Area: Older People (community)

Strategic Plan Engagement 2021

The Midlothian Health and Social Care Partnership is responsible for services that help people 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.

To help us in developing our new strategic plan we spoke with stakeholders, volunteers and people with lived experiences about their views on the services we deliver and what could be improved.

For the older people (community) plan we established a collaborative working group, involving 4 older citizens and 4 professionals from diverse professions within health, social care and the voluntary sector. The group members contributed their own experience and ideas, and also considered feedback from wider groups including Grassy Riggs, Ageing Well and people attending the St John and Kings Park Church café. Consultation feedback from surveys carried out in the 12 months preceding the strategic planning process were also considered.

We would like to thank the people, citizens, staff and partner organisations, who took part in the collaborative working group, and the people who contributed their ideas through other channels, including preceding consultations.

We worked with people for 4 months during 2021.

Questionnaires

- Care at home consultation December 2020 – 127 people
- Older People's Planning Group consultation November 2020 – 151 people

Interviews/focus groups

- Interviews for care at home consultation December 2020 – 39 people

Other engagement

- Strategic plan working group (collaborative) – 8 people including 4 older citizens

Prevention

Key points

Services that ask what matters and provide a holistic assessment – a "one stop shop"
For example the British Red Cross Neighbourhood Links Service, the Wellbeing Service at GP practices, Discharge to Assess

Services that help you to connect and to navigate the system
Like the British Red Cross Local Area Coordination Service

Community-based places where people can drop in and get support
Like Grassy Riggs, the St John's and Kings Park Church café

When information is brought together in one place
Like the British Red Cross community calendars

Being flexible and delivering services in different ways when appropriate
Such as online sessions offered by Connect Online or garden social groups

Community-led services, delivered by volunteers but supported by paid staff
Like Ageing Well, Connect Project

Opportunities for HSCP staff and older citizens to meet
To share ideas and knowledge, for example MOPA pre-pandemic, Mental Health Group, Hot Topics, Good Grief Working Group

Older people are not always valued
Their skills and assets are not recognised, the conversation is too often about older citizens being a burden, using services or needing support. We need to listen more to people's experiences and ideas.

It can be difficult to find out about the support that is available
There isn't one place to go where all information is easy to access. People depend on word-of-mouth.

Sometimes local facilities and activities are difficult to get to
This could be because of transport or geography. Venues need to be truly accessible.

Key points

Some people lack confidence to go out and about

This could be due to ongoing concern about Covid or for other reasons. We should provide support and a range of different ways for people to connect with each other.

Covid and restrictions have had a negative impact on many older people's health

In autumn 2020 many people said they were less active than before – including 50% of Ageing Well participants. The most common issue reported to the Red Cross in October 2020 was feelings of loneliness and isolation.

Can we connect better with people who live in care homes?

The vision would be that care homes are seen as a positive place to live, and are a part of the wider community.

Social contact is very important

Sometimes carers are the only source of social contact for an older person. People value day support and activities. More options should be provided.

Create more age-friendly, welcoming environments for older people to meet and find out about the support that is available

Work with partners to create age-friendly and accessible environments in every community that can be a place for sharing information.

Increase contact between HSCP staff, services and community groups

Prioritise opportunities for staff to visit community cafes, support groups etc. to improve relationships and communication.

Challenge Ageism

Recognise the contribution of older citizens and create more opportunity for older people to contribute and make a difference

Create more opportunities to hear the views and experiences of older people

Support MOPA to develop and grow.

Support & Treatment

Key points

Services that connect to other services work well
For example the Red Cross delivering library books, post-diagnostic support for dementia connecting with the day service, having a physiotherapist in every GP practice

Services that are consistent and can get to know you
So that if someone's condition changes they will notice it and take action. People who use care at home services told us that consistency is really important for building trust, feeling safe and improving independence.

The Extra Care Housing model where people can live in their own tenancies but also get extra care and support if needed e.g. Cowan Court, Hawthorne Gardens and new developments including Newmills Road in Dalkeith

Collaboration and joint working between families, third sector, health and social work – this has been getting better.

Using data more to make sure we are being proactive and reaching out to people who might need support e.g. the Frailty programme

Services that can offer direct access
So that anyone can access support without going to a gatekeeper or having to be eligible e.g. Speech and Language Therapy, physiotherapy in GP practices.

Services that help people to receive care at home instead of hospital
Such as Discharge to Assess and Hospital at Home

Accessing a GP appointment can be difficult for some older people
Some people find it difficult to use online appointment systems. There can be large numbers of people waiting to get through on the phone. Appointments are often carried out remotely and some people prefer in-person communication.

Access to support after hospital is not consistent
Not everyone is offered Discharge to Assess or Hospital at Home. Some people said they did not receive enough support after coming home from hospital.

There can be barriers to getting holistic support
Because of the way our services are set up, people may need to fill in forms, meet criteria or be referred to other services in order to get support that would have a great benefit to their lives and health overall. This can make people feel helpless and frustrated.

Key points

In some services staff change frequently
This means people are less likely to notice a change in someone's health or wellbeing and can affect trust and confidence.

It is important that services have enough time to spend with people
So that they don't feel rushed, can ask questions, and discuss other issues.

It is important that people have choice over how services are delivered and that support can be flexible so that it can change to meet the person's needs. If a service needs to change then it is important to communicate clearly with the person.

Is it possible to find ways to share information more easily, but safely and with confidence?
So that we can work more holistically with people

Can we work with older citizens to identify how to improve pathways so that people don't have to go to different places for support?

Develop different options for people to access services, especially GP services
Work with older people's groups to understand the barriers they face when accessing services and what makes a service accessible to them. Digital should be an option but not the only option.

Use community spaces to deliver services
Where possible using local accessible venues, for example CHIT service.

Make changes to our home care service so that it can respond more quickly to demand, and so that staff are valued and stay in their roles for longer, improving consistency.

Support in a Crisis

Engagement with older citizens did not generate any feedback or ideas about support needed in a crisis.