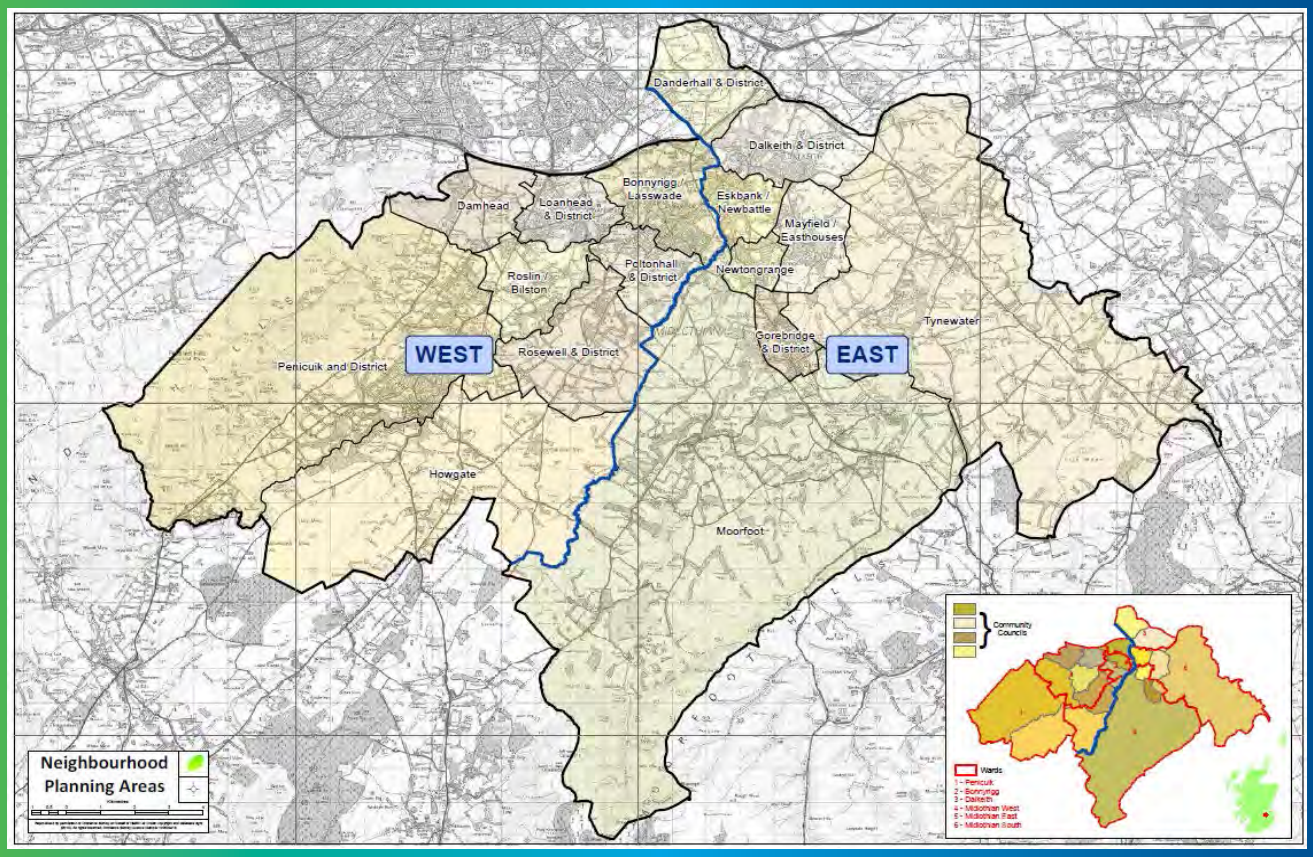
Midlothian

NHS Lothian

Midlothian's Health and Social Care **Delivery Plan** 2017-18



Content

Improving Health and Wellbeing

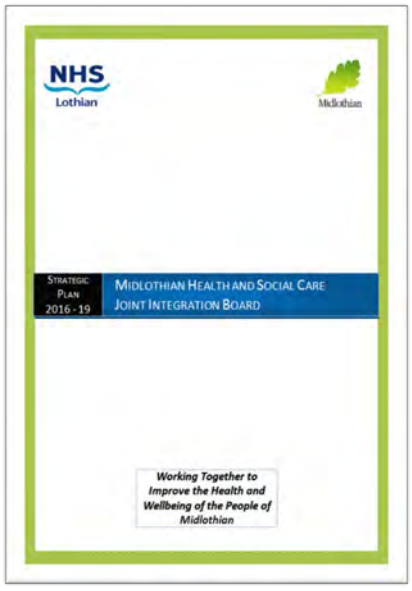
A New Approach to Health and Social Care Delivery

Due to new legislation in 2014, a new Health and Social Care Partnership, the Midlothian Integration Joint Board (IJB), is now responsible for planning the delivery of health and care services in Midlothian.

In March 2016, the IJB published its three-year Strategic Plan.

The Plan recognised the need for detailed work to develop more clear actions to improve health and care services.

This **2017-18 Delivery Plan** sets out how the Partnership will provide services during this period. It takes into account progress made during 2016-17 and seeks to address challenges that emerged during the past year.



Understanding People's Needs in Midlothian

As a result of a major house-building programme and people living longer, the population is likely to rise from 86,670 to approximately 92,800 in 2020, continuing to grow up to 2024 to a predicted level of 101,000. Faced with this growth in population, we must continually review what this means for delivering health and care services.

We based the 2016-19 Strategic Plan on an in-depth Joint Needs Assessment (insert hyperlink). It also incorporated our understanding of the views and concerns of the public.

An ongoing conversation with service users takes place through forums such as the Hot Topics and Older People's meetings.

This plan, developed by Midlothian Strategic Planning Group, continues to include User and Carer representation. We will continue to develop, shape and oversee its delivery.

More detailed actions and investments are contained in plans compiled by local Joint Planning Groups. These consider the needs of particular user groups such as the Older People's Planning Group.

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Content of the Plan

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

Midlothian Council elected to include services for offenders in the scope of the Integration Joint Board (IJB). This helps address the health and care needs that are often the root causes of offending behaviour. Developing ways of reducing offending remains the remit of the new **Community Justice and Safety Partnership.**

While it is vitally important that we develop strong links between adult and children's services, strategic planning for children's services remains the responsibility of **Getting it Right for Every Midlothian Child** group **(GIRFEMC)**.

The new IJB is not responsible for overseeing arrangements that protect people at risk of harm. This remains the responsibility of the **East and Midlothian Public Protection Committee (EMPPC)**. However, the services commissioned by the IJB have a crucial role in safeguarding people from harm and taking decisive steps to ensure we support and protect anyone considered at risk of harm.

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

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

How the Plan is Making Differences

By redesigning our services, we are better placed to deliver the key national outcomes. These include:

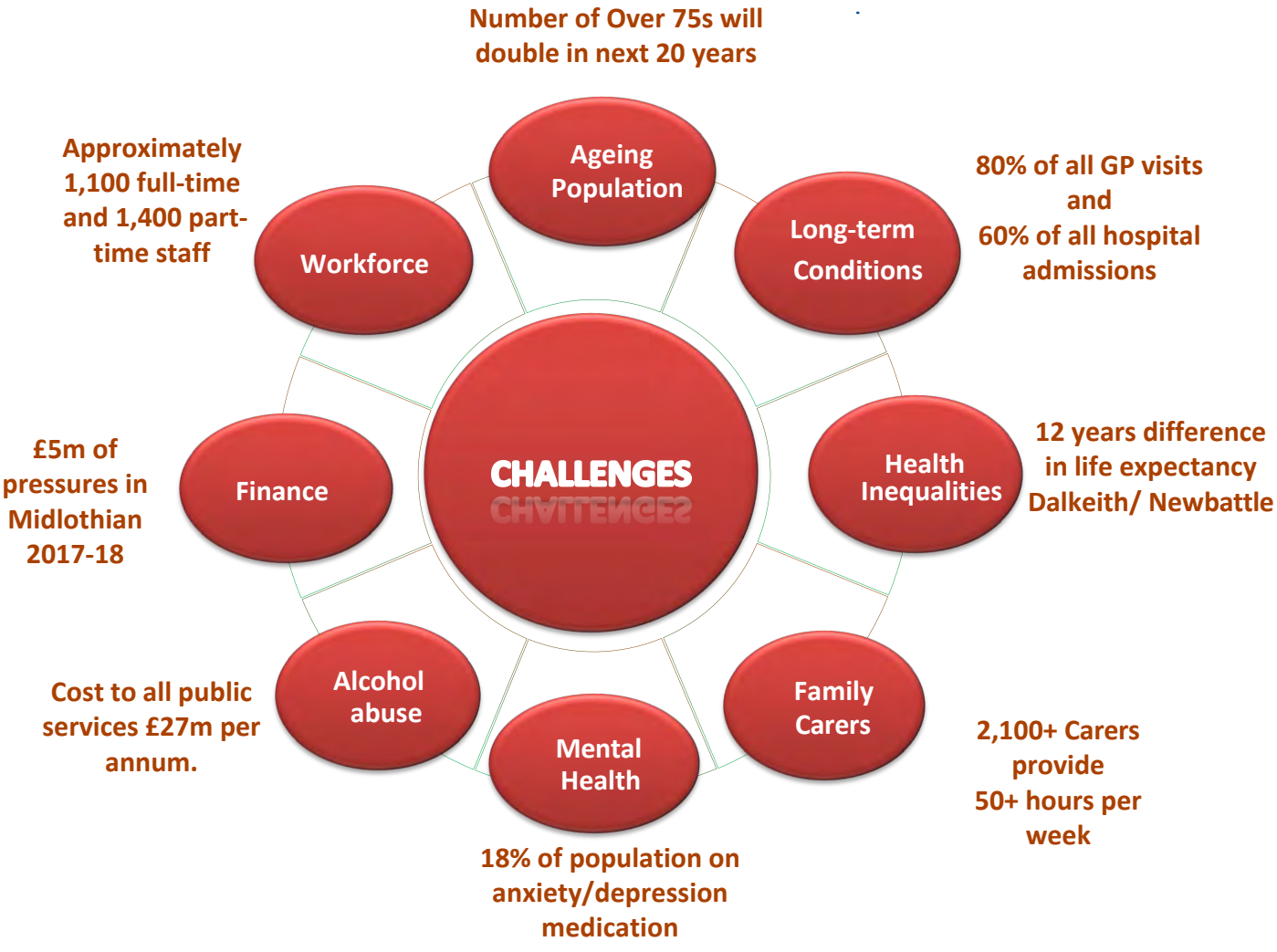
- people are being supported to remain at home for longer issues
- people are only going to hospital when necessary
- there is a real reduction in health inequalities.

The Partnership will publish an annual performance report on the impact that health and social care integration is having on the health and wellbeing of the Midlothian population.

The report will inform people on how the Partnership is using its resources and how it responds to the needs of localities within Midlothian.

Main Challenges

- More people who are frail or have dementia live for longer at home
- People are living longer with multiple long-term conditions
- Little progress is being made in reducing health inequalities
- All our services are under pressure



Our Vision

The creation of a new Health and Care Partnership provides an opportunity to make significant change in how we deliver health and care services.

'People in Midlothian will lead longer and healthier lives by getting the right advice, care, and support, in the right place, at the right time.'

We aim to achieve this ambitious vision by changing the emphasis of services, placing more importance and a greater proportion of our resources on the approaches described on the right hand side.

'We are fully committed to the principles of reducing inequalities, promoting opportunities and eliminating discrimination in line with the Equality Act and Human Rights legislation.'

Shifting Focus

Failure demand i.e. not getting it right	Prevention – Good physical and mental health:
Treatment and support	Recovery and reablement
Professional care	Self management and peer support
Reactive	Anticipatory care and planning for emergencies
Hospitals & care homes	Community based services e.g. Hospital at Home
Working in silos	Team working at local level
Opportunity costs	Improving quality and access
Health & care focus	Community planning i.e. *housing, income, transport*

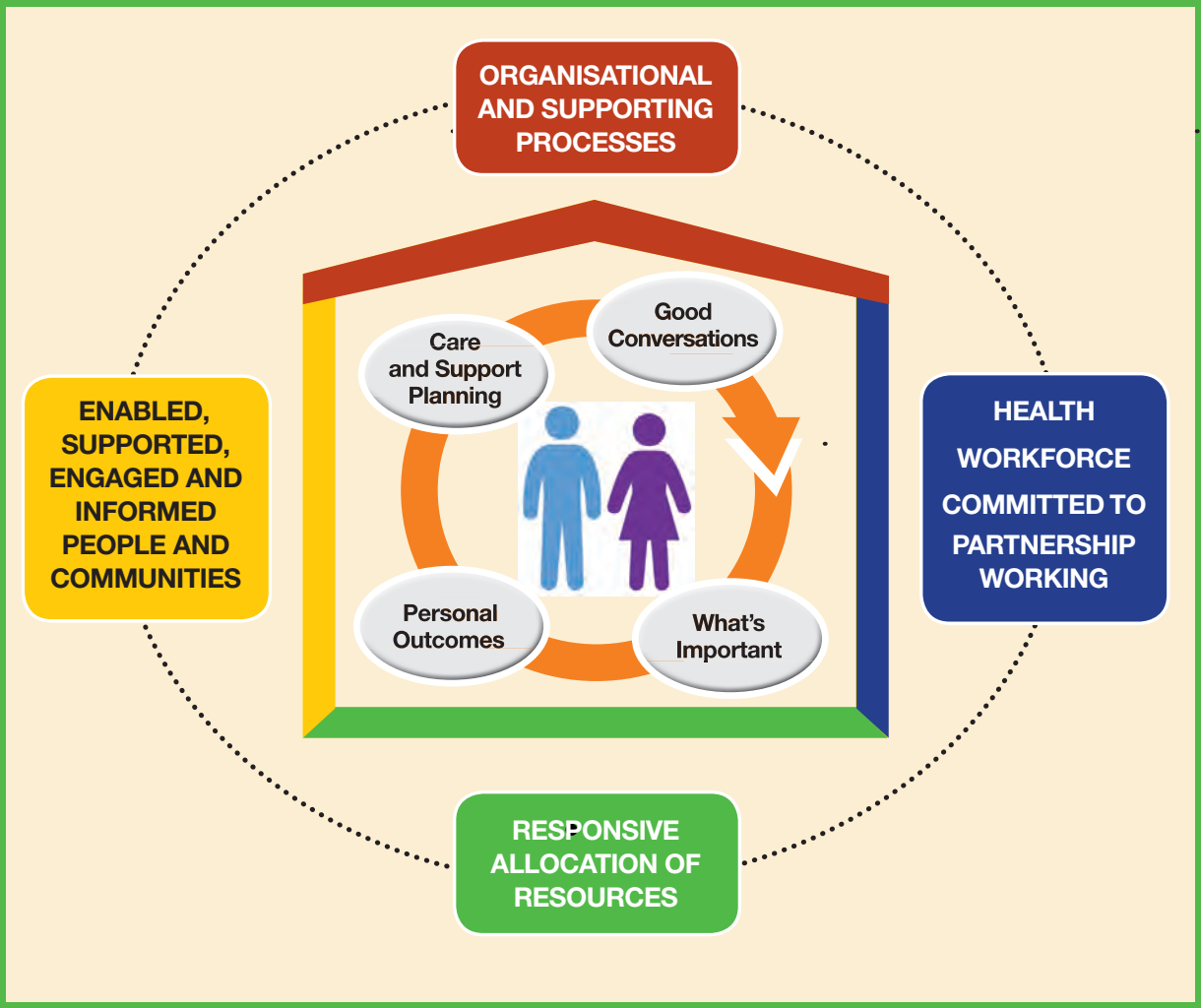
The Whole Person

We need to think differently about health:

- Focusing on the whole person not only the disease

- Recognising the importance of physical, mental and social wellbeing
- Recognising the role which families, carers and communities have in helping people to stay well

House of Care



The model we are adopting for delivering person-centred, integrated care is called the House of Care. This is about creating space for people to have 'a good conversation' on what is important to them and helping people recover or live well with their health conditions.

The Importance of Partnership Working

Organisational changes in the establishment of Health and Social Care Partnerships are important and already paying dividends.

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

Staying healthy needs support and advice on issues such as exercise, smoking, alcohol consumption and managing stress.

A growing concern is the increase in obesity. This now accounts for **80% of people who develop 'type 2' diabetes** and with it, the long-term risk of a range of health problems.

To help combat this, we will work with networks such as the "Food Alliance" and the "Physical Activity and Health Alliance"; Council Services such as Leisure and Recreation; and the Voluntary Sector generally.

Avoiding accidents or illnesses also requires strong partnership working. For example, the Fire Service helps reduce the likelihood of fire and other accidents such as falls in the home.

Pharmacists are an invaluable source of advice in managing illness, help with giving up smoking and immunisation against flu.

Social isolation closely links to physical and mental health problems. Creating opportunities through activities, groups and befriending are important. Social inclusion also depends upon having a decent income, having a job or being a volunteer, and being able to get about -transport can be a real barrier.

Staying warm is vital for older people. There is strong evidence that living in fuel poverty exacerbates health risks and that addressing fuel poverty can reduce winter deaths; injury and falls; improve mental health; and reduce respiratory illness and circulatory disease.

We need to increase awareness and develop stronger working relations with Changeworks and other third sector partners.

A third of people (31%) in Midlothian live in fuel poverty.

Key Approaches

Recovery

In recent years, our ambitions for recovery increased greatly. This is now the main goal in working with people who experience mental ill-health difficulties or the consequences of substance misuse.

Recovery involves helping people to regain a normal life by making it easier to gain employment, get about, have an adequate income, maintain social contacts ad coping with the challenges they face.

Technology

As in all lifestyles, we will support the transformation of our health and care services by making effective use of technology in work and with service users. New technology is likely to have a particular role in enabling people to manage their own health conditions better.

Information

There are a number of well laid out and comprehensive websites and directories available in Midlothian. However, users, carers, and even our staff, do not always know where to look or how to find information when faced with a change in life circumstances.

We must continue to invest in communication to ensure people are getting the right information and advice that enables them to look after their own health and well-being as far as possible.

Planning Ahead

Many people develop and live with long-term conditions such as cancer, heart disease or dementia.

We must find better ways of supporting them, their families and their carers by providing clear and concise information and developing individual anticipatory care plans (ACPs) - planning for the future to help people manage as their condition changes.

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

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

Key Approaches

Self- Management and Peer Support

Supporting people to manage their own health conditions reduces the demands on health services and social care, whilst giving them greater confidence and a sense of control. We will only strengthen self-management if we invest in providing support and education.

Within social care, the implementation of Self-Directed Support is enabling people to be more in control of their own care arrangements and to develop more creative ways of receiving support. This is a significant change and we are still learning lessons on providing services that are equity and sustainability.

Peer support is highly valued by people who are unpaid carers or who are coping with a particular health condition(s) such as mental health, physical disability or long-term illness. Powerful local examples of groups supporting one another include the Recovery Café for recovering drug users in Dalkeith.

Public Protection

Helping people live independently at home for longer involves making sure that they are also safe from abuse. The East Lothian and Midlothian Public Protection Office involves health, social care and police staff working together to support and protect adults and children who may be at risk of harm - be it physical, sexual, psychological and financial abuse. This approach also strengthens our capacity to respond to the impact of traumatic events on the lives of many victims of abuse.

For more information on Public Protection, visit

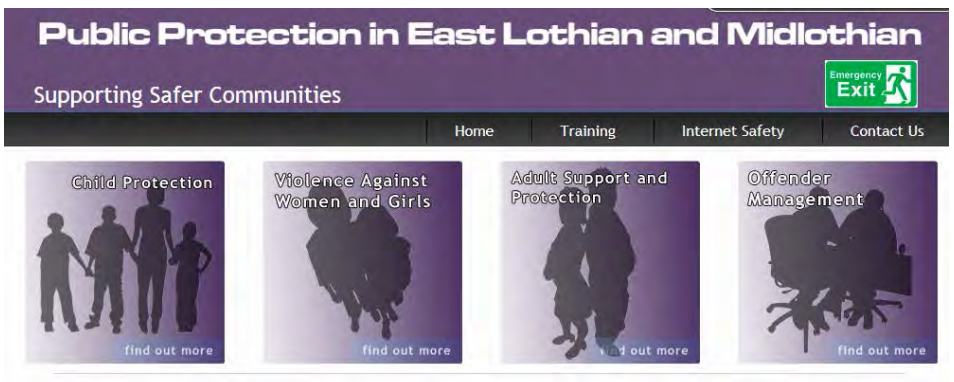
http://emppc.org.uk/home/

Violence against women

An issue that needs more attention is Domestic Abuse. Domestic abuse is not confined to gender-based violence but includes so called 'honour' based violence, female genital mutilation and forced marriage. Nor is domestic abuse confined to one gender or ethnic group. The statistics are shocking: for example 1 in 3 women will experience gender-based violence in their lifetime.

Midlothian has a particularly bad record - the sixth highest rate in Scotland during 2015-16. Our services are becoming more aware and alert to the impact of previous trauma in people's lives such as childhood sexual abuse. This issue comes up frequently with the new Wellbeing Practitioners based in eight of our Health Centres.

Giving people time to share their real concerns through good conversations is often the first step in tackling the issue. We must increase awareness and understanding of domestic abuse in all its forms amongst all staff including district nurses, care staff and GPs.



Prevention

The increasing numbers of people with Type 2 Diabetes requiring hospital admission; the number of older people admitted to hospital following a fall; and the high cost to all public services (approx £27m per year in Midlothian) of alcohol misuse are examples of the scope to reduce demands on the health service by focusing more on prevention.

And of course avoiding ill health where possible is good for people as well!

National Guidance

In relation to health and social care, community based care, anticipatory care and prevention are highlighted as the approaches required to ensure our services are sustainable.

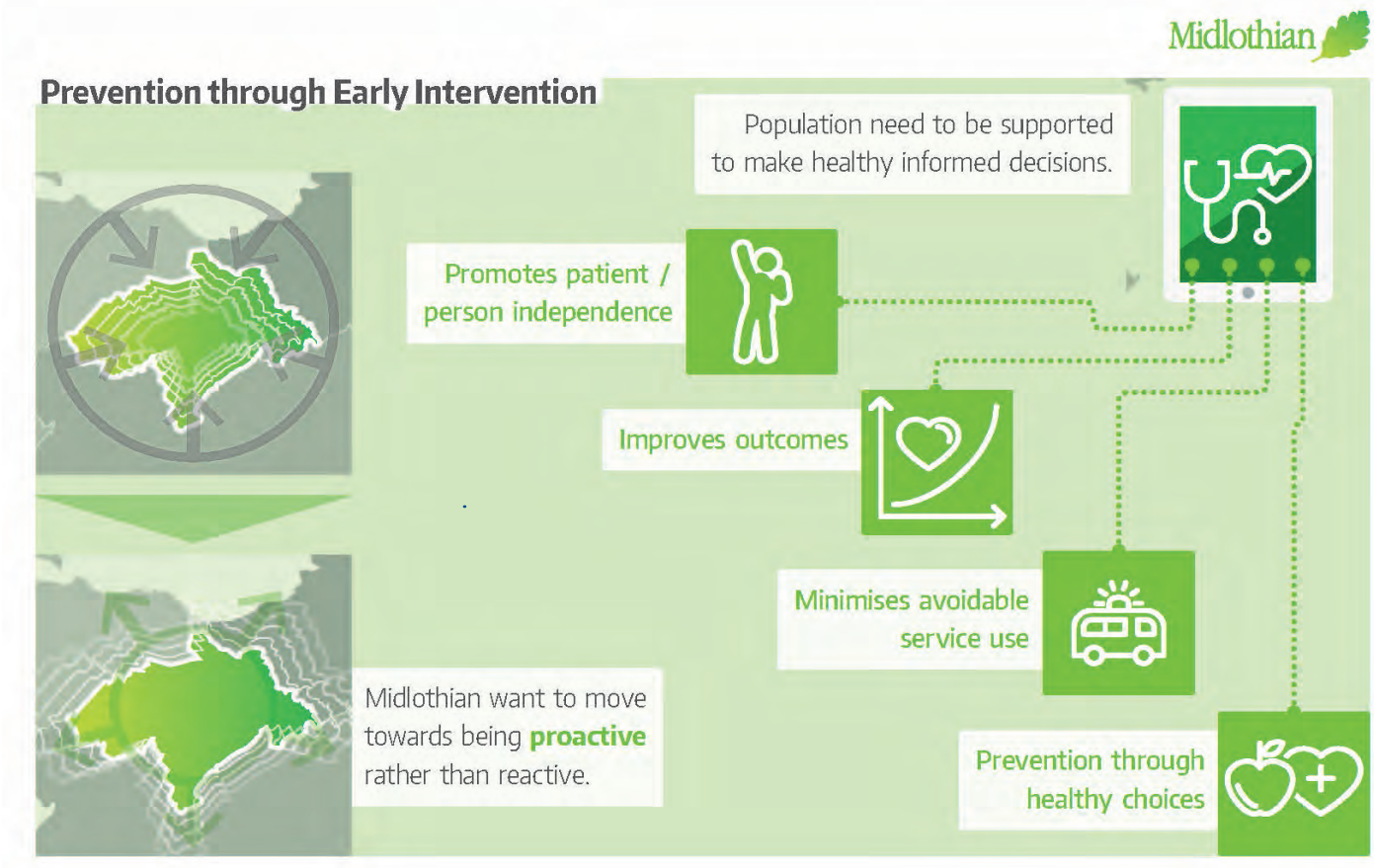
The Commission on the Future of Public Services (C Christie 2011) highlighted the importance of:

"prioritising expenditure on public services that prevent negative outcomes from arising".

New Service Challenges

There is a wide spread acknowledgement that prevention makes more sense than dealing with the problem after it occurs.

Nevertheless the financial pressures on public bodies are such that continuing to fund preventative approaches becomes more challenging.



Prevention

Progress in 2016

- We must acknowledge the work of Midlothian Leisure Services in supporting people with mental health, obesity or long-term health conditions. Alongside this, the Ageing Well programme, which harnesses local volunteers, enables many older people to stay active whether through walking, football, yoga or dance - and this programme is now available in care homes and sheltered housing complexes.
- Low income is a key factor in people's ability to stay well, whether having a warm home, eating well or being able to get out. As well as the more general support and advice available, there were three specific areas where we sought to increase people's income: working with people with mental health needs; supporting people with cancer; and providing income advice to unpaid carers.
- Through local Health Centres and national campaigns, we continue to promote preventative measures such as flu vaccination and encouraging take up of the bowel-screening programme.
- Work is underway by the Midlothian Food and Health Alliance to promote a more comprehensive approach to healthy eating including the Toot for Fruit Service; continuation of food banks; local growing projects; and the small grants programme in Mayfield, Gorebridge and Woodburn.

Key Actions for 2017-18

- Continue to develop our application of new technology to enable us to know that people are in need of support – whether in a crisis through telecare or through early detection of their health beginning to deteriorate.
- Build upon the work of the local Leisure Service to help implement a physical activity strategy to help improve people's health, reduce weight and take up new interests.
- Develop a stronger approach to creating employment opportunities, working with the council employability service, pursuing funding through the Big Lottery to address disability issues and making better links with specialist services such as for people with cancer or people who are deaf.

Working with Communities

In the implementation of the legislation and guidance on Integration, we are placing a great deal of emphasis on recognising the key part played by natural communities.

The Community Planning Partnership is developing strong links with local communities through neighbourhood planning groups.

In Health and Social Care, we are actively participating in the development of local services in the areas of deprivation - parts of Woodburn, Mayfield and Gorebridge.

This work focuses on addressing inequalities in line with the Community Planning Partnership's key objective during the period 2016-19.
We believe we are making good progress in public engagement generally, with regular topic based meetings on health and social care issues through the Hot Topics Forum. Alongside this, we continue to work closely with "communities of interest" such as family carers, older people and people with physical disabilities.

We now need to develop stronger links at a local level between staff working in local communities - GPs, District Nurses, Home Carers and staff in voluntary organisations.

New Guidance

Part 2 of The Community Empowerment Act 2015 came into force in December 2016.

This requires Community Planning Partnerships to involve community bodies at all stages of community planning and to produce "locality plans" for areas experiencing particular disadvantage.

Key Actions for 2017-18

1. Our next step is to pilot work in one locality that strengthens our support services to housebound people. The national Collaborative Leadership Programme and NHS Education Scotland support this initiative.

2. Continue to improve our understanding of need and use of resources, area by area, such as the numbers of older people admitted to hospital on an emergency basis. This will help us design services that are more responsive to local needs.

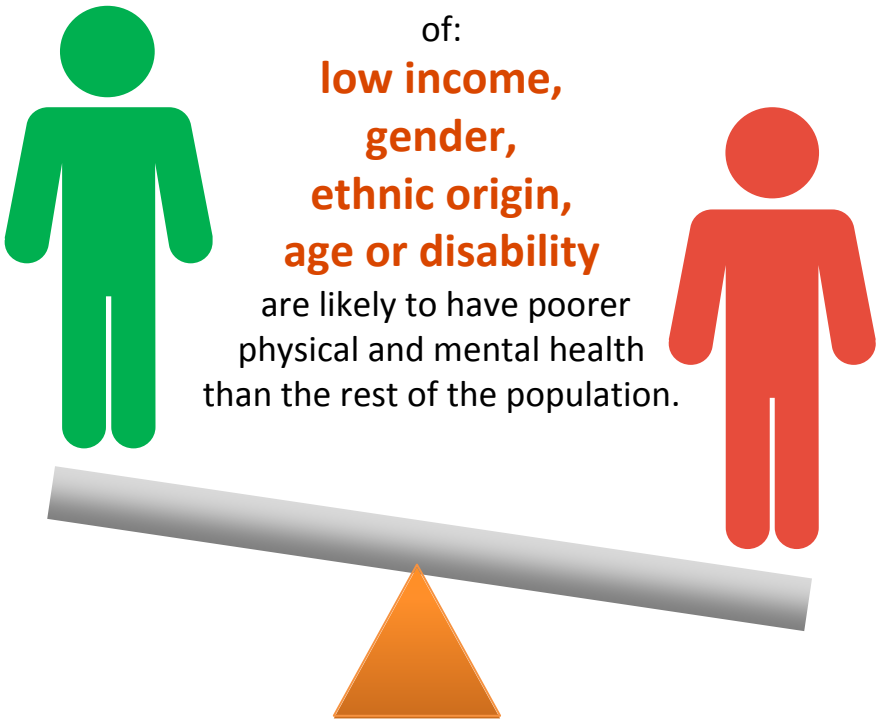
Health Inequalities

The term 'health inequalities' describes the poorer health experienced by some of our population in comparison with their neighbours.

Those who experience social disadvantage because of:

low income,
gender,
ethnic origin,
age or disability

are likely to have poorer physical and mental health than the rest of the population.



By far the most common reason for people to experience health inequalities is low income and the poorest in society die earlier with higher rates of disease.

Inequalities are often associated with geographical areas of high need -particularly parts of Dalkeith / Woodburn, Gorebridge and Mayfield / Easthouses. For example, a man living in Dalkeith is likely to **live 9 years less** than a man living in Newbattle and Dalhousie.

National Guidance

Scottish Government reinforced its commitment to addressing inequalities through Fairer Scotland Action Plan 2016 with a strong emphasis on addressing poverty.

What we really want to do is change deep-seated, multigenerational, deprivation, poverty and inequalities.

New Service Challenges

Through the national refreshing of the Scottish Index of Relative Deprivation it has emerged that:

one area of Loanhead now falls within the lowest **20%** of deprivation

We will consider how to channel our resources in response to this new challenge.

Health Inequalities

Progress in 2016

- The Community Planning Board developed a set of indicators that tell us whether we are making progress in reducing health inequalities.
- Resources secured to enable the continuation of the Community Health Inequalities Team working with people who are vulnerable such as unpaid carers and people who are homeless.
- A new mental health service – the Mental Wellbeing Access Point - established in Penicuik and Midlothian Community Hospital to enable people to obtain quick advice about appropriate sources of support.
- The Community Justice Authority introduced an advice and wellbeing service for people arrested or subject to a tagging order.
- The Spring support service for women offenders strengthened.
- The Wellbeing Service in place in two health centres, extended to a further six health centres. This service targets people with long-term health conditions and common health and social difficulties.
- MYPAS (Midlothian Young People's Advice Service) now provides a specific service in Dalkeith for LGBT Young People.
- A sexual health drop-in service, run by school nurses and MYPAS, established in Newbattle Community Centre.
- A new service for older people in Woodburn established – The Grassy Riggs - helping reduce isolation.
- Through the Coalfield Trust, a number of small locally managed programmes implemented in Woodburn.
- An additional recovery cafe for people with substance misuse problems established in Mayfield.
- An NHS funded community development worker helped support the establishment of the Mayfield In It Together initiative designed to improve the local quality of life, with town centre plans their top priority.

Key Actions for 2017-18

Much of the work started in 2016 needs continued support to ensure it is well organised and in a strong sustainable position:

- We will work with the Royal Infirmary to develop a stronger pathway to local services and support for young adults attending the hospital.
- We will develop ways of supporting people with disabilities or unpaid carers to gain or sustain their employment, working with the Council Employability Service and other specialist agencies.
- NHS Lothian and Midlothian Council will work together to provide a range of Food Programmes.
- We will strengthen the priority given by all staff to addressing poverty including closer working with specialist income maximisation services.
- Weight Management Programmes to be introduced to help address and prevent obesity and type 2 diabetes.
- We will work with specialist acute hospital staff to develop more locally based, preventative-focused services in the field of diabetes.
- We will work with Council Leisure Services to finalise and implement a local physical activity strategy.

Cancer

In the region of 2,140 people in Midlothian have had cancer.

This figure is predicted to rise due to the increased occurrence, as people get older.

People are increasingly surviving for longer following treatment for cancer with 50% of us now surviving cancer for 10 or more years.

National Guidance

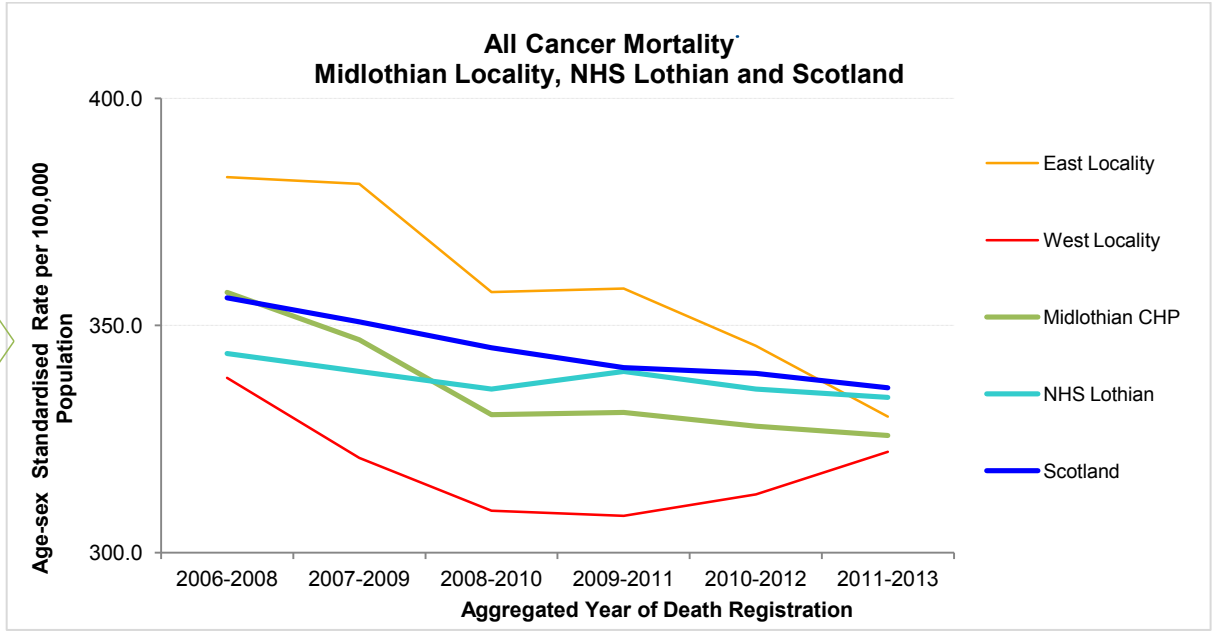
A new national Cancer Strategy Beating Cancer: **Ambition and Action** launched in March 2016. This comes with investment to tackle cancer by improving prevention, detection, diagnosis, treatment and after care for those affected.

In December 2016, the Health and Care Delivery Plan 2017-18 for IJBS included the expectation that the provision of palliative care at home will double by 2020 (see Palliative Care Section).

New Service Challenges

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

Death rates from cancer are falling



Cancer

Progress in 2016

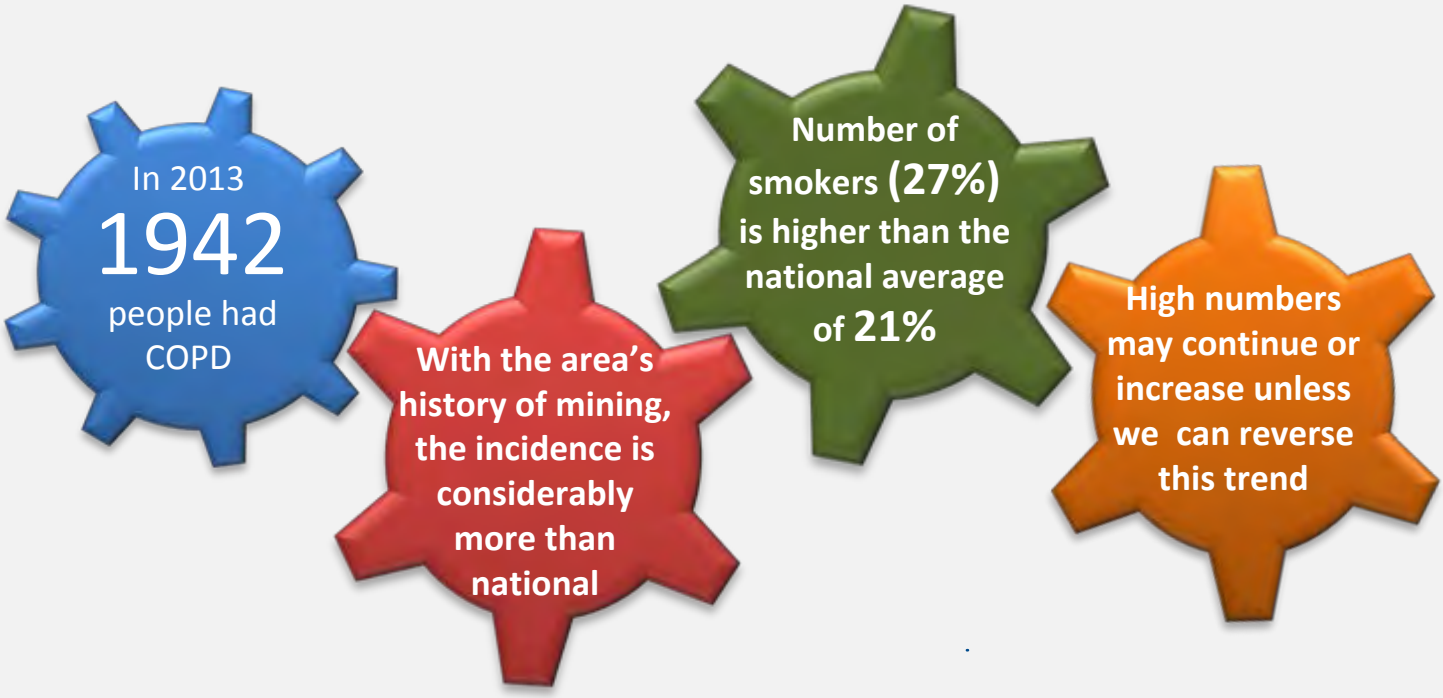
- We established the local TCAT project (Transforming Care After Treatment) to test a new and transformative approach to service delivery based on holistic needs assessment. The service is based in Lasswade Library and the community hospital where two Macmillan Rooms are established.
- Specialist services include Occupational Therapy, access to the specialist employment service based within the NHS Lothian's Work Support Services. Closer working relationships have been developed with VOCAL and the community health inequalities teams. Five members of the Council Leisure Service have undertaken specialist training in safe exercise for people with cancer.
- The specialist Macmillan Welfare benefits service generated an additional £400k (annualised £1.6m) income for people with cancer in quarter one of 2016-17. An evaluation of such services by Scottish Collaboration for Public Health Research and Policy concluded, "Few medical interventions can claim to have such a lasting and measurable impact on the lives of people."
- The local GP Cluster was successful in its application to use the Macmillan Quality Toolkit to improve quality of care for cancer patients.

Key Actions for 2017-18

- The Project Officer will promote the uptake of the TCAT project by holding regular sessions in the Western General Hospital. The implementation of the Quality Toolkit in Primary Care should also help raise the profile.
- We will pursue the introduction of a voluntary Complementary Therapy Service in response to the feedback from service users on pain management.
- We will consider plans to maintain a service to people with/treated for cancer beyond the life of TCAT as part of the broader approach to Health and Wellbeing work.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is a long-term lung disease that causes cough and breathlessness.



The rates of hospital admissions due to COPD related illness is also higher than national rates.

Progress in 2016

- The Pulmonary Rehabilitation (PR) Programme, a Lothian-wide physiotherapy led service continues to provide an exercise-based programme to people in Midlothian.
- Midlothian Active Choices (MAC) continues to promote and develop integrated pathways with NHS partners including Healthy Living Groups and the Wellbeing Team.

Key Actions for 2017-18

- Continue to explore how best to use technology to assist people in managing their own conditions.
- New post established in the MERRIT (Rapid Response and Hospital at Home Team) to work with people with advanced COPD and support them to remain at home rather than be admitted to hospital.

Neurological Conditions

Having a neurological condition is the most likely reason for experiencing complex and physical disability for people less than 65 years.

One in **97** people are affected by epilepsy

One person in every 500 has Parkinson's - estimate of 170 in Midlothian

Around **20** people living locally have Huntington's disease, an inherited condition that causes brain damage

The prevalence of Multiple Sclerosis is high whilst the number of those with Parkinson's Disease is increasing with an ageing population.

National Guidance

The Neurological Care Improvement Plan 2014-17 to improve care and outcomes for people with a neurological condition, describes this as:

'The missing millions experiencing disadvantages of complex disability at a young age with fragmented and inconsistent service provision across the public sector as a whole and within health and social care systems'

Progress in 2016

Specific developments in Midlothian intended to improve the lives of people with neurological conditions include:

- The Midlothian Community Physical Rehab Team (MCPRT) continues to provide long- term rehabilitation.
- The Scottish Huntington's Association provides specialist advice and support to those with Huntington's disease.
- A support and advice group for people with Multiple Sclerosis meets monthly supported by a Council Occupational Therapist.

New Service Challenges

The Joint Planning group for Physical Disability is the local planning forum that addresses issues arising from having a disability. There is a gap in addressing specific issues arising from having a neurological condition. We are now considering which of these issues could be addressed locally rather than on a Lothian wide basis.

Key Actions for 2017-18

- Strengthen local links with NHS Lothian forums addressing specific neurological conditions.
- The Physical Disability Planning Group to consider what role it can play in planning more effective services for people with neurological conditions.

Heart Disease

An estimated **7.8%** of men and **4.7%** of women are living with coronary heart disease (Scottish Health Survey 2014). The mortality rates for cardiovascular disease show a downward trend across Midlothian since 2006 for people less than 75 years similar to the national trend.

New Service Challenges

The increase in obesity brings an increased risk of heart disease; within the Lothians an estimated **27% of the adult population are obese** (2011). Those with heart disease may also be at risk of diabetes.

National Guidance

The Scottish Government and National Advisory Committee Heart Disease published a Heart Disease Improvement Plan in 2014. The Plan identifies **six priority areas for improvement** including prevention, rehabilitation and addressing the mental health needs of people affected by heart disease. There is also a shift towards a more patient-centred community based model of support.

Progress in 2016

While there are no new initiatives in Midlothian this past year to address heart disease specifically, the promotion of physical activity and weight management programmes contribute to the prevention of heart disease. We met with British Heart Foundation representatives to consider how they might support the development of services in Midlothian.

Key Actions for 2017-18

- Review our links to the NHS Lothian Heart Disease Strategy Programme Board and consider the scope to improve detection and management of hypertension.
- Improve our detection of possible heart disease with inequality groups through the work of the Community Health Inequalities Team.
- Consider the adoption of the British Heart Foundation House of Care work currently piloted elsewhere in Lothians.
- Review our health screening of people with learning disabilities to ensure early detection of heart disease.

Diabetes

DIABETES IS ON THE RISE

OVER

3500

People live with the condition in Midlothian

The majority are over 60 and there is a higher rate in areas of multiple deprivation

THERE ARE TWO DIFEREENT TYPES OF DIABETES

TYPE 1

Affects people at a younger age and treated with insulin injections to control symptoms

TYPE 2

Affects slightly older people and is often, but not always, associated with being overweight

Not all people with type 2 diabetes know they have the condition

National Guidance

'Diabetes Action Plan' and **'Diabetes Improvement Plan'** provide the national guidance for preventing and treating diabetes. The growing concern about obesity is reflected in the Government's 2016 publication - *It takes all of us to build a fairer Scotland.*

New Service Challenges

Diabetes UK describes diabetes as the fastest growing health threat of our times and an urgent public health issue. Since 1996, the number of people living with diabetes has more than doubled.

Diabetes

Progress in 2016

There is a lot of work going on to improve access for weight management:

- Working with leisure services and responding to direct referrals from acute hospitals with support provided both on an individual and group basis within Lasswade Leisure Centre and at Midlothian Community Hospital Gym
- Introduction of new and innovative motivational texting using FLORENCE. This also encourages self- monitoring weight changes
- Encouraging self-management through more active promotion of My Diabetes My Way
- The Community Health Inequalities Team piloted a Healthy Living Programme (a six session structured-education course) designed to promote health behaviour change in individuals identified as having pre-diabetes and therefore at high-risk of developing Type 2 diabetes.

Key Actions for 2017-18

a) Proactive work with people identified at risk of diabetes (pre-diabetes) to be implemented through key staff such as Health Inequalities Nurses-paying particular attention to people from minority ethnic groups at higher risk of diabetes

b) Identify and work with housebound people who are overweight and at risk of diabetes

c) Further promotion and implementation of the new Weight Management Pathway

d) Work with key staff in the Community Planning Partnership to implement a new Physical Activity Strategy to both prevent obesity and support weight management

e) Improved data/intelligence around Type 2 diabetes in Midlothian

f) Explore a further shift of care and support for people with type 2 diabetes from secondary to primary care. If possible, this would include a single Midlothian consultant providing an outpatient service in Midlothian working closely with the GPs in envisioning and planning future diabetes services.

Stroke

The numbers people who have experienced stroke discharged to their own homes (not including care homes) in Midlothian is around 110 per year.

Although cardiovascular disease (CVD) is largely preventable, stroke remains the third biggest killer in Scotland and the leading cause of disability.

Obesity, high alcohol intake and high blood pressure can all make a stroke more likely. When someone has a stroke, urgent intervention is important in helping reduce the long-term impact. Treatment has improved in recent years and the number of deaths of people under75 has reduced significantly. According to Scottish Health Survey 2015, there has been no significant reduction in strokes since 2003.

Progress in 2016

- Midlothian Community Physical Rehabilitation Service and the Reablement Team (approximately 25 per year) continue to provide follow up support to patients discharged from hospital.
- Midlothian Active Choices (MAC) is a physical activity referral service for people with health conditions including those who have had a stroke. The MAC co-ordinator completed **Exercise after Stroke** training, strengthening the service's capacity to support those with stroke and seeing around 100 people in 2016-17.

National Guidance

Scottish Stroke Improvement Plan launched in 2014.

The Plan places strong emphasis on improving the quality of care in hospital. It recognises the scope to improve the transition back to the community and the quality of life of people who have suffered a stroke.

New Service Challenges

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

Key Actions for 2017-18

- Continue to promote prevention through blood pressure screening, weight management activity and alcohol education.
- Review our approach to community based rehabilitation and intermediate care for stroke patients. There may be increased community resource opportunities following the transfer of resources from Liberton Hospital and the review of intermediate Highbank care services.
- As part of our broader approach to strengthening self-management, we will explore options for the application of technology as well as promoting self help advice (such as the self help website: http://selfhelp4stroke.org/).

Palliative Care

NHS Lothian describes palliative care as aiming to:

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

National Guidance

New guidelines and standards are being developed both locally and nationally, including the Palliative and End of Life Care Strategy and a Strategic Framework for Action on Palliative and End of Life Care 2016-2021.

New Service Challenges

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

Progress in 2016

We reviewed the arrangements for planning and delivering palliative care in light of the establishment of IJBs.

In Midlothian, we established a new Palliative Care Group, chaired by the Chief Nurse and developed a local action plan.

Specialist hospital and hospice care is still provided on a Lothian basis and Midlothian is represented on both the Managed Clinical Network and the Pan-Lothian Steering Group.

Key Actions for 2017-18

- Develop a local approach to raising awareness through initiatives such as To Absent Friends and Dying Matters.
- Strengthen partnership working between local nursing services and Marie Curie.
- Strengthen care provided in care homes through involvement in a research-based staff training programme and the adoption of a systematic approach to receiving feedback from families.
- Review and seek to strengthen bereavement support available within Midlothian.
- Review the support being provided locally to carers responding to reports such as Under Pressure produced by Macmillan.
- Increase capacity to provide community based care, in 2012-13 the percentage of last 6 months spent in a community setting was 92.6% above the national average of 91.2%.

Older People

14,700

The approximate number of people are over the age of 65 years in Midlothian

1/6th

of Midlothian's population

By 2035, this proportion will grow to one quarter of the population with those over 75 years expected to double over this 20-year period.

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

Old age does not come alone. There is a greater likelihood of developing long-term health conditions.

People over 85 years are at significantly greater risk of living with dementia with the incidence projected to rise to 1400 to 2800 by 2035.

We estimate that between 2,700 and 4,200 people are living with frailty in Midlothian, a distinctive health state related to the ageing process resulting in multiple body systems gradually losing their inbuilt reserves.

National Guidance

Reshaping Care for Older People (2011) continues to be the main reference point. The emphasis of this is on the need to provide much stronger community based care and reduce reliance on hospitals and care homes. We are making significant progress in Midlothian in this regard.

A new national strategy for dementia is under development and focuses on issues such as diagnosis, post diagnostic support and dementia friendly communities.

New Service Challenges

During 2016-17, the big challenge was the delivery of reliable good quality care at home services. One provider's contract was terminated whilst another has had difficulties in meeting its contractual obligations.

This not only had an impact on people who rely on this support, it also caused considerable pressure in other parts of the system including delays in hospital and waiting times for reablement services.

Older People

Progress in 2016

- Whilst the lack of capacity in 'care at home' services is a major problem,we further invested in Reablement, Rapid Response and Hospital at Home. This should strengthen our ability to prevent hospital admissions and promote people's recovery.

- In relation to dementia:
  - Joint work undertaken with Scottish Ambulance Service to prevent avoidable hospital admissions.
  - Joint dementia team now provide an immediate response to emergencies for people with dementia.
  - Worked with the Council's building services to provide more dementia friendly housing including through the Maintenance Programme.

- A new post created to provide specialist dementia support to care homes, complementing the existing nurse adviser post.

- We transformed Newbyres with a new staffing structure, including nursing staff, intended to enable the Home to support more people with advanced dementia.

- Tackling isolation remains a high priority. We made some improvements to day care with a new service established in the Community Hospital and a redesigned day care service- the Grassy Riggs - provided in Woodburn.

Key Actions for 2017-18

A programme of work is underway to develop more extra care housing. This includes new build in Dalkeith and the redesign of some existing sheltered housing schemes.

The expansion of provision of intermediate care in Highbank continues. Planning needs to take place for more suitable premises for this service.

Local GPs are leading work to identify people who are living with frailty with a view to providing earlier support.

The transfer of the rehabilitation service in Liberton Hospital to the Community Hospital and enhanced community services will take place in April.

Mental Health

One in four of us will experience mental health difficulties sometime in our lives.

National estimate is that mental health issues account for 45% of all illness.

In Midlothian 4.2% of the population report themselves as having a long-term mental health condition

Poor mental health is not distributed evenly across the population and there is evidence of mental health inequalities across Scotland.

Mental health affects those more deprived disproportionately.

In some Midlothian areas up to 25% receive medication for anxiety and/or depression compared to 18% as a whole.

National Guidance

A new national mental health strategy, with a focus on such issues as prevention, self-management; supporting mental health in primary care; and improving physical health, was the subject of consultation in 2016.

New Service Challenges

Increasingly recognised is the high incidence of mental health issues addressed through Primary Care.

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

Lengthy waiting lists for Psychological Therapies also exist and we must develop alternative approaches to minimise the length of time people, in distress, wait to receive support.

Mental Health

Progress in 2016

Through new funding for mental health in Primary Care, we set up an Access Point in Penicuik Health Centre and Midlothian Community Hospital to enable people to access appropriate support services.

Using a range of short term funding sources, we established a Wellbeing Service in two health centres. We rolled out to a further six in January 2017. A large proportion of the referrals made by GPs have a strong mental health dimension.

Key actions for 2017-18

- Continue planning work for the delivery of the acute and specialist services in the Royal Edinburgh Hospital. To ensure effective working between acute and community based staff, it is important to ensure, as far as possible, we treat patients from Midlothian in the same ward.
- Develop stronger joint working between substance misuse services and mental health services through the provision of a recovery hub. This places particular emphasis on promoting peer support.
- Strengthen rehabilitation by redesigning local services and ensuring access to the specialist NHS Lothian service.
- Develop a local strategy for ensuring quick access to appropriate support, including psychological therapies, building on the experience of the new Access Point and Wellbeing Services.
- Participate in the Maxout programme that seeks to transform the approach to employment, promotion of resilience, rehabilitation and interpersonal therapy.
- To ensure that people in crisis get quick access to the right type of support, including a place of safety, a joint approach agreed with the local police service, which is often the first agency to respond.

Physical Disability

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

Around 4,800 people between the ages of 16-64 years in Midlothian with a significant physical impairment.

This number includes those born with impairment, those who have been disabled through injury and those whose disability developed because of an illness.

Estimated 1200 people are wheelchair users in Midlothian.

There is national evidence that people with disabilities are more likely to experience health inequalities because they are more likely to live in poverty and disabled people experience discrimination in accessing and securing health services.

National Guidance

In December 2016, Scottish Govt announced A Fairer Scotland for Disabled People laying out a delivery plan through until 2021.

Although it covers all disabilities it is the first time there has been a national policy that covers people with physical disabilities.

New Service Challenges

Welfare Reform continues to be a major cause of concern for disabled people.

The devolution of powers to the Scottish Parliament includes:

- Disability Living Allowance
- Carer's Allowance
- Attendance Allowance
- Personal Independence Payment

It is too early to assess the impact on disabled people but the uncertainty over income entitlement is unsettling.

Physical Disability

Progress in 2016

In 2016, we focused on the development, approval and circulation of a new three-year plan. The plan continues to adopt a social model of disability aimed at removing barriers inhibiting everyday life.

There continues to be a strong emphasis on working across agencies, recognising that suitable housing, an adequate income, finding and keeping a job and being able to get about through accessible transport are critical to people's sense of wellbeing.

More specifically, we reflected on the importance of having good information about services and support in the development of a new Directory of Services, due for launch in February 2017.

Key Actions for 2017-18

- Development of plans to increase access to employment for people with disabilities including an application to the Big Lottery.
- Development of plans for a coordinated system for accessing good information in health and social care.
- Implementation of a more coordinated approach to housing for people with disabilities involving Adult Social Care, Housing and Melville Housing Association.
- Strengthen transport information in relation to taxis, buses and trains.
- Support local disabled people to apply to be part of the proposed 'experience panels', which will help shape the new devolved welfare benefits system

Sensory Impairment

An estimated 50% of sight loss is preventable or treatable.

In Midlothian, the 2011 census revealed that

5,656

people experienced some hearing impairment.

National estimate is that

1 in 6

of the population has a hearing loss.

Significant sight loss affects

1 in 30

In Midlothian, through the 2011 census,

1913

reported having sight loss impairment.

National Guidance

See Hear, published in 2014, is the national strategy developed to address sight and hearing impairment. This requires all Partnerships to produce and implement a local action plan.An Act is in place to improve access to British Sign Language services by all publicbodies in Scotland.

New Service Challenges

The link between Midlothian social work staff and those working for the specialist agencies - RNIB and Deaf Action - are not as strong as they could be. One factor is the absence of agreed access to shared information systems.

Sensory Impairment

Progress in 2016 - A number of small yet tangible improvements including:

Awareness raising through workshops and the work of the five local sensory impairment champions.

Basic sensory loss checks undertaken in care homes.

Council access to live sign language support through technology.

Increased uptake of hearing aid batteries provision in libraries and preparatory work with Audiology towards the provision of repairs and maintenance clinics utilising local volunteers.

Key Actions for 2017-18

As part of the Midlothian Community Hospital review, the option of Audiology and Ophthalmology clinics being held there to be fully assessed.

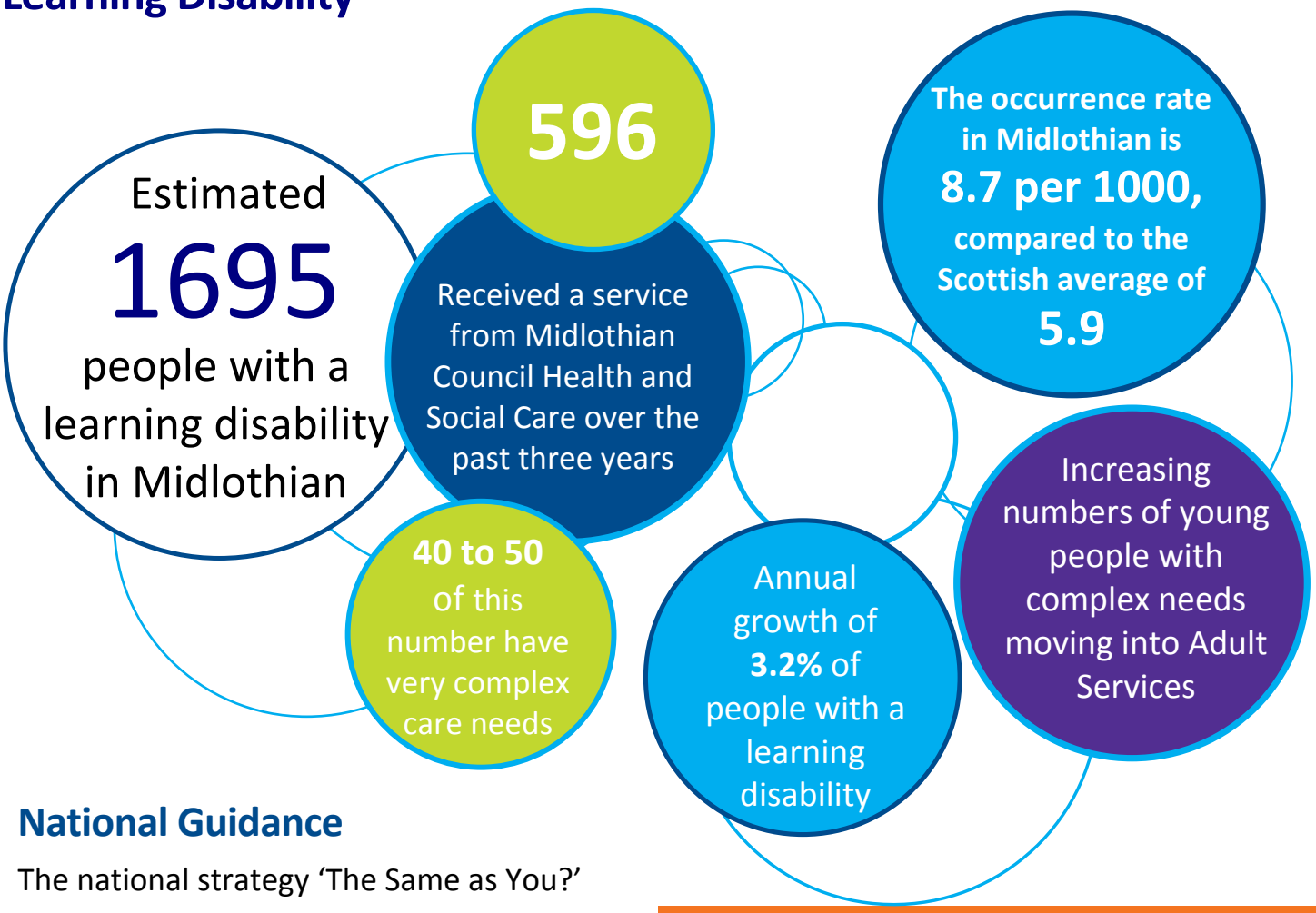
Launch of hearing aid maintenance and repair clinics in at least three libraries.

Sensory loss checks to be undertaken in social care settings such as day centres.

The application of technology to be promoted e.g. portable loop systems and the use of Contact Scotland (BSL interpreting service) in other public services.

Identify solutions for better information sharing between social work and specialist agencies.

Learning Disability



National Guidance

The national strategy 'The Same as You?' focused on ensuring services are as inclusive and community-based as possible. The more recent national strategy Keys to Life (2013) places an emphasis on human rights and tackling health inequalities.

New Service Challenges

Over recent years, expenditure in learning disability increased by over £2m per annum.

This is likely due to a strong commitment to providing individualised care packages alongside the numbers of young people moving through transition and needing high cost care packages.

The current approach is not financially sustainable. We are developing new approaches that ensure people's needs are met through more cost effective service design.

Progress in 2016

We developed new services including respite care provision in Woodburn; day services in Mayfield; and networks of mutual support in Dalkeith and Penicuik.

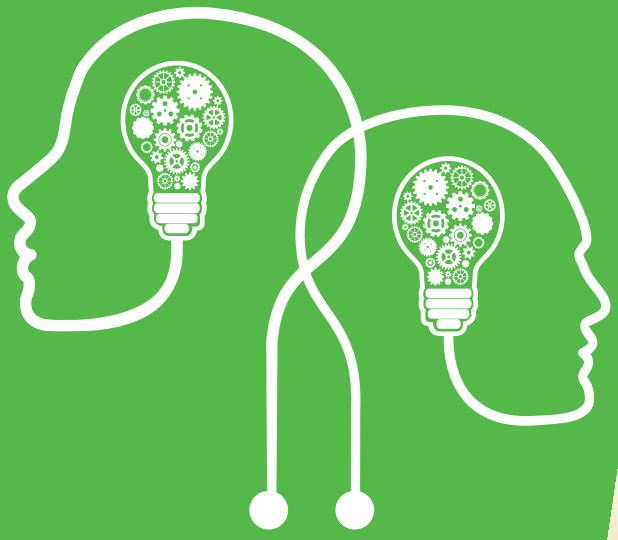
In view of the higher incidence of sensory impairment for people with learning disability, we are undertaking sensory checks in settings such as day centres.

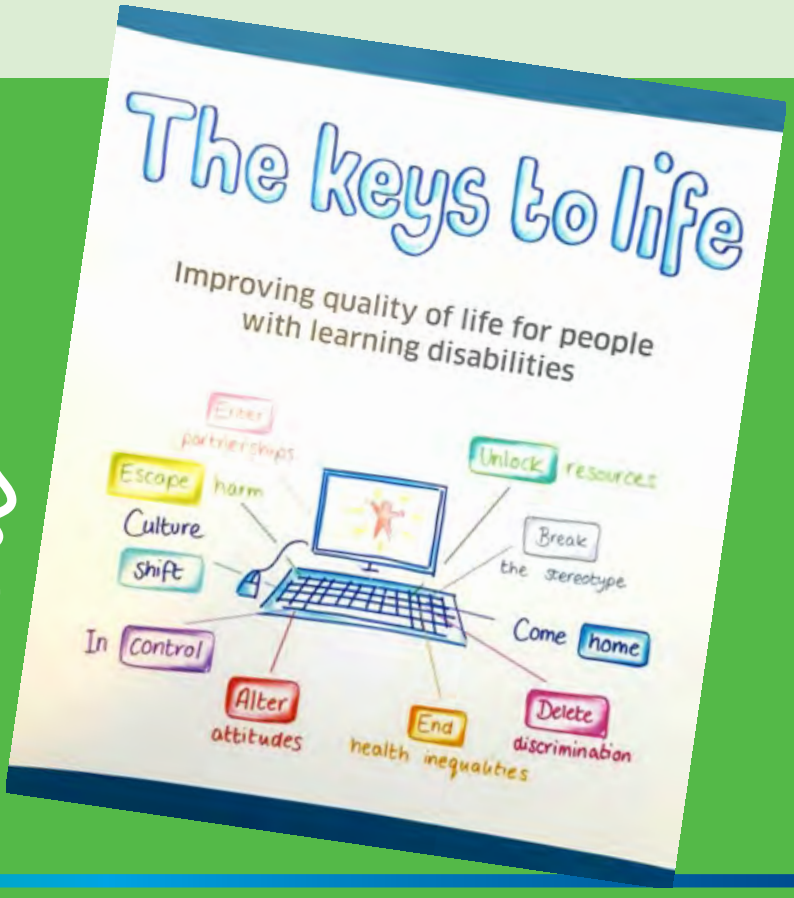
On a Lothian wide basis, plans are in place to enable the move towards more localised, community-based approaches to the delivery of specialist health services.

Learning Disability

Key Actions for 2017-18

- Finalise arrangements for the management of the community health team as a first step towards a more integrated and local approach.
- Strengthen the community team through the application of Midlothian's share of resources in the NHS Lothian Challenging Behaviour Team as well as those planned for the NHS Lothian 12 person unit.
- The 12 person complex care unit in Penicuik becomes operational.
- Review Day Services to ensure an appropriate balance of locally provided services including centre-based; community based; and opportunities for inclusion. If possible, we will reduce reliance on people travelling outside Midlothian to receive appropriate services.
- Strengthen arrangements for people moving from Education and Children's Services to Adult Services either through more effective interagency working or though the establishment of a single service.
- The three people still living in hospital settings to move to community based settings.

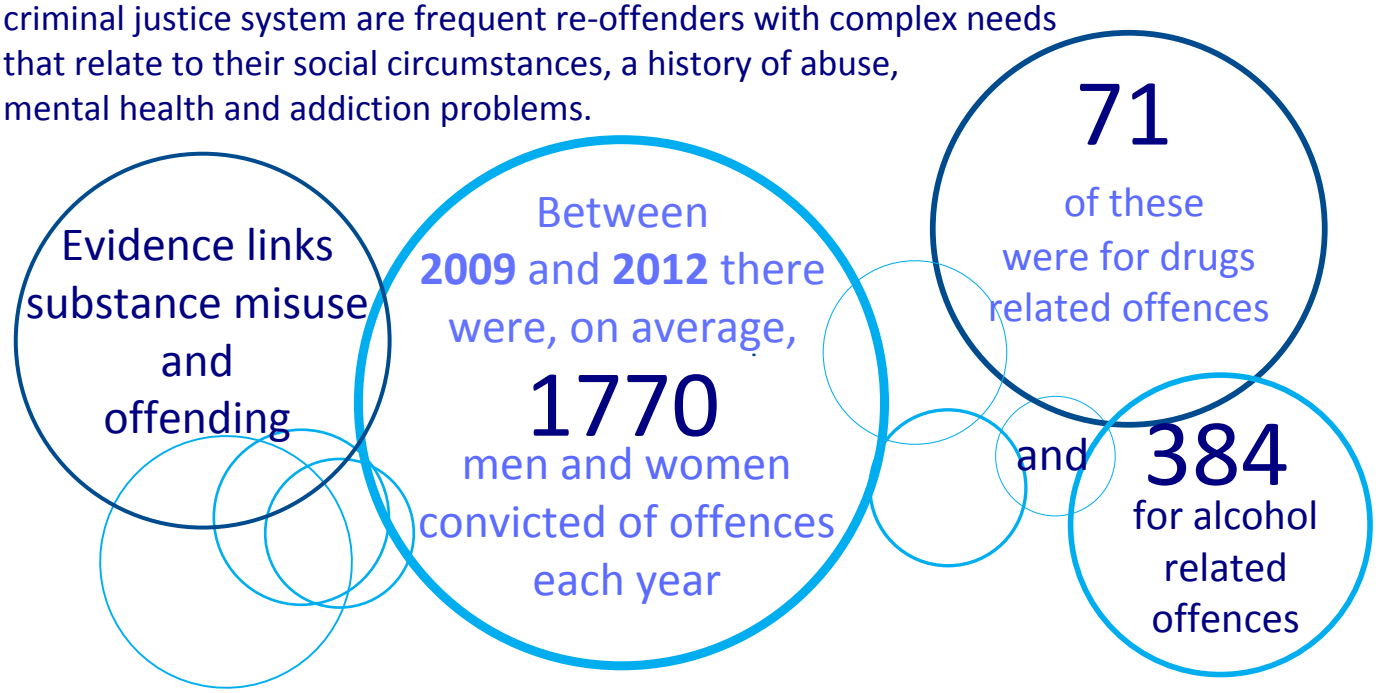




Offenders

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

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



Information from a full year's data from the main Criminal Justice Social Work risk assessment tool (LSCMI) indicated that between January 2012 and January 2013 at the point of assessment.

65% reported an alcohol problem at some point
34% reported a current alcohol problem
60% had a drug problem at some point
31% indicated a current drug problem

National Guidance

The new arrangements in the Community Justice (Scotland) Act 2016 take effect on 1st April 2017. These place stronger emphasis on partnership working including addressing health and wellbeing concerns recognised as significant in preventing further offending. The new structure is predicated on no one agency being able to reduce reoffending, and every health board is a statutory partner in the new arrangements.

New Service Challenges

The creation of the new Midlothian Community Safety and Justice Partnership will, by raising the profile, increase the demands on services to become more effective in meeting the health and social care needs of offenders.

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

Offenders

Progress in 2016

The **Spring** service, aimed at women with complex needs who have been involved in or at risk of offending now includes a social worker post to support women on a one to one basis to prepare for Spring and maximise the benefits of attendance. Spring now also includes an Occupational Therapist as part of the staff team. This post is being very helpful in the Reaching In, Reaching Out part of the programme, increasing participation in meaningful activities and occupations, whether these be daily living, targeted specific homemaking occupations, supported parenting, leisure activities or skills development for future employment.

A new service, **Fresh Start**, is engaging with individuals at the point of arrest to link them into relevant services, particularly in relation to substance misuse and mental health.

Spring

A service for women in Midlothian

Information for Women

Key Actions for 2017-18

The new Community Justice arrangements include the development and implementation of a Local Outcomes Improvement Plan and this will include actions planned to address health care needs.

The relationship between previous trauma events and offending is increasingly recognized. Options for strengthening support and counselling to be considered.

Midlothian has a high incidence of domestic abuse. We will explore options to improve or reduce domestic abuse and to work effectively with women and children. We will also explore options of working effectively with perpetrators.

Substance Misuse

The misuse of alcohol and drugs impacts, in a number of ways, on the lives of individuals, families and communities.

920

Estimated number individuals with problematic drug misuse (opiates)

1800+

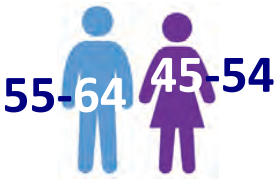
Children's lives affected in some way by parental substance misuse

473

In 2015, this was the amount of alcohol related hospital stays

4.33

The average number of drug related deaths for the period 2013-15



The highest rates alcohol related hospital stays were in these age groups

While cannabis is by far the most common illicit drug used, there is the growing problem with the misuse off prescribed medications such as opiate painkillers, tranquillisers and anti-depressants.

It is Midlothian's most deprived communities where the harmful effects of substance misuse are greatest. Rates of alcohol-related hospital admissions were nearly 7 times higher for people living in the most deprived areas compared with the least deprived.

National Guidance

The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem (2008) and Changing Scotland's Relationship with Alcohol: A Framework for Action (2009) remain the two cornerstone strategic documents.

New Challenges

Since April 2016, funding that Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) receives from the Scottish Government was reduced by 23%. We established a partnership group to make recommendations on how to make these savings while protecting the integrity of the Recovery Integrated System of Care (ROSC) that successfully developed a point noted in the Care Inspectorate report:

'Despite the complex challenges facing the ADP, it had successfully worked in partnership to re-align a large proportion of their budget to post treatment and recovery focussed services evidencing agility and an ability to jointly meet changing priorities.'

Substance Misuse

Progress in 2016

- The final MELDAP report noted 24 strengths of the partnership. These included:
  - MELDAP had consistently exceeded the three-week referral to treatment HEAT standard. In some cases, services were achieving 100% success rates indicating that overall the ADP was delivering effective access to services for individuals who required support.
  - It was evident that service users were offered high quality, evidence informed treatment, care and support interventions.
- Work started on the development of a Recovery Hub, bringing together substance misuse and mental health services.

Key actions for 2017-18

MELDAP will continue to implement the priorities set out in its Delivery Plan 2015-18. These include:

- Develop integrated Recovery Hub involving staff from substances misuse services, mental health services, council staff and third sector partners.
- Deliver actions to address areas for improvement noted in the Care Inspectorate report.
- As a member of the Midlothian Licensing Forum, work with the Licensing Board to produce a new Statement of Licensing Policy and oversee its implementation.
- Achieve balanced sustainable budget.

Primary Care

GPs

The demand for GP appointments is high with an estimated 0.5 million appointments offered each year in Midlothian. GPs are seeing approximately 10% of the Practice population every week. With recruitment difficulties and additional demands to support the frail elderly at home, in care homes and in-patient continuing care and step up/ down facilities, the pressure on GPs is increasing.

Community Nursing

With a shift from hospital care to care at home, community-nursing services provide care for people who are housebound, or who are unable to access their GP surgery. The services aim to support patients manage their conditions as independently as possible, and where appropriate, to avoid hospital admission. In line with the Lothian Palliative Care Strategy, we are increasingly managing people receiving palliative care, up to and including end of life care, within their own home or care home.

Medication

Medication is vital in helping people recover and keeping people well. The costs are high; Midlothian is spending almost £17m on prescribing out of the total health (including some hospital services) and care budget of £122m.

Dentistry

There is good access to an NHS dentist for people living in Midlothian with 84% of adults registered with a dentist (87% in Scotland, March 2015). Older people and people experiencing health inequalities are less likely to see a dentist compared with other areas in Scotland.

Sexual Health

Focus on reducing teenage pregnancy and unintended pregnancies for those over 20 years of age is growing; raising the uptake of LARC (long-acting reversible contraception); and increasing access to early abortion services.

Continence

We are implementing the main objectives of the report, **Promoting Continence in Lothian**, in Midlothian through a local coordinating group. We are also introducing protocols to improve support to people in their own homes and to care home residents.

Out of Hours

The role of Lothian Unscheduled Care Service (LUCS) is to provide urgent primary medical care services across Lothian in the evenings and weekends as well as on Public Holidays. We will consider the outcome of the national review before determining the best way forward in collaboration with the other Lothian IJBs.

Primary Care

National Guidance

- The national 2020 Vision for Scotland's Health Service is clear about the need to strengthen the role of primary care to keep people healthy in the community for as long as possible.
- In 2016-17, Scottish Government made £13m available to help deliver projects across Scotland that trial new ways of delivering health care in the community including addressing mental health issues.
- A National Review of Primary Care Out of Hours Services continues to consider how best to deliver out of hours services.

New Service Challenges

- Some Practices struggled to meet the standard of offering telephone advice or an appointment within 48 hours.
- During 2016-17, six GP Practices moved to restricted lists, limiting the number of new registrations.
- Raised public concerns through a range of open forums about access to their GP.
- The population in Midlothian is growing rapidly.
- The workload for community nursing teams is increasing alongside difficulties in recruiting district nurses.

Progress in 2016

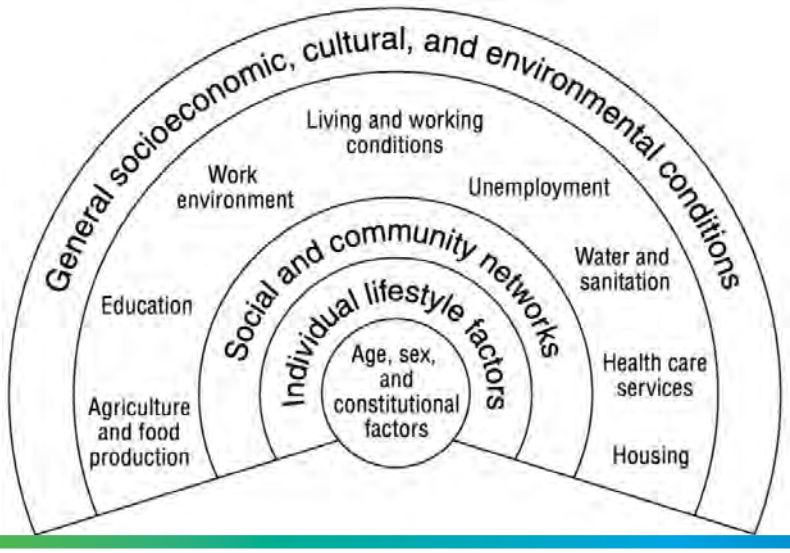
- A number of discussions held with the public e.g. Hot Topics, Older People and Community Councils.
- A number of new services introduced to Health Centres including the MW Access Point in Penicuik and Midlothian Community Hospital; the Wellbeing Service across eight Health Centres; and a Carers' Advice Service in Dalkeith Health Centre.
- Five pharmacists now working with Health Centres in East and Midlothian to support GPs on issues such as reviewing medication of patients discharged from hospital.
- We developed a local Prescribing Action Plan to manage the expenditure on medicines (approximately £17m per annum) within the allocated budget.
- An information leaflet **Do I need to see a GP?** published and distributed.

Primary Care

Key Actions for 2017-18

- A new Health Centre being built in Loanhead and will open late 2017-18 within the Community School campus.
- Continue to work on a Pan-Lothian basis to train and deploy nurses and physiotherapists trained to an advanced level to strengthen the skill mix in Health Centres.
- Work with GPs, social care staff and local voluntary organisations in Penicuik to pilot new ways of working with people who are housebound.
- Develop closer relationships with key specialist staff in the acute sector to provide more seamless services between hospital and home GPs.
- Upgrade of Health Centre premises in Newbyres.
- Open a new GP Practice in existing refurbished premises in Newtongrange.
- Work with the newly established GP Quality Cluster to help improve the quality of all health and care services.
- In line with the national review of 'out of hours' services, we will review our local arrangements on a multi-disciplinary basis.
- Contribute to the development of a new model of emergency health care such as out of hours care hubs across Lothians.
- Develop a local plan in collaboration with NHS Lothian Oral Health to improve the uptake of dental services by those groups less likely to do so i.e. people involved in offending.

The Determinants of Health



Care Packages

The number of people likely to need care packages in the future is difficult to predict.

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

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

Approximately

2000

adults are in receipt of some form of care package

Total social care 2016-17 budget iin the region of

£39m

National Guidance

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

New Service Challenges

The model of social care is changing, shifting to a more person-centred approach in seeking to address individual need and improve the person's outcomes. The implementation of Self-Directed Support enabled many people to exercise more control over their care arrangements. However, we need to pay more attention to overseeing care arrangements to ensure that we are as efficient as possible with our limited resources, whether this be in providing transport, day care or overnight support.

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

Care Packages

Progress in 2016

- Internal policies and processes reviewed to ensure we are providing services in a way that is both equitable and affordable.
- Staff development training programmes put in place to take more account of management of risks and for identifying the most cost effective way of meeting people's needs.
- The costs and efficiency of Council and external care services are in the process of being reviewed

Key Actions for 2017-18

- Develop stronger partnership working with health services and external providers.
- Continue to examine any opportunities to enable people to manage more independently with the support of new technology.
- Develop a communication strategy that ensures the public and our partner agencies understand and can support the changes we are putting in place.

Our Realistic Care, Realistic Expectations programme aims to provide services over the next three years within a reduced budget

Hospitals

National Guidance

The Ministerial Strategic Group for Health and Community Care agreed that for 2017/18 they will track the progress of Integration Authorities:

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

This demonstrates that a very high priority is attached to reducing avoidable use of acute hospital beds.

New Service Challenges

There is a need to reduce our use of Acute Hospital beds. A new national target is to reduce unscheduled care beds by 10% across Scotland. Patient safety reasons recognises that across the UK, at any one time, occupancy rates should not exceed 85%.

We have major challenges in the provision of care at home services. This led to delays in the availability of the Reablement Service and consequently arranging discharges form hospital. As a result, for a period during the year, our performance on delayed discharge deteriorated.

Our analysis of health inequalities identified a high incidence of preventable admissions from areas of multiple deprivations.

Hospitals

Midlothian Community Hospital (MCH)

New Challenges

The requirement to reduce use of acute hospital beds alongside the public's wish for services to be locally available means that we must make the maximum use of our local Community Hospital.

Progress in 2016

- **Out-patients clinics:** We worked with NHS Lothian Out-Patient Board and individual services such as Audiology to determine which services could be provided in this way without incurring significant additional costs.
- **Rehabilitation:** Plans are in place for the transfer on the 1st April 2017 of 24 post-acute rehabilitation beds for older people from Liberton Hospital to MCH.
- **Day Services:** We replaced the provision of day hospital services in MCH with a Day Care service, transferred from Highbank and Woodburn Day Care. This is a medium term arrangement until we can secure more suitable day care accommodation.

Key Actions for 2017-18

Outpatients clinics: Continue to explore opportunities for providing outpatient clinics in MCH and this may include the application of new technology for video conferencing.

Acute Hospitals

- Further investment made in the Hospital at Home Service-increasing capacity to supporting 15 patients at any one time.
- Nursing support to care homes also increased including the establishment of a nursing team in Newbyres Care Home.
- We continue to develop joint work with the Ambulance Service for people who have fallen and those with dementia.
- A new Physiotherapy post created to support people with advanced respiratory illness (COPD) and manage their condition without needing hospital admission.
- To ensure people are discharged quickly, we strengthened the In Reach Team.
- We maintained the Assisted Discharge Service provided by Red Cross.
- A Single Point of Contact in Midlothian for acute hospital staff established.
- In relation to younger people who attend the hospital regularly, some work undertaken to ensure a proactive approach to addressing their needs such as contact with the Homelessness Service.
- The joint dementia team increased its capacity with an additional social worker and introduced a duty system that works in partnership with Merrit to enable GPs to phone directly when there is a crisis/emergency. This is to avoid going to the Community Care duty team and ending up on a waiting list.

Hospitals

Acute Hospitals

Key Actions for 2017-18

- The rehabilitation pathway (24 beds) provided in Liberton Hospital will transfer to Midlothian Community Hospital in April.
- Midlothian has a high incidence of people admitted to hospital because of a fall, so we will focus more on developing a falls prevention strategy.
- Review the reasons why people admitted to hospital with conditions that in theory do not require hospital admission. This will enable us to understand better what services or support people need to avoid this happening.
- Implement a new approach to identifying people who are frail so that we can provide support at an earlier stage and help prevent some crisis admissions.
- Consider the local implications of the NHS Lothian Acute Hospital Plan proposals and what these will mean for the Midlothian population so we can make necessary adjustments to local services – for example more locally available out patient appointments.
- Review the provision of out-of-hours of Midlothian health and care services in light of the Ritchie review, and use this to improve provision and inform the Lothian-wide development of OOH provision.

Housing

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

The main objective of health and care reform is the reduction on the reliance on institutional care and hospitals. As we age, staying at home is a viable option for most of us. This depends on our home's location, accessibility, size, energy efficiency and proximity to local amenities.

National guidance encourages new build housing to incorporate design features that enable people to remain in their homes longer or easily adapt them.

National Guidance

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

New Challenges

The pace of house building impacts services and communities as the population grows. More specifically the Handyperson scheme providing a small repairs service ceased to trade leaving a gap locally.

Progress in 2016

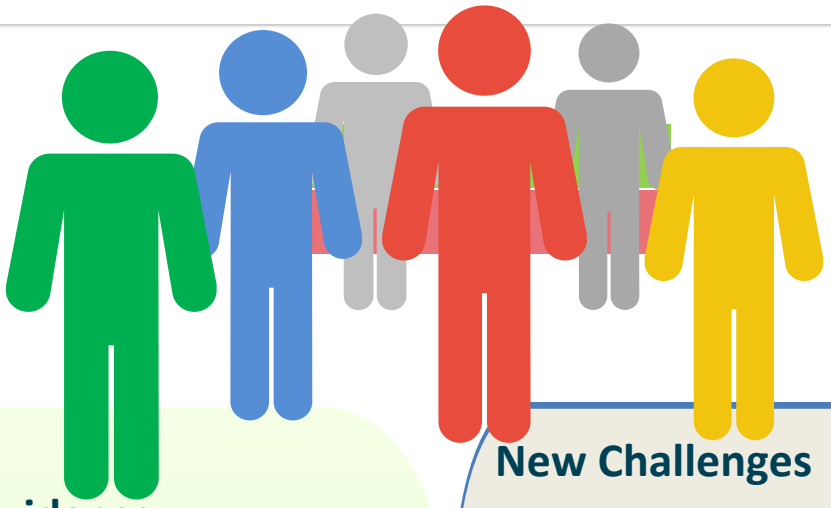
- The new Penicuik accommodation for people with complex needs is near completion and ready for use in Spring 2017.
- Council agreed an Extra Care Housing policy including a commitment to build a new facility in Dalkeith.
- A Social Landlord Register started the process of reshaping a sheltered housing complex in Mayfield to become an extra care facility.
- We put in place stronger joint working between social care and housing through the development of a Housing Options Policy that ensures we achieve the best choices for people in unsuitable accommodation.
- In relation to homelessness the new Health Inequalities services (CHIT) is seeking to address the health needs of people who are without suitable accommodation.

Key Actions for 2017-18

- Draw up detailed plans for new extra care facilities in Dalkeith and in Gore Avenue, Gorebridge.
- The up and running of new Complex Care Housing development.
- Implement a new initiative supporting young frequent attendees at the Royal Infirmary, with prevention of homelessness being a key objective.
- Explore options for replacing the Handyperson Service.

Workforce

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



National Guidance

Scottish Government states that we can only deliver health and social care services with the full engagement and contribution of a valued and skilled workforce. At the heart of the National Transformation agenda is a broader, more integrated, highly skilled, supported, and engaged workforce.

The Scottish Government published a consultation paper - National Health And Social Care Workforce Plan – this aims to support the development of a workforce planning system that progresses this agenda for use in each IJB partnership. This Workforce planning system is due for completion this spring 2017.

New Challenges

Recruitment of care workers across the sectors made more uncertain due to:

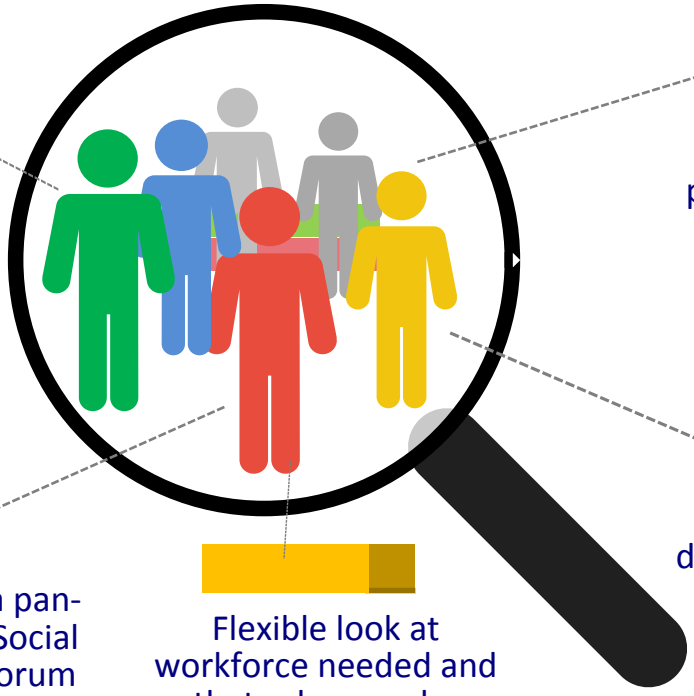
- Plans for Britain to leave EU and increasing reluctance of EU Nationals to seek work in Britain
- Increases in SSSC registration fees and pay being comparable with working in a supermarket

Releasing staff for training in order to 'up-skill' the workforce in more complex practice with service users in the community who have increasing levels of need.

New SSSC requirements for registration e.g. workers in a housing support services (probably 2017), which will require the workforce to acquire qualifications, and released from work to do so
Increasing workforce pressures in Primary Care with significant shortages of District Nurses.

Workforce

Progress in 2016



Delivery of programme of engagement with staff around culture, values and vision

Provision of a range of team development programmes for specific operational teams

Development of a detailed understanding of the workforce across NHS, Council and external sector in Midlothian as the basis for the production of a long term workforce plan

Establishment of a pan-Lothian Health & Social Care Workforce Forum and engaging with developments at a national level

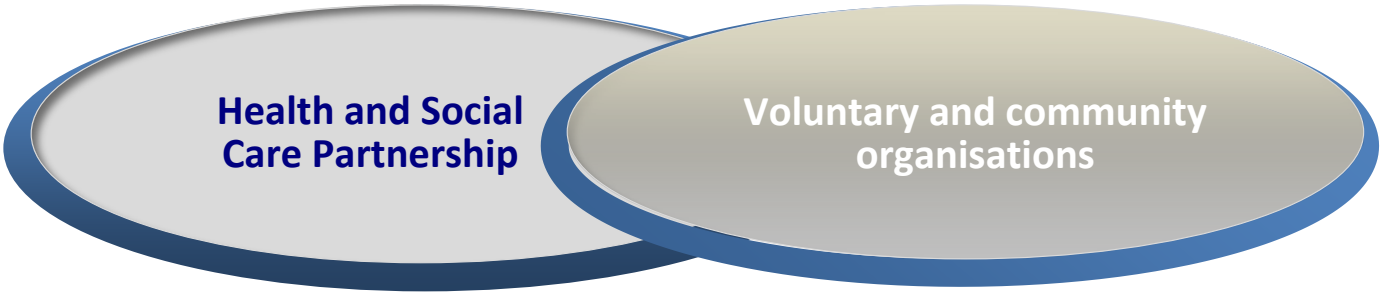
Flexible look at workforce needed and that roles may be different and/or new.

Key Actions for 2017-18

- **Induction:** Establish a shared approach to introduction to the Midlothian Health and Social Care Partnership including induction for Care at Home workers across Council, Third and independent Sector provision.
- **Team Development:** Seek opportunities to apply the Lothian Toolkit with our Third and Independent Sector providers.
- **Leadership:** Develop opportunities for leadership development at the Team Leader and operational frontline levels.
- **Health Inequalities:** Deliver a continuous programme for bite-sized workshops for all staff focusing on Health Inequalities.
- **Locality:** Focus on communities and shaping the workforce around their needs.
- **Recruitment and Retention:** In response to the challenging elements of recruitment and retention across the Partnership, continue to develop approaches to attract staff to caring roles across all agencies, focusing on the voluntary and independent sectors.
- **Roles:** Confirm the range and scope of the redesign of roles for the future, incorporating the roles the voluntary and private sector play in delivering services and support.
- **Workforce Plan:** Produce a Midlothian Health and Social Care Partnership Workforce Plan in line with Midlothian Integration Joint Board and Scottish Government requirements.

Voluntary Sector

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



National Guidance

The Community Empowerment Act reinforced the central role that the Voluntary Sector plays and strengthened the requirement for their inclusion in decision making generally in community planning.

Progress in 2016

- **The Voluntary Sector has representation on the IJB and the Strategic Planning Group as well as on client group specific planning groups.**
- **Increasingly the Voluntary Sector is working in closer partnership through co-location with statutory agencies in areas such as primary care, substance misuse, mental health, dementia and rapid response.**
- **Midlothian Voluntary Association (MVA) established and administers a development fund to promote Peer Support.**

Key Actions for 2017-18

- The Third Sector Reference Group to develop a strategy proposing how it can play a stronger role in the Health and Social Care Partnership in helping address the dual challenges of increased demand and reducing financial resources.
- Third Sector partners enabled to contribute at an operational level in designing new models of care in response to both financial and workforce pressures.

Technology-Enabled Care

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

The possibilities offered by new technology have grown considerably in recent years. Technology Enabled Care is about realising the potential of technology as an integral part of a person's care and support plan to enhance quality and/or improve efficiency across health, social and independent care as well as what is available in the market-place.

National Guidance

There is a National Telehealth and Telecare Delivery Plan and a £30million TEC fund. Midlothian is benefitting from additional funds to develop new approaches.

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

Interagency Informaiton Exchange will support client/patient informaiton sharing between health and social care

Business intelligence and data visualisation development to support greater real-time insight

Developing a TEC and Digital Health and Social Care Strategy Group within the partnership

Technology-Enabled Care (TEC)

Progress in 2016

Videoconferencing: Care Homes care for people who are particularly frail and vulnerable. Ensuring care home staff has the skills and knowledge needed is challenging as it can be difficult to release staff for training. We introduced videoconferencing to all Midlothian so that staff can receive training without having to leave the premises. We are also using videoconferencing to enable deaf people to access real time interpreting support.

Dementia: To encourage families and staff to consider using technology, we established an 'At Home Hub' in Midlothian Community Hospital. This provides an opportunity to learn about the possible use of equipment, resources and environmental adaptations.

Malnutrition Management: Dieticians are now using Health Call – an automated telephone system to support people with their weight management plans.

Key Actions for 2017-18

Realistic Care, Realistic Expectations: Find new sustainable ways of supporting people and enabling them to stay well. This means setting realistic expectations while achieving our statutory obligations as a needs-led service. We will review how we can enable new models of support through the adoption of technology in practice e.g. overnight care in learning disabilities.

Interagency Information Exchange introduced. This enables health and social care staff to access information about the needs and services provided by agencies to people they are working with.

eFrailty: People who are frail account for a significant proportion of those admitted to hospital. To shift away from crises care we will explore how best to use technology to identify people at most risk and provide support at an earlier stage to avoid crises arising

Information Hub: We will continue to explore affordable sustainable solutions to the challenge of providing easily accessible information - an issue regularly raised by the public.

Mobile Working: In order to find new models of care, we must find ways of working differently and more efficiently. Paperwork and travel time to process and file field activities are areas for improvement.