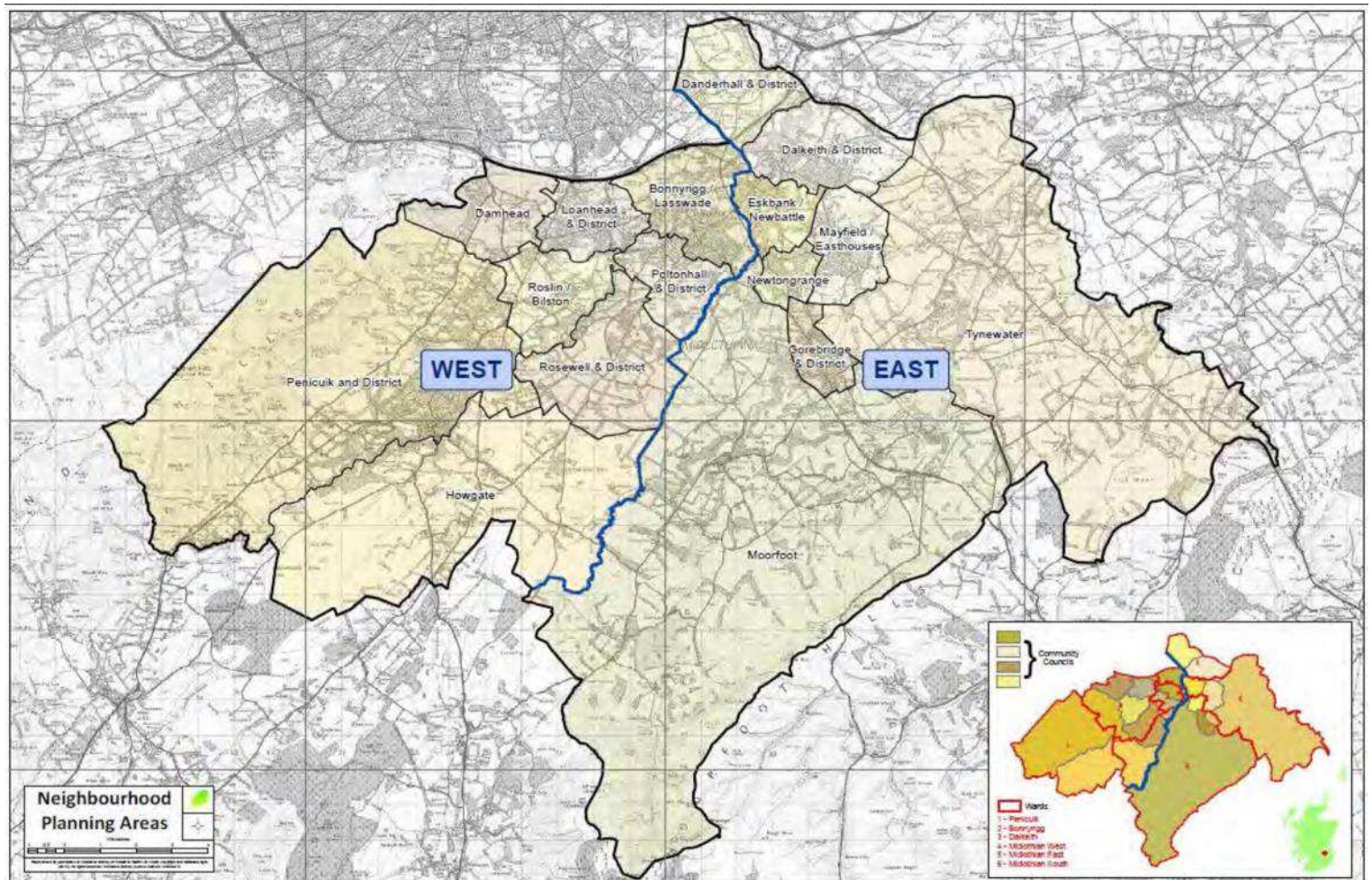


# Midlothian's Health & Social Care Integration Joint Board Annual Performance Report

2017-18 Ratified by IJB on August 2018



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# Foreword

Reflecting on our second year as an Integration Joint Board (IJB) gives an opportunity to think about where things have gone well in addition to the challenges we have faced as an organisation. Our vision remains that we want people in Midlothian to lead longer and healthier lives, with a continuing commitment that we offer the right care, advice and support in the right place at the right time.

The indicators for 2017/18 show us that across Scotland, our health and social care services face challenges. It is sobering to read the results and as an organisation, we take them seriously. Delayed discharges and the challenges to provide care at home services continue, but we need to be able to get people, many of whom have complex needs, home more quickly with the right care and support in place. In contrast, it is heartening to see positives reflecting how much more we now do in the community, with our admission rates, premature mortality rates and bed day rates all better than the Scottish average. In addition, the Care Commission has rated 89% of our care services as good or better, an improvement on last year. We also know from speaking directly with patients, families and service users of the positive impact that services are having in helping them be well and keep well.

Some highlights from our second year include:

- Investing in what works well e.g. Wellbeing Service, Access Point
- Supporting primary care - new practice at Newtongrange, new premises Loanhead
- Investing in innovation - new roles such as physiotherapists and pharmacists in GP practices
- Our continuing commitment to prevention, partnership working and involving our communities
- Having honest conversations with our staff, partners and communities about what is difficult, e.g. Care at Home and how we collectively agree on solutions - Realistic Care and Realistic Medicine agendas
- Using data well so that we understand our population's health and care needs as well as sharing information safely to improve how we deliver care

Our financial plan highlights the need to make efficient use of the resources available and change how we deliver services. If no changes are made then the increase in costs will significantly exceed the resources we have available. But doing things differently takes courage. It means changes for our workforce in terms of greater co-ordination and an ability to work with communities in a flexible and responsive way. We also need to consider where we deliver services and make sure our buildings are fit for purpose and provide opportunities for joint working as well as the needs of Midlothian's growing population. Public engagement is central to all of this and transforming health and care services will only succeed if the people who live and work in Midlothian understand the changes being considered; are able to influence these; and are prepared to support them

While challenges around finances remain, the growing demands on services and workforce pressures are not unique to Midlothian, but our response should be local and involve the people who live and work here. Midlothian benefits hugely from a vibrant third sector and a diverse range of user and carer groups to help us develop the services we need locally. Working collaboratively also supports our resolve to focus on prevention, which is not always easy in this financial climate.

I hope this Report demonstrates our commitment to community involvement, finding ways to support people earlier so that they can live well for longer and ensuring there is care and support in the community that fits better with everyday life.

Thinking about how each part of the health and social care 'system' relate to each other is important too. We know we are able to do more in community settings but this shift also means that there is an impact on community-based staff, unpaid carers and other partners, such as the third sector, which is reflected in the results. We need the 'whole system' to work for the 'whole system' to work. Easy to say and hard to do!

The initial focus of avoiding hospital admissions and tackling delayed discharges remains, but we are now developing a wider set of priorities and working with a broader range of partners that focus more on prevention and early intervention. Looking behind the numbers in our results, I want to emphasise the importance of partnerships and relationships. An IJB cannot make integration work on its own and must bring people together to make things happen that otherwise would not be possible. This is particularly the case for addressing inequalities and we continue to work with our community planning partners to tackle the wider determinants of health such as education, employment and housing.

While integration is not the goal in itself, it is the best way we have to plan and deliver services efficiently that will keep up with people's changing needs. How we do this needs collaboration and co-ordination. It is not about doing more of the same, or only changing where care takes place (in the community rather than in hospital). It is much broader than that and our ambitious programme of transformation is an approach I hope will address the challenges ahead.

In this second annual report, we have reported on our progress against the national outcomes that all IJBs are measured against, but we have also tried to explain who we are as an organisation and share the stories of the successes and challenges over 2017/18. My thanks to you all who contribute so much to the work we do.

**Allister Short, Chief Officer Midlothian IJB**

# Introduction

**Our vision is that people will lead longer and healthier lives by getting the right advice, care, and support, in the right place, at the right time**

The Scottish Government has 9 National Health and Wellbeing Outcomes and these are used by every IJB in Scotland, so you can see how Midlothian compares against the national average. Underneath each outcome are indicators, which show progress made and indicators can appear under more than one outcome (there are 19 indicators in total with 4 still in development).

The first nine indicators (see page 6) are based on annual survey feedback. In Midlothian, 1,977 people took part in the 2017/18 Health and Care survey, a response rate of 26%. Across Scotland, 132,972 people took part, a response rate of 22%. Where possible, we have also looked at local user feedback to help us understand what people think about the services they use, how supported they are to keep well and how involved they feel in decisions.

The remaining ten indicators are derived from organisational/system data which is collected for other reasons, but is used here to inform how we are performing.

## **Comparison with Scotland and with 2016/17 results**

When looking at Scotland as a whole, we can see that performance has worsened across many of the 19 indicators and this is echoed in Midlothian's results. For Midlothian, the only indicator from the Health and Care Survey showing an improvement is ***'being supported to live as independently as possible'*** and is now higher than the Scottish average. In 2016/17, Midlothian was higher than the Scottish average for the indicator relating to 'quality of life'. For 2017/18 we are now below the Scottish average. The indicator relating to carers has dropped for Midlothian and Scotland, but there seems to be a more marked impact locally.

Emergency admission rates and the number of days people spend in hospital when they are well enough to go home are both better than the Scottish average, but are worse than the 2016/17 Midlothian results. Premature mortality rate is also better than the Scottish average and an improvement on 2016/17. The continuing challenges Midlothian faces (along with many other parts of Scotland) in delivering care at home may be having an impact on unpaid carers, as well as extending people's time in hospital. We also know that as we do more to care for people at home, those who are in hospital often have complex needs. We have also seen a decrease in the number of Care Home places. These kinds of interrelated factors from different parts of the health and social care system give us some explanations. These relationships are highlighted, where appropriate within this Report. We also set out how we work as a Health and Social Care Partnership and offer examples of services and partnership working, all of which contribute towards the health and wellbeing outcomes.

# National Health & Wellbeing Outcomes

2017 /18 Performance at a glance - ISD (June 2018)



**92%**

Adults are able to look after their health very well or quite well

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	93	92
Scotland	n/a	n/a	n/a	94	93



**86%**

Adults supported at home agreed that they are supported to live as independently as possible

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	78	86
Scotland	n/a	n/a	n/a	84	81



**80%**

Adults supported at home agreed they had a say in how their help care or support was provided

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	85	80
Scotland	n/a	n/a	n/a	79	76



**71%**

Adults supported at home agreed that their health and social care services seemed to be well coordinated

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	75	71
Scotland	n/a	n/a	n/a	75	74



**71%**

Adults receiving any care or support rated it as excellent or good.

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	73	71
Scotland	n/a	n/a	n/a	81	80



**76%**

Adults had a positive experience of the care provided by their GP practice

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	80	76
Scotland	n/a	n/a	n/a	87	83



**73%**

Adults supported at home agreed their services and support had an impact on improving or maintaining their quality of life

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	86	73
Scotland	n/a	n/a	n/a	84	80



**32%**

Carers feel supported to continue in their caring role

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	40	32
Scotland	n/a	n/a	n/a	41	37

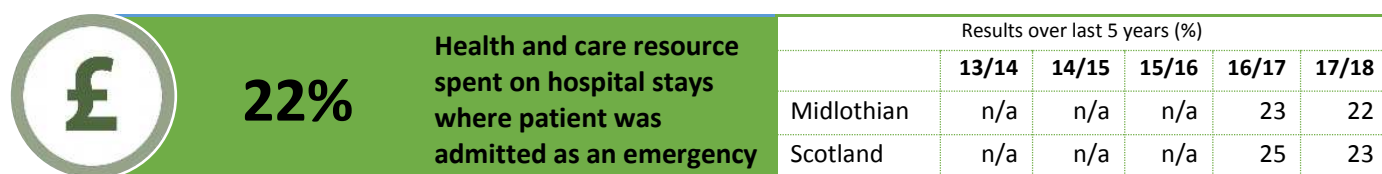
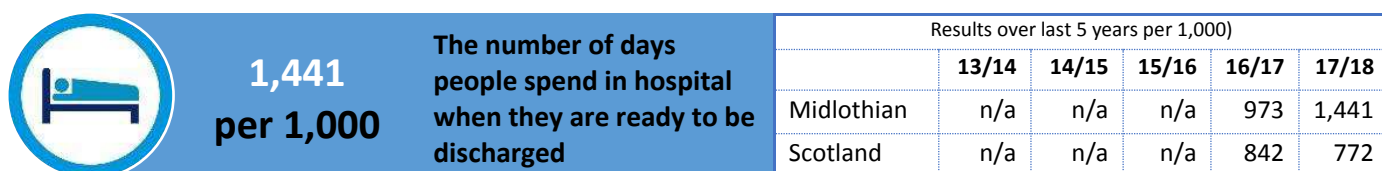
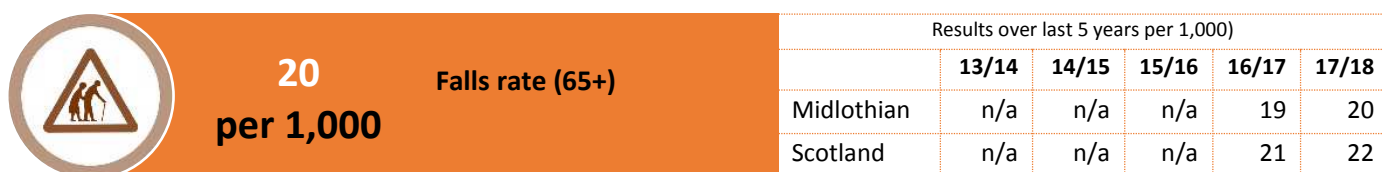
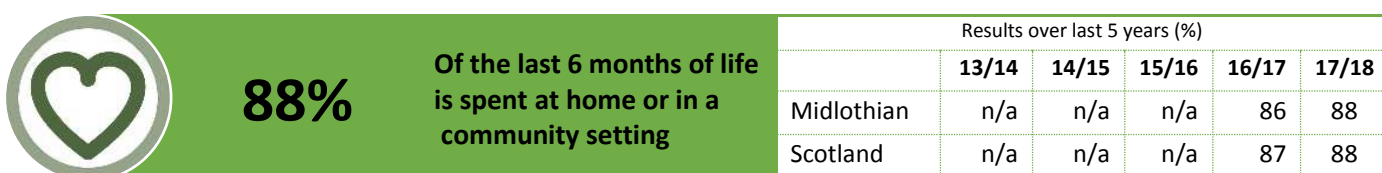
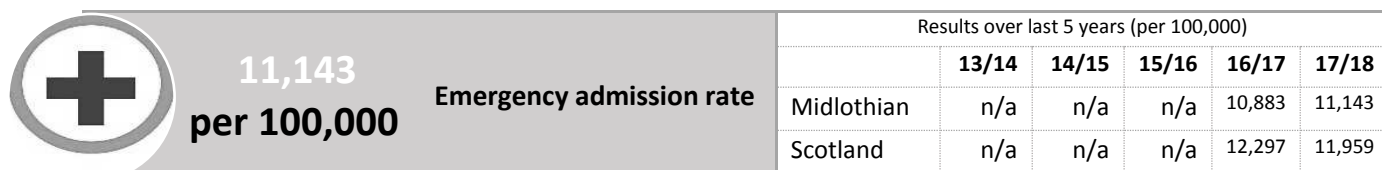
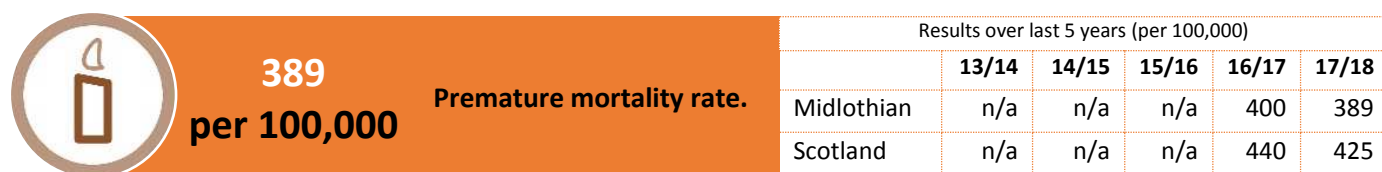


**79%**

Adults supported at home agreed they felt safe

Results over last 5 years (%)					
	13/14	14/15	15/16	16/17	17/18
Midlothian	n/a	n/a	n/a	82	79
Scotland	n/a	n/a	n/a	84	83





# Outcome 1 - Improved Health and Wellbeing

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

Our approach to improving health and wellbeing in Midlothian focuses on:

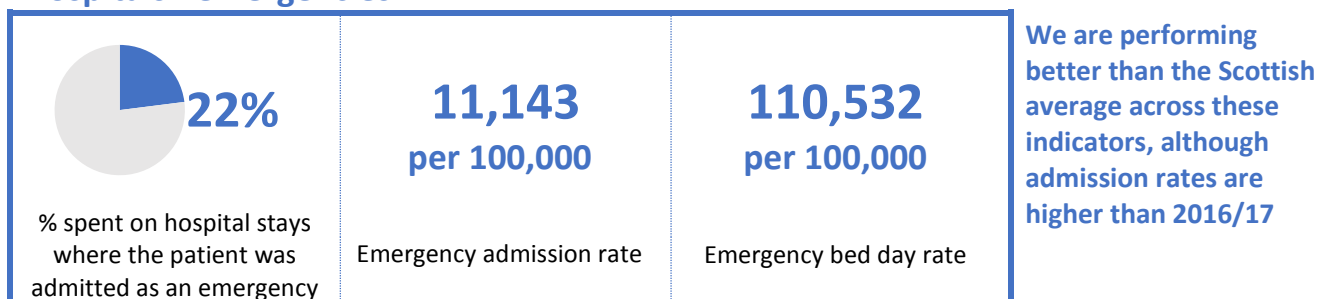
- Seeing the whole person and understanding what matters to them in their day to day life, not just their health issues. We call this our 'House of Care' model
- Improving our commitment to prevention and working in partnership with other agencies and our communities. Strong relationships help services work in a more joined up way and involving people in our plans and decisions gives us a better chance at successfully meeting the needs of people living in Midlothian
- Making sure our services are easy to use for people who need them, so they get the right help in the right place at the right time. Wherever possible, this will be close to home and help us reduce avoidable hospital admissions.

## How did we do?

### Adults supported at home



### Hospitals - emergencies





## Local services working to achieve this:

### Specialist Support

We have over 2000 people in Midlothian who are living with COPD. Our area's mining history means that this is a higher proportion of our residents than other parts of Lothian. An **Advanced Practitioner Physiotherapist for COPD** was appointed to support people in the community to help them manage their COPD at home and avoid hospital admission.

Claire works with patients who are attending hospital frequently because of their COPD. In the first year the service has worked with 65 patients and successfully avoided 30 hospital admissions.

If the average stay is 17 days per stay, this adds up to a potential reduction of 520 days spent in hospital by Midlothian residents.

Not only is this a much better patient experience, this is also a cost-effective approach to delivering services for the Health & Social Care Partnership.

*“I have learned how to deal with panics, I no longer phone the ambulance straight away*

*”*

*“Because of the help I have got at home now, I feel like I am not going into hospital as much.*

*”*

### Weight Management Services

Accessible services, like **Weight Management** help people get support when they need it. During 2017-18, 334 people were referred to the Service, which offers community based programmes, as well as specialist support involving NHS Lothian dietetic, psychology and physical activity programmes.

## Supporting people in a holistic way

Our 'House of Care' model has been central to Midlothian's vision. We know that lives are complex and that the challenges people are dealing with such as unemployment, money worries and managing long-term health conditions all have an impact on their ability to make choices that help them to live well.

The **Wellbeing Service** in partnership with the Thistle Foundation gives people time and space to consider what is going on in their lives and to develop their own ways to better manage their health and wellbeing. The 'good conversation' demonstrates our 'House of Care' approach to seeing the whole person. The top issues reported are family, relationships, money, housing and mental health.

People are treated as equal partners and the focus is on personal outcomes and self-management. It recognises the importance of prevention and anticipatory care and support. The evaluation has demonstrated that this approach supports people to take back control of their lives and by addressing the things that matter to them, feel better about themselves and more able to live well. GPs tell us that not only have the number of appointments fallen, but that when they do see people, the consultation is more productive.



809 people referred – more likely to be living in an area experiencing multiple deprivation.  
508 people supported via 1648 appointments

There is a significant increase in people's WEMWBS over time (this measures general mental wellbeing). On average, people have moved from a score of 35 at first appointment to 49 on discharge. This is just over the population average score.

## Outcome 2 - **Support to live in the community**

**People, including those with disabilities and long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community.**

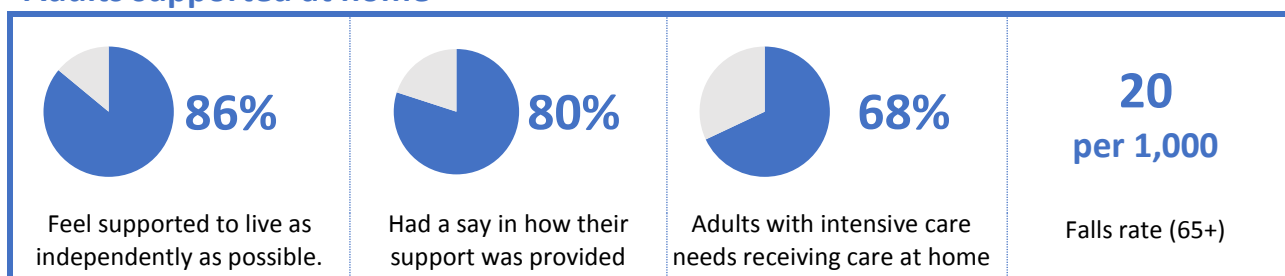
We continue to develop the services we need in our communities so that people only go into hospital when absolutely necessary. As a result, we can offer much more to support people to stay at home or in a homely setting. This means that the people we do have in hospital often have very complex needs. This, along with the fall in Care Home places is reflected in that many of our indicators have fallen in the last year, although more people did say that they felt supported to live independently and having a say in how care is provided remains higher than the Scottish average (but is lower than 2016/17 results).

The percentage of people spending the last 6 months of life at home or in a community setting has also increased, which is good news. Midlothian has a Palliative and End of Life Care Partnership Group who work together to improve the quality of life for Midlothian patients and their families, as they face the problems associated with any life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification and careful assessment and treatment of pain and other problems, physical, psychosocial or spiritual.

As well as supporting good working relationships, innovative approaches to supporting families following a bereavement in Newbyres Village Care Home has elicited positive feedback and is now routine practice.

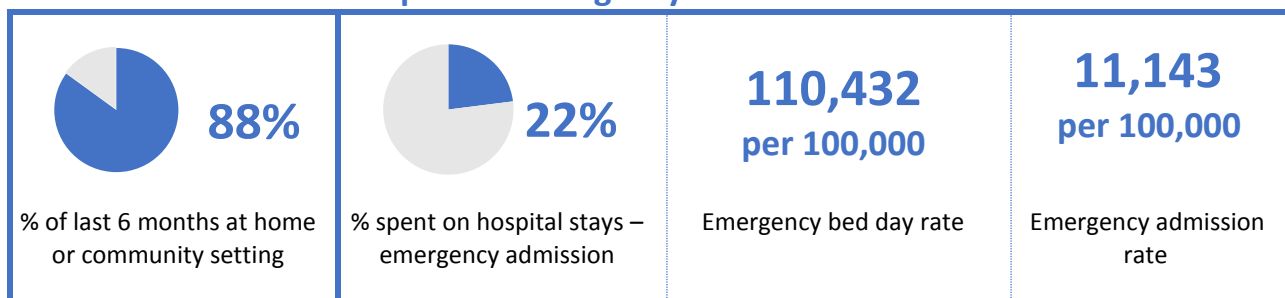
### How did we do?

#### Adults supported at home



#### End of life care

#### Hospitals - Emergency



## Hospitals - Discharge

<b>1,441</b> per 1,000	<b>107</b> per 1,000
No of days in hospital when ready to be discharged	Readmission within 28 days

## Local services working to achieve this:

### Purpose built accommodation

People with learning disabilities have the right to live longer, healthier lives, be able to participate fully in society and be treated fairly and equally. Being able to live independently is an important part of this vision.

New **purpose built accommodation** for 12 people with complex needs opened in Penicuik in October 2017. This enables more people to remain in Midlothian whilst ensuring their specialist needs can be met. The properties are all wheelchair accessible and were designed using the most up to date research and best practice in building design. The service also benefits from a full time Positive Behaviour Support Advisor to help avoid admission to in-patient services. One of the first tenants to move into Teviot Court commented on how the opportunity to move into this new accommodation will be truly life changing for him. He said:

*"Life will be better. I will no longer be in hospital. I have been in hospital far too long. Moving into my own home will enable me to live more independently, to learn new skills such as cooking and doing housework. I am looking forward to meeting new people, exploring my local neighbourhood and finding out about other things that I can join in with".*

Accommodation for the remaining patients who have lived in long-term hospital beds has now been arranged meaning that **no one with learning disability from Midlothian lives in hospital.**

Positive behavioural support for people with a Learning Disability and Safe House to avoid admission to In Patient Services

## Outcome 3 – Positive experiences & treated with dignity

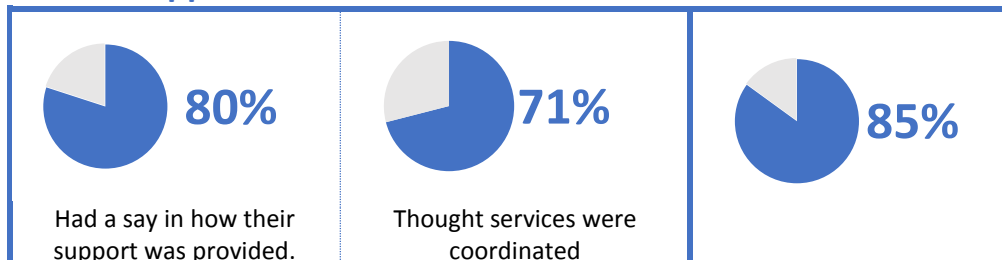
### People who use health and social care services have positive experiences of those services and have their dignity respected.

Feeling involved in your own care is important and Midlothian scores higher on this indicator than the Scottish average, although it is slightly lower than last year's figure. Services undergoing inspections did well in Midlothian with 89% rated as good or better, an improvement on 2016/17 results and above the Scottish average.

Health and Care Survey results are lower than last year, as are Scotland's and Midlothian is below the Scottish average. Challenges remain for Midlothian, such as access to GPs. There has been positive progress such as Loanhead Practice's move to purpose built premises part of the Paradykes development as well as some of our practices being able to re-open their lists, but we know there is still more to do.

### How did we do?

#### Adults supported at home

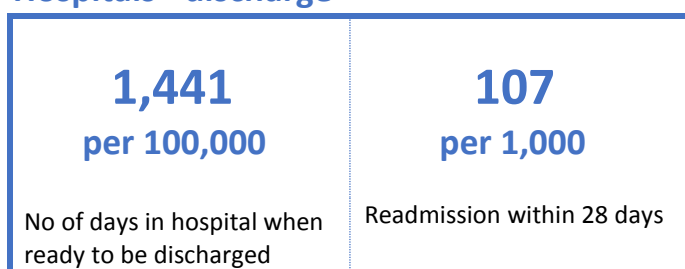


#### End of life care

#### General satisfaction with services



#### Hospitals - discharge



## Local services working to achieve this:

### Focusing on Frailty

We have started to **develop new ways of supporting our most frail people who find it hard to get out and about** in the Penicuik area. GPs, District Nurses, social care, VOCAL, Broomhill and Red Cross are all part of this work.

Understanding people's needs, good communication and sharing information safely are central to this.

As well as meeting health and care needs, practical support to enable people to live well and tackle issues such as loneliness are just as important.

### Peer Support

Many people in Midlothian experience difficult times, struggling with addictions, mental health problems or are at risk of offending. Approaches focusing on peer support, such as the **Recovery Cafe and SPRING** are part of our commitment to having the appropriate support and pathways in place for those at particular risks.

The **Midlothian and East Lothian Alcohol and Drug Partnership (MELDAP)** **challenged stigma** by promoting the role of the recovery community, employing and involving people with lived experience and providing peer volunteer training.

### Reducing times for help with mental health issues

Midlothian offers a responsive and accessible drop-in service, **Midlothian Access Point**.

No referral is needed, so the service is available when the person feels ready to seek help.

The number of people waiting for a long period for psychological services has reduced

The service became fully established in 2017/18 and funding is now identified for its continuation and expansion in 2018-19.



## Outcome 4 – Improved quality of life

### Health and Social Care services are centered on helping to maintain or improve the quality of life of people who use those services.

In comparison with last year, fewer people reported that services had an impact on maintaining or improving their quality of life and unlike last year, we are now lower than the Scottish average.

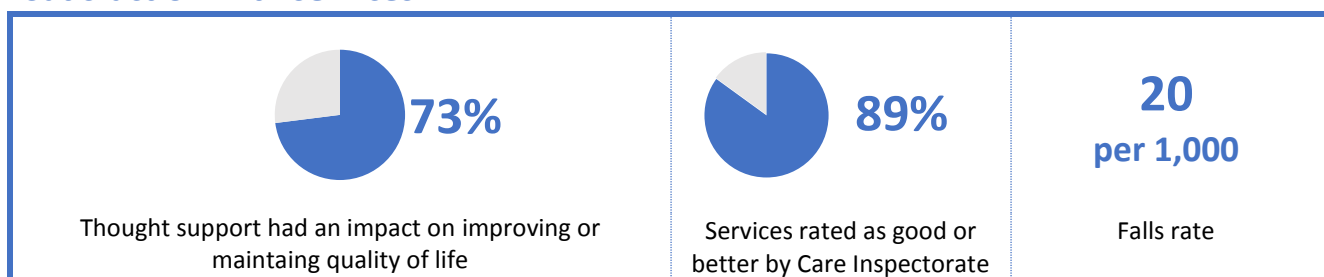
We know that for many in Midlothian, there are day to day struggles to contend with and it is often not easy to live well. We want our services to help and will continue to take notice of what people are telling us about our services, so while this is disappointing, these results show us that we need good partnership working more than ever. There are several examples of where we have seen positive progress made between health, social care and the voluntary sector.

Inspections are an important part of us understanding how good our care homes and day services are. The Care Inspectorate has visited a number of services and it is positive news that there has been an increase from 85% to 89% of services being rated as good or better, which is higher than the Scottish average.

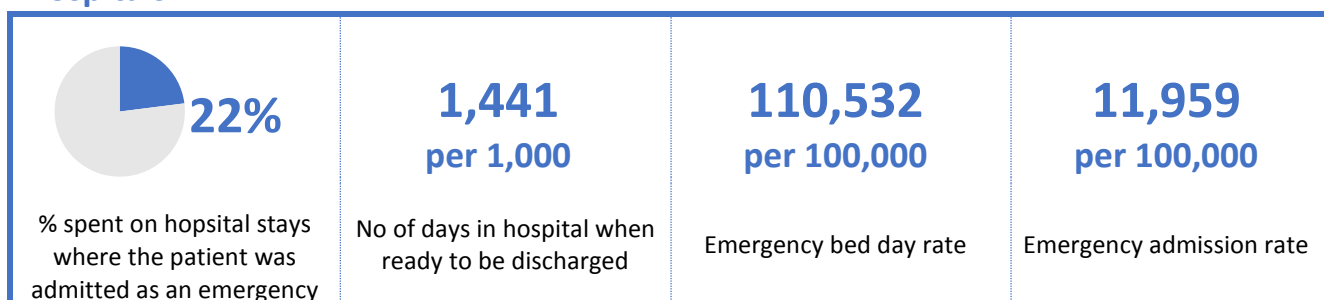
Getting people home from hospital once they are well enough to do so is not easy. No-one should face delays and we all want this situation to improve. The results for Midlothian are concerning and reflect the challenges we face with organising and delivering packages of care. We also know how much this impacts on families and carers when loved ones are in hospital. Work is on-going to make this a more responsive and efficient service with both in-house and external providers of Care at Home services. Looking at alternatives to care at home and reviewing packages as part of the 'Realistic Care' agenda is all part of trying to improve a difficult area for Midlothian.

### How did we do?

#### Satisfaction with services



#### Hospitals



## Local services working to achieve this:

### Tackling isolation and supporting independence

Our partnership work with **British Red Cross (BRC)** continues to grow and workers now attend social work duty team meetings and daily MERRIT (Midlothian Enhanced Rapid Response Team) meetings. This innovative development is making a positive difference to older people in Midlothian.

BRC provides opportunities to re-gain confidence and get out and about again through their Local Area Co-ordinators, as well as practical advice and support via the Neighbourhood Links service.

In addition, recognising that summer can be a time when families and friends head off on holiday, 465 older people were able to enjoy BRC's 'Summer Pop-Up' where a range of activities were on offer.

The MARC building in Woodburn was refurbished to enable the **Grassy Riggs** drop-in café and carer support service to open to older people at risk from social isolation and loneliness.

Between 165 and 370 people use the drop-in every month and the venue is well used by a range of services. This was only possible because community councillors, the Health & Social Care Partnership and the community came together to use a previously underused community building.

Opportunities for social interaction are vital and **Broomhill Day Centre** in Penicuik offers 125 places very week for older people who would find it difficult to leave their home independently. With its own mini buses and a dedicated team, the staff and volunteers offer a vibrant and stimulating service and are very much part of the community with fantastic links to local schools.

## Outcome 5 – Reduced Health Inequalities

### Health and Social Care services contribute to reducing health inequalities.

Inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. People affected by poverty and social disadvantage have poorer health outcomes than their neighbours with more resources. Other people also experience disadvantage - e.g. low income, gender, social position, ethnic origin, geography, age and disability.

Some health inequalities in Midlothian in areas affected by social disadvantage:

Early death due to coronary heart disease:	Hospital stay for a preventable reason:	Difference in Life expectancy:	Prescription for anxiety/ depression:	Children living in poverty .
x21 higher	15-20% more likely	7 years shorter	9% higher	25%

The Community Planning Board has developed a set of indicators that tell us whether we are making progress in reducing health inequalities and this work has been recognised as good practice in other parts of Scotland.

### How did we do?

<b>389</b> per 100,000	<b>11,143</b> per 100,000
Premature mortality rate	Emergency admission rate

The emergency admission rate and premature mortality rate are both better than the Scottish average and the latter is better than Midlothian's 2016/17 results.

## Local services working to achieve this:

### Support for offenders

We know that there is a connection between inequalities and offending and we strongly believe that by reducing inequalities there will be less crime and fewer victims.

**SPRING** supports women with complex needs who are at risk of or have been involved in offending. **Fresh Start** engages with individuals at the point of arrest and links them into relevant services such as substance misuse and mental health services.

**Spring Service** has increased support to women linked to the criminal justice system

#### Other Vulnerable Groups:

- Work with schools around **child poverty, school absence & smoking** prevention
- New pathways were developed to identify **families at risk of eviction** earlier and a pathway for people attending A+E

### Support for Vulnerable people

#### Community Health Inequalities Team (CHIT):

Provided **health assessments and support for vulnerable people**, e.g. homeless, carers, substance misuse, women involved with criminal justice, gypsy travellers.

Delivered a **6 week programme for people identified as having pre-diabetes** to support lifestyle changes to avoid or delay developing type 2 diabetes

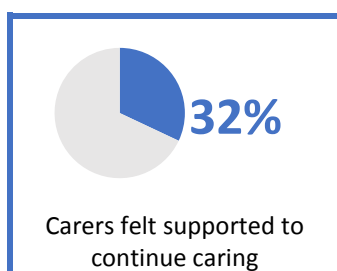
## Outcome 6 – Support for Carers

**People who are providing unpaid care are supported to look after their own Health and Wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.**

It is estimated that around 8000 people or 10% of our population have some form of caring role and as we move from hospital to community-based care, we know that much of that support is provided by carers. In the last 10 years, the number of people providing at least 20 hours of care each week has increased by 35.7% and over 2000 people (1 in 4 carers) care for over 50 hours each week.

As a Partnership, we recognise the level of commitment shown and value the quality of care being given. Quite simply, we could not do what we do without this contribution. As such, the fall in the % since last year is of great concern and while this is also reflected in the Scotland-wide results, the drop seems more marked at a local level.

### How did we do?



We need to understand what might lie behind these results and VOCAL's 2017 survey gives a helpful local picture:

[https://www.vocal.org.uk/wp-content/uploads/2018/03/CarerSurvey2017\\_Midlothian.pdf](https://www.vocal.org.uk/wp-content/uploads/2018/03/CarerSurvey2017_Midlothian.pdf)

The impact of caring on health and wellbeing is well documented in terms of finances, social isolation and the opportunity to get a break from caring responsibilities and all of these issues were echoed in VOCAL's survey.

In terms of what has contributed to this year's results, we need to consider the wider service issues in Midlothian that might offer some explanation, e.g. the challenges involved in setting up packages of care and carers stepping in to meet the need. Are we doing enough to ensure that carers are aware of the opportunities we have in Midlothian to get a break from caring duties? Can we work more collaboratively so that we get to know who has a caring role at an earlier stage? Will this help us identify 'early warning signs' so that we can offer support before a crisis happens and there is a risk that the person cannot continue in their caring role?

Looking forward, our Carers Strategy and Action Plan into 2019 aims to:

- Increase Carer Identification and Support
- Improve Access to Breaks from Caring
- Reduce Health Inequalities and Financial Hardship
- Embed a systematic approach to Emergency Planning

The new legislation brings an emphasis on focusing on the impact that caring has. As part of this, we have embarked on staff briefings to support this approach to working with carers in Midlothian.

## Local services working to achieve this:

### Emergency Planning

One area highlighted in the VOCAL survey was the worries carers have about what might happen if they can no longer carry out their caring role due to ill health or other changes in circumstances. The need to have 'Emergency Plans' in place is part of the new Carers legislation and is an area the Partnership have been piloting- a first in Scotland.

These are sensitive conversations to have, but important in terms of increasing involvement in decision making and helping people feel in control where possible in their lives.

### Respite

We have reintroduced funding (£30,000) for the Wee Breaks Service, recognising the importance of providing opportunities to ensure breaks from caring duties are accessible and available.



## Outcome 7- Safe from harm

### People using health and social care services are safe from harm.

Good joint working is strongly associated with supporting people to be safe from harm, as well as helping prevent avoidable risks. The East Lothian and Midlothian Public Protection Office involves health, social care and Police working together to support and protect adults and children who may be at risk of harm.

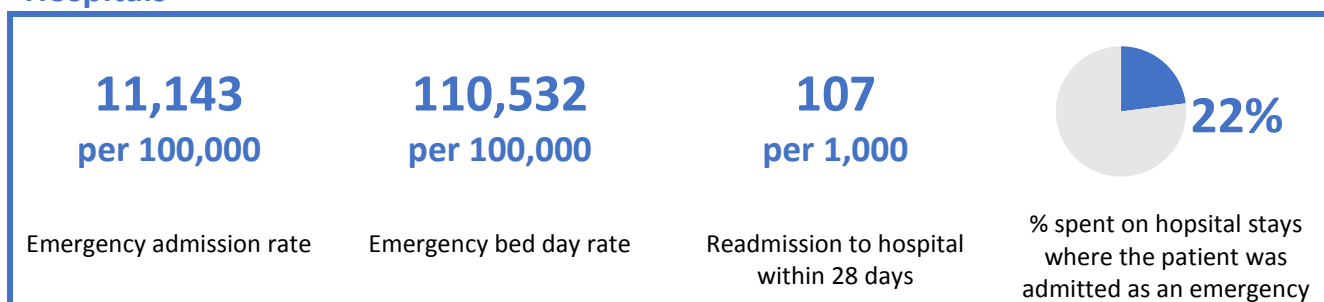
A lower % of adults who are supported at home reported feeling safe when compared with 2016/17 and Midlothian is lower than the Scottish average. The falls rate among people aged 65+ has reduced from a high of 23 in 2012/13 to 19 in 2016/17, with a slight increase to 20 in 2017/18. There is a well-established falls pathway in Midlothian and we are performing better than the Scottish average.

### How did we do?

#### Satisfaction with services



#### Hospitals



## Local services working to achieve this:

### Safe and Together

The “**Safe and Together**” approach involves working with both parents, with the aim of keeping children safe and together with the non-abusing parent

In view of the growing waiting lists we increased financial support to the voluntary organisation **Rape Crisis**, as well as awarding a 3 year contract to **Women’s Aid East and Midlothian**.

The **Spring Service** for women involved or at risk of offending worked in close partnership with a range of organisations including Women’s Aid, Community Health Inequalities Team and MELD. Staff have been trained in Mentalisation Based Therapy particularly useful for women who have experienced trauma and as a result have developed personality disorders.

## Outcome 8 – Engaged and Supported workforce

**People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

Integration brings change, in particular around staff working more closely together so that services are of a high quality and we make effective use of resources. To make progress in these areas, staff need to feel supported in their roles, have opportunities to learn together, as well as feel engaged and valued by the Health and Social Care Partnership.

2017-18 saw the first year of a survey for both health and social care staff, called 'iMatters'. Questions cover how people feel about their own role, in terms of being valued, involved and supported, as well as their experiences as being part of a team and how they view the organisation. 693 people took part, a response rate of 66%. The majority of responses were very positive, whether answering questions about individual roles, being part of a team or the organisation as a whole. The question about how good an experience working for Midlothian Health & Social Care Partnership is (where 1 is very poor and 10 is very good) gave a global score of 7.21.

### Local services working to achieve this:

#### Recruitment & Retention and Valuing Staff

All sectors had access to the Lothian's Team Development Toolkit and a programme for Team Leaders and operational frontline supervisors was developed.

Workshops continued and expanded in topic area to cover Health Inequalities.

Good Conversations lunchtime sessions for staff across all sectors of the H&SCP offered a time to reflect on what is working well and what could be better.

Videoconferencing makes it easier for Care Home staff to take part in training, reducing the need to travel off-site. 10 out of 11 care homes have participated. In the first 6 months a total of 12 training sessions have taken place, attended by 386 staff

New approaches to attract people into a career in care have been implemented - e.g using social media to attract young people to the profession.

Midlothian IJB Workforce Planning Framework was developed and service reviews have been addressing the redesign of roles for the future

Implementation of the Living Wage for social care staff.

## Outcome 9 – Efficient & Effective use of resources

### Resources are used effectively and efficiently in the provision of health and social care.

Redesigning services as laid out in the Strategic Plan can be funded by moving resources from one model of care to another. Additionally, in time, these shifts in emphasis will result in less costly services.

For example, moving from hospital to more community based services. The IJB has set a target of a reduction in occupied hospital bed days of 10% which would enable a significant transfer of resources to community service.

The Realistic Medicine and Realistic Care agendas are important frameworks for the Health and Social Care Partnership. Prescribing remains a main pressure. Medication is vital in helping people recover and keeping people well. However the costs are high; with £18.3m spent in Midlothian in 2017/18.

Having ‘good conversations’ with people receiving packages of care are taking place so that people’s needs are being reviewed as well as looking at what alternatives there are for care at home. The aim for each of these areas is that outcomes should be better for people as well a more efficient use of the money we have to spend.

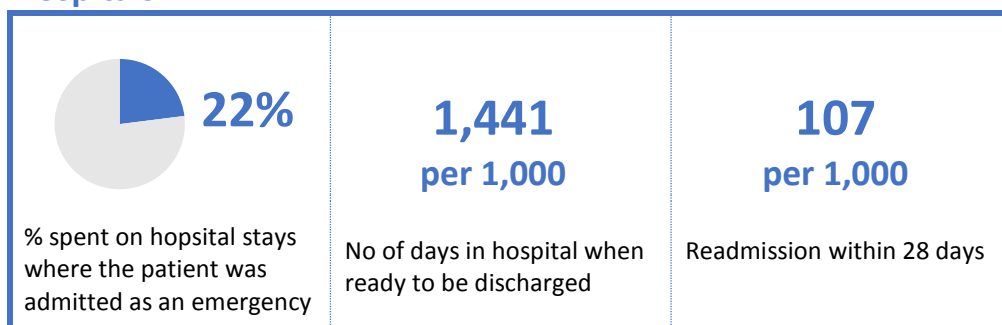
### How did we do

#### Adults supported at home



#### End of life care

#### Hospitals



# Our strategic plan - update

## Longer term conditions:

Cancer	<ul style="list-style-type: none"> <li>Established the local <b>Transforming Care After Treatment</b> project to test a new approach to service delivery based on holistic needs assessment.</li> <li>Continued to provide <b>specialist services</b> including Occupational Therapy, employment service (in the NHS Lothian's Work Support Services), complimentary therapy (by IRIS) and support with exercise (in council leisure centres).</li> <li>The specialist <b>Macmillan Welfare benefits service</b> generated an additional £1.6million for people with cancer in 2017-18. The local GP Cluster implemented the <b>Macmillan Quality Toolkit</b> to improve quality of care for cancer patients.</li> </ul>
COPD	<ul style="list-style-type: none"> <li>An <b>Advanced Practitioner Physiotherapist for COPD</b> was appointed to support people in the community to help them manage their COPD at home and avoid hospital admission. In the first seven months the service successfully avoided 30 hospital admissions.</li> <li>Strong links developed with the <b>Midlothian Stop Smoking Service</b> and the <b>Pulmonary Rehab (exercise) service</b> at Midlothian Community Hospital.</li> <li><b>Breathe Easy</b> support group meets monthly</li> </ul>
Neurological Conditions	<ul style="list-style-type: none"> <li>12 people with Multiple Sclerosis attend a <b>monthly support group</b>, facilitated by an Occupational Therapist.</li> <li>Health &amp; Social Care staff support people living with a neurological condition. This includes the <b>Midlothian Community Rehabilitation Team</b>.</li> <li>The <b>Lanfine Service</b> continues to provide an acute neurological specific inpatient service at Astley Ainslie Hospital plus individual community based support.</li> <li>Organisations with a focus on specific conditions such as Parkinson's Disease, Multiple Sclerosis and Epilepsy provide <b>specialist advice and support</b></li> </ul>
Heart Disease	<ul style="list-style-type: none"> <li>People were supported to keep healthy and reduce their risk of developing coronary heart disease. <b>Ageing Well, Midlothian Active Choices</b> and other programmes are important to this work as are mainstream services such as <b>Midlothian Leisure</b>, positive health advice from primary care colleagues, weight management support and do on.</li> <li>People who have experienced a heart attack or who have undergone cardiac surgery are visited at home by a <b>Cardiac Rehabilitation Nurse</b> and, later, they are supported to attend a <b>Cardiac Rehab programme</b> delivered at Gracemount Leisure Centre.</li> <li>People with co-morbidities may require more intensive support and monitoring. The Midlothian Cardiac Rehabilitation Nurse may refer them to a service at Astley Ainslie Hospital. This clinic includes psychological support, physical activity and different speakers. Strong links with Stop Smoking and welfare rights services exist.</li> </ul>
Diabetes &	<ul style="list-style-type: none"> <li><b>Made a commitment to tackle obesity and type 2 diabetes.</b></li> </ul>

Obesity	<ul style="list-style-type: none"> <li>• Work progressed to <b>reshape the weight management pathway</b>. Referrals are now triaged by the Weight Management Team who offer community based services such as Midlothian Active Choices, Ageing Well, Leisure Services, Community Health Inequalities Team (CHIT) or dietetic-led weight management group programmes delivered with Midlothian Leisure Services or individual assessment and treatment involving dietetic, psychology and physical activity support.</li> <li>• Delivered a <b>6 week programme for people identified as having pre-diabetes</b> to support lifestyle changes to avoid or delay developing type 2 diabetes. This was delivered by the Community Health Inequalities Team nurses.</li> <li>• During 16/17 172 people were referred (up 58% on previous year) to the NHS Lothian <b>Weight Management Service</b> and 71 (41%) engaged. Between April and September 2017 159 people were referred to the Weight Management Service. They were offered community based programmes (with Midlothian Leisure services) or specialist support involving NHS Lothian dietetic, psychology and physical activity programmes.</li> <li>• Launched a <b>women only exercise class</b> with Midlothian Muslim Community Centre and Midlothian Leisure.</li> <li>• £50,000 was made available in June 2017 for <b>healthy eating/food poverty programmes</b> across three target areas. Grants (up to £3,000) were awarded.</li> <li>• <b>Training on healthy eating, physical activity and Type 2 diabetes</b> was delivered to Midlothian staff from a range of agencies.</li> </ul>
Stroke	<ul style="list-style-type: none"> <li>• Services supported people to <b>reduce their risk factors</b> - e.g. Weight Management, Stop Smoking, Ageing Well and Midlothian Active Choices. Midlothian Leisure Services provided exercise groups for people recovering from a stroke.</li> <li>• <b>Supported self management, reablement and rehabilitation</b> was provided by mainstream services -e.g. Midlothian Community Physical Rehabilitation Team (MCPRT), MERRIT and Community Care Team. Supported self-management and health improvement support was provided from the Wellbeing Service in GP practices</li> <li>• People were supported to <b>return to employment</b> through the vocational rehabilitation programme delivered by MCPRT or by the Working Health Services team at Astley Ainslie Hospital.</li> <li>• Midlothian Chest, Heart &amp; Stroke lead a <b>Chest and Stroke Group</b> in Bonnyrigg and Penicuik. British Red Cross support by arranging transport from volunteers.</li> </ul>
Palliative Care	<ul style="list-style-type: none"> <li>• The local Palliative Care planning group continued to <b>review and improve the approach</b> to palliative care - and is viewed as a model of good practice across Lothians.</li> <li>• Staff skills have been strengthened through <b>video conferencing training programme</b> and a shared learning programme enabling people to learn from one another across services.</li> <li>• In Newbyres Care Home <b>feedback from bereaved families</b> is sought through questionnaires. A family bereavement group has also been established.</li> <li>• The Wellbeing Service ran "<b>New Beginnings</b>" workshops</li> <li>• <b>A series of events were held to raise awareness about dying</b></li> </ul>



## Service User Groups:

Older People	<ul style="list-style-type: none"> <li>Started to develop new ways of supporting people who are housebound in the Penicuik area involving agencies including pharmacists and voluntary organisations.</li> <li>Reshaped Newbyres Care Home to provide 24 specialist places for people with dementia.</li> <li>The MARC building in Woodburn was refurbished to enable the Grassy Riggs drop-in café and carer support service to open to older people at risk from social isolation</li> <li>Day services, community based services and care at home staff worked with pharmacists and GPs to strengthen the provision of medication.</li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>The Access Point became fully established.</li> <li>Established a triage service to support people in crisis when they come into contact with the police service.</li> <li>The number of people waiting for a long period for psychological services has reduced.</li> </ul>
Physical Disability	<ul style="list-style-type: none"> <li>New initiatives with <b>Edinburgh College and Life Long Learning and Employability</b> improved access to further education and employment.</li> <li><b>Information was provided</b> through newsletters, an updated directory of services and an easy read version of the local strategy.</li> <li><b>A new policy was developed</b> regarding adaptations to houses and a new approach to suitable housing was introduced described in the booklet “Support to Move”.</li> <li><b>The Wellbeing Service</b> provided support to people with long term health conditions in 8 Health Centres.</li> <li><b>A new approach to multidisciplinary working was tested in Penicuik</b> to support people who are housebound.</li> </ul>
Sensory Impairment	<ul style="list-style-type: none"> <li>An <b>awareness raising programme</b> was delivered to staff including care at home and care home workers, reception staff in Health Centres, Contact Centre and voluntary organisations</li> <li>Joint work with the <b>local fire service</b> has resulted in sensory impairment as a factor in home safety visits</li> <li><b>Hearing aid batteries</b> are now available in libraries including the mobile library and a repair service is being organised in libraries through volunteers</li> <li><b>Deaf Action and Royal National Institute for the Blind (RNIB)</b> provide more localised and integrated services being based one half day a week with the local social work team</li> <li>The Scottish Government service <b>contactSCOTLAND</b>, was promoted through our training and press releases. This service provides a live link to an on line BSL interpreter and facilitates communication with Public Bodies.</li> </ul>
Learning Disability	<ul style="list-style-type: none"> <li>Built accommodation for 12 people with complex needs opened in Penicuik.</li> <li>Accommodation for the remaining patients who have lived in long term hospital beds has been arranged - no one with learning disability from Midlothian lives in hospital.</li> <li>The NHS Lothian Learning Disability Service is now under local management</li> <li>A major programme of reviews has been undertaken to ensure that people’s needs are being met appropriately. These reviews have been guided by new policies designed to ensure that services are allocated an equitable and consistent way including policies on allocation of care, transport and day services</li> </ul>

Autism	<ul style="list-style-type: none"> <li>• The <b>Midlothian Autism Strategy</b> ‘Two Trumpets’ was launched.</li> <li>• An <b>awareness raising campaign</b> including ‘The Triad of Impairments and Other Works’ by artists Gayle Nelson and Fiona McDonald was exhibited to launch the strategy publicly and engage partners in the Autism Strategy.</li> <li>• <a href="http://autismideasinmidlothian.com">autismideasinmidlothian.com</a> was developed and launched. This incorporates a calendar feature on events and activities for Autistic People.</li> <li>• The <b>Midlothian Autism Facebook page</b> was launched.</li> <li>• An <b>Interactive Directory of Supports of Midlothian</b> resources was completed.</li> <li>• <b>Fit, Fab, and Fun a group for women</b> with a learning disability and/or autism in Midlothian was established.</li> <li>• Teviot Court, a development of <b>12 local authority houses for people with Complex Needs</b> was completed.</li> <li>• <b>Expert Panels</b> were established to develop elements of the strategy related to training, social opportunities, employment and communication.</li> </ul>
Criminal Justice	<ul style="list-style-type: none"> <li>• We tried new ways of tackling domestic abuse through the “Safe and Together” approach. This involves work with the non-abusing parent and the abusing parent aimed at keeping children safe and together with the non-abusing parent</li> <li>• Increased financial support to the voluntary organisation Rape Crisis. We also awarded a 3 year contract to Women’s Aid East and Midlothian.</li> <li>• The Spring Service for women worked in close partnership with a range of organisations including Women’s Aid, Community Health Inequalities Team and MELD. Staff have been trained in Mentalisation Based Therapy particularly useful for women who have experienced trauma and have developed personality disorders.</li> <li>• New governance arrangements through the Community Safety and Justice Board became operational and a Community Justice Improvement Plan was completed.</li> <li>• The Unpaid Work Service became more focussed on learning outcomes, for example people can now work towards an SVQ module.</li> </ul>
Substance Misuse	<ul style="list-style-type: none"> <li>• Continued to develop <b>Peer Support</b>. 14 people completed Peer Supporter Training in order to become a peer mentor or volunteer. A Peer Support Co-ordinator was appointed to co-ordinate a range of peer support activities including training across substance misuse, mental health and criminal justice services.</li> <li>• Primary Care, community staff and others were supported to deliver <b>Alcohol Brief Interventions</b>. 5457 East and Midlothian residents benefited.</li> <li>• Continued to work with partner agencies, families and drug users to keep people safe and <b>reduce drug related deaths</b>.</li> <li>• People in recovery were supported to gain qualifications and skills that will help them gain employment.</li> <li>• <b>Multi-agency training</b> was arranged. Over eighty staff members attended Children Affected by Parental Substance Misuse /GIRFEC training.</li> <li>• The <b>Horizons Recovery Café</b> had a weekly attendance of around 60 customers. A well attended and active SMART Recovery Group met at the café each Friday morning.</li> </ul>

# Locality Planning & Integration Principles

## Community Planning and Area Targeting

Midlothian is small, has lower than Scottish average levels of social exclusion and deprivation, but is the fastest growing area in Scotland and is likely to remain so for the next 10 years.

We have formally established two localities- East and West, but as these are newly defined, many national data sources cannot provide data at this level. However, we do know that East Midlothian has three areas of multiple deprivation- Dalkeith & Woodburn, Mayfield & Easthouses, and Gorebridge. In addition in West Midlothian there are two data zones in Loanhead and Bonnyrigg which have for the first time appeared as areas of concern in the 2016 Scottish Indicators of Multiple Deprivation.

Area Targeting is an approach to target the three areas in Midlothian with the highest levels of deprivation in terms of educational attainment, income, health, and access to local services. This work requires a Community Planning Partnership approach if we are to improve the outcomes for these communities.

Midlothian Health & Social Partnership contributes to this work; both in the planning and targeted delivery of certain services, for example the Wellbeing Service is now available to residents of all three areas.

As part of Midlothian's commitment to improving locality working, we wanted to look at how professionals work together to provide health and care for people, and how good the connections are between services and the local community. While the initial focus was on people who are housebound, the hope was that there would be wider learning that could be applied across Midlothian and with other cohorts of patients. Staff came together to share ideas and carry out small tests of change. We wanted to encourage everyone to look at their own practice and develop their ideas for how care could become better co-ordinated and for each professional to consider what should happen in terms of how they work together for the benefit of patients and staff. This has resulted in stronger relationships across services and innovative work that has continued with a view to repeating the approach in a different part of Midlothian.

## Local services working to achieve this:

### Locality Working - Collaborative Learning in Penicuik

The kind of changes we hoped to see:

Team Members:	More trust and stronger relationships
Across Teams:	More creative use of roles and working across boundaries
Health & Social Care Partnership:	Better use of technology, more community involvement and use of holistic Anticipatory Care Plans (ACPs)
People in our Communities:	A stronger focus on personal outcomes

The Community Empowerment Act 2015 requires that a locality outcome improvement plan - or Neighbourhood Plan-is in place for each priority area. Action plans were devised by the communities in dialogue with public sector managers to address their concerns which were then endorsed by the CPP as the 'plan for place' in each area. Reviewing and updating plans has been taking place and the most recent versions of each neighbourhood plan can be found here: [https://www.midlothian.gov.uk/downloads/download/32/neighbourhood\\_plans](https://www.midlothian.gov.uk/downloads/download/32/neighbourhood_plans)

The Dalkeith /Woodburn area and the Gorebridge area have reviewed and redeveloped their neighbourhood plans, which are available on the Council website (see link above).

Actions deriving from commitments made in the three Neighbourhood plans include:

- "Food Glorious Food" covering all 3 target communities involving over 500 local residents choosing to fund 16 projects on this topic
- Community agency led town centre masterplanning in Mayfield. This includes 5 key local community agencies working together, supported by the Council, which has agreed to prioritise the regeneration of the Mayfield Town Centre as a top priority in planning / economic development.
- The Council and a set of third sector partners are engaged in a redevelopment of the former clinic building in Woodburn occupied by the Grassy Riggs older people's day support service
- The Dalkeith area has been formally identified as "Overprovided" with alcohol sales outlets, the only area within Midlothian to be designated in this way by the Licensing Board. As a result the Board has been able to refuse a licence application for a further outlet for the first time

## Involving People

The Health and Social Care Partnership is only part of the picture. Strong relationships with other agencies and natural communities are needed if we are to achieve major change in the health and wellbeing of the population.

Across Midlothian we are lucky to have strong user groups such as Forward Mid, MOPA (Midlothian Older People's Assembly) and our Neighbourhood Planning groups, People First, Access Panel and People's Equality Group. Our on-line presence and newsletters help reach out to our communities and we are committed to getting out and about to where people already come together through our 'Hot Topics' public meetings.

Some examples from our Autism Group have enabled people to engage to great effect via social media. <https://autismideasinmidlothian.com/2018/05/15/proposal-for-upmo-autism-and-learning-disability-service-in-gorebridge/>

We also benefit from having user and carer representatives on planning groups for mental health, older people, carers, physical disability and learning disability as well as The Integration Joint Board itself.

# Finance

The IJB undertakes a detailed financial assurance on its budget process every year. This process looks at the budget offers from the partners (Midlothian Council and NHS Lothian) and considers whether the budget is fair and adequate.

In 2017/18, the IJB agreed to accept that the budget offers from the partners.

The IJB was underspent by c. £0.9m in 2017/18. This consists of an operational underspend of c. £0.7m with a further c. £0.2m carried forward from 2016/17. This has allowed the IJB to create a reserve and this £0.9m will be available to the IJB in 2018/19 for contingencies and short term investments.

The summary position is as follows:

Table 1 – 2017/18 summary

	Budget £000's	Actual £000's	Variance £000's
Health			
Core	59,617	59,270	347
Non-cash Limited	8,706	8,706	0
Hosted	12,755	12,567	188
Set Aside	18,154	18,572	-418
Social Care	38,806	38,267	539
<b>Total</b>	<b>138,038</b>	<b>137,382</b>	<b>656</b>

The actual costs made by Midlothian Council to the IJB cover the direct costs of the delivery of social care services in Midlothian. The health services managed by the Joint Director are charged to the IJB directly.

Charges for services not managed by the Joint Director, including acute hospitals and pan-Lothian services, e.g. dietetics, are estimated using the Health Budget Setting Model. Midlothian's charges are generally 10% of the Lothian spend.

'Non cash limited' services include the delivery of community dentistry, community opticians and community pharmacists. There is no budget for these services as such. Instead, the expenditure is supported in full by the Scottish Government.

Although the IJB was underspent in total there was significant pressure in the social care budgets which were offset by c. £1.0m of non-recurrent funding. This means that there is an underlying pressures with the social care budgets. This has been built into the IJB's financial planning processes for 2018/19.



## 2017/18 Financial Performance

The IJB's expenditure in 2017/18 for both services delivered by Midlothian Council and by NHS Lothian has been split into programmes as far as is possible. The performance of the whole IJB in 2017/18 was:

Programme	Budget £000's	Actuals £000's	Variance £000's
Older Peoples Services	26,064	23,894	2,170
Children's Services *	1,427	1,475	-48
Learning Disabilities	15,693	17,232	-1,539
Physical Disabilities	4,185	4,606	-420
Mental Health	8,624	8,611	13
Primary Care**	43,182	43,335	-152
Other	12,922	11,864	1,058
Acute Hospital Set Aside***	18,154	18,572	-418
Integrated Care Fund	6,332	6,332	
Substance Misuse	1,210	1,217	-7
Budgets carried forward	243		243
	<b>138,037</b>	<b>137,138</b>	<b>899</b>

*	children's services are health visitors managed by the Health & Social Care Partnership
**	Primary care expenditure covers all of the programmes above and includes: GPs Opticians (where there may be patient charges) Community Pharmacy Dentists (where there may be patient charges) Prescribing by GPs
***	Acute set-aside –this relates to the amount required for services in large (acute) hospitals, e.g. in-patient bed costs. There is a small element of out-patient services depending on how the delegated function is delivered. This includes the Accident and Emergency service at the RIE

### Social Care Fund

In 2017/18 the Scottish Government announced a second tranche of the social care fund (£107m nationally) to further support the delivery of the living wage and to provide further capacity to assist with being able to respond to increasing demand. Midlothian IJB's share of the total Social Care Fund was £5.1m and this was used in line with Scottish Government's guidance.

### Locality Working

The IJB has been developing, in line with the Public Bodies Act and its regulations, two localities within Midlothian. However, this work is at an early stage and it would not be meaningful to provide any financial analysis at a locality level for 2017/18. Our focus in developing locality

approaches has involved initiating work such as the Collaborative Learning Project in Penicuik (see page 30 for further details) where we are seeing tangible outcomes and testing out an approach that can be repeated in other parts of Midlothian.

## **2018/19 – Financial Challenges and expectations**

In March 2018 IJB undertook its annual financial assurance process to review the budget offers for 2018/19 from Midlothian Council and NHS Lothian. Again this process identified significant financial challenges but the IJB has accepted this budget as it passed the two tests of 'fair' and 'adequacy' as described above.

The IJB will also utilise its reserves in 18/19 to tackle the waiting times issues, to develop plans to reduce the IJB's use of Acute beds and to support any in-year operational pressures

As part of the financial planning process for 2017/18, the financial issues identified above in 2016/17 have been addressed – NHS Lothian has uplifted the GP Prescribing baseline to the 2016/17 expenditure level and the social care management team has developed a clear plan to rebalance the budget for learning disabilities services. The financial assurance exercise identified pressures within the IJB of c. £4.4m of which there are clear plans to deliver £2.8m with further plans being developed to balance the budget.

The challenge is, in financial terms, to continue the transformation of the services that deliver the IJB's delegated functions whilst continuing to deliver high quality health and social care to the population the IJB supports. The IJB has developed a financial strategy and outline financial plan which was presented to the IJB at its meetings in January and March 2018. The IJB continues to develop its multi-year financial plan that will clearly articulate how the resources available to the IJB will be used to deliver the ambitions of the Strategic Plan.

# Inspections of Service

The Care Inspectorate undertook both scheduled and unscheduled inspections across a range of IJB services during 2017/18. Overall, 89% of care services graded 'good' or better in Care Inspectorate inspections (the Midlothian figure was 85% in 2016/17. The Scottish average is 85%)

See Appendix 2 for a comprehensive list. Full reports can be viewed at <http://www.careinspectorate.com/index.php/care-services>

The Mental Welfare Commission undertook three inspections within mental health inpatient facilities during 2017/18.

## **Hermitage Ward, Royal Edinburgh Hospital**

5<sup>th</sup> April 2017 (Unannounced)

Recommendations:

- The ward manager should conduct an audit of all care plans and reviews and the progress that has been made following the visit in December 2015 so that progress can be consolidated and sustained.
- The ward manager should, in consultation with patients, audit the provision of activities on the ward and ensure that staffing levels reflect the needs of this particular group of patients

13<sup>th</sup> February 2018 (Announced)

Recommendations:

- Managers should review and agree an accepted template, standards for care plan documentation and evaluation for the ward
- Managers should update the electronic patient record system, so that information relating to the Adults with Incapacity (Scotland) Act 2000, can be added.

## **Rosbank Ward, Midlothian Community Hospital**

2<sup>nd</sup> May 2017 (Announced)

Recommendations- none. Improvements made since last visit on 26<sup>th</sup> May 2016.

Full reports can be viewed at:

<http://www.mwcscot.org.uk/publications/local-visit-reports/nhs-lothian/>

## **Other Inspections**

Midlothian has worked with Healthcare Improvement Scotland (HIS) as a test site to look at how best to inspect Community Hospitals. This experience resulted in very positive feedback from HIS and as a result inspection tools will be developed for use nationally.

NHS Lothian's Infection Control Team has worked with all wards in Midlothian Community Hospital inspecting standards across a range of areas, e.g. equipment, record keeping. All recommendations have been met, ensuring improved patient care and experience.

# Integration Functions & Governance Decisions

The Board and its committees have engaged in matters relating to good governance through consideration of reports and decisions on a wide variety of issues e.g.

1. **IJB Chair:** In keeping with the Integration Scheme, the responsibility for chairing moved from the Council to NHS Lothian in August.
2. **Chief Officer:** Following the retirement of the Chief Officer Eibhlin McHugh, Allister Short's appointment to the role was ratified by the IJB on 24 August
3. **Annual Performance Report:** The IJB's first Annual Report for 2016-17 was approved on 24<sup>th</sup> August and subsequently published on the internet.
4. **Annual Accounts:** The IJB Annual Accounts were considered and approved on 14<sup>th</sup> September and subsequently published on the internet
5. **Workforce Framework:** In response to the significant pressures and ongoing risks associated with the health and social care workforce, a Framework for the development of more detailed workforce plans was considered and approved.
6. **Directions and Delivery Plan 2018-19:** A new set of Directions to Midlothian Council and NHS Lothian were approved on 29<sup>th</sup> March and subsequently issued, along with the Midlothian Delivery Plan 2018-19.
7. **Financial Strategy:** In view of the current and predicted financial constraints a strategy for reshaping health and care services to be financially sustainable was approved accompanied by the first version of a more detailed three year financial plan

# Appendix 1

## List of Key Documents and Reports

### Midlothian Health & Social Care Partnership

- **Delivery Plan (2018-19)**  
<https://www.midlothian.gov.uk/downloads/file/2796/midlothians-health-and-social-care-delivery-plan-2018-19>
- **Strategic Plan and Strategic Plan-Easy Read version (2016-2019)**  
<https://www.midlothian.gov.uk/downloads/file/1738/strategic-plan-2016-19>  
<https://www.midlothian.gov.uk/downloads/file/1733/easy-read-summarised-strategic-plan>
- **Newsletters:**  
<https://www.midlothian.gov.uk/downloads/file/2772/health-and-social-care-integration-newsletter-spring-2018>
- **Joint Strategy for Older People In Midlothian (2016-2019)**  
<https://www.midlothian.gov.uk/info/200276/strategies-policies-and-campaigns/490/joint-strategy-for-older-people>
- **Community Planning in Midlothian**  
<https://www.midlothian.gov.uk/info/200284/your-community/214/community-planning-in-midlothian>
- **Carers Strategy (2017-2019)**  
<https://www.midlothian.gov.uk/downloads/file/2726/carers-strategy-and-action-plan-2017-2019>

## Appendix 2 List of Inspections 2017/18

		Care & Support	Environment	Staffing	Management & Leadership
Community Based	Midlothian Homecare	3	-	3	2
	McSence	5	-	5	5
	Midlothian Care at Home	3	-	3	2
	Shared Lives	5	-	5	5
	The Bungalow	5	-	-	5
	Mears Care	5	-	4	4
	Mears Home Care	2	-	3	3
	St Joseph's	6	5	5	5
	St Joseph's Circle 1	6	-	6	6
	St Joseph's Circle 2	6	-	6	6
	St Joseph's Circle 3	6	-	6	6
	Elcap	6	-	-	6
	Aspire	3	-	3	3
	Edge Autism	5	-	4	4
	Bluebird Care	6	-	5	5
	SCRT	2	2	2	2
Care Homes	Nazareth House	3	3	4	4
	Springfield Bank	1	2	1	1
	Thornlea	2	5	4	2
	Drummond Grange	4	4	4	4
	Pittendreich	3	3	3	3
	Archview Lodge	5	5	5	6
	Highbank	5	5	5	5
	Newbyres Village	5	5	5	5
	Rosehill	5	5	5	5
	Parkside Court	5	5	5	5
	Pine Villa	5	4	5	4
Day Centres	Highbank	4	4	4	4
	St David's Bradbury	5	4	4	3
	Broomhill	3	4	3	3