Adult and Social Care Service Plan

2021-22

Head of Adult and Social Care
Head of Primary Care and Older People's Services

Contents

1. Midlothian Health and Social Care Partnership Overview

The Service Plan is focused on the adult health and social care priorities in the Single Midlothian Plan 2021-22 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. This includes all community health and social care services for adults in Midlothian and some acute hospital-based services. 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.

2. Our Vision

Agreed by the IJB in December 2020, **our vision** is that people in Midlothian are enabled to lead longer and healthier 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.

Over the last twelve months Sport and Leisure and Welfare Rights have become an integral part of the service. As we develop our Strategic Plan for 2022-25, their vision and priorities will be intrinsically linked to our health and social care priorities.

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

Our core value is that our services will provide the right support, at the right time and in the right place. We will achieve this 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.

Our values are underpinned by the following principles

- **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. Public Engagement

Engagement is fundamental in helping us to plan and deliver our services. We follow the national engagement standards and ensure ongoing engagement with people and partner organisations through representatives from the third sector, carers and people with lived experience on all formal planning groups including the IJB, the Strategic Planning group and Service Area planning groups.

The Midlothian Health and Social Care Partnership's Public Engagement Statement sets out:

a) who we will consult and engage with;
b) our methods of consultation and engagement;
c) when we consult and engage;
d) our standards for community engagement; and
e) guidelines for effective communication.

We also use feedback from national consultation programmes such as the Scottish Governments Health and Care Experience Survey. The results of the 2019-20 Health and Care Experience Survey were published in October 2020. We are using this feedback to help identify areas for improvement by better understanding people's experiences of their local health and social care services and caring responsibilities in Midlothian.

5. Our Key Successes 2020-21

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 people in Midlothian are enabled to lead longer and healthier lives. 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 2020/21 Annual Report will be available in July 2021 and will be published online at https://www.midlothian.gov.uk/mhscp

As we have moved through the Covid pandemic, the top priority for the partnership has been the safety of patients, clients, communities and staff. In response to the situation it was important to be innovative and support clients effectively and safely during this time. Staff continued to see people face-to-face where this was essential, but in order to reduce face-to-face contact, where feasible, teams made a number of changes to how they delivered services throughout the pandemic.

As well as managing changes to existing services, the Partnership provided care and treatment to those who had contracted Covid-19 and their families. The Partnership provided support to partner agencies around changed provision, infection control and other requirements, including the provision of personal protective equipment (PPE) and staff testing.

Covid related services had to be established, often at short notice, as the pandemic escalated, such as the Covid Testing and Assessment Hub at Midlothian Community Hospital. Many staff across the Partnership were redeployed to other roles, assisting in care homes and PPE centres.

Partnership staff were very involved in the work of the Midlothian Care for People Group where members of the Community Planning Partnership and other partners coordinated a humanitarian response to the pandemic. Statutory and voluntary sector partners sought, as far as possible, to provide essential services to the whole population and particularly to those most directly affected by the imposition of lockdown. The Midlothian Care for People Group operated in a complex environment keeping abreast of new guidance and rapidly changing projections of need, whilst also keeping in close touch with policies and activities at national, regional and council level.

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

Covid-19 Pandemic

The impact of the COVID-19 pandemic brought many challenges and much disruption to the Health and Social Pare Partnership, its partners and the communities it serves. There was increased anxiety and pressure on many service users, unpaid carers and staff. While challenges may have changed over 2020, they will continue into 2021 and beyond. Covid will continue to influence how we delivers core services, work with partners and communities, deliver Covid related services, and develop our workforce.

A growing and aging population

We are the second smallest Local Authority in mainland Scotland but the fastest growing. This will continue to pose challenges for health and social care services whilst also changing some 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. 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.

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 concern. 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.

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 well documented. There is no doubt that we need to do things differently: the traditional approach to delivering health and care services is not financially sustainable.

Workforce Pressures

The Covid-19 pandemic has and will continue to influence the demand for, and deployment of, the health and social care workforce for the foreseeable future.

Recruitment and retention of nursing, care, allied health professional and medical staff will continue to be a challenge. Mass vaccination programmes and other large scale recruitment programmes related to COVID 19 have increased pressure on an already stretched resource.

How the workforce interacts with people has also changed with an increased use of digital or telephone interactions.

Unpaid carers

Unpaid carers fulfil significant, valuable and wide-ranging roles helping to keep people with care and support needs within our communities. During the pandemic many people have become carers for the first time, or seen changes to their caring role, resulting in them providing significantly more care for their elderly, sick or disabled family, friends and neighbours. Through this period Community services supporting carers have continued to offer a range of support, including digitally, and by telephone, though services supporting the person they provide support to may have been reduced, e.g. respite and day services, resulting in an impact on carers. It is essential that we work to reduce the significant pressure and impact of caring that carers report feeling, by continuing to explore innovative options to enable support to be given to both carers and the cared-for, and for there to be opportunities for breaks from caring leading to caring being more sustainable. We are constantly looking for ways to offer respite and support to reduce the stress and impact of caring.

Acute hospitals

Acute hospitals are under huge pressure due to unsustainable demand and financial restrictions. We need to invest in community based alternatives and work with carers to 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.

Emerging evidence from the Scottish Government describes that the impacts of the COVID-19 crisis are affecting some groups disproportionately; they are more likely to be infected with the virus and to experience poor health outcomes, including in some cases death. There are also concerns about the widening of economic inequalities with some groups more likely to experience unemployment and poverty.

These are arising from the direct and indirect effects of contracting the illness, as well as the lockdown measures put in place to control spread of the virus.

We work with our partners 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 to address 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.

Domestic abuse is also linked to inequalities. Although being female is the key risk factor for experiencing domestic abuse, not all women are equally at risk. Factors such as age, poverty, economic dependence, disability, homelessness and insecure immigration status can heighten women's vulnerability to abuse or entrap them further.

People living in some communities are more likely to be living in poorer health and 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 are more likely to experience emotional stress, anxiety, and fatigue. The impact of caring for others can significantly impact on their own physical, mental, and emotional health and wellbeing, also impacting on finances and relationships.

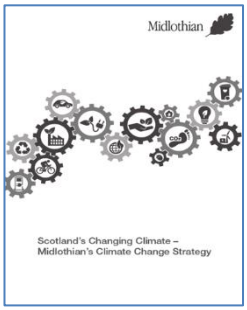
9. Sustainability of Health and Social Care Services

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.

10. Climate Change Emergency



Public services have an important role in shaping the climate change agenda, both in terms of protecting communities from the adverse impacts of climate change and in supporting a transition towards more sustainable living.

Midlothian Council at its meeting of 17th December 2019 declared a climate emergency that requires urgent action. The Health and Social Care Partnership is strongly committed to work in partnership and is supporting

the delivery of the Council's 2020 Climate Change Strategy approved in August 2020 which sets out the ambitious commitment to achieving a net zero carbon status by 2030.

11. Self-Assessment

Self-Assessment will be a high priority during 2021-22. The impact of the pandemic on society has been severe. It is essential Adult Health and Care reviews its priorities and its approach to service delivery to ensure it is fit for purpose in the post-pandemic future.

1. **Outcomes Approach:** The service has undertaken to implement a new approach to performance management, which will place Outcomes at the centre. This will entail mapping all activities at strategic and service levels and using this as the basis for improvement plans. Formal self-evaluation will be built into this programme of work with ongoing advice from the Care Inspectorate Link Inspector. The initial phase will focus upon Strategy; Number 11; and Frailty.

2. **Scirocco Exchange - Capacity Building for Integrated Care**: The Scirocco Exchange, a European Self-Evaluation Programme, was put on hold during the pandemic. This will be resurrected during 2021-22 with a focus on three areas: Population Management, Public Engagement and Digital Infrastructure. The plan is to establish links and learn from other European countries, such as the Basque Country, about how we can improve our work in these areas.

3. **Oversight Group:** To ensure self-assessment is embedded as a key requirement during 2021-22 a senior Oversight Group for Self-Evaluation activities will be established. The link inspector from the Care Inspectorate has agreed to join this group in an advisory capacity.

   The role of the group will include:

   a. Consideration of self-assessment activities in relation to major service redesign including Home First and Cancer Services.

   b. Oversee areas of weakness identified through the Outcome Mapping programme.

   c. Consider actions required as a result of the planned self-evaluation of the IJB.

   d. Take any action required arising from developing approaches to service evaluation at a national level by bodies such as the Care Inspectorate and Healthcare Improvement Scotland.

   e. Ensure the continued implementation of agreed actions from Self-Evaluation exercises including the MSG Improvement Plan and the Scirocco Programme.

4. **Joint Needs Assessment:** We oversee the production of a Joint Needs Assessment (JNA) to assess and forecast the health and wellbeing needs of the adult population in Midlothian. The data captured helps to inform key health care priorities; and focus commissioning in order to improve the physical and mental health and wellbeing of individuals and communities. The JNA informs the development of the Strategic Plan helping to ensure

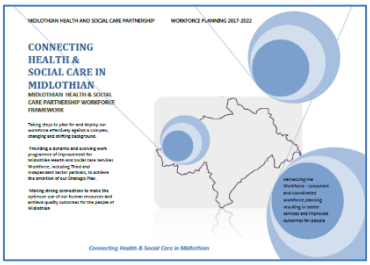
our health and social care services are designed in a planned, evidence based and transparent way to meet the current and future needs of the population.

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. The delegated funding to be offered to the Midlothian IJB, and the budget for non-delegated services, was approved at 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 to develop a 3 year Workforce Plan no later than 31st March 2022. An interim workforce plan was submitted to the Scottish Government in April 2021 to cover the period from April 2021 to March 2022 setting out a cohesive picture of our workforce across the Health and Social Care Partnership.

14. Performance Reporting

Integrated Joint Board

Performance reports are presented to the Midlothian IJB to monitor a core suite of national and local outcomes that support the delivery of our strategic priorities, and monitor the changes across the system of health and social care which need to take place in the design and delivery of our services. We have a legal requirement to report on the Directions set by the IJB and publish an Annual Performance Report.

The development of an outcome focused approach is being rolled out across the Health and Social Care Partnership to better evaluate the outcomes for service users and carers. Measuring the contribution made by each service is significantly complex and requires a combination of both hard data and qualitative information. The approach being adopted involves the development of Outcome Maps at each level of the organisation to capture the

steps that link the activities of the service to the outcomes that are most important. The use of a new software programme, OutNav, make it possible to capture and link a wide range of evidence for evaluating and demonstrating progress.

Midlothian Council

Performance reports are presented to Midlothian Council to demonstrate progress against the outcomes in the Single Midlothian Plan and key Service 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

Priorities for 2021-22

The community planning priorities and actions for 2021-22 set out under the 5 themes of community planning are designed to improve life outcomes for the people of Midlothian. These one year priorities are intended as steps towards achieving the three year outcomes (2019-22) and long term vision of the Community Planning Partners.

ADULT HEALTH AND SOCIAL CARE

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- Develop approaches to prevent or address isolation and reduce the detrimental impact on physical and mental health.
- People, including those with disabilities/long term conditions or who are frail are able, wherever possible, to live independently and in their own home.
- Health and Social Care have contributed to reducing health inequalities For example Work with MFIN to maximise income of people who are vulnerable or at particular risk of inequalities.
- Unpaid carers are supported to look after their own health and wellbeing.
- Multi-agency teams are supported to work in an integrated way and address the workforce challenges including recruitment and retention of health and social care staff.
- Engage with communities effectively. This includes implementation of the Engagement Statement and specific programme with CPP partners to foster asset-based community development approaches to work with communities.
- Work with partners, including communities, to develop the Strategic Plan for 2022-25.

COMMUNITY SAFETY and JUSTICE

Community justice

- Support people to attend school and/or gain qualifications
- Support people to reduce/manage drug use
- Work with young people to reduce early anti-social behaviour
- Help to improve family life and parenting skills
- 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
- Educate people regarding speeding, drink driving and responsibly parking

GETTING IT RIGHT FOR EVERY MIDLOTHIAN CHILD

- Raise educational attainment of care experienced children and young people and reduce the number excluded from school
- Improve access to services for children and young people needing support to maintain mental health and wellbeing
- Reduce child poverty across the county
- Improve access to the specialist services some children and young people require to help them recover from trauma

- Improve outcomes and experiences for care experienced young people transitioning into adulthood
- Raise the attainment of children and young people with additional support needs

IMPROVING OPPORTUNITIES FOR PEOPLE IN MIDLOTHIAN

- The number of households in poverty across Midlothian is reduced
- The number of children living in households in poverty is reduced
- Participation measures for young people over 16 increase
- The qualification levels of people in Midlothian increases
- The number of people who are economically active increases
- The annual turnover of third sector organisations and volunteering rates increases
- Health inequalities for people in Midlothian are reduced

SUSTAINABLE GROWTH in MIDLOTHIAN

Economy

- Maximise opportunities for inward investment and funding to the area
- Place based economic development approach to support the regeneration of Town Centres
- Work with Midlothian employers to understand skills needs and provide local employment opportunities
- Driving forward inclusive economic growth by working in partnership with stakeholders, and ensuring business community benefits in the supply chain to maximise opportunities for local people.

Housing

- Increasing the supply of affordable housing in Midlothian.
- Revise Midlothian Council's Housing Allocation Policy to address the backlog of homeless households already in temporary accommodation, and reduce the time taken to house homeless households in the future.
- Seek alternative models of temporary accommodation to end the need for bed and breakfast accommodation.
- Ensure homeless households are supported to access a wide range of housing options, including the private rented sector.
- Develop a 'housing first' approach in Midlothian to house homeless households with complex needs.
- Develop and implement a Homeless Prevention Strategy.

Climate

- Place the Climate Emergency and Midlothian Council's Climate Emergency Declaration at the centre of the replacement Midlothian Local Development Plan, and its development strategy and policies, so that the new plan facilitates promotion of carbon neutral development, mitigation of, and adaptation to, the effects of the Climate Emergency

Appendix B: Service Actions and Performance Indicators 2021-22

Action	Due Date	Performance Indicator	Target
Service Priority: Health Inequalities			
Support people living with long term health conditions or facing challenging life situations through the Midlothian Wellbeing service based in Midlothian GP Practices.	31.03.22	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.	31.03.22	Number of people who received a health assessment from the Community Health Inequalities Team.	150
Work with Red Cross to support people who are frail to access financial support available to them.	31.03.22	Additional benefit income to Midlothian residents identified as frail.	£150,000
Deliver Welfare Rights service to people with health and social care needs.	31.03.22	Number of people supported with cancer.	250
Service Priority: Assessment and Care Management			
Reduce waiting times for occupational therapy and social work services.	31.03.22	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.	31.03.22	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.	31.03.22	Number of Carers receiving 1:1 support via VOCAL	500
		Number of Carers receiving an adult carer support plan of their care needs by Adult Social Care.	Data only
		Number of Carers receiving an adult carer support plan of their care needs by VOCAL.	500
Support and enable Adult Carers to access breaks from caring through	31.03.22	Number of carers accessing short breaks through VOCAL Wee	300

Action	Due Date	Performance Indicator	Target
the VOCAL Wee Breaks Service.		Breaks Service.	
Service Priority: Older People			
Use efrailty data to inform prioritisation of Care at Home waiting list.	31.03.22	Monitor the percentage of people with moderate to high frailty waiting for a Care at Home package.	*Data only*
Implement block contracts for external Care at Home Providers	31.03.22	Block Contracts in place	100%
		Contractual requirements fulfilled	100%
Explore and expand options to offer day support to people in Midlothian to reduce isolation.	31.03.22	Number of people accessing day support to reduce isolation	*Data only*
Support older people to attend activity groups hosted by Ageing Well each year.	31.03.22	Number of people attending activity groups hosted by Ageing Well.	20,000
Consult with extra care housing tenants re the impact of Covid-19 on their health and welling and identify common themes of concern around future engagement in one to one, group or wider community settings to aid future extra care housing service planning.	31.03.22	Number of consultation questionnaires /interviews from Sept 2020 to March 2021.	2
		Number of extra care housing tenants consulted.	67
Work with Building Services and Housing to seek and achieve planning permission for extra care housing projects at Gorebridge and Bonnyrigg.	31.03.22	Planning permission granted for extra care housing at Gorebridge and Bonnyrigg.	2
Service Priority: Mental Health			
Implement Individual Placement Support specialist employment support for people with mental health issues.	31.03.22	Number of people (per annum) in employment or education following intervention.	13
Enhance community resources for social prescribing by running a specific stress control classes in community venues.	31.03.22	Number of stress control classes run in community venues.	1
Expand mental health development in Primary Care.	31.03.22	Number of individuals accessing the Midlothian Access Point.	600
Service Priority: Learning Disability			
Strengthen joint working of Learning Disability Services and care providers to inform longer-term changes in how adult social care is planned and delivered.	31.03.22	Activity of Day Service Providers' Group incorporated into the Remobilisation programme.	1
Support people with Profound and Multiple Learning Disabilities to live in suitable accommodation by supporting the renovation of Primrose Lodge in Loanhead for three people and with the provision of respite for two people.	31.03.22	Renovation of Primrose Lodge complete.	1

Action	Due Date	Performance Indicator	Target
Support people with complex needs in crisis by training practitioners on positive behavioral support as part of embedding PBS in Learning Disability services.	31.03.22	Positive behavioral support pathway to be updated to include staff training at level one.	1
Service Priority: Substance Misuse			
Ensure those most at risk of overdose have continued access to take-home Naloxone kits to.	31.03.22	Number of Naloxone kits replenished by MELD, SMS and Peer Workers.	*Data only*
Expand the offer of buprenorphine prolonged release injections as part of Medication Assisted Treatment options.	31.03.22	Number of people taking up offer of buprenorphine prolonged release injections.	*Data only*
Deliver 'rapid access to prescribing and treatment' to help individuals who have dropped out of treatment re-engage.	31.03.22	Number of people assisted via 'rapid access to prescribing and treatment'	*Data only*
Service Priority: Justice Service			
Further develop the No11 Practitioners Allocation Meeting to maximise the range of services offered to people involved in the justice service by working collaboratively with Health, Substance Misuse Services, Social Work, Housing and third sector agencies.	31.03.22	No 11 Allocation Meeting adapted to support individuals assessed suitable for the Alcohol Problem Solving Court.	1
Increase referrals through the Safe and Together approach for non-court mandated domestic abuse perpetrators.	31.03.22	Number of individuals referred through the Safe and Together approach.	4
Develop a trauma informed service that focuses on tailored, structured intervention and access to wraparound services for men on Community Payback Order supervision.	31.03.22	Service planned, designed and implemented.	1
Service Priority: Adult Support and Protection			
Raise awareness of self-neglect and hoarding.	31.03.22	Number of self-neglect and hoarding referrals which resulted in an investigation.	5
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.	31.03.22	Number of people referred to Weight Management Triage.	200
Improve awareness and understanding of sensory impairment among HSCP staff and partners by delivering training with RNIB and Deaf Action.	31.03.22	Number of training awareness sessions.	*Data only*
Encourage the need for early identification of housing needs and solutions by acting early and having the right housing conversation with individuals.	31.03.22	Number of housing solutions online training sessions.	2
		Number of people who attended housing solutions training	*Data only*

Action	Due Date	Performance Indicator	Target
		sessions	
Support those living with, or previously affected by cancer to stay active by taking part in physical activity to help prevent and manage some of the effects of treatment.	31.03.22	Number of referrals into Move More or equivalent physical activity referral programme from ICJ (Improving the Cancer Journey)	*Data only*
		% of the total participants in the physical activity programmes	*Data only*
Collaborative approach to develop a pathway for people living with a neurological condition.	31.12.23	Pathway activity development for 2021/22 completed for people living with a neurological condition.	100%
Service Priority: Digital			
Pursue and explore options to progress incrementally a data exchange mechanism between the Council and NHS Lothian to improve our use of health and social care data.	31.03.22	Data exchange mechanism between the Council and NHS Lothian is in place	1
Lead on development of national technology enabled care project exploring frailty system of care.	31.03.22	Completion of phase 3 and 4 of the national technology enabled care project.	1
Establish a mechanism that provides HSCP Senior Management oversight and proper business partner support within a governance framework for accountability to plan and deliver.	31.03.22	Digital Governance Group established	1
		Identified workstreams agreed	1

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.

Appendix C: Integrated Impact Assessment