Notice of Special Meeting and Agenda

Midlothian Integration Joint Board

Venue: **Virtual Meeting,**

Date: **Thursday, 17 March 2022**

Time: **14:00**

Morag Barrow
Chief Officer

Contact:
Clerk Name: Mike Broadway
Clerk Telephone: 0131 271 3160
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Further Information:

This is a meeting which is open to members of the public.

1 Welcome, Introductions and Apologies

2 Order of Business

Including notice of new business submitted as urgent for consideration at the end of the meeting.

3 Declaration of Interest

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

4 Public Reports

4.1 Chair's Update.

For Decision

4.2	Midlothian Integration Joint Board Strategic Plan 2022-2025 and Consultation Report – Paper Presented by Lois Marshall, Assistant Programme Manager.	3 - 158
4.3	Midlothian IJB – 2022/23 Budget Setting – Report by David King, Interim Chief Finance Officer.	159 - 178

5 Private Reports

No private business submitted for this meeting.

6 Date of Next Meeting

The next meeting of the Midlothian Integration Joint Board will be held on:

- 14 April 2021 at 2 pm - **Midlothian Integration Joint Board**
- 12 May 2021 at 2 pm - **Development Workshop**

Please Note that immediately upon conclusion of this Special Board meeting there will follow a Development Workshop session; papers for which will be circulated to Board Members only under separate cover.

Thursday 17th March 2.00pm

Midlothian Integration Joint Board Strategic Plan 2022-2025 and Consultation Report

Item number:	**4.2**

Executive summary

In order to meet the legal requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, Midlothian Integration Joint Board is required to publish a new Strategic Plan in 2022. Section 33 of the Act also places a duty on the IJB to publish a statement on the consultation undertaken on the plan.

This report presents the final draft of the Strategic Plan 2022-2025, and the accompanying consultation report for the plan.

Board members are asked to:

- **Approve the consultation report for the Strategic Plan 2022-2025**
- **Approve in principle (pending financial allocation confirmation) the final draft of the Strategic Plan 2022-2025**

Report

Midlothian Integration Joint Board Strategic Plan 2022-2025 and Consultation Report

1 Purpose

1.1 To present the final draft of the Midlothian IJB Strategic Plan 2022-2025 and the accompanying Consultation report

2 Recommendations

2.1 As a result of this report Members being asked to:

Approve the consultation report for the Strategic Plan 2022-2025

Approve in principle (pending financial allocation confirmation) the final draft of the Strategic Plan 2022-2025

3 Background and main report

3.1 In order to meet the legal requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, the Midlothian Integration Joint Board is required to develop, consult on, and publish a new Strategic Plan in 2022.

3.2 In line with the requirements of the act the plan must:

- set out the arrangements for the carrying out of the integration functions for the area of the local authority over the period of the plan,
- set out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes
- include such other material as the integration authority thinks fit.

3.3 Section 33 of the Act, and the Government guidance on Strategic Commissioning Plans, also places a duty on the IJB to undertake a wide and varied engagement in the development of the plan and publish a statement on the consultation undertaken alongside the new Strategic Plan.

Summary of Consultation and Engagement in the development of the plan

3.4 **Vision, values and timescales**
The new vision and values to support the strategic plan, and the proposed timescale for the development of the plan were discussed with a wide range of staff and key stakeholders including at SMT on 27th October, at SPG on 28th October 2020, at and at the IJB Development Workshop on 12th November 2020. They were agreed at the IJB on 10th December 2020.

3.5 **Strategic aims and key headings**

A new layout, and proposed key headings, were discussed with planning leads and key stakeholders in December 2020, a range of feedback was gathered and used to refine the layout and key headings to help ensure consistency across the plan and ensure a continued focus on prevention and early intervention. Ideas around joint strategic "priorities" or "aims" to support the strategic plan were discussed at Strategic Planning Group on 20th Jan and at Planning and Transformation Group on the 4th of February 2021. 6 draft strategic aims were developed based on: discussions with staff, stakeholders and planning groups, what local people had told us through consultations and engagement in the past year, current policies and local data. The 6 strategic aims were agreed by the IJB on 8th March 2021. A presentation on the proposed approach to the Housing Contribution Statement to support the Strategic Plan was presented to the IJB on the 13th of May 2021.

3.6 **Service area consultation and engagement**

Planning leads were asked in February 2021 to develop plans around the consultation and engagement that would support their development of their plans for each area, identifying what they knew already, what the gaps were, how they would reach people, and how they would use the feedback. To ensure that relevant consultations from different parts of the partnership were taken into account, and to prevent duplication, consultation reports from across the HSCP were collected and shared with all planning leads. Discussions were held on 23rd of March 2021 with all planning leads to support this.

A range of consultation and ongoing engagement with specific service users and stakeholders informed the development of the plan. This has included the involvement and engagement of a wide range of services users and their families as well as representative groups, such as joint planning groups (e.g Older People's Planning Group), advocacy and support organisations (MOPA, Forward Mid, Enable), carers organisations (VOCAL) staff, trade unions, providers, housing and those involved in local community planning. This has been captured in consultation reports for each area which are included in the full consultation report. A few areas haven't yet provided evidence of the consultation or engagement that has informed the initial development of their plans and therefore there are no individual reports on these areas. These are Public Protection, Under 18s, and Primary Care. These areas were covered at the IJB workshops and in the public consultation undertaken on the full draft plan.

3.7 **IJB workshops**

8 IJB workshops were held in October 2021 to discuss the proposals for the plan. The workshops supported engagement and discussion with a range of stakeholders. Attendees across the workshops included IJB board members, SPG members, third sector partners, Senior Management Team, NHS Lothian Director of Primary Care, members of the Finance team, Midlothian Clinical Director and the Director of Dentistry for NHS Lothian. Plans were updated taking into account feedback from the workshops, and the first draft plan was presented to the SPG for discussion on the 17th of November 2021.

3.8 **Public consultation**

The full draft of the strategic plan was presented to IJB on 9th December 2021 where approval was given to proceed with public consultation on the draft presented, following discussion at the IJB workshop in January. The IJB discussed

the plan and the budgetary pressures that could impact on aspirations for the plan at the IJB workshop in January 2022. The full public consultation on the draft plan began on 19th January 2022 and will close on 14th March.

3.9 **Consultation with key stakeholders**
As required by the Midlothian IJB integration scheme information on the consultation on the strategic plan has been shared with a wide range of key stakeholders including all neighbouring IJBs, NHS Lothian Medical Director, NHS Lothian Nurse Director, NHS Lothian Director of Public Health & Health Policy; NHS Lothian Allied Health Professionals Director.

3.10 **Wide and varied consultation**
To ensure a wide and varied consultation it was promoted in the Edinburgh Evening News on 24th of January, on the local community radio station Black Diamond, in the Midlothian Third Sector update on 25th January and 11th of February, on the Health in Mind website, on the Midspace website, in the Forward-Mid newsletter in February, shared with the IJB, with the Strategic Planning group, with all staff across Midlothian Council and the HSCP and with a wide range of third sector partners.

The consultation was promoted widely using a range of Social Media channels. The best performing post reached over 10,000 people and over 1,000 people engaged with it in some way. Paper copies of the consultation and draft plan have been made available in libraries across Midlothian, and approximately 43000 postcards with information on the consultation were delivered to every household in Midlothian.

3.11 **Local data and consultation supporting the plan**
Along with the draft plan and the consultation, the individual consultation reports for each area were published on the new HSCP website under the heading “What you told us”. Local data from the Joint Needs Assessment was shared for each area under the heading “What the data tells us”. This supported anyone responding to the consultation to consider how both engagement and data on local needs had influenced the development of each area of the plan.

3.12 **Integrated Impact Assessment**
Integrated Impact Assessment workshops were held in February 2022 to consider how best to ensure that there are no unintended adverse implications for equality groups arising as a result of the plan and consider how it supports the IJB in meeting the Public Sector Equality Duties and the Fairer Scotland Duty. A range of staff and stakeholders attended the workshops to support this area of work. A separate IIA report will be published.

3.13 **Feedback from consultation**
To date (8th March 2022) there have been 180 responses, and 802 page views of the HSCP webpage on the draft plan and consultation. The attached consultation report summarises the responses received from the public consultation
The feedback received from the public consultation has been shared on an ongoing basis with all planning leads and senior management to ensure this could be taken into account in the finalisation of the plans.

3.14 **Midlothian Strategic Plan 2022-2025 (final draft)**
The final draft of the strategic plan is attached, however as the consultation is still ongoing, and will close on Monday 14th of March, any feedback received in the final week will be shared with leads and if required a verbal update on the plan will be provided at SPG on 16th March and at the IJB on 17th March.

3.15 An update has been provided in relation to the development of the Acute section of the plan. Additional information has been added to describe the make-up of the IJB and the role of the SPG, and to describe how the IJB will meet the duty of Best Value. A separate 3-year workforce plan that will support the strategic plan is in development and will be published in June 2022 and therefore the Workforce section has been changed to include a high-level summary of our approach to workforce planning. The plan will be discussed at the IJB on Thursday 17th March in principle (pending financial allocation confirmation) before final approval and publication in April 2022.

4 Policy Implications

4.1 The new Strategic Commissioning Plan 2022-25 will influence all future service delivery, redesign and commissioning.

5 Directions

5.1 This new plan will have an impact on all future directions. Directions issued to NHS Lothian and Midlothian Council in 2022-203 will align with the Strategic Plan 2022-25.

6 Equalities Implications

6.1 An Equality Impact Assessment was undertaken on the draft Strategic Plan on 8th February 2022 to consider how best to ensure that there are no unintended adverse implications for equality groups arising as a result of the plan and its proposed implementation.

7 Resource Implications

7.1 Financial resource will be aligned to the Plan. Budgetary pressures may impact on aspirations for the Strategic Plan.

8 Risk

8.1 Challenges regarding an available workforce may impact on aspirations for the Strategic Plan.
8.2 Budgetary pressures may impact on aspirations for the Strategic Plan.

9 Involving people

9.1 A wide range of stakeholders across the Partnership have contributed to the development of the plan. This is detailed in the Consultation report.

10 Background Papers

AUTHOR'S NAME	Lois Marshall
DESIGNATION	Project Team Manager Neurological Conditions
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DATE	9th March 2022

Appendix 1 - Consultation Report
Appendix 2 - Midlothian IJB Strategic Plan 2022-2025 (final draft)

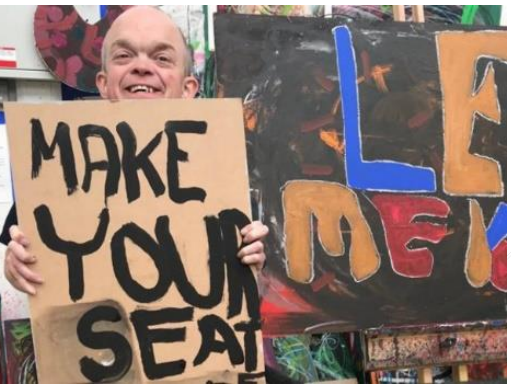
Midlothian
Health & Social Care

Midlothian Integration Joint Board

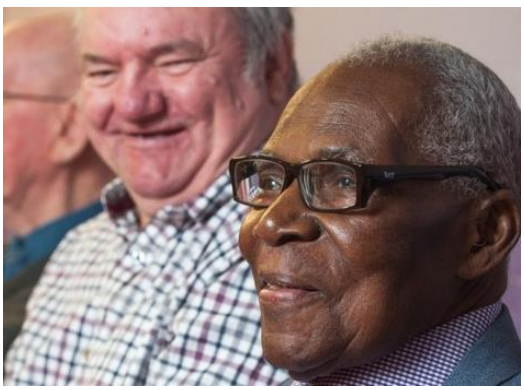
Strategic Plan

Consultation

2022-2025






Who we are

The Integration Joint Board (IJB) plan and direct health and social care services for the people of Midlothian. It is a planning and decision-making body that was created by Midlothian Council and NHS Lothian in 2015 and is responsible for the integrated budget (received from Midlothian Council and NHS Lothian). It allocates this in line with the objectives set out in its Strategic Plan. The IJB has a range of responsibilities and legal duties as outlined in the Public Bodies (Joint Working) (Scotland) Act (2014).

The IJB meets regularly and includes members from NHS Lothian and Midlothian Council, the Third Sector, staff and people who represent the interests of people and communities, patients, service users and carers.

The IJB is supported to develop and monitor the delivery of our Strategic Plan by the Strategic Planning Group – with representatives from Midlothian Council, NHS Lothian and the Third Sector. You can find the full list of services the IJB is responsible for at www.midlothian.gov.uk/mid-hscp in the Scheme of Integration. We have listed some of the services below:

NHS Lothian

Care in Hospitals which isn't planned (unscheduled care) including Accident and Emergency, Minor Injuries, Acute wards.
Midlothian Community Hospital
Community based health care (Primary care) including GPs, District Nurses, Dentists, Pharmacists, Mental Health services, Substance Use Services, Community Respiratory team
The following Health services for children and young people under 18: Health Visiting, School Nurses, Vaccinations of children.
Allied Health Professionals –including physiotherapists, dietitians, podiatrists
Palliative and End of Life Care

Midlothian

Social Work support for adults including adults with dementia, learning disabilities, older people
Day services for older adults and people with learning disabilities
Care at Home services
Health services for people who are homeless
Extra Care Housing for people who need housing with extra support
Services to support unpaid carers and breaks from caring
Care Homes
Services to address health and care needs of people in the justice system

What we are trying to achieve

We plan and direct a wide range of health and social care services and manage the allocation of the budget. We aim to:

- **Improve the quality of health and social care services** and achieve the 9 national health and wellbeing outcomes;
- **Change how health and social care is delivered** to better understand and meet the needs of the increasing number of people with long term health conditions, with complex needs and those who need support, working with people as partners in their health and social care.
- **Provide more support, treatment, and care for people in their homes, communities, or a homely setting** rather than in hospitals

Our Vision and Values

Vision: People in Midlothian are enabled to lead longer and healthier lives.

Values: We will provide the right support at the right time in the right place.

Our Strategic Aims

1. Increase people's support and opportunities to stay well, prevent ill or worsening health, and plan ahead.

2. Enable more people to get support, treatment and care in community and home-based settings.

3. Increase people's choice and control over their support and services.

4. Support more people with rehabilitation and recovery.

5. Improve our ability to promote and protect people's human rights, including social and economic rights and meet our duties under human rights law, through our services and support.

6. Expand our joint working, integration of services, and partnership work with primary care, third sector organisations, providers, unpaid carers, and communities to better meet people's needs.

Introduction

To meet our legal requirements we have a duty to undertake a wide and varied engagement while developing our Strategic Plan. This report is a summary of that consultation.

Consultation and engagement of our vision, values and strategic aims

The vision and values for the strategic plan were discussed with key staff - at the Planning and Transformation group, Strategic Planning Group, Senior Management Team and the Integration Joint Board. 6 draft strategic aims were developed based on discussions with staff, planning leads, planning groups and community partners, on what people had told us through consultations and engagement that had been undertaken in the past year and on current policies and information.

To ensure meaningful and accessible consultation the planning leads were asked to work with partners and front line staff to carry out a range of consultations – including online surveys, focus groups, 1:1 interviews and Question and Answer sessions. **Together they spoke to over 2,500 people**. The main findings of their consultations are described in this report and informed the first draft of the plan.

Consultation on the draft plan

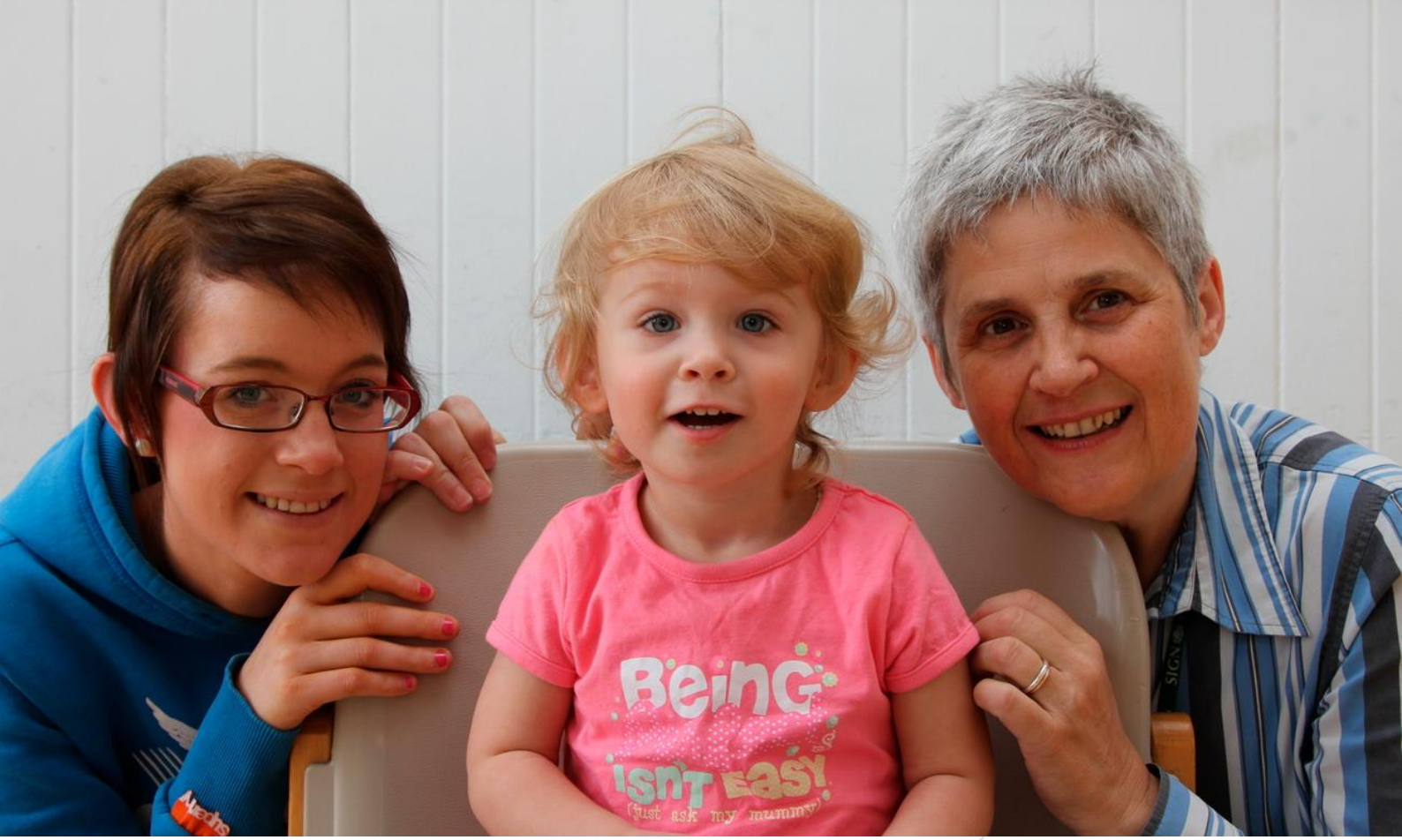
The draft of the plan was made available online, together with local data and findings from consultations. A link to this website was shared with a key stakeholders including neighbouring IJBs, NHS Lothian Medical Director, NHS Lothian Nurse Director, NHS Lothian Director of Public Health & Health Policy; NHS Lothian Allied Health Professions Director, the Strategic Planning group and the Integration Joint Board. It was also shared with the public and the third sector organisations online and through every library. A public awareness campaign to invite people to share their views consisted of links with third sector providers, social media posts, copies in local libraries and a postcard delivered to every household.
Over 100 people gave their comments online and by post.

Integrated Impact Assessment on the draft plan

An Integrated Impact Assessment was carried out on the draft plan to ensure that the proposed services and supports promote equality and address broader inequalities such as the impact on poverty on service access.

Our consultations

Contents



Overall Plan

Our draft of the Strategic Plan went out to public consultation for 8 weeks between 19th January 2022 and 14th March 2022. This gave people a chance to have a say on the plan as a whole.

The draft plan was displayed both online (on the Midlothian Health and Social Care Partnership website www.midlothian.gov.uk/mid-hscp) and in paper copies at every library. People could comment via an online questionnaire or a postal form.

We promoted this through a range of methods including social media posts on Facebook and Twitter, an article in local newspapers, mentions on local radio, related websites for third sector organisations (e.g. Midspace) and we sent around 43,000 postcards to every household in Midlothian to raise awareness.

People could feedback on any part of the plan and on the plan as a whole. Specific comments were fed back to each service area and comments on the general plan are included below.

Key points

Some people felt that the plan was good but that it needed more detail – especially as services are already under pressure.

"It all looks good but a bit vague! How is Midlothian going to do all this on less money (from the Gov) on the tail end of a global pandemic?"

"There is little in the plan with which any reasonable person would disagree. The test will rather lie in the degree to which the laudable aims in the plan can be fulfilled."

"I think you have a great plan on paper. But do you have the means to achieve it?"

"Overall it sounds very well considered whether it is implemented of course is another matter."

Some people mentioned the positive impact of some services and a desire to continue them.

"Please also continue to maintain the services currently provided in Penicuik public park and by the leisure centre, including the library (which i use); these are vital to the health & wellbeing of the community."

Some people mentioned the positive focus on prevention

"Pleased to see work included to keep people well and prevent a crisis happening rather than being reactive. Better value for money."

"I note that the aims on page 3 do not include reference to increasing people's independence - I feel that this is essential as due to aging population etc, resources may become stretched so if we can ensure people are more independent and resourceful, then there will be less pressure."

Some people felt there needs to be a greater focus on providing information on how to access services.

Some people said that they wanted services to be more flexible – to offer the right care, at the right time, in the right place

Some people mentioned the need to utilise volunteers more

"Volunteering and volunteers need to be imbedded into the plan as a whole…Volunteering as a whole has a place throughout the plan, not just at times of crisis but also to help prevent it"

Older People

(Community Services)

Planning group: Older People's Planning Group
Planning Lead: Catherine Evans

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

We would like to thank the **325** people, citizens, staff and partner organisations, who took part in the collaborative working group, and the people who contributed their ideas through other channels, including preceding consultations.
We worked with people for 4 months during 2021.

Questionnaires

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

Interviews/focus groups

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

Other engagement

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

Prevention & Early Intervention

Key points

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

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

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

Key points

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

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

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

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

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

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

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

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

Covid and restrictions have had a negative impact on many older people's health
In autumn 2020 many people said they were less active than before – including 50% of Ageing Well participants. The most common issue reported to the Red Cross in October 2020 was feelings of loneliness and isolation.

Key points

Can we connect better with people who live in care homes?
The vision would be that care homes are seen as a positive place to live, and are a part of the wider community.

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

Create more age-friendly, welcoming environments for older people to meet and find out about the support that is available
Work with partners to create age-friendly and accessible environments in every community that can be a place for sharing information.

Increase contact between HSCP staff, services and community groups
Prioritise opportunities for staff to visit community cafes, support groups etc. to improve relationships and communication.

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

Create more opportunities to hear the views and experiences of older people
Support MOPA to develop and grow.

Support & Treatment

Key points

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

Key points

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

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

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

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

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

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

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

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

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

Key points

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

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

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

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

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

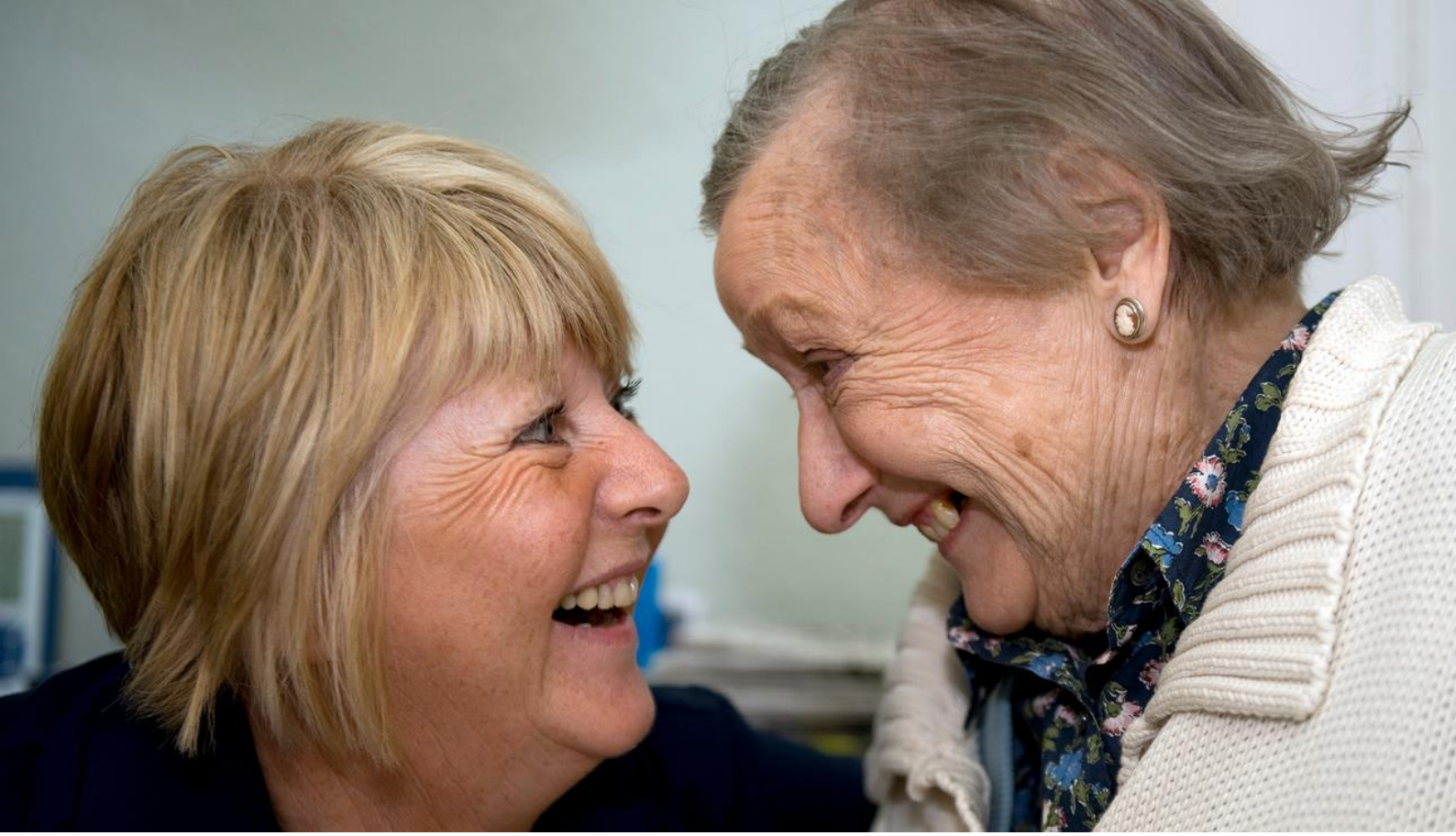
Develop different options for people to access services, especially GP services
Work with older people's groups to understand the barriers they face when accessing services and what makes a service accessible to them. Digital should be an option but not the only option.

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

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

Crisis & Emergency

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



Frailty

Planning group: TBC
Planning Lead: Amanda Fox

We would like to thank the **242 people** who took we spoke with, and the community organisations and service providers we met with.
We spoke to people throughout 2020 and 2021.

Technology Enable Care Pathfinder Project (89 people)

- Service Mapping Workshop with staff from a wide range of services (around 50 people)
- Multi Disciplinary Meeting – shadowing
- 1:1 interviews with people with lived experience and carers. (14 people)
- Questionnaires from people living with frailty and carers (25 people)

Staff and Patient questionnaires around Mid Med (140 patients, 13 staff)

Winter Frailty Team feedback

Assessments for health and wellbeing unmet need due to COVID.

Prevention

Key Points

Some people mentioned ways to 'age well' such as day centres and help from third sectors
"It's a lifeline… something she enjoys when the rest of the week is dominated by health interventions that can get her down"

Some people mentioned barriers to accessing services – including being reluctant to access services, not knowing about services or not being able to navigate the system.
"Older people don't want to be a bother. My mum feels she is pushed to the back of the queue"
"The OT gave us a list of day centres but no explanation that a referral was required so not very helpful. Need someone to sit down and explain how the system works rather than just phone numbers'
"It is hard trying to understand how systems work, getting services arranged and being the point of contact – It can take hours of phone calls"

Key Points

Some staff said there could be greater joint working

There is a need to collaborate with and within the third sector, and with external suppliers such as care homes and care at home providers.
Information needs to be shared and integrated within services, supporting collaboration, connecting people, overcoming barriers and preventing the loss of key information during the care pathway.

Support & Treatment

Key Points

Staff were motivated to achieve person-centred, preventative, holistic, realistic, effective, co-ordinated, safe, empathetic, dignified care to support people to live as they wish to, without barriers and with a good quality of life connected to their community.

Some services improved access to support – e.g. MidMed & Winter Frailty Team

Proactive input from specialists in Primary Care and Third sector organisations can increase people's access to future planning, benefits and initiatives such as blue badges and 'message in a bottle'
"I was surprised at how much help is available. You are doing a terrific job. Your service co-ordinator is doing an excellent job. Cannot praise her too highly."

It is important to value the carer's expertise

Carers are fundamental in the circle of care as they have important knowledge and expertise about the person they care for. It is important to value the carer's expertise and provide support, by understanding their needs, what is important to them and involving them in decisions about care and treatment.

Some people said the 'system' was too complex.

The system of care for people living with frailty is highly complex, with many different organisations, professionals and access points. For people living with frailty and carers this is challenging to navigate, co-ordinate care, understand 'who is who', and know what support is available when it is required.

Key Points

Some staff mentioned it can be hard to know what other services are supporting a person

It can be hard to get an overall picture of who is involved in someone's care. Staff have to check multiple systems to get a complete view – and many didn't have access to every system.

Some staff mentioned services could work together better – e.g. sharing consent and information.

People said that they were often asked the same information by multiple professionals and had to tell their story many times.

"If the nurse is late she misses the transport to the day centre. The driver tries to come back but it is not always possible and means she also misses lunch"

There was a wide range in people's experience at the GP.

Some people felt it was hard to get an appointment, they didn't understand their medications and wanted more continuity by seeing the same GP.

Support in a Crisis

Key Points

Some staff said there is a need for timely access to prioritised information in emergency situations.

Timely access to information is crucial, especially in emergency situations when professionals need to quickly understand the context. The information needed should be shown in chronological order, prioritised according to its importance and available to those who need it to manage care.

Some people mentioned difficulties organising Packages of Care – and this can influence other areas such as delayed discharge

"on one occasion mum was in hospital for 5 weeks when she could have been discharged after 8 days. Even though the Package of Care just needed to be reinstated she had 'to go back on the list'. I don't understand why her package of care could not just be put on hold'

Physical Disability & Sensory Impairment

Planning group: Physical Disability & Sensory Impairment
Planning Lead: Tom Welsh (Temp)

We would like to thank the **30** people with lived experience and staff who contributed, including members of Forward Mid and Enable, and the community organisations and service providers including Enable, Deaf Action, Sight Scotland, MVA, LCIL and the Physical Disability Team.

We spoke to people for 8 weeks from 22-07-2021 to 15 -09-2021.

Questionnaires completed

- 2 individual and 1 group questionnaire completed by Enable

Interviews/focus groups completed

- 5 interviews with representatives of Forward Mid and MVA one of which included manager of Lothian Coalition of Independent Living

Other engagement

- Interview with Director of Sight Scotland
- Interview with Director of Deaf Action
- Interviews with Team Leader and the Physical Disability Team
- Interviews with Project Officer for Extra Care Housing
- Information gathered through the course of engagement with other client groups including older people, and people with learning disabilities and with unpaid carers

Prevention & Early Intervention

Suitable Housing is crucial for people to manage independently

	Key Points
	Both Forward Mid and Enable mentioned the value of suitable housing in enabling people to be independent and have a better quality of life.
	Maintaining and repairing adaptations is important
	Some people felt that the Council and/or the IJB need to have more influence on the accessibility of housing built by private developers
	Some people thought a Care and Repair service would be helpful as long as it is of good quality and responsive to the needs of Disabled People

Information enables people to access the most appropriate supports

Key Points
Some people felt the Resource Directory was valuable**.** The importance of access to local information, available in one place, was reported by members of Forward Mid and Enable
Some people said it was helpful to ensure people know where to go for support whilst waiting on formal services. Easy access to information enabled people to access Community Supports making it more possible for them to look after their own health and wellbeing

Support to stay well – for both physical and mental wellbeing

Key Points
Access to leisure services can be a problem in some areas
Ongoing rehabilitation can help build and maintain strength
Recognition and support to address issues related to mental wellbeing and pain management would enable people to have a better quality of life
Some people felt Midlothian Council and NHS Lothian should strengthen their approach to the **employment of disabled people**. While enabling disabled people to find and retain employment is not within the control of the IJB, the Council and NHS Lothian can set an example as employers and influence other public bodies.

Support & Treatment

Aids and equipment support disabled people in everyday life.

Key Points
Delay in receiving such help not only increases risks but has an adverse effect of people's ability to cope and consequently their mental wellbeing

The new standards on Self-Directed Support were welcomed

Key Points

- There should be an implementation group involving service users
- It is a very lengthy document and should be distilled into a summary to be accessible for service users and frontline staff

Access to services is vital

Key Points

- The **Care at Home** service is, for some disabled people, critical to their ability to manage independently at home and with a reasonable quality of life. Without such support can mean a failure in Human Rights
- A quality assurance system for care at home services should involve service users in an ongoing way
- Lengthy waiting times for services such as **Occupational Therapy** is disabling bringing potential risks to disabled people.
- A review of physical access to all **health premises** –health centres, pharmacies, opticians etc.-should be undertaken
- There is a need to review the right balance of face-to-face contact with reilance on technology as we move out of the Pandemic

Crisis & Emergency

The absence of essential care at home services has been recognised as a major challenge for the HSCP. However, for people on Direct Payments there are very similar implications if there is an interruption of support provided by **Personal Assistants**

Key Points

- Back-up arrangements are needed whereby people who rely on Personal Assistants are able to quickly access a competent replacement in the event of illness; self-isolation; or resignation

Mental Health

Planning group: Adult Mental Health
Planning Lead: Karen Darroch

We would like to thank over **250** people (including over 90 staff) who took part and the many community organisations and service providers who helped us reach so many people. A large part of our consultation for the Strategic Plan was carried out as part of our consultation for the recommissioning of community services in autumn 2020. In addition we spoke to staff groups again in autumn 2021.

Questionnaires

- Consultation on recommissioning of services (79 questionnaires) - Community groups (e.g. MVA distribution list, NHS Get involved, Health in Mind), Public & Staff
- No 11 Feedback questionnaire
- Patient user feedback (20 replies) for Psychological Therapies

Interviews & focus groups

- Consultation on recommissioning of services (20 sessions) Staff (Primary Care Mental Health Nurses, Social Workers, Psychological Therapies Service, Health in Mind, Community Mental Health Team, Wellbeing Team, Mental Health Occupational Therapy, General Practitioner Cluster Leads, Health Inclusion Team, Psychiatry, Police Scotland) and people who use our services (CAPS)
- Weekly Outnav multi agency meetings to discuss outcomes for No 11.
- Discussion with all partners across Lothian for the Mental Health and Distress Pathways

Other engagement

- Meetings to agree actions, targets and finance with Health in Mind, CAPS, Occupational Therapy and Psychological Therapies
- Participation in consultations for shared actions in other areas of the plan e.g. Housing, Redesign of Urgent Care

Prevention & Early Intervention

Improve access to Community Mental Health Supports

Key Points

It is good to have a **central, well known point**
"It serves as one point of contact (address/tel number) for multiple services"

Key Points

Many people commented that building based support provides a **safe space**.

"people are fed up of groups, it's what we offer all the time, groups don't meet the need of a hub where people have a sense of community"

"sometimes it's about getting out of the house which in turn helps me to get out your head. The orchard centre seems to be the only place there is that offers a drop in and Safe space and place to go to sit in a safe environment.. It's unique in the sense of not being hidden away. (Like the hidden illness) It's not like an appointment service like a health service."

Some staff mentioned it may **reduce work for statutory services**

"It probably meets a huge need at a lower level. Is that what keeps them from becoming our clients?"

Many staff mentioned **stigma attached to the Orchard Centre**

"It can be a struggle to get people on board with a referral to the Orchard Centre – because of how it is described in the wider community – it can be quite intimidating."

"Hard to get away from the image of the 'orange door in Bonnyrigg'"

"I know a few cases, that because of that feeling, they declined any form of support"

Many staff mentioned **difficulties for new users of the Orchard Centre**.

"There is a group of people who don't want to attend as it can be seen as cliquey and intimidating."

A number of people mentioned the **unequal distribution of resources.**

"Offering support in more than one base could rebalance the distribution of resources across the county."

"It would be good to have a mix between a base and community outreach."

"It's important to have choice where you access support, I don't want to be in my home town"

Some people found it **hard to access Midlothian Access Point**

This was related to capacity at clinics and geographical locations. Maintaining a variety of options of access including digital and face to face was seen as a way to mitigate against this

"The drop in fills up very quickly – you have to get there early"

"The Midlothian access point could have outreach groups in community spaces in addition to the regular community hospital location"

Improve Physical Health

Key Points

Low levels of people being followed up for blood checks or offered screening.

Improve access to information about self-management

Key points

Most people said it is useful to have information in one place.
"It is completely essential … a single portal for everything."

Some people liked Midspace's local identity

Not everyone was aware of, or uses Midspace or the available services
"Finding out what help was available was difficult at the start"

Many people said the **information on Midspace is not always up to date**
"If we knew Midspace was up to date… it would make the world of difference"

Many people said they found it **hard to use Midspace**
"If you click on services you get a page of boxes. It is overwhelming."

Support & Treatment

Improve Holistic Support

Key Points

Some people said it was **easy to access Midlothian Access Point**.
"it's not complicated, it's easy to walk in and talk to a human being about their problems" "being assessed at the Midlothian community hospital quick and helpful - I honestly thought I was going to be admitted to an asylum and had a panic attack in the waiting room! Walked away feeling relieved and calmer just having seen someone and talking through what possible treatment I could get"

Key Points

Some staff commented on **positive support for people**
“The Access Point can be positive – it can signpost people and ‘put them on a pathway’”
“Staff agreed the ethos of No 11 and joint working improves patient/client pathways”

Many **services had a positive relationships** with MAP.
“Social prescribing is very complimentary to the Primary Care Team. It is important to the success of the work of Primary Care Mental Health nurses. The nurses offer specific, clear interventions and social prescribing, with long term support, dovetails/bridges support before and after this.”
“Mental Health services have never been better in the community. In the last few years … we (GPs) have seen a vast workload reduction”

Joint working could be strengthened.
"All teams in No 11 acknowledged the need to have a better understanding of each other's roles and service "

Advocacy

Key Points

Access to Advocacy could be improved.
“Several people highlighted the need to address people’s right to advocacy by increased awareness of the right to Independent Advocacy"
"Staff identified the need to ensure a planned approach to advocacy to ensure sufficient provision for all who are entitled"

Psychological therapy & Occupational Therapy

Key Points

"People found the service (psychological therapy) helpful" and "Most people stated they had been treated with care and compassion"

Staff acknowledged the need for "Patients to be seen on a timelier manner to improve patient pathways” (Occupational Therapy)

Housing

	Key Points
	"all staff agreed the value of the housing first model and the need to continue to support this provision"
	" some people stated the need to address the lack of specific matched housing needs for individuals with complex mental health needs"

Crisis & Emergency

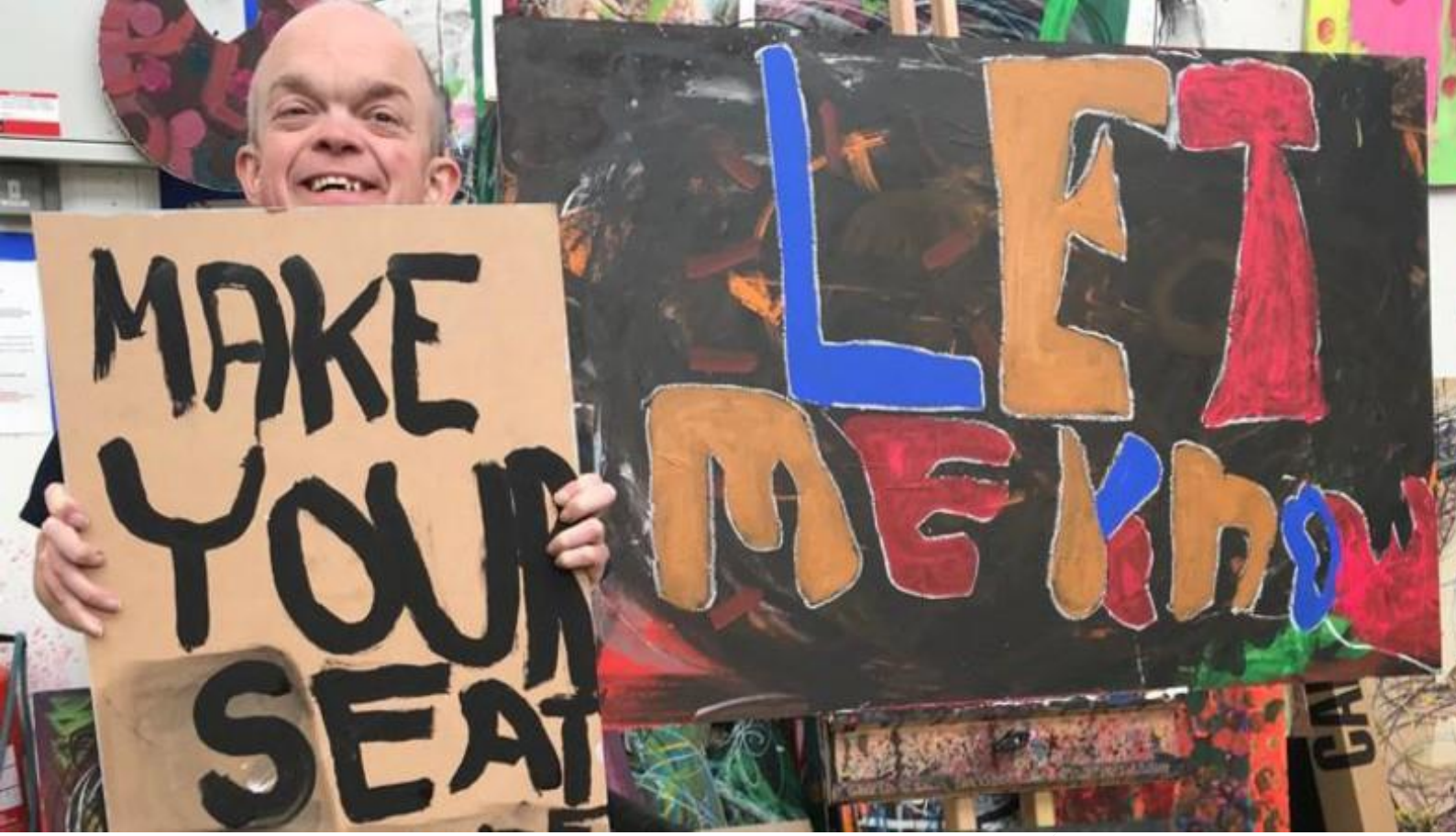
Same day access & A&E & Redesign of Urgent Care

	Key Points
	Some people stated that the local crisis line number can be used in **a Safety Plan.** “It has helped me not to harm myself, or worse. It has helped me out of some very bleak thoughts.”
	Some people felt it was helpful to have a **local service** - in addition to national services (e.g. Breathing Space, NHS24, Shout Out and The Samaritans). “It feels more accessible if someone is anxious - they can see the centre and get to know the staff.”
	Many people felt there may be better **alternatives** to a crisis line and a more intensive intervention, follow up and planning. “Distress Brief Intervention would fit with crisis support more effectively” “People want medication rather than to call a third sector crisis line.”
	The **hours of the crisis line are limited** – e.g. it is closed Christmas/New Year. It can’t offer **next day support** for crisis presentation related to social situations. “I need something online. I don't fall apart Monday to Friday 9-5!”

Key Points

People who use services and those supporting people in distress **found it difficult to get the right support at the right time**

"My husband was suicidal two years ago. I had to beg for a [name of service] appointment for him. [name of service] came three months later after I chased almost daily but again this was private health care. We received no additional support when it mattered the most…. I had to fight for support on my husband's behalf. It was exhausting and harrowing."



Learning Disability & Autism

Planning group: Learning Disability & Autism
Planning Lead: Duncan McIntyre

Who We Talked to

We spoke with over **160 people** during July, August and September 2021.

People First Members over two months at their four Midlothian groups

We held a Public Meeting with 25 people in Eskbank

The Learning Disability and Autism Providers held a meeting with 23 providers

The Learning Disability Team held a meeting.

The Learning Disability Strategy Group met three times to talk about the survey and the findings.

We did detailed work with 12 people with the most complex care needs and communication difficulties at Cherry Road

We sent out a survey through all the Provider Organisations and their user forums

We did two Online Surveys. One for Learning Disability and one for Autism. 98 people did the on line survey

People First Members wrote a letter to the Strategic Planning Group

Rights and Involvement in Care and Planning and Decision Making

People want equal rights whatever their gender, age or ability.
Everyone should be supported to make their own decisions about their life.
There are some people who do not have a voice yet, particularly those with Complex Needs and younger people.
People want to be involved in planning and decision making about their own health and care.

There were a lot of ideas about how we could make this happen:

- Speak with people on a regular basis to ensure they are getting the right health and care services.
- Speak directly to people with lived experience, not just their families.
- Promote supported decision making and offer training to staff.
- More advocacy groups to hear the views of a broader range of people with learning disability and autism.
- Gathering information about what works well for people and use it to plan.
- Making sure that key knowledge about people with complex needs is clearly evidenced in the outcomes they achieve
- Help people to get the skills and confidence to speak up
- Look at different ways to consult, easy read, pictorial questionnaires, meetings and gather feedback from individuals
- People with Learning Disability and Autism should be on the Expert Panels.
- We should educate people about their rights and educate others about learning disability and Autism
- We should implement the Charter for Involvement.

Health and Wellbeing

Staying Healthy and Well is very important to people.
Many people with a learning disability are not as healthy as other citizens.

There were a number of ideas to help improve people's health:

- Medical people like nurses, doctors, and hospital staff should be trained in understanding learning disability and autism.
- They should understand the health issues experienced by people with Learning Disability.
- Seeing the same medical professional for each appointment and having more time really
  helps.
- Getting a GP appointment can be difficult. The appointment systems don't always suit people with Learning Disability.
- There should be a good choice of more accessible and affordable physical activity like swimming and gym and exercise classes.
- There should be more accessible health information.
- There should be more help with mental health especially for men.

Transition

Young people want to reach their full potential and may need help and support to do this.
This can be in different areas of their lives like:

- going to school or college,
- moving from child to adult services,
- help getting a job, education or training,
- welfare and housing changes,
- and healthcare,

There were a number of ideas to help improve transitions:

- We should start working with young people and their families at an earlier age and develop better partnership with schools and Children's services.
- There should be more support and flexible choice after school.
- We should focus on getting it right for each young person.
- We should start planning earlier.

Feeling Safe

Everyone should feel safe in Midlothian Communities. This includes changing attitudes and behaviours so that disabled and vulnerable people can feel safe within their communities.

People want to

- feel safe at home
- when they are out and about

People said they need the skills to:

- Stay safe on line
- Know how to avoid scams
- Stay protected from financial exploitation

Keep Safe Spaces work well and there should be more.

Working Together

There are a lot of good examples of people working well together in Midlothian.

There are great relationships between people, their families, service providers and Health and Social Care. Good relationships between social work and social care staff really help in getting things right for people.

Organisations worked well together during COVID and we should build on these partnerships. There was a lot of really positive feedback from families and service providers who appreciated the flexibility and communication around the Midlothian response to the COVID Pandemic. In particular:

- Continuation of services,
- Creative responses and willingness to give things a go on all sides,
- Ability to still offer respite,
- Flexibility of services to enable us to meet critical needs ,
- Vaccination clinics.

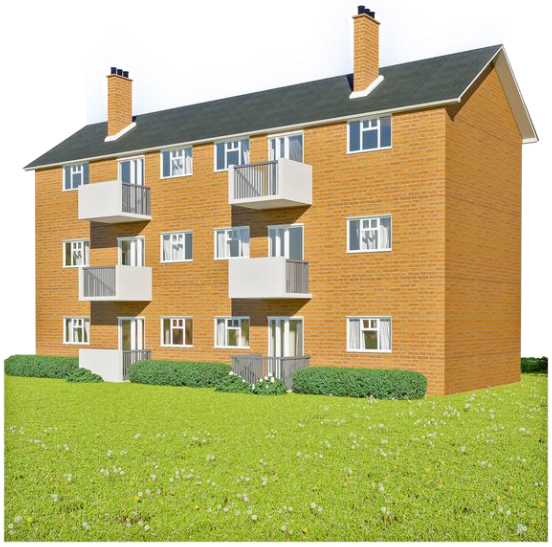
The dedicated Learning Disability Team has worked very well. It has helped to build relationships, develop peer support, and knowledge sharing.

People like face to face contact but we should continue to use technology for people who it works best for.

Housing

The right housing is a key part of being independent and feeling included in our community.

People with a learning disability and autism have a right to live in ordinary houses in ordinary streets with adaptations if required. This includes people with the most complex needs.



People said that:

- There should be more Housing Options including single tenancies and two people sharing.
- They should be able to choose where they live and who they live with.
- There is not enough affordable housing.
- There should be sufficient support to live independently.
- People with complex needs should be supported to live where they want to live.
- Partnership work between housing and Health and Social Care works well and should be developed
- There should be options for people with Dementia and Learning Disability to stay in Midlothian.

- There could be more respite and short break options particularly for:
  - those with physical needs
  - people with very complex behaviours who can be managed at home if parents and carers can get a break.

Support

The right support and the right staff make a big difference to people's experience. This means staff who are skilled, feel valued, motivated and supported. We should understand what works for people individually and not concentrate on service models that don't meet people's needs and expecting them to either fit in or be isolated in 1:1 packages which lack structure and meaning.
Some people cannot do the things they want to because of lack of staff. This means they get less choice than people without a learning disability. People say they could have more independence and make more decisions if they had more support.

At the moment, support only helps with basics like cooking, shopping and paying bills.
There should be more choice about support in Midlothian:

- Choice of staff, People would like to be involved in choosing their staff
- It is good to have consistent staff.
- Choice of hours,
- Choice of service providers.
- Small teams who people know and like.
- An allocated worker who people can get to know.

Support should be flexible and tailored. It should:

- support personal outcomes
- ensure that people's needs and desires impact on how services are delivered
- develop skills in ways that are meaningful for people
- Offer more bespoke support for people with complex needs and Profound and Multiple Learning Disability.
- Support older family carers
- Help people to get out into our communities and meet others.
- Promote independence to be active and do new things
- Offer Proactive approaches which can prevent a crisis
- Be about people not cost

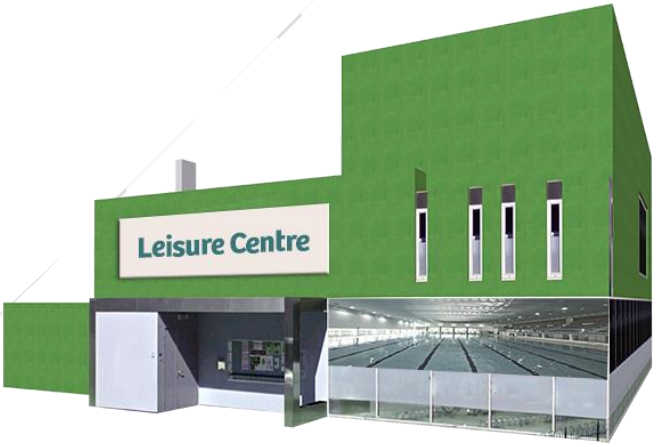
Good friendships and relationships are very important to people.
Monitoring and improving the quality of services and support offered to people is important. Support is sometimes better on paper than people's experience

Opportunities

People with a Learning Disability, and younger people in particular, want very different opportunities and the right support that is individualised and reflects their aspirations. People want to:

- Get out and meet more people
- Do a variety of interesting things
- Find a partner
- Build confidence after the pandemic.
- Be a good parent

(i) Day Opportunities



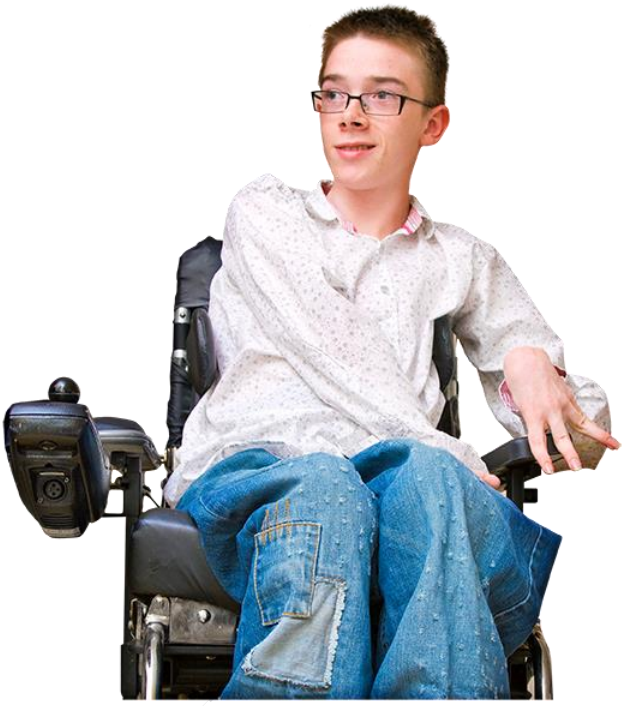
People said that they would like more choice of Day Support and flexible day services at different hours.

- More chance for a social life
- Social Opportunities like Get2gether, LAC football, walking and coffee, tea dances, discos,
- Community Access Teams for young people are good
- Being with friends and people we like.
- Be part of our community.
- Use local sports centres.
- Friendships and Relationships are really important
- Do a variety of interesting things
- Local Area Coordinators are good at helping people join local things.

Many Day Services were suspended because of COVID leaving nothing for some people to do.

Now Day Services should be started again. They should:

- Support people to build their confidence after pandemic.
- Some people have lost confidence after the pandemic and need support to make new friends.
- Continue with the type of creative and flexible services offered through pandemic



We need a choice of day support in the west of Midlothian.
Clearer policies needed for transport and access to day service
We could try a Befriender scheme.
We need more support and activity for autistic people without a learning disability.

And for people with the most complex needs:

- The pandemic has shown that people, families, housing support services and day services can work really well together,
- People with complex needs like variety of opportunity,
- Activity should be designed around shared interests and can support friendships and relationships,
- Activities can take place wherever they work best, at home, at a day centre, or in the community,
- Programmes can respond to the detail of people's interests and their right to learn and develop new skills and interests,
- Activity within the programme should change in relation to people's responses through a review system which helps to provide variety and build on what works ,
- Regular good quality feedback from those involved helps to develop a fuller understanding and improve people's support.
- Interactions and environments can be adapted so that people feel safe,
- Teamwork provides better quality outcomes for people with complex needs.

(ii) Jobs

People want more opportunity to work or get work experience and more support to help find and keep jobs.

- Opportunities for work experience
- Training for employers
- Real, permanent jobs
- Volunteering

(iii) Education

People would like:

- More adult education classes like literacy, numeracy and digital literacy.
- More life skills classes like planning and cooking meals.
- To be part of special interest groups like art or drawing. Not just go to groups for people with a learning disability.

Long Term Conditions

Planning group: TBC
Planning Lead: Hannah Cairns

People were consulted on Public Health during these consultations so findings have been merged to ensure we don't duplicate findings.

We would like to thank the **150 people** who took we spoke with, and the community organisations and service providers we met with.
We spoke to people for 1 week in Autumn 2021.

2 Focus groups completed (50 people)

- Long Term Conditions (34 people) – staff from Health, Social Care, Third Sector and people with lived experience.
- Neurological Conditions (16 people) – staff from Health and Social Care, people with lived experience

1 questionnaire (100 people)

- Community Respiratory Team consultation - staff from Health and Social Care, people with lived experience

Prevention

Increase physical activity & support to eat well

Key points

Links are improving with Sport and Leisure
Some staff mentioned referral pathways have been set up and are working well

Midlothian has lots of green space and opportunities
Some staff mentioned initiatives of local groups that are working well e.g. Park Runs, Greenscription and online walking groups.
Some staff mentioned Midway is successful in to 'get the messaging right' to support people to become motivated.

There are barriers to being active
Some staff mentioned barriers such as cost, embarrassment, location and hard to find up to date information.
'Make it less Lycra and local'

There has been a reduction of fitness levels for people who were shielding
Some staff mentioned the reduction in activity and the connection to frailty and more sedentary lifestyles.

Key points

Sport and Leisure Staff are not yet trained in supporting people with LTC

Some initiatives are working well

Some staff spoke of successful initiatives such as supporting carers, the Community Pantry and the online DESMOND app.

Staff need greater knowledge and confidence

Some staff said it was hard to have the confidence to raise the issue of weight and would like to know what support is available.

Improve detection and diagnosis and stop smoking

Key Points

Some initiatives are working well

Some staff mentioned targeted interventions that had supported people – e.g. COVID vaccinations for people with a learning disability.

Midlothian has lots of opportunities to support people

Some staff mentioned ways to work together– e.g. pharmacies offering detection and diagnosis, Health visitors, school nurses and all services using 'teachable moments'.. However some staff mentioned difficulties with systems such as Ad Hoc Blood Pressure monitoring in pharmacies.

Access to GP and Screening is not equal

Some staff mentioned inequalities in uptake

- Fewer uptake in less affluent areas
- Hard to offer screening if someone doesn't have an address e.g. homeless.
- GP appointments were 'a challenge' in deprived areas – could there be alternative routes into health advice'
- Fewer young people attend diabetic eye screening.
- Fewer men in deprived areas attend bowel cancer screening

Some staff said it would be good to increase chronic disease monitoring and develop expertise in Primary Care teams.

Key Points

It can be hard to support people at the start

Some staff mentioned it was hard to find their way around the system and we need to make it easier for people to self-manage after diagnosis. People need greater health literacy to understand their condition.

'If we want people to self-manage we have to make that easy – e.g. a buddy for walking and not just getting people to a group'
'Services are not always able to take people on'
'people need the skills to notice red flags'

We need to be more present in communities.

Online assessments can make it hard to spot deconditioning and some staff mentioned that people's confidence to 'look after themselves and use services is so low it prevents engagement'

Focus is turning to crisis

Some staff mentioned that their work is 'moving from early intervention to crisis led' but if they could see people early they might be able to 'stop situations turning into a crisis'

NHS Lothian not meeting targets for stopping smoking

Some staff mentioned services saw variations in referral rates from GPs

Support & Treatment

Heart Disease, COPD, Cancer, Long COVID, Stroke, Diabetes, Neurological

Key points

CRT is successful in supporting people with COPD

Some staff mentioned a reduction in unscheduled appointments for GPs and good collaborative working. CRT see lower levels of admission for people they support – maybe due to reduced anxiety, emergency meds and able to treat themselves early.

"What benefitted me most was classes, moral support and correct advice…. I was looked after very well by CRT'.
'More planned treatment/less crisis/better self-management'

ICJ is successful in supporting people with Cancer

Some staff mentioned that the 'good conversations' is useful in supporting people – not just for practical issues but for focusing on what is important. Some people with lived experience would also like support at the end of treatment.

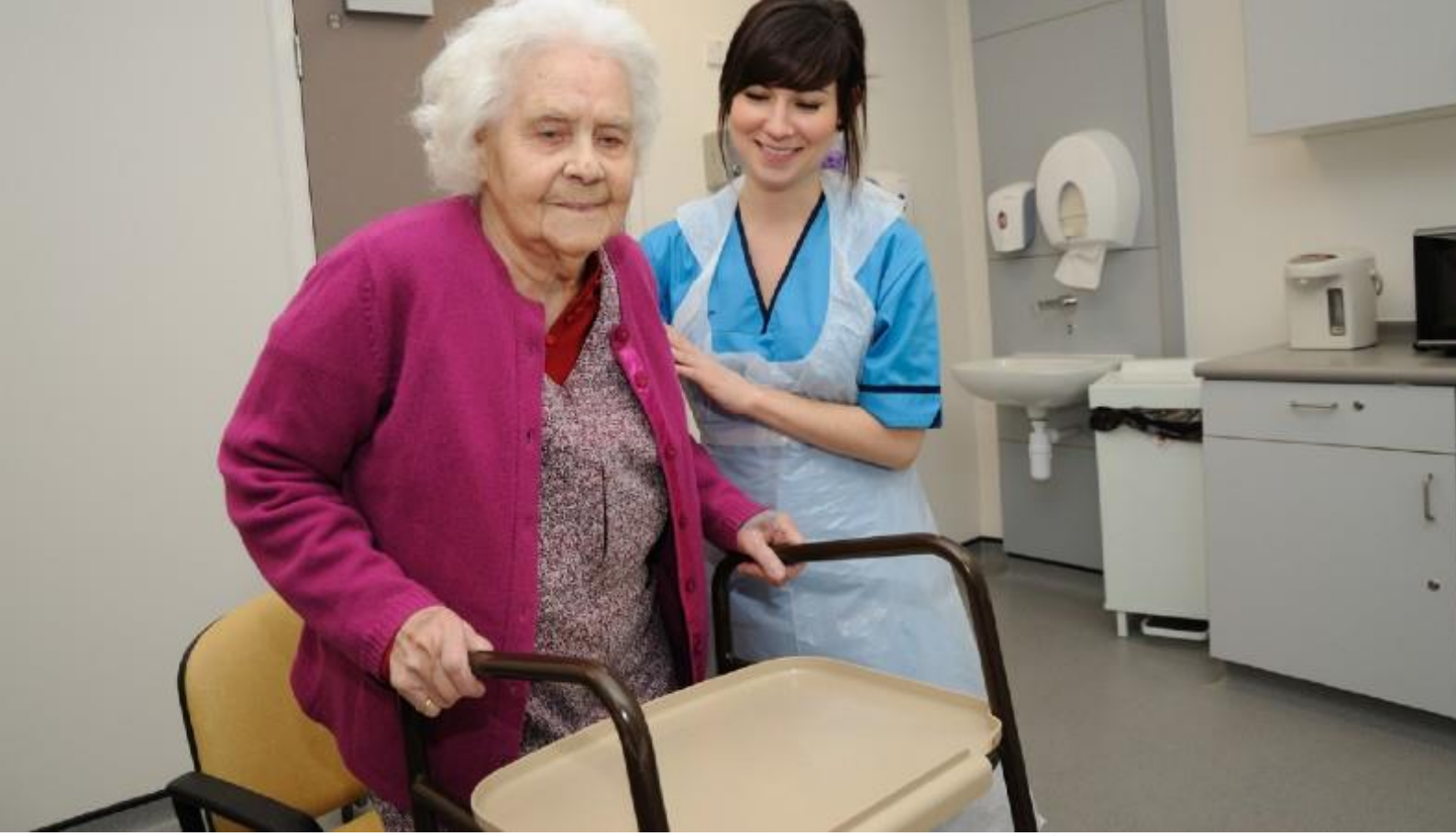
We need to make best use of what we have already

Some staff mentioned the practical things we can do – such as allow third sector partners to use our facilities. Funding of third sector services was also an issue

''it's not rocket science if the services are properly funded then you will end up with amazing services – we need to be given the tools and funding is one of them.' **We are supposed to be pushing people towards third sector but if we don't fund them they won't be there**.

Impact of COVID could be large

Some staff mentioned a worry that Long COVID could have an 'enormous impact'



Falls & Fracture Prevention

Planning group: Strategic Falls Group
Planning Lead: Gillian Chapman

The Falls & Fracture Prevention Action Plan has been informed by a local needs assessment and national policy and guidance, including the draft Scottish National Falls & Fracture Prevention Strategy 2019 – 2024. There are over 400 risk factors associated with falling making it a complex issue to tackle. Effective falls prevention requires a whole system approach that combines both universal and targeted actions. The feedback that has informed this strategy highlighted that the current provision of falls prevention initiatives in Midlothian is multi-layered, with some aspects having evolved locally and others county-wide. This strategy provides the opportunity for partners to work together on agreed priorities to ensure that Midlothian residents are able to benefit from effective, high quality falls prevention.

We spoke to people throughout 2021.

Prevention

Key Points

Some people mentioned the importance of gritters during the winter – especially in residential streets.

'You never see the gritter in my street and it's like an ice-rink'
'The gritters should prioritise places where older people live'
'We had a great team of young men last winter clearing the snow at **** – I wouldn't have been able to get out otherwise'.

Some people mentioned the effect of COVID-19 on their activity levels

'I used to go out walking a lot but don't want to now in case I bring the virus into the building'
'I have been less active'
'I have started buying my meals from *** as it's safer than going to the shops'
'No falls but much less active because I'm just in the flat.'
' I'm frightened to go out now'
'Less active, no falls'.
'I have lost weight, because I have no appetite and I feel scared to go out for a walk.'

Support & Treatment

Key Points

Some staff said training in falls prevention has been positive.

"The training got me thinking more of the issues surrounding frailty as well as the consequences of falls"
"The training increased my falls knowledge"

Staff said the work on the Falls Prevention Pathway was positive.

"Provides a more coordinated approach"
"Quicker return home for patients"
"Provides consistency, equity and fairness across Midlothian"
"Penicuik e-Frailty MDT meetings…. work really well in terms of clear communication and reducing duplication."
"should be able to be made [referral] over the telephone"
"Need to upskill staff in falls – also upskill staff in other key assessments
"Difficulty accessing / sharing information … across different providers… Key to operational success of Pathway"
"Unpaid carers- knowing how to get help and ease of access is important"

Support in a Crisis

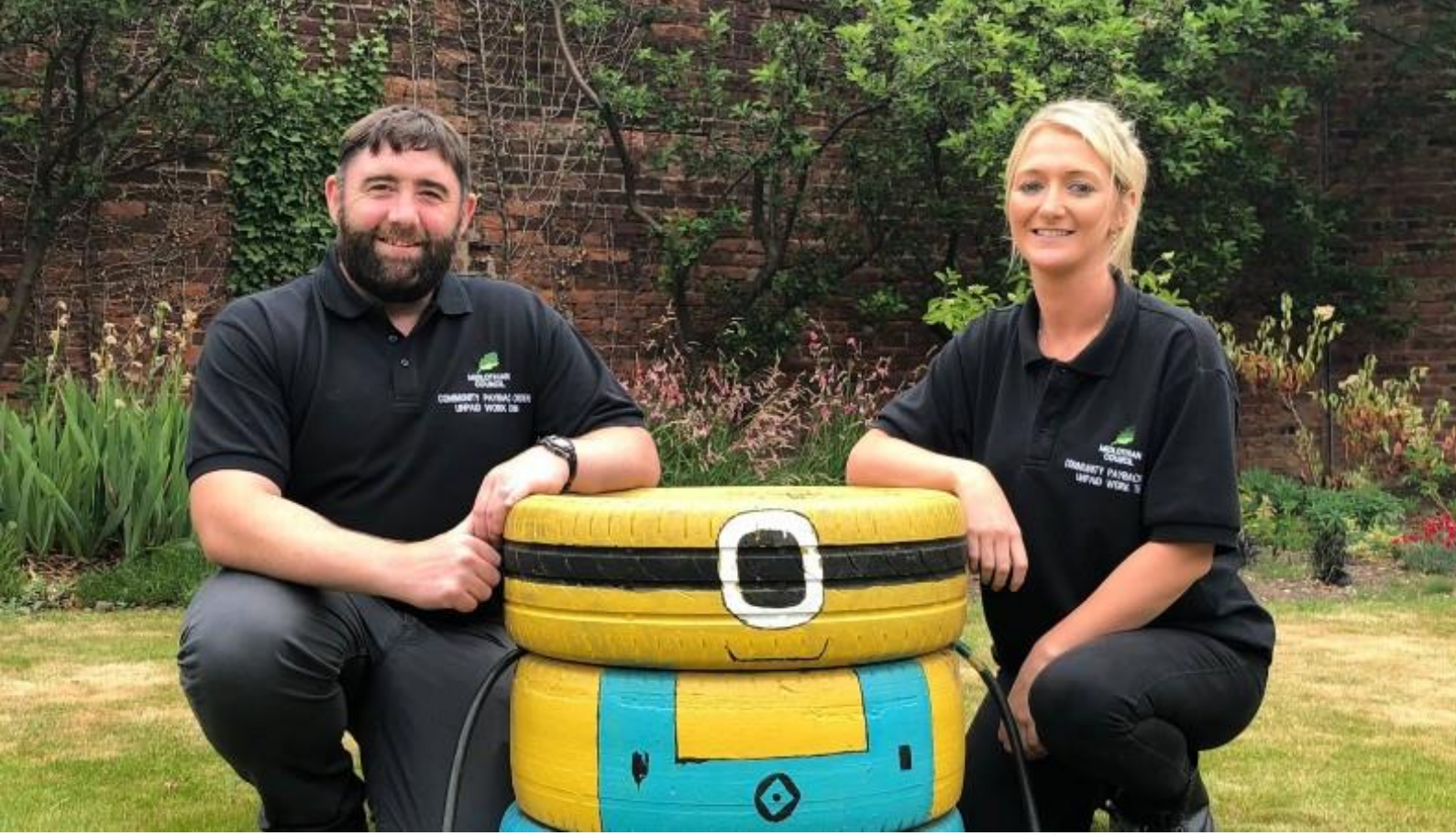
Key Points

Some people mentioned the importance of quick access to help after a fall.

'The Rapid Response team were amazing when my uncle fell at home. They told him that they would pass his details onto another team, and a Physio would be in touch to provide follow up help. The only criticism was that it took over a week for that to happen'.

Some people mentioned long waiting times for ambulances

'My terminally ill husband fell out of bed at 5am – I couldn't get him up off the floor, and I called an ambulance. We had to wait 5 hours for an ambulance to arrive, and it was so upsetting for us both, as I didn't know what to do. It was a horrible experience, at a horrible time.'



Community Justice

Planning group: Community Justice
Planning Lead: Fiona Kennedy

We would like to thank the **over 500 people** who we spoke with, and the community organisations and service providers we met with. We spoke to people for throughout 2019 and 2020.

Questionnaires completed (450)

- **Community Justice consultation** - including Midlothian residents who were incarcerated in HMP Edinburgh and HMP Cornton Vale and people who live and work in Midlothian. (May/June 2019)

Focus groups/1:1 interviews

- **Community Justice Outcomes and Improvement Plan workshop** with Community Payback service users (Feb 2020).
- **The Women's Service 'Spring' Annual consultation** with service users. (Nov 2020)
- **A focus group with women completing the Spring Service stepping stones project**. (Nov 2020)
- **Formal reviews, discussions on completion of the Order and six weekly focus groups** with people on Community Payback Orders. (Dec 2020)
- **CJOIP Workshop** - statutory partners; third sector organisations; service users with lived experience of the justice system; elected members and Board members. (Feb 2020)
- **Three briefing sessions with staff** who were moving into No. 11. (Summer 2019)
- **Consultation for a new men's service** with clients in the justice system (Feb 2021)

Other engagement

- Two weeks of public consultations at community centres (Nest; Pitcairn Centre; Pink Ladies; Grassy Riggs; Gorebridge Parish Church; Food banks; Leisure Centres x3; Libraries x3; Recovery Café; MELD; Mining Museum; GP surgeries; Orchard Centre; Parent and child groups held. (May – June 2019)
- Event for third sector organisations, service users and stakeholders. (80 people). (Nov 2019)
- **Community Planning Development Day** for statutory and non-statutory partners, members of the public and young people. (Nov 2019 & Nov 2020)
- **The citizen's panel**. (Winter 2020)

Key points

Just over half of respondents were aware of a service/support helping to prevent people from (re)offending in the local area.

Many people thought working with young people to reduce early anti-social behaviour was one of the highest priority areas to reduce reoffending. People mentioned a need for more preventative work at an early age. Diversion and education from offending, enhanced policing and tougher penalties, reducing alcohol provision and enforcing the law around sale of alcohol to young people, and encouraging parental responsibility were also perceived factors in reducing (re)offending.

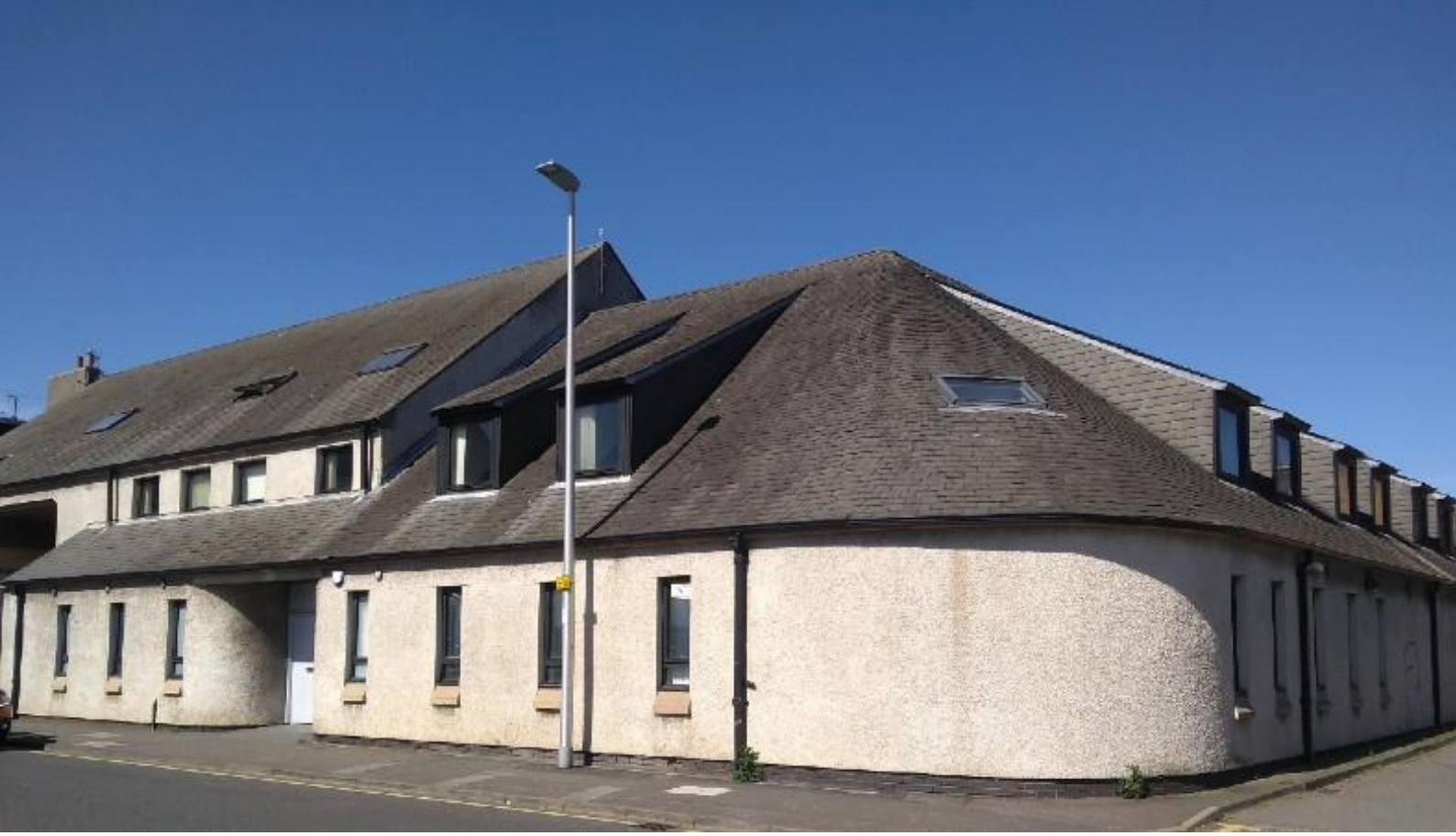
Some people thought supporting people to attend school and/or gain qualifications was important in reducing offending.
Suggestions included more active learning and vocational training, additional resources such as specialist provision and early intervention and parental support.

Some people thought supporting families and parents could reduce offending.
Suggestions included improving parental skills and parental education.

Some people thought supporting people with mental health issues could reduce offending.
Suggestions included the need for additional resource in mental health, and intervention in prisons.

There is work to do to raise awareness of organisations and services and their relevance to Community Justice.
In particular promotion of housing/homeless services, finance, and physical health services.

Some people noted a need for noticeable payback for communities and victims
Suggestions included improving local areas, helping more vulnerable members of the community, 'filling the gap' from council cutbacks, and restorative work with victims/survivors.
There was support for Unpaid Work that helps to develop skills, work experience or otherwise improves future prospects.



Substance use

Planning Group: MELDAP
Planning Lead: Martin Bonnar

We would like to thank over **90 people** who took part. As services for people affected by Substance Misuse are planned from 2020-23 Midlothian and East Lothian Drugs and Alcohol Partnership organised a consultation event at Horizons Café in Dalkeith in 2020.
After discussions with Peer Support Workers, they suggested that they [as people with lived experience] would be best placed to have an open and frank discussion with people who use services, families and carers and members of the public. It was agreed that MELDAP would not be involved in the consultation but would be available at the venue to answer any specific questions or queries.
MELDAP provided broad discussion points. These focused around 4 broad areas:
1. Preventing future harm caused by the misuse of alcohol and drugs
2. Reducing harm and promoting recovery
3. Protecting and safeguarding children, young people and communities
4. Commissioning and assuring high quality, cost effective outcomes focused services

The Scottish Government has suggested that Alcohol Drugs Partnership's will be required to develop annual Delivery Plans in the future. MELDAP will consult with people who use services, families and carers, members of the public and other stakeholders about future delivery plan priorities and hope to establish local forums for people with lived and living experience to become more involved in setting priorities and decision making.

Prevention & Early Intervention

Key points

Develop online resource providing people with help, **accurate evidence based information** around alcohol and drug use and local services.

Deliver more outreach **community focused harm reduction, treatment and support services** to individuals, families and communities most at risk of harm.

Support & Treatment

Key Points

- Further develop new ways to **engage with and support younger people** in accessing support for their alcohol and drug use.
- Work with people with lived and living experience, the recovery community and service managers and their staff to actively address issues associated with **stigma/discrimination**.
- Strengthen the role of peer workers as client advocates and develop **Independent Advocacy** service for adults and families.
- Work with **recovery communities** to expand both the range of and availability of services available to them and their families.
- Ensure all services are **'family' friendly and inclusive.**
- Work with partners to improve access to **travel passes and digital engagement** for clients involved in treatment and education services.

Crisis & Emergency

Key Points

- Build on the work of the low threshold service pilot, develop more **flexible, accessible services** particularly for people with a record of irregular attendance and sustained engagement.

RESOURCES

Workforce

Planning Group: Workforce Strategic Planning Group
Planning Lead: Anthea Fraser

We would like to thank over **300** people who we spoke with throughout the summer/autumn of 2021.

Questionnaires completed (264 people)

- Staff wellbeing survey 2021 (264 people)

Interviews/focus groups completed

- Peer support focus groups to specific teams for staff who have had high sickness absence and particularly related to stress/anxiety. (Facilitated by Wellbeing Lead)
- Focus group with Highbank and care at home staff (facilitated by See Me coordinator)

Other engagement

- Joint workforce development group (including third and independent sector, HR, Unions etc.)
- Feedback from all service leads on the priorities for future workforce development
- Learning and development practitioner engaging with team lead on their teams Learning and Development needs
- Staff Wellbeing group

Prevention & Early Intervention

Reducing the number of vacant posts will have a positive impact on the staff that are in post. To do this we must attract staff, focusing on the hard to fill posts and promoting health and social care roles as an attractive career choice.
We need to support and upskill staff and ensure staff are supported and valued. The most common theme was staff needed to be listened to, respected and valued in the work they do.

Key points

Most people felt supported by their immediate line manager

Staff didn't always feel acknowledged.
Staff have worked longer hours, picked up extra work, or worked in different capacities. Some staff felt managers didn't recognise this.
"they.. needed…to, be recognised for the job that they do by managers and for managers to have an understanding of how front line staff feel and their experiences"

Key points

Some people said they lacked support from colleagues and management
People mentioned feeling isolated from colleagues; unable to see close family and friends; unable to meet team in person.
Staff mentioned feeling a loss of leadership and investment in the team; lack of contact/support from manager.

People felt overloaded with work.
Staff said they felt overloaded as there were unrealistic demands/timescales and they had less time to carry out duties. Practicalities such as no space between Teams calls or not absorbing workload of absent staff added to the pressure. Staff mentioned the difficulty maintain a healthy work/life balance.

People need protected time for activities that kept them healthy and well.
Staff said it was hard to take time out to access support such as counselling, supervision, and physical activity. Some staff said they were unable to do basic things such as taking breaks or annual leave.
The most common reason for absence was "stress". There were 908 days lost from 01/2020 to 01/2021 for council employees in the HSCP and 1546 days lost from 04/2020 to 04/2021 for NHS staff in the HSCP.

Support & Treatment

Many people had been affected by the Pandemic – they are working from home more often, have increased workloads or changes to their roles or changes to ways of working.

Key points

Most people (over 50%) said they were coping well at work
People mentioned contact with colleagues, staying busy, exercise, having a supportive line manager, spirituality, flexible working and taking regular breaks as ways to manage at work.

Some people saw positives of working from home
They mentioned being able to take breaks outside and a better work life balance.

Key points

Many people said they were stressed and saw negative impacts on wellbeing.

People mentioned anxiety; worry; bereavement, additional workloads, PPE; difficulty referring clients/patients onwards with reduced service provision; 'relentless' demands but less staff; longer hours; not being refreshed after days off (just sitting at home); work-life balance and lack of well-being spaces at work

'First time in my work history I have been off for mental health issues'

'Have never felt as much stress at work in over 30 years service'

Some people mentioned physical issues such as weight gain, sleep issues, fatigue, less time outdoors.

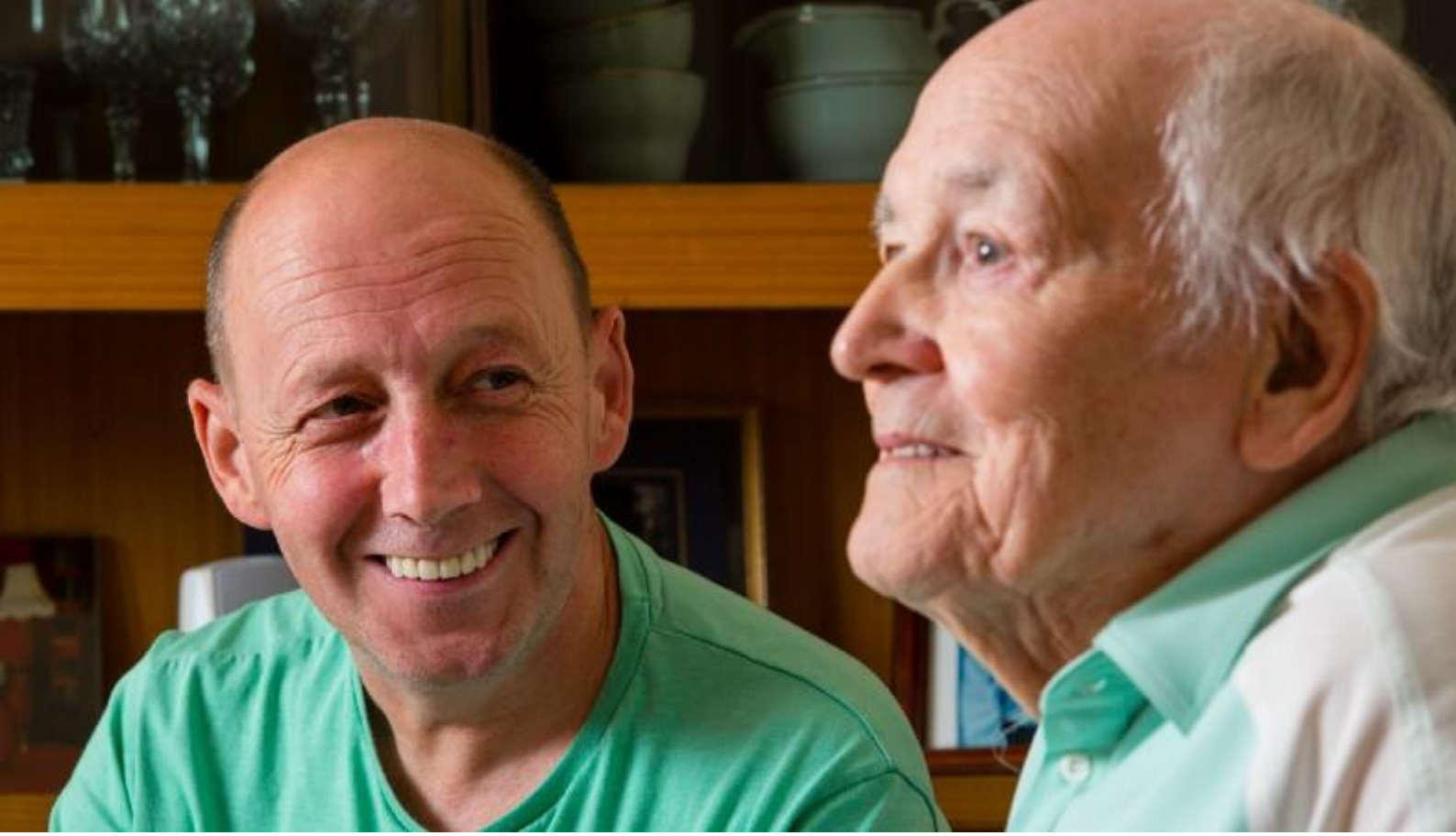
Crisis & Emergency

Key points

Some people valued the support from services such as counselling

Some staff didn't access the support services

People mentioned issues with waiting times/access, lack of awareness of services, difficulty finding time to access these or worries that other staff needed the services more than they did.



Unpaid Carer

Planning group: Carers Strategic Planning Group
Planning Lead: Shelagh Swithenbank

We would like to thank the **152 people** (including 62 staff) who took we spoke with, and the community organisations and service providers we met with including: Carers Action Midlothian; VOCAL Midlothian; and, Alzheimer Scotland. VOCAL Midlothian also carried out a survey with local carers in Sept – Oct 2021. 392 responses were received. Due to the shared themes, we've included some feedback.
We spoke to people for 6 weeks from August - September 2020.

93 Questionnaires completed

- Carers
- People who are cared for
- Staff - Third Sector, MHSCP NHS, MHSCP Council staff

12 Focus groups completed (42 people)

- Carers
- Staff - Third Sector, MHSCP NHS, MHSCP Council staff

17 x 1:1 Interviews

- Carers
- Staff - Third Sector, MHSCP NHS, MHSCP Council staff

Prevention & Early Intervention

Carer Identification

Early identification and connection to support, information and advice is of significant value to carers managing and being able to continue in their caring role for as long as they wish to do so.

Key Points

Active referrals and signposting which involve people make a difference

Carers spoke of trusting word of mouth referrals. A significant number of carers described word of mouth as having motivated them to make contact with services. Carers and staff thought carers were more likely to connect with services if there was a 'warm' hand over. There was a worry from staff that if help is not offered proactively carers can go unsupported until a crisis.

'We need to reach out not expect people to reach in'

'Carers often come along for support at a critical stage [...] If at a calm time, time can be taken, plans made, at a crisis then this is different.'

Key Points

Once you're in, you're in

A lot of people mentioned that once people are involved with services (third sector & public sector) they were likely to identify themselves as carers and be linked in to other support.

'Once you start with one support, this starts a snowball'

'It is not always easy to find out where to go for support; however, once contact is made with the support/s these are very effective'

A central starting point helps

People felt that a centralised point of initial information and support was helpful. People also spoke of good cross-referring happening between local statutory and third sector agencies.

'All organisations and what they can help with in one leaflet, found this useful'

'[name of organisation] as a centralised point of support is really useful'

VOCAL

77% of respondents who have engaged with VOCAL say that this has made a difference to their experience as a carer.

'Before speaking with VOCAL I didn't even know I was a carer even though I had been for a few years.'

'I know what is out there to support me if I want to access it.'

'They provided me with information I didn't know was available.'

Access to help is not visible enough

A strong recurrent theme was missed opportunities to 'identify' carers and tell them about possible support when the person cared for is in hospital and through GP surgeries.

People spoke of the need to increase staff training. Workload and time pressures were barriers. More visible, consistent and positive public awareness raising was also cited multiple times.

'I attended an appointment where I broke down [...] the person asked if I was ok, I wasn't but nothing was explored.

'The majority of carers are out there on their own, they don't necessarily have a clue who to go to or to get in contact with'

Key Points

It's not always easy to recognise when you become a carer

Many people felt that there is a high number of carers who don't recognise they are carers.

'It's hard to know *when* you become a carer.'

'It's difficult to adjust to being considered something other than just a husband or wife'

Stigma, guilt and value

In the focus groups stigma was discussed most strongly by parent carers and carers of someone with a substance misuse issue. Many people felt that more needs to be done to convey that identifying as a carer is a positive thing and can help.

People mentioned: having Carer ID as being positive, wanting better financial recognition/support and a need for consistent positive public awareness raising campaigns.

'That would make a difference in my opinion, to be valued for the contributions and sacrifices we make in our own lives to enable us to care.'

Future plans – see crisis section.

Support & Treatment

Improve access to Support, Information & Advice

Key Points

1:1 emotional support is essential

When speaking about feeling valued and listened to, most carers referred to third sector organisations. They spoke about 1:1 carer support and the difference it makes knowing they can pick up the phone or email, not feel judged and be guided through support. Carers felt that third sector organisations had the time to do this and were trusted to do this. Consistency of support was spoken about positively. Some carers referenced working with the same person from the beginning or for a long time.

Counselling support was also mentioned by many as an important 1:1 resource

'I know there is always someone on the end of the phone that can I can talk to'
'Professionals don't always make me feel good, for this I call [name of organisation]'
'It's nice to get away, but the guilt of going on a break, talking made a difference'
'It meant we were talking about me'.

VOCAL

'If I didn't have VOCAL to get help I would feel totally lost in my caring role.'
'Helped with acknowledging my feelings.'
'Knowing there is an organisation there to help with practical issues and emotional support who know how you feel was very important. I didn't feel so alone.'

Peer support is valuable

A lot of carers spoke about the power of having connections with people in similar situations – in peer Support groups and peer support which also offers support for the cared for person. Ways to build on peer support mentioned include: making it easier for staff to introduce carers to each other, opportunities for peer groups to help resolve wider issues e.g. replacement care, more co-located peer support (for the carer and cared for) and opportunities to mix and meet.

'Speaking to other carers and hearing how they manage makes you feel less alone and more able to keep going.'
'Being with people who know what you're going through without you having to explain'

Key Points

Access to third sector support is good

People spoke positively about timely access to support from third sector organisations. Carers and staff liked the fact that carers can self-refer to these services and that once you had contacted them the process was 'easy'.

'[name of organisation] and [name of organisation] were both easy to contact and responded quickly.'

VOCAL

53 respondents cited that the impact arose through VOCAL's information or Advice (service).

'The dementia classes were so useful in helping me understand.'

Consistent and informed health and social care support

A lot of carers said having consistent Health and Social Care workers would make a big difference. There was a contrast between the described rapport and trust with third sector organisation where people often mentioned having a consistent worker and time to be listened to, and that with public sector services where allocations were often described as short-term and multiple.

Carers described the value of someone knowing their situation, not having to repeat their story and knowing you can contact someone who will listen/proactively check in with you; alongside the importance of being treated as an equal.

The need for good information sharing systems between agencies or a centralised system was mentioned as part of this as was ensuring all staff are trained in good conversations.

'Hardest thing is starting a new relationship with a professional, it initiates all the emotion again'

'Unpaid carers are made to repeat their story multiple times.'

'You need to speak to someone who knows your circumstances and who will then call you every couple of months, someone who just knows your story and knows your situation.'

'Professionals need to work around barriers such as data protection, use common sense and do what makes a difference'.

Health and wellbeing support is not always at the right time or place

Several carers spoke about timing being a barrier to making use of health and wellbeing supports (training and wellbeing events or sessions).

It was felt that things should be local, with options both in the East and West of Midlothian. Penicuik was mentioned as an area where it is believed there is comparatively less support.

There was mixed feedback about digital versus physical support.

'A lot of things are during the day and I can't make this with work'

'Locality support would help [...] support in a community setting is important'

'Online support has been amazing but online can't replace face to face'

Improve Carer Health & Wellbeing

Key Points

Being able to take a break from caring is essential

A break from caring was one of the most talked about ways to help carers continue caring - both overnight breaks and smaller regular breaks as well as breaks and companionship provided by befriender services. Carers described different ways of coping, e.g. emotional support including 1:1 carer support and counselling to overcome barriers such as guilt.

Breaks which involved the cared for person were mentioned by a few people as positive.

'being able to be out socialising with others and being 'me' not just a carer'
'I don't want [the person I care for] to go into a home for a week, I just want a day to myself once in a while.'
'I don't always like it, I don't think my wife always likes it, but I appreciate the break and know it's part of keeping her living at home with me.'

VOCAL

25 respondents identified benefits accrued through time away from caring (either by going away or by using Wee Breaks funding more flexibly during Covid when this was not possible).
'Being able to access short breaks to help me recharge.'
'The support I received to achieve the break was positive and made a big difference to the person I cared for.'

Key Points

Replacement care is not accessible

Replacement care was a barrier to having a break from caring. Sitter services and residential respite were mentioned multiple times as services which make a big difference but which can be very hard to get, even in a crisis.

Carers spoke about the precariousness of support and several carers described lived experience of feeling pushed to breaking point.
Day to day support for the cared for person was described as lacking and/or with long waiting times. There were a few good examples of collaborative working mentioned e.g. third sector agencies working with statutory agencies to provide minor equipment and Adult Carer Support Plans.

‘While breaks are good and can make a big difference, they don’t fix problems in daily life. It is crucial that we help people get the basics right at home.’
‘Being able to do my running, walking, mindfulness and arranging days out, in order to do that you need support.’

‘I have not been able to use the breaks as in order for me to go anywhere or do anything, as I need someone to take care of my Mother’

‘I need to make a big jigsaw of things [care]. It only takes one part of that to tumble down and I cannot do anything’

‘What would make a difference? Volunteers who could help in giving me free time even if only 2hrs per week’.

Self-directed support was often described as not working; the money was there but the resources needed to achieve the outcomes were not (most mentioned: packages of care, sitter services, respite).
‘We’re giving them the money which they can’t spend. There are no resources even with all the flexibility of SDS’

Improve financial support & economic wellbeing

Key Points

People need more help to get money they are entitled to.

The impact of financial stress on a carer's health and wellbeing was mentioned multiple times. Financial hardship was also cited as a barrier to being able to plan ahead.

A need for more support with finances was highlighted, including help to apply for benefits and maximise income and finance 'checks'.

'Carers save the economy a fortune but financially are often left with very little.'

'I didn't know about Attendance Allowance or how to apply'

Workplace support should to be better

There were positive examples e.g. being supported to approach an employer to address issues but most comments focused on the need for work to be done with local businesses.

'It adds such a burden when you're not sure if your employer understands your situation or supports you.'

VOCAL

37 respondents identified positive financial impacts, including securing Power of Attorney and help with applying for support.

'I was not even aware we were entitled to the benefits that VOCAL helped me apply for.'

'I am unaware of the benefits system and they explained it to me.'

Crisis & Emergency

Planning ahead

Emergency and future planning can be areas of concern from carers, and we know that carers benefit from the opportunity to explore these issues and make plans – even if they are never used.

Key Points

Legal support makes a difference

‘Having POA in place provides a small piece of mind’

‘Carers … feel better once legal powers and processes are explained ... Knowledge is power.’

Emergency planning helps

Carers and staff who had completed an emergency plan viewed them as positive. It was said to give peace of mind and has helped some people have conversations they may not have otherwise had with their family.

There was a significant number of people who had not heard of emergency plans.

‘Planning for emergencies terrified me, keeps me up at night time [...] but it’s important’

‘These [emergency plans] should be offered to carers as a matter of course.’

VOCAL

‘Without them I would not have a care plan in place for my mother.’

A plan and access to resource should be offered from day one

A number of those consulted want to see space and time given at the beginning of someone’s caring journey to plan better. They want to know there is someone they can come back to and they want to have a consistent person to follow them in their caring journey. Anticipatory Care Planning could be a part of this.

There was mixed feedback about Adult Carer Support Plans. A significant number of people consulted had, had one. One of the worries raised was that this was not reviewed and did not necessarily lead to any action or change.

Several carers mentioned wanting to have more access to condition specific training.

‘It’s a confusing and chaotic journey’ someone needs to sit down with you at the beginning [...] explain things to you, tell you what help is available. They then need to check in with you as time goes by to see where things are at and guide you.’

‘I feel the Carer Support Plan, while good in concept, in practice is a useless exercise. It is created but nothing is acted upon as a result.’

‘Information can be overwhelming at first maybe it could be done in stages’

Acute Services

Planning group: Acute Services Planning Group
Planning Lead: Grace Cowan

We would like to thank over **130** people who we spoke with, and the community organisations and service providers we met with.
We spoke to people in 2021.

Questionnaires completed

- A&E attendance questionnaire – completed by RIE staff for everyone attending. 67 Midlothian attendances over 24 hour period, total 29 who chose to take part in questionnaire

Interviews/focus groups completed

- Midlothian People's Equality Group –alongside Older People's Planning Officer. 6 people
- NHS Lothian focus groups (x2) for Redesign of Urgent Care (organised by NHS Lothian and not specific to Midlothian, although there was representation)
- Focus group for Long Term Conditions – 34 attendees (staff from Health, Social Care, Third Sector, and people with lived experience)
- Home First stakeholder sessions for staff – 3 sessions, roughly 20 attendees at each
- Staff interviews with St John's Hospital and the Redesign of Urgent Care project team regarding Redesign of Urgent Care/Minor Injuries

Other engagement

- National engagement on the use of Near Me remote consultations
- NHS Lothian remote outpatient services engagement - questionnaire

Prevention & Early Intervention

Key points

Midlothian has lots of opportunities to support people
Some staff mentioned ways to work together– e.g. pharmacies offering detection and diagnosis, Health visitors, school nurses and all services using 'teachable moments'. However some staff mentioned difficulties with systems such as Ad Hoc Blood Pressure monitoring in pharmacies.

It can be hard to support people at the start
Some staff mentioned it was hard to find their way around the system and we need to make it easier for people to self-manage after diagnosis. People need greater health literacy to understand their condition.
'If we want people to self-manage we have to make that easy – e.g. a buddy for walking and not just getting people to a group'
'Services are not always able to take people on'
'people need the skills to notice red flags'

Key points

Focus is turning to crisis
Some staff mentioned that their work is 'moving from early intervention to crisis led' but if they could see people early they might be able to 'stop situations turning into a crisis'

Support & Treatment

Key points

Most people felt it was useful to have the option of remote consultations – recognising that there are some circumstances where this isn't appropriate, e.g., physical examinations, sensitive information, less confidence with use of digital technology
"any call…is far better than no contact at all"
"would not have to leave the comfort/safety of their own home"
"faster access, no need to travel"
"if [they] have bad results to relay then a remote…method would not be appropriate"

CRT is successful in supporting people with COPD
Some staff mentioned a reduction in unscheduled appointments for GPs and good collaborative working. CRT see lower levels of admission for people they support – maybe due to reduced anxiety, emergency meds and able to treat themselves early.
"What benefitted me most was classes, moral support and correct advice…. I was looked after very well by CRT'.
'More planned treatment/less crisis/better self-management'

Staff felt good communication and relationships between themselves and other teams worked well for following the Home First approach – while recognising that a lack of coordination between systems and pathways was a barrier to this but there were opportunities for innovation in practice.

Some people did not feel supported after leaving hospital
Pathways and services weren't joined up or they had different expectations of the support they would get once they were back home

Key points

Some people did not feel equipped to access digital or remote support - either due to digital literacy or access to the equipment required and/or private spaces to take part.

"I have a mobile phone and a laptop but now knowledge if either has a camera facility or can work a video"

"I do have concerns about confidentiality…"

"It is essential when implementing technology…that the individual patient has access to suitable equipment…which includes for those with a wide array of disabilities"

"[The] belief that anyone with a disability always has access to a carer who can assist at a medical appointment…is often not the case"

Crisis & Emergency

Key points

Most people attended A&E on the advice of another service – they were advised to attend A&E for example by their GP or 111

Staff recognised the positives of redirection of Emergency Department patients to scheduled appointments – they felt this helped patients to be seen more efficiently and reduce crowding in the waiting areas; however, staff acknowledged there were still some issues, e.g., around publicising, adding further steps in a patient's journey, and inflexible appointment times.

Midlothian Community Hospital

Planning group: TBC
Planning Lead: Kirsty Jack

We would like to thank all the people who took time to share their views and vision for Midlothian Community Hospital. We are especially grateful to the staff who provided representation of the thoughts and ideas of our patients, their carers, and other visitors to the Hospital in the Summer/Autumn of 2021.

Other engagement

- Consultation with Senior Medical Staff
- Consultation with clinicians from other service areas
- Information gathered through the course of engagement with volunteers, patients, and visitors to the hospital
- Information from community groups meeting for consultation on other areas of the plan

Prevention

Key points

Some staff mentioned the positive working relationship with VOCAL, Social Work and British Red Cross.
They said it was 'reassuring' to be able to signpost carers, access advice, improve referrals and has supported more older people to be financially secure

Some staff said that they would like to build stronger collaboration, develop their knowledge of and working relations with voluntary services.

Some staff said they would like to improve the information about the Hospital to ensure an accurate picture of our services is represented to our community.
This information should be available on line and in multiple sites.
Older people wanted to know more about what happens at the hospital and feel more connected to the hospital.

Support & Treatment

There is an opportunity to develop the hospital as a centre of excellence for the care and treatment of older people

Key points

Some staff mentioned a stronger collaboration with community teams due to the new staffing model for Mental Health Wards.

Some staff mentioned the activity coordinators had improved the quality of care for people with dementia
They have improved structure and routine and increased individualised therapeutic interactions and reduced isolation on the ward.

Some staff mentioned the culture of 'cross ward working' and working with volunteers was improving patient care.
Assistance and support from Loanesk to provide end of life care, was greatly appreciated. Cross working has allowed us to share our specialism with medical wards

Some staff mentioned that Clinical Decision Makers has been beneficial.
Having a colleague on shift, who has this additional training provides staff with advanced knowledge and reassurance when dealing with a deteriorating patient.

Some staff mentioned a need to routinely ask for feedback upon discharge to improve the quality of care for older people with mental illness

Some staff mentioned ways to improve access to and quality of care and treatment for out-patients including increasing nurse prescribers and clinical decision makers and cancer treatment.
Staff wanted education and training to support the delivery of a high standard or care that meets the needs of our patients. We want to enable our staff to knowledgably inform and encourage decision making for those in our care, and with their carers and loved ones. Our clinics will be developed to be able to support the delivery of a wide range of treatments and wellbeing initiatives locally and minimise the need for travel to sites across Lothian.

Support in a Crisis

Key points

Staff mentioned ways they support people's choice and control over their care and treatment.

Staff mentioned family meetings and 1:1s where patients are encouraged to ask questions about their care.

Nurses said they actively support patients to understand the legal side of admission and ensure that rights are being upheld.

Staff said copies of the mental health act, POA guardianship and specified persons are available for patients, staff and students to access and are routinely shared.

Sport & Leisure

Planning group: Attend - Falls, Long term Conditions, Older People
Planning Lead: Allan Blair

Interviews/focus groups completed

- Enable service user and staff focus group 03/08/21
- Carer consultations

Other engagement

- Ongoing daily customer interaction via Council feedback service and direct email and phone contact.

Prevention & Early Intervention

The need for equitable access to leisure facilities and physical activity opportunities was identified by many as a key component in maintaining and increasing the number of Midlothian residents who are physically active on a regular basis.
The issue of access was raised from a variety of points of view including financial, social and physical barriers that may prevent participation.

Key points

Support workers stated that **clients were treated like mainstream users** when attending a leisure centre, which was important to them.

Physically accessing some swimming pools was identified as difficult, combined with a lack of disability friendly changing facilities put people off attending.

Booking systems and processes were identified as not user friendly and **often relied on digital access** as phones weren't always answered at Leisure Centres

A **flexible attendance policy** was suggested by support staff for people whose impairment and support needs meant that they couldn't always attend regularly. Fear of losing a place in an activity was a frequent source of anxiety for clients

Users who were aware of the **Access Card** scheme thought was a good financial support and easy to get a card, however not all those who could benefit were aware of it.

Some participants were keen to access a **disability swimming club** which was only available on one evening at one site per week so they were on a waiting list.

The Carer's consultation 2020 reported that **financial support for gym memberships** was identified by carer's as important.

Support & Treatment

The ongoing need to support physical activity opportunities for people whose conditions could benefit from participation was identified across a wide range of stakeholders and participants.

Key points

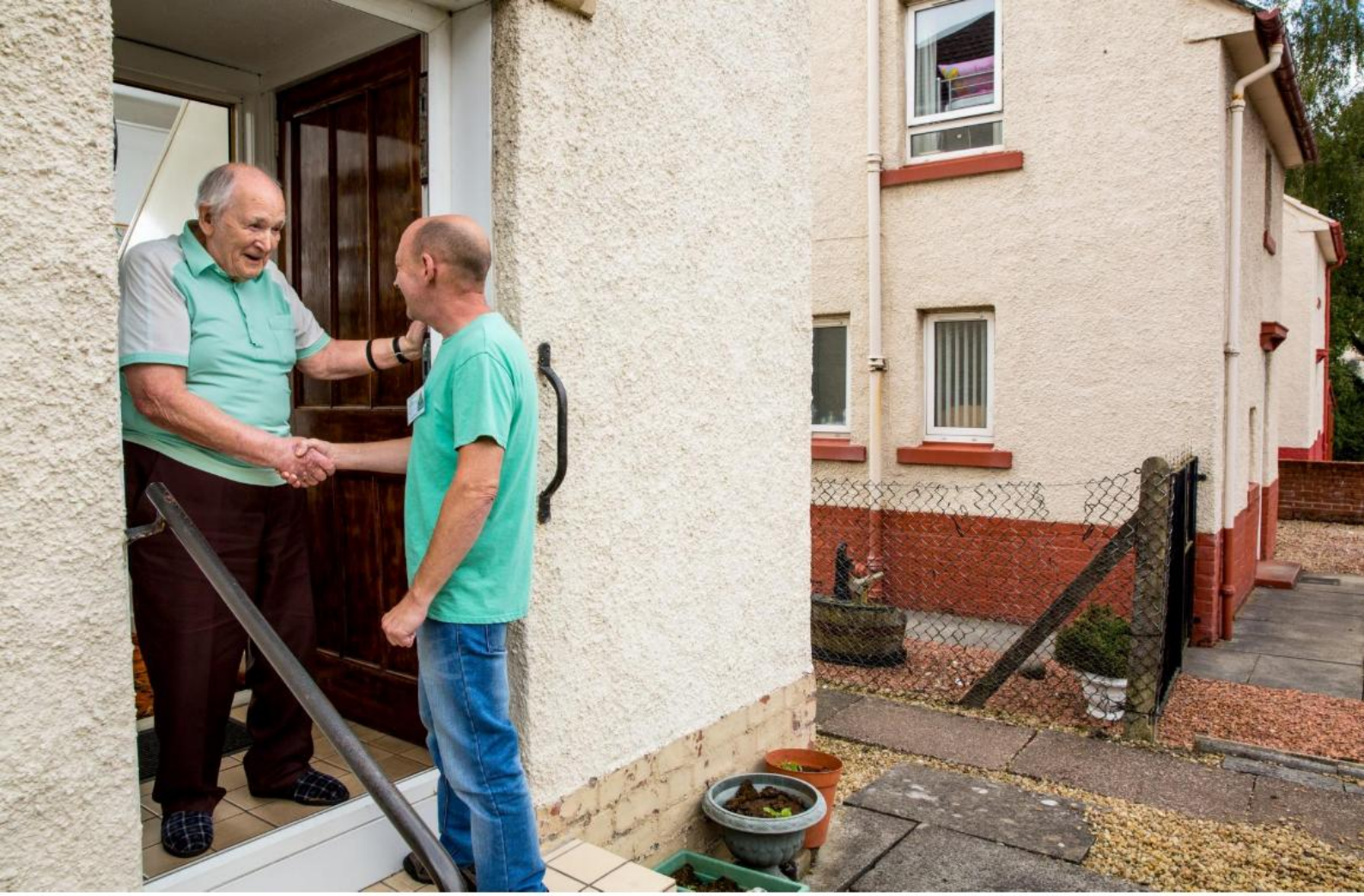
Most people said there was a need for Midlothian Active Choices and Ageing Well projects to continue and to grow.
The input of these projects is included in a number of other service's plans including Long Term Conditions, Older People and Falls Prevention.

Health and social care staff frequently request access to space for rehabilitation/treatment activities.
Musculoskeletal physiotherapy, Weight Management services, Let's Prevent services all currently use leisure facilities to deliver their physical activity interventions. Flu and Covid vaccination programmes are also accommodated in leisure facilities.

Crisis & Emergency

Key points

Sport & Leisure facilities identified as community resources with availability out with normal office hours.



Housing & Homelessness

Planning group: Health and Homelessness & Extra Care Housing
Planning Leads: Gillian Chapman

We would like to thank over **170 people** (including staff) who took part.

- Pre application consultation in support of application for planning permission for extra care housing (website, newspaper, letters to neighbouring properties, community councils, social media, online events 16 people attended)
- Consultation with Staff – statutory and third sector – on draft action plan (30 people)
- Engagement for the Local Housing Strategy 2021-26 (tenants and residents, landlords, third sector organisations through online sessions – 120 people)
- Consultations with staff in housing and homelessness including statutory and third sector (4people)

Prevention & Early Intervention

Improve advice & support to people at risk of homelessness

Key points

Some staff mentioned we should ensure all services support people – **'No Wrong Door'**

Many people mentioned the need to improve support to people **before they became homeless.**

"Various services need to work better together to help address the issues which may lead to homelessness: e.g. education, working with families; debt management; health care etc. - so a more joined-up approach rather than being seen as just a housing issue."

"Focus on the youth, 90% of people who are homeless probably had a troubled childhood which has led to this. Stop the cycle"

"Why do people become homeless support with managing money , behaviours , prep for young people who need to live alone"

"Work to tackle the causes of homelessness and challenge the stigma and morality that surrounds homelessness. Make sure that supports work together with individuals and work with people as proactively as possible to prevent the things that cause homelessness. Ensure the workforce is compassionate and well supported and make sure people get a permanent home quickly and that the home decorated, comfortable and homely on the first day of moving in to help people establish a sense of home…. Work to increase social housing. Home ownership is not achievable, affordable or desirable to all and the private rental sector provides expensive and often inferior quality housing with reduced tenure security. Ensure allocation of housing is proportionately fair, prioritising people who are homeless, homelessness is higher in areas where more houses were sold under RTB."

"More and better emergency accommodation. More support for people before they become homeless."

Offer increased housing choice & options. Reduce unmet specialist housing demand and increase awareness of Extra Care housing

Key points

Some people had specific questions about the building of extra care housing but were in agreement with the need for a community facility:

"While I am very keen to have answers to the above concerns I have no argument with a project which will enhance the environment and serve a useful and much needed facility for the community."

"Are there likely to be sirens and ambulances coming through the night for the intermediate care facility?"

Some staff mentioned that joint working was helping to accommodate people who need **adapted housing in a timely manner**.

Some people thought there was a **lack of choice of housing and a need for more social housing.**

"Please address the lack of affordable/ social housing in the area. Look at ways to prohibit private landlords from buying up large amounts of properties in an area."

"Too many large family homes being built ….. Local people not being able to afford homes within the community that they were brought up in and not enough local jobs."

"I am currently stuck in private housing. I cannot afford to save to get a deposit for a mortgage. More needs done to support the likes of my family who just earn too much to qualify for benefits so are lost in the housing system"

"Greater provision of affordable housing. Midlothian like many places has fallen foul of private owners/ landlords pricing families out of the area. Breaking up the essence of a community by fragmenting families by displacing them to other areas. Help for those that need it, more help for working families that do their best but are struggling."

Some staff mentioned **age was a barrier to accessing some housing** and suggested removing this criteria to accessing specialist accommodation, for example linking to the 'Going Home Report' for people with Learning Disability.

Key points

Some people felt that **housing providers should provide specialist housing**

"House builders should contribute a portion of their profits to building appropriate specialist housing"

"Private contractors should have to build some wheelchair housing on each site, not accessible housing as a basic building standard as this is not accessible for a wheelchair. Also more one level properties"

"Ask private housing companies to build a small number of specialised accommodation homes within each new estate that they wish to build. Stop them building 4&5 bedroom homes"

"Planning, Building Standards, Council Housing Department, RSLs and private housing developers need to work together to help address some of the issues. Private developers should not dictate what gets built on the basis of optimal profit alone, and need to recognise the impact they potentially have on communities. This may not simply be about building a proportion of single storey homes in each development, but could perhaps be about partnership developments of more specialist housing. The location of Extra Care Housing as an integrated part of the community is particularly important. An appropriate location for mainstream housing however, may not be appropriate for Extra Care housing and so this should always be a consideration."

A few people felt that the focus should **not be on providing adapted housing**

"We need to concentrate on housing that benefits the whole of Bonnyrigg, not for a few."

"Consult waiting lists and see what needs/disabilities/support people require before building housing that's unsuitable"

"The infrastructure needs to be in place before any type of housing is provided, especially where the people housed have specific needs. Our GP and social care services can hardly cope as it is"

"Midlothian Council have been facing a large deficit, yet seem intent on building more social housing. More expensive properties mean more council tax and higher spending. Which in turn means less deficit. It might sound harsh, but that's the reality when you face a shortfall."

Enable individuals & their families to make decisions regarding their long term care and support

Key points

Some people mentioned the importance of **long term planning and adaptations** to housing.

"You need more supported accommodation and wheelchair accessible housing is needed or help people adapt the house they are in or extend the house they are in so they don't have the distress of moving again."

"Adaptations – worried about the cost. Market housing providers should build with the later housing needs of residents in mind – homes which are easily adaptable."

"This really needs a broad multi-agency approach working closely with representatives of local communities so that, as far as possible, a proactive, planned approach is taken to providing specialist housing. Ideally this would be based on assessment of future need but would have to take account of the need for a reactive response for unforeseen circumstances."

Some people thought **choice should be limited**

"A clause in contract to stop elderly living in a huge house that a family needs"

"Thinking about older people perhaps more single person housing would allow people to downsize and free up family homes."

"Move people who don't require special housing to accommodate people who do."

Support & Treatment

Support for people in temporary accommodation, in recovery from substance misuse or who are homeless.

Key Points

Some staff mentioned the importance of **peer support and joint working** to support people – the Edinburgh Welcome Centre was given as an example of good practice.

Key Points

Some people mentioned the need for **alternatives to temporary accommodation**

"More permanent solutions need to be found as temporary arrangements such as B&Bs are unsatisfactory and expensive. Such temporary arrangements do not address the issue. Part of the solution is longer-term investment in suitable quality Council-owned accommodation on a longer-term temporary/permanent basis."

"I believe that social housing is key. Using intermediate housing such as halfway houses with shared accommodation could start to help the homeless with issues while giving them safe spaces to successfully re-integrate into social aspects of life. Social housing has been known to me as quite convoluted and not easy to move into smaller accommodation. If this can be revamped so that a large house could accommodate 4/5 homeless people with access to community projects."

"Can there be more social housing/ better use of existing vacant houses/ buildings"

"Unused building could be used for homeless rather than letting them fall into disrepair"

"Bring unused housing back into the housing stock"

Reduce avoidable hospital admissions/delayed discharge and enable people to live independently

Key Points

Some staff mentioned the need for a **wider range of accommodation options for people with Substance Misuse or Mental Health issues**.

Crisis & Emergency

No participants commented on this during the consultations but we will be consulting on reducing drug related deaths and non fatal overdoses in temporary accommodation over the next year.

Respite

Planning group: Respite & Short Breaks
Planning Lead: Gillian Chapman

We would like to thank the people who took we spoke with, and the community organisations and service providers we met with.
We spoke to people throughout 2021.

Prevention

Key Points

Some people mentioned that COVID-19 had left a gap in residential respite.

“When he's well my sleep's okay but when he's not it's awful. Sometimes I'm up ten times in the night with him. Twice I've got lost when out due to lack of sleep.”
“We’ve been unable to offer people residential respite because we don’t have Highbank and care homes can’t take people because of Covid 19. Felt bad because my client’s carer really needs a break.”

Some people mentioned there needs to be better equality of access to respite across Midlothian - that carers turn down respite because of the distance to the facility.

“Planned local respite can be very successful. Familiar face helps a lot.”
“Majority would say they don’t use it because of location.”
“Resilient communities rather than Day Care. More flexible. Longer day care hours”.
“People can have small geographical mindset - would travel within Penicuik, but not go to Dalkeith”.
“Travelling long distances is inappropriate for frail elderly people.”
‘Deprivation is a huge issue for accessing respite – how are you going to get there?”

Some people said respite wasn’t always in the right place, by the right service / person. Respite must be a positive experience.

“I would like respite to be suitable for my cared for person, and not just a ‘holding area’ that they can be put into until I come back to collect them.”
“Lack of local provision forces other alternatives, which are not always ideal.”
“Do we have the right to place people in respite when they don’t want to go, but the carer needs a break?”
“I would like to have a menu of service providers that I could access in different circumstances”.

Support & Treatment

Key Points

Some people mentioned the need for a clearer definition of respite.

When asked about respite, almost invariably people spoke about residential respite. Carers, and those supporting them, need to be aware of the availability of other respite services such as day opportunities and befriending, which should be clearly marketed as respite.

"What is respite and what is a break? It feels like it has been switched round by the NHS. Doing the shopping or going for a cup of tea is just living, it is not respite."

"I would like the carer to be considered as the beneficiary of respite care and assessed on that basis, rather than the assessment being done based on the needs of the cared for person."

Some carers prefer the term short break as they associate the word respite with relief from a burden, and they refuse to regard the person(s) for whom they are caring as a burden. In emergency care situations where the carers is unable to care for health or personal reasons, rather than because they are choosing to have a break, a different terms such as 'replacement care' may be clearer.

Some people said there needed to be better information on respite and how to access it.

There is very little information and guidance on what carers can expect in terms of accessing respite care. Carers are saying they often feel they have to "fight for it'.

"I do not want to be a Social Worker. I want the professionals who are paid to provide services or manage them for us to act proactively so that i can get on with the job I do – being a carer."

"Such a complicated system with so many people involved. Which one to contact?!"

Support in a Crisis

Key Points

Some people said that resources are not available to provide the core respite carers need which can lead to crisis and caring situations breaking down.

"My heart goes out to people we are not able to fully support in the way that we should be able to. It's awful going out to people and seeing situation they are living in. Don't want to raise hopes.

"I know of two or three caring situations that have broken down. It happens to carers especially when they can't sleep or they have mental health problems. Acute infections act as a trigger for carers – they can't cope."

"Difficult for Social Workers. Assess situation and see need, but don't have armoury to deal with this."

"Respite now happens at crisis point, was different 5 years ago. People often don't want to go home after respite – both the carer and the cared-for person find this. Now more advanced care needs, more challenging. Families caring for people at home for longer."

Some people mentioned difficulties in accessing emergency respite

"Not a 'hope in hell' of getting regular respite. In the past it was a responsive service which was able to help."

"Trying to get respite in an emergency is impossible. It just isn't there."

COMMUNICATING CLEARLY

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

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

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

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

Körler 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۔

Contact 0131 270 7500 or email: enquiries@midlothian.gov.uk

Midlothian
Health & Social Care

Midlothian Integration Joint Board

****DRAFT****

Strategic Plan

2022-2025

Who we are

The Integration Joint Board (IJB) plan and direct health and social care services for the people of Midlothian. It is a planning and decision-making body that was created by Midlothian Council and NHS Lothian in 2015 and is responsible for the integrated budget (received from Midlothian Council and NHS Lothian). It allocates this in line with the objectives set out in its Strategic Plan. The IJB has a range of responsibilities and legal duties as outlined in the Public Bodies (Joint Working) (Scotland) Act (2014).

The IJB meets regularly and includes members from NHS Lothian and Midlothian Council, the Third Sector, staff and people who represent the interests of people and communities, patients, service users and carers.

The IJB is supported to develop and monitor the delivery of our Strategic Plan by the Strategic Planning Group – with representatives from Midlothian Council, NHS Lothian and the Third Sector.

You can find the full list of services the IJB is responsible for at www.midlothian.gov.uk/mid-hscp in the Scheme of Integration. We have listed some of the services below:

NHS Lothian

Care in Hospitals which isn't planned (unscheduled care) including Accident and Emergency, Minor Injuries, Acute wards.
Midlothian Community Hospital
Community based health care (Primary care) including GPs, District Nurses, Dentists, Pharmacists, Mental Health services, Substance Use Services, Community Respiratory team
The following Health services for children and young people under 18: Health Visiting, School Nurses, Vaccinations of children.
Allied Health Professionals –including physiotherapists, dietitians, podiatrists
Palliative and End of Life Care

Midlothian

Social Work support for adults including adults with dementia, learning disabilities, older people
Day services for older adults and people with learning disabilities
Care at Home services
Health services for people who are homeless
Extra Care Housing for people who need housing with extra support
Services to support unpaid carers and breaks from caring
Care Homes
Services to address health and care needs of people in the justice system

What we are trying to achieve

We plan and direct a wide range of health and social care services and manage the allocation of the budget. We aim to:

- **Improve the quality of health and social care services** and achieve the 9 national health and wellbeing outcomes;
- **Change how health and social care is delivered** to better understand and meet the needs of the increasing number of people with long term health conditions, with complex needs and those who need support, working with people as partners in their health and social care.
- **Provide more support, treatment, and care for people in their homes, communities, or a homely setting** rather than in hospitals

Our Vision and Values

Vision: People in Midlothian are enabled to lead longer and healthier lives.

Values: We will provide the right support at the right time in the right place.

Our Strategic Aims

1. Increase people's support and opportunities to stay well, prevent ill or worsening health, and plan ahead.

2. Enable more people to get support, treatment and care in community and home-based settings.

3. Increase people's choice and control over their support and services.

4. Support more people with rehabilitation and recovery.

5. Improve our ability to promote and protect people's human rights, including social and economic rights and meet our duties under human rights law, through our services and support.

6. Expand our joint working, integration of services, and partnership work with primary care, third sector organisations, providers, unpaid carers, and communities to better meet people's needs.

Challenges we face

People expect to receive high quality health and care services when they need them, whether as a result of age, disability, sex, gender or long term health conditions. Yet there are a number of pressures on our services.

COVID-19
Covid 19 has had a huge impact on the services we plan and direct, our staff, and the people we support. As the COVID-19 pandemic continues it continues to influence how we deliver services and what we are able to deliver. COVID-19 impacts staff absence and also deployment as staff may be required to move to different roles to support our response. COVID-19 will continue to require additional resource, for example to deliver vaccination clinics, deliver services in line with guidance, coordinate staff COVID-19 testing, and manage PPE provision locally.

A growing and ageing population
Midlothian is the second smallest Local Authority in mainland Scotland but the fastest growing. This brings challenges for health and social care services and changes communities. As people live longer many more people will be living at home with frailty, dementia or multiple health conditions. An increasing number of people live on their own, and this may bring a risk of isolation.

Workforce pressures
There is reduced availability of staff with appropriate qualifications or skills, including General Practitioners, Social Care Workers and Staff Nurses. The COVID-19 pandemic will continue to influence the health and care workforce and programmes such as mass vaccination have increased pressure on already stretched resources.

Financial pressures
We need to do things differently: the traditional approach to delivering health and care services is no longer financially sustainable. However shifting resources from hospital and care home provision to community based services, and placing more emphasis on prevention, can be challenging especially with the financial constraints facing health and social work.

Independent Review of Adult Social Care (Feb 2021)
The Review looked at outcomes for people who use services, their carers and families and the experience of those working in the sector. There are likely to be significant changes to care services as a result.

Unpaid carers
Unpaid carers fulfil significant, valuable and wide-ranging roles, helping to keep people with care and support needs within our communities. During the pandemic many people became carers for the first time, or saw changes to their caring role, resulting in them providing significantly more

care for their elderly, sick or disabled family, friends and neighbours. Through this period services supporting carers continued to offer support, including digitally, and by telephone, though services supporting the person they provide support to may have been reduced, e.g. respite and day services, impacting on carers. Further work is required to reduce the significant pressure and impact of caring that carers reported, by continuing to explore innovative options to enable support to be given to both carers and the cared-for, and for there to be opportunities for breaks from caring.

Acute hospitals

Acute hospitals are under huge pressure due to unsustainable demand and financial, workforce and infrastructure challenges. Investing in community-based services and work with carers is required to minimise avoidable and inappropriate admissions and facilitate earlier discharge. By treating people closer to home, or in their own home we can help to prevent people needing to be admitted to hospital and improve people's outcomes.

Planning our workforce

The health and social care workforce is our greatest asset. We must continue to invest in developing a skilled, flexible and adaptable workforce to support people and communities achieve the outcomes that are most meaningful to them. How we deliver on the strategic objectives will require a clear and ambitious workforce plan. To do this, workforce planning must recognise both the local and national workforce challenges alongside the ambition to redesign and transform integrated service offers and supports.

Even in challenging circumstances, health and social care staff continue to demonstrate an incredible commitment to the health, care, wellness and wellbeing of people and communities. Of course, the impact of the COVID-19 pandemic remains far reaching for us all. It is important not to miss the opportunity to also embed staff wellbeing and wellness as a core element of our culture. Now, more than ever, our commitment to develop new and meaningful ways to support the wellness and wellbeing of staff, teams and services must remain a long-term priority.

The workforce plan (to be complete June 2022) will reflect the way we deliver services based on a shared responsibility to improve outcomes. It is vital to build a realistic and representative picture of the workforce required to realise those ambitions.

Our focus for workforce planning:

- Deliver the 2022-2025 Workforce Plan
- Attract staff to fill vacancies including hard to fill posts
- Reduce vacancies, retain, support and upskill staff
- Reduce workforce Inequalities
- Increase support with digital access

How can Digital Technology help us?

We live in a digital world and it is changing the way we work and provide services for you. We have to change the way plan and deliver services. Digital transformation is a key focus of the Scottish Government. A changing nation: how Scotland will thrive in a digital world*, and Scotland's Digital Health & Care Strategy** provide guidance from the Scottish Government about how we can best use digital technology to provide the right services for you, at the right time, at the right place.
Good health and social care relies on strong human relationships. Digital technology cannot replace those but can enhance them by transforming how we connect and keep in touch with services or monitor our own health. It can also help us capture and bring together information about people who use our services in a way that can help us plan and deliver them more effectively.
Our Digital Governance Group will make best use of digital technology across the organisation and consider issues such as: privacy; inclusion; choice; access; and control.

Our focus for digital development:

1. Supporting People

We will support our staff and people who use our services so everyone is comfortable and confident with these changes.

2. Equipment and Technology

We will support our staff and people who use our services to access new and existing digital technology

3. Improving Access to Person-Centred Care

We will support our network of partners to change our thinking and planning processes to explore alternative ways to deliver our services

*www.gov.scot/publications/a-changing-nation-how-scotland-will-thrive-in-a-digital-world
**www.gov.scot/publications/scotlands-digital-health-care-strategy

How we plan services

We write this Strategic Commissioning Plan (we call it a Strategic Plan) to set out how we will plan and deliver health and social care services over the next 3 years to improve and support the health and wellbeing of the people of Midlothian. It lets people know:

- What we want to achieve - through our vision and strategic aims
- The way we will do things - through our values
- What we will do, including what we will do differently to achieve our aims
- How we will use our budget and resources to do this
- How we will measure how well we are doing

Through the plan we must make big changes to how we plan and fund services to make sure that we can continue to meet the needs of our growing and ageing population, and that the challenges we laid out above can be addressed. This involves redesigning services, and a redistribution of resources, including financial resources. We must put more focus on prevention and early intervention and move resources from hospitals to community-based services. To support this each area of the plan has been split into 3 sections - prevention and early intervention, support and treatment, and crisis and emergency. This helps us to demonstrate how we are increasing the balance of our work across all services towards prevention and early intervention.

Understanding needs

To help us develop our plan we research and produce a **Joint Needs Assessment.** The Joint Needs Assessment uses different data to build up a picture of the key health and social care issues affecting people in Midlothian. It helps us ensure we plan and design services to meet the current and future health and social care needs of the population in Midlothian.

Localities

The law requires that we designate at least two 'localities' for planning purposes. We have 'west' and 'east' localities. However, as the smallest mainland authority operating as a Partnership, we cannot plan, organise and commission services in two separate localities which do not reflect any recognisable sense of belonging. Instead we focus on developing stronger links with our natural communities, including those identified by the Community Planning Partnership for 'area targeting'. Data will be produced annually for each locality and published in the Annual Report.

Engagement with people and partner organisations in Midlothian

We support representatives from the third sector, carers and people with lived experience to be part of our formal planning groups including the IJB, the Strategic Planning group and Service Area planning groups. Our Engagement Statement on www.midlothian.gov.uk/mid-hscp explains how we engage with people. To be successful and achieve our aims our plans need to be continually informed by engagement with people who use our services and their families and carers. We will continue to work with a wide range of people who live and work in Midlothian and stakeholders including third sector organisations, service providers, and staff.

Health inequalities

Health Inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. They disadvantage people and limit people's chance to live longer, healthier lives. For example people in the most affluent areas of Scotland, experience over 20 more years of good health compared to people in most deprived areas. The life expectancy of people with learning disabilities is substantially shorter than the average life expectancy in the UK.

COVID-19 has widened inequalities. The effects of contracting the illness, as well as the lockdown measures, are significant and unequal. The groups already experiencing health, economic and other inequalities, such as those in the most-deprived areas and people from ethnic minority backgrounds have been most affected. We have a duty to address inequalities, and to do this we must distribute resources and plan our services according to need.

Equality in Midlothian

We believe that everyone should have equal opportunities. No one should have worse life chances because of their sex or gender, what they believe, or whether they have a disability. Equality does not mean that everybody should be treated in the same way; sometimes services should be provided in a different way to meet the different needs of people. We are committed to working to reduce inequalities in Midlothian. Our Equalities Outcomes on www.midlothian.gov.uk/mid-hscpset out the key equalities areas we have identified and how we will work on these over the next 4 years.

Human rights

We are committed to developing a human-rights based approach. This means taking practical steps to put human rights principles and standards at the centre of our policies and day-to-day practices. This not just about protecting people's rights and preventing harm, it means improving and demonstrating how we fulfil rights including social, cultural and economic rights.

The approach provides a practical framework that supports decision-making at all levels, including day-to-day operational decisions. It will enable us to balance competing priorities and to demonstrate the basis for decisions in difficult circumstances.
Applying the approach complements our commitment to equality and reduction of health inequality as it prioritises people who face the biggest barriers to realising their rights. Applying this approach will mean that:

- People will know more about their rights, how to claim them and how to hold people to account
- Practitioners will be more aware about their role in promoting and upholding rights
- People will have greater opportunity to participate in decisions that affect their rights
- As an organisation we will be better able to demonstrate how we are fulfilling our human rights obligations
- We will be more accountable for our actions and decisions

The Midway

We are committed to our work on focussing on what matters to someone and looking for what is strong, not what is wrong. We call this approach “The Midway”. We will support our staff, and colleagues in the Council, Primary Care and Third Sector to help them develop how they work, and how they design their services using “The Midway” so that people are equal partners in care and treatment.

The Midway focuses on:

- **Beliefs and Values**: Our staff are facilitators not fixers. They recognise the person is an expert in their own life.
- **Good Conversations**: Our staff shift power to the person. They support self-management, building on coping, and hopes.
- **Understanding Trauma**: Our staff understand trauma. They recognise and respond to the impact of trauma.
- **Addressing Inequality**: Our staff recognise inequality. They address unfair disadvantaged people face.

Clinical Care & Governance

In delivering our plan over the next 3 years we need to make sure that we provide high quality, safe and person centered services, continually improve our services, and that everyone working in the organisations understands their responsibility for this. Clinical and care governance is the process by which we do this. It ensures accountability for the quality, safety, effectiveness and person centredness of Midlothian HSCP Services is monitored and assured.

Best value

In delivering our plan we need to ensure we meet the duty of Best Value as outlined in the Local Government in Scotland Act 2003. This means ensuring there is good governance, good management of our resources, and ongoing improvement, so we deliver the best possible outcomes for the public with the money and resources we have available. To help us to do this the IJB must make sure there are arrangements in place for looking at performance, progress towards achieving objectives, and holding partners to account.

How we measure performance

We measure our performance to see what is working well, what can be improved and how well we are meeting the key aims of integration, our strategic aims and progressing our strategic plan.
We look at:

- Our annual performance report
- Quarterly reports across a range of services
- A performance framework with quantitative measures (in development).
- Quarterly reports to the Scottish Government Ministerial Strategic Group (MSG) Indicators
- Reports on progress against directions

How we put our plan into action

To put our plan into action we send written instructions to NHS Lothian and Midlothian Council. These instructions are called **Directions**.

The Directions tell NHS Lothian and Midlothian Council what services they need to deliver, and the budget they have been allocated to do this from the IJB budget. A Direction must be given for every function that has been delegated to the IJB.

We need to issue directions and look at how well they are being delivered.

Directions are sent at the start of each year but can be updated on an ongoing basis throughout the year as IJBs can make decisions which will mean changes to services or new investments during the year and they will need to provide Directions on these.

How we will use our budget

Each year both partners (Midlothian Council and NHS Lothian) agree the contribution they will allocate to the IJB for the health and social care services that the IJB is responsible for. This is the IJB Budget. The budget is limited by the resources available to the partners. The IJB may receive additional Scottish Government funding through the year.

The IJB's financial plan explains in financial terms, how the IJB will deliver this 3-year strategic plan. A separate detailed medium term financial plan is being developed covering the period of this new Strategic Plan.

Financial Risks and Challenges

Pressures from pay awards and improved terms and conditions (the move towards 'fair work' practices in commissioned services). It is not clear if the partners will be fully funded for these investments in staff and therefore if there will be a financial pressure on the IJB

Covid 19 Pandemic. From March 2020 to March 2022 a range of additional funds were made available to support the large costs of delivering health and social care services during the COVID-19 pandemic. It's currently unclear how much, if any of these funds will be available in 2022/23 and beyond whilst it is clear that a range of costs due to the COVID-19 pandemic will continue.

Drug cost pressures- as new drugs and new drug treatment regimes become available these cost pressures have historically been greater than any resource increases. Part of this challenge will be the increased costs of vaccinations arising from both a new model of delivery and the impact of the COVID-19 pandemic.

Inflation – health and social care inflation runs higher than general inflation, inflation is projected to increase over (at least) 22/23.

Demographic – growing older population and growing demand generated by an increasing overall population. The financial model that changes resource allocations to Councils and Health Boards as their populations numbers change has a considerable lag and population increase creates a significant demand and cost pressure. The challenge of caring and supporting an ageing population is an underpinning theme for the IJB.

Operational Pressures – The challenges outlined above will be greater than any additional financial resources to meet them. This will mean that the IJB need to make big changes to how health and social care is delivered in order to deliver the services, care and support needed with the money that is available.

Annual Budget - Assumptions

As the budget for the IJB is set on an annual basis in March/April each year we have to estimate the budget for the 3 years of the plan:
NHS Lothian – in 2022/23 we anticipate a possible 2.0% uplift on all budgets and an element to cover the increase in employers National Insurance costs per the UK government's latest plan.
Midlothian Council - Additional funds are being made available to invest in social care and to allow the social care providers to lift the base pay rates for their employees to £10.50 per hour and these funds will be made available to the IJB. However, the settlement for the Council's suggest that no uplift from the Scottish Government will be available to fund pay awards or further demand.

Our estimated annual budget for 2022/23 has not yet been finalised but the values based on the 21/22 budget as an illustration are £144.2m* This is split up into four parts: -

1. **Social Care** (from Midlothian Council). **£47.7m***
   This is for the adult social care services in Midlothian.

2. **Health - Core Services** (From NHS Lothian). **£65.1m***
   These are local health services which are managed by the HSCP. These include primary care services (GPs, pharmacists etc), district nursing, community mental health teams, community learning disability teams, and Midlothian Community Hospital.

3. **Health - Hosted Services** (from NHS Lothian) **£13.6m***
   These are services are managed on a pan-Lothian basis. The IJB has a share of the total budget for these services based on its population. These services include the mental health and learning disability in-patient services in the Royal Edinburgh Hospital, the rehabilitation in-patient services at the Astley Ainslie Hospital and the sexual health services at Lauriston.

4. **Health - Set Aside budgets** (from NHS Lothian). **£17.8m***
   The IJB has functions delegated to it, referred to as unscheduled care services (Accident and Emergency and unplanned admissions) which are managed by NHS Lothian's Acute Hospital system. The IJB's budget includes a share of these services, again based broadly on population. The budget is 'set aside' by NHS Lothian on the IJB's behalf.

The IJB's budget is for the direct costs of the services that it is responsible for. This means its budgets do not include any resources for the running costs of property (e.g. cleaning, utility costs, rent, maintenance) and do not include any administrative overhead costs (e.g. finance, HR, IT, estates and other services). The IJB does have a capital budget or own any property or assets.

Our plans

Older People

(Community Services)

Planning group: Older People's Planning Group
Planning Lead: Catherine Evans

Prevention & Early Intervention

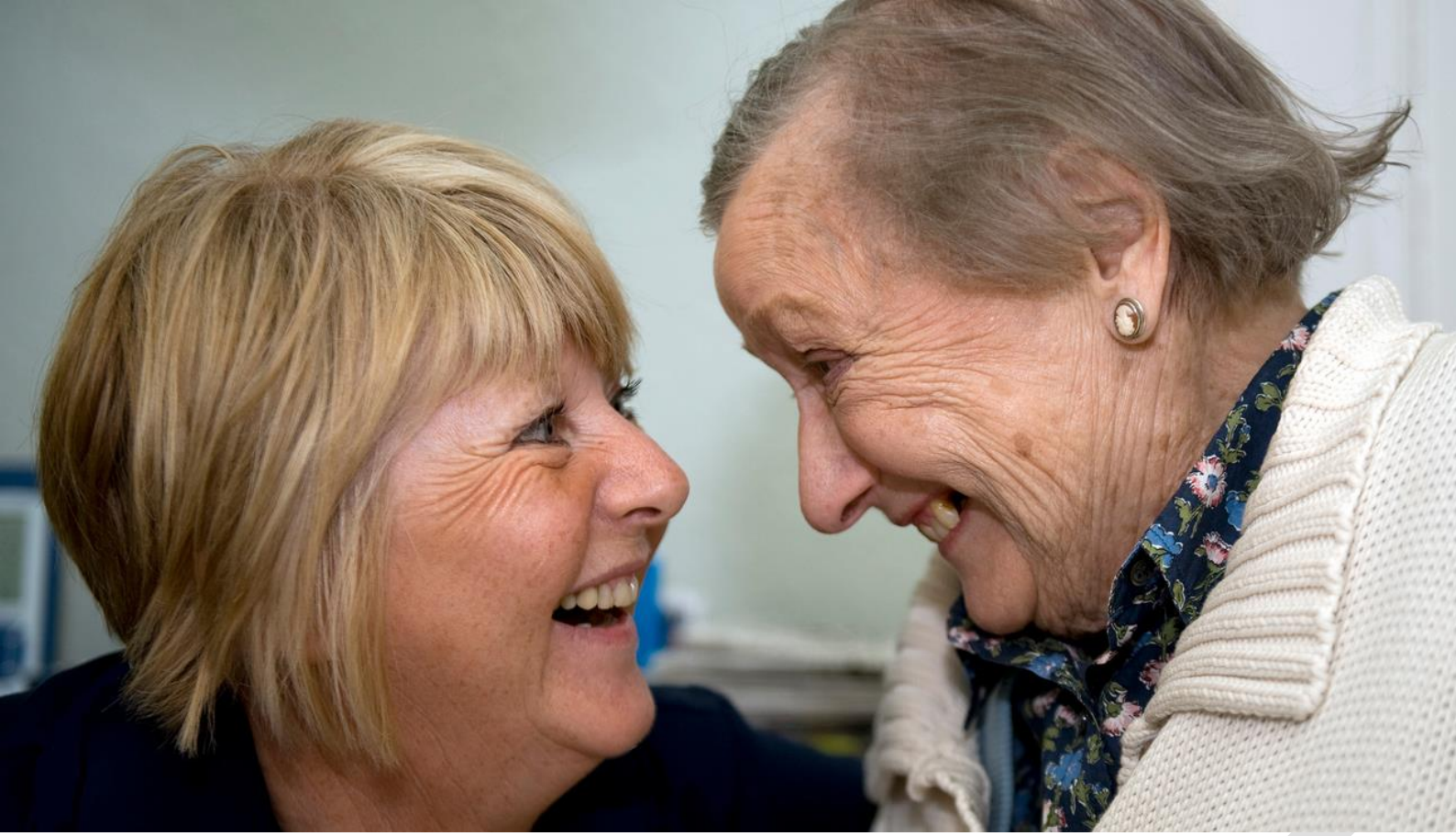
- Improve accessible information so that people know what is going on in their community and what services can help them
- Create opportunities for older people to connect to others and contribute to their community
- Provide support that promotes being active, independent, confident and financially secure
- Support people to make plans for their future health and wellbeing
- Build stronger collaboration with older people, the voluntary sector and other partners to improve outcomes for older people

Support & Treatment

- Provide services that are accessible, available, appropriate and of high quality across Midlothian.
- Improve awareness and fulfilment of human rights for older citizens.
- Provide services that connect well with each other and work holistically to support people.
- Develop appropriate day support for all older people to reduce isolation and increase social connection
- Design services and systems so that people have more control over decisions that affect them.
- Support more people with rehabilitation and recovery at home or close to home
- Improve physical, digital and personnel infrastructure

Crisis & Emergency

- Increase likelihood that emergency care is person-centred through increased use of emergency plans and supported decision making



Frailty

Planning group: TBC
Planning Lead: Amanda Fox

Prevention & Early Intervention

- Identify people who are living with frailty
- Improve anticipatory care planning support for people living with frailty
- Make it easier for people with frailty to access support from third sector organisations

Support & Treatment

- Improve coordination of care in the community for people living with frailty
- Support services to identify people living with frailty to improve treatment plans
- Improve the support offered to people with frailty by Primary Care

Crisis & Emergency

- Develop approaches to reduce avoidable unscheduled activity

Physical Disability & Sensory Impairment

Planning group: Physical Disability & Sensory Impairment
Planning Lead: Tom Welsh

Prevention & Early Intervention

- Increase the availability of suitable housing.
- Improve access to wider public services
- Reshape services in light of improved understanding of needs and barriers faced by Disabled People in relation to health and social care

Support & Treatment

- Improve access to health and social care services.
- Develop Self Directed Support in line with Social Work Scotland's new standards
- Increase access to community-based rehabilitation
- Strengthen local services for people with a Visual Impairment
- Strengthen local services for people with a Hearing Impairment
- Deliver local services for Adults with Complex and Exceptional Needs (ACENS)

Crisis & Emergency

- Improve support to Disabled People and their Carers to plan ahead and reduce stress and uncertainty at times of crises

Mental Health

Planning group: Adult Mental Health
Planning Lead: Karen Darroch

Prevention & Early Intervention

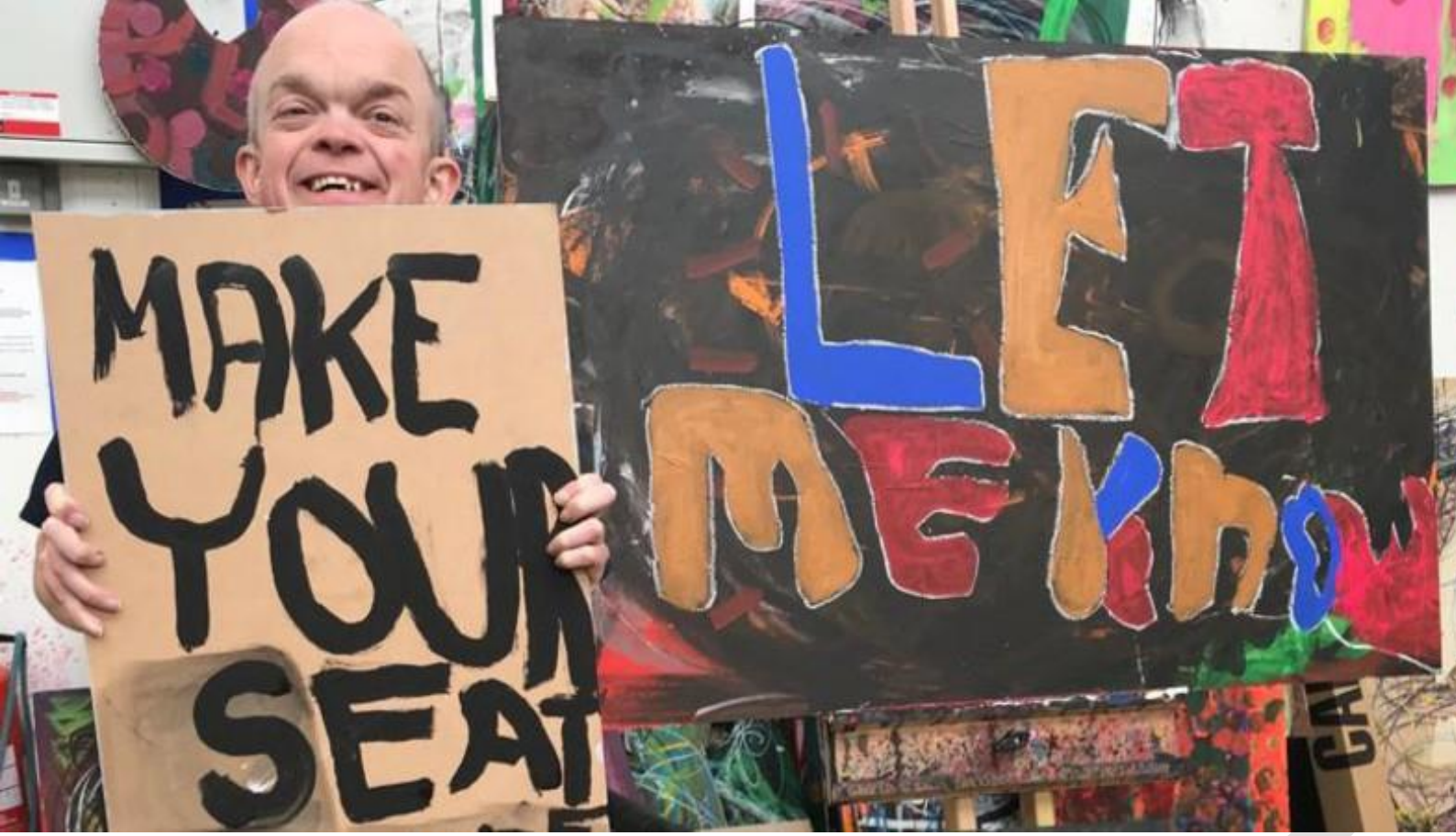
- Improve access to Community Mental Health Supports
- Suicide Prevention
- Improve physical health
- Improve access to information about self-management

Support & Treatment

- Improve holistic support
- Reduce waiting times for Psychological Therapy
- Reduce waiting times for Occupational Therapy
- Improve the provision of appropriate housing

Crisis & Emergency

- Improve same day access for people with Mental Health and crisis/distress
- Improve support for people who attend A&E frequently
- Improve access to Mental Health and wellbeing services through the Redesign of Urgent Care



Learning Disability & Autism

Planning group: Learning Disability & Autism
Planning Lead: Duncan McIntyre

Prevention & Early Intervention

- Empower people with learning disabilities and Autism to recognise and realise their human rights and to participate in community life free from fear, harassment and abuse.
- Support the wellbeing of people with Learning Disabilities and Autism throughout their life.
- Improve the Experience of Transition from School to Adult Life and Create appropriate developmental opportunities in Adult Life.

Support & Treatment

- Develop a greater range of Housing Options for People with Learning Disability and Autism.
- Increase the availability of Flexible and Person Centred Day Opportunities to support greater choice including the development of appropriate community opportunities and services for people with complex needs.
- Review Transport to ensure more flexible and tailored provision.
- Develop Robust Community Services incorporating Positive Behavioural Support to support People with Complex Needs in crisis.
- Develop a Broader Range of Respite and Breaks Support for People with Learning Disability and Autism.
- Improve information on Advice, Support and Services for Autistic People and People with a Learning Disability.

Crisis & Emergency

- Support disabled people to participate in community life, free from fear of harassment and abuse.
- Support People with Complex Care Needs in Crisis

Long Term Conditions

Planning group: TBC
Planning Lead: Hannah Cairns

Prevention & Early Intervention

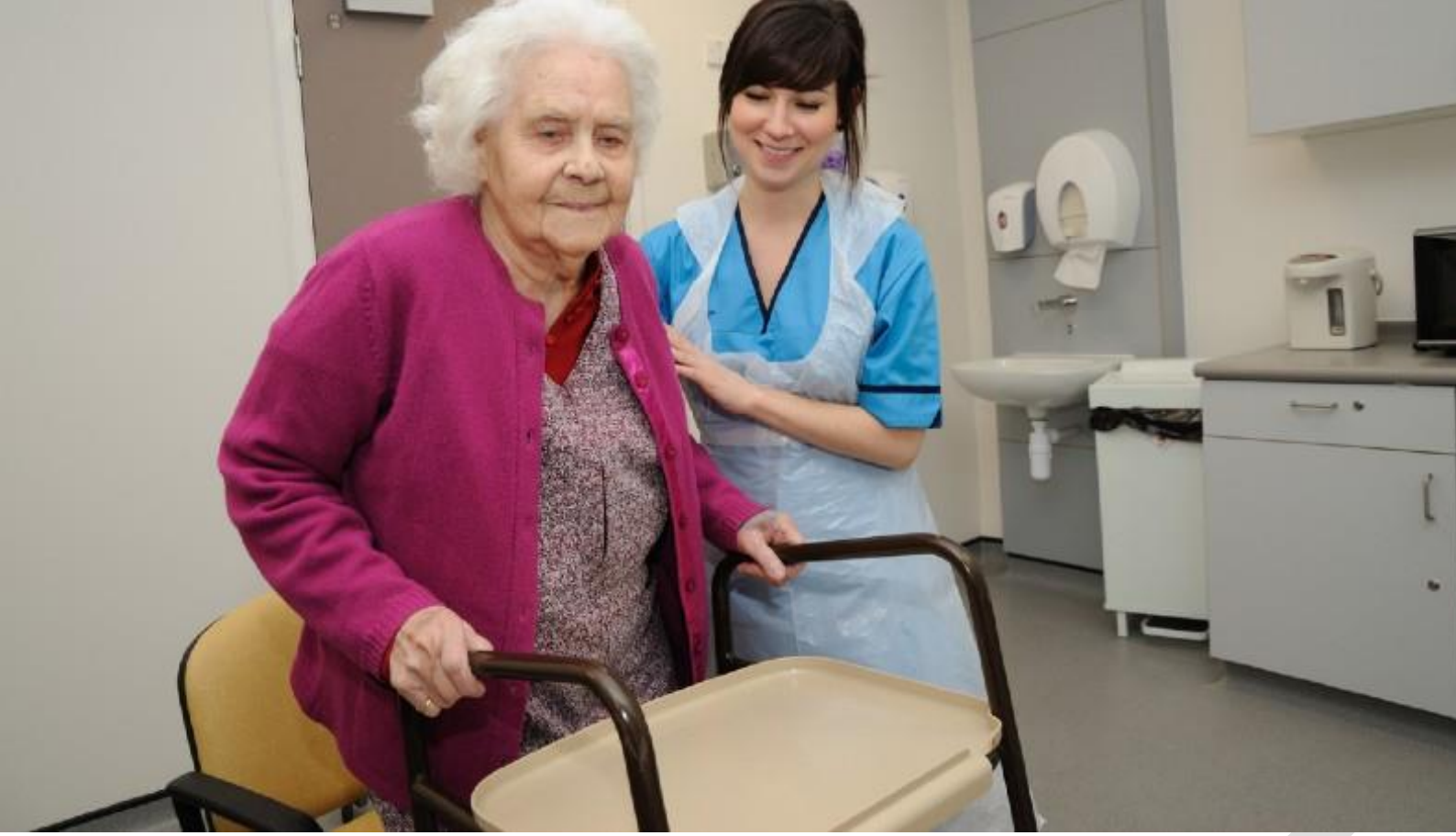
- Increase the number of people who are supported to be more physically active
- Increase the number of people who are supported to eat well.
- Improve screening & early detection e.g. cancer & type II diabetes
- Increase the number of people who are supported to address money worries.
- Increase the number of people who are supported to stop smoking

Support & Treatment

- Embed the Midway - Support self-management, understanding trauma & addressing inequalities.
- Improve how we support people to plan for the future
- Improve community-based support for people with Heart Disease.
- Increase number of people managing COPD at home.
- Provide local support and treatment for people with Cancer
- Establish appropriate support pathways for people with Long Covid
- Improve access to rehabilitation and rehabilitation outcomes for people post Stroke
- Improve support to manage Type 2 Diabetes and increase remission
- Improve support and outcomes for people with neurological conditions.

Crisis & Emergency

- Reduce hospital discharge delays resulting from housing needs



Falls & Fracture Prevention

Planning group: Strategic Falls Group
Planning Lead: Gillian Chapman

Prevention & Early Intervention

- Reduce number of falls during winter
- Improve knowledge of ways to reduce risk of falls
- Improve identification of people at risk of falls
- Increase physical activity programmes and falls prevention activities
- Improve knowledge of and access to home safety measures

Support & Treatment

- Train staff to promote strategies and community resources
- Build an integrated approach to falls and fracture prevention

Crisis & Emergency

- Provide timely, specialist, personalised care and support when someone has fallen.
- Improve outcomes after a fall

Under 18

Planning group: GIRFEC, Children and Young People Wellbeing Board, EMPPC

Planning Lead: Fiona Stratton

This plan describes the services for children and young people which are the responsibility of the Midlothian IJB.

A wide range of other services for children and young people are planned and managed from other parts of the NHS Lothian system, by Midlothian Council and the third sector. The Midlothian GIRFEC Board has oversight of the development and delivery of the Integrated Children's Services Plan which covers the full range of health and social care services for children and young people.

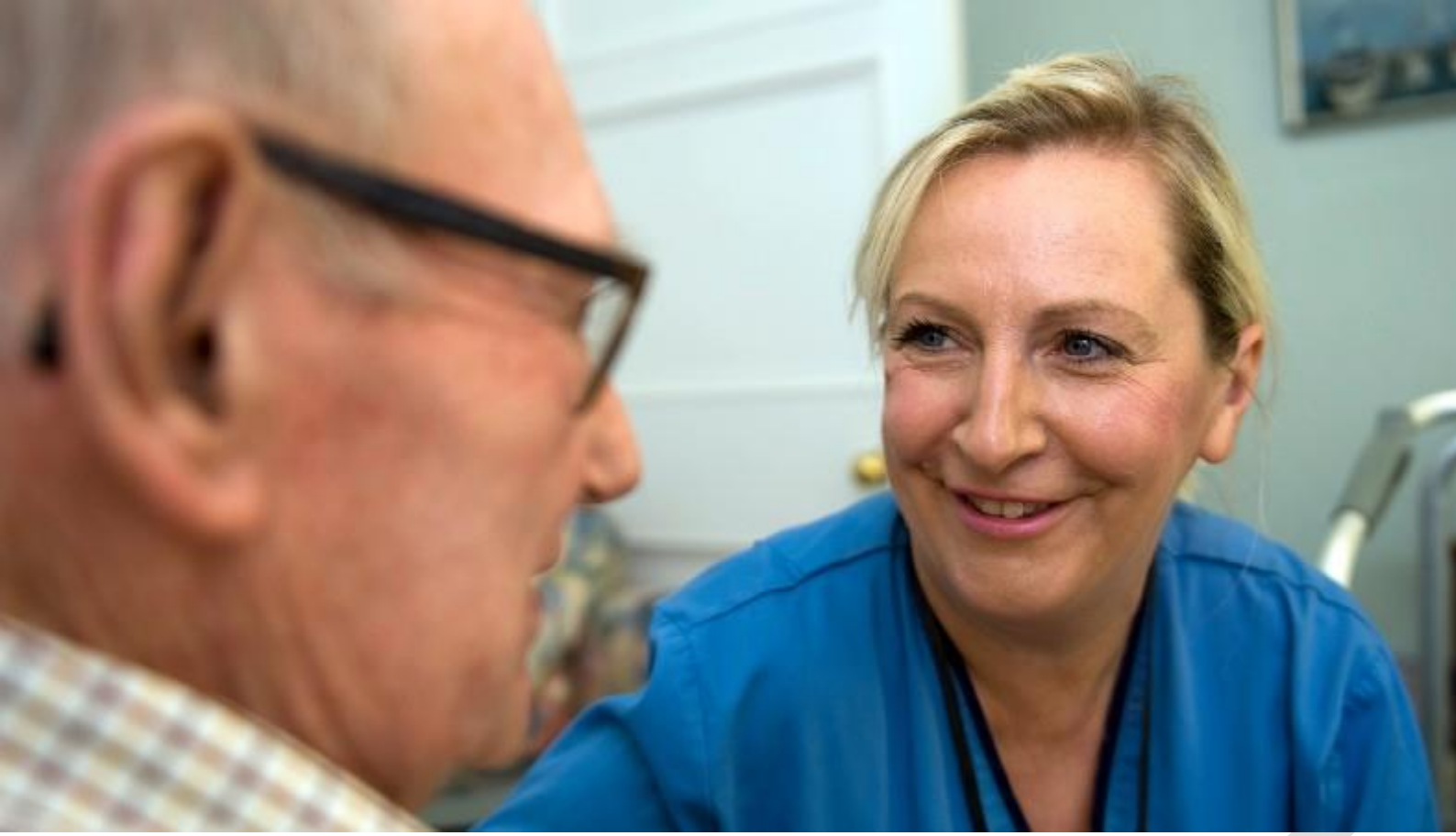
Prevention & Early Intervention

- Monitor health of children and young people.
- Reduce inequality.
- Support Parents
- Prevent avoidable illness

Support & Treatment

- Improve children and young people's physical & mental health
- Improve capacity for strategic planning of services

Crisis & Emergency



Public Protection

(Adult Protection & Violence Against Women and Girls)

Planning group: East Lothian and Midlothian Public Protection
Planning Lead: Kirsty MacDiarmid

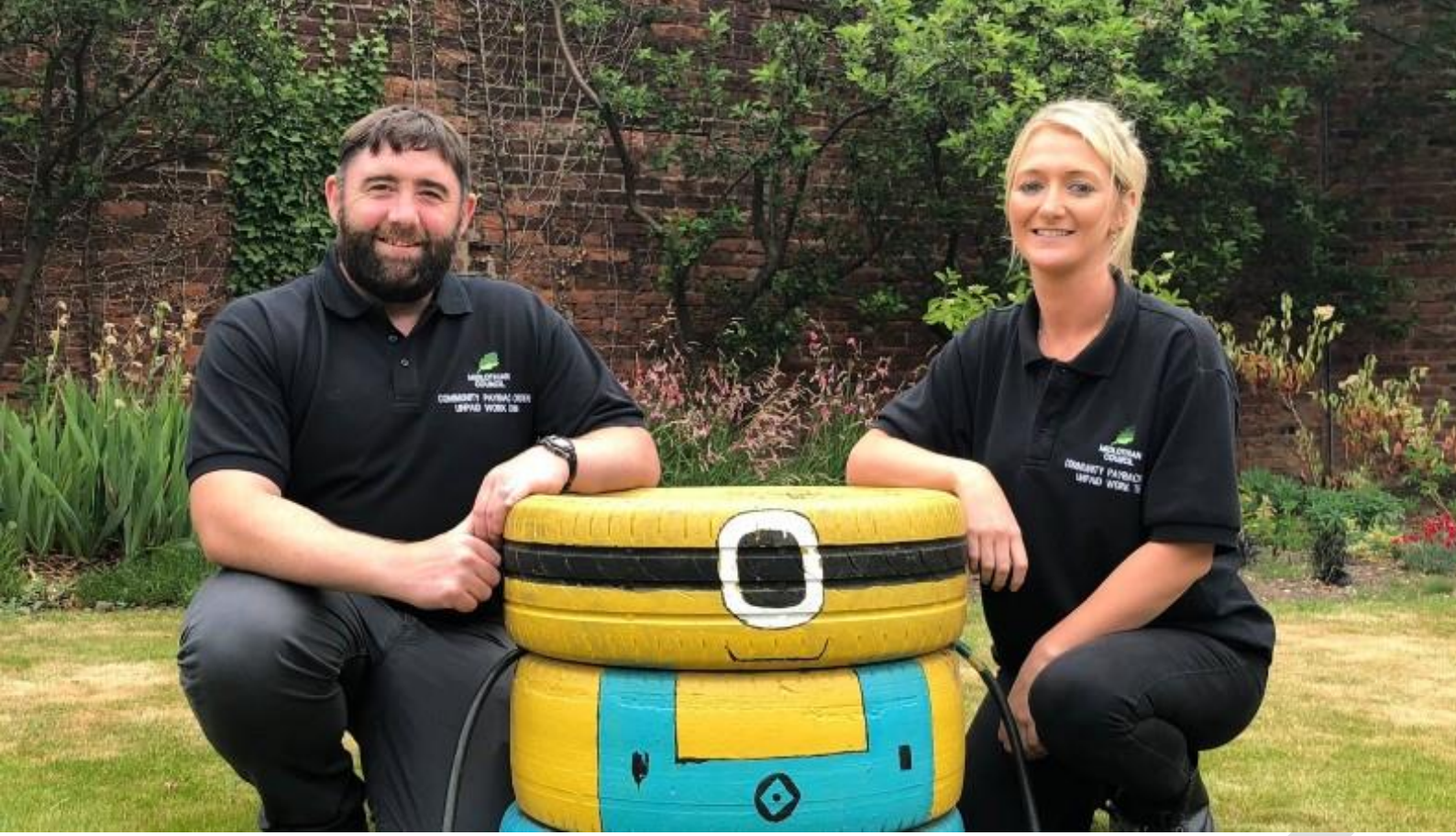
Prevention & Early Intervention

- Improve risk management of Adult Support and Protection practice in care homes
- Improve staff knowledge about Adult Support and Protection and improve transfer of learning into practice
- Support staff to manage cases that do not meet Adult Support and Protection criteria
- Improve staff knowledge about Violence Against Women and Girls and improve transfer of learning into practice
- Strengthen Midlothian's commitment to embed the Equally Safe priorities to prevent and tackle violence against women and girls

Support & Treatment

- Support the HSCP to fulfil their statutory duties to report concerns about harm and co-operate with Adult Support and Protection investigations
- Improve supports for survivors and interventions for perpetrators of gender based violence

Crisis & Emergency



Community Justice

Planning group: Community Justice
Planning Lead: Fiona Kennedy

Prevention & Early Intervention

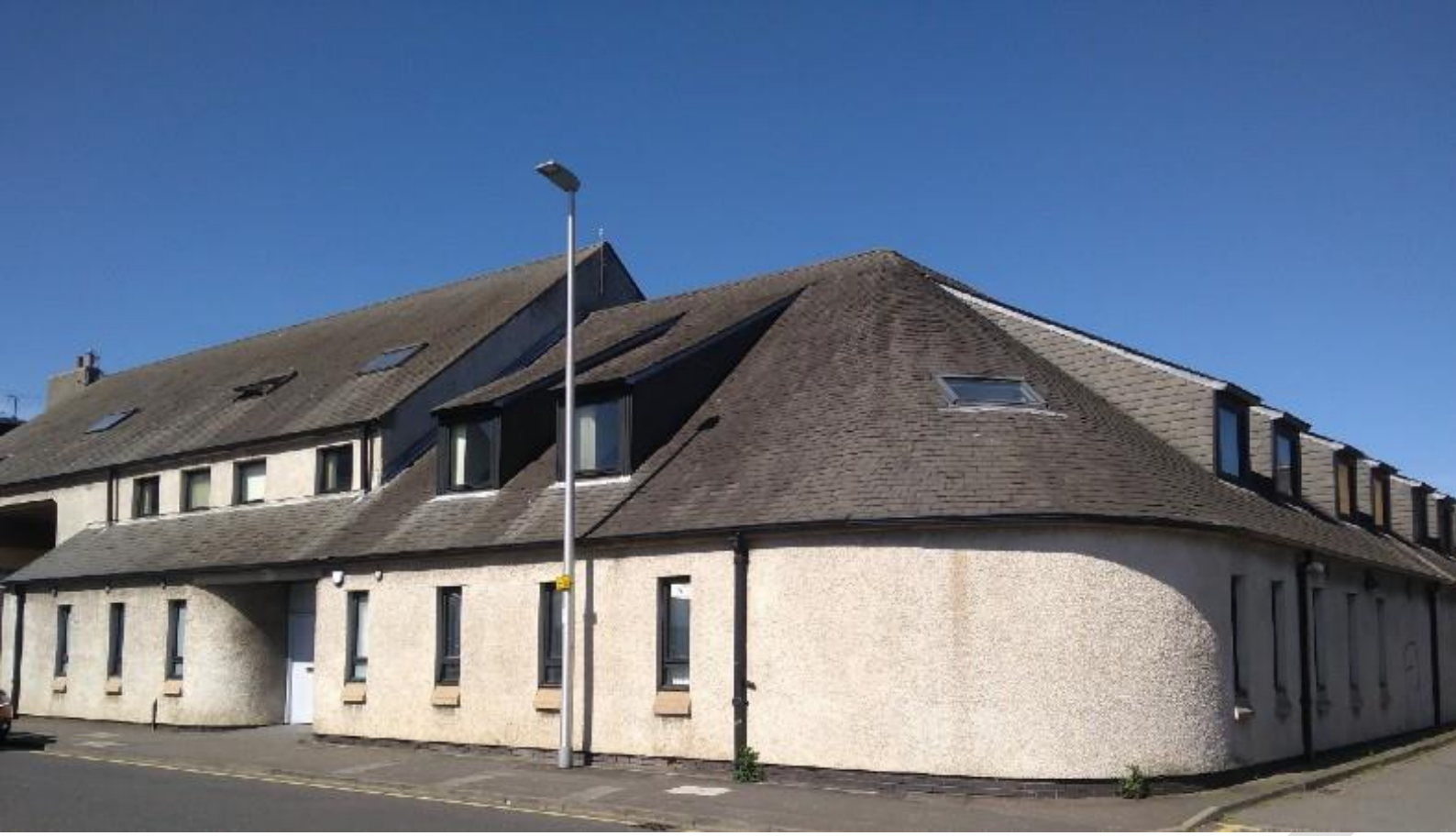
- Improve understanding of Community Justice.
- Plan and deliver services in a strategic and collaborative way
- Prevent and reduce the risk of further offending.

Support & Treatment

- Improve relationships and opportunities to enable participation in education, employment and leisure.
- Improve resilience and capacity for change and self-management.
- Improve life chances through addressing needs, including; health; financial inclusion; housing and safety.

Crisis & Emergency

- Improve access to the services people require, including welfare, health and wellbeing, housing and employability



Substance Use

Planning Group: MELDAP
Planning Lead: Martin Bonnar

Prevention & Early Intervention

- Preventing Future Harm Caused By The Misuse Of Alcohol And Drugs
- Protecting and Safeguarding Children, Young People and Communities

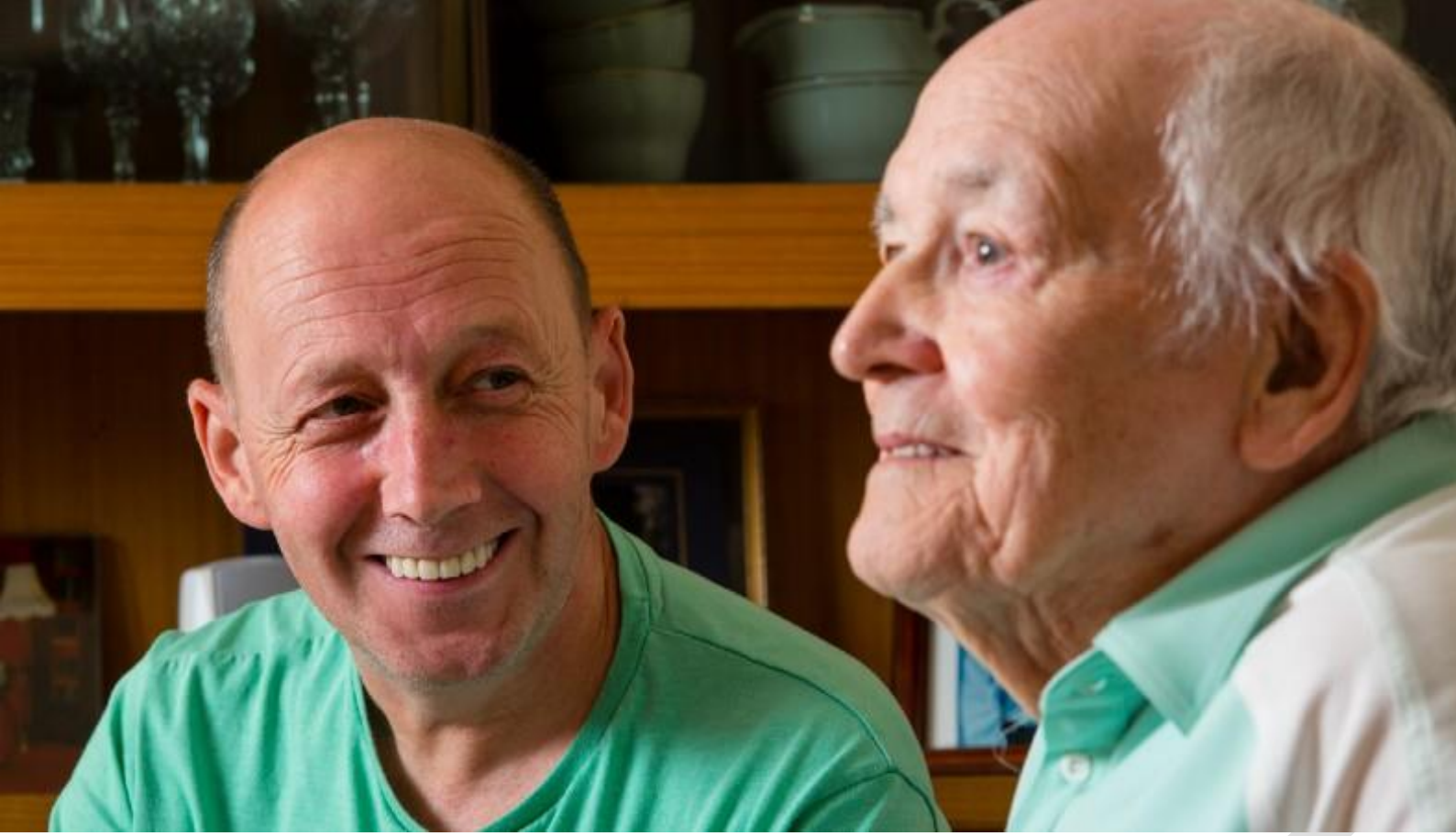
Support & Treatment

- Reducing Harm and Promoting Recovery.
- Commissioning and Assuring High Quality, Cost Effective Outcomes Focused Services

Crisis & Emergency

- Reducing Harm and Promoting Recovery.

RESOURCES



Unpaid Carers

Planning group: Carers Strategic Planning Group
Planning Lead: Shelagh Swithenbank

Prevention & Early Intervention

- Identify more carers
- Increase numbers of carers with future plans.
- Improve carer involvement in service design and delivery.

Support & Treatment

- Improve access to Support, Information and Advice.
- Improve Carer Health & Wellbeing including Breaks from Caring
- Improve Carer's Financial Support and Economic Wellbeing

Crisis & Emergency

- Planning Ahead: Support carers to have discussions and make plans to support the health and wellbeing of themselves and the people they care for in the event of a crisis or emergency.

Respite

Planning group: Respite & Short Breaks
Planning Lead: Gillian Chapman

Prevention & Early Intervention

- Improve Overnight Respite
- Improve equality of access to respite across Midlothian
- Plan respite for future need – efficient & effective use of resources.

Support & Treatment

- Improve quality of respite
- Improve Procedures for Planning and Accessing Respite.
- Improve Information on Respite

Crisis & Emergency

- Reduce potentially preventable hospital admissions

Primary Care

Planning group: TBC

Planning Lead: Grace Cowan

Prevention & Early Intervention

- Develop the Community Treatment and Care services to support all practices.
- Develop Pharmacotherapy services in General Practice to improving medicines management and access to medicines.
- Develop the MSK APP service to enable more people to access timely assessment and intervention for their MSK condition and reduce the requirement for GP involvement, ED attendance or onward referral.

Support & Treatment

- Provide a comprehensive vaccination programme including Seasonal Flu and COVID Booster vaccinations
- Develop Primary Care premises to meet service requirements and respond to population growth
- Improve communication about primary care to improve sign-posting to the right support
- Support uptake and optimisation of technology across primary care
- Increase the adoption of data-led collaboration between General Practices and the HSCP to improve health outcomes for people.

Crisis & Emergency

- Review admission to hospital via Primary Care services in evenings, at night and weekends through the Lothian Unscheduled Care Service to facilitate provision of care close to home.

Acute Services

Planning group: Acute Services Planning Group
Planning Lead: Grace Cowan

To ensure appropriate use of acute services and unscheduled care we are working in collaboration with NHS Lothian and neighbouring IJBs to identify opportunities for transformation. This process is based on shared decision making and shared responsibility for the delivery of outcomes in this area.

New agreements, collaborative plans and reporting are currently being agreed in partnership and this plan will be updated accordingly.

Midlothian Community Hospital

Planning group: TBC
Planning Lead: Kirsty Jack

Prevention & Early Intervention

- Improve accessible information about Midlothian Community Hospital and the services it provides
- Support more older people to be financially secure
- Build stronger collaboration with older people, the voluntary sector and other partners to improve outcomes for older people

Support & Treatment

- Improve processes to ensure services at Midlothian Community Hospital are operating effectively and efficiently.
- Improve quality of care for older people with mental illness
- Improve quality of care for people with dementia
- Increase the provision of holistic care
- Improve access to and quality of care and treatment for out-patients.
- Improve people's choice and control over their care and treatment and participation in decision making.
- Improve awareness and fulfilment of human rights for older citizens, including people who live in care or treatment facilities
- Support more people with rehabilitation and recovery.

Crisis & Emergency

- Increase likelihood that emergency care is person-centred through increased use of emergency plans and supported decision making

Sport & Leisure

Planning group: Attend - Falls, Long term Conditions, Older People
Planning Lead: Allan Blair

Prevention & Early Intervention

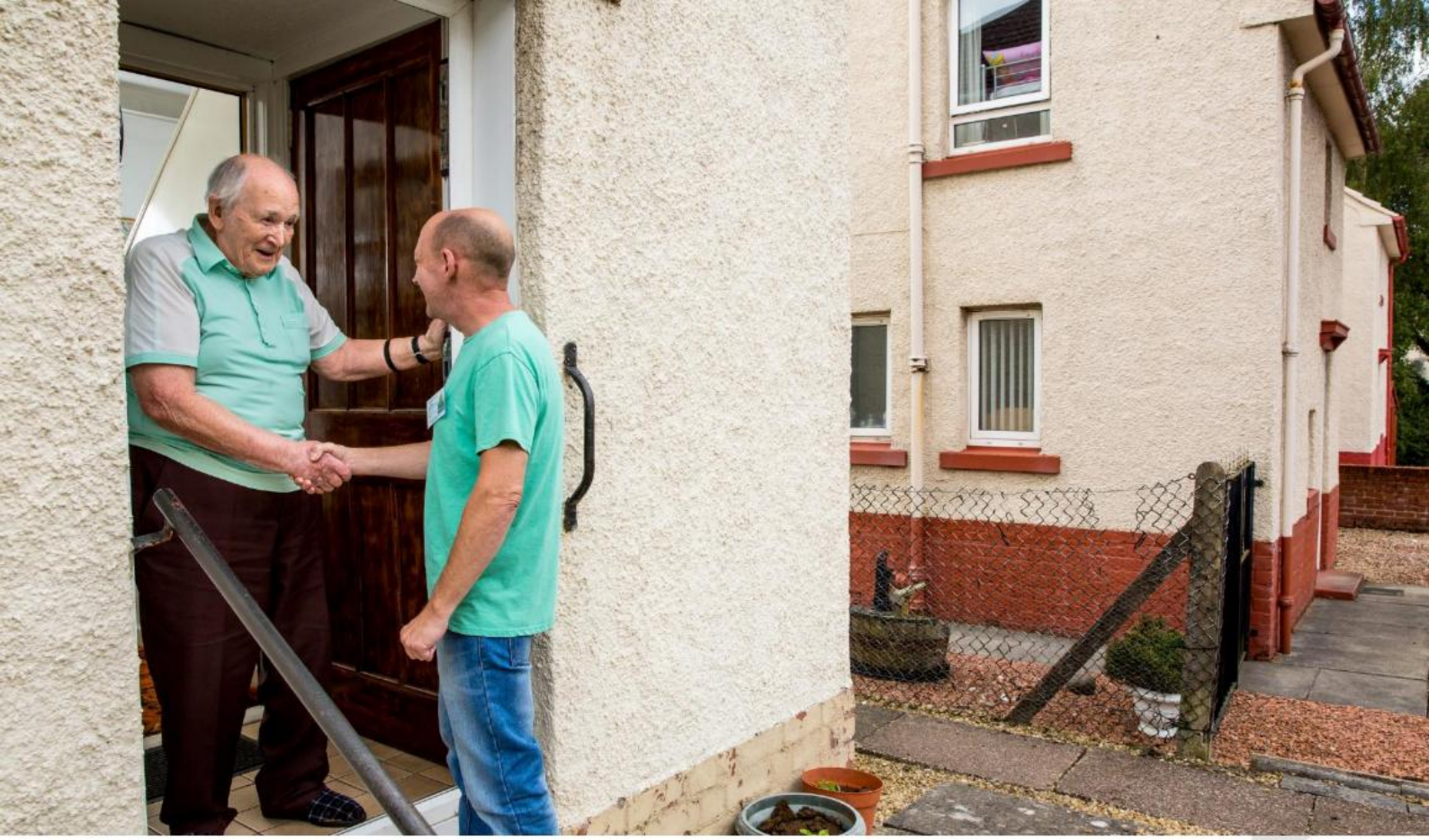
- Improve equity of access to all physical activity opportunities.
- Increase the number of people having a positive experience at a Sport & Leisure venue or activity.

Support & Treatment

- Increase community based support opportunities.

Crisis & Emergency

- Increase support for communities in crisis or emergency.



Housing & Homelessness

Planning group: Health and Homelessness & Extra Care Housing
Planning Leads: Gillian Chapman

Prevention & Early Intervention

- Improve advice & support to people at risk of homelessness.
- Offer increased housing choice and options.
- Reduce unmet specialist housing demand.
- Increase awareness of Extra Care Housing to public & professionals
- Enable individuals & their families to make decisions regarding their long term care and support.

Support & Treatment

- Increase the number of people accessing support in temporary accommodation.
- Increase choice and control for recovery from substance misuse.
- Improve support for people who are homeless with complex and multiple needs
- Reduce avoidable hospital admissions / delayed discharges.
- Enable people to live independently.

Crisis & Emergency

- Reduce drug related deaths and non-fatal overdoses in supported temporary accommodation
- Make best use of available housing resources

Housing Contribution Statement

Introduction

Affordable, good quality, suitable housing in safe and connected neighbourhoods is vital for good health and wellbeing.

This Housing Contribution Statement describes the contribution that housing and related services play in delivering good health and social care.

Supporting people to live independently in their own home for as long as possible while managing complex needs in the community requires joint working. This statement sets out how housing and related services will work in partnership with the Integration Joint Board to achieve the outcomes in this Strategic Plan.

The main issues that affect housing and housing related support include:

- **An increase in demand for services** as people are living longer and have more complex long-term conditions
- **A shortage of suitable housing** for people who:
    - have a learning disability,
    - mental health issues
    - substance misuse problems
    - have bariatric conditions
    - use a wheelchair
    - are leaving hospital
- Design and provision of housing for people with dementia
- **Budget pressures** in relation to adaptions and differences in funding relating to tenure
- **Health implications for people who experience homelessness**
- **Pressures on temporary accommodation for homeless households**
- **Challenges faced by Care Experience Young People**

While Housing and Homelessness is not a delegated function to the Integration Joint Board housing is represented on the Strategic Planning Group and Integration and Housing sub-group and service specific strategic groups. The Health and Social Care Partnership, housing providers and 3rd sector organisations are represented at the Local Housing Strategy Strategic Working Groups and there are close links at an operational level.

Links to other Strategies

This statement links to a number of local strategies:

Local Housing Strategy (2021-2026)

www.midlothian.gov.uk/downloads/file/4206/midlothian_local_housing_strategy_2021-2026

This outlines Midlothian Council's vision that **"All households in Midlothian will be able to access housing that is affordable and of good quality in sustainable communities."**

It aims to do this within 5 years by:

- Increasing access to housing and the supply of new housing across all tenures
- Improving Place Making
- Homeless households and those threatened with homelessness are able to access support and advice services and all unintentionally homeless households will be able to access settled accommodation.
- The needs of households will be addressed and all households will have equal access to housing and housing services.
- Housing in all tenures will be more energy efficient and fewer households will live in, or be at risk of, fuel poverty.
- Improving the condition of housing across all tenures.
- Improving Integration of Housing, Health and Social Care

Strategic Housing Investment Plan (annual)

www.midlothian.gov.uk/downloads/file/4107/strategic_housing_investment_plan_202122_to_202526

This sets out social housing building projects planned for the next five years by Midlothian Council and Registered Social Landlords (Housing Associations). The Scottish Government provide funding through the Affordable Housing Supply Programme to support this.

The plan also includes information on housing provision for wheelchair users – including plans to build 484 'specialist homes' that includes wheelchair housing, amenity housing, bariatric housing and extra care housing.

Rapid Rehousing Transition Plan

www.midlothian.gov.uk/downloads/file/4108/rapid_rehousing_transition_plan_202021-202324

This plan explains how Midlothian will use the Rapid Rehousing model for homeless applicants to ensure:

- People have a settled, mainstream housing outcome as quickly as possible
- Time spent in any form of temporary accommodation is reduced to a minimum, with the fewer transitions the better
- When temporary accommodation is needed, the optimum type is mainstream, furnished and within a local community.

Shared Outcomes:

The Midlothian Integration Joint Board Strategic Plan aims for 2022-2025 are:

- Increase people's support and opportunities to stay well, prevent ill or worsening health, and plan ahead
- Enable more people to get support, treatment and care in community and home-based settings.
- Increase people's choice and control over their support and services.
- Support more people with rehabilitation and recovery.
- Improve our ability to promote and protect people's human rights, including social and economic rights and meet our duties under human rights law, through our services and support.
- Expand our joint working, integration of services, and partnership work with primary care, third sector organisations, providers, unpaid carers, and communities to better meet people's needs.

Housing can contribute to these aims by:

AIM	PREVENTION EARLY INTERVENTION
2,6	Deliver further Housing Solutions training sessions to Health and Social Care staff and other partner organisations.
5,6	Occupational Therapist/Community Health Specialist input for all new build general housing
3,5,6	Partnership working with Children's Services to develop a homeless prevention pathway for care experienced and looked after young people.
1,6	Investigate the implications of significant projected numbers of older households for specialist and general housing
1,2	Ensure new build general needs accommodation is future proofed to accommodate wheelchair users & capable of being adapted to suit a range of needs including the elderly and those with dementia
1,6	Target energy efficiency advice at households most at risk of fuel poverty
3,5,6	Ensure staff are able to deliver a full range of Housing Options advice regardless of tenure. Provided access to training the Housing Options Training Toolkit.
3,5,6	Ensure a person centred approach is taken to the delivery of all housing options, homelessness and tenancy management functions by having a trauma informed workforce.

AIM	SUPPORT & TREATMENT
1,3	Develop 104 extra-care housing flats/bungalows in Midlothian by 2023
2,3	Develop at least 101 new amenity houses in Midlothian by 2022
1,3	Develop 4 bariatric properties in Midlothian by 2023
2,3	Develop 12 units for households with learning disability and or complex care needs by 2023
3,5	Develop an increased number of new homes with adaptations for specialist provision by 2022.
3,5	Set wheelchair supply targets which will ensure a % of new build properties are wheelchair accessible
1,2,6	Undertake feasibility study of delivering Care and Repair Services in Midlothian
3,5	Develop 484 units of specialist housing over a five-year period to 2026 (97 units per annum).
1,2,6	Investigate increasing provision of specialist housing via remodelling existing provision which could be developed by the public or private sector.
3,5	Open Market Purchase Scheme (the purchase of ex local authority properties from the open market) to purchase 10 'specialist homes' per annum
1,2	Complex Care facility to be built in Bonnyrigg
1,6	Carry out a comprehensive review of sheltered and retirement housing to ascertain effectiveness
1,5	Implementing 'Housing First' for those with long-term/repeated instances of homeless.

AIM	CRISIS & EMERGENCY SUPPORT
2,4	Increase the number of intermediate care properties by using 6 Midlothian Council properties for intermediate care.
3	Reduce the time taken for homeless households to secure a permanent Housing outcome.
1,5	Improving the quality of temporary accommodation, particularly that which is provided to households without children

Adaptations

Adaptations, from grab rails to wet floor showers, enable people to live as independently as possible in their own homes, improve their health and wellbeing and can reduce the need for further Health and Social Care services.

Major adaptations are completed by an Occupational Therapist after consideration by the Occupational Therapy Panel - line with eligibility criteria, property type and the long-term cost effective solutions. Agreement to requests are based on need not the tenure of the property.

The Occupational Therapy and Housing Partnership group supports decisions made by the panel and considers the kinds of properties that are adapted to consider the wider need of housing.

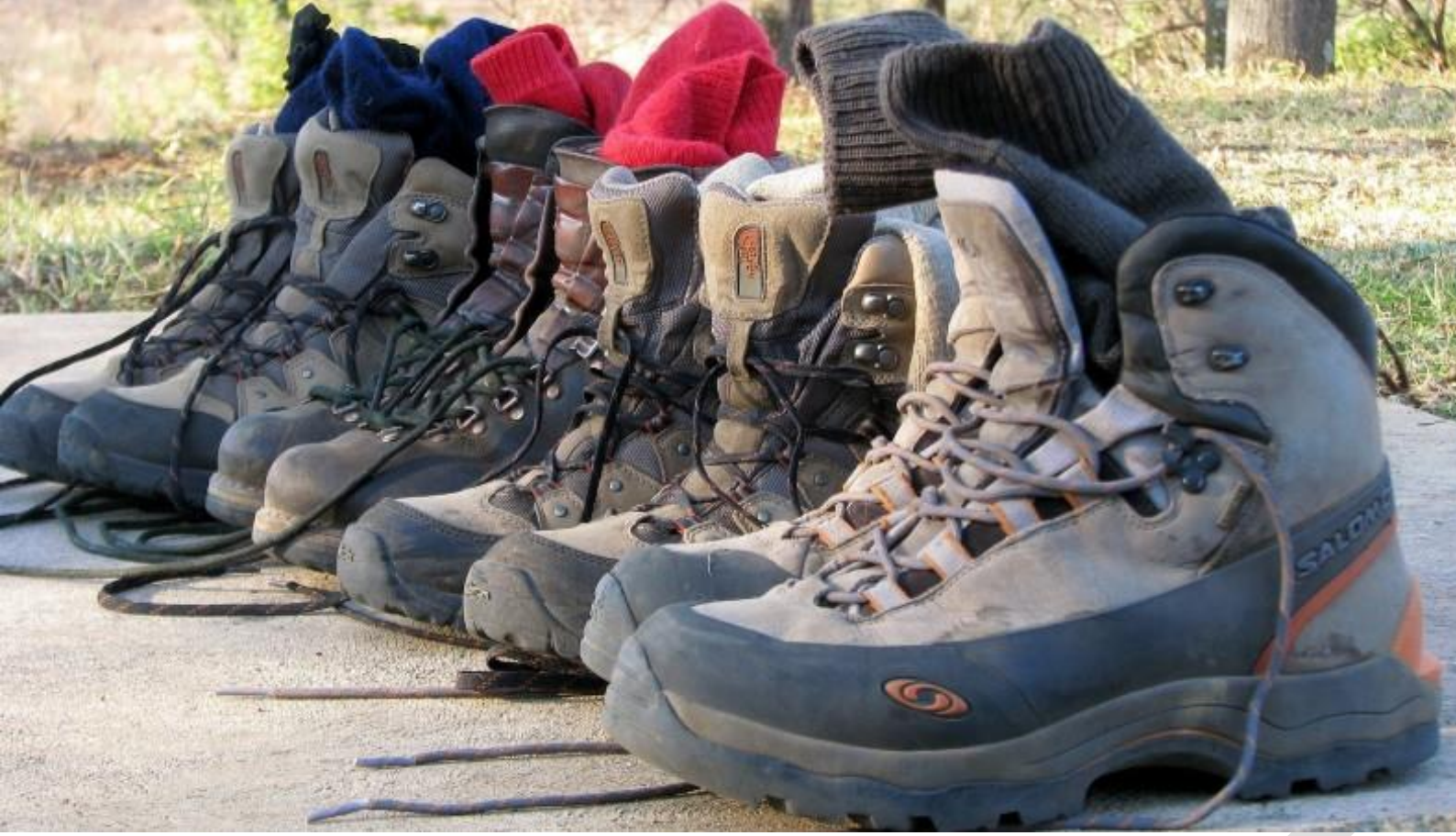
Funding of Adaptations

The funding for adaptations is dependent on the tenure of the property.

- **Council Housing owned by Midlothian Council** - funded by the Housing Revenues Account (check with Alan Ramage). Add stats (can be provided by Alan/Fiona).
- **Registered Social Housing owned by registered social landlords** - funded directly from the Scottish Government. Add stats (Brook McGee at Castle Rock may provide stats along with Nancy Booth @ Melville).
- **Private Sector Adaptations owned by private landlords -** funded through a Home Improvement Grant. Applicants for a grant are entitled to 80% of mandatory work and those in receipt of certain benefits qualify for 100%. Some adaptations are considered discretionary - environmental health who support the grant are consulted in these cases and they are not funded to the same value as mandatory grants. The owner of the property is responsible for maintaining and servicing any adaptations after installation. (I would check this with Edel Ryan to make sure she is in agreement). Add Stats (Edel Ryan).

All staff in the Health and Social Care Partnership, Housing and the Voluntary Sector are offered training in how to have early conversations around housing needs.

There is ongoing work to open up assessment for minor adaptations to agencies including housing. Currently the voluntary sector support assessment for minor adaptations.



Public Health

Planning group: Public Health Reference Group (TBC)
Planning lead: TBC

Prevention & Early Intervention

- Increase the number of people who are supported to be more physically active.
- Increase the number of people who are supported to address money worries.
- Increase the number of people who are supported to stop smoking
- Increase the number of people who are supported to eat well
- Improve screening & early detection e.g. cancer & type II diabetes

Support & Treatment

- Embed the Midway - Support self-management, understanding trauma & addressing inequalities
- Increase access to health and wellbeing support for people at higher risk of health inequalities.

Crisis & Emergency

COMMUNICATING CLEARLY

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

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

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

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

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۔

Contact 0131 270 7500 or email: enquiries@midlothian.gov.uk

Midlothian Integration Joint Board

17th March 2022

Midlothian IJB - 2022/23 Budget Setting

Item number:	**4.3**

Executive summary

The IJB is required to set a balanced budget before the start of the financial year. This paper lays out the budget proposals and the challenges therein for the IJB's budget for the financial year 2022/23. The paper lays out the budget offers from the partners, considers if these meet the Scottish Government's guidelines and the IJB's own tests of fair and adequate. The paper then considers, using the indicative information currently available, the financial projection for the IJB in 22/23 and reflects if this will allow the IJB to set a balanced budget. It is important, as part of the process, that the IJB considers the impact of the 21/22 position on the IJB reserves (which are estimated to increase significantly from the position at the end of 21/22) and then supports a plan to utilise these reserves both to underpin the 22/23 financial position and also to support (non-recurrently) further transformational work.

Board members are asked to:

1. ***Agree that the budget offer from Midlothian Council meets the Scottish Government criteria.***
2. ***Agree that the budget offer from NHS Lothian meets the Scottish Government criteria.***
3. ***Note the projected movement in the IJB's Reserves***
4. ***Note the projected financial position for 2022/23***
5. ***Agree that the 2022/23 budget proposal is, at this time, balanced and therefore agree to the IJB's outline 22/23 budget***

Report

Midlothian IJB – 2022/23 Budget Setting

1 Purpose

1.1 This paper has the following objectives: -

- To seek agreement to the 22/23 budget offers from the IJB's partners – Midlothian Council and NHS Lothian
- To lay out the projected financial position for the IJB in 22/23, and to consider the projected increase in the IJB's reserves and the utilisation of these reserves.
- To consider if the IJB can set a balanced budget for 22/23

2 Recommendations

2.1 As a result of this report Members are asked to: -

- Agree that the budget offer from Midlothian Council meets the Scottish Government criteria.
- Agree that the budget offer from NHS Lothian meets the Scottish Government criteria.
- Note the projected movement in the IJB's Reserves
- Note the projected financial position for 2022/23
- Agree that the 2022/23 budget proposal is, at this time, balanced and therefore agree to the IJB's outline 22/23 budget

3 Background and main report

3.1 Background and process

The IJB is required to set a balanced budget before the start of the financial year as laid out in the local authority regulations that govern the IJB. Midlothian Council have set a budget but NHS Lothian will not formally set a budget until its April Board meeting. NHS Lothian is required to break-even at the end of the financial year and therefore its April paper generally does not show a balanced position but shows a potential overspend position and therefore reflects the financial challenge that requires to be managed in year.

Both partners are required to make formal budget offers to the IJB prior to the start of the financial year and both have, although NHS Lothian's offer is indicative in that it has not yet been formally agreed and there will be further allocations made to the Board (which will then become part of the IJB's budget, for example the GMS uplift) in year.

The IJB's practice is to subject the partners' budget offers to 3 tests :-

- Does the offer meet the guidelines laid down by the Scottish Government as part of its budget setting process ?
- Is the offer 'fair' – that is a fair and reasonable amount given the overall resources available to the partner ?
- Is the offer 'adequate' – that is will this offer allow the IJB to set a balanced budget?

As part of the 22/23 budget setting process, the IJB had a finance workshop in January (at which the partners' CFOs reflected on the impact of the Scottish Governments settlement on their respective organisations) and a paper was presented to the IJB in February providing further financial analysis and further detail.

The final part of the process is for the IJB to consider the partners budget offers as above and then, having considered the projected financial position in 2022/23 to set (if possible) a balanced budget.

3.2 Budget Offers from the partners

The budget offer letters from the partners are attached.

Midlothian Council.

The Scottish Government's guidelines for Councils are that the budget offer should be at least the base recurring budget plus the appropriate share of the additional allocations made available for social care in the 22/23 budget settlement. Midlothian council has met those guidelines. It's clear both from examining the Scottish Government's 22/23 budget and the briefing given to the IJB by the Council's CFO that the 22/23 settlement was very challenging. On that basis, the offer can certainly be seen as fair. In terms of adequacy, it seems that the base position (that is before any further 22/23 allocations), although underpinned by a considerable amount of support for Covid pressures will break-even. Without additional resources in 22/23 this position would probably not be sustainable but the additional funding from the 22/23 settlement should resolve any pressures. The Midlothian Council offer meets the IJB acceptance criteria.

NHS Lothian

The Scottish Government's guidelines for Health Boards are that the offer should be at least the recurrent baseline plus a 2% uplift on that baseline plus cover for the increased costs of the employers NI contributions that will come into force after April. The offer meets that criteria. It should be remembered that the baseline on which the 2% is calculated is less that the operational baseline which contains elements of funding which are not uplifted through the baseline. That is why multiplying the apparent baseline by 2% produces a slightly different value. Given previous discussions the offer can be seen as a fair share of the resources available to the Health Board. The issue of adequacy is slightly more challenging given that the projection shows an overspend position for the IJB. However, and this is discussed further below, actions are in train to manage this position and the NHS Lothian offer meets the IJB's acceptance criteria.

3.3 Reserves

The finance paper presented to the IJB at its February meeting noted that there would be an underspend position for the IJB at the close of 21/22. The position won't finally be known until the end of April when the partners declare an out-turn 21/22 position, but NHS Lothian is forecasting an underspend and the impact of the additional Winter funding received by the IJB in November (this was reported to the IJB at its December '21 meeting) will generate a significant carry forward. This will mean that, excluding Covid, the IJB's reserves will increase significantly (perhaps by c. £3.0m) although much of that will be earmarked funds.

As was discussed in the February Finance paper, there has been a significant financial pressure caused by the impact of the Covid pandemic and that has been underpinned by additional funds from the Scottish Government. That pressure will continue into 22/23. The Scottish Government has made a further allocation (letter of 25th February 2022 – attached) to Health Boards and Integration Joint Boards to cover the costs of Covid in 21/22 with the clear assumption that an element of these funds will be carried forward into 22/23 to cover the costs of Covid in that financial year. Work is currently underway to finalise the value of the amount to be carried forward but it is expected to provide cover for the majority of the currently projected 22/23 Covid costs.

In summary, the value of the IJB's reserves (both general and earmarked) will be greater at the end of 21/22 than they were at the end of 20/21. Clearly this allows the IJB a considerable level of comfort when setting its 22/23 budget, however there are two key points :

1. That funding from reserves is non-recurrent and therefore if non-recurrent funding is being used to support recurrent expenditure then further plans need to be developed to support the 23/24 position. This work is already underway and is discussed further below,
2. That the IJB's general reserve is more than adequate to meet the target in its reserves policy and it is proposed that elements of these funds should be used to drive forward transformational work to support the delivery of the strategic plan. That has already happened with the appointment of the performance team but further developments could be considered.

3.4 Financial Projection for 22/23.

This was discussed in detail in the February paper and the projections have not materially changed. In summary the key elements are :-

Core health and Social Care budgets – these are the local health budgets and the social care budgets managed by the HSCP. A detailed exercise has been undertaken by the HSCP management team and its finance support to examine the pressures in their budgets and the ambitions to invest elements of the new funding to develop improved services. This exercise has now resulted in balanced position for 22/23 albeit with an element of non-recurrent support (earmarked funds for Care at Home and Interim Care being brought forward from 21/22 as described above). Once this exercise is finalised – having agreed the 21/22 out-turn position – further work will consider the 23/24 position.

Set Aside and Hosted – the February paper indicated a net (net of Covid funding) pressure of c. £1.0m of which c. £830,000 was Set Aside. Management of pressures in the hosted services will be supported by the HSCP management team but the key concern at this time is the projected pressures within the Set Aside budget. Work has started with Acute colleagues to understand these issues more fully and for the IJB, if possible, to support the delivery of recovery plans. NHS Lothian has an excellent record of achieving financial balance and further assurance will be sought as to the management of this pressure.

Covid – the above is all predicated on the assumption that the continuing financial pressures generated by the Covid pandemic can be supported. As was discussed above, much of this will be delivered through the carry forward of the unused 21/22 Covid funding and the Scottish Government is clear that its ambition is to support all health and social care Covid pressures in 22/23 if this is achievable. The planning assumption at this time is that the Covid pressures will be covered in 22/23 but, as has been stated before, the management teams must now develop exit strategies for these Covid generated costs because funds will not be available in 23/24.

3.5 Setting a balanced budget

Based on the information available at this time, the IJB is able to set a balanced budget for 22/23 albeit with financial risks around its Set Aside budget and financial pressures generated by the continuing Covid pandemic.

It is proposed, therefore, that the IJB accepts the budget offers from the partners and sets a balanced budget in 22/23 based on these assumptions.

This budget being :-

Midlothian Integration Board

Indicative Budget 2022/23

	Midlothian Council £000's	NHS Lothian £000's	Total £000's
Base Budget	47,752	91,446	139,198
Uplifts & Add'n Allocs	8,934	1,480	10,414
2022/23 Base Budget	56,686	92,926	149,612

Notes

NHS Lothian Offer is indicative. The GMS uplift will be available post April 2022
Of the MLC Uplift, £8.7m is part of the Scottish Government's 22/23 settlement for social care

3.6 Next Steps

Having set a budget for 22/23, the IJB can move forward and incorporate the appropriate budgets into its 22/23 directions. Work will continue with the HSCP management team and other colleagues to refine the operational budgets and further reports will come back to the IJB during the financial year as to the performance of

the partners against its budget and an analysis of those elements that are being funded non-recurrently. Further work is also underway to sketch out the financial position for 23/24 and this will be part of the further development of the IJB's financial plan.

4 Policy Implications

4.1 There are no policy implications from this report, however policies may require to be revised arising from any operational or transformation proposals to balance the IJB's financial plan.

5 Directions

5.1 There are no implications on directions from this report.

6 Equalities Implications

6.1 There are no equalities implications from this report

7 Resource Implications

7.1 The resources implications of this report are laid out in the body of this report.

8 Risk

8.1 The risks raised by this report are already included within the IJB risk register, any further risks arising from any proposals will be included in the register as required.

9 Involving people

9.1 The IJB's meetings are recorded and available to the public and all of its papers are available on the internet.

10 Background Papers

10.1 Finance Report to the IJB in February 2022.

AUTHOR'S NAME	David King
DESIGNATION	Interim Chief Finance Officer
CONTACT INFO	David.king4@nhslothian.scot.nhs.uk
DATE	March 2022

Appendices:

Appendix 1 - Full Year Recurring Expenditure
Appendix 2 - Offer from Midlothian Council and response
Appendix 3 - Offer from NHS Lothian and response
Appendix 4 - Further Covid Funding 2021-22.

Update - xx/01/22

APPENDIX 3 - 2021/22 DRAFT FINANCIAL PLAN SUMMARY BY INTEGRATED JOINT BOARDS

	Mid Lothian IJB
	£k
Full Year Recurring Expenditure Budget	**91,446**
Baseline Pressures	**(356)**
Projected Expenditure Uplifts & Commitments	(1,018)
Growth and Other Commitments	(1,596)
Policy Decisions	0
Strategic Investments	0
Essential Service Development	(16)
Unscheduled Care	(12)
Projected Expenditure Uplifts & Commitments	**(2,642)**
Percentage of Recurring Budget	*(2.9%)*
Projected Costs	**(2,999)**
Recurring Resources	
Base Uplift	867
National Insurance (HSC Levy)	
NRAC	
OHB Income	
Non Recurring Resources	
VPAS	50
Reserves	
Asset Disposal	
Flexibility	
Additional Resources	**917**
Financial Outlook Gap before FRP's	**(2,081)**
Financial Recovery Plans	**585**
Financial Outlook Gap after FRP's	**(1,496)**
Percentage of Recurring Budget	*(1.6%)*
Additional Covid Costs	**(6,464)**
Total Financial Outlook Gap	**(7,961)**
Balance of Uplift	613
Final estimated outturn - 22/23	**(7,348)**

Update - 21/10/21

APPENDIX 3 - 2021/22 DRAFT FINANCIAL PLAN SUMMARY BY INTEGRATED JOINT BOARDS

	Mid Lothian IJB
	£k
Full Year Recurring Expenditure Budget	**91,695**
Baseline Pressures	**(1,062)**
Projected Expenditure Uplifts & Commitments	(961)
Growth and Other Commitments	(1,122)
Policy Decisions	
Strategic Investments	
Essential Service Development	(16)
Unscheduled Care	(12)
Projected Expenditure Uplifts & Commitments	**(2,111)**
Percentage of Recurring Budget	*(2.3%)*
Projected Costs	**(3,173)**
Recurring Resources	
Base Uplift	810
OHB Income	
Non Recurring Resources	
VPAS	50
Reserves	
Flexibility	
Additional Resources	**860**
Financial Outlook Gap before FRP's	**(2,314)**
Financial Recovery Plans	**100**
Financial Outlook Gap after FRP's	**(2,213)**
Percentage of Recurring Budget	*(2.4%)*
Additional Covid Costs	
Total Financial Outlook Gap	**(2,213)**

Place
Financial Services
Midlothian Council
Midlothian House
Buccleuch Street
Dalkeith
EH22 1DN

Executive Director
Kevin Anderson

Midlothian

15 February 2022

Morag Barrow
Chief Officer
Midlothian Integration Joint Board
Fairfield House
8 Lothian Road
DALKEITH
EH22 3AA

Dear Morag

ALLOCATION TO MIDLOTHIAN INTEGRATION JOINT BOARD 2022-23

Following today's Council meeting I am writing to confirm that an allocation to the Integration Joint Board of £56.438 million has been agreed.

This offer of funding is subject to final confirmation of the quantum and distribution of funding for new burdens.

The allocation is made up as follows:-

Base allocation	£47.752 million
Additional SG funding:	
New Funding for Health & Social Care	£3.020 million
Living Wage (uplift to £9.50)	£0.457 million
Living Wage (uplift to £10.02)	£2.276 million
Care at Home Capacity	£1.891 million
Interim Care/Beds	£0.305 million
Carers' Act	£0.306 million
Free Personal & Nursing Care Uplift	£0.225 million
MHO Capacity Funding	£0.061 million
Trauma Informed Practice	£0.050 million
Appropriate Adult Funding	£0.016 million
Other adjustments	£0.079 million
Allocation	**£56.438 million**

Your Ref:
Our Ref:

Tel 0131-271-3132
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Midlothian House
Buccleuch Street
Dalkeith
EH22 1DN

Executive Director
Kevin Anderson

Midlothian

I hope that you will find that the offer meets the requirements set out in letter of 9th December 2021 to NHS Chief Executives from the Director of Health Finance and Governance within Scottish Government. In addition please note that the funding reflects the overall financial position of the Council and the level of Scottish Government grant support to the Council 2022-23 and in turn the Council's continued support to both the IJB and integration in general.

I would be grateful if you could confirm in due course Midlothian Integration Joint Board's acceptance of the 2022-23 allocation.

Yours sincerely

Gary Fairley
Chief Officer Corporate Solutions
gary.fairley@midlothian.gov.uk

cc David King, Interim Chief Financial Officer Midlothian IJB
Ruth Nichols, Senior Accountant

Morag Barrow,
Chief Officer
Midlothian Integration Joint Board
8 Lothian Road,
Dalkeith, EH22 3AA

Place
Financial Services
Midlothian Council
Midlothian House
Buccleuch Street
Dalkeith
EH22 1DN

7thMarch 2022

Dear Gary,

Midlothian Council – Budget Offer to Midlothian Integration Joint Board 2022/23.

Thank you for your letter of 15th February setting out the Council's 2022/23 allocation to the Integration Joint Board. May I apologise for the delay in replying but as you know (and as you say in your letter) it has taken a little while just to clarify the final distribution of the Scottish Government's 2022/23 settlement.

I agree that the Council's offer – and we will need make some minor amendments to the values in the light of further information from the Scottish Government – meets the criteria, that is the 22/23 allocation being the agreed recurrent baseline plus the Midlothian share of the additional £554m.

The IJB will meet on 17th March to set it's budget for 22/23 and I will let you know thereafter the outcome from that meeting.

As I mentioned above, I am now in receipt of revised values for the distribution of the £554m along with the distribution of a further £22m for social work (which had not been circulated when you wrote your original letter) and I am appending that detail to this letter. We can confirm these exact values when you have had an opportunity to fully consider the updated local authority funding circular.

Yours sincerely,

Interim Chief Finance Officer

Cc Morag Barrow, Chief Officer
Ruth Nichols, Senior Accountant

Movements between offer letter and updated position

	Nation-ally £m	**Midlothian £m**	Offer letter	Movement	
Carers	20.4	0.306	0.306	0.000	
FPNC	15.0	0.225	0.225	0.000	
20/21 RLW	30.5	0.457	0.457	0.000	
21/22 RLW	144.0	2.190	2.276	-0.086	I think our estimate was based on the wrong GAE
Care at Home	124.0	1.870	1.891	-0.021	An error in the original analysis
Interim Care	20.0	0.305	0.305	0.000	
Social Care Investment	200.0	3.040	3.02	0.020	Slight GAE difference ?
Add'n £22n for Social Work	22.0	0.335		0.335	We didn't have this when the letter was written
	575.9	**8.728**			
Add'n Items					
MHO Capacity Funding		0.061	0.061	0.000	
Trauma Informed Practice		0.050	0.050	0.000	
Appropriate Adult Funding		0.016	0.016	0.000	
Other Adjustments		0.079	0.079	0.000	
Totals		8.934	8.686	0.248	

Lothian NHS Board

Finance Director's Office
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

Telephone 0131 536 9000

www.nhslothian.scot.nhs.uk

By Email Only

Letter to Chief Officer & Chief Finance Officer of Midlothian IJB

Date 10 March 2022
Your Ref
Our Ref

Enquiries to Craig Marriott
Extension 35543
Direct Line 0131 465 5543
Email Craig.Marriott@nhslothian.scot.nhs.uk

Dear Colleagues,

MIDLOTHIAN IJB – INDICATIVE UPLIFT FOR 2022/23

Further to NHS Lothian's Finance and Resources (F&R) Committee on January 17th, I write to update you on the position relating to uplift to be allocated to Midlothian IJB by NHS Lothian in 2022/23.

We have yet to conclude our financial planning process, and we will look to take a final iteration of the Plan through our F&R Committee on the 21st of March, with final sign off at our Board meeting on the 6th April. The figures shared with you at this stage are therefore indicative until the final Plan has been agreed, and the final SG uplift settlement has been confirmed after the pay uplift for 22/23 is resolved.

In total, and based on the indicative allocation communicated to Boards on the 9th of December from the Scottish Government, NHS Lothian will receive an uplift allocation of 2% against baseline for 2022/23, equating to £31.9m. As agreed and per previous years, we will pass through the full share of this settlement to each IJB, based on budget shares.

The Plan shared at the January Committee recognised a budget of £91,446k for Midlothian IJB. Net of GMS (which will receive a separate uplift allocation) the total recurring budget equates to £78,658k, although this still includes elements of budget beyond the baseline.

The total proportionate share of the £31.9m to be passed through to Midlothian IJB has been calculated at £1,480k. We have assumed that each IJB will continue to prioritise funding of pay awards. At this stage, the Plan for Midlothian IJB shows the following share of resource requirements (see Appendix for further detail):

Pay Uplift	£ 867k
Balance of Uplift	£ 613k
Total Uplift	£1,480k

In addition to this allocation, the SG has provided a further allocation to meet the additional costs of employer national insurance. Our intention is to ensure all parts of the NHS system will be fully funded to meet increases in actual costs. We will keep you updated in this regard.

The final review of the NHS Lothian Financial Plan will conclude shortly, and further updates will be incorporated in the final iteration in terms of any agreed changes to the IJB mapping table for 2022/23 (where these are agreed with CFOs), additional savings and efficiencies identified and any further additional resourses allocated. A further update on 2022/23 budgets will be provided to you at this time. We would also reiterate that the pay award for 22/23 has yet to be finalised, and there may yet be additional funding due to Boards (and IJBs) as a result of any additional resource released to accommodate any pay agreement. We will of course keep you updated with developments.

Given that our financial planning indicates that the level of uplift is insufficient to meet all cost pressures in the system, I am keen to understand from Midlothian IJB as early as possible how its Directions will shape the delivery of efficiency savings in 2022/23 and the application of resources in support of financial balance.

I would be happy to have further discussion with your IJB in advance of the final confirmation on the application of health resources in 2022/23.

Yours sincerely

CRAIG MARRIOTT
Deputy Director of Finance

Morag Barrow,
Chief Officer
Midlothian Integration Joint Board
8 Lothian Road,
Dalkeith, EH22 3AA

Lothian NHS Board
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

By Email

7thMarch 2022

Dear Craig,

NHS Lothian – Budget Offer to Midlothian Integration Joint Board 2022/23.

Thank you for your letter of 25th February setting out the Health Board's 2022/23 allocation to the Integration Joint Board. May I apologise for the delay in replying.

I agree that NHS Lothian's indicative offer meets the criteria set down by the Scottish Government in its 22/23 budget settlement. That is a 2% uplift on the recurrent baseline (and I appreciate the issues around the Board's recurrent baseline and the recurrent budget) along with cover for the costs of the employers National Insurance increase which will come into effect in April 2022.

I note your other comments and the IJB remains committed to delivering its strategic plan within the financial resources available and, as part of its transformational work, will seek to reduce financial pressures on its partners as appropriate.

The IJB will meet on 17th March to set its budget for 22/23 and I will let you know thereafter the outcome from that meeting.

Yours sincerely,

Interim Chief Finance Officer

Cc Morag Barrow, Chief Officer

Andrew McCreadie, Head of Management Accounting

Health Finance, Corporate Governance & Value Directorate
Richard McCallum, Director

T: 0131-244 3475
E: richard.mccallum@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

HSCP Chief Finance Officers
NHS Board Directors of Finance
Cc:
HSCP Chief Officers
Local Government Directors of Finance
NHS Chief Executives

via email

25th February 2022

Colleagues

Further Covid funding 2021-22

Following the recent submission of your Quarter 3 financial returns, I am writing to confirm further funding of £981 million for NHS Boards and Integration Authorities to meet Covid-19 costs and to support the continuing impact of the pandemic. This funding is being provided on a non-repayable basis and includes provision for under-delivery of savings. While I anticipate that funding will be allocated in line with **Annexes A and B**, it will be a matter for NHS Boards and Integration Authorities to agree any revisions where appropriate to take account of local circumstances.

Within the overall funding outlined above, £619 million is being provided for Integration Authorities, which includes funding for a range of Covid-19 measures. The significant disruption to services has created a backlog of demand as well as increasing unmet need and frailty of service users. Investment is needed across day care services, care at home and to support unscheduled care, to keep people within the community, where possible and safe to do so, to avoid unplanned admissions and impacts on delayed discharges. Alongside this is the impact on mental health and services have been stepped up through, for example, Mental Health Assessment Units. This funding will also cover sustainability payments to social care providers and additional staff costs across Health & Social Care.

Where funding remains at year end 2021-22, this must be carried in an earmarked reserve for Covid-19 purposes in line with usual accounting arrangements for Integration Authorities, and I expect that this funding to be used before further allocations are made through the Local Mobilisation Planning process. This can be used to support continuation of costs which were funded in 2021-22 as a direct result of Covid-19. Use of these allocations to meet Covid-19 expenditure should be agreed by the IJB Chief Finance Officer and the NHS Board Director of Finance. The funding should be targeted at meeting all additional costs of responding to the Covid pandemic in the Integration Authority as well as the NHS Board.

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Any proposed utilisation of the earmarked reserves to meet new expenditure that had not been funded in 2021-22 will require agreement from the Scottish Government, and it will remain important that reserves are not used to fund recurring expenditure, given the non-recurring nature of Covid funding.

Thank you for your support and engagement during 2021-22 and I look forward to continued close work with you as we take forward plans for 2022-23 and beyond.

Yours sincerely

Richard McCallum
Director of Health Finance and Governance

Annex A Funding by Board Area

Further Covid-19 Funding (£000s)	Health Board	HSCP	Total
NHS Ayrshire & Arran	14,420	42,765	57,185
NHS Borders	7,471	17,575	25,046
NHS Dumfries & Galloway	13,997	16,146	30,143
NHS Fife	20,947	43,961	64,908
NHS Forth Valley	7,531	32,355	39,886
NHS Grampian	7,533	55,697	63,230
NHS Greater Glasgow & Clyde	88,484	132,917	221,401
NHS Highland	10,947	37,604	48,551
NHS Lanarkshire	15,121	68,810	83,931
NHS Lothian	31,641	114,566	146,207
NHS Orkney	2,575	3,746	6,321
NHS Shetland	999	3,620	4,619
NHS Tayside	2,441	45,355	47,796
NHS Western Isles	1,608	3,887	5,495
NHS National Services Scotland	118,110	-	118,110
Scottish Ambulance Service	11,326	-	11,326
NHS Education for Scotland	- 1,909	-	- 1,909
NHS 24	-	-	-
NHS National Waiting Times Centre	5,436	-	5,436
The State Hospital	-	-	-
Public Health Scotland	3,071	-	3,071
Healthcare Improvement Scotland	- 176	-	- 176
Total	**361,573**	**619,004**	**980,577**

Please note these figures represent the total funding across several allocations (PPE, Test & Protect, Vaccinations and General Covid Funding). A detailed analysis will be provided to each NHS Territorial Board setting out the split across Board and Integration Authorities.

Annex B Total Funding by Integration Authority

Integration Authority	Further Covid-19 Funding £000s
East Ayrshire	14,143
North Ayrshire	15,891
South Ayrshire	12,731
Scottish Borders	17,575
Dumfries and Galloway	16,146
Fife	43,961
Clackmannanshire & Stirling	16,819
Falkirk	15,536
Aberdeen City	24,317
Aberdeenshire	19,675
Moray	11,705
East Dunbartonshire	9,930
East Renfrewshire	14,781
Glasgow City	73,130
Inverclyde	10,370
Renfrewshire	16,964
West Dunbartonshire	7,741
Argyll & Bute	11,881
North Highland	25,724
North Lanarkshire	32,102
South Lanarkshire	36,708
East Lothian	13,537
Edinburgh City	70,314
Midlothian	9,506
West Lothian	21,209
Orkney	3,746
Shetland	3,620
Angus	11,843
Dundee	16,784
Perth & Kinross	16,728
Western Isles	3,887
Total	**619,004**

Please note these figures represent the total funding across several allocations (PPE, Test & Protect, Vaccinations and General Covid Funding). A detailed analysis will be provided to each NHS Territorial Board setting out the split across Board and Integration Authorities.