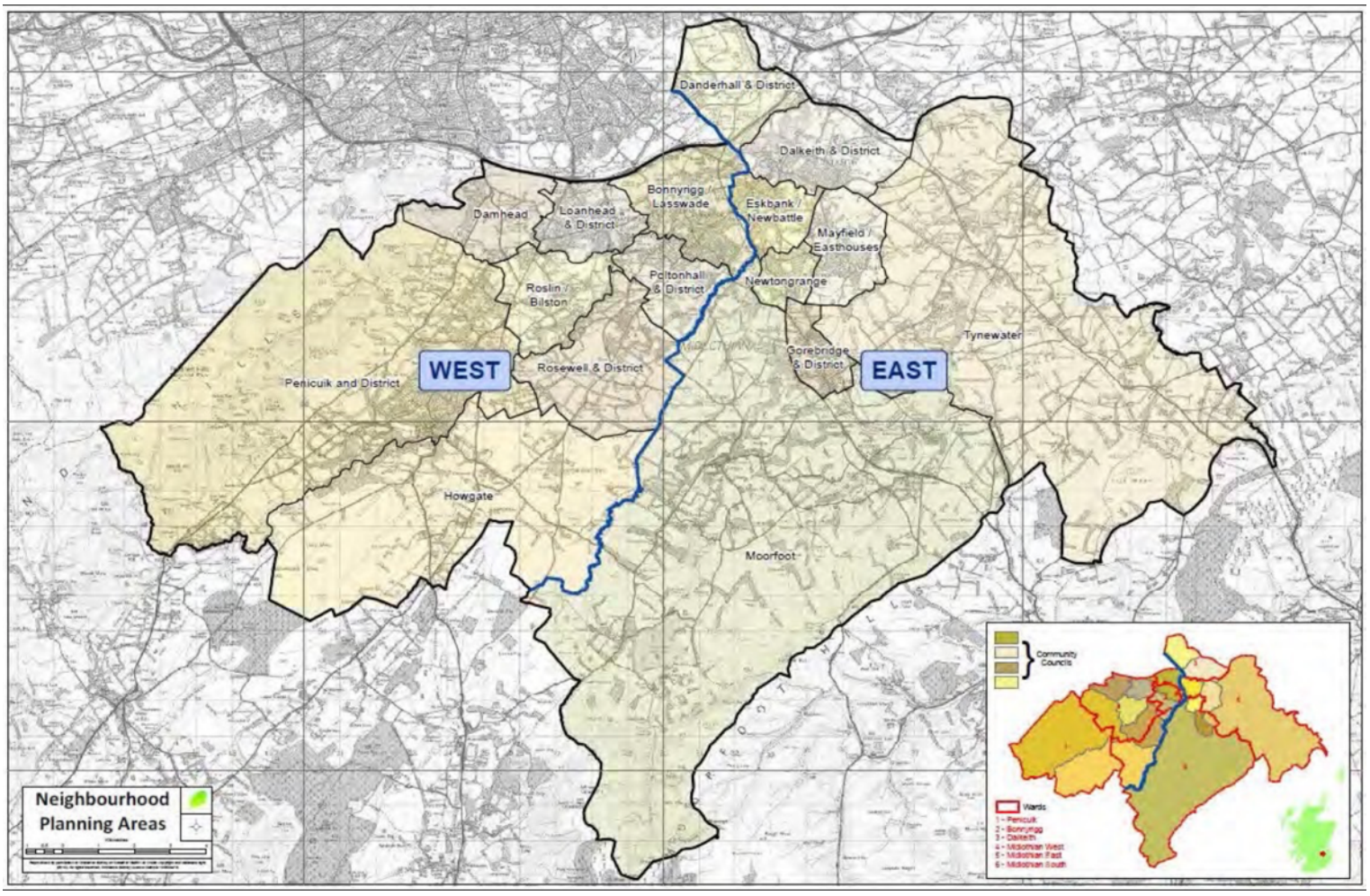
Midlothian's Health & Social Care

Delivery Plan 2018 - 19



Contents

Improving Health and Wellbeing

A New Approach to Health and Social Care Delivery

In 2014, the Midlothian Integration Joint Board (IJB) became responsible for planning and overseeing the delivery of local health and social care services. There are very significant challenges facing health and social care including the Public Sector financial position and major workforce pressures such as shortages of GPs and Community Nurses and difficulties recruiting and retaining Care at Home workers. In Midlothian, we have the added challenge of responding to a rapidly growing population, with predictions of an increase from 86,670 to 100,000 by 2024.

We believe that integration offers very real opportunities to redesign our services that will not only meet these challenges but will result in improved health and wellbeing for the people of Midlothian through the delivery of truly joined up services. We aim to support people to stay healthy and to help people to recover from ill health as fully as possible. We cannot achieve this on our own. Good housing is crucial. Working in close partnership with voluntary organisations makes success much more likely. Most importantly, we need the support and contributions of people who use health and care services to help us ensure they are good quality and that we are using our resources as effectively as possible.

The role of families and unpaid carers cannot be overstated, and we will continue to recognise their expertise and the quality of care they provide.

Understanding People's Needs in Midlothian

In **2016**, the IJB published a 3 year Strategic Plan with clear actions to improve health and care services. We based this 2016-19 on a **Joint Needs Assessment** and our understanding of the views and concerns of the public.

This Plan sets out how the Partnership will provide services during **2018-19**. It takes into account progress made during **2017-18** and addresses challenges that emerged during the past year.

This plan has been drawn up by Midlothian Strategic Planning Group which will continue to develop, shape and oversee its development. More detailed actions and investments are contained in plans compiled by local Joint Planning Groups. These consider the needs of older people, people with disabilities or long term health conditions, unpaid carers, people with mental health needs and those with substance misuse needs.

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Content of this plan

The IJB is responsible for the full range of community health and care services for adults, including some acute hospital based services.

Midlothian Council chose to include services for offenders in the scope of the IJB. This helps address the health and care needs that are often the root causes of offending. Developing ways to reduce offending remains the remit of the **Community Justice and Safety Partnership**.

Links between adult and children's services are important, but strategic planning for children's services remains the responsibility of the **Getting it Right for Every Midlothian Child** group.

The IJB is not responsible for arrangements to protect people at risk of harm. This remains the responsibility of the **East and Midlothian Public Protection Committee.** However services commissioned by the IJB have a role in safeguarding people from harm and ensuring we support and protect anyone considered at risk.

This 1 year Delivery Plan summarises the key steps planned in our main service areas and describes the continuation of work with all partners and local communities to transform health and care services.

Although the very significant reductions in public spending make service redesign essential, we genuinely believe there are many changes we can make for the better, despite these financial pressures.

How the plan is making a difference

The Partnership is committed to making progress against the Government's six priority areas. We report our performance on these regularly to the IJB. Alongside this the 12 projects of our 2018/19 Transformation Programme will monitor progress against measurable indicators.

Of equal importance is improving our ability to measure our progress in longer-term redesign of health and care services. This will include monitoring our use of resources e.g. checking that our expenditure on preventative services is increasing. It will also involve better understanding our progress on objectives such as promoting recovery and reducing avoidable admissions to hospital

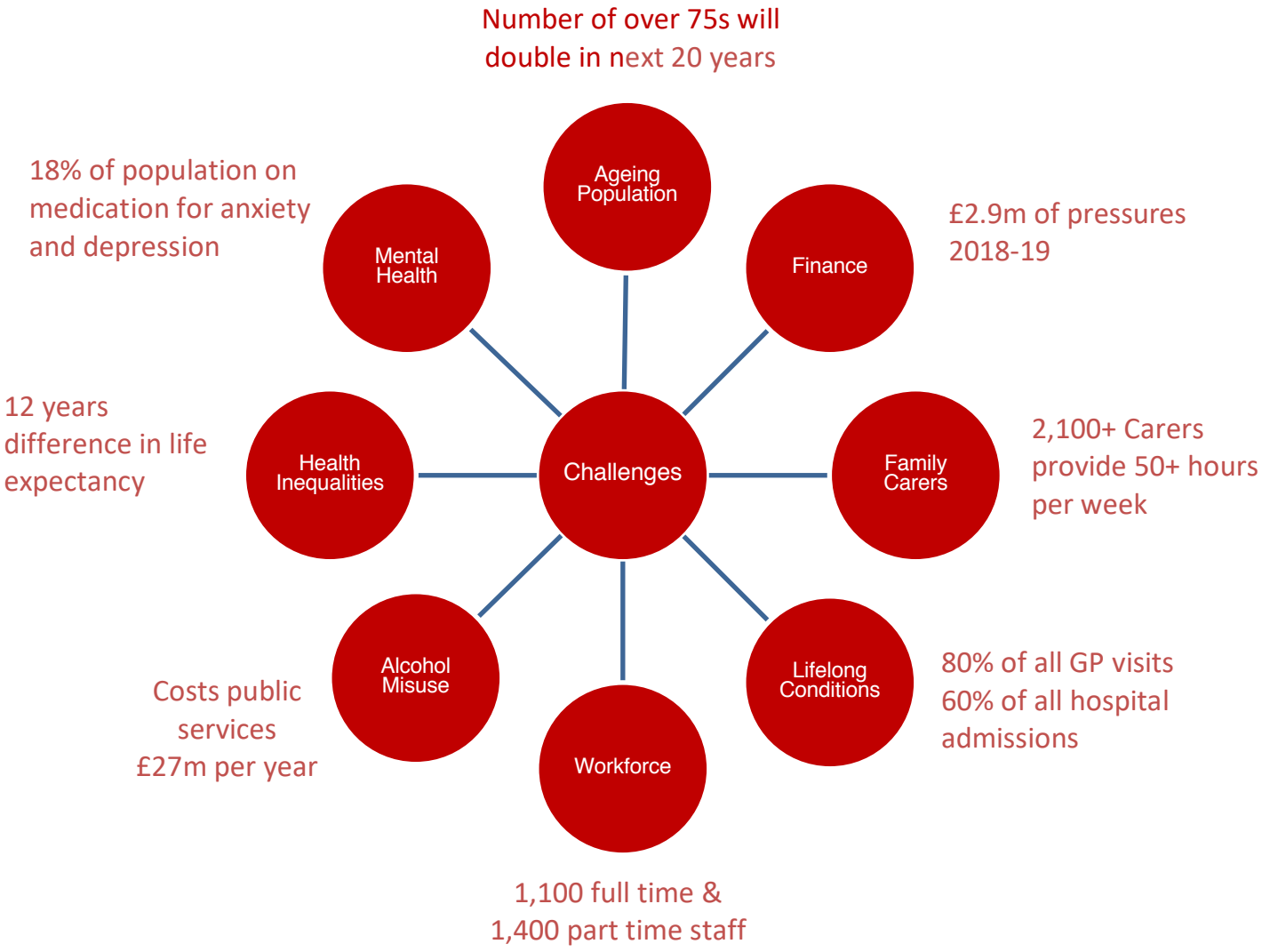
The IJB will publish an annual report on the impact of health and social care integration on the health and wellbeing of the Midlothian population, how it is using its resources and how it responds to the needs of localities. IJB ANNUAL REPORT 2016-17

By redesigning our services, we are better placed to deliver key national outcomes:

- people are supported to remain at home for longer
- people only go to hospital when necessary
- there is a reduction in health inequalities

Main Challenges

- **More people who are frail or have dementia want to be supported to live at home for longer.**
- **People are living longer with multiple long-term conditions.**
- **Little progress is being made in reducing health inequalities.**
- **All our services are under financial pressures.**
- **People are staying too long in hospital after they are fit to be discharged.**
- **Recruitment and retention of staff such as GPs, community nurses and care workers.**



Our Vision - Shifting Focus

The Health and Social Care Partnership will make significant changes in how we deliver health and care services.

'People in Midlothian will lead longer and healthier lives and will get the right advice, care, and support, in the right place at the right time'. We aim to achieve this ambitious vision by changing the emphasis of our services.

Past	Future
Treatment & Support	Recovery & Reablement
Failure Demand (not getting it right)	Prevention - Good Physical and Mental Health
Reactive	Anticipatory Care & Planning for Emergencies
Professional Care	Self Management & Peer Support
Working in Silos	Team Working at Local Level
Hospitals & Care Home	Community Based Services e.g. Hospital at Home
Health & Care Focus	Community Planning i.e. housing, income, transport
Opportunity Costs	Improving Quality & Access

The Whole Person

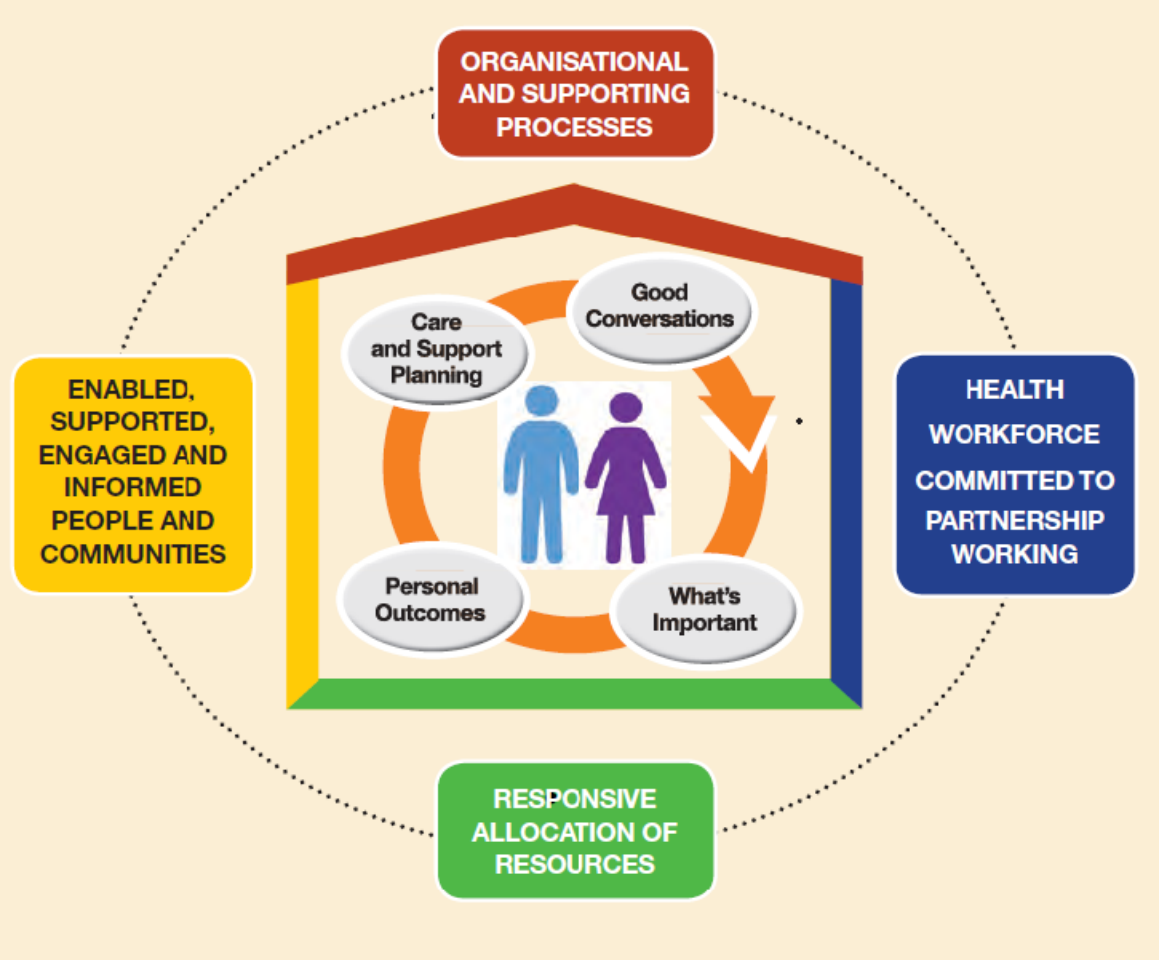
We need to think differently about health and wellbeing. We need to:

- Focus on the whole person not only the disease.
- Recognise the importance of physical, mental and social wellbeing.
- Recognise the role of families, carers and communities in helping people stay well.

Our services are increasingly recognising that it is important to consider a person's mental health when responding to physical health and social wellbeing.

House of Care

One of the models we use for delivering person-centred, integrated care is the House of Care. This creates space for people to have 'a good conversation' on what is important to them and helps them recover or live well with their health conditions.



Partnership Working

We will only achieve major change in the health and wellbeing of the population through strong partnerships with other agencies and natural communities.

Examples of good partnership working include:

Staying healthy	People need support and advice on issues such as exercise, smoking, alcohol consumption and managing stress. To help combat obesity, we will work with networks such as the "**Food Alliance**", the "**Physical Activity and Health Alliance"**, **Leisure and Recreation**, and the **Voluntary Sector.**
Reducing Social isolation	Isolation is linked to physical and mental health problems. Creating opportunities through activities, groups and befriending is important. Social inclusion also depends upon having a decent income, having a job or being a volunteer, and being able to get about - transport can be a real barrier. A Connected Scotland is the Government's report on social isolation.
Avoiding accidents or illness	The **Fire Service** helps reduce the likelihood of fire and other accidents such as falls in the home. **Pharmacists** are an invaluable source of advice in managing illness, help with giving up smoking and immunisation against flu.
Staying warm	Addressing fuel poverty can reduce winter deaths; injury and falls; improve mental health; and reduce respiratory illness and circulatory disease. We need to increase awareness and develop stronger working relations with **Changeworks** and other third sector partners

Key Approaches

Information

There are websites and directories but not everyone knows how to access them.

We must continue to invest in communication to ensure that everyone gets the right information, in the right place, at the right time.

Planning Ahead

Many people develop and live with long term conditions such as cancer, heart disease or dementia. We must find better ways to support them, their families and their carers by providing clear and concise information and developing individual Anticipatory Care Plans. Planning for the future can help people manage as their condition changes.

Unpaid carers tell us that they could manage crises more effectively if there was a methodical and widespread approach to planning for emergencies - particularly when the carer is suddenly unable to provide support

We will promote the benefits of having a Power of Attorney to ensure that families have the legal power to act on behalf of their relatives when they are not capable of making their own decisions.

Recovery

Recovery is the goal for people who experience mental ill health or the consequences of substance misuse.

Recovery is more likely if people are supported to gain employment, get about, have an income, maintain social contacts and cope with new challenges.

Technology

We will make effective use of technology to enable people to manage their own health conditions.

Advocacy

People who are vulnerable, for instance due to mental illness, sometimes need support having their voice heard on issues that matter to them.

There are a number of local sources of advocacy, but we will review whether the current arrangements are appropriate.

Public Protection

Whilst public protection issues permeate across all areas of this plan, the East Lothian and Midlothian Public Protection Committee (EMPPC) was established in July 2014 to provide leadership and oversight of the governance arrangements for Child Protection; Adult Support and Protection; Violence Against Women and Girls; and Offender Management, on behalf of the East Lothian and Midlothian Critical Services Oversight Group (CSOG).

DOMESTIC ABUSE

Attitudes towards domestic abuse have changed considerably – it isn't that long ago ago that some people were of the mindset that domestic abuse - especially if it didn't involve physical violence - was a private matter. Opinions have changed but work is needed to challenge lingering outdated or dismissive attitudes. Scotland has adopted an innovative and radical Domestic Abuse Act that creates a specific offence of "abusive behaviour in relation to a partner or ex-partner" that includes psychological abuse such as coercive and controlling behaviour as well as violence.

The East Lothian and Midlothian Public Protection Office ran training on domestic abuse, its impact and advice on how to talk about it. A Gender Based Violence eLearning module will be available on Learnpro. Social work, health, police, women's aid, criminal justice and other teams attended training on the Safe & Together model with the non offending parent. Midlothian Council is introducing a new policy and action plan on gender based violence.

The year ahead offers opportunities to:

DEVELOP A SHARED UNDERSTANDING - All staff and volunteers should have a good understanding of violence against women and girls: the impact on those affected; its causes, the scale of the problem and risk factors which increase vulnerability to abuse.

PREVENTION - Public education should challenge attitudes and behaviours that perpetuate gender inequality. We need to influence local policies and practice – in the workforce, the school, the health programme, the home and across our communities.

PROVISION - Local services should protect, empower and support women and children while holding perpetrators to account. This includes refuge services, support to women at high risk of harm, mental health and substance misuse, group work, learning and employability support, children's groups and individual support, court advocacy and welfare rights advice.

PARTICIPATION - People with lived experience of domestic abuse should be involved in service planning and review and peer support.

Self Management

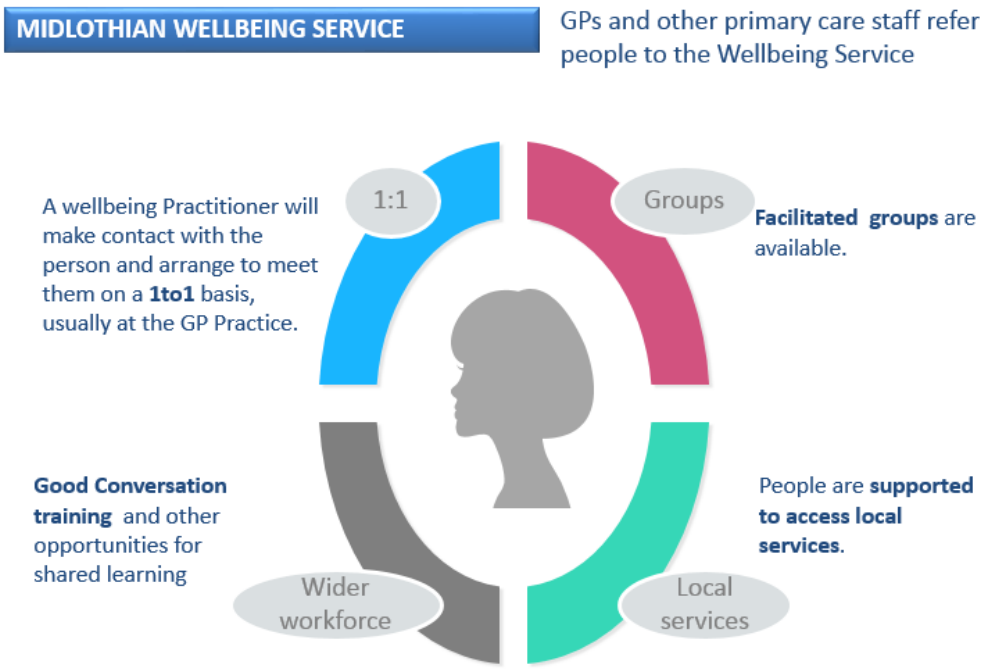
The **Wellbeing Service** supports self management. It is a pioneering collaboration in 8 GP Practices and is an important component of the primary care team, providing prompt and comprehensive support to people, often those who have complex health and social issues in their lives.

It provides person-centred care and support that treats people as equal partners, focuses on personal outcomes, supports a person's role in managing their health and wellbeing, and recognises the importance of prevention and anticipatory care.

People who have complex lives can find managing social, financial, health and other matters can weigh heavily upon them. Self management support, a vital element of person centred care, was hard to access for many. The service has strong evidence that it is making a notable difference to people who engage.

Wellbeing Practitioners provide time and space to have a 'good conversation' about what it important to people and how they can move forward with some of the challenging issues in their life, including health and social issues. The good conversation approach harnesses the role of the person: their strengths, social networks and community supports.

In 2018 - 19 we will commission the service to ensure that the supoprt of a Wellbeing Practitioner is available in all 12 GP Practices. This will be financed through a range of funding sources including the Government's commitment to establish link workers in GP Practices across Scotland.



Prevention - Why focus on prevention?

We are committed to improving health whilst also reducing health inequalities. We also face high demands on public services while public spending is being squeezed, so it is particularly important that services improve health and reduce people's need for costly health treatments. Investment in prevention can have a range of impacts that help meet these goals while managing these pressures.

Prevention can improve population health by:

- **Preventing health problems** - (primary prevention)
  e.g. supporting people to enjoy a healthy diet and to be physically active.
- **Stopping health problems from getting worse -** (secondary prevention)
  e.g. screening programmes such as breast, bowel and cervical screening.
- **Reducing the impact of disease** -(tertiary prevention).
  e.g. supporting people with long term lung disease to manage their condition, such as the COPD service.

Prevention can help to reduce health inequalities. For this to happen, prevention needs to be at least as effective in groups of the population with the worst health.

Prevention can help reduce public spending pressures by:

- **Reducing the length of time people spend in ill health** rather than just increasing life expectancy
- **Reducing demands** for public services
- **Freeing up resources** for other uses

Reducing health inequalities must remain central to service planning around prevention. We will increase the proportion of IJB budget spent on preventative work

PROGRESS IN 2017-18

- **Preventing health problems - (primary prevention)**
  - Flu Vaccination Programme encouraged children, pregnant women, people with long-term conditions, people over 65 and Health and Social Care staff to be vaccinated.

- **Stopping health problems from getting worse - (secondary prevention)**
  - Midlothian Bowel Screening Programme invited 148 men who have mental health or substance misuse problems or who were homeless to attend a 'Health Screening Check Up'. 45 attended (30.4%). 18% took a test and 1 had cancer diagnosed.
  - Weight Management Service supported people to reach a healthy weight and reduce the likelihood of problems such as heart disease and type 2 diabetes. A pathway was developed and referrals increased from 109 (2015/16) to 172 (2016/17). Multi-agency training on healthy eating and physical activity resources took place.

- **Reducing the impact on people's health and wellbeing - (tertiary prevention)**
  - Midlothian Active Choices + Ageing Well supported people with long term lung or heart disease to be active and to manage their condition

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Design and implement a comprehensive prevention strategy. This will be informed by a proposed regional approach to prevention.

- Support people to **stop smoking**, including pregnant women and local workforce.

- Develop a **multi-agency strategy to prevent people developing type 2 diabetes**

- Increase the number of people receiving **weight management support.**

- Increased focus on **health and homelessness**.

- **Increase family income** through healthy start vouchers and benefit reviews.

- Support a multi-agency **Physical Activity Strategy**.

- Continue to develop **health and wellbeing services** for people in homeless hostels, in mental health services and people who frequently attend A&E.

- Ensure that **welfare advice services** are accessible to people who need them.

Working with Communities

We need to develop stronger links with communities and the public. We need to communicate better about the challenges we face and how we are seeking to address them. We need to improve our ability to listen and act upon feedback about the services we provide. We must create a stronger sense of partnership with communities, unpaid carers and service users to help promote physical and mental wellbeing and healthier lifestyles. We have some good foundations to build upon.

Strong user groups such as:
- Forward Mid
- CAM (Carers Action Midlothian)
- MOPA (Midlothian Older People's Assembly)
- Neighbourhood Planning groups - linked with the Community Planning Partnership
- People First
- Access Panel
- People's Equality Group

Publications and online resources such as:
- The Health and Social Care Partnership's quarterly newsletter,
- Directories of Older People's services
- Disabled People's Directory
- Wee Breaks
- Autism in Midlothian
- Lothian Disability Sport
- Weekly Calendars listing all groups for older people
- Newsletters on topics such as winter and transport.
- Leaflets e.g. "Do I need to see a GP?"

Public meetings such as:
The Hot Topics Forum is a well-established way for the Partnership to seek involvement of the public on a range of issues facing the Partnership.

User and Carer representatives on groups such as:
- Planning groups for mental health, older people, carers, physical disability and learning disability
- The Integration Joint Board itself.

PROGRESS IN 2017-18

- Contributed to the work of agencies seeking to provide support to people living in less well-off areas -e.g. Woodburn, Mayfield, Gorebridge and Loanhead.
- Developed stronger partnerships with agencies in Penicuik to support people who are housebound (with support from the Collaborative Leadership Programme).
- Ran Public Engagement programmes to address the challenges facing Primary Care and the provision of care packages.

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Design and Implement a new Public Engagement Strategy.
- Through "**Collective Voice**" encourage participation of service users in supporting and advising other users to manage their condition.
- Work with established groups to develop **Hot Topics public consultation**.
- Deliver a **public engagement strategy** to support the Transformation Programme.
- Listen to and act on feedback and ideas from **unpaid carers and service users**.
- Develop a **clear identity for the IJB** including a distinct online presence.

Health Inequalities

Inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. People affected by poverty and social disadvantage have poorer health outcomes than their neighbours with more resources. Other people also experience disadvantage - e.g. low income, gender, social position, ethnic origin, geography, age and disability.

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

Early death due to **coronary heart disease**:	Hospital stay for a **preventable reason**:	Difference in **Life expectancy:**	Prescription for **anxiety/ depression**:	**Children living in poverty** .
X21 higher	15-20% more likely	7 years shorter	9% higher	25%

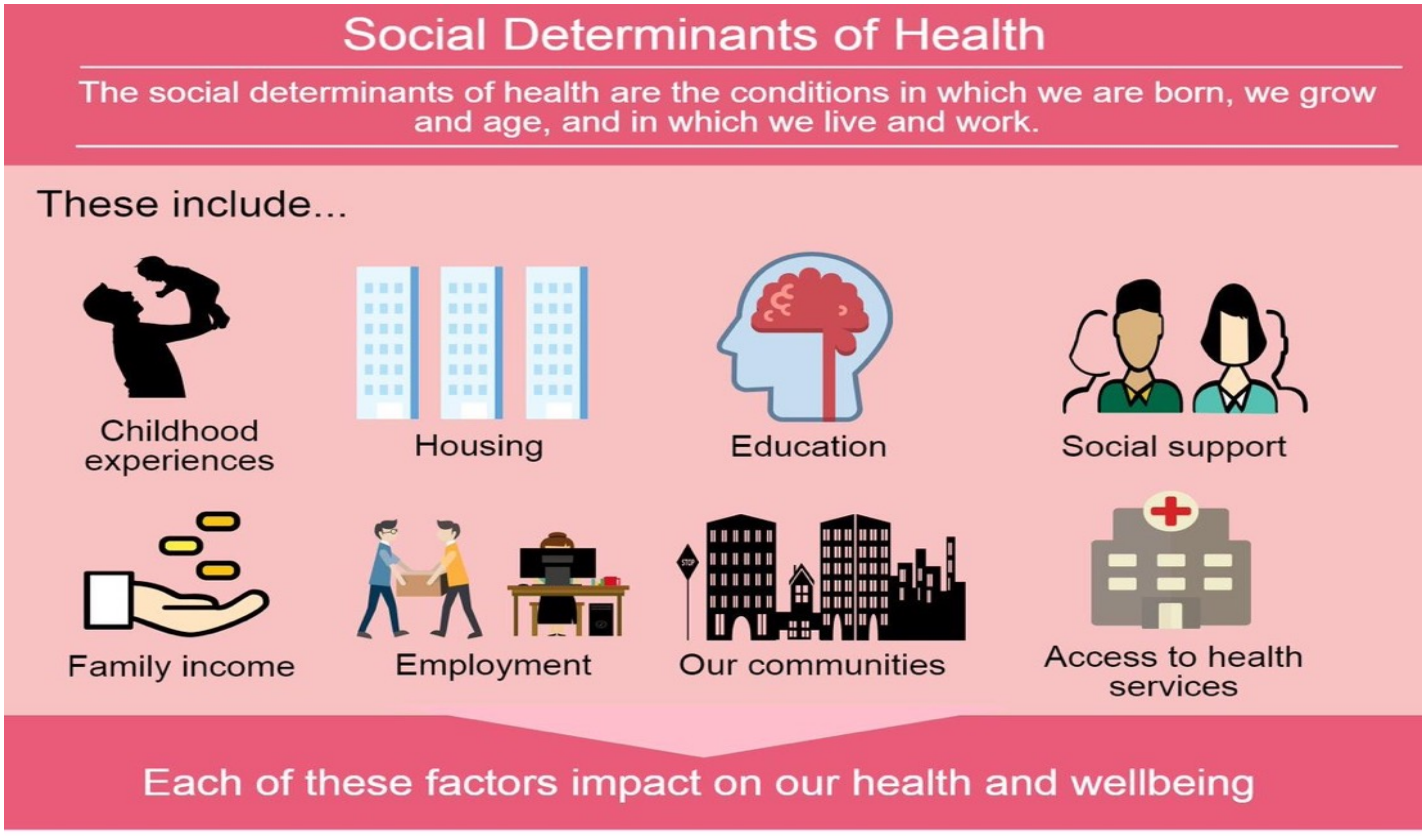


Image – Health Scotland

PROGRESS IN 2017-18

- The Community Health Inequalities Team provided **health assessments and support for vulnerable people** e.g. homeless, carers, substance misuse, women involved with criminal justice, gypsy travellers.
- The **Wellbeing Service** and the **Midlothian Access Point** supported people with mental health and social issues.
- Work began to reshape **Young People Mental Health** Services/pathway.
- **Spring Service** increased support to women linked to the criminal justice system.
- The Midlothian and East Lothian Alcohol and Drug Partnership (MELDAP) **challenged stigma** by promoting the role of the recovery community, employing and involving people with lived experience and providing peer volunteer training.
- C**arer organisations** increased links **with financial inclusion services.**
- Work with schools around **child poverty, school absence & smoking prevention.**
- Work began to identify support for **loss and bereavement**.
- The MARC building in Woodburn was refurbished to enable the **Grassy Riggs** drop-in café and carer support service to open to older people at risk from social isolation.
- New pathways were developed to identify **families at risk of eviction** earlier and a pathway for people attending A+E.

KEY ACTIONS FOR 2018-19

- **Income maximisation services** to be launched that will work with local families.
- Gain multiagency commitment to an **Obesity/Type 2 Diabetes Prevention Strategy.**
- Secure a future for **Wellbeing Service and Community Health Inequalities team**.
- Improve links to health services & support for **people leaving prison**.
- **Local area work** in Woodburn/Dalkeith, Mayfield/Easthouses and Gorebridge.
- Continue **Welfare Rights support** to people with cancer and/or mental health problems.

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 than national average occurrence of cancer, diabetes, depression, hypertension and asthma.

In this plan we have highlighted the conditions that affect a significant number of people, however there are a wide range of other long term conditions for which we will continue to provide support. For example we will contribute to the Lothian implementation of national programmes such as the new out-patient care pathways for people diagnosed with coeliac disease, irritable bowel syndrome and inflammatory bowel disease.

Many people have more than one condition – this is known as Multiple Morbidity

- 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 two or more conditions 10-15 years earlier than people living in affluent areas.
- There is increasing recognition of the greater vulnerability to mental health problems for those living with long term health conditions.

Hospital Stays

It is estimated that people with long-term conditions are twice as likely to be admitted to hospital, have a longer length of stay and account for 80% of all GP visits and for 60% of hospital admissions.

Choice and Control

There is a growing view that people living with long term conditions should be supported to be more involved in decision-making, more in control of their own care and more confident about managing the impact of their conditions on their lives.

The House of Care (section 1.2.2) is a way of describing what is needed to encourage the development of this approach. Using the image of a house helps us to appreciate how all the parts need to be in place, equally strong and joined up for this approach to be successful.

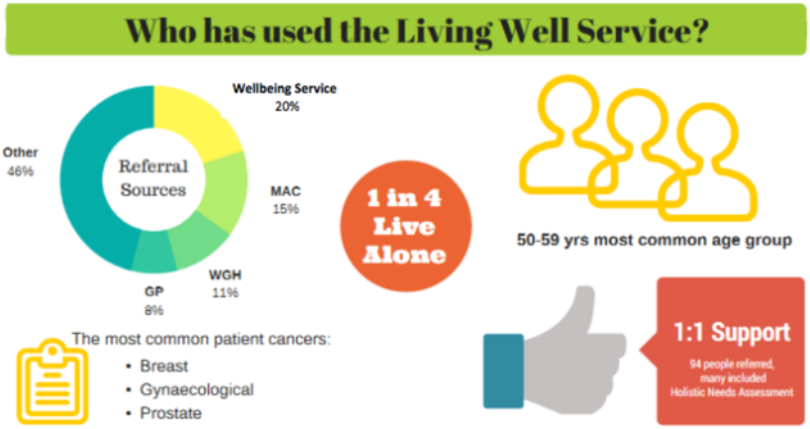
Long Term Conditions: Key Actions

Cancer	• The Wellbeing Service and The Macmillan programme "Improving Cancer Journey across Lothian" will support people.
COPD	• Review the service to improve how people access it and how it links to local services. • Strengthen referrals to the Fatigue Anxiety Breathlessness class at the Marie Curie Centre. • Strengthen close working with MERRIT team in referring for equipment, referral to Physio/ OT and Community Care Assistants. Strengthen close working with Hospital at Home team. • Liaise regularly with Community Respiratory Team in Edinburgh Royal Infirmary. • Smoking prevention work in local secondary schools.
Neurological Conditions	• Increase community based support through reprovision of in-patient and out-patient services at Astley Ainslie Hospital. • Improve our understanding of the experiences of and number of people living with a neurological condition to plan and improve hospital and community based services. • Improve housing options to support people to live in their own home for as long as possible and to look at extra-care housing. • Work to meet new standards set by Healthcare Improvement Scotland for neurological care and support.
Heart Disease	• Review community based support. • Improve our Stop Smoking rates. • Ensure the Physical Activity Strategy caters for people recovering from ill health. • Support the Midlothian Food Alliance to tackle food poverty
Diabetes & Obesity	• Develop strategies with Midlothian Community Planning Partnership and colleagues in Borders, Fife, East Lothian, West Lothian and Edinburgh • Work with GPs on healthy weight and referrals to the Weight Management Service. • People with lived experience will influence service planning and delivery. • Investigate a weight management programme for people with a learning disability.
Stroke	• Improve our understanding of people's experience and engage service users and carers to inform and improve service delivery. • Review and strengthen community based rehabilitation and intermediate care – especially the new Integrated Stroke Unit at the Royal Infirmary. • Strengthen (supported) self-management options including investigating telehealth.
Palliative Care	• Improve support to carers. • Strengthen Anticipatory Care Plans. • Compile a leaflet of support services. • Reduce the amount of time people spend in acute hospital when they are dying, with the supports of district nurses, Marie Curie nurses and the Community Hospital.

Cancer

Midlothian's Living Well after Treatment Project was launched in June 2016 and ran until November 2017. Its purpose was to ensure everyone affected by cancer had the opportunity to access practical, emotional and financial support.

In Midlothian there are approximately **2,200 people** living with the effects of cancer and this is projected to rise significantly as the number of older people increases. There are more than **500** new diagnosis of cancer each year.

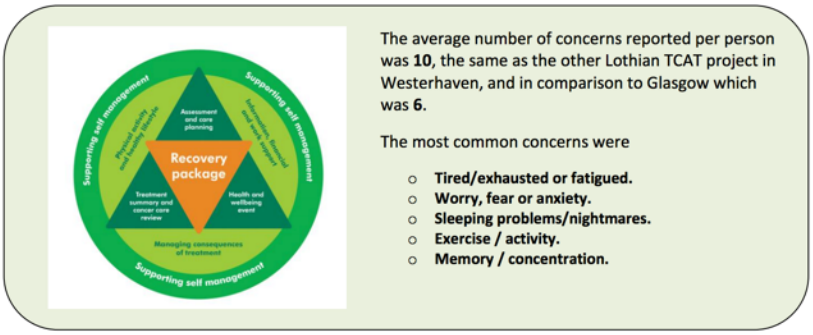


National guidance:

Beating Cancer: Ambition and Action (2016).

The National Health and Care Delivery Plan (2017-18)

Concerns responded to by the Living Well Service

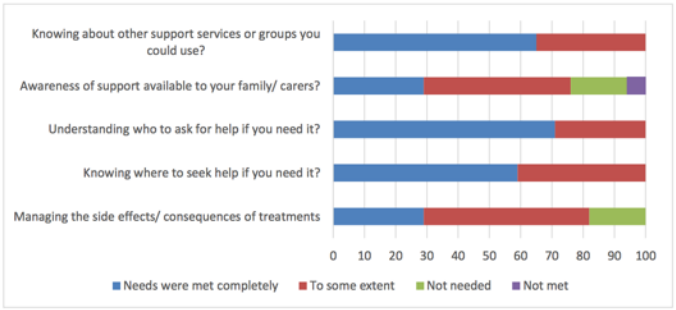


The average number of concerns reported per person was **10**, the same as the other Lothian TCAT project in Westerhaven, and in comparison to Glasgow which was **6**.

The most common concerns were

- **Tired/exhausted or fatigued.**
- **Worry, fear or anxiety.**
- **Sleeping problems/nightmares.**
- **Exercise / activity.**
- **Memory / concentration.**

What difference has the Midlothian Living Well after Treatment Project made?



New Challenges:

The national funding for the local Transforming Care after Treatment (TCAT) programme ended in November 2017.

PROGRESS IN 2017-18

- Established the local **Transforming Care After Treatment** project to test a new approach to service delivery based on holistic needs assessment.
- Continued to provide **specialist services** including Occupational Therapy, employment service (in the NHS Lothian's Work Support Services), complimentary therapy (provided by IRIS) and support with exercise (in council leisure centres).
- The specialist **Macmillan Welfare benefits service** generated an additional £1.6million for people with cancer in 2017-18. An evaluation of such services by Scottish Collaboration for Public Health Research and Policy concluded, "Few medical interventions can claim to have such a lasting and measurable impact on the lives of people."
- The local GP Cluster implemented the **Macmillan Quality Toolkit** to improve quality of care for cancer patients.

KEY ACTIONS FOR 2018-19

- Since November 2017 the **Wellbeing Service** has provided support to people living with cancer and will continue to do so in 2018/19.
- The Macmillan Programme "**Improving Cancer Journey across Lothian**" will support people in Lothian soon after diagnosis.

Chronic Obstructive Pulmonary Disease (COPD)

COPD is a term for long term, progressive lung disease that causes coughs and breathlessness and increased sputum. It affects breathing, causes weight loss and muscle loss and other co-morbidities. It can reduce quality of life, increase levels of dependency, result in a greater use of health and social care services and acute hospital admissions. It can also cause carers to experience stress and poorer health.

2000 people live with COPD

Up to 3% of the population

This is higher than the rest of Lothian

The most significant risk factor is smoking.

24.5% of people in Midlothian smoke.

This is higher than the rest of Scotland (22%)

There are a number of hospital admissions due to COPD

900 hospital admissions (2015/16)

17 days average stay

£7.7m cost of the stays

The number of people with COPD is expected to INCREASE.

This will affect older females in particular due to longer life expectancy.

This will cost £207m in Scotland by 2030.

COPD will be the 3rd most likely cause of admission to secondary care by 2020

PROGRESS IN 2017-18

- An **Advanced Practitioner Physiotherapist for COPD** was appointed to support people in the community to help them manage their COPD at home and avoid hospital admission. She works with patients who are attending hospital frequently because of their COPD. In the first year the service has worked with 65 patients.
- In the first seven months the service successfully avoided 30 hospital admissions (if the average stay is 17 days per stay this adds up to a potential reduction of 520 bed days).
- Strong links developed with the **Midlothian Stop Smoking Service** and the **Pulmonary Rehab (exercise) service** at Midlothian Community Hospital.
- ***Breathe Easy*** support group meets monthly and members participate in regular activities

KEY ACTIONS FOR 2018-19

- Work will progress to review the service. This will include work to improve how people access the service and how it links to other local services that could benefit people with COPD.
- Strengthen referrals to the **Fatigue Anxiety Breathlessness class** at the Marie Curie Centre. Good for patients with severe disease and high level of symptoms day to day.
- Strengthen close working with **Midlothian Enhanced Rapid Response Team** (MERRIT) in referring for equipment, referral to Physio/ OT and Community Care Assistants. Strengthen close working with **Hospital at Home team** in patients with COPD including shared care.
- Liaise regularly with **Edinburgh Community Respiratory Team** in Edinburgh Royal Infirmary with case discussions regularly with Respiratory Consultants and Respiratory Specialist nurses.
- **Smoking prevention** work in local secondary schools – during 2018-19 this will involve Penicuik, Newbattle, Lasswade Secondary Schools.

Neurological Conditions

Neurological conditions include epilepsy, seizures, chronic headache and migraine, Parkinson's disease, multiple sclerosis, acquired brain injury, Huntington's disease, dystonia, functional neurological symptoms, cerebral palsy, motor neurone disease and muscular dystrophy.

Common neurological symptoms include dizziness, seizures, paralysis, headache and sensory symptoms. Neurological problems can be acquired as a result of injury (primarily brain injury) from trauma or surgical intervention.

Neurological conditions are the most common cause of serious disability in Scotland and have a major impact on Health & Social Care services.

There are a number of specialist organisations that provide advice and support. One example is the Scottish Huntington's Lothian Service which improves the quality of lives of those affected by Huntington's Disease (HD) and their families through timely specialist assessment, condition management, information, advice, advocacy and emotional support. It also provides practical help with adaptations, equipment, support to access benefits and services. It supports multi-disciplinary teams in the Health and Social Care Partnership with information, educational sessions, and case management support.

New Service Challenges

There are an estimated **ONE MILLION people** in Scotland living with a neurological condition that has a significant impact on their lives.

MULTIPLE SCLEROSIS (MS), has a particularly high prevalence in Scotland.

National guidelines:

The Neurological Care Improvement Plan (2014-17) aims to improve care and outcomes or people with a neurological condition.

PROGRESS IN 2017-18

- 12 people living with Multiple Sclerosis attend a **monthly support group**, facilitated by an Occupational Therapist.
- Health & Social Care staff continue to support people living with a neurological condition. This includes the **Midlothian Community Rehabilitation Team**.
- The **Lanfine Service** continues to provide an acute neurological specific inpatient service at Astley Ainslie Hospital plus individual community based support.
- Organisations with a focus on specific conditions such as Parkinson's Disease, Multiple Sclerosis and Epilepsy provide **specialist advice and support** to people living with the condition and their family.

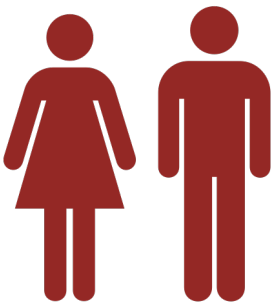
KEY ACTIONS FOR 2018-19

- Increase community based support through **reprovision of in-patient and out-patient services at Astley Ainslie Hospital**.
- Work with partners **to improve our understanding of the experiences of and number of people living with a neurological condition**. This will help us to plan and improve hospital and community based services. The Physical Disability Planning Group will continue to influence and support this work.
- Work with partners to **improve housing options** to support people to live in their own home for as long as possible and to look at extra-care housing options.
- Work to **meet new standards** set by Healthcare Improvement Scotland (HIS) for neurological care and support, published by early 2019.

Heart disease

There has been a downward trend in deaths from coronary heart disease in Scotland, and Midlothian, over the last 10 years, in particular for those less than 75 years old. Nationally chances of surviving for 30 days after being admitted to hospital as an emergency after your first heart attack has increased from 86% to nearly 93%.

However, the decline has not been at the pace of decline in neighbouring northern European countries. Coronary heart disease will remain a major public health problem in Scotland for several decades. It is still a leading cause of death and is a national clinical priority for Scotland.



Coronary heart disease is higher in males than females.

Scotland has a high prevalence of the risk factors associated with heart disease such as smoking and physical inactivity

1400
people were admitted to hospital because of heart disease. (2016/17)

350
people had experienced a heart attack

240
people had heart failure

National guidance:
Heart Disease Improvement Plan (2014).

Service Challenges

People who are more deprived in Midlothian are more likely to be admitted to hospital (up to 23 times more likely in some instances)

PROGRESS IN 2017-18

- People were supported to keep healthy and reduce their risk of developing coronary heart disease. **Ageing Well, Midlothian Active Choices** and other programmes are important to this work as are mainstream services such as **Midlothian Leisure**, positive health advice from primary care colleagues, weight management support and do on.

- People who have experienced a heart attack or who have undergone cardiac surgery are visited at home by a **Cardiac Rehabilitation Nurse** in Midlothian and, when they are able, they are supported to attend a **Cardiac Rehab programme** delivered at Gracemount Leisure Centre.

- People with co-morbidities may require more intensive support and monitoring. The Midlothian Cardiac Rehabilitation Nurse will visit them at home and may refer them to a service at Astley Ainslie Hospital. This clinic include psychological support, physical activity and different speakers. Strong links with Stop Smoking and welfare rights services exist.

KEY ACTIONS FOR 2018-19

- Review our **community based support** for people with coronary heart disease in collaboration with the acute hospitals.

- **Improve our Stop Smoking** rates.

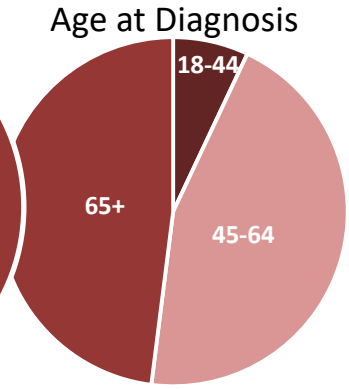
- Ensure that the **Physical Activity Strategy and other strategic developments** cater for the needs of people recovering from a period of ill health

- Support the **Midlothian Food Alliance** in its work to tackle food poverty

Diabetes & Obesity

Diabetes (Type 2) impacts on daily living and can result in serious health complications such as kidney disease, vascular problems and vision loss. The causal factors include personal lifestyle, access to healthy diet and exercise, mental health and deprivation. Prevention, and the avoidance of complications, would be extremely cost-effective.

1451 people were diagnosed with diabetes (2013-2018)



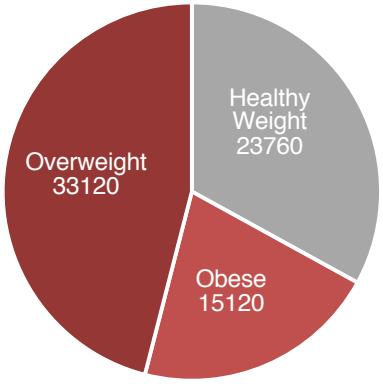
56 people were diagnosed with pre-diabetes (2017)

Obesity is the main modifiable risk factor. 80% of adults with Type 2 Diabetes are overweight and Obese adults are x5 more likely to be diagnosed with diabetes than adults of a healthy weight.

Scotland has one of the **highest levels of obesity in the world**

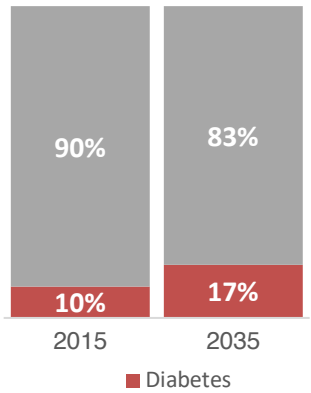
(only Mexico and the USA have higher rates in OECD countries)

Number of overweight adults
(Midlothian - based on Scottish rates)



Unless we tackle obesity and Type 2 Diabetes the proportion of the NHS budget spent on Diabetes will **rise to 17%**

% of NHS spend
(Scotland)



Deprivation is linked to obesity and type 2 diabetes. Type 2 diabetes is 40% more common among people in the most deprived areas compared with those in the least deprived. People from black, Asian and other minority ethnic groups are at an equivalent risk of type 2 diabetes at lower BMI levels than white European populations.

Some issues of obesity are related to poverty, e.g. the cost of healthy food, leisure activities and low level mental health issues. There may also be issues around support in rural communities. A reshaped system for obesity and diabetes will involve services that mitigate the impact of inequality.

PROGRESS IN 2017-18

- **Made a commitment to tackle obesity and type 2 diabetes**.

- Work progressed to **reshape the weight management pathway**. Referrals are now triaged by the Weight Management Team who offer community based services such as Midlothian Active Choices, Ageing Well, Leisure Services, Community Health Inequalities Team (CHIT) or dietetic–led weight management group programmes delivered with Midlothian Leisure Services or individual assessment and treatment involving dietetic, psychology and physical activity support.

- Delivered a **6 week programme for people identified as having pre-diabetes** to support lifestyle changes to avoid or delay developing type 2 diabetes. This was delivered by the Community Health Inequalities Team nurses.

- During 16/17 172 people were referred (up 58% on previous year) to the NHS Lothian **Weight Management Service** and 71 (41%) engaged. Between April and September 2017 159 people were referred to the Weight Management Service. They were offered community based programmes (with Midlothian Leisure services) or specialist support involving NHS Lothian dietetic, psychology and physical activity programmes.

- Launched a **women only exercise class** with Midlothian Muslim Community Centre and Midlothian Leisure.

- £50,000 was made available in June 2017 for **healthy eating/food poverty programmes** across three target areas. Grants (up to £3,000) were awarded.

- **Training on healthy eating, physical activity and Type 2 diabetes** was delivered to Midlothian staff from a range of agencies.

KEY ACTIONS FOR 2018-19

- **Develop a strategy** with Midlothian Community Planning Partnership.

- Work with GP practices on raising discussions around a healthy weight and increasing referrals to the **Weight Management Service**.

- Work with colleagues in Borders, Fife, East Lothian, West Lothian and Edinburgh to **develop a regional strategy** to Diabetes (Type 2) prevention.

- **People with lived experience** will influence service planning and delivery.

- Investigate a **weight management programme for people with a learning disability**.

Stroke

A stroke is a serious and life-threatening condition. It occurs when the blood supply to part of the brain is compromised, often by a blood clot blocking an artery or a damaged blood vessel that ruptures, resulting in a bleed. The effects of a stroke may alter someone's ability to move, feel, think, communicate and function. There are hospital and community based stroke services that can support people to make the best possible recovery.

The risk of a stroke can be reduced through a healthy lifestyle:

- eating a healthy diet
- taking regular exercise
- drinking alcohol in moderation
- not smoking

Certain conditions increase the risk of having a stroke, including:

- high blood pressure
- high cholesterol
- irregular heart beat
- diabetes

People with these conditions are advised and supported to manage them – e.g. by lowering high blood pressure or cholesterol levels.

110 people
a year return home from hospital after a stroke

They are supported by specialist nurses and local rehabilitation services

Scottish Stroke Care Audit (2017) NHS Lothian achieved the acute inpatient stroke bundle standards in 66.6% of cases. (National range 42.9-81.1%)

New Service Challenges

The creation of the Royal Infirmary Integrated Stroke Unit, whilst creating a more specialist and coherent hospital service, resulted in shorter lengths of stay that places more responsibility of community services to provide follow-up rehabilitation.

National guidance :
Scottish Stroke Improvement Plan (2014).

PROGRESS IN 2017-18

- Services supported people to **reduce their risk factors** - e.g. Weight Management, Stop Smoking, Ageing Well and Midlothian Active Choices. Midlothian Leisure Services provided exercise groups for people recovering from a stroke.

- **Supported self management, reablement and rehabilitation** was provided by mainstream services -e.g. Midlothian Community Physical Rehabilitation Team (MCPRT), MERRIT and Community Care Team. Supported self-management and health improvement support was provided from the Wellbeing Service in GP practices using the 1:1 'good conversation' approach, group work and peer support.

- People were supported to **return to employment** through the vocational rehabilitation programme delivered by MCPRT or by the Working Health Services team at Astley Ainslie Hospital.

- Midlothian Chest, Heart & Stroke lead a **Chest and Stroke Group** in Bonnyrigg and Penicuik. British Red Cross support by arranging transport from volunteers.

KEY ACTIONS FOR 2018-19

- **Improve our understanding of people's experience** of stroke.

- **Engage service users and carers** to inform and improve service delivery.

- **Review and potentially strengthen community based rehabilitation and intermediate care** – especially in relation to the new Integrated Stroke Unit at the Royal Infirmary which is resulting in earlier discharge of people back to their local community.

- Continue to **strengthen (supported) self management** options.

- **Investigate telehealth** options for treatment and rehabilitation following a stroke.

Palliative Care

Palliative care aims to improve the quality of life of patients and their families facing the problems associated with any life limiting illness, through the prevention and relief of suffering by means of early identification and careful assessment and treatment of pain and other problems, physical, psychosocial or spiritual.

Death happens. We can all help each other with death, dying and bereavement. **Good Life, Good Death, Good Grief** is working to make Scotland a place where there is more openness about death, dying and bereavement so that:

- People are aware of ways to live with death, dying and bereavement
- People feel better equipped to support each other through the difficult times that can come with death, dying and bereavement

It brings together individuals and organisations that share this vision. It is never too early to think about planning ahead for illness and death – making plans when you're healthy means there is less to think about if you get sick.

National guidance:

A Strategic Framework for Action on Palliative and End of Life Care (2016-21)

Service Challenge:

The national Health and Social Care Delivery Plan (2016) includes a requirement to double the end of life provision in the community by 2021 and reduce the numbers of people dying in hospital.

PROGRESS IN 2017-18

- The local Palliative Care planning group continued to **review and improve the approach** to palliative care - and is viewed as a model of good practice across Lothians.
- Staff skills have been strengthened through **video conferencing training programme** and a shared learning programme enabling people to learn from one another across services.
- In Newbyres Care Home **feedback from bereaved families** is sought through questionnaires. A family bereavement group has also been established.
- The Wellbeing Service ran "**New Beginnings**" workshops to help people after bereavement.
- **A series of events were held to raise awareness about dying** including To Absent Friends; Dying Matters; and a Hot Topics workshop. Midlothian Community Hospital, held an open day.

KEY ACTIONS FOR 2018-19

- The local Palliative Care planning group will consider how to **improve support to carers** of people receiving palliative care, in line with the national report Carers-Under Pressure.
- **Strengthen the approach to completing Anticipatory Care Plans**.
- **Compile a leaflet of support services** (e.g. Cruise and Faith organisations) to ensure support is available when needed.
- Extend the use of **feedback questionnaires to other settings** following their use in Newbyres.
- **Reduce the amount of time people spend in acute hospital** when they are dying, with the supports of district nurses, Marie Curie nurses and the Community Hospital.

Service User Groups: Key Actions

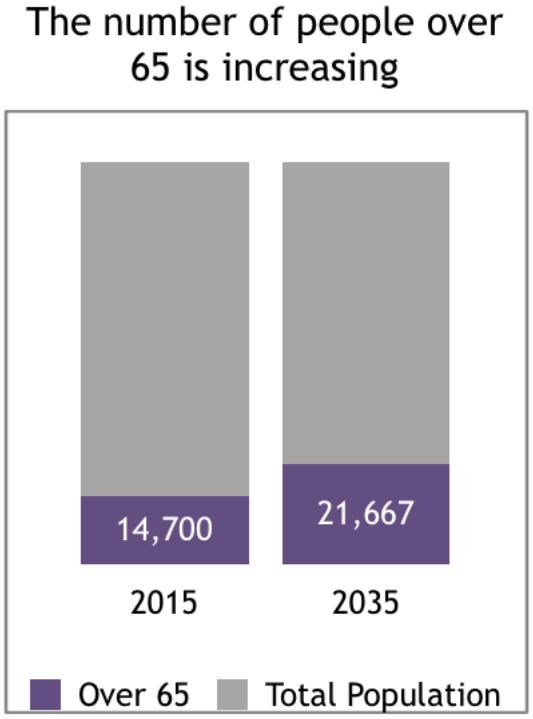
Older People	• **REALISTIC CARE REALISTIC MEDICINE PROGRAMME** • Develop a Care Home Strategy looking at - Extra Care Housing - Plans will be developed for this in Dalkeith. - Strengthening Support Systems - Reviewing Decision Making re Admissions • Implement New Approaches to Delivery of Care at Home - Reablement - Complex Care - New Philosophy - Supplement Family/Community Supports • Build 12 specialist houses in Gorebridge - due to be completed by summer 2019. • Develop plans to replace Highbank intermediate care service with purpose built facilities. • The project led by GPs to identify people who have the condition of "frailty" will get underway which will support early identification and intervention. In partnership with Red Cross and GPs people living with mild frailty will be offered community based support.
Mental Health	• **REALISTIC CARE REALISTIC MEDICINE** • Expand Community Based Services - Expand group work and alternatives for self-help such as bibliotherapy and guided self-help. • Revise service to assist people into employment. • Day services will be more recovery focused and community based. Areas of multiple deprivation will be targeted. • Build on the triage service with Police Scotland to improve working relationships between all agencies. • Develop mechanisms for working together on issues that require a pan-Lothian response e.g. the re-provision of the Royal Edinburgh Hospital. • Develop plans for the Recovery Hub in Dalkeith. People attending the Hub will have access to Peer Support alongside services from NHS, social work and voluntary sector organisations. • Work with GPs to support people with presenting in Primary Care.
Physical Disability	• Promote and expand peer support group, Café Connect, to younger adults. • Map the unmet need for respite for under 65s and explore utilisation of Midlothian Council property for this purpose. • Develop and improve accessibility of the Adult Learning Programme. • Engage effectively with disabled people, their families and carers. • Launch the Disabled People's Assembly. • Create a Taxi directory.
Sensory Impairment	• Expand the number of sensory champions. • Implement the British Sign Language legislation. • Continue to work with the Fire Service. • Hearing Aid Maintenance and Repair Clinics will be established in Libraries, using volunteers but with Audiology support. Develop and promote this at the Community Hospital and expand the available services to include e.g. balance clinics.

Learning Disability	• **REALISTIC CARE, REALISTIC MEDICINE** • Reshape Day Services - ensure people receive services which they are interested in and are appropriate to their needs, in particular for young people leaving school. • Reshape Housing - Provide more shared accommodation. Pursue plans to transform Primrose Lodge in Loanhead into a facility providing residential and respite care. • Reshape Care Packages - Continue the programme of reviews of care packages and explore how technology can enable people to live safely and more independently. • Build on the introduction of the new 12 person service in Penicuik by improving the behavioural support services to people in their own homes.
Criminal Justice	• **REALISTIC CARE REALISTIC MEDICINE** Strengthen Prevention and Recovery in Criminal Justice • Work in partnership with services in mental health and substance misuse through being collocated in the new Recovery Hub in Dalkeith. • Equip our staff to respond to people who suffered trauma using the "Survive and Thrive" approach. • Increase our capacity to prevent offending by providing more peer support and help to address substance misuse. • Arrest Referral, a service designed to work with people from the point of arrest, will be reintroduced in combination with a support service for people subject to electronic monitoring (usually on release from prison).
Substance Misuse	• Develop integrated Recovery Hub involving staff from substance misuse services, mental health services, criminal justice social work staff and third sector partners. • Address areas for improvement noted in the Care Inspectorate report. • Produce a new Statement of Licensing Policy and oversee its implementation. • Collect information relating to alcohol use e.g. the numbers of babies born with Foetal Alcohol Spectrum Disorders (FASD) and alcohol related hospital admissions. • Strengthen Peer Support in the context of more assertive approaches to engaging with harder to reach clients and those who drop out of services.
Autism	• Review and refresh 'Two Trumpets' and the work of the Expert Panels. • Develop a Midlothian Specific Menu of Interventions. • Establish a Midlothian Community of Practice for Positive Behavioural Support. • We will build upon the Safe House model to avoid admission to hospital other than for assessment or treatment. • We will map Midlothian Training against Optimising Outcomes, the NES Autism Training Framework.

Older People

The majority of older people live without any formal support. Many make a very significant contribution as volunteers, helping local organisations, participating in local government, providing unpaid care or being supportive grandparents.

However old age does not come alone. There is a greater likelihood of developing long term health conditions. People over 85 are at a greater risk of living with dementia. There may be **2,800** people with dementia in 20 years.



Up to 4,200

people are living with frailty, a state related to ageing resulting in multiple body systems gradually losing their inbuilt reserves

Service Challenges

The continuing challenge of recruiting and retaining a care at home workforce is reflected elsewhere in Scotland and is requiring a new approach to a career path in social care.

National guidance:
Reshaping care for Older People (2011)

Local guidance:
Joint Strategy for Older People

PROGRESS IN 2017-18

- Started to **develop new ways of supporting people who are housebound** in the Penicuik area involving a wide range of agencies including pharmacists and voluntary organisations.
- **Reshaped Newbyres Care Home** to provide 24 specialist places for people with dementia.
- The MARC building in Woodburn was refurbished to enable the **Grassy Riggs** drop-in café and carer support service to open to older people at risk from social isolation and loneliness
- Day services, community based services and care at home staff worked with **pharmacists and GPs to strengthen the provision of medication.**

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Develop a Care Home Strategy looking at
  - Extra Care Housing - develop plans for extra care housing in Dalkeith.
  - Strengthening Support Systems
  - Reviewing Decision Making re Admissions
- Implement New Approaches to Delivery of Care at Home
  - Reablement
  - Complex Care
  - New Philosophy - Supplement Family/Community Supports
- **Build 12 specialist houses** in Gorebridge - due to be completed by Summer 2019.
- **Develop plans to replace Highbank intermediate care service** with purpose built facilities.
- The project led by GPs to **identify people who have the condition of "frailty"** will get underway which will suport early identification and intervention. In partnership with Red Cross and GPs people living with mild frailty will be offered community based support.

Mental Health

15%

of adults reported symptoms of a mental health condition (Scotland) (2012 – 2015)

National Guidance:

Mental Health Strategy (2017 – 2027)

The Suicide Prevention Action Plan (2018)

Local Guidance:

Mental Health Action Plan

The Scottish Govt. have committed to a further 800 mental health workers in Scotland. We will need to determine how best to use these additional resources.

45%

of all illness is related to mental health

New Service Challenges

A high incidence of mental health issues are addressed through Primary Care.

Alongside the heavy reliance on medication, the success of new services confirms the priority that must be given to improving 'Good Mental Health for All'.

Lengthy waiting lists for Psychological Therapies exist. We must develop alternative approaches to minimise the time people in distress wait to receive support.

Poor mental health disproportionately affects those more deprived.

On average 18% of people are on medication for anxiety or depression but in some areas this is as high as

25%

PROGRESS IN 2017-18

- The **Access Point** became fully established. Funding was identified for its continuation in 2018-19.
- Established a triage service to support people in crisis when they come into contact with the **police service**.
- **The number of people waiting for a long period for psychological services has reduced**.

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Expand Community Based Services - Expand group work and offer alternatives for self help such as bibliotherapy and guided self-help reducing referrals to clinical psychology.
- Revise our approach to offering a service to **assist people into employment**.
- **Day services will be more recovery focused and more community based** - therefore more easily accessible. Areas of multiple deprivation will be targeted.
- Build on the triage service developed with **Police Scotland** to improve working relationships between all agencies supporting people in a mental health crisis.
- Develop mechanisms for working together on issues that require a **pan-Lothian response** including the re-provision of the Royal Edinburgh Hospital.
- Develop plans for the operation of the new **Recovery Hub in Dalkeith**. People attending the Hub will have access to Peer Support alongside services from NHS, social work and voluntary sector organisations.
- Work with the GP Cluster to determine how to support people with mental health issues **presenting in Primary Care.**

Physical Disability

The Equality Act (2010) defines disability as a physical or mental impairment that has a 'substantial and long-term adverse effect on people's ability to carry out day to day activities'

Planning services is undertaken in partnership with the service user group Forward Mid. They take a lead role on publications including newsletters and directories.

4,800

people between 16-64 have a significant physical impairment

This includes people born with impairment and those who have been disabled through injury or illness

New Service Challenges

Planning for the implications of the implementation of Free Personal Care for the under 65s

Mitigating the ongoing changes to the Welfare Benefits System which have had a disproportionate impact on the disabled community.

National guidance:
A Fairer Scotland for Disabled People (2016).

Local guidance:
Physical Disability Planning Group Action Plan

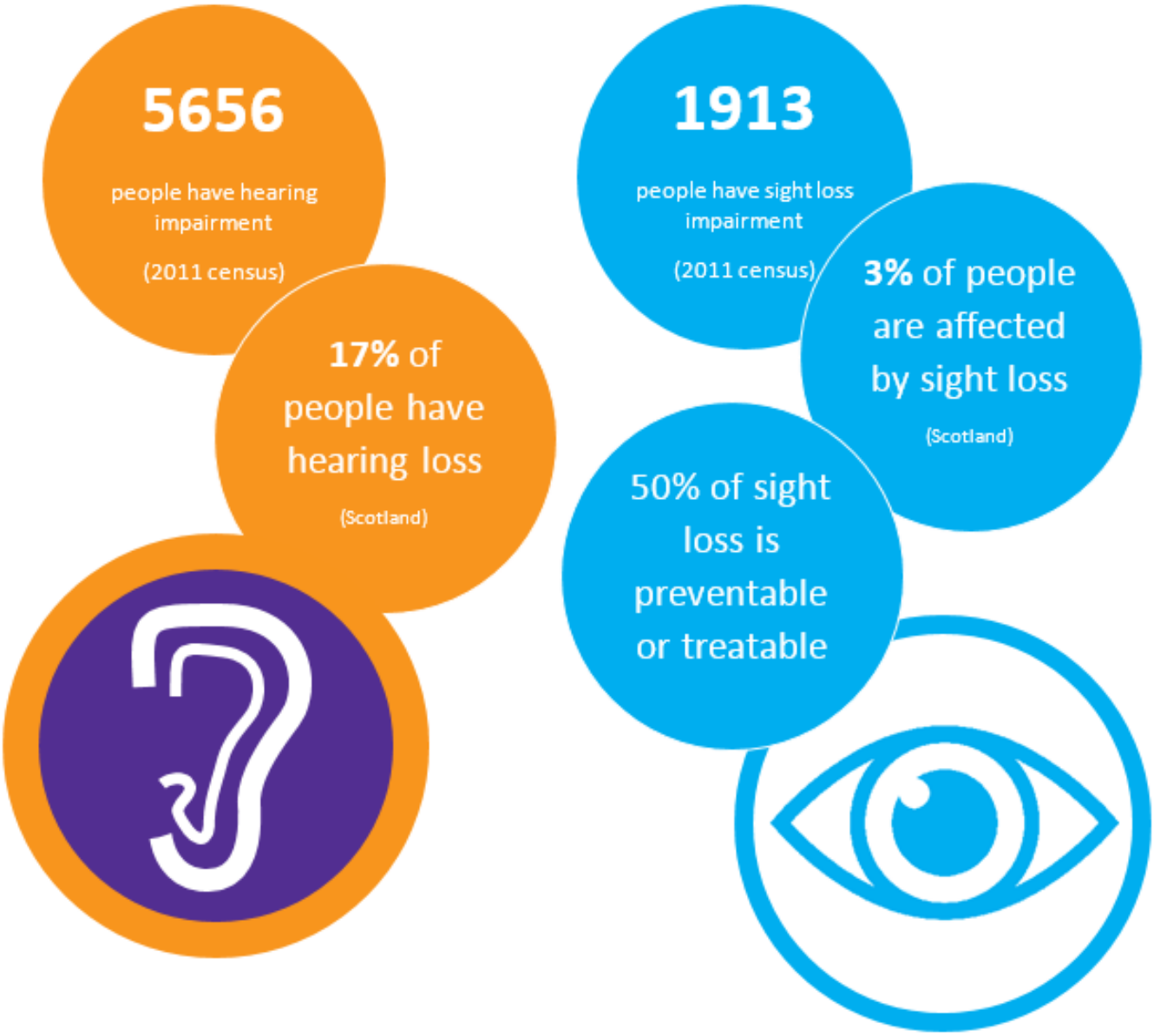
PROGRESS IN 2017 -18

- New initiatives with **Edinburgh College and Life Long Learning and Employability** improved access to further education and employment.
- **Information was provided** through newsletters, an updated directory of services and an easy read version of the local strategy.
- **A new policy was developed** regarding adaptations to houses and a new approach to suitable housing was introduced described in the booklet "Support to Move".
- **The Wellbeing Service** provided support to people with long term health conditions in 8 Health Centres.
- **A new approach to multidisciplinary working was tested in Penicuik** to support people who are housebound.

KEY ACTIONS FOR 2018-19

- Promote and expand peer support group, **Café Connect**, to younger adults with disability.
- Map the unmet need for **respite provision for under 65s** with physical disability and explore potential utilisation of Midlothian Council property for this purpose.
- Develop and improve accessibility of the **Adult Learning Programme** to ensure equal access for disabled people.
- Continue to make use of communication methods to **engage effectively** with disabled people, their families and carers, encouraging increased participation.
- Create and launch **Midlothian Disabled People's Assembly**.
- Create a **Midlothian Taxi directory** to provide information for disabled people, on suitability for their individual needs, of each taxi operating in Midlothian.

Sensory Impairment



National Guidance:

See Hear (2014).

British Sign Language Bill

Local guidance:

Midlothian See Hear Action Plan

New Service Challenges

See Hear funding reduced resulting in reduction in dedicated staff hours available to take this work forward.

The BSL Bill means a Local Plan requires development. This requires resources in staff time and implementation costs

PROGRESS IN 2017 -18

- An **awareness raising programme** was delivered to staff including care at home and care home workers, reception staff in Health Centres, Contact Centre staff and staff in voluntary organisations
- Joint work with the **local fire service** has resulted in sensory impairment as a factor in home safety visits
- **Hearing aid batteries** are now available in libraries including the mobile library and a repair service is being organised in libraries through volunteers
- **Deaf Action and Royal National Institute for the Blind (RNIB)** now provide more localised and integrated services being based one half day a week with the local social work team
- The Scottish Government service **contactSCOTLAND,** was promoted through our training and press releases. This service provides a live link to an on line BSL interpreter and facilitates communication with Public Bodies

KEY ACTIONS FOR 2018-19

- **Expand the number of local sensory champions** through further training provided by Scottish Government
- Implement the new **British Sign Language legislation**
- Continue to work with the **Scottish Fire Service** to ensure sensory impairment is given the appropriate consideration and that referral pathways are effective and straight forward
- **Hearing Aid Maintenance and Repair Clinics** will be established in Libraries, using volunteers but with Audiology support. Develop and promote this at the Community Hospital as well as expanding the available services to include eg balance clinics.

Learning Disability

The national strategy THE SAME AS YOU? Published in 2000, presented the vision that people with learning disabilities have the right to live longer, healthier lives, be able to participate fully in society and be treated fairly and equally. This vision still remains appropriate today.

National guidance:
Keys to Life (2013)

Local guidance:
Learning Disability Modernisation and Redesign Programme (2018)

Service Challenges

The number of people with a learning disability in Midlothian is growing each year.

Over recent years expenditure in learning disability has increased by over £2m per year. The current approach is not financially sustainable. We are developing new approaches that ensure people's needs are met through more cost-effective service design

PROGRESS IN 2017 -18

- New **purpose built accommodation** for 12 people with complex needs opened in Penicuik. This enables more people to remain in Midlothian whilst ensuring their specialist needs can be met.

- Accommodation for the remaining patients who have lived in long term hospital beds has now been arranged meaning that **no one with learning disability from Midlothian lives in hospital.**

- The **NHS Lothian Learning Disability Service** is now under local management arrangements increasing our capacity to work in a more integrated way with other local services.

- A **major programme of reviews** has been undertaken to ensure that people's needs are being met appropriately. These reviews have been guided by new policies designed to ensure that services are allocated an equitable and consistent way including policies on allocation of care, transport and day services

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE, REALISTIC MEDICINE PROGRAMME**
- **Reshape Day Services** - Following a major review of services during 2017-18 we will begin to implement new approaches to day services. These are designed to ensure that people receive services which they are interested in and are appropriate to their needs. We are particularly concerned to make sure that there are local services for young people leaving school who do not wish to go to more traditional day centres.

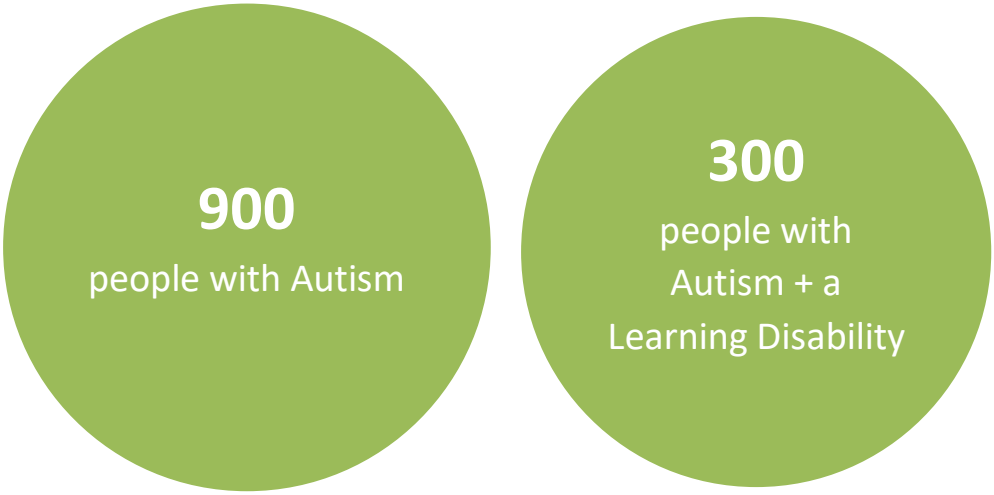
- **Reshape Housing** - Continue to work with the Council to provide more shared accommodation. We will also pursue plans to transform Primrose Lodge in Loanhead into a facility providing both residential and respite care.

- **Reshape Care Packages** - Continue the programme of reviews of care packages and explore how technology can enable people to live safely and more independently.

- Build on the introduction of the new 12 person service in Penicuik by **improving the behavioural support services** to people in their own homes.

Autism

The notion that people with autism should have agency in their own lives and that services should be more flexible and imaginative when working with autistic people and their parents and carers – and the enormous impact this makes when done successfully – was a theme that was common to all the autistic people and the families we met.



National guidance:
The Scottish Strategy for Autism Outcomes and Priorities 2018-2021

Local guidance:
Two Trumpets – Midlothian's Autism Strategy

Service Challenges

The main challenge now for the Autism Strategy Group is to continue the direct involvement of people with Autism and their families, using their experience to shape our actions. The website is being further developed to become more conversational and we are commissioning articles involving people with lived experience. These will lead to practical collaborative actions and sharing of experiences.

PROGRESS IN 2017 -18

- The **Midlothian Autism Strategy** 'Two Trumpets' was launched.
- An **awareness raising campaign** including 'The Triad of Impairments and Other Works' by artists Gayle Nelson and Fiona McDonald was exhibited to launch the strategy publicly and engage partners in the Autism Strategy.
- ***autismideasinmidlothian.com*** was developed and launched. This incorporates a calendar feature on events and activities for Autistic People.
- The **Midlothian Autism Facebook page** was launched.
- An **Interactive Directory of Supports of Midlothian** resources was completed.
- **Fit, Fab, and Fun a group for women** with a learning disability and/or autism in Midlothian was established.
- Teviot Court, a development of **12 local authority houses for people with Complex Needs** was completed.
- **Expert Panels** were established to develop elements of the strategy related to training, social opportunities, employment and communication.

KEY ACTIONS FOR 2018-19

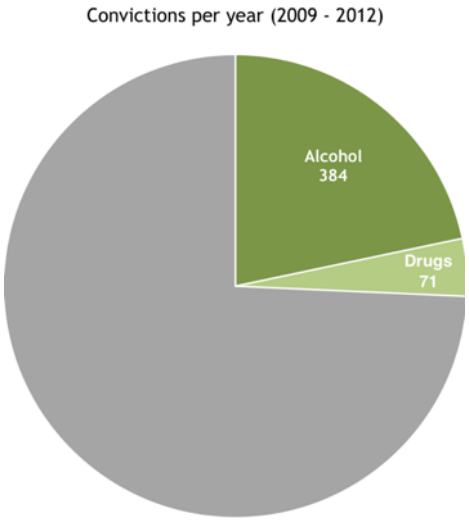
- We will **review and refresh 'Two Trumpets'** and the work of the Expert Panels.
- We will develop a **Midlothian Specific Menu of Interventions.**
- We will establish a **Midlothian Community of Practice for Positive Behavioural Support.**
- We will build upon the **Safe House model** to avoid admission to hospital other than for assessment or treatment.
- We will **map Midlothian Training against Optimising Outcomes, the NES Autism Training Framework**.

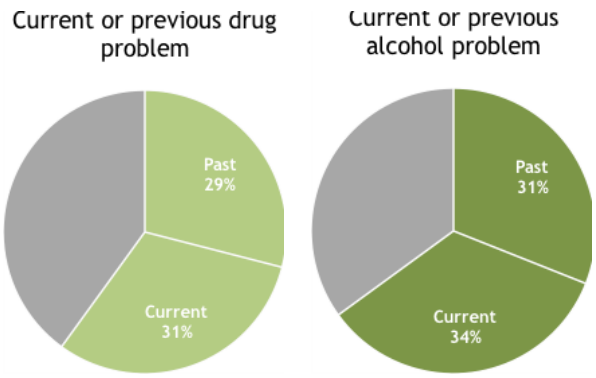
Criminal Justice

People who offend, or are at risk of doing so, are much more likely to experience multiple and complex health issues.

The Commission on Women Offenders Report 2012 highlighted that many women in the criminal justice system are frequent re-offenders with complex needs that relate to their social circumstances, a history of abuse, mental health and addiction problems.

Evidence links substance misuse and offending:





Criminal Justice Social Work Risk Assessment (2012-2013)

National Guidance:
The Community Justice (Scotland) Act (2016)

Local guidance:
Midlothian Community Safety and Justice Strategy

New Service Challenges
The Midlothian Community Safety and Justice Partnership will raise the profile and increase the demands on services to meet the health and social care needs of offenders.

It is important that all agencies, which can have an impact on the issues related to reoffending, are aware of the role they can play and willing to work in partnership to achieve the outcomes in the improvement plan. This includes mental and physical health services and drug and alcohol agencies

PROGRESS IN 2017-18

- We tried new ways of tackling domestic abuse through the "**Safe and Together**" approach. This involves work with the non-abusing parent and the abusing parent aimed at keeping children safe and together with the non-abusing parent

- In view of the growing waiting lists we increased financial support to the voluntary organisation **Rape Crisis**. We also awarded a 3 year contract to **Women's Aid East and Midlothian**.

- The **Spring Service** for women involved or at risk of offending worked in close partnership with a range of organisations including Women's Aid, Community Health Inequalities Team and MELD. Staff have been trained in **Mentalisation Based Therapy** particularly useful for women who have experienced trauma and have developed personality disorders.

- New governance arrangements through the Community Safety and Justice Board became operational and a **Community Justice Improvement Plan** was completed.

- The **Unpaid Work Service** became more focussed on learning outcomes, for example people can now work towards an SVQ module.

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Strengthen Prevention and Recovery in Criminal Justice

- Work in partnership with services in mental health and substance misuse through being collocated in the new **Recovery Hub** in Dalkeith.

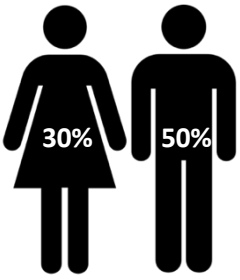
- Continue to equip our staff to respond to people who suffered trauma in the past using the **"Survive and Thrive"** approach.

- Increase our capacity to prevent offending by providing more **peer support** and help to address substance misuse.

- **Arrest Referral**, a service designed to work with people from the point of arrest, will be reintroduced in combination with a support service for people subject to electronic monitoring (usually on release from prison).

Substance Misuse

Alcohol - Alcohol misuse contributes to a wide range of health problems, deaths, hospital admissions, unintentional injuries and a range of diseases such as cancer.



As a nation we drink too much (Number of people who regularly drink over the sensible drinking guidelines)

50p
Minimum unit price from May 2018

This will reduce alcohol consumption in harmful drinkers by 10%.

345
hospital admissions (2016/17)

530.6 per 100,000

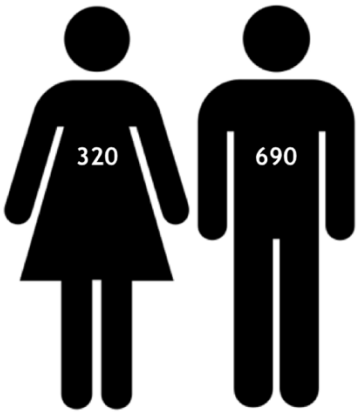
This is higher than the rest of Scotland.

X2

Alcohol attributable injuries are double for women than men

Drugs - A drug problem is the problematic use of opiates (including methadone) and/or benzodiazepines and implies routine and prolonged use. People with drug problems are often marginalised in society and can have multiple complex needs.

Addressing wider social inequalities, for example in housing and employment, and tackling poverty, can play a role in the prevention of drug misuse and associated harms.



Number of individuals with a drug problem (aged 15 - 64.)

This is a higher % of men than the rest of Scotland, especially males aged 25-34

8 drug related deaths (2016)
Estimates suggest this will be higher in 2017

PROGRESS IN 2017 -18

- Continued to develop **Peer Support**. 14 people completed Peer Supporter Training in order to become a peer mentor or volunteer. A Peer Support Co-ordinator was appointed to co-ordinate a range of peer support activities including training across substance misuse, mental health and criminal justice services.
- Primary Care, community staff and others were supported to deliver **Alcohol Brief Interventions**. 5457 East and Midlothian residents benefited.
- Continued to work with partner agencies, families and drug users to keep people safe and **reduce drug related deaths**.
- People in recovery were supported to gain qualifications and skills that will help them gain employment. Seventy three people engaged in the **Recovery College** in Dalkeith during 2016-17.
- **Multi-agency training** was arranged. Over eighty staff members attended Children Affected by Parental Substance Misuse /GIRFEC training.
- The **Horizons Recovery Café** had a weekly attendance of around 60 customers. A well attended and active SMART Recovery Group met at the café each Friday morning.

KEY ACTIONS FOR 2018-19

- Develop integrated **Recovery Hub** involving staff from substance misuse services, mental health services, criminal justice social work staff and third sector partners.
- **Address areas for improvement** noted in the Care Inspectorate report.
- Produce a new **Statement of Licensing Policy** and oversee its implementation.
- **Collect information relating to alcohol use** e.g. the numbers of babies born with Foetal Alcohol Spectrum Disorders (FASD) and alcohol related hospital admissions.
- **Strengthen Peer Support** in the context of more assertive approaches to engaging with harder to reach clients and those who drop out of services. This will include 'harm reduction' support.

Artists impression of the new Recovery Hub in Dalkeith.

Resources – key shifts in their use.

Redesigning services as laid out in the Strategic Plan can be funded by moving resources from one model of care to another. Additionally, in time, these shifts in emphasis will result in less costly services.

- **Move from Failure Demand to Prevention**.
  Prevention is good for people and the utilisation of health and social care resources. Much preventative activity is delivered by partners within the broader Community Planning Partnership including employability support services, housing and leisure services. This reflects the findings of the Christie Commission on the future of public services.

- **Move from Hospital or Care Homes to Community Based Services**
  People wish to remain at home for as long as possible and only go into hospital if absolutely necessary. There is scope to provide more services in the community. The IJB has committed to a reduction in occupied hospital bed days of 10% which would enable a significant transfer of resources to community services.

- **Move from Treatment and Support to Recovery and Reablement**
  Emphasising recovery by providing more intensive support to enable people to recover as far as possible is reflected clearly in areas such as mental illness and substance misuse and a more proactive approach to rehabilitation is being adopted in areas such as stroke and in the delivery of care at home services.

- **Improved Quality and Access**
  High quality services and enabling quick access to them is likely to lead to reduced costs. People awaiting access to treatment for addiction or to psychological therapies are vulnerable to deteriorating further. People delayed in hospital are more likely to lose their independence skills.

- **Move from Working in Silos to Team Working**
  To provide holistic care we need to strengthen our approach to team working with joint teams across health, social care and voluntary organisations. We will also seek to create more effective working relations between based in local communities.

- **Move from Reactive to Anticipatory Care Planning**
  People with long term health conditions and disabilities need to be supported to plan ahead in response to their condition or their life circumstances changing significantly. This includes Power of Attorney arrangements, emergency planning and anticipatory care planning.

Resources: Key Actions

Primary Care	• **REALISTIC CARE REALISTIC MEDICINE PROGRAMME** Reshape Primary Care Reduce Spend on Prescribing Develop a Coherent Approach to Out of Hours Services • Plan for increasing need arising from the growing population. • Work with GPs to support the new Scottish GP contract including employing more Pharmacists, Physiotherapists, mental health nurses and Wellbeing workers. • Focus on reducing ill health through, for example, screening, health promotion programmes such as tackling obesity. • Working with GP Practices and the GP cluster we will continue to develop our understanding of frailty and reach out to people who are identified as frail. • Recruit more Health Visitors. • Develop the role of school nurses. • Train more nurses to cope with growing demand as more people are supported at home rather than in hospital.
Care Packages	• Consider opportunities for more integrated working through front line services. • Evaluate the Penicuik Housebound Project to consider opportunities for more locally based assessment and care management. • Support a new approach to transition from children's services. • Promote the Active and Independent Living Programme through the Occupational Therapy. • Ensure people have their needs assessed regularly.
Hospitals	• **REALISTIC CARE REALISTIC MEDICINE** Reduce acute hospital emergency bed days • Review the decision-making arrangements about where people are discharged to from acute hospitals. The options include Intermediate Care in Highbank; support from the Reablement Service; support from the Hospital at Home and Rapid Response Service, and two of the wards within Midlothian Community Hospital. • Address preventable admissions (people admitted to hospital who could have remained at home with treatment and support) – e.g. encourage people to be immunised against the 'flu'. • Improve pathways to local services - provide more localised services including outpatient clinics and day treatment at Midlothian Community Hospital. • Strengthen Community based support to People with Chronic Conditions - e.g. provide more services for diabetes in the community rather than in acute hospitals. • Develop a Care At Home and Delayed Discharge action plan. • Start winter planning in May to ensure we are fully ready for winter 2018/19.

Carers	• **REALISTIC CARE REALISTIC MEDICINE PROGRAMME** Implement the local Carers Strategy • Implement the new Carers Act including: • Implement the new Eligibility Criteria for services to carers • Introduce the new approach to Adult Carer Support Plans • Work with voluntary organisations to complete a Carers Census to understand how many carers there are and the level of support they provide • Work with voluntary organisations to further promote more flexible approaches to the provision of short breaks and respite care. • Continue to participate in the Penicuik Housebound Project exploring how best to support carers (as part of Penicuik locality work). • Improve services to carers who are supporting people in receipt of palliative care.
Housing and Property	• Develop a detailed plan for extra care housing. • Planning for the development of extra care housing in Dalkeith. • Alter contracts with sheltered housing providers as their style of support changes. • Develop a local property strategy to plan for future requirements including new or expanded health centres and a replacement for Highbank Intermediate Care Centre. • Prepare a brochure of all types of supported accommodation in Midlothian.
Workforce	• Complete action plans for each service area of the Midlothian Health and Social Care Partnership. • Support opportunities for Team Leader and team development. • Delivery of opportunities for good conversations between staff and senior managers on transformation and challenge. • Focus on working closely with communities • Develop excellent induction to the Partnership. • A career in care - continue investment in promoting a Career in Care.
Voluntary Sector	• Hold quarterly meetings between Health and Social Care senior managers and representatives of the voluntary sector providers.
Technology Enabled Care	• Review how we can enable new models of support through the adoption of technology e.g. overnight care in learning disabilities. • Out of Hours GP: Explore the potential to develop telehealth assessment/review by unscheduled GP care services in care homes using videoconferencing. • Data: support appropriate sharing of information between health and social care. • Provide easily accessible information to the public and local services. • Telecare: The existing analogue UK telecoms infrastructure is being replaced by a digital one. Our existing analogue equipment is also likely to be rendered obsolete. • Explore new service offerings e.g. activity monitoring combined with other key measures to explore risk of falls.

Primary Care

Primary care is the first point of contact with the NHS. Nationally and in Midlothian we are in the process of transforming Primary Care. This is recognition of the growing demand and the workforce pressures in General Practice and Community Nursing.

Services include:

- G.P.s,
- district nurses,
- Physiotherapists,
- Occupational Therapists
- Pharmacists.

Other services in the wider primary care team

- Dentists
- Opticians
- Continence Advice
- Urgent out of hours medical services provided by Lothian Unscheduled Care Service across Lothians

£18.3m

spent on medication (2017/18) - a large proportion of our budget.

National Guidance

2020 Vision for Scotland's Health Service is clear about the need to strengthen the role of primary care to keep people healthy in the community for as long as possible.

A National Review of Primary Care Out of Hours Services continues to consider how best to deliver out of hours services.

New Service Challenges

Some Practices struggled to meet the standard of offering telephone advice or an appointment within 48 hours.

During 2017-18, six GP Practices were working with restricted lists, limiting the number of new registrations.

The public raised concerns through a range of open forums about access to their GP.

The population in Midlothian is growing rapidly. The workload for community nursing teams is increasing, alongside difficulties in recruiting

PROGRESS IN 2017 -18

- A new health centre was built and opened in Loanhead.
- New physiotherapy and pharmacy services were established in some health centres.
- The interagency project in Penicuik to support housebound patients made progress.
- A GP surgery has been created in Newtongrange and will open in 2018.
- All GP Practices completed the Macmillan Cancer Care project.

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Reshape Primary Care
  Reduce Spend on Prescribing
  Develop a Coherent Approach to Out of Hours Services
- We will continue to plan for increasing requests for primary care from the growing population.
- We will work with local GPs to support the implementation of the new Scottish GP contract including employing more Pharmacists, Physiotherapists, mental health nurses and Wellbeing workers.
- We will continue to focus on health improvement and tackling inequalities, through for example, screening, health promotion programmes such as tackling obesity.
- Working with GP Practices and the GP cluster we will continue to develop our understanding of frailty within the community and reach out to people who are identified as frail.
- Recruit more Health Visitors to meet the new pathway providing more home visits to children.
- Develop the role of school nurses as part of the national transformation programme.
- Continue to train more nurses to cope with growing demand as more people are supported at home rather than in hospital. This is made more challenging with the number of people retiring from the profession.

Care Packages

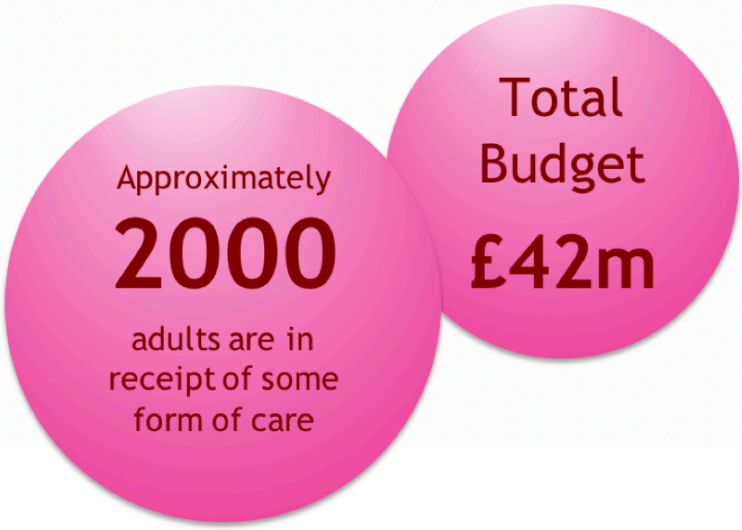
The number of people who will need care packages is difficult to predict.

While the number of older people and the number of children surviving with complex needs is growing, the emphasis on prevention, rehabilitation and recovery is likely to reduce demand.

Nevertheless the major financial challenge facing public bodies combined with growing workforce shortages in social care mean it is critical that we review our approach to the delivery of care packages.

National Guidance

The report by the Chief Medical Officer - **Realistic Medicine** – has prompted a similar reflection on our approach to social care in Midlothian



New Service Challenges,

The model of social care is changing, shifting to be more person centred to address individual need and improve the person's outcomes.

Self Directed Support enabled many people to exercise more control over their care. However, we need to pay more attention to overseeing care arrangements to ensure that we are as efficient as possible with our limited resources, whether this be in providing transport, day care or overnight support.

We must be alert to more cost-effective ways of meeting people's needs, such as making full use of local voluntary resources and new technology. Our goal is to retain this more person centred approach to providing care services in ways that are realistic.

PROGRESS IN 2017 -18

- A range of new policies were approved to ensure services are provided equitably. These included Fair Allocation of Care, Transport and Day Services.
- A Review Team made good progress in reviewing packages of care for people who had not had their needs reassessed for some time. This will ensure people are getting the right level and type of support including making best use of new technology.
- Stronger interagency working has been supported by enabling organisations such as Red Cross, Deaf Action and Royal Institute for the Blind to be based alongside the social work team each week.
- A Public Engagement Strategy helped the public understand the changes required in social care in response to financial pressures and workforce shortages.

KEY ACTIONS FOR 2018-19

- Consider how to strengthen involvement of families during the process of assessment, design of support and development of Anticipatory Care Plans.
- Following the changes planned in the management structures towards more integrated arrangements further work will be undertaken to consider opportunities for more integrated working through front line services.
- Evaluate the Penicuik Housebound Project to consider opportunities for more locally based assessment and care management.
- Support a new approach to transition from children's services following implementation of a new policy to strengthen this.
- Promote the Active and Independent Living Programme through the Occupational Therapy service in both health and social work to promote independence and self-management.
- Ensure people have their needs assessed regularly with a target for all care packages to be reviewed at least once a year.

Hospitals

There are a number of hospitals for patients in Midlothian.

Midlothian Community Hospital:

-20 continuing care beds for frail elderly patients
-20 rehabilitation beds for older people
-44 beds for elderly patients with mental health needs.
-Physiotherapy and occupational therapy,
-Out-patient department
-Lothian's GP Out-of-Hours service
-X Ray Department

Royal Edinburgh:

-Beds for patients with acute psychiatric and mental health needs, including treatment for learning disabilities and dementia.
-Specialist treatment for alcohol problems and young people's mental health.

Astley Ainslie:

-Rehabilitation services for adults with acquired brain injury, stroke, orthopaedic injuries, limb amputation, and progressive neurological disorders such as multiple sclerosis (MS).
-Community Services for patients with chronic pain, cardiac rehabilitation and angina management.
-The South-East Mobility and Rehabilitation Technology (SMART) Centre
-Lanfine Service - for adults with progressive neurological conditions.

Royal Infirmary Edinburgh:

- With a 24hr A&E department, it provides a full range of acute medical and surgical services for patients across Lothian and specialist services for people from across the south east of Scotland and beyond.
-Surgical, medical and maternity

Western General Edinburgh

Regional centre for cancer, neuroscience and infectious diseases

St John's:

-Plastic Surgery

New Service Challenges

Midlothian has prided itself on its performance with delayed discharge (people fit to be discharged but not able to do so because the necessary care arrangements were not in place). Our performance deteriorated in 2017-18 despite a huge effort by a wide range of staff.

One factor was the lack of care at home staff. While the situation has improved we have work to do to ensure people can be discharged as soon as they are fit to do so. We are seeking to expand extra care housing as well as trying to grow the capacity of communities to support older people and avoid isolation.

National Guidance:

Ministerial Strategic Group for Health and Community Care tracks:

- Unplanned hospital admissions
- Occupied bed days for unscheduled care and A&E
- Delayed discharges
- End of life care
- Spend across institutional and community services

PROGRESS IN 2017 -18

- Explored the possibility of most frail elderly patients from Midlothian being admitted to the Royal Infirmary unless they require specialist treatment only available in the Western General. Progress has been limited in part because of the national work considering a more regional approach to Acute Hospitals.

- Specialist services for people with respiratory diseases are now provided through the MERRIT team helping to maintain people at home rather than being admitted to hospital.

- The rehabilitation services previously provided in Liberton Hospital have transferred to Midlothian Community Hospital.

- A Public Engagement Strategy helped ensure the public understand and are able to support the changes required in social care in response to financial pressures and workforce shortages.

- Daily meetings take place involving Health and Social Work staff including Midlothian Commuity Hospital and the Dementia Team to consider arrangements for patients in acute hospitals.

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Reduce acute hospital emergency bed days

- Review the decision-making arrangements about where people are discharged to from acute hospitals. The options include Intermediate Care in Highbank; support from the Reablement Service; support from the Hospital at Home and Rapid Response Service, and two of the wards within Midlothian Community Hospital.

- Address preventable admissions (people admitted to hospital who could have remained at home with treatment and support) - This will include a campaign to encourage people and staff to be immunised against the 'flu'.

- Improve pathways to local services - Continue to explore how to provide more localised services including outpatient clinics and day treatment at Midlothian Community Hospital.

- Strengthen Community based support to People with Chronic Conditions - e.g. Explore ways to provide more services for diabetes in the community rather than in acute hospitals.

- Develop a Care At Home and Delayed Discharge action plan.

- Start winter planning in May to ensure we are fully ready for winter 2018/19.

Carers

Figures reveal that a significant part of the 'shift of the balance of care' is undertaken by unpaid carers and reflected in the increase in the intensity of caring. For example over just ten years the number of people caring for over 20 hours in Midlothian increased by 35.7%

National Guidance:
The Carers (Scotland) Act **(2016)**

Local Guidance:
Midlothian Carer strategy and action plan **(2017 – 2019)**

New Challenges

In 2017 – 18 a number of pilot projects were undertaken across the country. The aim of the pilots was to test out various provisions of the Act in certain discrete localities so that any learning and good practice could be shared on a Scotland wide basis prior to the Act's commencement.

The introduction of the new Act has resulted in a range of new guidance and responsibilities for the Partnership and organisations involved in supporting carers including the completion of an annual census of unpaid carers.

PROGRESS IN 2017 -18

- Completion and publication of a new local Carers Strategy which focusses on the following key areas:
  - being identified and valued earlier
  - more informed and confident carers
  - improved health and wellbeing
  - being more involved in support planning
  - improved financial wellbeing
  - carer awareness in employment and education

- Successful pilot of Adult Carer Support Plans including the completion of Emergency Plans for Carers

- Development and approval of local Eligibility Criteria for Carers in line with the new Carers Act

- Reintroduced funding (£30,000) for the Wee Breaks Service

- Support for Carers health and wellbeing provided through the Community Health Inequalities Team

KEY ACTIONS FOR 2018-19

- **REALISTIC CARE REALISTIC MEDICINE PROGRAMME**
  Implement the local Carers Strategy

- Implement the new Carers Act including:
  - Implement the new Eligibility Criteria for services to carers
  - Introduce the new approach to Adult Carer Support Plans
  - Work with voluntary organisations to complete a Carers Census to understand how many carers there are and the level of support they provide

- Work with voluntary organisations to further promote more flexible approaches to the provision of short breaks and respite care.

- Continue to participate in the Penicuik Housebound Project exploring how best to support carers (as part of Penicuik locality work).

- Improve services to carers who are supporting people in receipt of palliative care.

Housing and Property

Changes to the organisation of health and social care focused on services provided by the NHS and Council Social Care services. However we recognise the critical role played by housing providers through the need for the inclusion of a Housing Contribution Statement in our Strategic Plan.

The main objective of health and social care reform is the reduction on the reliance on institutional care and hospitals.

As we age, staying at home is a viable option for most of us. This depends on our home's location, accessibility, size, energy efficiency and proximity to local amenities. National guidance encourages new build housing to incorporate design features that enable people to remain in their homes longer or easily adapt them.

National guidance

The Scottish Government will work to increase the supply of affordable housing in Scotland to deliver at least 50,000 affordable homes, of which 70% will be for social rent

New Challenges

The pace of house building impacts services and communities as the population grows.

By April 2018 there will no longer be any registered sheltered housing in Midlothian. The Council's increased provision of alternative types of accommodation, for example, extra care housing, will help alleviate this over the coming years.

New purpose built accommodation for people with complex needs at Teviot Court in Penicuik.

PROGRESS IN 2017-18

- Opened new purpose built accommodation for 12 people with complex needs at Teviot Court in Penicuik.
- Completed detailed planning for 12 new extra care bungalows in Gorebridge - this includes 2 houses for bariatric patients. The houses should be complete by summer 2019.
- The Council agreed as part of the new housing programme that extra care housing should be built for older people while more shared accommodation will be built for people with learning disabilities.
- The Council continued to work with Viewpoint Housing Association to remodel existing accomodation to extra care housing. This will add to services already available at Cowan Court and Hawthorn Gardens in Loanhead (Trust Housing Association).
- New guidance, "Support to Move - A guide for people in Midlothian", supported people whose accommodation is becoming unsuitable and may be thinking of adaptations or a move.
- Negotiations with private developers resulted in a recognition that they should make a contribution to the provision of new health centres to help address the demands of a growing population.
- Midlothian Council agreed to fund a new Recovery Hub for services in mental health, substance misuse and criminal justice. As well as health and social work staff, teams from the voluntary sector and Peer Supporters will also be based there.

KEY ACTIONS FOR 2018-19

- Develop a detailed plan for extra care housing across Midlothian.
- Undertake detailed planning on the development of extra care housing in Dalkeith on the Newmills Road Site (Ex Dalkeith High School).
- Alter existing contracts with sheltered housing providers as their style of support changes.
- Develop a local property strategy to plan for future requirements including new or expanded health centres and a replacement for Highbank Intermediate Care Centre.
- Prepare a brochure of all types of supported accommodation in Midlothian.

Workforce

The Midlothian Health and Social Care Workforce Framework will provide a bedrock for the full Workforce Plan, made up of individual Service Plans by being:

- future-focused
- integrated with strategic and financial planning
- dynamic and responsive to the complex, changing and shifting landscape
- understanding of the need to link service outcomes and the workforce required to deliver these
- relevant to all people who work across health and social care and being the focal point for staff to develop their skills within the context of transformation
- involved in planning and modelling sustainable, affordable approaches to support health and social care integration for the future

We want to support the people of Midlothian to maintain healthy, independent lives and have access to services and community resources that support their health and wellbeing. To do this we need to nurture a high quality, skilled, courageous and compassionate workforce that promotes dignity, safety and respect, taking a strengths-based approach to supporting the people of Midlothian. Successfully implementing this plan provides a consistent and positive step towards meeting that commitment and our ambition.

National guidance: There has been a wide range of national guidance. This reflects the growing reception of the need to plan for the workforce needs of Health and Social Care.

- **Scottish National strategy for H & SC Workforce Planning**.
- **Safe and effective Staffing**.
- **National Regional Workforce Planning for NHS services**
- Investment through the Active and Independent Living Programme
- **National Strategy for Community Justice**
- **Mental Health Strategy 2017-2027**
- **Integration Digital Health and Social Care Strategy**

New challenges

Expansion of Early Learning & Child Care will have an impact on recruitment to Social Care services

PROGRESS IN 2017 -18

- All sectors had access to the **Lothian's Team Development Toolkit**.
- A programme of **varied opportunities for Team Leaders and operational frontline supervisors** was developed.
- Workshops continued and expanded in topic area to cover **Health Inequalities**.
- **New approaches to attract people into a career in care** have been implemented - e.g using social media to attract young people to the profession.
- Service reviews have been addressing the **redesign of roles for the future**.
- Implementation of the **Living Wage** for social care staff.
- **Midlothian IJB Workforce Planning Framework** was developed and provides a foundation for individual service action planning.

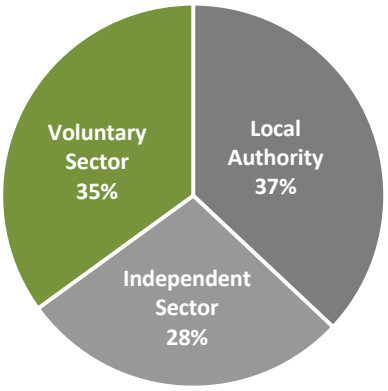
KEY ACTIONS FOR 2018-19

- Complete **action plans for each service area** of the Midlothian Health and Social Care Partnership: Working together; Leadership; Skills & knowledge; Staff health and wellbeing; Recruitment & retention; Working with neighbourhoods and communities; Communication.
- Continue to support opportunities for Team Leader and team development, making good use of the **Lothians Team Development toolkit**.
- Opportunities for **good conversations between staff and senior managers** on transformation and challenge.
- **Work closely with communities**: Bridging the gap and building trust and confidence.
- **Develop excellent induction for staff** - setting the scene and the approach and expectation of the H & SCP from the start
- Continue investment in **promoting a Career in Care** working closely with partners in the voluntary and independent sectors.

Voluntary Sector

Voluntary and community organisations play a critical role in the provision of social care services in Midlothian. They are the major provider of services to people with learning disabilities and mental health needs. They are central to reducing isolation through lunch clubs, day centres, buddy schemes, local area coordination and peer support.

While public service finances have had an impact on voluntary organisations it is worth recognising that 35% of the total Adult Social Care budget spend is with the voluntary sector



National Guidance
The Community Empowerment Act.

PROGRESS IN 2017 -18

- The voluntary sector was represented on the IJB, the Strategic Planning Group & on all specific planning groups.
- The voluntary sector worked in closer partnership through co-location with statutory agencies in areas such as primary care, substance misuse, mental health, dementia, rapid response and in health centres. Voluntary organisations have contributed to the redesign of learning disability day services and to the pilot project related to the Carers Act

KEY ACTIONS FOR 2018-19

- Hold quarterly meetings between Health and Social Care senior managers and representatives of the voluntary sector providers in order to develop and implement new approaches to the delivery of Health and Social Care.

Technology Enabled Care

The traditional service model for health and social care will not be able to cope with the financial pressures and the ageing population. We must find new ways of supporting people and enabling them to stay well that are sustainable. Increasingly this will include redesigning services to embed and incorporate the right technologies to support new care models. This approach is in line with the wider impact of new technology in our day to day lives.

It is not simply about the right 'kit' but how the right care can be supported by technology. For example the delivery of better care can be facilitated by helping family members share information about the person for whom they are caring with one another as well as with health and social care staff; a simple smartphone or computer can support this but fundamentally the focus is supporting good communication.

National guidance:

Digital Health and Social Care Strategy (2008)

Service Challenges:

Later this year the current TEC (Technology Enabled Care) Programme is due to end. Details of the next round of funding have yet to be announced.

PROGRESS IN 2017 -18

- Videoconferencing – Since February 2017 videoconferencing has increased participation in training and reduced travel. 10 of the 11 care homes participated. Staff can attend training within their care home, delivered remotely using the equipment. Within the first 6 months we had delivered a total of 12 training sessions, attended by 386 staff.

- eFrailty - the eFrailty Index assessment within GP practice computer programmes can help to identify people with frailty. The Partnership also invested in a tool to access data from each practice to support strategic planning and develop services.

- Malnutrition Management - we used technology to monitor patients receiving dietetics care for malnutrition.

KEY ACTIONS FOR 2018-19

- Realistic Care, Realistic Expectations: We will review how we can enable new models of support through the adoption of technology in practice e.g. overnight care in learning disabilities.

- Out of Hours GP: Explore the potential to develop telehealth assessment/review by unscheduled GP care services in care homes using videoconferencing.

- Data: Progress developments to support appropriate sharing of information between health and social care.

- Information Hub: Explore solutions to provide easily accessible information to the public and local services.

- Telecare: The existing analogue UK telecoms infrastructure is being replaced by a digital one. This has consequences for telecare as our existing analogue equipment is also likely to be rendered obsolete.

- Explore new service offerings e.g. activity monitoring combined with other key measures to explore risk of falls.

COMMUNICATING CLEARLY

We are happy to translate on request and provide information and publications in other formats, including Braille, tape or large print.

如有需要我們樂意提供翻譯本，和其他版本的資訊與刊物，包括盲人點字、錄音帶或大字體。

Zapewnimy tłumaczenie na żądanie oraz dostarczymy informacje i publikacje w innych formatach, w tym Braillem, na kasecie magnetofonowej lub dużym drukiem.

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Körler icin kabartma yazilar, kaset ve büyük nüshalar da dahil olmak üzere, istenilen bilgileri saglamak ve tercüme etmekten memnuniyet duyariz.

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

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