Midlothian
Health & Social Care

Midlothian Integration Joint Board

Strategic Plan

2022-2025





Foreword

Who we are

The Integration Joint Board (IJB) plan and direct the health and social care services for the people of Midlothian. These services are delivered by the Midlothian Health and Social Care Partnership (Social care and Community health care services and local hospital services) and by NHS Lothian (hospital based services). You can find the full list of delegated services at www.midlothian.gov.uk/mid-hscp. in the Scheme of Integration. We manage some services (including Podiatry, Adults with Complex and Exceptional Needs Service (Complex Care) and Dietetics) for all of Lothian on behalf of NHS Lothian. Other IJBs host services on our behalf.

The Health and Social Care Partnership work with third sector organisations and independent providers. All staff in the partnership are employed by either Midlothian Council or NHS Lothian.

The partnership brings together parts of Midlothian Council and NHS Lothian to help you live well and get support when you need it - from care homes to care at home, primary care to telecare, voluntary organisations to vaccinations. We have listed some of the services below:

NHS Lothian

Care in Hospitals which isn't planned (unscheduled care) including Accident and Emergency, Minor Injuries, Acute wards.

Midlothian Community Hospital

Community based health care (Primary care) including GPs, District Nurses, Dentists, Pharmacists, Mental Health services, Substance Use Services, Community Respiratory team

The following Health services for children and young people under 18: Health Visiting, School Nurses, Vaccinations of children.

Allied Health Professionals –including physiotherapists, dietitians, podiatrists

Palliative and End of Life Care

Midlothian

Social Work support for adults including adults with dementia, learning disabilities, older people

Day services for older adults and people with learning disabilities

Care at Home services

Health services for people who are homeless

Extra Care Housing for people who need housing with extra support

Services to support unpaid carers and breaks from caring

Care Homes

Services to address health and care needs of people in the justice system

What we are trying to achieve

The IJB plan and direct health and social care services and manage the allocation of the budget of approximately £150 million per year. We aim to:

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

Our Vision and Values 2022-2025

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

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

Our Strategic Aims 2022-2025

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

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

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

4. Support more people with rehabilitation and recovery.

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

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

Challenges we face

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

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

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

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

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

Unpaid carers
Unpaid carers fulfil significant, valuable and wide-ranging roles, helping to keep people with care and support needs within our communities. During the pandemic many people became carers for the first time, or saw changes to their caring role, resulting in them providing significantly more care for their elderly, sick or disabled family, friends and neighbours. Through this period services supporting carers continued to offer a range of support, including digitally, and by telephone, though services supporting the person they provide support to may have been reduced, e.g. respite and day services, impacting on carers. Further work is required to reduce the significant pressure and impact of caring that carers reported, by continuing to explore innovative options to enable support to be given to both carers and the cared-for, and for there to be opportunities for breaks from caring.

Acute hospitals

Acute hospitals are under huge pressure due to unsustainable demand and financial, workforce and at times infrastructure restrictions. Investing in community based services and work with carers is required to minimise avoidable and inappropriate admissions and facilitate earlier discharge. By treating people closer to home, or in their own home the HSCP can support admission avoidance and improve people's outcomes.

COVID-19

Covid 19 will continued to influence how the delivery of core services, it will impact staff absence and deployment, and will required additional resource, for example to deliver vaccination clinics, deliver services in line with guidance , coordinate staff testing, and manage PPE provision locally.

How can Digital Technology help us?

The COVID pandemic and the restrictions it put on all of us has shaken up the way we provide services. We have become more comfortable using technology and 'doing things a little differently'. This change is here to stay and digital technology will play a part in all of our services over the next three years.

Digital technology can allow us to keep in touch with our GPs from the comfort of our living rooms, control everyday devices by talking to them and keep a track of our health through miniature computers we wear on our wrists.

Digital technology can also help us collect information about people who use our services in a way that can help us plan and deliver them more effectively. This might mean using anonymous data to help us understand when the busy periods at A&E are or it might mean allowing you to share your story with a number of people who support you so you don't need to repeat yourself.

Our Digital Governance Group supports us to make best use of new technology and make sure we use it in a co-ordinated way, taking into account issues such as privacy, inclusion, choice, and power.

Our core themes to support our digital development:

1. **Building an infrastructure that helps us work together**
   Integrating health and social care services requires us to share data across NHS and council services and with the third sector, carers and people who use our services. We need to build an infrastructure that helps us to do this.

2. **Person Centred Care**
   A Digital approach will help us consider how care can become more about people and not the process. With a clear understanding of people's needs we can ensure the right technology, is used at the right time, in the right place, in the right way and that it enhances quality.

3. **Asset management and optimisation**.
   We will need a culture change in adopting new thinking, embracing new skills and delivery models and in our organisational planning. This will require leadership and strategic support, and training, to develop closer relationships across a range of stakeholders.

How we plan services

Strategic Plan

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

Our strategic plan lets people know:

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

Through the plan we must make big changes to how we plan and fund services to make sure that we can continue to meet the needs of our growing and ageing population, and that the challenges we laid out above can be addressed. This involves redesigning services, and a redistribution of resources, including financial resources. We must put more focus on prevention and early intervention and move resources from hospitals to community-based services.

Assessment of Need

To help us develop our plan we research and produce a **Joint Needs Assessment.** The Joint Needs Assessment helps us ensure we plan and design our health to meet the current and future health and social care needs of the population in Midlothian. It uses a variety of available data to build up a picture of the key health and social care issues affecting the Midlothian population
To develop the plan we work with a wide range of stakeholders including staff, people who use our services, voluntary organisations, unpaid carers, providers and the public

Localities

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

Clinical Care & Governance

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

Engagement with people in Midlothian

We are developing our engagement with people and partner organisations through supporting representatives from the third sector, carers and people with lived experience on our formal planning groups including the IJB, the Strategic Planning group and Service Area planning groups. Our Engagement Statement outlines how we engage with people.

To be successful and achieve our aims our plans need to be continually informed by engagement with people who use our services and their families and carers. We must also continue to work with a wide range of people who live and work in Midlothian and stakeholders to inform our plans, including third sector organisations, service providers and staff.

Inequalities

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

Covid-19 has widened health inequalities as it has affected those already experiencing health inequalities more, such as those in the most-deprived areas and people from ethnic minority backgrounds. We have a duty to address inequalities, and to do this we must distribute resources and plan our services according to need so that they do not make inequalities worse, and may help in reducing them.

Equality in Midlothian

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

Human rights

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

The approach provides a practical framework that supports decision-making at all levels, including day-to-day operational decisions. It will enable us to balance competing priorities and to demonstrate the basis for decisions in difficult circumstances.

Applying the approach complements our commitment to equality and reduction of health inequality as it prioritises people who face the biggest barriers to realising their rights. Applying this approach will mean that:

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

How we measure performance

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

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

How we put our plan into action

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

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

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

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

Finance page Note to IJB: To be finalised following IJB Workshop

Budget and Financial Plan

The IJB's Strategic Plan is the foundation for the development and preparation of the IJB's financial plan which lays out in financial terms, how the IJB will deliver its strategic plan.

The IJB can only use the resources available to it (the IJB's budget) to deliver the strategic plan. The budgets for the IJB are to fund the services that have been delegated to it from its partners Midlothian Council and NHS Lothian.

Our annual budget is £144.2m* This is split up into four parts: -

1. **Social Care** (from Midlothian Council). **£47.7m***
   This is for the adult social care services in Midlothian. These services are managed operational by the Midlothian Health and Social Care Partnership (HSCP)

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

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

4. **Health Set Aside budgets** (from NHS Lothian). **£17.8m***
   The IJB has functions delegated to it, referred to as unscheduled care services (Accident and Emergency and unplanned admissions) which are managed by NHS Lothian's Acute Hospital system. The IJB's budget includes a share of these services, again based broadly on population. The budget is 'set aside' by NHS Lothian on the IJB's behalf. These services are :- Accident and Emergency, Cardiology, Diabetes, Endocrinology, Gastroenterology, General Medicine, Geriatric Medicine, Rehabilitation Medicine, Respiratory Medicine and various ancillary support services for the above. They are delivered at the Royal Infirmary of Edinburgh, the Western General Hospital and St. John's Hospital.

*budgets to be discussed at IJB Workshop in January 2022.

Financial Risks

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

Strategic Developments and Changes

The financial resources available to the IJB are generally fixed at the time of the setting of the annual budget (in March each year) – although further resources may be made available by the Scottish Government in year – and are limited by the resources available to the partners.

This poses challenges to the development of a 3 year plan, as we only have the budget confirmed for the current year.

The Strategic plan, as part of the transformational process, will redesign the delivery of services and may also require additional investments in these services. However, the IJB only has four sources to fund any additional investments -

1. New resources from the SG and that will be generally agreed as part of the budget setting process.
2. A transfer of resources from elsewhere within the IJB's budget. For example as part of the change in the balance of care from institutional to community in theory resources should be releasable from institutional services. However, any such change would have to make a sustained and significant impact to allow a such a movement of resources
3. A reorganisation of budgets 'internally' – that is redesign within a service or a reallocation of the budgets currently available to the IJB.
4. The IJB may decide to disinvest in a current services in order to support a development. Clearly an appropriate process will have to be followed to ensure that any decisions reached are appropriate

Redesign work requires elements of double running costs to be covered to continue to cover the costs of services as they are, whilst also covering the cost of developing new approaches and redesign. This could be funded from within the IJB's reserves if agreed.

Our plans

Contents

Older People

(Community Services)

Planning group: Older People's Planning Group

Planning Lead: Catherine Evans

Older People 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

- Provide services that are accessible, available, appropriate and of high quality across Midlothian – including GP practices, home care, care homes and dementia services.
- Improve awareness and fulfilment of human rights for older citizens, including people who live in care or treatment facilities or receive care in their own homes.
- Provide services that connect well with each other and work holistically to support people – including mental and physical health teams, Midlothian Community Hospital, Primary Care and Community Services.
- Develop appropriate day support for all older people to reduce isolation and increase social connection
- Design services and systems so that people have more control over decisions that affect them.
- Support more people with rehabilitation and recovery at home or close to home
- Improve physical, digital and personnel infrastructure

Crisis & Emergency

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

Frailty

Planning group: TBC

Planning Lead: Jamie Megaw

Prevention & Early Intervention

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

Support & Treatment

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

Crisis & Emergency

- Develop approaches to reduce avoidable unscheduled activity

Physical Disability & Sensory Impairment

Planning group: Physical Disability & Sensory Impairment

Planning Lead: Tom Welsh (Temp)

Physical Disability & Sensory Impairment 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

- Improve access to health and social care services including reducing waiting times for Occupational Therapy and for equipment/aids, improve access to respite, local health care premises and remote consultations.
- Develop Self Directed Support in line with Social Work Scotland's new standards
- Increase access to community-based rehabilitation
- Strengthen local services for people with a Visual Impairment
- Strengthen local services for people with a Hearing Impairment
- Deliver local services for Adults with Complex and Exceptional Needs (ACENS)

Crisis & Emergency

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

Mental Health

Planning group: Adult Mental Health

Planning Lead: Sheena Lowrie

Mental Health 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

- Improve access to Community Mental Health Supports including more local provision through changing the location of services e.g. The Orchard Centre
- Suicide Prevention
- Improve physical health including screening and monitoring
- Improve access to information about self-management including Midspace

Support & Treatment

- Improve holistic support including integrating service in No11, working with MELDAP, Homelessness services and supporting people who have experienced Trauma.
- Reduce waiting times for Psychological Therapy
- Reduce waiting times for Occupational Therapy
- Improve the provision of appropriate Housing including Grade 4 and 5 housing for residents at Royal Edinburgh Hospital, supporting people who experience homelessness.

Crisis & Emergency

- Improve same day access for people with Mental Health and crisis/distress including the Mental Health and Resilience Service and Distress Brief Interventions.
- Improve support for people who attend A&E frequently
- Improve access to Mental Health and well being services through the Redesign Urgent Care

Learning Disability & Autism

Planning group: Learning Disability & Autism

Planning Lead: Duncan McIntyre

Learning Disability & Autism 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

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

Crisis & Emergency

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

Long Term Conditions

Planning group: TBC
Planning Lead: TBC

Long Term Conditions 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

- Embed the Midway - Support self-management, understanding trauma & addressing inequalities and increase chronic disease management.
- Improve how we support people to plan for the future
- Improve community-based support for people with Heart Disease including preventing avoidable admissions to hospital and increasing access to community based rehabilitation.
- Increase number of people managing COPD at home including expanding the Community Respiratory Team
- Provide local support and treatment for people with Cancer
- Establish appropriate support pathways for people with Long Covid
- Improve access to rehabilitation and rehabilitation outcomes for people post Stroke
- Improve support to manage Type 2 Diabetes and increase remission and support women with gestational diabetes.
- Establish appropriate support pathways and improve outcomes for people with neurological conditions.

Crisis & Emergency

- Reduce preventable admissions to A&E
- Reduce hospital discharge delays resulting from housing needs

Falls & Fracture Prevention

Planning group: Strategic Falls Group

Planning Lead: Gillian Chapman

Falls & Fracture Prevention 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

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

Crisis & Emergency

- Provide timely, specialist, personalised care and support when someone has fallen including working with the Emergency Services, Midlothian Community Hospital and On Calls Falls Service.
- Improve outcomes after a fall

Palliative & End of Life Care

Planning group: Palliative and End of Life Partnership Group

Planning Lead: Fiona Stratton

Palliative & End of Life Care 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

- Improve people's choice and control over their support & treatment
- Improve how people plan for the future.

Support & Treatment

- Improve and develop services for people receiving palliative care
- Improve bereavement support

Crisis & Emergency

- Reduce preventable admissions to hospital
- Improve discharge from hospital

Under 18

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

Planning Lead: Fiona Stratton

Under 18s 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

- Monitor health of children and young people including Health visitors and School Nurses.
- Reduce inequality including Care Experienced Children and where Domestic Violence, Substance Misuse and money or housing worries are occurring or suspected.
- Support Parents
- Prevent avoidable illness including vaccinations, early detection and healthy weight.

Support & Treatment

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

Crisis & Emergency

Public Protection

(Adult Protection & Violence Against Women and Girls)

Planning group: East Lothian and Midlothian Public Protection

Planning Lead: Kirsty MacDiarmid

Public Protection 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

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

Crisis & Emergency

n/a

Community Justice

Planning group: Community Justice

Planning Lead: Fiona Kennedy

Prevention & Early Intervention

- Improve understanding of Community Justice.
- Plan and deliver services in a strategic and collaborative way
- Prevent and reduce the risk of further offending including restorative justice and community payback orders.

Support & Treatment

- Improve relationships and opportunities to enable participation in education, employment and leisure.
- Improve resilience and capacity for change and self-management including the SPRING service.
- Improve life chances through addressing needs, including; health; financial inclusion; housing and safety including Fresh Start and No 11.

Crisis & Emergency

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

Substance Misuse

Planning Group: MELDAP

Planning Lead: Martin Bonnar

Substance Misuse 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

- Reducing Harm and Promoting Recovery including improving waiting times and geographical access
- Commissioning and Assuring High Quality, Cost Effective Outcomes Focused Services

Crisis & Emergency

- Reducing Harm and Promoting Recovery including out of hours access to recovery hubs, assistance at A&E and polydrug overdose

RESOURCES

Workforce

Planning Group: Workforce Strategic Planning Group

Planning Lead: Anthea Fraser

Prevention & Early Intervention

- Attract staff to fill vacancies including ‘Hard to Fill’ posts.
- Reduce vacancies and retain, support and upskill staff

Support & Treatment

- Reduce workforce inequalities
- Increase support with digital access

Crisis & Emergency

Unpaid Carer

Planning group: Carers Strategic Planning Group

Planning Lead: Shelagh Swithenbank

Prevention & Early Intervention

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

Support & Treatment

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

Crisis & Emergency

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

Primary Care

Planning lead: Jamie Megaw

Planning Group: TBC

Prevention & Early Intervention

- Develop the Community Treatment and Care services to support all practices.
- Develop Pharmacotherapy services in General Practice to improving medicines management and access to medicines.
- Develop the MSK APP service to enable more people to access timely assessment and intervention for their MSK condition and reduce the requirement for GP involvement, ED attendance or onward referral.
- Maintain and improve access to the Primary Care Mental Health and the Wellbeing services to support people needing mental health support.
- Develop a joint HSCP/Quality Cluster quality improvement plan including collaborating on improving the coordination and continuity of primary care for people living with frailty

Support & Treatment

- Provide a comprehensive vaccination programme including Seasonal Flu and COVID Booster vaccinations
- Develop Primary Care premises to meet service requirements and respond to population growth – including health and care facilities in Danderhall for the Shawfair Development Area, and developing plans for South Bonnyrigg/Rosewell
- Improve communication about primary care to improve sign-posting to the right support
- Support uptake and optimisation of technology across primary care
- Increase the adoption of data-led collaboration between General Practices and the HSCP to improve health outcomes for people.

Crisis & Emergency

- Provide access to primary care services in evenings, at night and weekends through the Lothian Unscheduled Care Service
- Collaborate with General Practices to support improvement to access.

Acute Services

Planning group: Acute Services Planning Group

Planning Lead:

Prevention & Early Intervention

- Reduce potentially preventable admissions through early diagnosis, reduce admissions from falls, flu & COVID,
- Establish community-based early intervention support for people to reduce the need for acute care

Support & Treatment

- Maintain delayed discharge occupied bed days at 40% below the 2017/18 rate.
- Maintain the number of people living in and receiving care in the community at 97% or higher.

Crisis & Emergency

- Maintain attendances to A&E at 2017/18 level.
- Reduce unscheduled admissions by 5% compared to 2017/18.
- Reduce unscheduled occupied bed days by 10% compared to 2017/18.

Midlothian Community Hospital

Planning group: TBC

Planning Lead: Kirsty Jack

Midlothian Community Hospital - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

- Improve processes to ensure services at MCH are operating effectively and efficiently including a new staffing model for Mental Health wards, recruitment and admissions
- Improve quality of care for older people with mental illness
- Improve quality of care for people with dementia
- Increase the provision of holistic care including creating a culture of 'cross ward working' and working with volunteers
- Improve access to and quality of care and treatment for out-patients including increasing nurse prescribers and clinical decision makers and cancer treatment.
- Improve people's choice and control over their care and treatment and participation in decision making including good conversations, anticipatory care plans and advocacy.
- Improve awareness and fulfilment of human rights for older citizens, including people who live in care or treatment facilities
- Support more people with rehabilitation and recovery.

Crisis & Emergency

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

Sport & Leisure

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

Planning Lead: Allan Blair

Sport & Leisure 2022-25 - Midlothian Health and Social Care Partnership

(plan will note sport and leisure is not a delegated function)

Prevention & Early Intervention

- Improve equity of access to all physical activity opportunities including financial difficulties and protected characteristics.
- Increase the number of people having a positive experience at a Sport & Leisure venue or activity through training staff.

Support & Treatment

- Increase community based support opportunities including Midlothian Active Choices, Ageing Well and providing clinical/rehabilitation spaces.

Crisis & Emergency

- Increase support for communities in crisis or emergency including the Keep Safe Scotland scheme.

Housing & Homelessness

Planning group: Health and Homelessness & Extra Care Housing

Planning Leads: Becky Hilton & Gillian Chapman

Housing & Homelessness 2022-25 - Midlothian Health and Social Care Partnership

Prevention & Early Intervention

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

Support & Treatment

- Increase the number of people accessing support in temporary accommodation including peer support, advocacy and access to digital devices.
- Increase choice and control for recovery from substance misuse including an 'Oxford House' (a self run, self supported recovery house)
- Improve support for people who are homeless with complex and multiple needs
- Reduce avoidable hospital admissions / delayed discharges including use of intermediate care flats.
- Enable people to live independently including a 'Care & Repair' scheme and Technology Enhanced Care

Crisis & Emergency

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

Housing Contribution Statement

Introduction

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

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

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

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

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

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

Links to other Strategies

This statement links to a number of local strategies:

Local Housing Strategy (2021-2026)

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

It aims to do this within 5 years by:

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

Strategic Housing Investment Plan (annual)

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

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

Rapid Rehousing Transition Plan

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

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

Shared Outcomes:

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

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

Housing can contribute to these aims by:

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

AIM PREVENTION EARLY INTERVENTION

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

AIM CRISIS & EMERGENCY SUPPORT

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

Adaptations

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

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

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

Funding of Adaptations

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

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

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

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

Respite

Planning group: Respite & Short Breaks

Planning Lead: Gillian Chapman

Prevention & Early Intervention

- Improve Overnight Respite including working with existing providers, Extra Care Housing and Respite at Home
- Improve equality of access to respite across Midlothian
- Plan respite for future need – efficient & effective use of resources including a new respite facility.

Support & Treatment

- Improve quality of respite
- Improve Procedures for Planning and Accessing Respite including separating planned and emergency care, SDS and transport.
- Improve Information on Respite

Crisis & Emergency

- Reduce potentially preventable hospital admissions

Public Health

Planning group: Public Health Reference Group (TBC)

Planning lead: Becky Hilton

Prevention & Early Intervention

- Increase the number of people who are supported to be more physically active including green health prescriptions, Get Moving with Counterweights, Let's Prevent Diabetes, Midlothian Active Choices and Ageing Well.
- Increase the number of people who are supported to address money worries including Good Conversations and benefits.
- Increase the number of people who are supported to stop smoking
- Increase the number of people who are supported to eat well
- Improve screening & early detection e.g. cancer & type II diabetes

Support & Treatment

- Embed the Midway - Support self-management, understanding trauma & addressing inequalities
- Increase access to health and wellbeing support for people at higher risk of health inequalities including people in homeless accommodation, carers, people in receipt of drug and alcohol services or justice services and gypsy travellers.

Crisis & Emergency