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.

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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

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