North-West Locality Committee

6.30pm, Wednesday 30 January 2019

North West Locality Improvement Plan – Health and Wellbeing Update

Item number	8.5
Report number	
Executive/routine	
Wards	
Council Commitments	

Executive Summary

This report updated the North West Locality Committee on progress made within the Health and Wellbeing section of the Locality Improvement Plan, with a particular focus on accessing primary care and improving mental health and wellbeing.

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Report

North West Locality Improvement Plan – Health and Wellbeing Update

Recommendations

1.1 It is recommended that the North West Locality Committee notes the progress in developing the Health and Wellbeing section of the Locality Improvement Plan (LIP) 2017 – 2022

Background

2.1 In April 2018 the Locality Committee considered a report North West Edinburgh Health and Social Care Update and requested a further update on ongoing work in early 2019. This report focuses on partnership activity as expressed in the Locality Improvement Plan (LIP).

2.2 Four key outcomes were included in the Health and Wellbeing chapter of the LIP, all within the broader strategic framework of tackling and reducing poverty and health inequalities:

2.2.1 Accessible GP and supporting services, with appropriate time for consultation;

2.2.2 Better equipped services to support independent living, and help people in need of support and care to remain at home;

2.2.3 Key facilities in our communities are more accessible, affordable and welcoming and people know how to get support and access resources;

2.2.4 Reduce poor mental health and isolation by providing more opportunities for social engagement, and support measures are in place to care for the range of mental health and wellbeing issues that exist.

2.3 A LIP Health and Wellbeing Group has been established to oversee progress against achieving these outcomes and consists of representatives from the Health and Social Care Partnership, the Forth & Inverleith and Almond Voluntary Sector Fora, EVOC, North West Public Social Partnership, NHS Lothian, City of Edinburgh Council, General Practice (GP's) and the Independent sector. Representatives have a responsibility and commitment to engage with services, groups and people that use services to ensure a wide, fuller community engagement.

Main report

3.1 It is recognised that many locality and city-wide services already provide interventions that actively contribute to achieving the four outcomes included within the LIP. This includes, for example, nursing care and therapy input as well as additionality within health centres as provided by the Edinburgh Primary Care Strategic Commissioning Plan. The group has therefore focused on collaborative activities that help achieve & strengthen the outcomes outlined in 2.1 above. This report provides details on activity and progress made during 2018.

Accessible GP and supporting services, with appropriate time for consultation

3.2 Baseline data has not yet been available for demonstrating improvement of accessibility of GP Practices, despite work being undertaken across the Locality to manage demand and improve access. Each GP Practice has been contacted and requested to provide the following information:

- What is your Practice List Size?
- How many appointments do you offer per week?
- Annual number of appointments not attended in 2017
- Annual number of appointments not attended in 2018
- How many Carers are registered with your Practice?

3.3 The data is currently being gathered and will help provide baseline data for annual reporting of the LIP. In addition, the group will monitor the number of Practices with closed lists, of which there are currently none in North-West Edinburgh. Patient satisfaction surveys are also in place for each Practice that will be used to monitor progress, although the frequency of every 2 years will limit the ability to use this in an ongoing, routine way.

3.4 GPs in each cluster meet monthly with the management team of the North-West Locality and share good practice. This includes experience of testing new ways of working. Actions taken by practices to improve accessibility have included:

3.4.1 GPs phoning people back to triage whether they need to be seen by a GP, Practice Nurse, Link Worker or require a phone consultation

3.4.2 Restricted appointment system to guarantee being seen same day

3.4.3 Text reminder systems, with the aim of reducing missed appointments and maximising capacity

3.5 In September 2018, a North-West GP engagement event was held with over 40 GPs in attendance and included colleagues from the third sector, hospital services and Community Mental Health Teams. It's aim was to inform GPs of the LIP, share good practice and explore opportunities for improving mental health and wellbeing in North- West Edinburgh. The event was positively received with feedback being fed into, and actioned by, the North-West Edinburgh Mental Health Public Social Partnership.

Better equipped services to support independent living, and help people in need of support and care to remain at home

3.6 While not led through the Health and Wellbeing Group, there are two new initiatives in North-West Edinburgh that will support people to remain at home and be discharged from hospital earlier:

3.6.1 From January 2019, Hospital at Home has been rolled out to North-West Edinburgh and provides treatment for some frail older people in their own home as an alternative to acute admission. The multi-disciplinary medical team will work closely with community services to ensure that a holistic, person centred approach is delivered with predicted benefits being related to prevention of admission to hospital.

3.6.2 Discharge 2 Assess was piloted on 7 January 2019 in collaboration between the North West Edinburgh Health & Social Care Partnership Hub and Western General Hospital and promotes speedy discharge from hospital when people are stable for home. Led by an Occupational Therapist and Physiotherapist, assessment will be started at home within one working day with rehabilitation provided for up to 6 weeks.

3.7 Weekly planning meetings take place with our key Care at Home providers. Significant improvement has been made in discharging people that need a package of care. At 31 December 2018, there were 4 people delayed in hospital waiting for a package of care compared with 30 at the end of July.

Key facilities in our communities are more accessible, affordable and welcoming and people know how to get support and access resources

3.8 Work on pathways for accessing services is a priority for the Health and Social Care Partnership in 2019 onwards, including how people are supported to access different services that meet people's needs.

3.9 Work, has however, been successfully undertaken to make services more accessible in the community. Community Link Workers have been funded to work in 13 of the 14 GP Practices in North-West Edinburgh. Link Workers are generalist social practitioners who support people to access and attend services, groups and activities that are available locally and fit their preferences, with the aim of maintaining or improving their health and wellbeing. A Link Worker supports people identified via their GP, to identify their own strengths and challenges and supports the national work around self and case management; Long Term Conditions: and the national strategies around Tackling Social Isolation & Inequalities in Health.

3.10 In December 2018, a North-West Link Worker event was held, bringing together a wide range of organisations that provide health and wellbeing services in the area to update them of the LIP Health and Wellbeing priorities and explore how services can better work together to meet the needs of North-West Edinburgh citizens.

3.11 The Health and Wellbeing Group will review feedback from the event at it's next meeting in February and provide support to the establishment of a locality Network.

Reduce poor mental health and isolation by providing more opportunities for social engagement, and support measures are in place to care for the range of mental health issues that exist

3.12 The Edinburgh Mental Health Public Social Partnership (PSP) is a multi-agency partnership that is taking the lead for helping achieve this outcome. Through working with local communities, the NW Locality PSP has identified gaps in services and resources and works to address these gaps. A city-wide specialist mental health group, Health In Mind, has been funded with additional posts to provide one-to-one and group support in South Queensferry and Stockbridge for people requiring support with their mental health and wellbeing. Further funding has been identified for Health in Mind to provide free 12 week wellbeing courses for local people – with close partnership working with the Community Mental Health Team and wider partners such as Police Scotland and the Family & Household Support Teams via the North-West Community Improvement.

3.13 Work is in the early stages to introduce open access "Thrive" centres across the city, including in North-West Edinburgh, with multi agency and multi professional team input offering brief assessment and formulation leading to a jointly agreed plan with the client regarding next steps. Next steps may include support with social problems; distress brief intervention; psycho-education; community connecting; employment and meaningful activities; arts; green activities; group psychological therapy; individual psychological therapy; medication review. This model was supported by primary care colleagues at the recent GP event.

3.14 In addition to the above, a North-West Physical Activity Alliance event was held with over 20 delegates participating in a structured groupwork activity to thematically map out physical activity opportunities and assets, as well as potential gaps, across the locality. Participants included officers from the Health & Social Care Partnership, the City of Edinburgh Council, third sector organisations, Edinburgh Leisure and NHS Lothian. Work is currently underway to process the data collected from the mapping exercise. This will enable the development of a dynamic planning tool that will allow a greater understanding of what assets are available within the locality in relation to physical activity; how these are distributed; and where overlaps and gaps might be.

3.15 Similar locality information events/seminars have been provided by our locality based Public Health Practitioner, who has a key role in the identification and eradication of the causes and effects of both poverty and health inequalities. Recent events provide have focused on domestic abuse: community engagement; tackling poverty and promoting benefit / employment uptake.

Measures of success

4.1 Available data is currently more individual service specific. There has been a lack of baseline data for many of the joint activities with success based on agreed actions being achieved within the LIP. Measures are therefore being developed under each outcome with baseline data gathered during 2018-2019, as exampled in 3.2.1.

4.2 The Locality Public Social Partnership produce a quarterly outcome based report that provides direct feedback from service users on the impact services have had on their lives and wellbeing. This is now being reported directly to the Health and Wellbeing Group.

Financial impact

5.1 There are no current specific financial impacts with regard to the LIP, with any Council costs being contained within existing budgets. Improved joint action planning and service delivery should result in better services for citizens at no additional cost.

Risk, policy, compliance and governance impact

6.1 Health and Social Care Partnership operational performance is reported to the Integration Joint Board. This report focuses on partnership working led by the Health and Social Care Partnership through the North West Health and Wellbeing Group.

Equalities impact

7.1 Locality planning activity contributes to the delivery of the Equality Act 2010 general duties of advancing equality of opportunity and fostering good relations.

7.2 An IIA has been carried out as part of the Action Planning process of the LIPs, which has identified no specific concerns.

Sustainability impact

8.1 The LIPs have been screened under Schedule 2 of the Environmental (Scotland) Act 2005. This self-assessment has determined that there are no negative environmental impacts and a Strategic Environmental Assessment is not required.

Consultation and engagement

9.1 The development of the LIPs has been a collaborative process involving the community and partners, with the LIP priorities having been informed by considerable public engagement.

9.2 Involving the community in the development and delivery of the action plans, including supporting and empowering local people to lead on improvement project, is key to the success of this Health and Wellbeing component of the plan.

9.3 As stated in section 3.2.4 And 3.6 engagement events have occurred in North-West Edinburgh bringing together a wide range of stakeholders working in the area to help improve relationships, raise awareness of the LIP and develop collective action to achieve the agreed outcomes.

9.4 The Mental Health Public Social Partnership is encouraging active involvement from other community partners, for example North Edinburgh Community Shed and Lifelong Learning. The group is committed to ensuring that the needs of service users are included in their monthly meetings, and are seeking to ensure effective ways to motivate and interest people, for example, a quarterly information or engagement event that will make best used of their lived experience. However, in terms of approach, new activities have been strongly guided by feedback from people with lived experience.

Background reading/external references

None.

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Appendices

None.