Midlothian

Adult and Social Care Service Plan 2020-21

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1. MIDLOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP OVERVIEW

The Service Plan is focused on the adult health and care outcomes in the Single Midlothian Plan and the Midlothian Health and Social Care Partnership Strategic Plan for 2019-22. The Strategic Plan is the foundation to the delivery of our services promoting prevention and early intervention and centered on helping to maintain and improve health and wellbeing.

The Midlothian Health and Social Care Partnership serves a population of 91,340, and is responsible for services that help adults live well and get support when they need it. Many voluntary sector and independent providers work with us to deliver the objectives of the Partnership, and while the Partnership is governed by the Integration Joint Board (IJB) it is also a thematic group of the Midlothian Community Planning Partnership.

From the 1st April 2020, the service areas of Sport and Leisure and Welfare Rights will transfer to the Partnership as part of the wider Midlothian Council Management Review. Both areas are closely linked to improving health and wellbeing with a focus on early intervention.

2. OUR VISION

Our vision is that everyone in Midlothian will have the right advice, care and support; in the right place; at the right time to lead long and healthy lives.

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

With the inclusion of Sport and Leisure and Welfare Rights in April 2020 work has begun to ensure these services are intrinsically linked to the Midlothian Health and Social Care Partnership Strategic Plan.

Sport and Leisure

Our vision is an active Midlothian where everyone benefits from sport. We will encourage and support individuals:

- To be physically active every day.
- Keep moving at home and at work.
- Take an active approach to getting around.
- Take part in sport because we see it being relevant to our lives.
- Be involved in ways that suit us.
- By improving the customer experience through self-evaluation.

By reducing barriers and encouraging inclusion we aim to increase the benefits of sport. For some of us, by taking part, for others, through our communities. An active Midlothian is one where people are encouraged to participate, progress and achieve in sport. At the same time people become more active and stay active.

Welfare Rights

Our vision is to support individuals in need of assistance by offering free, confidential, personalised and impartial advice on a wide range of financial matters, and take a preventative approach for identifying vulnerable individuals. We will work with and support individuals:

- To budget and maximise income.
- To check entitlements and get support making claims for benefits.
- To access advice about debts and help gain control of their finances.
- To assist with challenging and pursuing appeals.
- To address the financial consequences of adults with a diagnosis of cancer.

3. Our Values

We will achieve our ambitious vision by placing more importance and a greater proportion of our resources on our key values. This will not be achieved overnight; changes in the way in which health and care services are delivered take time.

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

- **Independence, Choice and Control:** You should be able to manage your condition and control your support. We will support you to live independently at home and promote the principles of independent living and equality.

- **Support the person not just the condition:** Your support/treatment should consider key issues affecting your life as well as supporting you to manage your condition.
- **Recovery:** You should be supported to recover good health and independence as far as

possible.

- **Coordinated Care:** Everyone who provides your care should be working together.

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

- **Public Protection:** You should feel safe at home and in your community.

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

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

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

4. Consultation and Engagement

Communication and engagement is fundamental in helping us to provide the right information, at the right time and in the right place, ensuring our services are led by listening to user feedback.

The Midlothian Health and Social Care Partnership's Communications and Engagement Plan for 2020-21 demonstrates our commitment to delivering a personal and respectful customer experience. The plan sets out:

a) who we will communicate and engage with;
b) our methods of communication and engagement;
c) when we communicate and engage; and
d) guidelines for effective communication.

There is consultation activity led by our partners in Midlothian, for example a carer survey, and national consultation programmes such as the Scottish Governments Health and Care Experience Survey. This is carried out biannually to help understand more

about the quality of health and social care services offered across Scotland and identify areas for improvement. The results on the 2019-20 Health and Care Experience Survey will be available later this year and will help us better understand people' experiences of their local health and social care services and caring responsibilities in Midlothian.

5. Our Key Successes 2019-20

Our Midlothian Health and Social Care Partnership Annual Performance Report provides a sense of the depth and breadth of the work which contributes to our vision that the people in Midlothian should live well and get the care, advice and support they need at the right time. With the help of facts and figures, case studies and feedback from our communities the report highlights our key successes over the previous 12 months.

The 2019-20 Annual Report is currently in development and will be available in August 2020. The Report will be published online at Midlothian Health and Social Care Partnership

6. Our Priority Areas

1. LONG TERM CONDITIONS

Cancer

- Explore ways to deliver treatments locally, in particular chemotherapy.
- Implement the new 'Improving Cancer Journey' to provide support to people after a diagnosis of cancer.

Respiratory Disease

- Reduce rates of smoking and support people to maintain a healthy weight.
- Strengthen partnership working with MERRIT, Marie Curie and Edinburgh Community Respiratory team.

Neurological Conditions

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

Stroke

- Reduce rates of smoking and support people to maintain a healthy weight.
- Look to develop ways of integrating rehabilitation into community services.
- Review our community based support by working with the Edinburgh Stroke Unit.

Diabetes & Obesity

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

Sensory Impairment

- Improve awareness and understanding of sensory impairment among staff.
- Work with acute colleagues to detect vision and hearing loss early through clinics and checks.
- Work with acute colleagues to provide services locally such as audiology maintenance clinics.

Palliative Care

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

2. SERVICE USERS GROUPS

Older People (65+)

- Identify frail people and provide early intervention using GP, and health and social care data.
- Strengthen the Ageing Well project to help reduce isolation and promote activity.
- Strengthen systems to reduce people being delayed in hospital e.g. Flow hub.
- Through the development of intermediate care services, improve the care planning system both to simplify and fully involve service users.

Mental Health

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

Physical Disability

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

Learning Disability

- Commission new build housing for people with learning disability using clustered models supported by technology enabled care.
- Implement a range of changes to the provision of day services including more local services and more age appropriate services.

- Develop community based services using Positive Behavioral Support for people with complex care needs.

Autism

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

Justice Service

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

Substance Misuse

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

3. RESOURCES

Primary Care

- Increase capacity in GP practices.

Social Care Support

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

Hospitals

- Strengthen the pathway for people who present at acute hospital whose needs are more social in nature.
- Increase the role of Hospital at Home.
- Reduce the number of people whose discharge is delayed.
- Develop models of care that support reduced attendance at Accident/Emergency.

Carers

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

Workforce

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

Communities

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

Third Sector

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

Housing and Property

- Plan the development of a range of extra care housing schemes to support Midlothian residents to be cared for within Midlothian.

Technology Enabled Care (TEC)

- Improve our use of health and social care data to understand and respond to the needs of the population.
- Introduce TEC systems to lessen the need to travel into hospital for clinics and appointments.
- Use technology to help people remain at home for as long as possible.

7. Our Challenges

A growing and aging population

We are the second smallest Local Authority in mainland Scotland but the fastest growing. 12,000 new houses will be built in the next 3 years. This will pose challenges for all our health and social care services whilst also changing the face of some of the local communities. As people live for longer many more people will be living at home with frailty and/or dementia and/or multiple health conditions. An increasing number of people live on their own, and for some this will bring a risk of isolation.

Higher Rates of Long-Term Conditions

Managing long-term conditions is one of the biggest challenges facing health care services worldwide, with 60% of all deaths attributable to them. Midlothian has a higher incidence than the national prevalence of cancer, diabetes, depression, hypertension, chronic obstructive pulmonary disease and asthma. Older people are more susceptible to developing long-term conditions; most over 65s have two or more conditions and most over 75s have three or more conditions. People living in areas of multiple deprivation are at particular risk with, for example, a much greater likelihood of early death from heart failure. They are also likely to develop 2 or more conditions 10-15 years earlier than people living in affluent areas. It is estimated that people with long-term conditions are twice as likely to be admitted to hospital and have a longer length of stay accounting for 80% of all GP visits and for 60% of hospital admissions.

High rates of mental health needs

Many mental health problems are preventable, and almost all are treatable, so people can either fully recover or manage their conditions successfully and live fulfilling healthy lives as far as possible. The incidence of mental health issues in Midlothian, while similar to the rest

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

Our services are under pressure

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

Financial pressures

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

Workforce Pressures

Two of the main areas of concern to the public in recent times have been difficulties in accessing primary care and not always receiving care at home despite being assessed as in need of the service. Recruitment and retention is a growing problem in health and social care. There is a shortage of GPs; a significant proportion of District Nurses are nearing retirement; while care at home providers find it difficult to attract and keep care at home workers despite measures such as the living wage and guaranteed hours. The aging population means these pressures will almost certainly increase. There is a clear need to plan ahead and find alternative solutions to ensure services are able to meet people's needs.

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

Acute hospitals

Acute hospitals are under huge pressure due to unsustainable demand and financial restrictions. We need to invest in community based alternatives that will minimise avoidable and inappropriate admissions and facilitate earlier discharge. By treating people closer to home, or in their own home we can support admission avoidance and improve patient outcomes.

8. Health Inequality across Midlothian

Health inequalities are the unfair and avoidable differences in people's health across social

groups and between different groups.

The Midlothian Health and Social Care Partnership is increasing the focus on prevention and early intervention, planning service delivery according to greatest need where appropriate, and working to ensure our workforce understands inequality, its impact on people's health and wellbeing and how services should respond to this.

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

People affected by poverty and social disadvantage have poorer health and are more likely to die at a younger age than their neighbours with more resources. People also experience disadvantage through, gender, sexual orientation, social position, ethnic origin, geography, age and disability.

People living in some communities are more likely to be living in poorer health and to die younger with higher rates of cancer, stroke, diabetes and heart disease. People with disabilities are more likely to have lower educational achievements, higher rates of poverty and poorer health outcomes. Unpaid or family carers are more likely to experience emotional stress, anxiety, and fatigue. The impact of caring for others can significantly impact on their own physical health and wellbeing, finances and relationships.

9. Sustainability of Health and Social Care Services

The delivery of integrated care is fundamental in providing sustainable adult and social care services. We are working to develop efficient, effective and sustainable approaches to supporting our service users against the challenges we face.

- We are promoting healthy lifestyles and supporting people to manage their own health and live independently.
- We are improving pathways to the services available and developing alternative community based services.
- We are developing our use of technology enable care to support independent living and better understand our health and social care data.
- We are creating strong local community links and redesigning and delivering services with the support of the third sector.
- Our Workforce Plan is focused on improving staff recruitment and retainment and developing a flexible and skilled workforce.

- Our Financial Strategy sets out our planned approach to delivering our strategic priorities and supporting financial sustainability.

10. Climate Change Emergency

Midlothian Council passed a motion at its meeting of 17th December 2019 agreeing to declare a climate emergency that requires urgent action. The Health and Social Care Partnership is strongly committed to work in partnership and play its part in Midlothian Council's Climate Change Strategy and NHS Scotland's Climate Change Emergency Commitments.

The Board of NHS Lothian has identified the potential for a focus on environmental sustainability as a catalyst for innovation and redesigning clinical pathways and services, and there is active and ongoing engagement with general practices in Midlothian looking at the Royal College of General Practice's Green Impact tool and other actions.

A comprehensive climate change action plan will be developed during 2020 by the Midlothian Health and Social Care Partnership.

11. Self-Assessment

Strategic Direction/Delivery
A range of activities were carried out during 2018-19 in the preparation of our 2019-22 Strategic Plan. This included the preparation of an updated Joint Needs Assessment and reflection on our performance and delivery of provision. This work provided the foundation for service action plans.

Ministerial Strategic Group Improvement Plan
The Ministerial Steering Group (MSG) for Integrated Joint Boards reviewed progress on integration during 2018, and in March 2019 the Partnership completed an evidence based self-assessment matrix, based on the six key areas of improvement highlighted by Audit Scotland:

1. Commitment to collaborative leadership and building relationships.
2. Effective strategic planning for improvement.
3. Integrated finances and financial planning.
4. Agreed governance and accountability arrangements.
5. Ability and willingness to share information.
6. Meaningful and sustained engagement.

Subsequent to this self-assessment we are in the process of implementing an MSG Improvement Plan.

Scirocco Knowledge Exchange
We are participating in the Scirocco Exchange maturity assessment programme. This EU funded programme will assist us to self-assess the partnerships maturity around integration and participate in a knowledge exchange programme involving 8 European sites.

The first self-assessment phase was completed on 14th January 2020 when Scirocco

facilitators from the Scottish Government led a workshop where each of the twelve assessment areas were debated and a score agreed.

The report from the facilitators is awaited. We will soon be matched to other areas as part of the knowledge exchange programme. Following this an improvement plan will be developed. Participation in this programme will support us in our ambition for continuous improvement around health and social care integration.

Staff Self-Evaluation

Health and social care staff participate in the annual iMatter programme. The annual survey covers how staff feel individually, as part of a team and as part of an organisation. 731 staff responded to the iMatter Survey, a response rate of 66%. The outcomes of this survey is considered by team managers in collaboration with team members identifying actions to be taken to address the key issues identified.

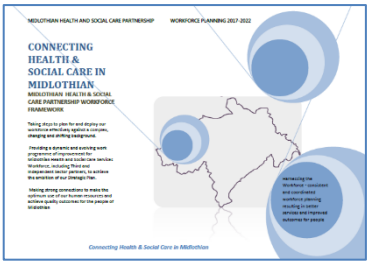
Customer Service Excellence

Self-assessment enables the partnership to understand the expectations and needs of those who use our services. This insight helps inform service development and improve the customer experience.

12. Financial Strategy

The Midlothian Health and Social Care Partnerships Financial Strategy articulates, in financial terms, how the strategic plan will be delivered whilst also outlining the measures that will be taken to reduce its costs and ensure that the IJB fulfills its responsibilities to the Midlothian population within the financial resources available. The 2019-22 Financial Strategy was approved in September 2018, and a 5 year action plan in June 2019. The budget for Midlothian Council Adult Social Care services is managed directly by the Midlothian Health and Social Care Partnership, and details of the delegated funding to the Midlothian IJB will be available after February Council.

13. Workforce Plan



Consistent and coordinated workforce planning results in better services and improved outcomes for our service users. The Midlothian Health and Social Care Partnerships Workforce Plan for 2017-22 brings together information about our workforce across all sectors of our partnership and recognises that workforce planning is a central corporate responsibility for NHS Lothian, Midlothian Council and the many voluntary and independent health and care providers which provide services in Midlothian. The Plan provides a strong foundation to build on, as integration progresses, and is currently being refreshed based on Scottish Government guidance.

14. Performance Reporting

Integrated Joint Board

Performance reports are presented to the Midlothian IJB to monitor a core suite of national outcomes and data indicators monitoring change across the system of health and social care and to support the delivery of our strategic priorities. We have a legal requirement to publish an Annual Performance Report.

Discussions have begun on developing a tool that will help us effectively capture both quantitative and qualitative evidence, and support a consistent approach to data collection and reporting. The tool will enable us to better understand the multiple factors that influence change, and identify how all our services contribute to delivering our strategic priorities and improving outcomes.

Midlothian Council

Quarterly performance reports are presented to Midlothian Council to demonstrate progress against the outcomes in the Single Midlothian Plan and key services priorities for the year. The report is introduced by a front page highlighting the successes and challenges during the period of review. This is followed by a performance indicator summary, an action section and a performance indicator section. Performance reports are published online.

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

Customer/Stakeholder	Financial Health
▪ Improving outcomes for children, young people and their families. ▪ **Ensuring Midlothian is a safe place to live, work and grow up in.** ▪ **Creating opportunities for all and reducing inequalities.** ▪ Growing the local economy and supporting businesses. ▪ **Responding to growing demand for Housing and Adult Social Care Services.**	▪ **Maintaining financial sustainability and maximising funding sources.** ▪ **Making optimal use of available resources.** ▪ **Reducing costs and eliminating waste.**

Service Improvement	Learning and Growth
▪ **Improve Community engagement Strengthen partnerships.** ▪ **Improve and align processes, Services and infrastructure.** ▪ **Manage and reduce risk.**	▪ **Develop employee knowledge, skills and abilities.** ▪ **Improve engagement and collaboration.** ▪ **Develop a high performance workforce.**

Appendix A: Single Midlothian Plan Priorities

Midlothian Community Planning Partnership Board agreed that all partners will focus for the 3 years from 2019 until 2022 on how they can contribute to the following outcomes:-

- Reduced inequalities in the health of our population
- Reduced inequalities in the outcomes of learning in our population
- Reduced inequalities in the economic circumstances of our population

Each Thematic group has identified their draft 2020/21 priorities which link to the 3 agreed outcomes stated above.

ADULT HEALTH AND CARE (2020/21)

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

COMMUNITY SAFETY and JUSTICE draft outcomes (2020/21)

Community justice

- Help to improve family life and parenting skills
- Support people to attend school and /or gain qualifications
- Support people with mental health issues

Community safety

- Reduce violent crime
- Reduce substance (alcohol and drug) misuse
- Reduce domestic abuse and protect women and girls
- Reduce serious and organised crime to make communities safer
- Reduce dishonesty crimes (including housebreaking, vehicle crime and shoplifting)

GETTING IT RIGHT FOR EVERY MIDLOTHIAN CHILD (2020/21)

- Increase support to children and young people affected by domestic violence, parental alcohol or drug misuse
- Increase the range of alternative services on offer to children and young people requiring support for their mental health
- Reduce the proportion of children and young people living in households affected by poverty * shared with IOM
- Reduce the time taken to find permanent placements for looked after children and young people
- Increase the proportion of children and young people who feel safe in their homes, communities, schools and on line

IMPROVING OPPORTUNITIES FOR PEOPLE IN MIDLOTHIAN (2020/21)

- Reduce the number of children and young people living in households affected by poverty * reporting also linked to GIRFEMC Board
- Support people out of poverty and welfare dependency
- Reduce health inequalities

SUSTAINABLE GROWTH in MIDLOTHIAN (2020/21)

Housing

- Engage with house builders on insulation, energy efficiency and biodiversity mitigations
- Deliver further affordable housing
- Implement the rapid rehousing transition plan
- Increase provision of accommodation for homeless households

Economic development

- Integrate Midlothian with the regional economy and promote the region internationally
- Improve the skills landscape
- Increase economic participation
- Build on the success of our key sectors
- Improve the vibrancy of our town centres and make them more environmentally friendly
- Accelerate growth through infrastructure upgrades

Environment

- Implement the local biodiversity action plan
- Increase active travel
- Implement Penicuik THI/CARS and take up of grant
- Implement climate change strategy with partners

Appendix B: Service Actions and Performance Indicators 2020-21

Action	Due Date	Performance Indicator	Target
Service Priority: Health Inequalities			
Support people with long term health conditions through the wellbeing service that has been introduced in all 12 GP Practices.	31.03.21	Number of people receiving the wellbeing service across all 12 GP Practices.	1,000
Support people vulnerable to health inequalities by referral to the Community Health and Inequalities Team.	31.03.21	Number of referrals to Community Health Inequalities Team.	280
Work with Red Cross to support people who are frail to access financial support available to them.	31.03.21	Additional benefit income to Midlothian residents identified as frail.	£150,000
Deliver welfare rights service to people with health care needs and who are vulnerable or particular risk of inequalities.	31.03.21	Number of people supported with cancer.	250
Service Priority: Assessment and Care Management			
Reduce waiting times for occupational therapy and social work services.	31.03.21	Average wait time for occupational therapy services.	6 weeks
		Average wait time for social work services.	6 weeks
Continue to implement and monitor self-directed support.	31.03.21	Proportion of people choosing SDS Option 1	*Note 1*
		Proportion of people choosing SDS Option 2	*Note 1*
		Proportion of people choosing SDS Option 3	*Note 1*
		Proportion of people choosing SDS Option 4	*Note 1*
		Increase % of people who feel they are participating more in activities of their choice.	75%
Service Priority: Carers			
Provide carers with the tools and skills to manage their caring role through the provision of Adult Carer Support Plans and 1 to 1 support.	31.03.21	Number of Carers receiving 1:1 support via VOCAL	*Note 2*
		Number of Carers receiving an adult carer support plan of their care needs by Adult Social Care.	*Note 2*
		Number of Carers receiving an adult carer support plan of their care needs by VOCAL.	*Note 2*
Enable Carers to have breaks from caring through the VOCAL Wee Breaks Service.	31.03.21	Number of carers accessing short breaks through VOCAL Wee Breaks Service.	*Note 2*
Support unpaid carers to maximise their income by accessing services	31.03.21	Additional carer income generated through contact with	*Data only*

Action	Due Date	Performance Indicator	Target
and surgeries provided by Penicuik CAB.		Penicuik CAB (annual measure).	
Service Priority: Older People			
Develop and deliver pilot for Roaming Day Care in partnership with Volunteer Midlothian.	31.03.21	Number of clients participating in Roaming Day Care pilot.	4
Use efrailty data to inform prioritisation of Care at Home waiting list.	31.03.21	Reduce by 10% the number of people with high frailty waiting for a Care at Home package.	*tbc*
Strengthen our hospital at home service by relocating to Midlothian Community Hospital and promoting uptake through GPs and Flow Centre.	31.03.21	Number of individuals receiving support from Hospital at Home.	450
Support older people to attend activity groups hosted by Ageing Well each year.	31.03.21	Number of people attending activity groups hosted by Ageing Well each year.	20,000
Increase community awareness of extra care housing by running a series of extra care housing events across Midlothian.	31.03.21	Number of extra care housing public events.	8
		Number of attendees at extra care housing events.	90
Work with Building Services and Housing to seek and achieve planning permission for extra care housing projects at Gorebridge, Dalkeith and Bonnyrigg.	31.03.21	Planning permission granted for extra care housing at Gorebridge, Dalkeith and Bonnyrigg.	3
Service Priority: Mental Health			
Implement Individual Placement Support specialist employment support for people with mental health issues.	31.03.21	Number of people (per annum) in employment or education following intervention.	18
Enhance community resources for social prescribing by running a specific stress control classes in community venues.	31.03.21	Number of stress control classes run in community venues.	2
Expand mental health development in Primary Care.	31.03.21	Number of Midlothian GP Practices with a Primary Care Mental Health Nurse.	12
		Number of individuals accessing the Midlothian Access Point.	*Note 2*
Service Priority: Learning Disability			
Provide support and opportunities for adults with learning disabilities and autism by expanding day opportunities for young people in Midlothian in partnership with voluntary sector partners.	31.03.21	Number of people with autism engaged in day activities.	*Data only*
Support people with Profound and Multiple Learning Disabilities to live in suitable accommodation by putting in place a programme of works for the renovation of Primrose Lodge in Loanhead for three people and	31.03.21	Primary Lodge certified as available.	1

Action	Due Date	Performance Indicator	Target
the provision of respite for two people.			
Support people with complex needs in crisis by training practitioners on positive behavioral support as part of a programme of positive behavioral support in Midlothian.	31.03.21	Number of practitioners trained on positive behavioral support as part of a programme of positive behavioral support in Midlothian.	*Data only*
Service Priority: Substance Misuse			
Expand the reach of the take-home Naloxone kits to those most at risk of overdose.	31.03.21		
Run pilot of a SMART recovery group for veterans to increase the range of treatment and recovery interventions.	31.03.21		
Develop 'rapid access to prescribing and treatment' to help individuals who have dropped out of treatment re-engage.	31.03.21		
Service Priority: Justice Service			
Maximise the range of services offered to people involved in the justice service by working collaboratively to develop and consolidate the No11 Practitioners Allocation Meeting.	31.03.21		
Increase referrals through the Safe and Together approach for non-court mandated domestic abuse perpetrators.	31.03.21	Number of individuals referred through the Safe and Together approach.	4
Develop Trauma Informed holistic services for men on Community Payback Orders not attending accredited programmes such as Caledonian.	31.03.21		
Service Priority: Adult Support and Protection			
Raise awareness of self-neglect and hoarding.	31.03.21	Number of self-neglect and hoarding referrals which resulted in an investigation.	tbc
Service Priority: Adults with long term conditions, physical disabilities and sensory impairment			
Deliver weight management programmes to help address and prevent obesity and type 2 diabetes.	31.03.21	Number of people referred to weight management triage	200
Initiation of audiology clinics in Midlothian Community Hospital to improve service accessibility.	31.03.21		
Improve awareness and understanding of sensory impairment among HSCP staff and partners by delivering 2 half days of training with RNIB and Deaf Action.	31.03.21	Number of training awareness sessions.	1
Contribute to the implementation of the British Sign Language Plan to improve equity of access to services and support for BSL users.	31.03.21		

Action	Due Date	Performance Indicator	Target
Put in place a housing group to determine how to increase choice, numbers and accessibility to increase the availability of suitable housing.	31.03.21		
Service Priority: Digital			
Improve our use of health and social care data by achieving a data exchange mechanism between Council and NHS Lothian and building a data structure for data exchange and visualisation.	31.03.21		
Support the development of improved informatics for MERRIT by maximising use of TRAKCARE for intermediate care to achieve efficiencies via streamlined workflows.	31.03.21		
Lessen the need for travel to clinics and appointments by extending 'attend anywhere' video conferencing where services are willing to adopt.	31.03.21	Number of services utilising 'attend anywhere' video conferencing	2

Note 1 There is no target for self-directed support options as this is included in order to monitor the spread of uptake which is determined by service user choice and includes those under the age of 18.
Note 2 Target will be informed following collation of 2019-20 Q4 data.

Appendix C: Integrated Impact Assessment