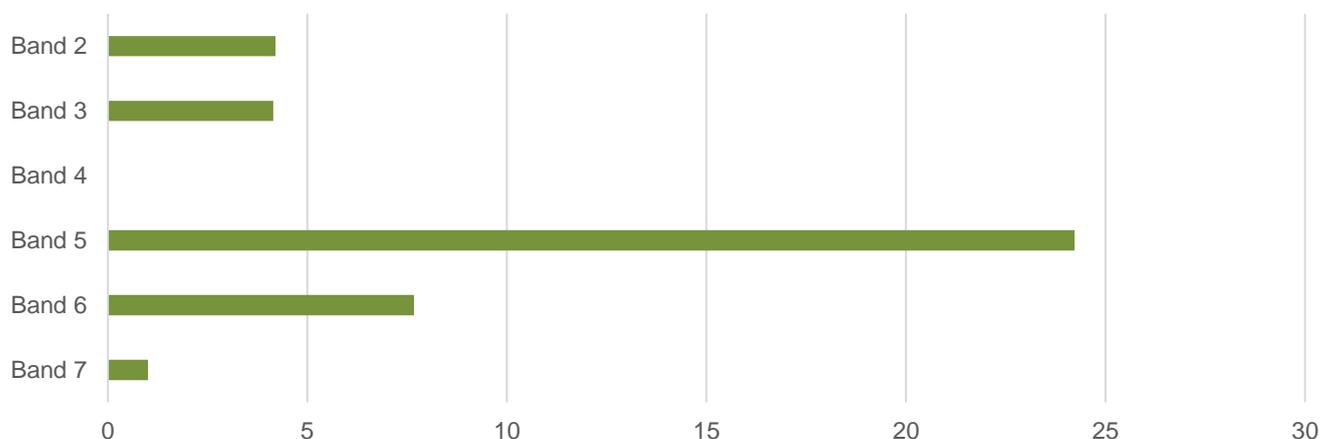


Data source: *Information Services Division*. [Accessed: November 2018].

The estimated number and Whole Time Equivalent (WTE) have both slightly decreased from 2015, however the response rate in 2015 was low, so figures for 2017 only are shown above.

The District Nursing Team comprises of 41 whole time equivalent workers. They work across the whole of Midlothian and provide 24 hour support.

**FIGURE 54. NUMBER OF DISTRICT NURSING TEAM**



Data source: *Internal NHS Payroll Data*. [Accessed Jan. 2019].

Similar information for community nurses was only available at a Lothian level until 2015. This showed an increase in the total numbers of community nurses in the Lothians. (Information and Statistics Division of NHS Scotland.) While we cannot quantify the number of community nurses the increased focus on community responses has led to several new community nursing posts e.g. the Hospital at Home Team (7 nursing staff) and the Community Health Inequalities Team (2.6 nursing posts). Higher numbers of nursing staff are employed in the Midlothian Community Hospital. This is as a direct result of the remodeling of the hospital (2017) to create a rehabilitation and assessment ward for older people - previously hosted at Liberton Hospital. This ward has been staffed on a ratio of 60% registered nurse: 40% non-registered nurse, having 1.3 whole time equivalent nurses per bed.

We are facing a specific pressure point in District Nursing as a number of staff are nearing retirement age and young graduates are less likely to choose District Nursing as a career path than other areas of nursing.

Anecdotally we know that demand is high for nursing care but there is insufficient data to measure this. Demand is often masked by the fact that many teams cannot run a waiting list due to the nature of the work. There is also no data routinely collected on how long people have to wait to see a Practice Nurse but access to Practice Nurses has not been raised as an issue through the 2019 consultation in the way that access to a GP has.

Within the new GP contract which came into force on the 1<sup>st</sup> April 2018 there is an emphasis on enhanced nursing roles. These advanced nurse practitioners will have advanced assessment skills, clinical decision making and be qualified non-medical prescribers.

There is a need to better quantify and record the demand, and describe the pressure points for nursing in Midlothian in addition to capturing accurate workforce data. The movement towards community based solutions and multidisciplinary working needs to be considered alongside the particular pressure points for recruitment and retention. e.g. district nursing. It is also important to forward plan for these advanced nursing roles to allow for the time it takes to achieve the qualifications required.

## Allied Health professionals

Allied Health Professionals (AHP) encompass a broad group of professionals working in a range of health and care settings including patients' homes, hospitals, community based teams and surgeries. They work alongside doctors, dentists and nurses. The partnership directly employs Occupational Therapists (in Council and NHS) as well as Physiotherapists in NHS with a total of **60** whole time equivalent employed across health and social care<sup>126</sup>.

Podiatrists, Speech and Language Therapists, Arts Therapists, Radiographers and Dietitians are Lothian-wide NHS services which provide patient care to Midlothian residents. Arts Therapy and Dietetics are hosted in Midlothian so respective heads of Service form part of the Midlothian Management Team and the associated budget is held in Midlothian. The service employs 100 whole time equivalent Dietetic staff and 7 Arts Therapy staff who work across NHS Lothian.

The new GP contract came into force in April 2018. Under the plans physiotherapists will work as part of multi-disciplinary primary care teams providing a first point of contact service within the practice setting. Health and Social Care Partnerships are also required to embed Musculoskeletal services in practice teams within which Advanced Practitioner Physiotherapist will hold a caseload without the need for a GP referral. Three practices (Pathhead, Newbattle, Strathesk) were identified in 2017 to test this new model. The service has been operational since May 2018 and was rolled out to 50% of practices by the end of 2018<sup>127</sup>.

Occupational Therapists work across the Adults Social Care Team. Both Occupational Therapists and Physiotherapists work within MERRIT, Reablement, Midlothian Community Physical Rehabilitation Team (MCPRT) in Midlothian Community Hospital with older adult patients, the Community Learning Disability Team, Dementia Team, Joint Mental Health Team and Spring (Support to women who are at risk of offending) and Substance Misuse Service

The Allied Health Professional workforce is currently under review both nationally and at local level. This includes consideration of the support staff and the development of Advanced Practitioner roles. This is consistent with the direction of the GP contract and shifting the balance of care from hospital to community.

There is a recognition that the existing national AHP data is incomplete, inconsistent and there are issues with accuracy. In response to this the Scottish Government has approved the development of an Allied Health Profession Operational Measures Dataset aimed to capture national data. There are initial discussions on how this is to be implemented at a local level within NHS data system TRAK and Midlothian Council system MOSAIC. A national project providing a snapshot of Allied Health Professional activity was carried out in 2018 and outcome data is awaited from Scottish Government Allied Health Professional Directorate. This was part of the Strategic plan for Scotland AILP (Active and Independent Living Programme)

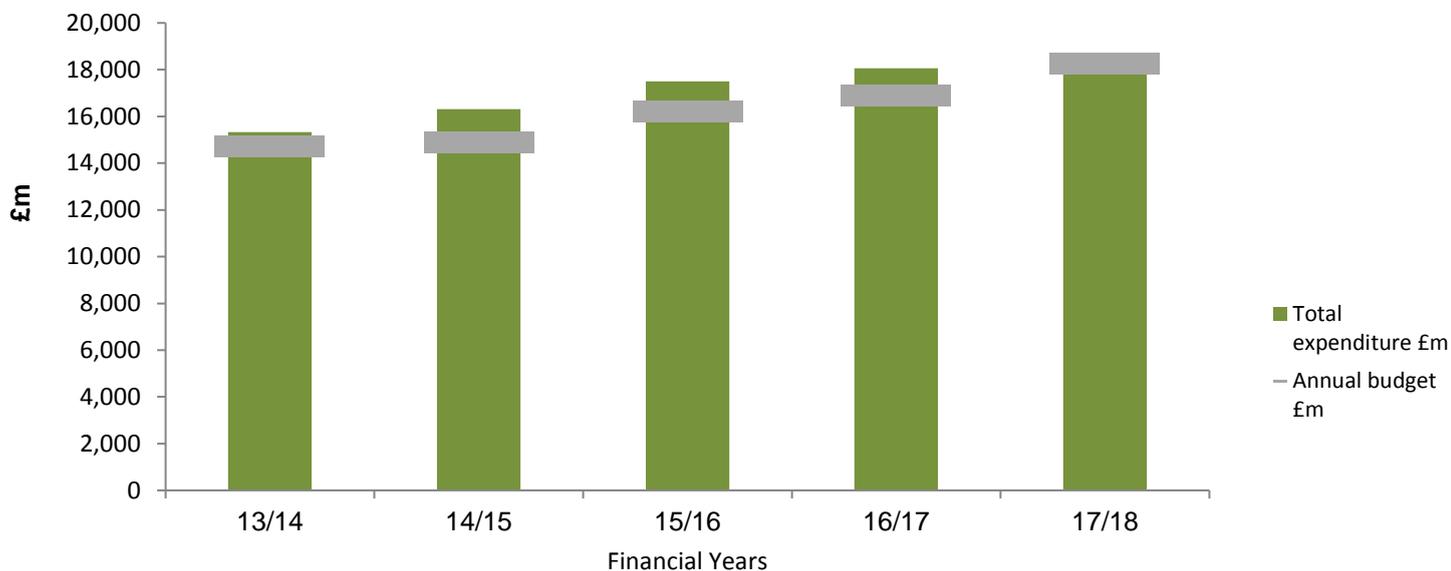
Consideration needs to be given at a local level as to how best collect, measure and analyse Allied Health Professional data. There is some data as all Staff are using electronic systems, however this information needs to be better used in our planning. Consideration of reliable, timely and local data will be useful for strengthening our understanding of Allied Health Professional roles and service development.

## Prescribed medication

£18m of the £131 million IJB budget is spent on drugs prescribed.

Efforts to reduce this cost safely whilst encouraging patient self-management of symptoms where appropriate include encouraging healthy lifestyles, the Wellbeing Service, “healthy reading” and exercise referral schemes.

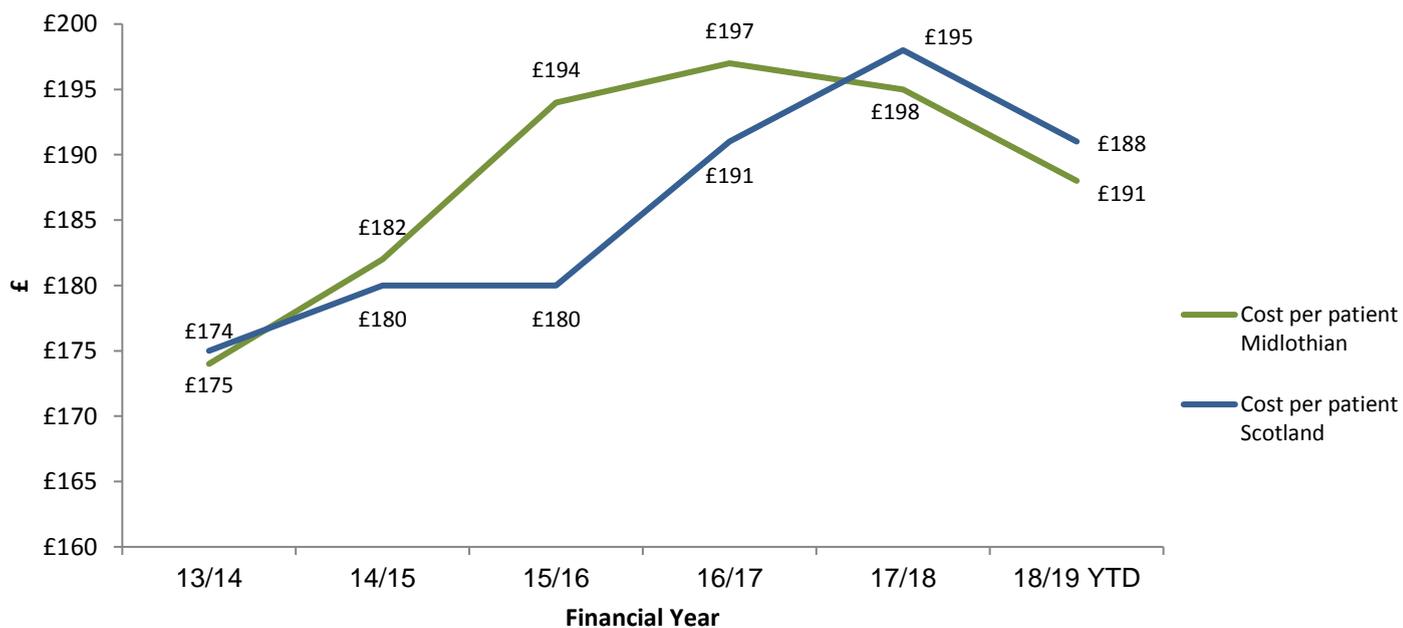
FIGURE 55. PRESCRIBING SPEND VS BUDGET



Data source: NHS Lothian Internal Data: *PRISMS* (Accessed Dec. 2018).

**£195 is the average GP prescribing cost per patient (2017/18)**, lower than a Scotland average of £198<sup>128</sup>. In 2015 spending was higher than the Scottish average by £2 and was growing faster than the rest of Lothian and Scotland. Work has been done reducing items (polypharmacy) and the push of ‘realistic care realistic medicine’.

FIGURE 56. PRESCRIBING COST PER PATIENT



Data source: NHS Lothian Internal Data: *PRISMS* (Accessed Dec. 2018).

The most frequently prescribed medicines quarter one of 2017/18 were:

- Omeprazole
- Co-codamol
- Salbutamol inhalor
- Paracetamol

The most expensive items which for the same quarter were:

- Apixaban,
- Fostair inhaler,
- Freestyle Libre sensor kit
- Relva Ellipta Inhalor<sup>129</sup>.

Regardless of savings made the overall cost is expected to continue to increase (albeit at a lower rate). This is as a result of an ageing population and the fact that people are living longer with co morbidity.

In NHS Scotland, **medication is by far the most common form of medical intervention.**

**Four out of five people aged over 75 years take a prescription medicine and 36 per cent are taking four or more<sup>130</sup>.**

The Scottish review of polypharmacy prescribing data (10+ BNF paragraphs plus a high risk medicine) by deprivation demonstrates that multi-morbidity, and its associated problems, presents 10 to 15 years earlier in more deprived communities<sup>131</sup>.

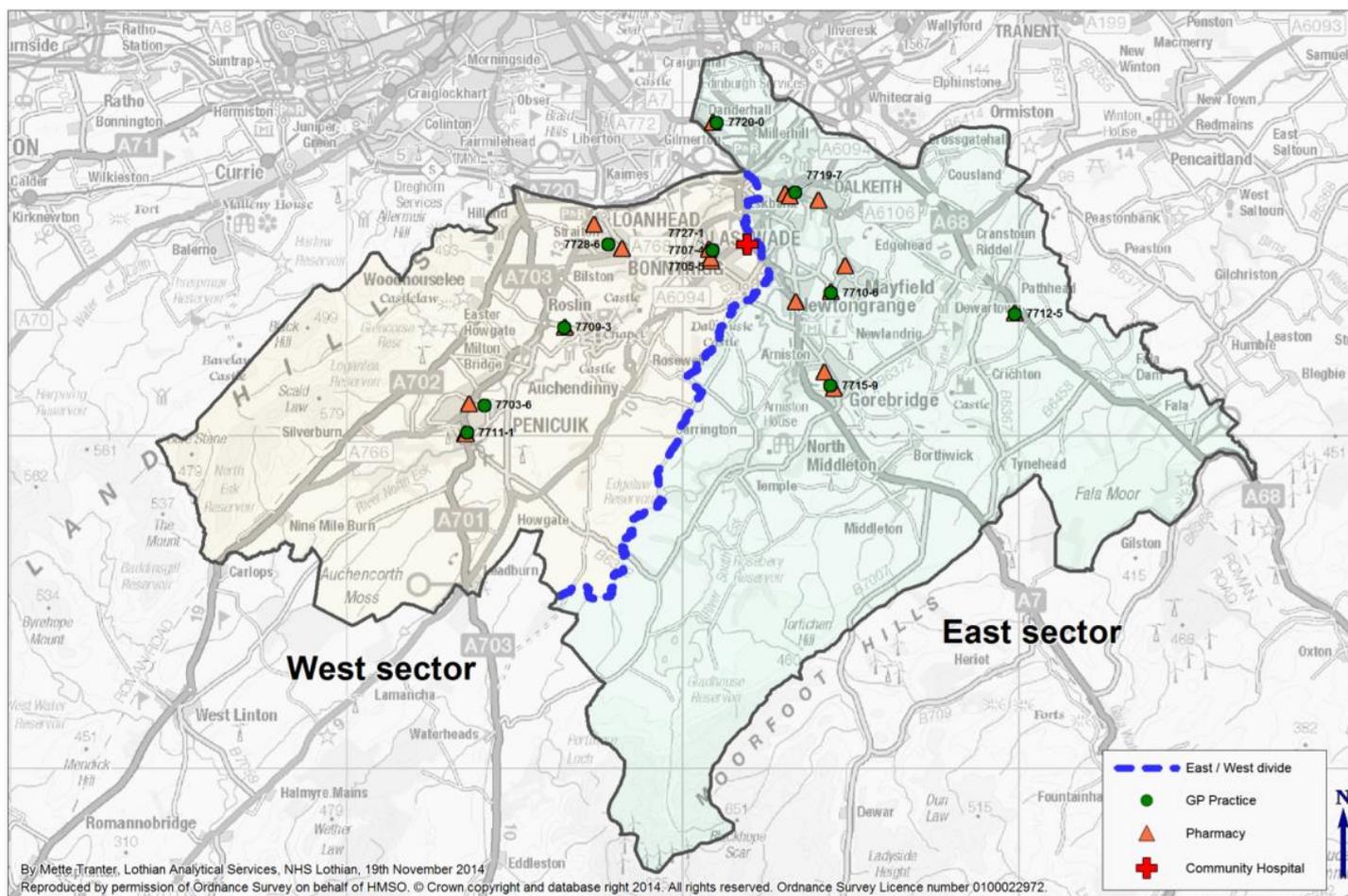
It is suggested that up to 50 per cent of drugs are not taken as prescribed, many drugs in common use can cause problems and adverse reactions to medicines are implicated in 5 - 17 per cent of hospital admissions<sup>132</sup>. Furthermore it is estimated nationally that 50% of hospital admissions for adverse drug events for those aged 65 and over and on 5 or more medications are preventable.

The continued growth of spend and associated challenges to maintain spend within the allocated prescription budget has implications for prescribing. The successful focus on reviewing and reducing items per patient alongside reviewing high cost items and those most frequently prescribed highlights areas of priority to improve health and reduce expenditure. Particular attention is required on those over 65 and those living in our more deprived communities as national evidence shows these are areas of high risk.

## Community Pharmacy

There are **19 pharmacies**, most of which open until 6pm, with one opening until 10pm; and on a Sunday. Pharmacies are located in the areas of greater population density, the more dense the population the higher number of pharmacies there are.

FIGURE 57. GP PRACTICES AND PHARMACIES IN MIDLOTHIAN CHP



The community pharmacy contract aims to use the skills and knowledge of pharmacists better, ensuring that all patients have access to support in the management of their medicines as well as providing a minor ailments service for advice on such conditions as hay fever, athletes foot and cold sores. All pharmacies in Midlothian also now operate a pharmacy first service for women aged between 16 and 65 for the treatment of UTIs and impetigo.

The Midlothian Primary Care Implementation Plan (2018) sets out how the pharmacotherapy part of the new GP contract which came into force in April 2018 will be implemented. This will see the introduction of pharmacy and prescribing support in every GP practice providing all core elements by 2021.

Pharmacy First and the new GP contract introduce a greater role and stronger focus on pharmacy and prescribing support. This will have training, recruitment and practical implications for all those involved in the provision of these services.

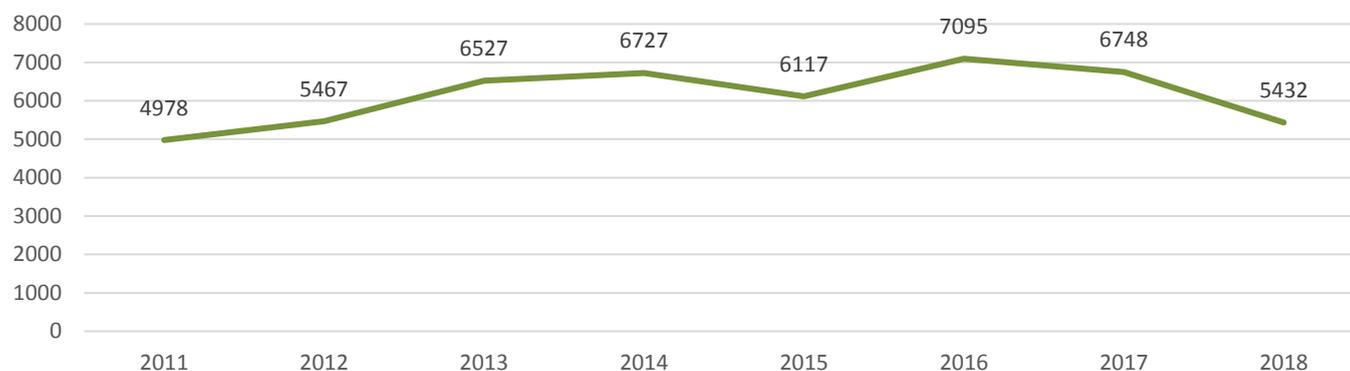
# Adult Social Care

Adult Social Care relates to the assessment of care and support needs and provision of support across all adult and older people client groups. It comprises of the following field work staff: **29.7** Social Workers (includes Mental Health Officers), **9.8** Occupational Therapists, **9.2** Community Care Assistants and **8** team leaders (numbers are whole time equivalent). A restructure of Adult Social Care is underway (2018/19) with the proposal to focus on specialist teams, categorised by client group, and with an emphasis on closer joint working with health colleagues. This restructure includes a proposal to create an enhanced Community Care Assistant role.

**2000** adults are in receipt of a care package funded through the Adults and Social Care Team. There are almost **double** the number of referrals for those aged 65+ compared to those under the age of 65.

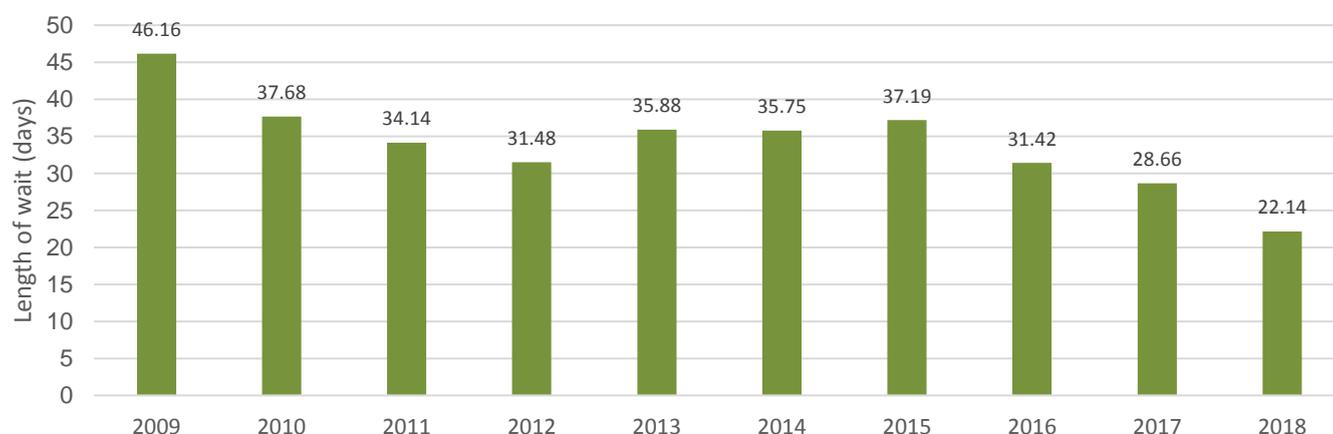
**76%** people who are in receipt of support said it helps them live independently **82%** staff agree with this<sup>133</sup>. **80%** people and staff believe the support provided helps people feel safe<sup>134</sup>. **65%** people who receive support at home and **43%** of Health and Social Care staff believe that support is provided at the right time<sup>135</sup>.

FIGURE 58. NUMBER OF REFERRALS TO ADULT SOCIAL WORK (SOCIAL WORK, COMMUNITY OT AND COMMUNITY CARE ASSISTANTS)



Data source: Midlothian Council internal data. *Mosaic*. [Accessed Dec 2018]. (Based on the numbers at Q4 of each year. Note: this is the number of referrals made, not the number of individuals involved. An individual can have multiple referrals).

FIGURE 59. FIGURE 57. WAIT TIME BETWEEN REFERRAL TO ADULT SOCIAL WORK AND ALLOCATION OF A WORKER (SOCIAL WORK, COMMUNITY OT AND COMMUNITY CARE ASSISTANTS)



Data source: Midlothian Council internal data. *Mosaic*. [Accessed Dec 2018].

In 2018 the average wait time between referral and assignment to a worker was **22 days**<sup>136</sup>. Referrals are screened on the basis of urgency. Those requiring an Adult Support and Protection response must be assigned to a Council

Officer within 24 hours and other urgent referrals are assigned within a short timescale, therefore the difference between the shortest and longest wait is large (longest wait can be several months).

The reducing numbers of referrals and average wait time for Adults and Social Care correlates with the promotion of realistic care, realistic expectations. As this is two year's data it is not clear whether this is a continuing trend but the reasons behind this may warrant further analysis and consideration.

## Day Opportunities

There is one learning centre for adults with complex learning disabilities based in Bonnyrigg which is open Monday – Friday. **50** people use this centre every week. CAT, the Community Access Team, supports adults with Learning Disabilities through programmes of activities in 5 community hubs (2 in Mayfield, 1 in Penicuik, 1 in Dalkeith, 1 in Lasswade). These hubs support **162** people<sup>137</sup>.

There are 4 day centres for older people, one of which is dementia specific. They support **95** people per week.

Many day opportunities are run or supported through the third sector such as Local Area Co-ordination and Befriending. People also use self-directed support to build personalised and creative day opportunities.

## Residential care

### Over 65

The private sector is the largest provider of care homes for older people. The voluntary sector provides proportionally more care home places in Midlothian than in Scotland as a whole. There is a move to support more people at home with complex needs, this means people living in care homes tend to have more complex needs.

The number of care homes owned by the partnership reduced from 3 in 2015 to 1 in 2017. One care home was closed in 2015 (Pentland House) and another (Highbank) has become a transitional hub providing rehab, respite and interim care linked to hospital discharge. A small number of permanent residents remain at Highbank, hence its inclusion in the table below. The remaining partnership care home (Newbyres) now provides both residential and nursing care. It previously provided residential care.

TABLE 8. RESIDENTIAL CARE PROVISION FOR MIDLOTHIAN

|                                   | Homes           |                   |           |  | Residents       |                   |            |
|-----------------------------------|-----------------|-------------------|-----------|--|-----------------|-------------------|------------|
|                                   | Local Authority | Private/Voluntary | Total     |  | Local Authority | Private/Voluntary | Total      |
| <b>31<sup>st</sup> March 2018</b> |                 |                   |           |  |                 |                   |            |
| <b>Midlothian</b>                 | 2               | 11                | 13        |  | 69              | 229               | 298        |
| <b>Lothian</b>                    |                 | 32                | 32        |  |                 | 105               | 105        |
| <b>Other Areas</b>                |                 | 23                | 23        |  |                 | 38                | 38         |
| <b>TOTAL 2018</b>                 |                 |                   | <b>68</b> |  |                 |                   | <b>441</b> |
| <b>31<sup>st</sup> March 2017</b> |                 |                   |           |  |                 |                   |            |
| <b>Midlothian</b>                 | 2               | 13                | 15        |  | 65              | 237               | 302        |
| <b>Lothian</b>                    |                 | 36                | 36        |  |                 | 107               | 107        |
| <b>Other Areas</b>                |                 | 26                | 26        |  |                 | 44                | 44         |
| <b>TOTAL 2017</b>                 |                 |                   | <b>77</b> |  |                 |                   | <b>453</b> |
| <b>TOTAL 2015-16</b>              | 2               | 54                | 56        |  | 49              | 321               | 370        |
| <b>TOTAL 2014-15</b>              | 2               | 54                | 56        |  | 49              | 321               | 370        |
| <b>TOTAL 2013-14</b>              | 3               | 50                | 53        |  | 83              | 294               | 377        |
| <b>TOTAL 2012-13</b>              | 3               | 54                | 57        |  | 84              | 297               | 381        |
| <b>TOTAL 2011-12</b>              | <b>3</b>        | <b>56</b>         | <b>59</b> |  | <b>129</b>      | <b>282</b>        | <b>411</b> |

Data source: Community Planning Research & Information Group. (2017). *Midlothian Moving Forward Community Planning for Midlothian*. And Midlothian Council Internal Data. *Mosaic*. [Accessed: Dec 2017].

The number of care homes relates to the number of homes in which Midlothian has responsibility for funding clients, whether in whole or in part, not the total number of homes (with the exception of Midlothian Council homes). While most people moving to a care home continue to reside in Midlothian some people move out of area, mainly into neighbouring Lothian Authorities. Midlothian retains responsibility for the funding of these placements.

There was a large **increase in the number of Midlothian funded care home residents** in 2017 and 2018 in comparison to previous years and also in the number of care homes residents are funded in. This goes against the trend of general decline between 2011 and 2016, which can be traced back to 2003. The change is believed to be linked to capacity issues with Care at Home services (see Care at Home Section below).

The average care home stay was **22** months in 2017/18 compared to **23.5** months in 2011/12 and the average resident age in 2017/18 was **85**. The balance between residential and nursing placements has shifted with more nursing beds in Midlothian.

## Under 65

There are **2** residential care homes registered in Midlothian to support adults with a learning disability, there are plans for one of these to deregister. The other provides care to older adults with a learning disability. The majority of this support is now provided under more flexible models of support such as housing support.

There is **1** registered care home in Midlothian to support adults with a physical disability and 1 care home in the Southside of neighboring Edinburgh which supports a number of Midlothian residents.

## Respite

**Learning Disability** - 1 dedicated facility with 3 bedrooms, alongside a small team (currently 7) of shared lives carers

**Adults over 65** - 12 dedicated respite beds across two Local Authority owned care homes.

**Adults with a physical disability** - no dedicated facilities

**Adults with a long term condition** – no dedicated facilities. Previous use of hospital beds at the Astley Ainslie Hospital for respite admissions have ceased. This has been identified as an area of difficulty.

Self-directed support has resulted in an increase in respite being provided in alternative ways to traditional residential care. Almost **20%** of funded respite requests in 2018 used options 1,2 or 4 of Self Directed Support<sup>138</sup>. This is not suitable or desirable for all.

## Care at Home

The main focus of care at home services is personal care. Most people in receipt of care at home are 65 and over. Personal care is non chargeable for people over the age of 65 with an assessed need. From April 2019 it will also be non-chargeable for those under 65.

Around **700** people each week are able to live in their own homes because of Care at Home services. This means the scheduling of **12,000** visits each week, 1,700 per day or 115 visits every hour or more or less 1 visit every 30 seconds. The minimum scheduled visit time is 15 minutes. Inhouse care workers drive around 37,000 miles each month providing care. The equivalent data for walked routes is not currently available<sup>139</sup>.

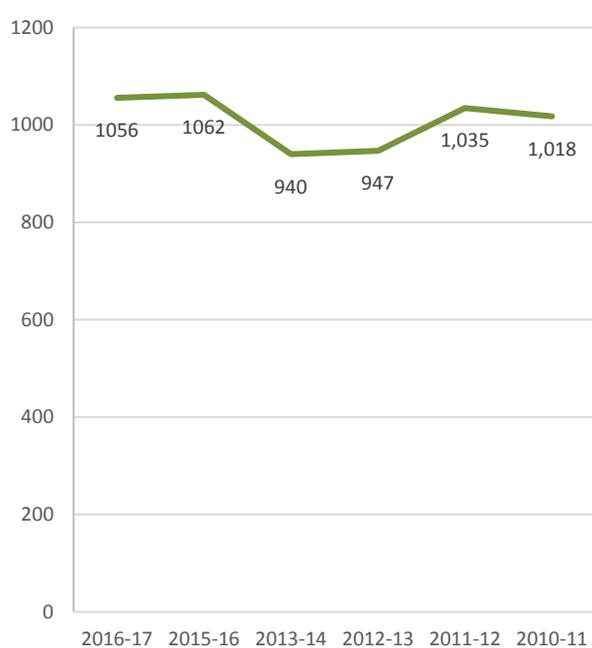
Over **200** care workers across 3 care at home teams provide 2,500 hours of care per week to **310** individuals. The independent sector is the main provider of care at home for older people providing 3,100 hours of care per week to 370 individuals. For other client groups the voluntary sector tends to be the main provider.

The intensity of demand for Care at Home services requires incredibly skilled coordination as home care must flex around the daily changing lives of people, hospital & GP appointments, family, unpaid carers, day care, holidays, sickness etc.

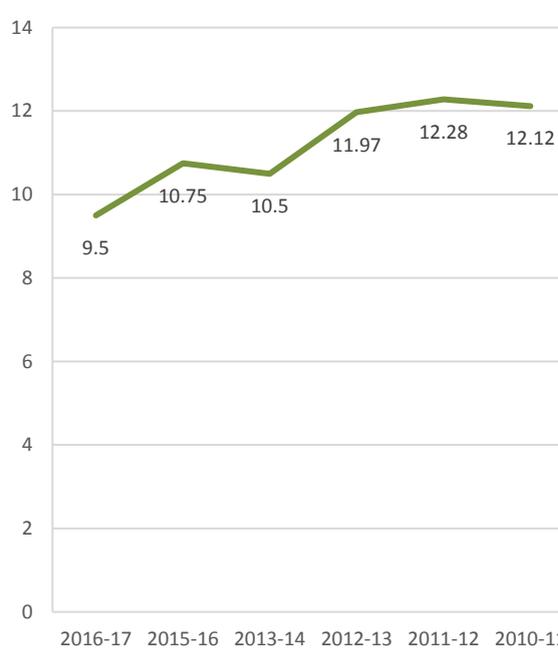
There are particular known challenges with capacity, recruitment and retention in care at home specific to older people. These challenges are more pronounced in the independent sector where terms and conditions of employment differ.

Assessed requests for Care at Home support are screened on the basis of urgency and need. This include hospital discharge referrals. Some people wait a long time for a consistent care provider or package of care – up to a year. SDS enables people to exercise choice and control over their care but with this comes the additional challenge of balancing this with the ability to meet the needs of as many people as possible.

**FIGURE 60. NUMBER OF PEOPLE RECEIVING CARE AT HOME SERVICES**



**FIGURE 61. AVERAGE HOURS OF CARE RECEIVED BY AN INDIVIDUAL WEEKLY**



Data source: Community Planning Research & Information Group. (2017). *Midlothian Moving Forward Community Planning for Midlothian*.

As our largest population increase is predicted to be in those aged 75 and over (see projected population section) the challenges of providing care at home will likely increase. This requires a whole system approach and response involving communities and all sectors of care to better support people to live well in the surroundings and with the care they choose. The further exploration of the use of technology to collaboratively respond to both planned and unplanned need is also recognised as important.

The link between the sudden increase in numbers of older people moving to care homes and capacity challenges in Care at Home warrants further exploration. The impact on systems, assessment and supports of the introduction of free personal care for those under 65 with an assessed need also needs further exploration.

# Hospitals

## Unscheduled Care

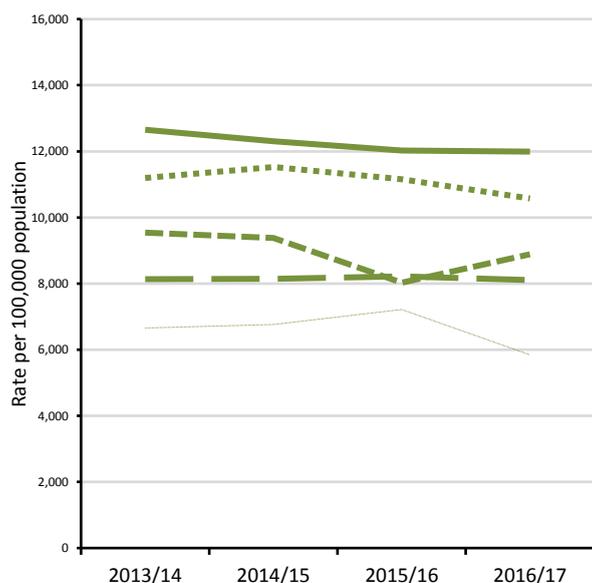
Unscheduled hospital admissions are not planned, usually arising as a result of an emergency. This data includes unscheduled admissions for Midlothian residents to any hospital in Lothian. £18m of the £131m IJB budget is 'set aside' for the provision of unscheduled care. The Royal Infirmary of Edinburgh is considered Midlothian's District General Hospital and is therefore where the vast majority of unscheduled care is provided.

**On average 8,500** people are admitted every year as unplanned admissions. This accounted for **10-11%** of all unplanned admissions in Lothian between 2012/13 and 2016/17.

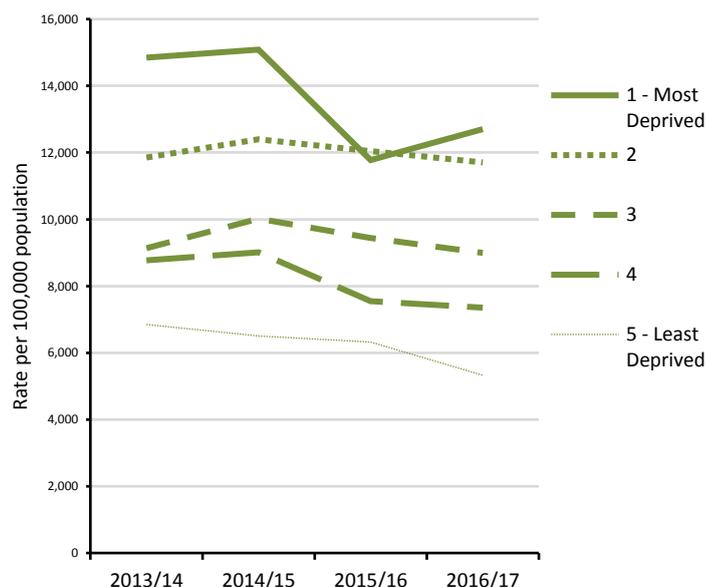
The number of nights people spend in hospital is reducing.

Admission rates are higher among patients who live in areas of higher deprivation.

**FIGURE 62. CRUDE EMERGENCY ADMISSION RATES BY SMD QUINTILE EAST LOCALITY**



**FIGURE 63. CRUDE EMERGENCY ADMISSION RATES BY SMD QUINTILE WEST LOCALITY**



Data source: *Scottish Morbidity Record*. [Accessed Aug. 2018].

The cost of unplanned admissions to hospitals is very high; nationally it accounts for a third of the total budget on health and social care for older people and this is consistent with Midlothian's spend.

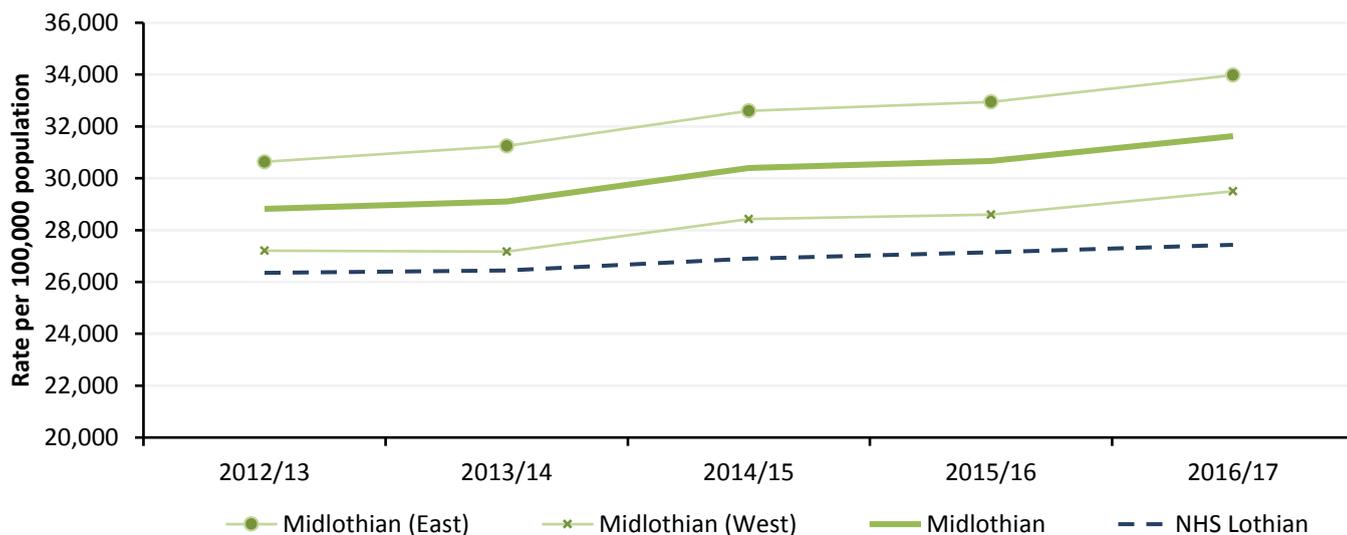
The local Rapid Response Service has responded to **1,397** emergency falls call outs (2017/18) and the Hospital at Home service has had **2,751** occupied 'virtual ward' bed days supporting people in the community, both reducing length of stay and preventing hospital admissions. Other areas of targeted community intervention include COPD, frailty (8,500 people of which half are under 75) and alcohol related admissions.

## A&E

On average there were 20,640 attendances per year to A&E from Midlothian to Lothian hospitals. This accounted for **11 -11.5%** of all A&E attendance across NHS Lothian (2012 – 2017)

**A&E attendance rates have been increasing** over a number of years and continue to do so. Overall crude rate per 100,000 residents A&E attendance by Midlothian residents has remained higher than for NHS Lothian as a whole. There is a consistent trend for higher A&E attendance rates from the east locality of Midlothian in comparison to the west; this is likely to reflect the higher levels of socioeconomic deprivation in the East Locality.

FIGURE 64. CRUDE RATE PER 100,000 RESIDENTS OF A&E ATTENDANCE 2012/13 – 2016/17

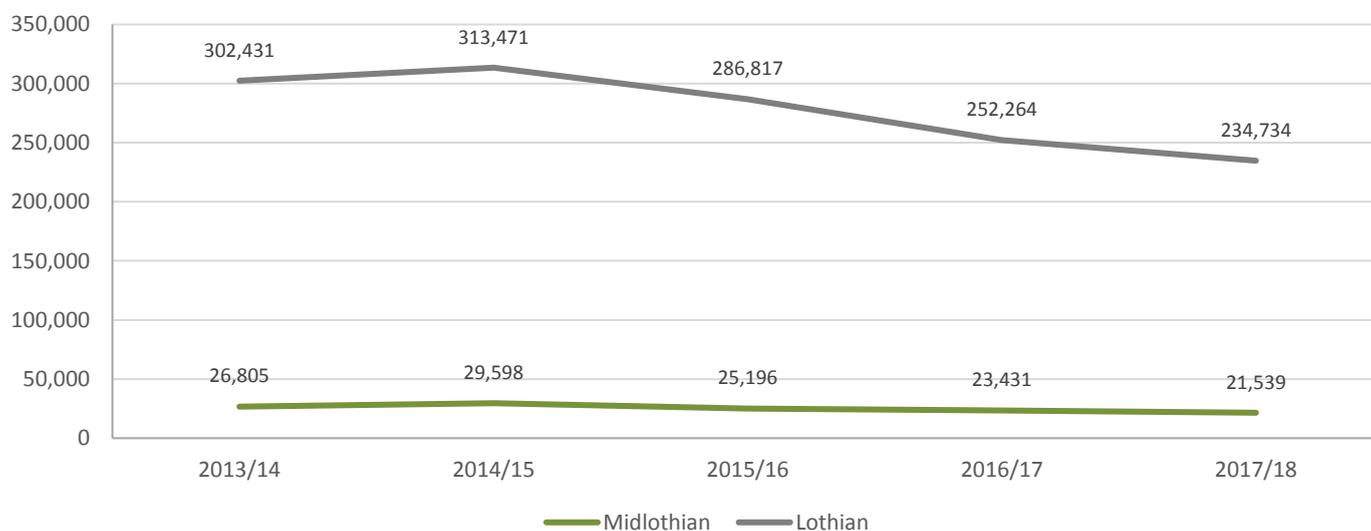


Data source: [Information Services Division](#). (2014). [Accessed Oct 2018].

## Scheduled Care

Scheduled care is not a delegated function but the data completes the picture of hospital attendance and provides a useful comparison alongside unscheduled care and A&E admissions.

FIGURE 65. TOTAL OCCUPIED BED DAYS FOR PLANNED ADMISSIONS



## Utilisation of Midlothian Community Hospital

Midlothian Community Hospital opened in 2010. It has 6 inpatient wards with 20 beds per ward with the exception of the 2 mental health wards which have 24 beds each. The hospital provides care for people who are very ill or are in the advanced stages of dementia alongside inpatient assessment and continuing and complex care of older people with acute mental health needs. In 2016 it was remodeled to incorporate a rehab and assessment ward for older people. This replaced the previous service provided by Liberton hospital, Edinburgh. The hospital also has an X-ray and outpatient department.

## Delayed Discharge

A delayed discharge is when a patient is clinically ready to leave hospital but cannot do so. More than 1,000 hospital bed days are lost each month nationally due to delayed discharge<sup>140</sup>

TABLE 9. NUMBER OF DELAYED DISCHARGES (2018)

|                                       | Apr       | May       | Jun       | Jul       | Aug       | Sep       |
|---------------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|
| <b>Total</b>                          | <b>37</b> | <b>48</b> | <b>40</b> | <b>38</b> | <b>30</b> | <b>42</b> |
| <b>Health and Social Care Reasons</b> |           |           |           |           |           |           |
| <b>Total</b>                          | <b>34</b> | <b>44</b> | <b>36</b> | <b>35</b> | <b>28</b> | <b>42</b> |
| Assessment                            | 3         | 7         | 4         | 1         | -         | 2         |
| Funding                               | -         | -         | -         | -         | -         | -         |
| Place availability                    | 12        | 15        | 12        | 15        | 15        | 12        |
| Care arrangements                     | 19        | 22        | 20        | 19        | 13        | 28        |
| Transport                             | -         | -         | -         | -         | -         | -         |
| <b>Code 9 Reasons</b>                 |           |           |           |           |           |           |
| <b>Total</b>                          | <b>3</b>  | <b>4</b>  | <b>4</b>  | <b>3</b>  | <b>2</b>  | <b>-</b>  |
| Adult with incapacity (AWI)           | 2         | 4         | 4         | 2         | 2         | -         |
| Other (Not AWI)                       | 1         | -         | -         | 1         | -         | -         |

Data source: *Information Service Division Scotland*. (2018). [Accessed Nov. 2018]

TABLE 10. LENGTH OF DELAY 6 MONTH AVERAGE (APRIL-SEP 2018)

| Duration of Delay        | Midlothian | Scotland |
|--------------------------|------------|----------|
| Between 1 and 3 days     | 19%        | 18%      |
| > 3 days up to 2 weeks   | 25%        | 24%      |
| > 2 weeks up to 4 weeks  | 24%        | 17%      |
| > 4 weeks up to 6 weeks  | 10%        | 11%      |
| > 6 weeks up to 12 weeks | 13%        | 15%      |
| 3 + months               | 8%         | 15%      |

Data source: *Information Service Division Scotland*. (2018). [Accessed Nov. 2018]

A long delay can increase the risk of the patient falling ill again, lead to the loss of life skills, independence or mobility and could increase the requirement of a care home placement due to deteriorating health and mobility. People who are delayed more than 72 hours have worse outcomes than those who go home sooner. The Scottish Government set a target in 2015 that people shouldn't be delayed for more than two weeks. We are investing resources to reduce the number of delayed discharges and the number of days patients spend delayed by earlier identification for supported discharge and a new *discharge to assess* team which is likely to be active in early 2019

**The majority of people who go into hospital are discharged on their planned discharge day.**

Most people who are delayed are delayed for **more than 2 weeks**. This is also true for Scotland as a whole.

**Only 1 in 5 Midlothian residents who are delayed are discharged within the 3 day commitment.**

More people over the age of 75 are admitted to hospital than any other age group. In recognition of this we converted a care home facility for older people into a discharge hub with 31 intermediate care beds (6 with a focus on rehabilitation), 6 respite beds, 3 permanent residents & 1 emergency bed. All of these generally run at full occupancy. A new facility will replace Highbank, with 40 beds and the plans are for it to open in 2020.

Deprivation and locality are factors to be considered when looking at ways to reduce unscheduled hospital admissions. There is evidence to show that reducing polypharmacy and increasing continuity of care are effective at reducing unscheduled hospital admissions.

Very few people are delayed waiting for a social care assessment. Delays in arranging care at home is the main cause of delay. Care home placements are also an area of significant challenge. We need to look at how the moving on policy is applied and code 9 delays. These are cross cutting issues affecting both community and hospital teams, and a whole system approach is required to reduce the number of patients who experience delays and the number of days they spend delayed.

# Carers

The Carers (Scotland) Act 2016 defines a carer as someone who provides or intends to provide care for someone else which is not paid or part of voluntary work. When the care is provided to someone under the age of 18 it does not include care provided as a result of their age. The legislation introduces new rights in the recognition of needs of carers, and also placed new responsibilities on local authorities and health boards.

Carers provide physical, emotional and practical support in a variety of circumstances. They experience a range of impacts on themselves (both in level of intensity and also in range of outcome areas).

**9.9%** of the population are carers which is about **9,000 people**<sup>141</sup> compared to 9.3% for Scotland. Many carers do not identify what they do is “caring” and that they are a carer - young carers and carers from minority ethnic groups are thought to feature within this population.

**2,173 people reported providing more than 50 hours care per week**<sup>142</sup>.

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

The majority of carers providing help or care within the home provide care to a parent, closely followed by care to other relatives including spouses, children and siblings<sup>143</sup>

**Over one third of carers** felt that their caring role had negatively impacted on their health and wellbeing<sup>144</sup>. Intensive caring can result in carers being twice as likely to experience ill-health as non carers; up to **70%** of carers will hide the fact that their health is suffering and **42%** of carers agree that they feel isolated from family and friends<sup>145</sup>

**Only 32% of carers feel supported to continue in their caring role**<sup>146</sup>, lower than the Scottish average of 37%.

Across Scotland the largest proportion of households with a carer (28%) are in the 20% most deprived data zones in the Scottish Index of Multiple Deprivation. There is evidence of the financial and economic impact of caring: a third of carers are paying for care out of their own savings; a quarter have had to reduce their working hours and a fifth have had to give up work altogether. 11% have lost out on NI or pension contributions as a result<sup>147</sup>

**Less than half of carers** say that they have had time away from caring in the past year<sup>148</sup>. More than a third say that they have never had time away at all. 86% of those who have taken time away from caring say that it has made it easier for them to continue in their caring role. As part of the legislative changes a break from caring must be considered when carrying out an Adult Carer Support Plan. The consideration of emergency planning for carers is also requirement of the new legislation and is seen as helpful in promoting a prevention agenda. 77% of respondents expressed concern about contingency planning.<sup>149</sup>

The 68% of carers providing care to people not living with them reported that they did not access any external support. Carers who access support reported that the most common type of service utilised was practical support including transport (22% of carers)

VOCAL Midlothian are the main source of support to carers locally. The VOCAL Survey 2017 indicates that two thirds of respondents said that the help they receive from VOCAL makes a big difference to their ability to care. Respondents identify a range of positive impacts, focusing on health, the provision of information, financial assistance, time away from caring, and learning new skills. In recognition of the updated definition of a carer and the duties under the Act Midlothian has chosen to delegate some of these duties to the local carers centre (VOCAL).

Carers provide the bulk of care to older people and those with disabilities. The new Act creates more opportunities to support carers. The impact of this on resources needs to be balanced with the impact of supporting carers well. The significant challenge in providing care at home, in addition to the shift towards enabling and encouraging self-directed care by people, has consequences for those providing unpaid care within our communities.

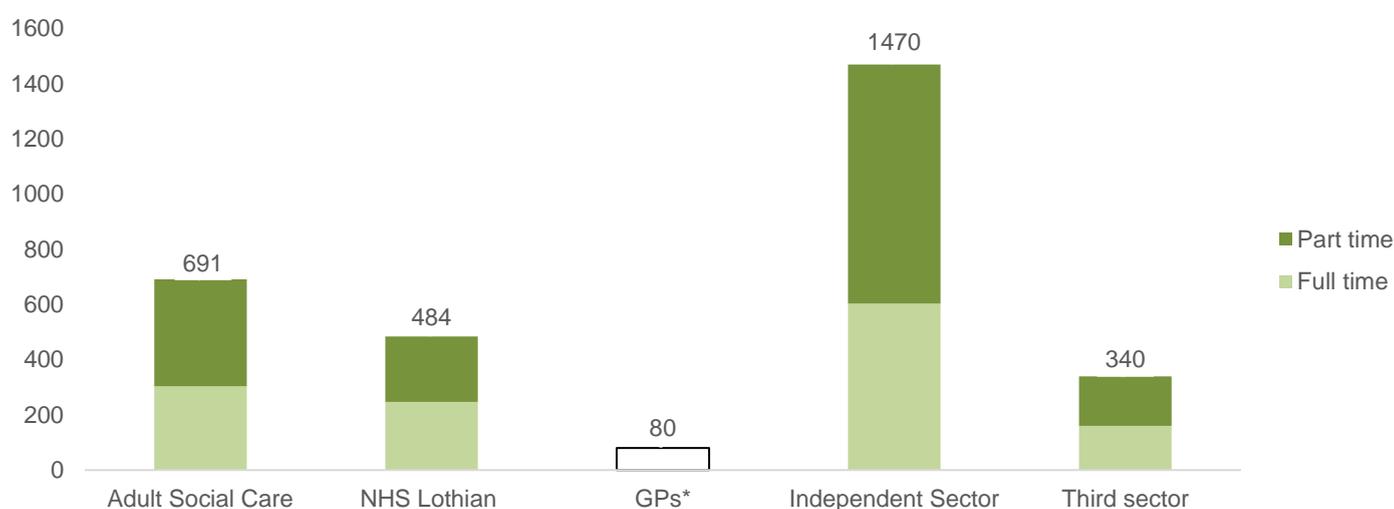
As well as providing support we need to ensure a proactive approach to prevention in respect of impact, and recognise and address areas of significant inequality in outcomes due to the compounding factors of being a carer.

# Workforce

Our workforce includes Midlothian Council's Adult Health and Social Care staff (e.g. Social Work, Community Care assistants, Care workers, Allied Health Professionals) and some NHS Lothian staff (e.g. Allied Health Professionals, medical and nursing (not practice nursing), GPs, Unscheduled care in hospitals, and community health services and the community hospital). The majority of the IJB's £131million budget is spent on staffing. This will increase with population growth.

We are the biggest employer in Midlothian and work alongside the independent sector (private social/healthcare companies) and the third sector (not for profit organisations).

FIGURE 66. NUMBERS OF STAFF BY SECTOR



Data source: Midlothian Health and Social Care Partnership. *Workforce Analysis 2016* and [Information Service Division](#) [Accessed Dec. 2019]. \*GP data is an estimate in the absence of a 100% survey response rate. Staff within both hosted and acute hospital services are not included here, as we await accurate figures.

**Over 75% of the workforce** (including independent and voluntary sector) is female (2016).

A significant number of staff are employed part time. This is an increasing trend in several areas including GPs. As more people chose to work less than full time, it is necessary to employ more people to fulfil whole time equivalents 29.5% of people have been in their job for **less than 2 years**. 17.5% have been in post between **11 - 15 years** (2016).

The largest percentage of partnership staff fall within the age range **45-60** (2016). 21.8% of the whole time equivalent are aged 55+ (NHS Payroll data 2018). Nursing has the highest number of older employees with 40% of staff (band 5-7) aged 50 or over. Data is currently not available to this level for council employees.

There is limited information on the primary care workforce. Information suggests little change in the number of GPs or practice nurses in Midlothian but an increasing number of younger GPs are working less than full time.

Recruitment is a growing problem across several areas including GPs and District Nursing. Despite changes to terms and conditions such as guaranteed hours and the Living Wage, it is a particular challenge in the field of care at home which is a high risk area with many people in need of social care support not receiving it during 2017-18. We need to look at ways to encourage people to remain in post, or encourage young people into a career in care. We face challenges of experience and skills loss through retirement particularly, over the next 15 years and particularly in nursing.

# Third Sector

The third sector includes community groups; voluntary organisations; social enterprises; some sports clubs, and charities. Many third sector organisations rely on volunteers to operate and they are run by boards or management committees made up of local people.

The third sector plays a significant role in local communities and works alongside health and social care services supporting vulnerable people; providing services and promoting community cohesion. Groups range in size and formality.

There are at least **700** voluntary sector groups and organisations including more than **50** uniformed youth groups e.g. Brownies, Guides, Cubs, and Scouts; and small informal local or interest groups, such as art clubs and walking groups.

**There are 228** registered charities (voluntary organisations or community groups) who identified their main operating area as Midlothian (although some also operate outside of Midlothian e.g. Melville Housing Association)(2017)<sup>150</sup>. This figure excludes grant-making trusts, churches, overseas charities, and education/research charities. The total income of these charities was **£35,995,491**<sup>151</sup>. Over and above these charities are those that work in Midlothian but are based elsewhere as is the case for many of the larger charities.

The Health and Social Care Partnership has contracts with approximately **40 organisations** that accounts for **33% of the total Adult Social Care budget**. A number of community care providers, and Lothian-wide organisations, for example, CAPS; Health in Mind (including the Orchard Centre); VOCAL; Castle Rock Edinvar Housing Association and Enable Scotland are registered elsewhere.

Voluntary organisations, charities, community groups, and social enterprises are supported by the Midlothian Third Sector Interface which consists of Midlothian Voluntary Action (MVA); the Volunteer Centre Midlothian; and SEAM (Social Enterprise Alliance Midlothian)

**340 people are in paid employment** through the voluntary sector across areas of health and social care (2015/16)<sup>152</sup>. These figures cannot be directly compared with that in previous years as a number of registered services have been “reclassified from earlier data”.

## Volunteering

Around **29%** of adults are involved in formal volunteering<sup>153</sup>. This is a slight reduction on previous estimates but still represents about **19,000 people**. In addition to this are those who volunteer informally<sup>154</sup>. Issues relating to volunteering and volunteers are represented locally by Volunteer Midlothian. To ensure that good quality volunteering opportunities are available for everyone a Volunteering Charter for Midlothian has been drawn up with the aim to raise standards within volunteering.

The Third Sector in its many shapes and sizes is an integral player in delivering supports and promoting community cohesion across Midlothian. The volunteer headcount represents a significant workforce and the value they bring to the communities of Midlothian is integral to enabling the Health and Social Care Partnership to achieve partnership outcomes particularly in the areas of prevention and early intervention including opportunities for physical activity, companionship and the pursuit of hobbies such as music or crafts. Lowering numbers of volunteers nationally and the dip in the Midlothian numbers need to be looked at alongside the introduction of the Volunteering Charter in order to best promote and continue to create volunteering opportunities locally.

# Technology Enabled Care

Technology Enabled Care describes care, supported by technology. We have been awarded national Technology Enabled Care monies to support a projects including provision of technology and service transformation. We have core services providing routine Telecare which provides remote access to care through a dedicated alarm unit with various peripherals (e.g. smoke detector, flood, detector, movement sensors).

**1,700** people have a community alarm/telecare service (provided by Midlothian Council)<sup>155</sup>.

By 2025 telecare will 'go digital'. This will require significant investment of resources. There is an anticipated increased revenue cost in providing this service. A capital spend for this has been profiled over the next 4/5 years.

The Learning Disability Service has been exploring the potential of telecare to support redesign of sleepovers in care packages. This work is on-going on a case-by-case basis. It is looking at how reassurance can be provided through activity monitoring (e.g. Just Checking), telecare, and analytics.

**5 practices** are participating in the Scale-Up BP project - to change the model of blood pressure monitoring in primary care by remotely transmitting data and receiving care instruction saving travel and face-to-face visits.

**100 people** have been involved with the community malnutrition service – to monitor progress and compliance with Oral Nutritional Supplement prescription<sup>156</sup>.

**Around 8,500 people** may be supported with the Electronic Frailty Index - a tool to identify and stratify frailty that will help us use data understand demand, need and to support service redesign evaluation<sup>157</sup>.

The capabilities provided by technology are needed but the evidence suggests that general efforts to implement information-technology in health are extremely difficult due to complex interrelated technical, social, and organisational factors.

Technology Enabled Care can represent best value and offer creative solutions but finding areas to redesign requires significant effort to understand *need* and there is a tension between balancing the redesign of transactions with service designs that are person centred.

## 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.

ਅਸੀਂ ਮੰਗ ਕਰਨ ਤੇ ਖੁਸ਼ੀ ਨਾਲ ਅਨੁਵਾਦ ਅਤੇ ਜਾਣਕਾਰੀ ਤੇ ਹੋਰ ਰੂਪਾਂ ਵਿੱਚ ਪ੍ਰਕਾਸ਼ਨ ਪ੍ਰਦਾਨ ਕਰਾਂਗੇ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਬਰੇਲ, ਟੇਪ ਜਾਂ ਵੱਡੀ ਛਪਾਈ ਸ਼ਾਮਲ ਹਨ।

Körler için kabartma yazılar, kaset ve büyük nüshalar da dahil olmak üzere, istenilen bilgileri sağlamak ve tercüme etmekten memnuniyet duyarız.

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

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Key Contributors

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- <sup>1</sup> World Health Organisation. (2019). Available at: <http://www.who.int/hia/about/glos/en/index1.html> [Accessed July 2018].
- <sup>2</sup> Scottish Public Health Observatory. [https://scotland.shinyapps.io/ScotPHO\\_profiles\\_tool](https://scotland.shinyapps.io/ScotPHO_profiles_tool) [Accessed Sept. 2018].
- <sup>3</sup> Scottish Public Health Observatory. [https://scotland.shinyapps.io/ScotPHO\\_profiles\\_tool](https://scotland.shinyapps.io/ScotPHO_profiles_tool) [Accessed Sept. 2018].
- <sup>4</sup> Scottish Public Health Observatory. [https://scotland.shinyapps.io/ScotPHO\\_profiles\\_tool](https://scotland.shinyapps.io/ScotPHO_profiles_tool) [Accessed Sept. 2018].
- <sup>5</sup> Information Services Division. <https://www.isdscotland.org> [Accessed Sept 2018].
- <sup>6</sup> Community Planning Research & Information Group. (2017). *Midlothian Moving Forward Community Planning for Midlothian*.
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