Midlothian Council
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Relative to Item No 10

STRATEGIC PLAN 2016 - 19

MIDLOTHIAN HEALTH AND SOCIAL CARE JOINT INTEGRATION BOARD

Working Together to Improve the Health and Wellbeing of the People of Midlothian

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1. IMPROVING HEALTH AND WELLBEING

1.1.1 A New Approach to the Delivery of Health and Social Care

Scottish Government passed legislation in 2014 requiring health and social work services to become integrated. This is regarded as the biggest change in the organisation of the National Health Service since its creation in 1948.

A new Health and Social Care Partnership, the Integration Joint Board (IJB), is now responsible for planning health and care services for the Midlothian population.

WHY HAVE WE WRITTEN THIS PLAN?

This Plan sets out how the Partnership will provide services over the next three years. It will be updated each year to take account of changing needs and to take advantage of new opportunities to redesign services as they arise.

We need to strike the right balance between long term planning of services and responding to new challenges. We must also make sure that we maximise breakthroughs in medical science and new technology, and respond to changes in the delivery and funding of public services.

1.1.2 Understanding the Needs of People in Midlothian

Midlothian is a small Local Authority, the second smallest in mainland Scotland in population terms. As a result of a major house building programme, the number is likely to rise from 81,156 to approximately 95,490 in 2020, continuing to grow up to 2024 to a predicted level of 99,136. Our largest towns are in the region of 20,000.

Primary Care Services are based in local communities, however, other services are provided across Midlothian and, in relation to some health services, across Lothian.

There are significant differences between communities within Midlothian in terms of their histories, resources, assets, and needs. There is also a large, very rural, more isolated area to the south of the County.

This plan takes an overview of Midlothian and has been developed based on:

- knowing and learning about the needs of people in Midlothian - these are described in the *Joint Needs Assessment* (appendix 1)
- gaining an understanding of the experiences and views of users and carers on our current services - the findings can be found in the "*Summary of Feedback for Community Groups and Individuals"* (appendix 2)
- drawing upon the issues raised by the public in recent years through the 16 Midlothian Neighbourhood Planning Groups
- having conversations with health and social work staff and with representatives of voluntary and independent organisations to understand their views on how

services could change to become more effective

We have also considered issues and planned service developments in East and West Midlothian (see map in appendix 4) with a particular focus on those communities with high levels of deprivation.

The Plan has been prepared by the Midlothian Strategic Planning Group (appendix 3), which includes user and carer representation. The Group will continue to develop the plan and oversee its delivery. The Group will also seek to be inclusive of the many organisations and groups that have an interest in health and social care including the *Public Partnership Forum* and the *Community Care Collaborative*, both established to provide continuing feedback from User and Carer Groups across Midlothian.

1.1.3 Content of the Plan

The scope of the Midlothian Partnership is outlined in the Integration Scheme. This covers the full range of community health and care services for adults whilst also including some acute hospital-based services.

Midlothian Council has elected to include the health and care services for offenders. This will strengthen the local approach to addressing the root causes of offending behaviour. Developing ways of reducing offending will remain the responsibility of the Safer Communities Board.

While some children's services such as health visiting and school nursing will fall under the governance of the Partnership, we will ensure that the strategic planning of these services is firmly aligned with the Community Planning Group's, *Getting it Right for Every Midlothian Child* (*GIRFEC*).

Close working between children's services and adult services will remain vital to ensure effective working with the whole family. Additionally, supporting children with special needs as they move into adulthood is a particularly important challenge and we need to ensure their transition is as smooth as possible.

The new Integration Joint Board (IJB) will not be directly responsible for overseeing arrangements that protect people at risk of harm. This will remain the responsibility of the *East and Midlothian Public Protection Committee* (EMPPC); a the key strategic group dealing with public protection matters across East and Midlothian, which includes representatives from Social Work, Police Scotland, NHS Lothian, Education, Housing and the Third Sector.

The services commissioned by the IJB, however, have a crucial role in both safeguarding people from harm in the first place and in taking decisive steps to ensure that any individual or group considered at risk of harm are identified, supported and protected.

It is important that, when planning changes to services, the IJB takes great vigilance to ensure that the risk of harm is not likely to be increased as a result; indeed service changes should always seek to strengthen arrangements for

ensuring sufficient checks are in place for people to stay safe whilst enabling them to have a greater choice on how they live their lives.

The Plan outlines the key areas of service redesign that will take place over the next three years. It provides detailed information on the changes initiated during 2015/16 using new funding available to the Partnership. The use of these resources will be particularly influential in reshaping local services during the lifetime of the Plan.

Importantly, the Plan outlines how services will be delivered differently. Changing health and care services for the better requires that we improve the quality as well as the type and volume of service being provided. It is not just *what* is provided but *how* services are delivered.

A key element in changing the approach to service delivery will centre upon service providers becoming more connected to and working with local communities. The relatively small size of the Midlothian communities provides a real opportunity to engage with local people.

Planning services across health and care is a complex exercise and will require all four Lothian Integration Joint Boards to work together. Whilst changes to the design of these services will be critical to achieving the long term aims of the integration legislation, it is important that the changes are managed in a way that ensures stability and continuity of service delivery for users and carers.

Developing detailed plans for future years will be undertaken during 2016/17. This will include working closely with Acute Hospitals and NHS Lothian Services to ensure that pan-Lothian services are more responsive to the needs of Midlothian people and, wherever possible, to provide these services locally.

1.1.4 Knowing What Difference the Plan is Making

By redesigning our services, we will be better placed to deliver the key national outcomes. This will include measures, which indicate whether:

- people are being supported to remain at home for longer
- people are only going to hospital when necessary
- people are enabled to return home from hospital as soon as they are fit to do so
- people are able to manage their health conditions
- there is a real reduction in health inequalities
- carers are able to continue coping with their caring role

The Partnership will publish an annual performance report on the impact that health and social care integration has had on the health and wellbeing of the Midlothian population. It will include:

- reporting on measures that indicate whether outcomes for users and carers have improved
- feedback from users and carers about their experience of the quality of health and social care services

The report will enable people to be informed on how the Partnership has used its resources and how it has responded to the needs of localities within Midlothian. The information we will use to measure outcomes and quality are detailed in appendix 7.

1.2 REFORMING HEALTH AND CARE IN MIDLOTHIAN

1.2.1 Our Vision

The creation of a new Health and Care Partnership provides an opportunity for the most significant change in decades to how health and care is delivered. It is important that we grasp this opportunity to transform service delivery and use this to achieve the Partnership's vision of:

"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 will aim to achieve this ambitious vision by:

- placing much greater emphasis on supporting people to recover and return home
- working with the whole person
- improving patient pathways
- working together with carers and local communities
- developing stronger partnerships with a range of public, private and voluntary agencies

Underlying this vision and the key objectives of the plan, there is a firm commitment to the principles of reducing inequalities, promoting opportunities and eliminating discrimination in line with the Equality Act and with Human Rights legislation.

1.2.2 Work with the Whole Person

We need to think differently about "health". We must:

- focus on the whole person not just the disease
- recognise the interdependence of physical, mental and social wellbeing as crucial to quality of life of disabled people and those living with long term conditions
- think differently about disability and embrace the principles of independent living
- recognise the role that families, carers, communities and the

environment play in supporting people to stay well, recover from ill-health and manage independently

This approach will demand more seamless services - the delivery of care, which is truly joined up and person-centred.

The establishment of a single health and social care budget, including a significant proportion of acute hospital resources, provides the opportunity to create more integrated care between hospital and primary care services and health and social care services.

The NHS Lothian 10 year Plan seeks to design services around patients:

- ***Callum*** who has mental health needs (see Section 8)
- ***Scott,*** a frail older person (see Section 9)
- ***Hannah,*** a middle aged person with a long term condition (see Section 6)

There is a growing view that people with a range of health and care needs can and should be more:

- involved in decision-making
- in control of their own care
- confident about managing the symptoms of their illness

The proposed model for delivering person-centred, integrated care is the *"House of Care"*.

This concept is based upon creating space for people to have "a good conversation" about what is important to them and delivering a plan that will help people with such health conditions to live well.

The approach provides a common framework for delivering person-centred care building on the strengths of individuals and communities (see national plan: *Many conditions, One Life: Living Well with Multiple Conditions*).

1.3 THE MAIN CHALLENGES

1.3.1 More people who are frail or have dementia are living for longer at home

The health of the population is improving, people are living longer and, as a result, there are growing numbers of older people.

By 2035, the proportion of people in Midlothian over the age of 65 years will have grown to a quarter of the total population.

While many older people enjoy good health there will inevitably be increased pressure on health and care services and on unpaid carers.

With increasing age comes the likelihood of living with long-term conditions and requiring more frequent support from health service and social care services. We must support older people to stay in good health and recover as fully as possible following ill-health (see section 9).

1.3.2 People are living longer with multiple Long Term Conditions

Managing long-term conditions is one of the biggest challenges facing health care services worldwide.

People with long-term conditions account for 80% of all GP visits and 60% of all hospital admissions. Midlothian has a higher occurrence than nationally of a range of conditions including cancer, diabetes, depression, hypertension and asthma.

Older people are more susceptible to developing long-term conditions; most people over 65 have two or more conditions and most over 75s have three or more conditions.

People living in areas of multiple deprivation are at particular risk with, for example, a much greater likelihood of early death from heart failure. They are also likely to develop two or more conditions 10-15 years earlier than people living in affluent areas (see section 6).

1.3.3 There has been little progress in reducing Health Inequalities

Another reason for the move to Integration is the need to radically strengthen how we reduce the health inequalities in our Midlothian communities.

People living in particular communities are more likely be in poorer health with higher rates of cancer, stroke, diabetes and heart disease and are likely to die younger.

People with disabilities are also more likely to have lower educational achievements, higher rates of poverty and poorer health outcomes.

While ethnic minority groups are small in Midlothian - 4% of the population - we must ensure services are equally accessible and yet responsive to their differing cultural needs.

We must also recognise the impact of caring responsibilities on family members

who themselves are likely to experience poorer health (see section 3).

1.3.4 Our Services are under pressure

People place a high value on being able to access effective health services when required. They expect to receive high quality care services, when needed, whether as a result of age, disability or long term health conditions.

The financial pressures on public services are severe, with the difficulties facing national health services never far from the attention of the media.

We must Use our Services Wisely

Locally the Council continues to face major cuts in its overall budget but has sought to protect social care budgets from the level of cuts required in other services.

There is no doubt that we need to do things differently: the traditional approach to delivering health and care services is no longer financially sustainable.

1.4 WORKING IN PARTNERSHIP - KEY TO SUCCESS

1.4.1 Promoting Health and Wellbeing

Scottish Government has described the principal outcome of Integration as:

"People are able to look after their own health and wellbeing and live in good health for longer".

Being encouraged to live active healthy lives depends upon a wide range of services such as the provision of walkways and cycle-paths, and access to affordable fruit and vegetables**.**

During 2016/17, we will review our overall approach to prevention to ensure that the current services are effective. We will do this by working closely with local networks such as the Food Alliance; with Council Services such as Leisure and Recreation; and with the voluntary sector generally.

1.4.2 Addressing Health Inequalities

A recent national report by Audit Scotland concluded that reducing health inequalities remains very challenging and requires effective partnership working across organisations.

In Midlothian, a range of partnership groups work together through *Community Planning* to reduce inequalities including the Joint Health Improvement Partnership (JHIP), the Midlothian Employment Action Network (MEAN) and Midlothian Financial Inclusion Network (MFIN).

1.4.3 Promoting Social Inclusion

There is clear evidence of the positive impact on people's health when they feel involved in their local community.

It is difficult to quantify the extent of the problem of loneliness and social exclusion as it is such a subjective experience. However, the Midlothian 2012 Citizens Panel survey found that, when asked how "connected" and how much did "they participate" in their local community, 48% said "very little" and 13% said "not at all".

While isolation amongst older people (see section 9) is receiving increased attention, we know social contact is also important yet challenging for people with mental health difficulties, addiction, sensory impairment, long term health conditions and disabilities.

With a growing proportion of the population who live alone, currently 28% in Midlothian and expected to rise to 33% over the next twenty years, there is a risk that this problem will increase.

Inclusion depends on income and employment or volunteering opportunities, and we must work with Community Planning Partners to address some of these root causes of poor mental and physical ill health. These issues are considered in section 3 on Health Inequalities.

Inclusion also depends upon affordable transport and we must work closely with private, public and third sector transport agencies to improve access.

Transport is a long-standing concern in Midlothian with problems such as travelling to health appointments and difficulty in accessing suitable transport to attend community groups and services. This is often raised as an issue when people are asked about their experiences, regardless of the topic of the consultation or the group of people involved.

A Transport Working Group was set up in 2014 involving representatives of SEStran (South East Scotland Transport partnership) and the Community Transport Association. This is looking at options to address the lack of affordable, accessible community transport for people living in Midlothian.

One option being considered is to make fuller use of Midlothian Council Transport Division and NHS pool cars. This would involve making use of existing vehicles at 'down times' and working in partnership with British Red Cross volunteer drivers.

1.4.4 Integration of Health and Social Care

The creation of the local Health and Care Partnership builds on a long history of joint working in areas such as mental health. However, we have a long way go to fully integrate our services; over the coming year we will work with staff and voluntary organisations to examine how to improve partnership working. This will initially focus on learning disability services, substance misuse services, occupational therapy services and links between primary care and social care services.

While the emphasis has been on the integration of health and social work, there is no doubt that we need to continue to strengthen links with a wide

range of services. The benefits of doing so have been clear in recent times, working together with, for example, the libraries and leisure centres.

The relationship between health, social care and people who use services will be central to a successful redesign of health and care as is illustrated by the House of Care model (see section 1.2).

1.5 OUR KEY PRIORITIES FOR CHANGE

1.5.1 Staying Healthy and Preventing Injury, Illness and Disability

Wellbeing: Supporting people to stay healthy is not a new idea. For example, Health Promotion, MELDAP (Midlothian and East Lothian Drug and Alcohol Partnership), and the local Licensing Board are all participating in campaign programmes such as "anti-smoking" and "drink sensibly", which have met with varying degrees of success.

These campaigns continue to be a priority given the strong link to ill-health: for example the smoking cessation service aims to reduce smoking by 2.5% every two years.

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

The promotion of healthy life-styles is evident in the provision of a whole range of physical activities such as walking, tai chi, dancing and attendance at Council leisure centres which offer reduced charges. This work is coordinated by the *Physical Activity and Health Alliance* and delivered through programmes such as Ageing Well, which has over 600 older people participating regularly.

We must continue to develop ways of encouraging healthy eating which is coordinated by the *Food and Health Alliance*, and to strengthen our capacity to reduce social isolation (see section 9.4). We must pay particular attention to supporting the many thousands of unpaid carers in Midlothian to stay in good health, despite the pressures they experience in their role and the adverse impact this can have on their health.

Accidents: The *Community Safety Partnership* takes a lead in developing measures to reduce accidental injuries and deaths.

One of the main issues to be addressed by health and social care services is reducing injury arising from older people falling and this is considered in some detail in section 9.3.

We must also work closely with key agencies such as the Fire and Rescue Service in reducing accidents at home, identifying and referring people who are particularly vulnerable to house fires; for example in 2013-14, 10% of house fires in Midlothian occurred where the victim was under the influence of alcohol.

Infectious Disease: The success of immunisation programmes to prevent infectious disease is an issue, which we will review during the lifetime of this Plan.

During 2016/17, we will take steps to strengthen the local campaign to increase the take up of the influenza immunisation programme, with a particular emphasis on targeting care staff, unpaid carers and care home residents.

Screening and Early Diagnosis: There is potential to complement the national screening programmes for particular illnesses. One current local example is screening for COPD (chronic airways diseases) in the area covered by the Newbattle Practice, targeted at smokers between 55 and75.

Consideration is also being given to targeting smokers on the diabetes register particularly in areas of deprivation. This could be rolled out and extended to other illnesses/conditions e.g. people who are obese and at risk of diabetes. The *Diabetes – Keep Well Team* is piloting the use of a prevention programme for people at high risk of developing diabetes.

There may also be potential for our local rapid response service - MERRIT - to follow up discharges for people with a recent diagnosis of COPD.

Access to the right services will be more effective if people with specific health problems have their condition diagnosed earlier and this Plan includes steps to achieving this for people with dementia, sensory impairment and autistic spectrum disorder.

Fuel Poverty: A third of people (31%) in Midlothian live in fuel poverty. There is strong evidence that living in fuel poverty exacerbates health risks. In older people, blood pressure rises when they are exposed to low temperatures, increasing their risk of heart attack and strokes.

Getting support to be affordably warm at home can have a significant impact on people's health and wellbeing. Facts show that addressing fuel poverty can reduce:

- excess winter deaths; injury and falls; and help improve mental health
- respiratory illness and circulatory disease -the most common health problems experienced by people living in cold homes

The local *Warm & Well* project, which specifically targets households with health issues, has seen people's situations transformed: nearly 70% of clients said they felt happy about their health and wellbeing after such support compared with just 17% before. We need to increase awareness and develop stronger working relations with *Changeworks* and other third sector partners.

1.5.2 Enabling People to Recover or Live Well with their Long Term Health Condition

We must increase the emphasis we place on helping people to recover their independence and lead a normal life. Professions such as physiotherapy,

occupational therapists and speech and language therapists are dedicated to the provision of rehabilitation from illness such as stroke or from injuries such as hip fractures.

In recent years our ambitions for recovery have 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 is not just about delivering health and social care services differently. It is about helping people to regain a normal life by making it easier to gain employment, get about, have an adequate income, maintain social contacts and being able to cope with the challenges they face (see section 6).

Locally, we have already invested heavily in services such as intermediate care beds and 'reablement' – a care at home service designed to enable people to regain their skills and independence as far as possible following injury or illness.

We need now to develop the "***House of Care***" approach, shifting the emphasis to people managing their own long-term health conditions and being able to enjoy a reasonable quality of life. We recognise that people, including carers, will need effective support to make this shift (see section 1.2).

1.5.3 Keeping People Safe from Risk of Harm

While being able to live independently for longer and in the privacy of one's own home is a central theme of this plan, we must also make sure people are safe from abuse.

This requires a very strong approach to combating abuse of any type, both at home and within care homes. The creation of the Public Protection Unit involving health, social care and police staff, all working together with the wider community, will strengthen our efforts to address concerns about physical, sexual, psychological and financial abuse. It will do so in a way that works across the whole life-span.

This approach also strengthens our capacity to respond to the impact of traumatic events on the lives of many victims of abuse and their increased vulnerability to risk of harm as a consequence.

1.6 HOW WILL WE PROVIDE SERVICES DIFFERENTLY

1.6.1 Treat People as Individuals

The principle of 'personalisation' has been a key driver for health and care services in recent years. This is reflected in the move towards a greater focus on improving outcomes for individuals rather than on providing services or treating particular health conditions.

"What matters to you?"
rather than
"What is the matter with you?"

As explained in section 1.2, NHS Lothian's 10 year plan - Our Health, Our Care, Our Future - places strong emphasis on

treating the whole person. Midlothian social care services, however, are increasingly focused upon meeting the desired outcomes for each individual.

We need to continue to strengthen this approach to the provision of services clearly recognising the uniqueness of each individual and their carer(s).

1.6.2 Information and Communication

A common theme throughout our programme of consultation with the public was the need for accessible information about where to find help and advice.

While there are comprehensive websites and directories, users, carers and our staff do not always know where to look for information *when faced with a change in life circumstances*.

Alongside improving accessibility to information, there is a need to provide more capacity to flag this and support people effectively, building on the approach adopted by Local Area Co-ordination services.

This involves not just giving people information but supporting them to access the services relevant to them.

We will invest in communication to help build on the many established local approaches, including Midlothian Voluntary Action's website, libraries and the national website *ALISS* (A local information system for Scotland).

1.6.3 Access to Services and Treatment

The need to improve access to health advice in the community has been a strong message from the public.

Alongside quicker and more direct access, there is a desire for more health services, including outpatient clinics, day-treatment and rehabilitation, to be provided locally, whether in Midlothian Community Hospital, (see section 5), Health Centres, public facilities such as libraries or at home.

There is also a need to provide information, in a better way, on the range of available health service advice and how this can be accessed.

1.6.4 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 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. This requires a shift in emphasis by health and care staff to support people to be more "in charge" of their own health.

There is a generally held view that it would be helpful to roll out more comprehensive and holistic ACPs, an approach already used effectively for people living in care homes and for Palliative Care patients.

We will aim to roll out this approach, looking first at patients with complex health care needs and those recently discharged from hospital - see work of the PACT team (section 3.3). Some investment will be needed to enable an accelerated approach to such development.

We must ensure that Accident and Emergency Staff and the Ambulance Service are able to access ACPs to enable them to make the most appropriate decisions for each patient.

In a similar vein, unpaid carers have raised their concerns that crises would be managed much more effectively if there was a more methodical and widespread approach to planning for emergencies. This will be addressed by the Carers Strategy Group.

Looking to the long term future is particularly important for families caring for a relative with learning disabilities.

The benefits of ensuring 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, will be promoted through a campaign to increase the use of Power of Attorney and when appropriate, welfare or financial guardianship through the Adults with Incapacity legislation.

1.6.5 Self-Management

Supporting people to manage their own health conditions reduces the demands on health services and social care and gives confidence and a sense of control to service users.

Self-management also encourages and supports people to make adjustments in all areas of their lives whether in relation to employment, financial matters, leisure and more broadly, addressing the emotional impact of having long-term conditions.

Self-management will only be strengthened if we invest in providing support and education. A number of developments are described later in this plan including the application of telehealthcare, which can give people more confidence to manage their own condition(s).

1.6.6 Self-Directed Support

Another key dimension to people exercising more control over their lives has been the implementation of Self-Directed Support.

This legislation enables people, including carers, to be more directly in control of their own care arrangements, providing more flexibility about the type and timing of care for the service user and their family.

This will have a significant impact on the way in which services are delivered reflecting the general shift away from traditional service provision to alternative and more creative ways for individuals to receive support.

A small project team including users and carers will continue to coordinate the implementation of Self Directed support in both directly provided and commissioned services.

INVESTMENT IN SELF DIRECTED SUPPORT INCLUDES Scottish Government funding (£40k per year for three years) for advice and information services in Midlothian provided by LCiL and VOCAL) and building capacity among providers.

1.6.7 Peer Support

There is growing evidence that peer support is highly valued by people who are unpaid carers or who are coping with a particular health condition(s) such as substance misuse, mental health, physical disability or long term illness such as cancer.

We have some powerful local examples of groups of people supporting one another such as the Recovery Café for recovering drug users in Dalkeith.

This peer support is a very effective way of providing self-help, useful information and credible encouragement. It depends on support from organisations such as Midlothian Voluntary Action, those involved in the provision of Local Area Coordination (Enable, Red Cross and Volunteer Midlothian) or on particularly active individuals taking the initiative and encouraging such developments.

We need to develop a more consistent approach that enables people in all communities to access this form of support. The first task is to compile a comprehensive picture of peer support groups in Midlothian.

INVESTMENT IN PEER SUPPORT INCLUDES an allocation of £20,000 to enable Midlothian Voluntary Action to develop more peer support.

1.6.8 Coordinated Care

More people have a range of complex health conditions as a result of people living longer. People who are over 75 are likely to have three or more long- term conditions and may require ongoing health and care support services.

We must ensure that staff work together to provide seamless services and coordinated care arrangements for people with complex health conditions. Anew framework*, The House of Care* (see section 1. 2), is being introduced to help guide the design of services to achieve a more joined-up approach.

Similarly the Dementia Team is developing a new approach (Dementia Practice Coordination) to ensure care of people with dementia is effectively coordinated.

1.6.9 Working together with Users and Carers

There has been a growing shift to working in partnership with users and carers of health and social care services. This is now referred to as co-production, a process of continuing dialogue between people who provide and people who use services, and supporting people to self-manage.

One local example of this approach has been the use of “Family Group Conferencing” for those affected by dementia whereby extended families have been more directly involved and in control of care arrangements for their relative.

2. WORKING IN LOCALITIES

There is an increasing recognition that active, supportive communities are fundamental to a good quality of life for people vulnerable through age, illness or disability. It is particularly important in addressing the harmful effects of social isolation, which can lead to poorer physical and mental ill health and an increased risk of hospital or care home admission.

We have strong local communities in Midlothian and we must do more to harness the strengths they can bring to improving health and wellbeing. We know that key to this includes establishing more effective communication channels and demonstrating a stronger commitment to working with voluntary organisations functioning in those localities.

There are also related challenges for our local health and care services in finding ways of working more closely with volunteers (see section 11.4) and unpaid carers (see section 10), and recognising that these groups rather than formal public services, are critical to the health and wellbeing of the Midlothian population.

Midlothian is small, both geographically and in population terms. Due to the practicalities and implications of planning and commissioning on a small scale, it has been agreed to operate on an East/West approach to the establishment of two localities.

Our intention is to develop better connectedness to the natural communities of Midlothian through creating stronger relationships with Community Councils and Neighbourhood Planning Groups, whilst acknowledging that the East/West split does not reflect any recognisable sense of belonging or indeed formal organisation of services.

Alongside this, we will continue to work with the newly reformed Public Partnership Forum (*The Hot Topics Group*) now addressing social care issues as well as health matters, and with groups who have a specific area of interest e.g. Learning Disability, rather than a geographical focus - known as *communities of interest*.

There is much work to do to better understand the needs and current use of our resources in our communities. In many regards our approach until now has been to plan services on a Midlothian wide basis. Our priority over 2016/17 will be to develop a much fuller understanding of the varying needs and assets of each community.

As our East/West localities are newly defined geographical entities, not previously considered by key data providers, this creates challenges for us. Previously the Joint Strategic Needs Assessment used routinely available data sources to identify key health issues affecting the Midlothian population.

Many national data sources are currently unable to provide information at locality

level, limiting our ability to tailor commissioning of services for the two Midlothian locality areas.

We do know that the key distinguishing feature of East Midlothian compared to West Midlothian is the presence of three areas of multiple deprivation (parts of Gorebridge, Mayfield and, Woodburn [Dalkeith & District]).

In these areas, the life expectancy can be significantly (up to 12 years) less than for people residing in more affluent areas of Midlothian. Although 'All Cause Mortality rates' for the population of Midlothian as a whole demonstrates a consistent downward trend, this hides variation in disease specific mortality in East and West localities.

As is described in section 3 we will seek to develop more effective approaches to addressing Health Inequalities wherever people live. However our key focus in East Midlothian will be to work alongside Community Planning Partners in targeting the three areas of multiple deprivation.

Details of specific plans for East and West Midlothian are outlined in appendix 4.

3. ADDRESSING HEALTH INEQUALITIES

3.1 WHAT ARE "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, social position, gender, ethnic origin, age or disability are likely to have poorer physical and mental health than the rest of the population. By far the commonest reason for people to experience health inequalities is low income.

The poorest in our society die earlier and have higher rates of disease. People struggling with poverty and low income have poorer mental health and wellbeing than those with higher incomes and positive life chances.

Scientific evidence now helps explain how deprivation and other forms of chronic stress lead to poor health.

Addressing health inequalities is a complex challenge and requires actions to be taken by many different agencies working closely with communities.

We need to make sure that people vulnerable to or experiencing inequalities have good access to all public services.

By working closely with other agencies we need to reduce social inequality through addressing poverty, promoting employment opportunities, providing suitable housing etc. This will mean increasing resources to those in greatest need.

Addressing Health Inequalities is a major challenge and one which the new Health

and Social Care Partnerships are expected to make a significant contribution.

As policies and programmes are developed as part of the strategic planning process, they will be expected to actively consider any potential impact on health inequalities and report on steps that will be taken to reduce these.

It is only through concerted efforts across all parts of our services that we will address this issue.

3.2 NEEDS ASSESSMENT

In Midlothian there are significant inequalities in health between people who are socially and economically well off, and those who are socially disadvantaged. For example a man living in Dalkeith is likely to live 12 years less than a man living in Newbattle and Dalhousie.

People living in the most deprived communities are more likely to have poorer physical and mental health throughout their lives.

Health inequalities do not just affect the most deprived communities and individuals. For almost every health indicator there is a clear link between poor health and decreasing affluence while people disadvantaged by race, disability or gender also have poorer health (see Joint Needs Assessment appendix 1).

There are strong links between health inequality and mental health; for example deprivation is a known risk factor for poor mental health. The need to take action to reduce health inequalities will be a key message of the forthcoming Scottish Government Report: *Good Mental Health for All*.

There is also a very strong connection between health inequalities and homelessness. A 2014 review of the health of over 2500 homeless people in England found a much higher prevalence of physical and mental health problems and substance misuse issues in the homeless population compared to the general population.

There are 8 data zones in Midlothian in the most deprived 20% areas in Scotland.

These data zones are concentrated in Dalkeith / Woodburn, Mayfield / Easthouses and Gorebridge. Data zones in the most deprived 20-30% are spread more widely in Midlothian including parts of Loanhead, Penicuik and Rosewell.

An additional challenge is ensuring that we identify people affected by deprivation who are living outside these identifiable areas. Some estimates suggest that around half of people experiencing deprivation live outside geographical areas that are readily identified as experiencing deprivation.

Our services need to work consistently to identify those who are facing disadvantage so that people can access the support they need.

3.3 HEALTH AND DEPRIVATION

The Joint Needs Assessment (appendix 1) clearly shows that people living in areas of multiple deprivation are at particular risk of developing Long Term Health Conditions with, for example, a much greater likelihood of early death from heart failure.

They are also likely to develop 2 or more conditions 10-15 years earlier than people living in affluent areas.

Deprivation is also strongly linked to the risk of an emergency hospital admission.

Reducing health inequalities is a matter of social justice but it is also in the interests of the health care system to reduce preventable ill health.

We will look to support people to develop confidence in self-management, coping with their long term conditions and leading as healthy lifestyles as possible (see sections 4.5 & 6.2 outlining plans to provide health and wellbeing support).

We have also begun working with the PACT Team (Patient Experience and Anticipatory Care Plan Team) in the Royal Infirmary. This provides a targeted service for people whose illnesses and life circumstances bring them into regular contact with the hospital. The first action will be to develop stronger links and effective information sharing between the PACT Service and local GP Practices.

3.4 HEALTH, HOUSING AND HOMELESSNESS

Evidence suggests that living in poor housing can lead to an increased risk of cardiovascular and respiratory disease as well as to anxiety and depression.

Dampness, mould, and structural defects that increase the risk of an accident also present hazards to health.

The Council has, over a number of years, invested significantly in new build programmes and extensive upgrading of existing properties.

Similarly Social Landlords (Housing Associations) have an overall objective to provide high quality housing whether through new build or by upgrading properties through improvements to insulation, heating, double glazing etcetera. Alongside this, they provide housing support services such as money advice, income maximisation and advice on adaptations.

There is also a strong connection between homelessness and health inequalities. It was described in the recent Scottish Public Health Network report as a ‘late marker’ of severe and complex disadvantage, which can be identified over the life-course of individuals.

Unfortunately, homeless people experience much higher levels of physical ill-health, mental ill-health, alcohol abuse and illicit drug use than the rest of the population and dual diagnosis is frequent.

Injuries through assaults are also a threat to the physical and psychological health of homeless people.

Health problems develop at a much younger age and the average age of death for a homeless person is 47 years, compared to 77 in the general population.

The provision of a new facility in Penicuik during 2015/16 will create an opportunity to provide focused support to residents regarding their health and wellbeing. This could include advice and information on dentistry, mental health, smoking and healthy eating as well as income and employment advice.

We will develop a coordinated approach to providing such support linking to the *House of Care* work (see section 6.2).

More generally there is considerable scope to be more proactive in addressing the health care needs of people who are homeless and we will work with the Homelessness Service and the Health and Wellbeing Team to refresh concrete plans to achieve this.

3.5 HEALTH INEQUALITIES AND DISABILITY

Health inequality is not only associated with particular geographical areas; there is a strong link to long term disabilities.

People with learning disability are at particular risk of being four times more likely to die from a treatable illness.

Measures have been taken to address these inequalities and are summarised in the Learning Disability section (7.3). We need to develop a similar, proactive approach with people with physical disabilities.

3.6 VETERANS

Veterans of the armed forces and their families can face many challenges upon leaving the services. These can include mental health issues, ill-health and disability affecting their quality of life and opportunities to find employment.

Locally we are fortunate to have a dedicated support service based in Dalkeith - Lothian Veterans Service. This provides advice on health, housing, employment and comradeship.

We must develop closer links with this service and more generally ensure that veterans are signposted and provided with appropriate support.

3.7 LGBT (Lesbian, Gay, Bisexual, and Transgender)

The national report on health inequalities, Equally Well (2008) reported that lesbian/gay/bisexual and transgender people experience lower self-esteem and higher rates of mental health problems, which have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use.

While there is no local data available, national estimates suggest between 5 - 8% of the population may be LGBT.

It is important to ensure that services are readily accessible for people within this significant portion of the population. For instance it is estimated that older LGBT people are 5 times less likely to access services than other older people.

Awareness raising and staff training programmes will be designed to help address the needs of those who are LGBT.

3.8 TARGETTED PARTNERSHIP WORKING IN AREAS OF DEPRIVATION

The Community Planning Partnership has given a strong commitment to working together to address inequalities in the three areas of multiple deprivation and is seeking to attract funding including through the European Union to support such work.

This project will seek to improve outcomes for residents of these areas by engaging local public services and the local community to investigate the causes of poorer outcomes and develop actions to reduce these gaps.

The Health and Care Partnership will play an active part in this work and if the EU project bid is successful there will be a dedicated Health Promotion Specialist working as part of the core team.

Alongside this, NHS Lothian has commissioned Midlothian Voluntary Action to support community work in Mayfield and Easthouses.

INVESTMENT IN AREA TARGETING WORK INCLUDES a Community Empowerment Development Worker £30,000 (NHS Lothian) and, if successful, EU funding for a dedicated Health Promotion Specialist.

3.9 INCOME MAXIMISATION

While employment rates are above the Scottish average, 12.5% of the Midlothian population have a lower income than the national average. Poorer health is consistently associated with poverty.

The economic downturn had a particularly adverse effect on areas with high levels of deprivation including parts of Gorebridge, Woodburn and Dalkeith.

Welfare Reform has been a major source of concern and hardship to many people in Midlothian and the Council has sought to mitigate the worst effects through a range of proactive measures:

- The Midlothian Area Resource Coordination for Hardship (MARCH) project supports people whose health and wellbeing may be affected by low income
- The Citizen Advice Bureaux (CAB) operates advice surgeries in Newbattle and Newbyres Health Centres and also targets people with mental health problems in the Orchard Centre, the Royal Edinburgh Hospital and Midlothian Community Hospital)
- CAB provides a dedicated service for unpaid carers (see section 9)

- The Council and local Social Landlords provide welfare benefits advice and money advice
- There is a dedicated Macmillan income maximisation service for people with cancer (see section 6)
- The *Money Matters Toolkit* is now being used by frontline health and social care staff to check about hardship issues and provide direct referral to local services
- A new service – VOCAL Advocacy Service- is being established to support carers and the people they support, with face to face assessments for Personal Independence Payments and Employment Support Allowance

The Low Commission Report (June 2015) on the impact on health of an inadequate income reminds us that *patients may well have problems in their everyday lives that may be causing or exacerbating their mental and physical health or may be getting in the way of their recovery.*

INVESTMENT IN INCOME MAXIMISATION WORK INCLUDES CAB Service for Unpaid Carers £12,500 (Carers Information Strategy) and MacMillan Income Maximisation post £35,000

3.10 FUEL POVERTY

Those most vulnerable to fuel poverty and cold homes include the elderly, disabled people and people with existing physical and mental ill health.

These groups are often living on fixed incomes and so cannot cope with fuel price rises. Evidence shows that:

- they spend longer in their homes and require longer periods of heating
- their temperature control is weaker
- they are more likely to have existing medical conditions, and live in the least energy efficient properties

Front-line support staff have frequent contact with vulnerable people and are well placed to target support that promotes warmer and healthier homes, and prevention of worsening health issues.

3.11 EMPLOYMENT

Employment is a *key factor* in wellbeing, both in helping reduce poverty and as a result of the psychological benefits of being in work – a sense of worth, social contact etc.

Midlothian Employment Area Network seeks to improve opportunities for education, employment and training for people in Midlothian.

Support to find employment is provided by the Council's *Midlothian Training Services* and by specialist voluntary organisations.

Funding through social work has been provided to support this work in areas such as mental health, substance misuse and learning disability.

Alongside this, NHS Lothian *Working Health Services* provides advice for people who do not have access to occupational health in their workplace and are struggling at work because of their health.

Support and advice for people with long term health conditions or enduring mental health needs is available through specialist Occupational Therapists.

We will review the scope for strengthening these types of services for other vulnerable groups such as unpaid carers and people with physical disabilities.

3.12 HEALTH AND WELLBEING

The Health Promotion Service is involved in a range of local initiatives to address inequalities in areas such as Sexual Health, Drugs and Alcohol, Smoking, Mental Health, Ageing Well, Money Matters, Community Empowerment and through groups such as the Health Promoting Hospital Group, Physical Activity Health Alliance and the Food and Health Alliance.

The *Keep Well* programme has been based in two General Practices and seeks to support people to change their behaviours and improve their health outcomes. It provides 1-1 sessions with health coaches alongside signposting to a range of services whether related to activity, diet, smoking cessation or alcohol reduction.

This programme supplied a wealth of learning on working with people and providing them with support to make positive lifestyle choices, including health behaviour change and access to a range of services.

We are now reviewing our approach and considering how best to support people with long term conditions to better manage their own health in line with the *House of Care* model (see Section 1.2).

In recognition of the high incidence of Long Term Conditions in areas of deprivation, a pilot project is planned in the area covered by the Newbattle GP Practice (Mayfield and surrounding area), alongside a similar project in West Midlothian, to develop peer support, provide lifestyle advice and promote people's capacity for self-management.

INVESTMENTS IN WELLBEING INCLUDE:

- Health and Wellbeing Practitioners (House of Care) £40,000 Integrated Care Fund ICF
- Specialist Occupational Therapists £70,000 ICF
- Dietetics Weight Management £25,000 ICF
- Public Health Practitioner £40,000 ICF

4. RESHAPING PRIMARY CARE

4.1 POLICY

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.

Primary Care is also considered critical to tackling health inequalities and to addressing the challenges facing unscheduled care in hospitals.

The NHS Lothian 10 year strategy Our Health, Our Care, Our Future, highlights the vital role that Primary Care will play. While much of the planning and service redesign will, in time, be managed at a local level through the IJB, there are a range of issues which are being managed on a Lothian wide basis.

The key long-term priority of the *NHS Lothian Primary Care Forward Group* is the development of a new model of care to support the frail elderly (see section 9).

4.2 NEEDS ASSESSMENT

4.2.1 GPs

The demand for GP appointments is high and it is estimated that about 0.5 million appointments are 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, in-patient continuing care and step up/down facilities in addition to supporting their core practice population needs, the pressures on GPs are increasing.

The number of GPs working in Midlothian has increased slightly between 2008/9 and 2012/13. However, working practices are changing, with increasing numbers of younger GPs choosing to work less than full-time hours.

As a result, some Practices have struggled to meet the standard of offering telephone advice or an appointment within 48 hours and this has been the subject of concerns raised by the public.

We need to find ways of ensuring that the best use of their limited time is being made and that our health services are being used wisely. This includes reducing missed appointments, more self-help through easier access to information, promoting the use of recovery networks and by seeking the advice of other primary care professionals.

Alongside this, we need to develop alternatives including more direct access to social care services and working more closely with GP practices.

We will continually review with each of the local GP Practices what support and alternative ways of working would help reduce pressure on GPs. This will include:

- considering the potential to increase the role of nurses and pharmacists
- reviewing the medical and nursing services provided to care home residents

4.2.2 Nursing

Community nursing services provide care for people who are housebound, or who, for health reasons, are unable to access their GP surgery. Services are available

between the hours of 8am and midnight, and through NHS24 outwith these hours.

The services aim to support patients to manage their conditions as independently as possible, and where appropriate to avoid hospital admission. The role of community nursing staff is vital to enable patients to manage their health conditions without necessarily requiring the attention of their GP.

Steps are being taken to increase further the skills of community nurses, including the training and appointment of Advanced Nurse Practitioners, who will be able to provide nursing care which, in the past, has only been available in a hospital setting. Investment in a *hospital at home service* as part of the Midlothian Enhanced Rapid Response and Intervention Team (MERRIT) is allowing patients to receive this advanced care within their own home.

There is a shift from hospital care to care at home, with services now being provided that were previously only available in a hospital setting. In addition we are facilitating earlier discharge to reduce hospital length of stay.

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 (see section 6.4).

This has resulted in an increasing workload for community nursing teams and as a consequence, we are reviewing our district nursing services. This will ensure we work in the most efficient way to meet growing demand and that we can continue to provide person-centred care of the highest standard.

Recent information indicates an overall 1.5% increase in the community nursing workforce in the past 3 years, mainly achieved through a changing skill mix of the district nursing workforce. Further investment will be required if we are to meet the growing needs of the increased frail elderly population and complexity of caring for people with long term conditions in the community.

We are developing our workforce to ensure they have the skills and competencies required to provide a quality service to the local community. New roles are being created such as the Care Home Nurse Advisor, to ensure the quality of nursing care within our care homes is also of a high standard and that this is demonstrated during inspections.

An added concern in Midlothian is that the service is dependent upon an ageing workforce and plans are being drawn up to ensure the service is sustainable in the longer term.

As part of our broader workforce planning strategy (see Section 11) we will review the future needs of the service in conjunction with NHS Lothian.

4.2.3 Allied Health Professionals (AHPs)

The role and scope of allied health professionals (physiotherapists, occupational therapists, speech and

language therapists and dieticians) to support GPs within Primary Care is in the early stages of being developed for Midlothian.

The aim is to offer more responsive and accessible services that contribute to diagnosis, support and alternatives to treatment that will support self management and preventative, health-promoting treatment.

4.2.4 Primary Care Premises

There are 12 GP Practices in Midlothian operating from 10 premises. A number of these premises are good quality and modern, the latest being the new Dalkeith Health Centre.

A number of GP practices in Midlothian have, or are likely, to outgrow the capacity of their premises and plans are being developed to address the main pressure points.

As part of the move to strengthen and expand Health Centre facilities in Loanhead and Gorebridge, consideration is also being given as to how to design improved arrangements for access to appropriate care.

Further developments to support improvements and capacity will be brought forward for consideration by NHS Lothian in relation to Penicuik, Danderhall and Newbattle.

The direction of travel in Midlothian, supported by General Practice, is to extend existing capacity to manage increased demand rather than introduce a new Practice to the area.

This position will remain under continual review with the Midlothian population set to grow by 5.5% between 2010/20, alongside the added pressure brought about by the continuing trend of treating more people at home rather than in hospital.

4.3 DELIVERY OF PRIMARY CARE

4.3.1 Better use of the wider Primary Care Team

Local opticians provide open access to expert care for eye problems.

District nurses and practice nurses are skilled practitioners who can diagnose and treat many conditions without the need for a GP's advice.

For muscular and skeletal conditions physiotherapy services can be accessed directly by patients via the MATS (Muscular-Skeletal Advice and Triage Service) advice line which is open every afternoon.

Dentists provide expert oral care advice, and NHS and private podiatrists provide a range of treatments for lower limb problems.

There is considerable potential to maximise the resource of Community Pharmacists in line with the national strategy: Prescribing for Excellence. This includes addressing minor illnesses, smoking cessation and pharmacy

provision of a chronic medication service for those with long term conditions.

There is considerable scope to do more in ensuring the public are better informed and have clearer pathways about when to go to a member of the wider primary care team. This will include improving the provision of information through local and national websites.

4.3.2 Improved Access

There are a range of options to be explored to improve patients' access to health services.

Local GP Practices have been testing telephone triage as way of speeding up access to health advice. Triage can take the form of a GP, nurse or receptionist helping to guide patients to the most appropriate resource.

It is increasingly possible to undertake various investigations in health centres rather than in hospital; in Midlothian *coagucheck* – a ' near patient' blood test - is provided by GPs and is considerably more convenient for patients to use than the system currently used elsewhere in Lothian.

Other tests could be provided but resources will need to be transferred from hospital settings although there are plans to restart ambulatory blood pressure monitoring, initially in West Midlothian via the Penicuik GP Practice.

Similarly, more minor injuries could be dealt with in the community rather than in hospital if GPs and Community Nurses were better resourced.

We will consider a satellite nurse practitioner from Accident & Emergency at the Royal Infirmary being based in Midlothian Community Hospital.

4.4 SKILL MIX

Advanced Nurse Practitioners (ANPs)

There is considerable scope for strengthening Health Centres and Specialist Teams such as MERRIT by recruiting ANPs. This will also have the benefit of supporting a reduction in GP workload.

Whilst the direction, implementation and management of this approach needs to be undertaken at a local level, there is support for this being progressed initially on a Lothian-wide basis.

Health Centre-based Pharmacists

Pharmacists employed directly by NHS Lothian and directed by the Prescribing Adviser could undertake medicine reconciliation and other prescribing projects. This includes repeat prescriptions which constitute a high proportion of the total prescribing budget of £14.4m per annum.

This would reduce GP workload, improve patient safety and assist practices, which will drive cost savings.

Work is underway on a pan-Lothian basis to review funding for polypharmacy reviews with GPs.

Health Care Assistants

An expansion of this workforce could support GP and District Nurse workloads.

Training is available through a variety of sources and modern apprenticeships may provide a source of funding. Ensuring appropriate clinical governance will be vital.

Scottish Ambulance Service (SAS)

The service is committed to becoming more directly involved with local services and utilising the skills of paramedics when they have down time. Joint work is already in place in relation to falls and responding to call outs for patients with dementia.

There is the potential for the service to provide more direct treatment rather than transport patients to hospital and thereby avoiding admission. SAS are also prepared to work proactively in areas such as anticipatory care planning.

4.5 HEALTH AND WELLBEING

People who have long-term conditions account for 80% of GP appointments. It is vital that we develop other ways of supporting people to manage their own conditions more effectively through staff who can spend more time with patients and signpost them to relevant support and specialist advice.

The *House of Care* approach will be piloted in two health centres focusing upon people with long term health conditions generally (section 6.3.).

In relation to people with cancer, Midlothian is participating in the national 'Transforming Care after Treatment' programme (section 6.3).

Providing quick access to Psychological Therapies remains challenging in Midlothian (see section 8.2). However, there are opportunities to improve access to community based services for people with "common" mental health problems who do not require psychiatric support. A new approach is being developed to provide a single point of contact in health centres or other suitable venues, to signpost people to relevant services.

4.6 PRESCRIBING

Within Midlothian, pharmacies are located in the areas of greater population density. Medication is vital in helping people recover and keeping people well. However the costs are high; almost £15m of the total £45m budget for NHS Services in Midlothian is spent on prescribing.

Considerable effort is being made to reduce these costs safely whilst developing alternatives such as "healthy reading" and exercise referral schemes.

The new community pharmacy contract aims to use the skills and knowledge of pharmacists better. This will ensure that all patients have access to support in the management of their medicines as well as providing a minor ailment service for advice on such conditions as hay fever, athlete's foot and cold sores.

4.7 DENTISTRY

There is good access to an NHS dentist for people living in Midlothian with 81% of adults registered with a dentist (83% in Scotland, March 2014).

There is a dental strategy for Lothian but it is out of date and a new one will be developed during 2015.

Older people (and children under 3) are less likely to see a dentist in Midlothian compared with other areas in Scotland.

The objective is to increase the registration rates for older people and for people who are housebound or living in a care home.

4.8 OPHTHALMOLOGY

A Lothian Eye Health Network is being established in 2015/16.

This network is a system of collaboration between GPs and optometrists to have patients with eye problems assessed in the community and when necessary, to utilise the new optometry referral pathways to allow effective triage by ophthalmology services.

This collaborative network may encourage individuals with eye problems to approach optometrists as a first point of contact rather than GPs.

4.9 CONTINENCE SERVICE

The main objectives of the report, *Promoting Continence in Lothian*, are being implemented in Midlothian.

These include the Continence Promotion Pathway and the Adult Urinary Continence Protocol that are intended to improve support to people in their own homes and to care home residents.

The option of providing a continence clinic in Midlothian will be assessed.

The Continence Service will be launching a "Urinary Catheter Patient Passport" which allows patients and/or carer to be more informed and able to manage their catheter.

4.10 OUT OF HOURS

The role of Lothian Unscheduled Care Service (LUCS) is to provide urgent primary medical care services across Lothian from 6 pm to 8 am Monday to Thursday, and from 6pm Friday to 8am Monday as well as on Public Holidays.

All requests for healthcare from members of the public come to LUCS hub via NHS 24, who handle external calls. Following triage, they then pass to LUCS the calls assessed as needing the advice of a Doctor, a home visit or to be seen at a Primary Care Emergency Centre (PCEC).

The service was the subject of a review during 2014 but in light of public comments and an impending national review, no major changes were made.

We will await the outcome of the national review before determining the best way forward in collaboration with the other Lothian IJBs.

4.11 SEXUAL HEALTH and BLOOD BORNE VIRUSES (BBVs)

There is an increased focus on reducing teenage pregnancy as well as unintended pregnancies for those over 20 years of age; increasing uptake of LARC (long-acting reversible contraception); and increasing access to early abortion services.

There is also a commitment to:

- reducing infection and transmission of sexually transmitted infection and BBVs (primarily HIV and Hepatitis B and C)
- improving gender reassignment services
- improving sexual health and relationship education in schools and community settings

This will involve work with:

- children and young people
- men who have sex with men
- women and men involved in the sex industry
- people who use drugs
- people with a diagnosis of HIV and Hepatitis C
- men and women who could benefit from other sexual health services

Work will continue to improve access to services, in both primary care and specialist services. However there will also be an increased focus on self management. Specialist sexual health and BBV services are delivered by staff from Chalmers Clinic and clinics in Midlothian.

Patients will continue to be redirected to general practice where appropriate and information and advice will be made available on Lothian Sexual and Reproductive Health websites. The Lothian Sexual Health Strategic Programme Board will direct this work.

They will also continue to pursue an integrated approach with other service areas in order to maximise opportunities for long term positive sexual health outcomes for priority groups.

4.12 HEALTH VISITORS AND SCHOOL NURSES

Whilst the strategic planning responsibility for health visiting and school nurses is a delegated function of the Integrated Joint Board, we also recognise the established strong partnership working within Children's Services across Midlothian and the existing alignment to the Integrated Children's Services Plan, which reports through the GIRFEMC (Getting it Right for Every Midlothian Child) Board.

It is proposed that this arrangement will continue and the IJB will support and endorse the Integrated Children's Services Plan when it is refreshed in 2016. This will ensure that Health Visiting and School Nursing are firmly embedded within the strategic planning processes within

Midlothian, whilst also providing assurance in terms of governance and accountability. The current Integrated Children's Services Plan can be accessed here.

There are significant challenges currently facing Health Visiting in Midlothian in relation to recruitment and retention of staff and to the introduction of the Named Person and other aspects of the Children & Young People's Act. Whilst these are being managed operationally, both within Midlothian and across NHS Lothian, these will potentially impact on service ability to deliver against strategic outcomes.

SERVICE REDESIGN AND INVESTMENTS IN PRIMARY CARE INCLUDE:

- Capital Investment by NHSL of between £40,000 and £100,000 to upgrade local Health Centre provision And in 2017-18, in the region of £3.5m for new Health Centre facilities in Loanhead
- NHS Lothian-wide Primary Care developments including Phlebotomy, Diabetes, improving Access, Training for Advance Nurse Practitioners (Midlothian share approx. £100,000)
- Provision of Health and Wellbeing advice in Health Centres £50,000 ICF
- Appointment of Pharmacist to support GPs £50,000 ICF
- Medication Management - Home Care £5,000 ICF
- Medication Management Advice to MERRIT & Intermediate Care Services £19,000 (ICF)
- GPs home based blood pressure monitoring - £10,000 (ICF)
- Extended COPD Screening in Primary Care £15,000 ICF

5. MAKING BETTER USE OF OUR HOSPITALS

5.1 NEEDS ASSESSMENT

The capacity of acute hospitals to deliver high quality, targeted and timely services depends upon community services being able to prevent inappropriate or avoidable admissions and ensuring the fastest possible discharge.

Likewise the effectiveness of community services depends upon good quality and timely information from hospital staff.

Any impediment to smooth working of the hospital has a direct impact on people from Midlothian who require acute hospital care.

Midlothian Partnership has a shared interest with the acute sector in maximising the efficiency of the hospital systems. In particular, we recognise that delayed discharge, even for a day, is in no-one's interests and that while Midlothian has consistently met national discharge target in recent years, we should be working towards the complete elimination of delays in hospital.

Furthermore we are also keen to ensure there are a range of interventions which avoid unplanned admissions and A&E attendances.

THERE ARE THREE MAIN STRANDS TO THE WORK BEING DELIVERED WITHIN MIDLOTHIAN:

- Admission Prevention
- Facilitating Early Discharge
- Intermediate Care

We recognise that there is no silver bullet to solving the challenge of reducing unscheduled care but rather a range of evidence-based interventions that have a cumulative effect of ensuring people can be cared for in their own home or community setting.

In seeking to change the model and balance of care, we must develop a more sophisticated understanding of how the Midlothian population is using acute hospitals. This will help determine what services to put in place to provide safe and effective alternatives.

We welcome the planned introduction of the 72 hours target for delayed discharge from 2018. We recognise that we must review all the approaches and processes associated with our relevant community based services.

We are being supported by Scottish Government, which has initiated a national programme of work to reduce reliance on hospital beds.

Our performance in relation to repeat emergency admissions, whilst improving, remains relatively poor. We are taking further action to reduce unnecessary admissions including more intermediate care beds.

The local rapid response service – *MERRIT* - now incorporates a *Hospital at Home Service* which in 2014/15 responded to 178 referrals, 74% of which were for people over 75.

The service has recently extended its hours to evenings and weekends and we will assess the need for an overnight social care service.

5.2 ACUTE HOSPITALS

Discharge Hub

The development of the Discharge Hub within the acute services has created an opportunity to establish a single point of contact between the Hub and Midlothian social care services.

All discharge-related enquiries from the Hub for Midlothian residents will be channelled through a single number and triaged to the relevant local service. This will ensure appropriate referrals and increased knowledge of support services available locally, as well as making it easier for the Hub to arrange discharges of patients from acute settings.

To support improved discharge arrangements there is an undertaking to explore methods of improving liaison between hospital consultants and GPs. This will include work shadowing,

attendance by consultants at local Professional Forums and an evaluation of the potential benefits of teleconferencing, used successfully in other parts of the country such as the Western Isles.

In-Reach

The In-Reach Service has been very successful in enabling Midlothian to consistently meet delayed discharge targets. With the move towards avoiding delays beyond 72 hours this service will be further strengthened.

There are plans to support the hospital In-Reach team through an additional community care assistant to ensure more timely discharge from hospital.

Given the high proportion of bed days lost as a result of "Health" related delays, we will pilot the presence of a District Nurse in the In Reach Team to help 'pull out' patients for whom there is judged to be sufficient health practitioner capacity in the community to enable safe, early discharge.

Finally the involvement of unpaid carers in the discharge arrangements is critical. The Carers In-Reach Worker piloted in recent years will be continued and we will work with hospital staff to overcome confidentiality issues to ensure carers are able to support their relative effectively upon discharge. If hospital discharge is well-planned and the right services put in place then there is a much greater likelihood of the cared-for person remaining at home with carer support.

Discharge to Assess Model

Midlothian Partnership has committed to explore the impact on both the hospital system, and on the wellbeing of patients and their carers, of adopting an approach which assesses people's needs following discharge rather than undertake this process in an acute hospital setting.

Initially the project focused on unscheduled orthopaedic admissions particularly amongst the frail elderly population and supporting the discharge of patients with COPD (chronic airways disease) from Liberton Hospital.

It has now been extended to include all unscheduled acute admissions to RIE and Liberton Hospital including general medicine, medicine of the elderly and stroke.

Current capacity is limited to weekdays and is dependent on available packages of care. If, however, this approach proves successful then therapies such as occupational therapy, physiotherapy and speech and language therapy will need to be enhanced.

Discharge arrangements for Patients with Complex Needs

There is a particular concern that patients with complex needs, particularly those with dementia, are vulnerable to longer length of stays in hospital.

This sometimes arises as a result of legal proceedings being taken by families to obtain Guardianship.

A review of the legal position is being pursued to reduce potentially unhelpful delays in hospital for people living with dementia.

We will also promote a campaign to encourage more people to arrange Power of Attorney at an earlier stage - an approach that has met with success in other parts of the country.

Liberton Hospital

Liberton currently provides approximately 33 post-acute beds primarily for Older People from Midlothian.

This service will transfer to the local Community Hospital and to enhanced community based rehabilitation services. This, however, depends upon East Lothian hospital bed capacity increasing enabling East Lothian patients to move from Midlothian Community Hospital.

Reablement

Discharge to community settings is dependent on the capacity of the Reablement Service to respond very quickly to referrals.

To ensure we can meet the two week target and work towards the new 72 hour for delayed discharge, we will increase the capacity of this service.

5.3. MIDLOTHIAN COMMUNITY HOSPITAL (MCH)

Out-patient clinics

There is physical space to hold outpatient clinics in MCH rather than people undertaking journeys to one of the Edinburgh hospitals.

For some conditions this will not be possible because of the need for specialist professionals or equipment.

Work is underway with the NHS Lothian Out-Patient Board to determine which services could be provided in this way without incurring significant additional costs. There may be a need to strengthen transport systems within Midlothian to ensure good access to MCH.

We have seen the benefit of extending provision of X-Rays in MCH and there have been active discussions about the feasibility of providing local audiology clinics given the difficulties associated with attending the clinic in the centre of Edinburgh. (Clinics in Midlothian)

Continuing Care

Over the past 10-15 years there has been a move away from providing long-term care in hospital settings. People who need long-term 24 hour care should have this provided in a homely setting.

We will continue to try to reduce the length of time people spend in hospital including those with terminal illness, seeking wherever possible to enable people to die at home.

We have seen the length of stay in our wards reduce in recent months as patients are admitted nearer the end of their life.

Our wards continue to have a reputation for excellent palliative and end of life care provision.

Through continued training and education of our staff we will continue to make admission to our wards a positive experience and treat our patients with dignity and respect.

Rehabilitation

Additional capacity will be available in MCH when developments in East Lothian allow in the region of 24 patients to return to their home area.

This provides an opportunity to establish post-acute rehabilitation services for older people in MCH rather than in Liberton Hospital, which will improve links with local health and care services and support a successful return home.

Day Hospital Services

A review of this service has been undertaken and to ensure high quality, safe services, the numbers of people attending each day will be reduced.

This will be managed in conjunction with the Day Services Review to ensure that people whose primary needs are social rather than medical are able to access appropriate services.

INVESTMENTS TO REDUCE PRESSURES ON THE HOSPITAL SYSTEM INCLUDE:

- Extension of Hospital In-Reach, Increased Intermediate Care Beds, Assisted Discharge and Single Point of Contact Total £432,000 Delayed Discharge Monies
- Transfer of Inpatient Provision (20 beds) from Liberton Hospital to Community Hospital
- Transfer of resources from Liberton Hospital to support 15 patients at home
- Further expansion of Reablement Service £164,000 Delayed Discharge Fund
- Hospital to Home Reablement service £100k in 2015/16 from ICF (full year £164,000)
- Discharge to Assess Model £41,000 Delayed Discharge Fund
- Overnight Care – Subject to option appraisal £46,000 Delayed Discharge Fund
- Volunteer Service –support following discharge £60,000 ICF

6. SUPPORTING PEOPLE WITH LONG TERM HEALTH CONDITIONS

6.1 NEEDS ASSESSMENT

Managing long-term conditions is one of the biggest challenges facing health care services worldwide, with 60% of all deaths attributable to them.

Midlothian has a higher occurrence than nationally of cancer, diabetes, depression, hypertension and asthma. Older people are more susceptible to developing long-

term conditions; most over 65s have two or more conditions and most over 75s have three or more conditions. (This is referred to as 'multiple morbidity').

People living in areas of multiple deprivation are at particular risk with, for example, a much greater likelihood of early death from heart failure. They are also likely to develop two or more conditions 10-15 years earlier than people living in affluent areas.

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

6.2 LIVING WITH A LONG TERM CONDITION

6.2.1 Work with whole person (*Hannah)* and House of Care

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

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

6.2.2 Self Management and Quality of Life

Increased priority has been given to supporting and enabling people to manage their own conditions such as Multiple Sclerosis, Parkinson's disease and COPD- diseases of the lung - which are particularly common given Midlothian's history of mining.

Self-management is not just managing the condition itself but also how it influences the person's lifestyle. This includes:

- activities such as employment, leisure and social contacts
- being able to adjust to the emotional impact - being told you have a condition there may be no cure for can be devastating both for the person and their families

Building on previous work undertaken around stroke pathway, we will seek to develop support through specialist occupational therapists, other AHPs and the Third Sector

The importance of maintaining a healthy lifestyle is particularly important and services such *Midlothian Active Choices* will be extended to support people to eat well, stay active and take suitable exercise

6.2.3 Rehabilitation- Under 65s

Early access to rehabilitation is vital for conditions such as stroke, as is the ongoing support to maximise the potential for recovery.

We need to ensure that intensive rehabilitation is available to people under 65. The option of providing this service in Highbank care facility will be considered during 2015-16.

Sustaining and enhancing current service provision delivered by the Midlothian Community Physical Rehab Team (MCPRT) will also be important

6.2.4 Multi-morbidity

As people age they are more likely to have a long term condition; people over 75 are likely to have three or more conditions while people living in areas of deprivation will be at risk of developing long term conditions at a much earlier age.

It is therefore important that services learn to support the person and their carers rather than just treating the condition and doing this places particular responsibility upon hospital staff to ensure coordinated treatment and support.

A range of developments are planned through the Integrated Care Fund (£1.44m) which, although not specific to people with long term conditions, will enhance local service responses. These include rehabilitation, in-reach, intermediate care and services designed to prevent isolation.

SPECIFIC INVESTMENTS INCLUDE:

- Health and Wellbeing Practitioners- £80,000 ICF and Scottish Govt funding
- Specialist Occupational Therapists £75,000 ICF
- Public Health Practitioner £45,000 ICF
- *Midlothian Active Choices* £40,000 ICF

6.3. SUPPORTING PEOPLE WITH PARTICULAR CONDITIONS

6.3.1 Diabetes

An increasing concern for local health services is the rising number of people living with diabetes.

In part, the higher numbers of people with diabetes is due to better survival; in part it is because diabetes is more common with age and our population is living longer.

We may also be detecting diabetes earlier than in the past. It is estimated that 3533 people live with the condition in Midlothian; the majority are over 60 and there is a higher rate in areas of multiple deprivation.

We need to work harder to help all people with diabetes stay healthy and in particular, reduce the number of people with 'type 1' whose diabetes is poorly controlled.

There are two broad types of diabetes, 'type 1' affects younger people and they are treated with insulin injections to control their symptoms. Type 2 affects slightly older people and is often, although not always, associated with being overweight or obese.

We will continue with work to implement the national Diabetes Action Plan including supporting self-management. We will also invest in the provision of more weight management courses through our Dietetics Service.

INVESTMENTS INCLUDE a specific project to address Weight Management £25,000 ICF.

6.3.2 Cancer

People are increasingly surviving for longer following treatment for cancer.

At this present time there are in the region of 2140 people in Midlothian who have had cancer.

Services have focused upon treatment mainly at the Western General, with active follow up and support through Primary Care. Marie Curie staff and the local Community Nursing Service provide care and support for people who are terminally ill.

The Partnership has been successful in its application to participate in the Macmillan Cancer Support 'Transforming Care after Treatment' programme to test a new and transformative approach to service delivery.

This programme aims to ensure people who are diagnosed with cancer are prepared for and supported to live with the consequences of the diagnosis and its treatment.

The primary aim is to enable people to access services through effective signposting and good information. This will be achieved by a process called a "holistic needs assessment", designed to identify which aspects of life people need assistance with following treatment. These assessments will be conducted both in the community and by staff in the Western General Hospital.

We will also increase access to physical exercise, healthy eating advice, social activity, as well as supporting people to manage their lives more effectively through lifestyle management courses, employment and benefits advice.

INVESTMENTS IN THIS AREA INCLUDE

£50,000 per annum 2015/17 to develop local services *Transforming Care after Treatment* and continued funding for the Macmillan Income Maximisation Officer post.

6.3.3 Stroke

The numbers of stroke patients discharged to their own homes in Midlothian (i.e. not into care homes) is around 90 per annum.

There are established pathways and collaborative services available to support early discharge and community rehabilitation.

Work is ongoing to ensure adequate intensity of rehabilitation for stroke survivors in the Midlothian community and services are constantly evolving to meet the demands of this population.

The ongoing collaboration of the rehabilitation (MCPRT) and rapid response

services (MERRIT) working with third sector partner organisations is providing this local rehabilitation pathway.

Stroke-trained exercise professionals currently provide a pathway into exercise after stroke in Midlothian, delivered in a number of Leisure Centres.

Vocational rehabilitation and self management can be delivered locally. Specialist services required by some people living with stroke in Midlothian can be accessed in the City of Edinburgh such as psychology, specialist outpatient rehabilitation for younger stroke patients, postural management, orthotics and driving assessment.

It is important that patients have access to stroke specialists at an appropriate intensity and duration based on the needs of the individual in hospital. However there is scope to move people sooner from acute hospital settings and provide rehabilitation nearer home. We will examine the potential for doing so in both Midlothian Community Hospital and Highbank Care Facility as well as promoting a "discharge to assess" model.

The creation of the new 44 bedded Integrated Stroke Unit at Royal Infirmary is based on the assumption that the length of stay there will be 12/14 days so the development of stronger community based services will be vital.

6.3.4 Heart Disease

The Scottish Government and National Advisory Committee Heart Disease (NACHD) published a Heart Disease Improvement Plan in 2014 setting out the nationally agreed priorities to improve Heart Disease Services for health and social care.

The Plan identifies six priority areas for improvement including prevention, rehabilitation and addressing the mental health needs of people affected by heart disease.

The Heart Disease Strategy Programme Board in NHS Lothian is leading on the implementation of this plan and we will work with this Board to strengthen our approach to heart disease locally.

6.3.5 Chronic Obstructive Airways Disease

The Pulmonary Rehabilitation (PR) Programme is a Lothian wide physiotherapy-led service. It is available for anyone with chronic lung disease and provides an exercise based programme with a large educational and self management component within the community.

This expanding service has built on success within Midlothian and has recently been streamlined and strengthened with additional staffing, and a corresponding reduction in waiting times. It is also looking to increase the number of venues across Midlothian to increase availability.

The original service set up across East and Midlothian, led on remote telehealthcare provision to offer increased access, availability and uptake especially for those in rural and remote areas.

This service has been expanded and now provides additional occupational therapy, nutritional screening and first line nutritional support.

Overall the PR service has a robust evidence base in its contribution to acute admission avoidance.

Acute and crises support in the community continues to be strengthened by Rapid Response and the developing Hospital at Home team (MERRIT).

6.3.6 Neurological Conditions (including Epilepsy, Parkinson's Disease and Multiple Sclerosis)

The Neurological Care Improvement Plan 2014-17 was recently published to improve care and outcomes for people with a neurological condition, often described 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'.

Services need to be more joined and pathways strengthened.

Having a neurological condition is the most likely reason for experiencing complex and physical disability for people aged under 65.

A newly formed Lothian Neurological Leadership Group is focusing on improving neurological care and outcomes from acute to rehabilitation and longer term management. Initial work will focus on the pathway for people with headache / migraine and on strengthening self management approaches.

A project providing specialist rehabilitation services for people with Myalgic Encephalomyelitis and Chronic Fatigue Syndrome has been piloted over the past two years across Lothian.

Government funding comes to an end in March 2016 and consideration will need to be given to the lessons learned and implications for future service delivery in Midlothian.

As well as the Lothian wide services that are based at WGH, RIE (Integrated Stroke Services) and rehabilitation at Astley Ainslie Hospital, our local MERRIT service will respond to urgent / acute aspects of assessment and intensive rehabilitation in the community for people with a neurological condition.

For those individuals requiring longer term community rehabilitation (and possibly supported self management) there is provision by Midlothian Community Physical Rehab Team (MCPRT), consisting of occupational therapy, physiotherapy and speech and language therapy input.

Locally work is currently being undertaken to build on the progress made on the Early Supported Discharge pathway. This was for people following stroke within Midlothian and for those with other

neurological conditions, for example multiple sclerosis, Parkinson's disease, epilepsy and motor neurone disease.

6.4 PALLIATIVE CARE

High quality palliative care is central to all our services and we strive to achieve a person-centred approach to care, up to and including care at end of life.

Primary Care services focus on early identification of the need for palliative care, which will ensure that people receive a gradual, holistic, anticipatory approach to their care needs.

This is particularly important for the increasing population who also live with dementia, which can make diagnosis more challenging. We are working to ensure early identification of the deteriorating patient in all settings.

We are encouraging early conversations to establish people's wishes and choices in relation to care at the end of their life, including place of death. Services are changing to ensure care is given according to need and not diagnosis.

With many more people living with multiple long term conditions, often non-cancer related, it is important our staff recognise the course of dying and can respond appropriately.

We are working to ensure an engaged workforce with the necessary skills to create positive experiences for their patients and their families.

For the more complex cases, support is available from specialist palliative care services provided by Marie Curie.

New guidelines and standards are being developed both locally and nationally, and are being implemented across all settings in Lothian.

Specialist services are being redesigned and recognising the changing needs of our care home population, there is a focus on support to care homes to improve standards.

Social care staff have an important role to play. Increased attention is required to ensure that they receive appropriate training from health staff and specialist services – principally Marie Curie and Macmillan.

This has been a particular priority for care home staff and care homes in Midlothian, which are considered to be providing high quality palliative care. This is being supported by our Care Home Nurse Advisor.

One of the key measures of success is the proportion of people who are supported to die at home or in a care home rather than in a hospital setting. In Midlothian this figure is calculated to be 92.6% which shows a small increase since 2008 and is above the national average.

In real terms this does represent progress, as the numbers of people surviving for longer with conditions, such as cancer, increase. It is important to recognise that for some people, a transfer to hospice or

hospital for end of life care may be appropriate.

This makes it difficult to quantify the scope for further progress and also highlights the importance of measuring place of care in addition to place of death.

There is a concern amongst practitioners that it is important to mirror the very high quality standards provided for people with cancer, with those for people who have non-cancer conditions. We would hope to see a more balanced approach as we move forward.

Where hospital care is required Midlothian Community Hospital has had an increasingly important role to play in providing a high quality local service, enabling families and friends to maintain regular contact.

Our wards and staff already have a reputation for providing high standards of care, particularly for those nearing the end of their life.

We will continue to ensure our staff, and the facility they work in, provide the highest standards of care to our population.

The strengthening of the Rapid Response Service and the establishment of the 'hospital at home' service (MERRIT) has increased our capacity to avoid hospital admissions for people receiving palliative care at home as they work closely with our GPs and community nursing staff.

We must continue to improve standards and provide the best quality care in all settings; ensuring people are cared for in the right setting and receive the support they require. In this regard, we will take steps to establish a local palliative care steering group to oversee the quality of service delivery, provision of training and monitoring of outcomes for users and families.

We will also work with the local population to facilitate a change in attitudes to death, dying and bereavement and through this ensure conversations are had when appropriate and any health inequalities relating to end of life care are addressed.

7. ADDRESSING THE NEEDS OF PEOPLE WITH LIFE - LONG DISABILITIES

Closely linked to long term conditions is the prevalence of disability.

People who have developed particular conditions such as stroke may be disabled as a result, while people with learning disabilities are more likely to have other conditions such as diabetes or epilepsy.

The common theme in this section is a consideration of how the Partnership can take steps to deliver services that promote *Independent Living* as a basic human right.

7.1 PHYSICAL DISABILITIES

7.1.1 Needs assessment and national policy

The focus in this section of the Plan is on removing barriers to a normal life. 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*.

The most recent estimates suggest there are approximately 3900 people between the ages of 16-64 in Midlothian who have a significant physical impairment. This includes those born with impairment, those who have been disabled through injury and those whose disability has developed as a result of an illness.

Prevalence studies indicate that 1200 of these will be wheelchair users in Midlothian.

Unlike other areas of health and social care there is no national policy driving improvements for service users; in Midlothian this gap has been increasingly filled by service users working co-productively with public services.

7.1.2 Health Inequalities

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

There is the added link to health inequalities in that people experiencing social deprivation are more likely to become disabled for example through accidents, intentional injury and coronary vascular disease.

A proactive approach to addressing inequalities is needed, building on the successful work undertaken locally in the field of learning disability. This will be considered through the Joint Physical Disability Planning Group

7.1.3 Inclusion

The primary concern of local people with disabilities has been the need for improvements in access to mainstream services including suitable housing, transport, employment and physical access to buildings.

Ensuring housing is suitable, including through adaptations and providing equipment to support independent living, can make a huge difference to people's ability to manage independently. Leisure activity and social contact are also very important.

The Local Area Coordination services provided by Enable Volunteer Midlothian and the Red Cross support people to access and develop such opportunities.

Welfare Reform has been a major worry for people with disabilities and both the Voluntary Sector and Midlothian Council have sought to provide support and advice to mitigate the impact of these reforms on local people.

Access remains a problem in relation to transport (section 1.4.3), public buildings and the built environment. *Midlothian Access Panel* continues to have a key role to play in improving physical accessibility but there remains a need to develop more comprehensive information about accessibility.

Employment has been an area in which very limited progress has been made. There is now a commitment to key agencies coming together to develop an improvement plan and this will hopefully include amongst others Job Centre Plus, Business Gateways, the Council and FE Colleges .

7.1.4 Information and Support

The local User Group, *Forward Mid*, has been proactive in compiling a service directory, newsletters and its own website to provide information on useful services and accessibility.

Work has also been taken forward through Council libraries to disseminate information to people with disabilities.

Progress has also been made in promoting peer support as an effective way of sharing information as well as providing credible psychological support.

7.1.5 Self-Directed Support

Promoting independent living involves supporting disabled people to have the same freedom, choice dignity and control as other citizens in all aspects of life.

Increasing opportunities for people to be in control of their lives has been strengthened through the implementation of new legislation.

People with disabilities have traditionally been the main users of Direct Payments and are actively involved in the implementation of Self-Directed Support (SDS see section 1.6.4). For some people SDS provides a very important means of maintaining control over their day to day lives.

We are at an early stage of this new way of working and there will be a continued programme of work to ensure that self directed support is easily accessed and managed for those who wish to do so.

IMPROVEMENTS TO SERVICES INCLUDE INVESTMENTS AND SERVICE REDESIGN:

- With integration there is an opportunity to streamline access to Occupational Therapy in all areas and this work is underway to reduce duplication especially at transition points on an individual's journey
- The work planned in relation to people with Long Term Conditions through the *House of Care* pilots in Primary Care will be of direct benefit to some people with disabilities

INVESTMENTS INCLUDE a £40,000 Integrated Care Fund and £40,000 NHS Lothian.

Highbank Care Home is increasingly providing short term care for assessment and rehabilitation purposes.

Whilst this is primarily for older people, work will be undertaken to scope out the need to adapt the facility to meet the needs of younger people with disabilities or complex health needs.

We need to continue to find ways of improving access to buildings and services including seeking to strengthen the role and influence of the Access Panel.

7.2 SENSORY IMPAIRMENT

7.2.1 Needs Assessment and national policy

See Hear, the national strategy developed to address sight and hearing impairment, was published in 2014. This requires all Partnerships to produce and implement a local action plan.

Nationally it is estimated that 1 in 6 of the population have a hearing loss; in Midlothian the 2011 census revealed that 5656 were aware of experiencing some hearing impairment.

Significant sight loss is estimated to affect 1 in 30 of the population; in Midlothian through the Census, 1913 reported having such impairment.

7.2.2 Communication support

The ability to communicate effectively is a major factor in people being able to live independently and feel included.

New legislation is being drafted to increase access to British Sign Language services.

Technology offers new opportunities to access support; for instance teleconferencing is now being made available to enable people access to sign language.

Improving access to communication supports will require work across all agencies, public and private, in Midlothian. This will include working with NHS Lothian Audiology to provide more services locally where possible; an example during 2014 was the provision of replacement hearing aid batteries through local libraries rather than having to travel into Edinburgh.

The possibility of providing services such as testing or hearing aid repairs services will be considered as part of the review of the Community Hospital.

7.2.3 Early diagnosis

There is a need to improve diagnosis; for instance it is estimated that 50% of sight loss is preventable or treatable - eye tests are free and readily accessible.

Deteriorating sight amongst older people can result in injury from falls.

Deteriorating hearing can make social interaction more difficult and increase isolation and yet people delay addressing the problem for many years.

We need to increase awareness amongst all staff in health and care to be alert to possible sight or hearing loss and where appropriate undertake sensory checks for people most at risk.

Older people are most vulnerable and sensory impairment can remain hidden for people who have had a stroke, live with dementia or have learning disabilities, and as a result, more likely to have some degree of sight or hearing loss.

We must also raise awareness of the benefits of referral to specialist agencies, and in the case of sight loss, of registration.

In addition, early diagnosis can help contribute towards prevention of falls and injury. Sensory Impairment Champions have been trained to support local training and improve awareness within their services.

INVESTMENTS TO ADDRESS SENSORY IMPAIRMENT INCLUDE A £15,000 *See Hear* monies for the Development and implementation of a local improvement plan.

7. 3. LEARNING DISABILITIES

7.3.1 Needs Assessment and national policy

The development of services has been driven by the national strategy '*The Same as You?'* and its focus on ensuring services are as inclusive and community-based as possible.

The new national strategy 2013 Keys to Life, places an emphasis on human rights, tackling health inequality, and living an ordinary life with Individualised local solutions for people.

It is estimated that there are 1695 People with a Learning Disability in Midlothian, 620 of who received a service from Midlothian Council Health and Social Care over the past three years. 40 to 50 of these people have very Complex Care Needs.

The occurrence rate using the latter figure is 8.7 per 1000, where the Scottish Average is 5.9.

One of the contributing factors to the higher figure in Midlothian is likely to have been the presence of a large learning disability hospital, St Joseph's, which closed in the late 1990s when residents moved to houses located across the county.

In addition to an expected average annual growth in numbers of people with a learning disability of 3.2%, there is a need for change driven by a combination of constrained resources, increasing demand and changing expectations.

The growth in the number of people with a Learning Disability known to Midlothian Council from 2012 to 2013 alone was 565 to 596 or 5.5%.

7.3.2 Health inequality

Reducing the stark health inequalities faced by people with a learning disability is a key priority.

Initiatives have included better ways of combating hate crime and helping people to safely manage social media and the use of the internet.

Work has been successfully undertaken in areas such as sexual health, supporting people to maintain a healthy weight and to access dentistry.

Focused attention is now being given to hidden sight and hearing impairment. Two trained sensory impairment champions are based in local learning disability services.

7.3.3 Accommodation

Many people, who previously would have lived in hospital or residential care, now live successfully in supported accommodation on their own or in small groups. However, for a few people this model of care has proven very expensive. It is estimated that the cost of care for 37 individuals is in the region of £5 million per year.

Approximately 40 people in Midlothian have particularly complex needs and building has started on a 12 person unit in Penicuik. This will provide local facilities and will enable people to retain their family links whilst reducing the cost of specialist provision from elsewhere in the country.

This service will also develop local expertise and best practice in supporting people with complex needs using approaches such as Positive Behavioural Support.

Alongside this there is a need to provide more suitable accommodation for those with lower levels of need. Proposals are being developed in collaboration with housing providers.

7.3.4 Older People

There is significant growth in the number of older people with a Learning Disability as better health care has helped increase life expectancy.

Very recently, funding has been obtained to encourage older people with a learning disability to be more physically active.

People with learning disabilities have an increased risk of developing dementia as they age than others and generally develop dementia at a younger age.

We need to review our services and staff training programmes to ensure that their multiple needs are being met.

7.3.5 Transition to Adulthood

More young people with complex needs are surviving into adulthood. We need to continue to strengthen the transition to adult services.

The increased emphasis over the past two years on people using local facilities with support from the Community Access Team rather than going to day centres has been very successful. This is despite supported employment opportunities continuing to be very limited given the general economic climate.

More recently steps have been taken to provide more local day activity facilities for young people rather than them having to travel to Edinburgh.

7.3.6 Respite and Short Breaks

Short Breaks provide a chance for family carers to have a break from caring and

provides an opportunity for them to meet new people and do new things. Currently Short Breaks for people with a Learning Disability could be in a Respite Unit or going to stay at another person's house.

From April 2016 we plan to offer a wider range of services with less reliance on traditional buildings based respite and more opportunity for flexible breaks.

Service Redesign

The Council's contribution to the delivery of services for people with learning disability is in excess of £11 million per annum.

In view of the overall reduction in the Council's budget, service redesign proposals are being drawn up for the delivery of supported accommodation, respite care, day services and care packages to find more efficient ways of continuing to meet people's needs. The savings target is approximately £500,000 per annum.

ALONGSIDE THIS THE FOLLOWING INVESTMENTS ARE PLANNED:

- Build programme for the new 12 person complex care unit £3million (capital)
- Redesign and integration of local health and social care staff teams with transfer of central NHSL management budget to support this change
- Additional funding to address care needs of youngsters leaving school £400,000 p.a. (2015/16)

8. PROMOTING MENTAL WELLBEING

8.1 SUPPORTING PEOPLE WITH AUTISM

8.1.1 Needs Assessment and National Policy

The Scottish Strategy for Autism was published in 2011.

Its first indicator of good practice has been the presence of local Autism Strategies, which have been developed in co-operation with people across the autism spectrum, carers, and professionals.

Midlothian published its Autism Spectrum Disorder Strategy in draft form in March 2014.

The subsequent writing of the full strategy is being facilitated by a local arts organisation in partnership with a creative writer who has family experience of Autism.

The idea is to bring together a collective authorship that harnesses the experience and knowledge of people who are close to autism as part of their everyday life.

This will be complete by autumn 2015 and will detail how we plan to improve things for people with autism, making sure that the right people and the right services are there to support them at the points in their life when they most need it.

We estimate that there are 748 people in Midlothian with some form of autism. Midlothian Community Care Services know about 62 people with autism and Midlothian Children's Services know of 226 young people.

It costs £1.5 million to look after somebody with Autism and a Learning Disability for their lifetime. A small number of people cost a lot more. It costs £900,000 for somebody with Autism and no Learning Disability.

Many adults with Asperger's syndrome do not seek social care or health service support, but have a higher likelihood of remaining unemployed, and of mental health issues.

8.1.2 Diagnosis

Timely diagnosis, accompanied by clear information and early support and intervention, has emerged as the key issue locally.

The strategy focuses on the importance of early diagnosis and personalised support for people right across the spectrum, and their families, setting out a clear pathway for them.

8.1.3 Transition from school

The Autism strategy presents an opportunity to address the needs of people with autism throughout the whole of their life. This includes:

- during those early years when parents need help and support to understand autism and to begin to prepare their child for a life of inclusion rather than segregation
- after they finish education, when entry into adult life and building independence may be challenging as a consequence of losing the structure that schools provide to parents and young people with Autism

Young people with Autism should experience a personalised and carefully planned transition from school and children's services.

8.1.4 Opportunities for people with Autism Spectrum Disorder

The local strategy details the development of a range of personalised services to support adults with autism to live independently, with a particular focus on supporting participation in meaningful activities including employment.

8.1.5 The Built Environment

A built environment is a key determinant of successful outcomes for people with autism spectrum disorder.

We are well advanced in our plans to develop and build Council tenancies specifically designed for the needs of people with Autism and Complex Care needs.

8.1.6 The Regional Autism Service

The Lothian Autism Action Group is responsible for developing a matched care model for people with autism who do not have a Learning Disability, and taking forward a plan of action to ensure that resources and services are available across

Lothian to provide care, treatment and support.

The group provides second opinion assessments, works jointly with colleagues in Midlothian to support individuals and takes referrals for complex cases while individual patients remain part of local services.

8.1.7 Implementation of local action plan

The Midlothian Autism Spectrum Disorder Strategy Group is a core group that includes representatives from Children's and Adult Services, Resource Managers, Psychology Services in schools, Regeneration and Community Planning, and partners from NHS Lothian. Its objective is to further develop and implement the Strategy for Midlothian and to oversee the action plan.

More detailed planning of services for adults who have autism in addition to a learning disability is covered in section 7.3.

INVESTMENTS IN THIS AREA INCLUDE

£35,000 to develop and implement the local action plan through commissioning a specialist local voluntary organisation to lead this area of work

8.2 PREVENTING MENTAL HEALTH PROBLEMS AND PROMOTING WELLBEING

8.2.1 Needs Assessment

Mental Health problems are very common. One in four of us will experience difficulties sometime in our lives. It is very important that we promote positive mental wellbeing.

Poor mental health is not distributed evenly across the population and there is evidence of mental health inequalities across Scotland. Health inequalities are unfair differences in the health of the population that occur across social classes or between population groups. These are largely determined by social and economic factors and the way that resources of income, power and wealth are distributed. Recent reviews have shown that the distribution of these resources has a significant impact on both physical and mental health.

Nationally it is estimated that mental health issues account for 45% of all illness. This was reinforced locally by a snapshot survey undertaken by a local GP who found that for one third of his patients' mental health was the main presenting issue and for another third, mental health issues were a significant factor.

In Midlothian 4.2% of the population have a long term mental health condition.

Developing new approaches to prevention, treatment and recovery have been outlined in national and Lothian wide strategies (Sense of Belonging) and these have helped shape our approach in Midlothian.

8.2.2 Psychiatric Support

Midlothian has seen very significant changes in the approach to treating and

supporting people with acute mental health problems.

Provision for acute inpatient services for adults was transferred from Rosslynlee Hospital to the Royal Edinburgh in 2007. Health, social work and voluntary services in the community were also strengthened.

As a result, fewer people are admitted to hospital (seventh lowest rate in Scotland) and spend less time there when admission is necessary. There has however been growing concern about the impact of new psychoactive substances (also known as Legal Highs) leading to serious mental health problems and self-harm.

More generally there is a need to strengthen joint working between mental health and substance misuse services, given the numbers of people who abuse substances and are experiencing mental health problems.

The in-patient facilities in the Royal Edinburgh Hospital are being redesigned. We will ensure that the needs of Midlothian's patients continue to be fully met in the new facilities due to open in 2016.

For older people with mental health problems, Midlothian Community Hospital provides 24 inpatient assessment beds and 24 continuing care beds.

8.2.3 Support in a Crisis

The changes referred to in paragraph 8.2.2 included the establishment of the *Joint Mental Health Team* made up of the Intensive Home Treatment Team (IHTT), the Continued Recovery Team (CRT) and the Psychological Therapies Service (PTS). It is a multi-disciplinary team employed by NHS Lothian and Midlothian Council, and works closely with voluntary organisations to support people at home rather than in a hospital setting.

The local Suicide Prevention Strategy aims to reduce the incidence of suicide through a range of approaches. These include raising staff awareness and ensuring that people who are in distress know how to access support.

We need to do more to follow up on people who self-harm, many of whom will attend A&E Departments (in 2008/09, a snap shot survey found there were 169 patients from Midlothian discharged following injury through self-harm). Work is underway to offer support more quickly.

8.2.4 Providing Alternatives to Medication

We need to reduce those factors that contribute to poor mental health (risk factors) and promote factors that enhance good mental health (protective factors).

In Midlothian, 16% of all patients are receiving medications for anxiety, depression or psychosis. While such medication is often very effective, many people would prefer to be provided with alternative forms of support.

Historically, Midlothian has not performed well in providing quick access to

psychological therapies - a national HEAT target.

A review is underway to speed up access and identify alternative forms of support for people who do require this form of intervention. This includes providing direct access to staff who can guide people to alternatives such as support groups, physical exercise programmes or healthy reading (there is a specialist Bibilotherapist based with the Midlothian library service).

Through some limited new Scottish Government funding there will be the potential to begin to develop quicker and more direct access to services. Direct access to services has been a common theme in the feedback received from the public.

For many, being able to find employment and have a decent income will have a particularly important role in enabling them to recover. Support is available through Midlothian Training Services and through a "Want to Work" programme supported by the Mental Health Team. A review of employment support is underway to consider whether the current arrangements can be strengthened further.

For others the opportunity to take on a volunteering role can be helpful in recovery and Volunteer Midlothian has a vital role to play in supporting people to access such opportunities, although care must be taken not to jeopardise entitlement to benefits and a subsequent drop in income.

People with long term health conditions are vulnerable to also experiencing poor mental health. The work planned under the *House of Care* model (section 1.2.2) will help develop responses that take account of people's emotional vulnerability when having to cope with long term health conditions.

It is also the case that people with mental health problems often have poor physical health and we must take steps to ensure they have equality of access to the appropriate health care they require.

INVESTMENTS IN MENTAL HEALTH WILL INCLUDE £30,000 through the Mental Health Innovation Fund to develop *Gateways* for mental health and wellbeing issues in Primary Care settings

8.3. ENCOURAGING AND SUPPORTING RECOVERY FROM ALCOHOL OR DRUG MISUSE

8.3.1 Needs Assessment and National Policy

The issue of substance misuse is an emotive one - there is a need to ensure that services recognise the complex causes and the very significant effect on individuals and their families.

There is a strong link between substance misuse and inequalities; some people who misuse drugs and/or alcohol can also experience significant mental health problems; and substance misuse is a common issue affecting people who come

into contact with the Criminal Justice System.

The problem:

- affects the quality of life and, eventually, the physical wellbeing of the individual
- results in family breakdown
- affects the sense of community and public safety
- leads to crime
- causes significant demands on the health system whether through accidents or long term acquired brain injury

There are approximately 570 regular drug users in Midlothian with, on average, 7 drugs-related deaths per year.

Midlothian residents accounted for 1233 discharges from hospital in 2012 following the abuse of alcohol.

1500 children are estimated to live in households in Midlothian where one or both parents have some level of problematic alcohol abuse.

An emerging issue of major concern locally and nationally is that of New Psychoactive Substances, which are difficult to control, have very serious health consequences and have led to a particular demand on mental health services.

8.3.2 Prevention

The Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) include Midlothian and East Lothian Councils, NHS Lothian, Police Scotland and the Voluntary Sector.

Together the Partnership works to raise awareness of the work to reduce the harm caused to individuals, families and communities by the misuse of alcohol and drugs.

One of its primary objectives is to shift the emphasis and the use of resources away from specialist treatment and pay more attention to prevention and early intervention.

Counselling, education, enhancement of employability skills, paid or voluntary employment and access to sport and leisure can all support people at risk of developing serious alcohol and drug abuse.

8.3.3 Focus on Recovery

Research tells us that people often make a full recovery. It may take some people years but “recovery is the norm” (Scottish Government 2010). Yet this is not always reflected in the way in which we provide services. We need to adopt a more positive and optimistic approach when working with people who have substance misuse problems.

MELDAP have established a pilot ‘Recovery College’ in Midlothian providing adult education opportunities for people to manage their own recovery.

We must also invest more in supporting people to return to employment, building on the success of LEAP (Lothian and Edinburgh Abstinence Programme); as with people with mental health needs, being in work increases the likelihood of a full recovery.

8.3.4 Access to Treatment

Accessing treatment quickly is vital. Good progress has been made over the past 18 months with 95% of people seeking assistance being seen within the target time of three weeks. This has been made possible by moving towards a self-referral system: *Gateways to Recovery.*

We must build on this and ensure that people also obtain quick access to support for any co-existing mental health issues.

8.3.5 Support

Peer support has proved particularly effective in supporting recovery with a flourishing 'Horizons Cafe' well established in Dalkeith.

MELDAP has also expanded a pilot Peer Support Worker role within Midlothian. This role is proving successful in assisting people to access and sustain contact with services that assist in the development of their recovery from substance misuse.

A more neglected area is that of unpaid carers, which includes young carers (children of parents with substance misuse problems) and kinship carers, grandparents who may be supporting their offspring and their grandchildren as a result of alcohol or drug misuse. MELDAP is considering whether it is possible to fund more dedicated support for carers.

8.3.6 Partnership Working

Addressing substance misuse involves the cooperation of a wide range of public and third sector agencies.

Recent steps have been taken to ensure closer working with other bodies such as the Police through the creation of a Public Protection Office, which recognises the close links between domestic abuse, offending and substance misuse.

Operationally we are now establishing closer links between mental health substance misuse and offender services.

During 2015/16 we will work towards the creation of more integrated health and care services in substance misuse; currently NHS Lothian services are provided on a Lothian wide basis and there is common agreement that a more localised approach will be beneficial.

However, for the more specialist services provided across Lothian, we must ensure that people in Midlothian access these services when the need arises:

- **LEAP:** LEAP is a treatment and rehabilitation programme for those dependent on alcohol and other drugs. It is suitable for those who want to achieve a substance-free recovery. Currently MELDAP purchases 10 places at LEAP for people in Midlothian. Between 70% and 80% of people successfully complete the programme and continue to use aftercare support.

MELDAP will investigate the need and options for increased investment in this successful service.

- **RITSON CLINIC:** The Ritson Clinic is a Lothian wide residential stabilisation, reduction and detox unit for people with drug and alcohol misuse issues. MELDAP partners have been involved in discussions about the re-provisioning of the Ritson Clinic service. As a result, clinic staff will engage more closely with people and services within Midlothian communities. This will seek to maximise a smooth transition in and out of the clinic as part of a care pathway.

- **HARM REDUCTION TEAM:** Harm Reduction services in Midlothian are provided by staff from the NEON service (based in the Harm Reduction Team). These include Needle Exchange and Blood Borne Virus services. Discussions are planned regarding the future development of service delivery to Midlothian.

8.4 MEETING THE HEALTH AND CARE NEEDS OF OFFENDERS

8.4.1 Needs Assessment and National Policy

A report published in England in 2012 (*Balancing Act*) highlighted the health inequalities experienced by people in contact with the criminal justice system as being well above the national average.

In addition to those in a custodial setting, this includes offenders serving community sentences and those in contact with the criminal justice system on suspicion of committing a criminal offence.

People who have, or are at risk of offending, are much more likely to experience multiple and complex health issues, including mental and physical health problems, learning difficulties and substance misuse. *They are three times more likely to die prematurely and ten times more likely to commit suicide.*

8.4.2 Mental Health and Substance Misuse

The high occurrence of mental health problems, substance misuse and offending behaviour has long been recognised.

In Midlothian between 2009 and 2012 there were on average 1770 people convicted of offences each year, of which 260 were young offenders, 71 were convicted of drugs related offences and 384 were convicted of alcohol related offences.

The continuing challenge is how to ensure that support to address underlying problems is available at an early stage.

Of particular concern is how to provide psychological services to people who not uncommonly have a history of being abused and other traumatic life experiences, which leads to various forms of self-harm including self-medicating with drugs and alcohol.

We need to work with colleagues in Community Justice to improve access to such services. Alongside this we need to strengthen the availability of peer support such as that provided locally by CLEAR and Pink Ladies.

8.4.3 Women offenders

The national report published in 2012 *Commission on Women Offenders* reported that the female prison population in Scotland has doubled in the past 10 years.

It highlighted that many women in the criminal justice system are frequent re-offenders with complex needs that relate to their social circumstances, previous history of abuse and mental health and addiction problems.

The local *Spring* service has been developed on a multi-agency approach based on the Willow model and is delivered by local authority, health and voluntary sector staff.

The service is aimed at women with multiple and complex needs who have been involved in, or who are at risk of, offending.

The project provides cognitive behavioural therapy, support with social skills and advice on substance misuse, sexual health and lifestyle.

In 2015/16 additional funding will be required to sustain the service in Midlothian.

INVESTMENTS TO HELP ADDRESS THE HEALTH AND CARE NEEDS OF OFFENDERS INCLUDE £15,000 through the Integrated Care Fund to support the Spring Service for Women at Risk of Offending £15,000 ICF.

9. OUR AGEING POPULATION: THE CHALLENGES (Scott)

9.1 NEEDS ASSESSMENT AND NATIONAL POLICY

Approximately 14,000 people are over the age of 65 in Midlothian: one sixth of the population. By 2035, this proportion will have grown to one quarter of the population.

The number of people over 75 is expected to double over this 20 year period, and the number of people over 90 is expected to treble.

Amongst this number there will be many older people who are also undertaking a caring role, supporting their partner in response to frailty and long term health conditions.

The fact that we are living longer is a cause for celebration. Increasing numbers of older people should not be considered a problem for society.

The majority of older people live independently without any formal support and many make a very significant contribution as volunteers, helping run

local organisations and participating in local government, or as carers or supportive grandparents.

Nevertheless old age does not come alone. There is a greater likelihood of developing long-term health conditions and those over 85 are at significantly greater risk of living with dementia.

Older people are also at risk of *frailty*, which is a distinctive health state related to the ageing process. It results in multiple body systems gradually losing their inbuilt reserves.

Living with frailty typically means a person is at a higher risk of sudden deterioration in their physical and mental health.

It is estimated that 10% of people over 65 have frailty and this rises to between a quarter and a half of those aged over 85. This would suggest there are between 2,700 and 4,200 people living with frailty in Midlothian.

This very significant change in population might suggest we need to plan for major investments in areas such as day care and care home provision. However, over the previous 7/8 years, we have seen the impact of the transformation of local services with investments in home care, rehabilitation and local area coordination and a significant drop in care home and long stay inpatient provision.

The challenge is to continue to develop this approach, promoting good health, enabling recovery, and meeting people's needs in more inclusive ways.

In this regard, Midlothian will receive some support from the Joint improvement Team (Scottish Government) to develop further our approach to frailty.

A key area of focus for this improvement work will be determining whether the approaches currently in place are having the right impact and outcomes for people living with frailty (and their family and carers).

This will also identify what further work is required, where the gaps are and, crucially, will ensure there is alignment across the frailty pathway. Particular attention will be given to mainstream service provision across health, social care and housing.

The work will draw upon the patient pathways that have been developed by NHS Lothian, which emphasises the need to see people within the context of their lives and to understand what is important to them.

9.2 COMMUNITY SERVICES

Care at home services have been the subject of a major re-tendering exercise and the new providers took over service delivery from April 2015.

The tender requirements sought to help address the recruitment and retention issues but there remain significant challenges in developing a sustainable social care workforce.

We need to continue to strengthen reablement services particularly in supporting earlier hospital discharge.

The planned extension to the service will allow for an average of 15 hospital referrals per week and an average package of care of 10 hours per week.

All referrals will be responded to within one working day and package of care will start within two working days of receipt of referral.

We will also review the possible need for overnight care at home services to ensure people can remain at home rather than move into hospital or a care home.

Alongside this we must continue to support older people to stay healthy by:

- remaining physically active, having strong social networks
- avoiding smoking and excessive alcohol
- staying warm and safe in winter

Ageing Well programmes, Day Services provided through the Voluntary Sector and Local Area Coordination services will continue to be funded by the Partnership, and where possible, strengthened.

9.3 INTENSIVE SUPPORT INCLUDING RESPONSES TO CRISIS

9.3.1 MERRIT (Midlothian Enhanced Rapid Response Intervention Team)

As described in the section on hospital pressures it is vital that we provide services that help avoid unnecessary hospital admissions and support people to be discharged as quickly as they are fit to do so.

The enhanced rapid response service (MERRIT) is now fully operational and it is about to be extended to evenings and weekends.

This will support a further reduction in unplanned admissions. The significant expansion of the service has led to the establishment of a *Hospital at Home* model to avoid unplanned admissions to acute hospital.

This new development now provides a real alternative to hospital admission, dealing with an average of 15 new referrals a month for a wide range of medical conditions.

AN INVESTMENT OF £77,750 will be made to enhance the operating hours (NHS Lothian –Uncommitted Frailty Budget).

9.3.2 Falls

Older people are at particular risk of falling; 30% of the 65+ population and 50% of those over 80 fall each year.

Falling is the commonest reason for older people for being admitted to hospital.

Approximately 50% of older people who fracture their hip are never functional walkers again and 20% will die within six months.

The costs associated with treatment and longer term care are considerable and has become a growing focus of attention.

In Midlothian we need to do more to prevent falls through risk assessments by all multidisciplinary teams, physiotherapy, exercise programmes and the use of telehealthcare technology.

Screening people who have fallen can help reduce the likelihood of a reoccurrence; while diet changes and drug treatments for osteoporosis can reduce the likelihood of a fracture from falling.

The Falls Coordinator provides falls education, information and advice and assessment for complex residents of care homes.

The Midlothian falls service for uninjured fallers responds to approximately 90 calls a month with the 75+ the major group.

Falls Pathways have been established with NHS 24, Scottish Ambulance Service, Fire and Rescue Service (Bariatric/Fallen Uninjured Person) and Police Scotland.

The Pathways are providing appropriate referrals to the Falls Service and ensure that emergency service resources are appropriately triaged. The service offers follow-up support and assessment of a range of risk factors to reduce the likelihood of further incidents of falling.

Despite the considerable activity of the Falls Response Service, the rate of admissions to hospital as a result of a fall has risen significantly in Midlothian in 2012/13, higher than elsewhere in Lothian and in Scotland as a whole.

Further analysis is needed to establish whether this is as a result of a few individuals falling frequently or whether a larger number of individuals are affected.

Stronger partnership working with Scottish Ambulance Service and preventative work undertaken in care homes over the past 12 months will hopefully have helped arrest this upward trend.

The Falls Practitioner within the MERRIT Team is able to provide a falls follow up to all residents while work is underway to identify Falls Champions within the Care Homes.

INVESTMENTS TO HELP ADDRESS THE ISSUE OF FALLS INCLUDE:

- Telehealthcare & Falls Strategy Development Work £30,000 ICF
- Falls Response Service £39,000 ICF
- Falls Co-ordinator £9,000 ICF

9.3.3 Step-Down Beds

The increasing number of beds in Highbank Care Home enables both early discharge and prevention of admission.

We believe there is considerable potential to further extend assessment and rehabilitation outwith the acute hospitals, supported with additional occupational therapy input to help improved rehabilitation.

This will enable the 'Discharge to Assess' model to be piloted in Midlothian. This will be achieved by creating 7 additional beds in Highbank through the relocation of the MERRIT team base to Bonnyrigg Health Centre.

There will be a need to consider the long term suitability of the accommodation in Highbank given the age and limitations such as lack of en suite facilities.

INVESTMENTS TO HELP PROVIDE STEP DOWN FACILITIES INCLUDE:

- Maintain Intermediate Care in Highbank £405,000 ICF
- 7 additional beds in Highbank £79,000

9.4 ADDRESSING ISOLATION

9.4.1 Impact of isolation on health

Isolation and the importance of relationships were highlighted by a wide range of people. It has a particularly high profile in relation to older people including those with dementia.

Bereavement, social isolation, loss of employment and debt can make us more vulnerable in terms of our mental wellbeing whilst increased mobility of families has weakened the family care network.

The effects of isolation can include increased blood pressure, abnormal stress response, heart disease and poor sleep, and substantially increased chances of developing dementia. There is a strong association with depression.

The impact of isolation is complex and can include an increase in self-destructive habits (over eating, alcohol consumption, and smoking and lowered activity levels). In older age social isolation is a significant factor leading to admission to care homes.

Joseph Rowntree research found that stronger social relationships lead to a 50% increased likelihood of survival.

We know that medication rates for common mental health problems - depression, anxiety etc - are high with 16% of the Midlothian population on some form of medication.

Reducing isolation, whilst not the only solution (medication can be very effective for some people), will undoubtedly contribute positively to people's sense of wellbeing.

9.4.2 Local Area Coordination and Third Sector Day Services

The traditional approach of attendance at day centres works well for some people and there is a strong network of local voluntary organisations providing such a service.

The model of Local Area Coordination, which has been traditionally applied in Learning Disability has been extended to older people and people with dementia alongside similar services such as *neighbourhood links*. This enables people who are housebound to use new technology to stay in touch with families.

This approach of enabling people to become more connected with their own community is based on strong evidence that Neighbourhood Approaches to Loneliness are particularly effective in combating loneliness.

We will work with Third Sector providers to review how to maximise our resources to reach as many people as possible.

INVESTMENTS PLANNED TO HELP ADDRESS ISOLATION OF OLDER PEOPLE INCLUDE:

- Continuation of Local Area Coordination £154,000 ICF
- Development of Peer Support £20,000 ICF
- Continued additional funding to Day Services £61,000 ICF
- Part funding of Ageing Well Programme £11,000 ICF

9.5 CARE HOMES

Although there is a strong emphasis on enabling people to stay at home or in extra care housing for longer, care homes will continue to play a vital, albeit a changing role.

In Midlothian, at any one time, 400 older people are supported in a care home. This figure represents a drop in recent years mainly because people are being admitted at a later stage with the average length of stay now being just over a year.

This is when their health condition(s) is such that they need to be in a more protected environment with constant care – particularly those with advanced dementia and those in the latter stage of their lives.

There have been some concerns about the quality of service provided and given the increasing vulnerability and complexity of care home residents, we need to be fully confident that they are being well looked after.

This requires further investment in staff training and some work has been undertaken to make teleconferencing facilities more available so that staff can access training more easily.

One key element of our review of care home provision is a consideration of how to ensure the best possible medical and nursing arrangements. This is being considered as part of the broader review of Primary Care (see Section 4).

We will look to strengthen the contribution of other disciplines such as dieticians, and speech and language therapists. Alongside this, occupational therapists will explore opportunities to enhance the environment in relation to residents with dementia.

Given the increasing emphasis on care at home and the development of extra care housing we will look to redesign the model of care in Newbyres, recognising the increased need of residents in terms of their physical health and growing numbers in the advanced stage of dementia.

INVESTMENTS TO HELP SUPPORT THE DEVELOPMENT OF CARE HOME SERVICES INCLUDE a Care Home Nurse Advisor £54,000 ICF

9.6 DEMENTIA

9.6.1 Needs Assessment

While dementia is a condition that can affect younger people (there are approximately 50 people under 65 living with dementia in Midlothian), it is strongly linked with increasing age with 31% of people over the age of 85 estimated to be affected.

The rapidly ageing population will result in significantly more people living with dementia rising from approximately 1400 to 2800 by 2035.

People with dementia are also very likely to have other long term conditions affecting their health and some will have undiagnosed sight loss.

Providing services for people with dementia is estimated to account for 24% of the total health and care expenditure by the Partnership for people aged over 65.

9.6.2 Early Diagnosis and Post Diagnostic support

There is a drive to increase the rate of diagnosis of dementia. However, that is only of real value if follow up support is available.

A new role of post diagnostic support was introduced in 2013, working alongside the specialist health and social care team. This will continue and the capacity of this service will be increased in 2015-16.

We will also explore how best to support younger people with dementia, recognising their life circumstances may be very different; they may for instance be parents or in employment.

We introduced a new way of working with families referred to as 'Family Group Conferencing'. This has been successful in empowering family members to support their relatives in a coordinated way, and we are now considering how best to sustain this approach beyond the pilot phase.

9.6.3 Support in later stages

Midlothian was one of three pilot sites for the first National Strategy.

This led to new service developments such as the establishment of a Single Team (health, social work and voluntary sector). This should help ensure that people receive a more coordinated service than in the past.

Providing carer support and reassurance is possible through telecare such as "wandering" alerts. As described in the

Technology section (see section 11.5), we hope to extend the use of new technology for people with dementia. Day services and local area coordination are crucial in providing activity companionship and respite for carers.

There a range of supports from Day Hospital to Alzheimer specialist day care, local voluntary day centres for older people and the Volunteer Service Local Area Coordinator for people with dementia.

We will undertake a full review of these services to ensure access to the right type of support.

9.6.4 Acute Hospital Care

There are particular concerns about the experience of people with dementia admitted to acute hospitals where they are likely to stay significantly longer than a patient of the same age and physical condition but not living with dementia.

The move towards a 72 hour target for discharge will encourage new approaches but it will be important that people with dementia are given the time necessary to make appropriate discharge arrangements.

It will place even greater importance on working in close partnership with unpaid carers, ensuring the necessary supports are in place and reducing the likelihood of readmission.

Supporting people with dementia in acute hospital requires careful planning; the unfamiliar surroundings and the general business of acute hospital settings can lead to distress and agitation.

Strengthening arrangements for people with dementia in acute settings is being enhanced by the work of AHP Dementia Champions.

The use of anticipatory care plans and an increased take up of Power of Attorney (see section 1.6.4) may help ensure that quick but more appropriate decisions can be made both at the point of admission and in planning discharge.

Alongside this we will seek to reduce unnecessary admissions of people with dementia to acute hospitals given the distress this can cause.

This will entail the Single Dementia Team working alongside the MERRIT (rapid response service) and the Scottish Ambulance Service with whom a hospital at home referral pathway has been developed.

9.6.5 Environment and Dementia Friendly Communities

Midlothian has been selected to be a site for Scottish Government's testing of Alzheimer Scotland's 8 Pillars Model of Community Support. We will have a particular focus on finding ways to make people's houses more 'dementia friendly'.

Joint work is also underway with Council Commercial Services to encourage more dementia friendly designed housing and to enable housing and maintenance staff to take measures that may support people with dementia in their own homes.

More generally, as with mental health, there is a need to enable everyone to better understand dementia and its effects, helping to make our communities more "dementia friendly".

INVESTMENTS IN SUPPORTING PEOPLE WITH DEMENTIA AND THEIR CARERS INCLUDE:

- Dementia Link Workers (Post Diagnostic Support) Two posts £72,000 - ICF
- 8 Pillars Project-Housing Guides, Training Programmes etc £50,000 Dementia 8 Pillars Monies
- Carers Support Worker £15,000 - Carers Information Strategy monies
- Local Area Coordination £26,000 - ICF

10. UNPAID CARERS - OUR KEY PARTNER

10.1 NEEDS ASSESSMENT

Relatives, friend and neighbours are often the main unpaid source of support without necessarily identifying themselves as "carers".

There are approximately 14,000 people in Midlothian in a caring role with 70% receiving no support themselves.

Their contribution is estimated to be in the region of £170 million per year - almost twice as much as the budget for the local health and social care service.

While much attention is focused on the negative aspects of caring, it is important to also consider the positive aspects to understand the range of factors that can sustain carers in their role. We need interventions to reduce the negative aspects of caring and to enhance the positive aspects.

While many carers view their role as a personal responsibility and one which they can manage without formal support, we believe many carers in need of support remain hidden. This includes young carers or carers from minority ethnic backgrounds.

Of particular concern are those carers who are providing in excess of 50 hours care per week. It is estimated there are 2160 in Midlothian.

It is worth noting that carers living in more deprived areas are more likely to provide longer hours of care than other carers.

10.2 IDENTIFICATION

Carers cannot be supported without being identified. In recent years proactive work has been undertaken to identify hidden carers and provide support, particularly in local schools.

Local voluntary organisations are exploring how to more effectively reach carers from minority ethnic groups (approximately 4% of the Midlothian carers' population) and this includes having access to interpreting resources and culturally sensitive support.

GPs and other members of the primary health care team's contact with patients has been considered a particularly effective way to identify hidden carers.

We need to ensure that there is easy access to support, following identification, as there is little value in simply placing people on a GP Practice carers' register.

10.3 ASSESSMENT

Good progress has been made through joint working between VOCAL and Council staff in improving the effectiveness and quality of outcomes based carers' assessments.

Further work will be required to embrace the changes planned through legislation to strengthen carers' rights and support provided through the Carers (Scotland) Bill.

10.4 GOOD HEALTH

Poor carer health and wellbeing is concerning for both the carer and the cared for person.

There is a wealth of evidence that carers may experience ill-health particularly as the intensity of care giving increases (13% of Midlothian reporting that their health is bad or very bad if they are providing 50+ hours of care).

Research quoted by Carers Scotland has found that *8 in 10 carers surveyed in Scotland say that looking after a relative or friend has had a negative impact on their health, including not getting enough sleep, feeling stressed and experiencing depression.*

We must consider what other proactive steps can be taken to reduce the adverse health impact of caring in addition to the following:

- carers are now entitled to the annual flu immunisation
- emotional support is provided through peer groups
- access to breaks from caring (see section 10.5)

This will include developing a more planned approach to dealing with emergencies (see section 1.6.4).

10.5 ACCESS TO RESPITE

A more flexible and individualised approach to respite care is being developed through the establishment of the Wee Breaks service**.**

The continued implementation of funding of breaks from caring and self-Directed Support will enable individuals to exercise more direct control over the type and timing of breaks.

However, as more carers are identified and more people with complex needs are supported at home it is likely that further investment in respite care will be needed.

There are particular issues concerning the type and capacity in the provision of respite care for people with learning disabilities and for those with dementia.

Options for redesign of these services will be developed.

10.6 INFORMATION, ADVICE AND SUPPORT

VOCAL has established a new Carers Centre in Dalkeith providing a hub for the provision of information, advice and support.

Demand for individual support is growing and as a result more emphasis is being placed on enabling access to peer support.

Many services including Crossroads and those voluntary organisations providing day services for older people have their own dedicated carer support arrangements and these are being strengthened in areas such as dementia and substance misuse.

Financial advice has been a particularly significant issue in recent times in reaction to the Welfare Reform changes. Specialist provision continues to be provided through Citizens Advice Bureaux.

Carers Scotland quotes that new research based on the experiences of carers across the UK reveals that almost half of carers in Scotland are struggling to make ends meet.

41% of carers in Scotland want increasing financial support for families providing unpaid care to be Government's top priority.

INVESTMENTS IN SUPPORTING CARERS WILL INCLUDE

- Carers Support Services £63,000 (Carers Information Strategy) + £7,000 MC
- Vocal Support Worker service £44,577
- Alzheimer's Scotland Support worker £15,947
- CAB £12,648
- Hospital In Reach Carer Support Worker £35,000 (ICF)
- Carers Support - Older People attending Day Services £61,000 (ICF)
- Carers Support in Primary Care – Pilot Project £35,000 (ICF)

11. MAKING BEST USE OF OUR RESOURCES

11.1 HOUSING

11.1.1 Projecting future need

Suitable housing has long been regarded as vital in supporting people who are frail or have some form of disability to live successfully in the community.

Staying at home is a viable option for most of us as we age, depending 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 there longer

or more easily adapt their homes: "Building for Life".

11.1.2 Adaptations

Most people wish to stay in their own homes and every year the Council assist people to make the necessary adaptations to their property to enable them to do so.

Funding for adaptations comes from a variety of sources and in total, costs in the region of £1.2 million per annum.

Local analysis indicates that a higher proportion of social rented housing tenants are older and may require more support to live independently.

Consequently the projections are that the number of people requiring adaptations to their homes will rise from 247 in 2013/14 to 430 in 2017/18 with significant cost implications.

11.1.3 Extra care housing

Midlothian Council continues to build new housing and giving some priority to the needs of older people, most recently through the construction of Cowan Court extra-care housing in Penicuik. We must consider the need for similar services for people who are not yet frail older people but nevertheless are living with complex or multiple long term health conditions.

We are working with Housing Associations to redesign some sheltered housing schemes for older people to enable those with higher levels of need to be supported.

Overall there are 310 apartments in 11 schemes that might be considered for potential future adaptation for extra care service provision. Hawthorn Gardens (Trust) in Loanhead has already successfully changed its design and model of care to extra care.

Three other schemes are being developed through a Public Social Partnership approach involving fully the providers in the design of the services.

Gore Avenue extra care housing in Gorebridge will be rebuilt with the opportunity to make more effective use of the 12 houses.

We need to promote the development of extra care housing in the private sector; 63% of people in Midlothian live in the private sector and half of the tenants in Cowan Court were owner occupiers, some of whom would have preferred to retain a capital asset.

INVESTMENTS IN DEVELOPING SUITABLE HOUSING INCLUDE £48,000 for an Extra Care Housing Officer

11.1.4 Complex care housing

Midlothian Council is developing 12 new homes specifically to meet the housing needs for people with complex learning disabilities enabling them to live in Midlothian in a homely setting. This will be operational later in 2016-17.

INVESTMENTS TO DEVELOP COMPLEX CARE ACCOMMODATION WILL INCLUDE capital costs £3m (Council)

11.1.5 Homelessness and Housing Support

As described in the section (3.4) on Health Inequalities, homeless people experience poorer physical and mental health than the general population.

Though most homeless households do not have specific health needs, a significant number have health needs relating to mental health, alcohol abuse and illicit drug use and where dual diagnosis is frequent.

Prevention approaches through housing options resolves housing needs for some, those with more complex needs are becoming a higher proportion of homelessness applications.

There is a need to ensure the right to housing should be equally available, accessible and adaptable and of good quality to people experiencing homelessness.

Research conducted into the housing needs of ex-personnel indicated armed forces, and their families, have specific housing needs that require support. (see section 3.6) For example, ex-service personnel are more vulnerable to homelessness than the population at large, and professional pressures can present problems for finding stable housing for soldiers and their families as they may move frequently to new postings.

In addition to homeless households, tenants currently resident in affordable housing may also require support in order to live in independently in their existing tenancy, such as being provided with advice on overcoming addiction, coping with debt and life skills.

Affordable housing providers generally provide their own support services for their tenants and this could be utilised more in ensuring the health and wellbeing of tenants. As described in the chapter on health inequalities fuel poverty (Section 3.9) is a particular concern given its impact on health and wellbeing.

INVESTMENTS TO HELP ADDRESS FUEL POVERTY WILL INCLUDE a programme of external wall insulation for *harder to treat* housing.

Health and social care integration provides a new structure and set of outcomes by which work on health and homelessness can be delivered, with opportunities for more collaborative working between housing and health.

There is also an opportunity through health and social care integration to maximise the connections between housing / homelessness and appropriate health services. This will ensure those individuals and families affected by homelessness are supported by all of the necessary agencies.

11.1.6 Specialist Housing Needs

There are 4,664 households on Midlothian Council's Housing List and 612 of these households require accommodation suited for their medical needs, such as

requiring ground floor accommodation or specialist, extra care housing.

Midlothian Council continues to provide a small number of wheelchair adapted new build housing as part of its Phase 2 housing programme, in addition to providing specialist housing provision and extra care housing.

However, specialist housing provision is more expensive to develop. This hinders development of particular types of accommodation as grant funding from Scottish Government is limited and is not increased to address the additional costs of providing specialist accommodation.

Midlothian Council operates a shared Gypsy/Traveller Site with East Lothian Council to ensure that these households can access good facilities, including use of a community room that can be used by a health visitor. Improved provision of suitable accommodation is likely to address health inequalities experienced by this group.

11.1.7 Dementia friendly 8 Pillars work

Midlothian is working as a national test site exploring how better housing design can assist people with dementia to live more safely at home. This includes compiling guidance for designers, builders and property owners in all sectors.

It will also involve providing training and resource material for maintenance staff and for families who may have a proactive interest in ensuring housing is appropriate for the relatives at the early stage of dementia.

Alongside this we must ensure that our specialist facilities are dementia friendly - a recent example being the provision of new day care facilities provided by Alzheimer Scotland in Bonnyrigg.

INVESTMENTS TO SUPPORT THE 8 PILLARS WORK WILL INCLUDE Project Management £25,000

11.1.8 Handyperson Service

On a day to day basis people sometimes require support with small repairs, changing light bulbs etc. and over the past two years we have been provided a *Handyperson Service* through a local social enterprise company.

The plan is to gradually move towards a self- financing model with service users paying the costs of materials along with an affordable charge for labour costs.

MONIES WILL NEED TO BE IDENTIFIED to ensure the continuation of the service during 2016/17 whilst the service expands and is able to be self-sustaining.

During 2015/16 the cost of the Handyperson service is £29,000 plus the separately funded cost of adaptation materials, rails etc.

11.2 WORKFORCE

11.2.1 Success Depends on Staff and on Effective Teams

The challenges described in this paper can only be met by a fully-equipped and motivated workforce.

The establishment of the Partnership should support the development of a culture of staff from all sectors working together as part of a whole, joined-up system.

The move towards more joint services requires staff from different organisations learning to work together and we must provide support to ensure these changes are successful.

11.2.2 Organisational Development

The increasing emphasis on self-management and self-directed support will depend upon all staff embracing a philosophy of working in genuine partnership with service users/patients and carers.

We have made good progress in enabling staff to be more outcome focused in providing care packages.

This shift towards a more personalised approach is reflected in the delivery of health services.

The NHS Lothian 10 year strategy lays very strong emphasis on working with the whole person rather than focusing only on treating the presenting medical condition. This is likely to require achieving a different balance of specialist and generalist skills.

This personalised approach is complemented within social services through Self-Directed Support (SDS) legislation and accompanying development work to implement SDS.

The increased priority given to *recovery* will entail staff developing increased skills to work with and help motivate people who may not be optimistic about their future, given the conditions they are living with such as cancer or the challenges they are dealing with such as drug dependence or depression.

11.2.3 Learning and Development

The growing emphasis on supporting people at home with complex health and social care problems will only be successful if we ensure that staff are able to access appropriate training and to ensure that we have the right mix of skills. For example, as we seek to rely less on hospital care we will need to support the development of more advanced skills for community nurse, allied health professionals and for care at home staff.

The ability to respond more effectively to the whole person means that we need to continue to strengthen every member of staff's awareness of the impact of issues or conditions that are common but not always recognised or acknowledged by service users themselves. These include early stages of dementia, hearing and sight loss, the emotional impact of becoming more isolated, over reliance on

alcohol or the cumulative impact of being in a caring role.

11.2.4 Communication and Engagement

Ensuring that people work effectively together across organisations, particularly at a local level, will require creating opportunities for people to establish positive working relationships and contribute to the development of improved services for users.

A series of locality engagement events is planned for 2015/16 as is a programme for the multidisciplinary professional forums. This will be continued in 2016/17.

Communication in the form of newsletters, websites and the use of social media will be put in place as part of a broader communication strategy.

There will be a focus on ensuring that communication is accessible to staff and citizens who do not use email, websites or social media.

11.2.5 Workforce Planning

We must also ensure we have effective recruitment and retention policies. In areas such as district nursing and home care we have an ageing staff group, whilst in social care services generally there is a need to improve our retention of staff as high turnover is both wasteful of resources and disruptive to service users.

This will include marketing Midlothian as a rewarding place to work given the shortages anticipated in some professions.

Supporting people at home will also require a continued expansion of 24/7 staffing; District Nursing Services already do so; the Intensive Home Treatment Team in Mental Health operates until 10pm; while the rapid response service (MERRIT) has recently moved to weekend working.

We also need to strike the right balance on the skill levels achievable in community care services and recognising when more specialist skills and services are needed. For instance, we may need to be more realistic about managing very challenging behaviour in home settings.

We will need to consider all of these issues as decisions are taken about the possibility of localising some of the 'hosted' services currently managed across the whole of NHS Lothian. Work is underway to develop a workforce plan across health and social care, including the third and independent sector.

This is needed to ensure that we are able to respond to the growing needs of an ageing population, the changing model of care through reducing reliance upon hospitals and care homes, and a strong societal expectation for high quality and safe health and social care services.

We will work with the Midlothian Employment Action Network and Economic Development to develop a more strategic approach to health and social care workforce issues. During 2015/16, Scottish Government funding of £71,500 was applied to the delivery of the Organisational Development (OD) Plan.

It is likely that some additional OD capacity will continue to be needed during 2016/17 and work will be undertaken to identify sources of funding.

11.3 FINANCES

11.3.1 Background

The Strategic Plan has to be driven by the financial resources available to the IJB. These resources will then be used to action the plan.

The financial element of the Strategic Plan is laid out in section 39 of the Public Bodies (Joint Working) Act (2014), which requires the IJB to publish an annual financial statement.

11.3.2 Initial amount available to the IJB

This section lays out an indicative value for the proposed IJB's budgets for 2015/16.

The IJB's budget is derived from the budgets set by NHS Lothian and Midlothian Council and is split is made up of four elements.

- **ADULT SOCIAL CARE**: this is the budget as set by Midlothian Council
- **COMMUNITY HEALTH PARTNERSHIP:** core services being Community Nursing, Community Allied Health Professionals, Midlothian Community Hospital, GMS, GP Prescribing and Resource Transfer budgets. These are the budgets set for 2015/16 based on the NHS Lothian financial plan agreed on 1st April 2015
- **DELEGATED HOSTED SERVICES:** hosted services are managed on a pan-Lothian basis by the CHPs. The shares of these pan-Lothian budgets are based on an historic model and a programme is being developed to agree a mechanism to share the budgets
- **ACUTE SERVICES:** delegated to the IJB. This is not part of the 'payment' but is a *'set aside'* budget held by NHS Lothian on the IJB's behalf. Again, the shares across the IJBs have been prepared on a historic basis

While establishing the core budgets for Adult Social Care and Community Health Services is relatively straightforward, work continues to ensure that the allocation to the IJB is sufficient given the responsibilities that move to the IJB. This process is referred to as "Due Diligence".

Calculating the Midlothian share of Lothian wide services', including its share of acute services, is more complicated. Some initial calculations have been made but work will continue during 2015-16 to agree a process that best reflects need but which also ensures the continuing stability of these services.

It is vital that an approach is agreed, which is fair and equitable and does not place the IJB at significant financial risk; currently the variations in spend in areas such as prescribing are managed on a pan-Lothian basis.

The initial budget for the IJB is an indicative outline but it does enable the Partnership to agree its specific plans 2016/17, while continuing to develop as the resource allocation to the IJB is more clearly defined and processes for redesigning services provided on a pan-Lothian basis are determined.

Table 1 below lays out the indicative IJB budget for 2015/16 although as mentioned, work on the Health budgets is still being finalised. As outlined previously, there are four main elements to the IJB's budget.

The Council and the Health Board will indicate what the future resources available to the IJB will be over the three years of the financial plan and this table will describe the planned changes in financial terms.

Table 1 – Indicative IJB 15/16 Budget	
Health Set Aside	***£000's***
Acute Delegated	16,221
Integrated Payment	
CHP Core Services	16,792
GMS	12,125
Prescribing	14,583
Resource Transfer	4,727
Hosted	10,522
Adult Social Care	36,929
Total	**95,679**
Total Resources	**£111,900**

11.3.3 Indication of change reflected within the Strategic Plan

The opening allocation of resources will be analysed by 'programmes' (Older People, Mental Health, Learning Disabilities etc) for the first year of the plan.

The ambitions and planned changes reflected in the Strategic Plan will then be modelled in financial terms. This will then illustrate the impact of the plan on those programmes. The required shift in the balance of care means that it is essential that there will be no further planned investments in the acute services delegated to the IJB including capital investments, which have revenue implications. The layout may be as illustrated below:

Programme	2016/17 £000's	2017/18 £000's	2018/19 £000's
Older People Services			
Learning Disabilities			
Physical Disabilities			
Mental Health			
Primary Care			
Other			
Acute Set Aside			
Integrated Care Fund			
	111,900	**111,900**	**111,900**

11.3.4'Directions'

The Public Bodies (Joint Working) Act describes how the IJB will action its Strategic Plan by issuing 'directions' to both the Council and the Health Board as appropriate.

These 'directions' will be issued for each function delegated to the IJB and will lay out how much is to be spent in order to deliver that delegated function per the Strategic Plan.

It is important that these directions map clearly onto the strategic plan and even if no changes are proposed to the current provision of any function delegated, then that position will be reflected in the plan to support the IJB's 'direction'.

11.3.5 Annual Financial Statement

The annual financial statement will therefore lay out the matters as discussed above.

Currently there is no agreed template for this statement but as this is developed, it will be included in the next draft of the Strategic Plan.

11.4 WORKING WITH THE THIRD SECTOR

11.4.1 Role

Third Sector organisations play a major 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 central to helping reduce isolation, particularly of older people, in the provision of lunch clubs, day centres and, more recently, buddy schemes and local area coordination services.

11.4.2 Self Help and Peer Support

As previously referred to, peer support has an increasingly important role in enabling people to cope with and recover from social care and health issues.

The voluntary sector is particularly effective in nurturing such support systems and Midlothian Voluntary Action will be allocated additional resources to ensure more people have access to such support.

11.4.3 Contribution of Volunteers

There is a strong tradition in Midlothian of people giving of their time to support others.

The value of this support is estimated to be in the region of £36m per annum with 37% of the population reporting that they are involved in volunteering in some capacity.

When this is set alongside the estimated £170m per annum contributed by unpaid carers then it becomes clear that sustainable health and care services are completely dependent on a culture of co-production with local people and communities.

11.5 TECHNOLOGY ENABLED CARE

11.5.1 Telecare

Telecare offers a wide range of devices to support people live safely in their own homes.

As well as a basic service to summon assistance, used by some 1900 people in Midlothian, a range of devices are used to monitor. For example:

- when someone with dementia may have wandered from their home at night
- when someone who is frail has not got out of bed in the morning indicating a possible health problem
- to summon support in walking for someone who is unsteady on their feet

The possible use of smart technology (phones/tablets) to help family members share information with one another, and as appropriate, with health and care staff, about the person for whom they are caring enabling us to pick up possible deterioration at an earlier stage.

INVESTMENT of £93,000 in telecare will continue to be made through the Integrated Care Fund ICF

11.5.2 Video conferencing

The important role of care homes in providing high quality care to the local population is well recognised by the Partnership.

A key aspect to support a sustainable approach to high quality care has been to ensure ongoing support and training for care home staff.

Care home staff turn-over is high and the ability to release staff for offsite training has proved consistently limited.

Creating an on-site hub for staff to engage in weekly tele-education should reduce a significant barrier to training in turn enhancing the care delivered to residents.

Following pilot projects in three homes in 2014/15, new Government funding will enable the roll out of the facility to all 11 care homes.

11.5.3 Assessment

The importance of early intervention and prevention is a central theme of this Plan.

Through the use of a basic frailty assessment (see section 9.1), families can help monitor the changing needs of their relative, and can also provide helpful hints for carers.

The frailty assessment enables self/carer reported measurement of function in daily life using indicator of frailty that scores individuals according to risk.

Results are recorded in a patient held record and assessment can be repeated over time to record changes.

The patient is at liberty to chose who they share their results with i.e. family, friends, local services or to keep the information private.

11.5.4 Dementia

Midlothian is keen to broaden the application of telecare services; as a test site for the 8 Pillars Framework for Dementia.

There are technologies available that can support the care of people with dementia. One example is *Just Checking* - this technology uses wireless movement sensors positioned round the home to detect movement.

The kits can be used to provide peace of mind and for assessment purposes by building up a daily pattern of activity over time (a few weeks).

Following piloting of this technology, new Government funds will enable the expansion of this service and the development of other technologies to support people with dementia and their carers.

In addition, an area in Midlothian Community Hospital has been dedicated to be a 'dementia and telecare hub' where equipment, resources and adaptations to the environment can be demonstrated and tried by service users, carers and staff.

THE NEW MONIES OF £67,500 allocated through the national Technology-Enabled Care Development Programme will be applied during 2016/17.