NHS LOTHIAN

Healthcare Governance Committee
8th September 2020

Chief Officer

HEALTHCARE GOVERNANCE COMMITTEE ANNUAL REPORT
MIDLOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Committee consider the actions taken and service developments planned within Midlothian Health and Social Care Partnership (HSCP), to identify the risks, develop services to mitigate these risks and provide quality assurance and governance of our services.

Any member wishing additional information should contact the Director of Midlothian HSCP in advance of the meeting.

2 Recommendations

2.1 Confirm that the healthcare governance arrangements for Midlothian HSCP as described in this paper provide moderate assurance to committee members.

2.2 Support the developments within the partnership which have improved patient care.

2.3 Note the key risks identified, particularly in relation to the delivery of patient-centred, safe and effective care, and the actions taken to mitigate these risks.

2.4 Note specific actions taken due to COVID-19 pandemic to ensure continued safe provision of services.

2.5 Note the developments planned for the coming year.

3 Discussion of Key Issues

3.1 Older People

An ageing population, with increasing co-morbidity, continues to challenge service delivery. A significant focus for this year has been to improve efficiency, whilst continuing to deliver high quality care to the Midlothian population. There has been a significant focus on building the workforce to improve response times, as well as maximising the available capacity.

Three areas for particular highlight are noted below, but these are only a few of many work streams that are making a difference to the older people. Compassionate leadership is integral to the service model planning, as well as a focus on developing the teams to be able to have the courage to manage, and to have the difficult conversations this often requires.

3.1.1 **Delayed Discharges**

A key factor in Midlothian HSCP ability to achieve the delayed discharge target relates to the ability to provide care at home. Currently the demand within Midlothian for care at home exceeds the ability to provide the amount required. Various measures have deployed to improve performance in this area.

A full review of the service has led to improved systems and processes, meaning all availability can be seen on a daily basis, allowing best use of the capacity available. The service continues to work with three external providers, which has worked well over the past year.

The challenges faced are not related to finance but to the availability of carers prepared to work in this role. With this in mind Midlothian HSCP has established a new Carer Academy, funded mobile teams and built a locum bureau to develop capacity, as well as provide resilience over winter

Other measures deployed to improve performance in reducing delays are

- Midlothian Integrated Flow Hub established - dedicated tracking role in place
- Multi disciplinary Team/Multi agency team daily huddles to review all delayed patients
- Intermediate care bed flow improved with additional team working with the 31 beds in Highbank Intermediate Care Facility
- Step down beds identified in Midlothian Community Hospital to support flow for Rehabilitation
- Discharge to Assess (DC2A) team has been expanded to facilitate 7 day working and since have exceeded £1m cost of hospital bed days saved.
- Use of technology to improve pathways, and safety for older people reducing direct contact with the use of video consultations
- Enhancement and investment to increase Community Respiratory Team to improve management of COPD. The service model is being developed to meet increasing demand.
- Expanded Care Home Support Team (CHST) continues to provide support and education within local care homes. Including daily contact and weekly visits to monitor standards.
- CHST to develop comprehensive ACPs for patients in care homes - this has been delayed due to COVID-19.
- GP Practices resourced to have a frailty lead in each Practice, to ensure all severely frail people have ACPs in place, polypharmacy reviews and geriatric assessment.
- A pilot using the RESTORE2 tool (physical deterioration of resident and escalation tool for care homes) is being implemented by the Care Home Support Team. This will support nursing staff and carers to make appropriate

assessment of deteriorating residents, facilitating early escalation and intervention.

- Commencing work to provide a clear vision for community rehabilitation and enablement, with the key communication of home first. This will be implemented with a view to improving performance around discharge home from intermediate care, Midlothian Community Hospital and Hospital at Home settings.

3.1.2 **Care Homes**

Care homes are an essential part of how some of the most vulnerable people are cared for within communities. With 11 care homes, and 552 beds, under the care of Midlothian HSCP, there is a duty to ensure that the quality of care delivered meets the required needs for every individual living there and that health and social care national standards are met.

Within Midlothian HSCP there is one care home with 61 beds and one intermediate care facility with 40 beds, both run by the HSCP. The remaining 9 Midlothian care homes are run by external providers, with a mix of private and charitable organisations.

All care homes in Midlothian are supported by the Care Home Support Team. This is a multi-disciplinary team, led by the Care Home Team Manager, and includes adult Nurses, Community Psychiatric Nurses, Occupational Therapists, Social Workers and a Quality Assurance Practitioner. The team has close links to the wider multidisciplinary team such as District Nurses, Dieticians, GPs, Hospital at Home and Marie Curie nurse specialists. It is also working to develop close working links with the Care Inspectorate.

Under the care home assurance process, each care home is contacted on a daily basis by a member of the CHST and regular visits to the homes are carried out on a weekly basis. There has been weekly teleconference calls to the care home managers group which has provide information/advise/support and also sought feedback and provide reassurance around their roles of managing the home during COVID-19. Current engagement with Midlothian care homes is good, with one exception. This situation has been escalated within NHS Lothian and with the Care Inspectorate.

Staff in care homes where they have had COVID-19 have found the experience particularly challenging and stressful and they have been provided with support and guidance on dealing with their experience. Family members too have found the experience of not being able to visit their loved ones very stressful and distressing, and Midlothian HSCP has worked with care homes to support new ways of working to allow greater contact using technology. This situation has eased with the introduction of visiting in care homes but this has also brought challenges as care homes work to ensure residents staff and visitors remain safe.

At the time of writing this report Midlothian care homes have had no residents confirmed positive since June 2020. This is due to high levels of infection control management and ongoing risk assessment of every aspect to reduce the risks of COVID-19 being introduced into the home.

There is a need for ongoing training/guidance and support from the CHST with regular infection control monitoring and training for staff on supporting residents who have severe frailty and might still feel isolated.

3.1.3 Care at Home

There are three externally contracted providers in Midlothian delivering care at home to older people. In addition there is a large internal service which makes up around 45% of the total care at home service for older people in Midlothian. All care at home services have managed to continue their normal service delivery in recent months.

COVID-19 has had a significant effect on the workforce within care at home services. Many staff within the internal care at home service received letters advising them to shield due to their own health conditions. This impacted highly on the service delivery, reducing capacity.

Alongside this a number of families of clients who required the service of care at home decided they did not wish carers coming into their family member's home during COVID-19 so their services were suspended until the family advised otherwise. No packages of care were reduced by Midlothian HSCP due to COVID-19.

There have been very few clients receiving a care at home service that have contracted COVID-19. Care at home staff have been highly vigilant in ensuring they are following the infection control protocol and have had access to a range of appropriate PPE.

There have been weekly care at home provider teleconference calls and support out with to ensure effective partnership working has been maintained. This has reduced now and the Quality Assurance Officer for care at home keeps in regular contact with the providers, as does the Service Manager for Older People.

Following an appropriate risk assessment carers who have been shielding are returning to work. This has assisted in increasing the capacity of services. Geographical remapping has also been undertaken during this time to reduce the travel of carers to different areas in Midlothian and keep them confined to small geographical areas. This has assisted in increasing capacity, reducing travel time and reducing the risk of COVID-19 spreading to other areas in Midlothian.

3.2 New ways of working

COVID-19 has lead to rapid change in deployment of new technologies from the technical services supporting the Partnership.

- Where practical and possible, staff have been enabled to work remotely either by direct provision of laptop/smartphone or by enrolment in a Remote

Access solution. Combined with a pragmatic policy of supporting remote working staff have been able to work effectively during COVID-19 lockdown (and coming out of lockdown) and remain productive

- Adoption of remote video consultation across a range of services through NHS Near Me supported by NHS Lothian eHealth's rollout project
- Adoption of various business continuity tools e.g. Zoom and Microsoft Teams to support remote working and seek to offer a degree of *connection* when working in isolation from colleagues
- Provision of iPads to support virtual visiting and remote health care access at: Highbank, Newbyres, Midlothian Community Hospital and Cowan Court
- Provision of Kindle Fires to support virtual visiting at Midlothian Community Hospital
- Continuing Scottish Government TEC Pathfinders project to support technology into local frailty pathways of care in collaboration with the Digital Health & Care Institute / Glasgow School of Art.
- Seeking to establish infrastructure for automated dashboard for HSCP performance indicators/situational awareness.
- Continuing to develop and embed frailty care models
- GP access through telephone triage and remote video consultation

3.3 Mental Health

3.3.1 Access to Community Mental Health Services

The Midlothian HSCP Wellbeing Service is now available in all 12 Midlothian GP Practices. This is a service providing person centred care and support, care that treats people as equal partners, focuses on personal outcomes, supports their role in managing their health and wellbeing, and recognises the importance of prevention and anticipatory care and support. Over 43% of people attending reported that they have a mental health difficulty (anxiety, depression, past trauma, eating disorder etc.)

Midlothian Access Point (MAP) is available via telephone triage at the point of self referral. Capacity for delivery and ongoing Social Prescribing has been increased using Scottish Government Action 15 funding. The service is open access, no referral or appointment is required. The service will guide people to access the support they need to increase their mental wellbeing, reducing low mood and feelings of stress whilst increasing confidence and self-esteem. As of September there will be Primary Care Mental Health Nurses in all 12 Midlothian GP practices.

Within Substance Misuse Services (SMS) a well-established Gateway service allows for easy access to services and reduces waiting times. This has moved to initial triage taking place over the phone. This has worked well and will be retained post COVID-19. As part of the Waiting Times Local Delivery Plan Standard – Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) increased capacity and investment in Midlothian SMS. The team has instigated a "Low Threshold" clinic in Midlothian to target those 'hardly reached' individuals who are at higher risk. This has been happening via Assertive Outreach but will shortly be reinstated as a group with social distancing/ infection control measures in place.

This response uses nurses and peer support workers to engage this group and actively support them into treatment and psycho-social support. Referrals to SMS have increased by 25% over the period – heroin and poly-drug abuse in the main account of this increase.

Currently 85% of people are seen within 3 week target. The team have initiated rapid access opiate replacement. This can be as soon as next day for those most at risk of death. Closure of Ritson Clinic and LEAP due to COVID-19 (both inpatient detox facilities) did create challenges in how to support some high risk individuals in the community. These have now reopened but there are significant waits to access services. A more assertive outreach programme to people in their homes was delivered throughout in order to mitigate the risks presented by this. A shared care Standard Operating Procedure (SOP) has been developed with Third Sector Midlothian and East Lothian Drug service (MELD). MELD will provide 2-4 weekly support and SMS will undertake prescribing reviews every 3-6 months as indicated clinically.

Over the past year staff from across mental health, substance misuse, Justice and Third Sector have co-located in 'No.11' in Dalkeith, allowing for a new trauma informed, collaborative way of working with and supporting individuals, particularly those with multiple complex needs. The service is part of the Scottish Government's Trauma Informed Workforce Pilot. There have already been some excellent examples of joint working to support vulnerable clients and this continues to be developed via a number of routes focussed on the building where services can come together.

The most significant challenge within mental health service remains access to Psychological Therapies with waiting times remaining high. Funding has now been made available to increase staffing levels, both on a permanent and a temporary basis in order to address the backlog and to ensure that staffing levels are appropriate to meet underlying needs. The Psychological Therapies Team has worked hard to develop a new, leaner model of service provision which is due to be implemented in September 2020 and waiting times are anticipated to fall following this. The model is based upon attachment theory and evidence based theories.

3.3.2 **Older People's Mental Health**

Midlothian HSCP approach to care is person-centred, aiming to support people to stay healthy and to recover from ill health as fully as possible. Last year a short life working group was set up to explore the redesign opportunities arising from the reconfiguration of beds within Midlothian Community Hospital.

Due to COVID-19, the process of reconfiguring the old age mental health beds was expedited. At this time the remaining East Lothian patients were repatriated to their own area. This enabled the transfer of long stay patients within Glenlee long stay ward to the vacant beds within Rossbank ward.

Rossbank Unit now consists of two wards. Penny Lane provides 12 beds for admission and assessment of those with moderate to severe Dementia with a proportion of these beds caring for people for longer periods of time. In line with ward procedures, patients requiring longer term care will be reviewed on a 3 monthly basis to ensure that they are being cared for in the most appropriate

environment to meet their needs. Rose Lane ward has 8 beds. These beds are predominantly for assessment of patients with a functional mental health problem but will also provide assessment to those with mild to moderate Dementia. Patients will be cared for in the most appropriate ward within the unit to meet their needs.

As Midlothian HSCP reconfigure the service there will be closer working relationships between the in-patient area, the Dementia team, the functional older people's mental health team and the Care Home Support Team. Improving collaboration between these teams will improve the patient's journey through the services. Staff continue to work together to explore the areas where there may be gaps in the service provided.

The Dementia team is currently undergoing some changes to the staffing structure. This will ensure that Midlothian HSCP can provide the right care at the right time to those who need it. Development of a seven day service supported from the inpatient staff is one of the focuses of the coming year. This will include the provision of crisis care.

COVID-19 has had a significant impact on the service. Although technology has advanced it hasn't always been appropriate or possible to use systems to assess, diagnose or review this particular patient group. Carers in particular have had to face challenges such as self isolating, having additional supports such as day care removed, being unable to visit loved ones in hospital and the effects of overall loneliness.

Visiting has now recommenced within the hospital in keeping with current guidelines and although initially family members were very keen to visit, this has reduced significantly. This may be an indication of people's continuing fears for either contracting COVID-19 or transmitting the disease to their loved ones.

Staff have now settled into new ways of working. Ward staff are consistent with their approach to wearing PPE. Risk assessments are robustly used during admission and discharge of patients.

Community staff implemented a triage system to ensure those who needed face to face visits and those most at risk were seen immediately. There are no waiting lists within the two teams. Face to face visits are now increasing as restrictions relax. Each visit is risk assessed with the team before it goes ahead and appropriate PPE is worn.

3.4 Learning Disability Services

No Midlothian citizen with complex care needs is currently delayed in hospital and nobody lives away from the area, other than through their own choice.

Supporting independent living is a key priority for Learning Disability Services. Work is ongoing to develop a range of housing options based on individual needs and ensure individuals can access appropriate housing as their needs change.

The model of proactive behavioural support services continues to be developed within Midlothian. The Positive Behavioural Support Project Lead is progressing two main areas of work. Plans are being developed for a programme of training to

enhance skills within the workforce and embed positive behavioural approaches in practice. In addition the project lead is providing direct support in the care planning for individuals at greatest risk and working with their care teams to ensure positive behavioural approaches are being used to meet their needs.

Day Services for people with Learning Disabilities have been impacted by COVID-19. Plans are being developed for the re-opening these services however there will be a reduced capacity as a result of physical distancing and infection control requirements. Additionally there will be limited capacity to provide transport to and from day services. Midlothian HSCP will be working with Day Service Providers to support them to redesign their services and prioritise service provision. Also with Supported Living Providers to assist them to develop engaging and fulfilling daytime support for individuals who may not be able to return to day services.

3.5 Primary Care

3.5.1 Impact of COVID-19 Pandemic

All Midlothian practices have remained open throughout the COVID-19 Pandemic. Contingency plans were developed for the buddying or grouping of practices if there were critical issues with staffing. There was additional funding provided to all practices for the increased costs associated with the COVID-19 response as per Scottish Government guidance.

General Practices perform a critical role in the COVID-19 response. During 2020 Practices have responded to the changing demands from their patients, managing staff absence, implementing rapidly changing guidance and transforming their service delivery models with greater use of telephone and digital consultations.

Patients who believe they require GP attention have been assessed by practices throughout. In some early weeks of the crisis demand was quadrupled in practices. All practices in Midlothian managed to remain open during the COVID-19 response but some changes have occurred as a result of the pandemic. For example, there has been shift within practices as lockdown is further relaxed and there is a remobilisation of services. There has been a significant change with the move to total-telephone-triage, with an increase in practices fully adopting a total-telephone-triage for all patient contacts. All Midlothian practices have implemented total-telephone-triage. All patients speak to a GP on the phone prior to being given an appointment. Many problems can be sorted without face to face contact.

‘Near me ‘ video consultation takes place where appropriate. There has also been an increase in the use of Near-Me with nine Midlothian practices together completing over 200 video consultations in July.

Triaged face to face consultations are taking place in practices with use of PPE and enhanced infection control measure.

There has been a considerable increase in the number of ACPs written for vulnerable patients. Practices stayed open for Easter and May Public holidays.

Midlothian HSCP is endeavouring to support practices through the pandemic. For example, a practice has been supported to pilot a new patient access model ‘e-consult’

whereby patients access the practice's clinical services via an internet portal. The Lead GP for the pilot (a member of the Midlothian GP Management Group) has compiled a detailed report and guide for other practices who may wish to implement 'e-consult' themselves. This was presented at a GP representatives meeting and the offer made to provide support to other practices if requested.

Another member of the Midlothian GP Management Group has produced a toolkit on improving access which has been presented to all Midlothian practices.

The process for Primary Care for remobilisation has been agreed across NHS Lothian with robust involvement from HSCPs and Independent Contractors.

3.5.2 **Primary Care Improvement Plan**.

The Primary Care Improvement Plan (PCIP) is a four-year plan in response to the 2018 GMS (Scotland) Contract and the associated Memorandum of Understanding. The Plan describes the process to transfer activity from General Practice teams to the HSCP. It is now Year 3 of the plan. In Year 1 the priority was to develop the Musculoskeletal Advanced Physiotherapy Practitioner service, extend the Wellbeing link worker service, and transfer some vaccination activity. Year 2 focused on the extension of the pharmacotherapy support and establishment of the new Primary Care Mental Health service (PCMHS). In Year 3 the focus is on extending the PCMHS to all practices and developing the Community Treatment And Care Centres.

3.5.3 **Musculoskeletal Advanced Practitioner Physiotherapy team**

This service has been in place in all Midlothian GP Practices since January 2020. As a result of COVID-19, the service was withdrawn for a temporary period, whilst staff were redirected to other areas of priority work. However the service has since been reinstated in all GP Practices. The strategic principal of this work remains the same – to redirect appropriate patients from GP Practice to Advanced Physiotherapy Practitioners.

Midlothian HSCP has successfully recruited at Band 7 but currently not every GP Practice has a sufficient number of MSK clinical sessions for the population they serve. Part of the re-mobilisation following COVID-19 will aim to address this issue with further recruitment.

By January 2020, the data shows:

- Over 10,000 appointments made with the MSK APP team
- 86% of patients seen had no prior GP face to face appointment for the same condition
- Low onward referral rate, 90% of cases being managed in Primary Care
- No waiting list for access
- High levels of service user satisfaction

The MSK APP service has continued to expand throughout 2019-2020, being one of the only GP APP services nationally that is available in every GP practice in the HSCP. Furthermore, Midlothian had three APP staff successfully complete their

non-medical prescribing training and saw another two members of staff commence this training. One staff member successfully completed a career fellowship which has helped shape and drive the national agenda for advance practice physiotherapy. This work is now being progressed to doctorate level. Midlothian also supported a number of other areas nationally to implement a similar service within their local HSCP.

3.5.4 **Pharmacotherapy**

All Midlothian Practices are now receiving some Level 1 support from Midlothian HSCP Pharmacists and Pharmacy Technicians and this work stream remains on track with the milestones described in the PCIP. Progress is contingent on successful recruitment to posts and there are now signs that it is becoming difficult to recruit as other HSCP areas are advertising for new posts and staff leave for posts in other areas.

If initially unable to recruit to the level of banding required, this may be extended to review skill mix and train individuals internally, and using the current more experienced pharmacist workforce as mentors/trainers. This approach should help the new service become self sufficient as time progresses

Data collected by the new service for the year 19/20 shows:

- 12,968 Medicines Reconciliations were completed.
- 4858 Telephone encounters were carried out
- 730 Shortage issues were dealt with.

It is estimated that this has saved approximately 2283 hours of GP time.
As well as this over 3,500 medication reviews have been carried out by the Pharmacy teams.

It is hoped that in the coming year the service will develop further to allow some aspects of level 2 and 3 of pharmacotherapy to be delivered. This will provide variety to the work undertaken by the team and provide more job satisfaction which in turn will support staff retention.

3.5.5 **Vaccination Transformation Programme**

Childhood Vaccinations were transferred from practices in Year 1 of the PCIP. Travel Vaccinations were also to be transferred in Year 1 but this is being progressed as a pan-Lothian service.

The responsibility for annual Flu Vaccinations was to be transferred to Midlothian HSCP in Year 3 which means that for 2020 the responsibility remains with practice teams. There are several exceptions to this with Midlothian HSCP taking on responsibility for specific cohorts this year including: Housebound; Care homes; Nursing homes; Children 2-5s. Midlothian HSCP is also taking on responsibility for the Shielding Patient cohort and their household members (6,500 people based on practice returns). Midlothian HSCP will also provide additional staff to practice teams to assist with the 2020 flu vaccination programme. Further details about the Seasonal Flu programme are described later in this report.

Transfer of Shingles and Pneumovax has been delayed but will be incorporated into the Community Treatment and Care (CTAC) programme during Year 3.

3.5.6 Community Treatment and Care (CTAC)

Phase 1 of CTAC development is underway in Midlothian and will be established this autumn. Three practices (Penicuik, Eastfield, Roslin) have agreed to develop the model within the HSCP during this phase. A combination of five Health Care Assistants and five Community Nurse posts have been funded for this phase and recruitment is in progress. A new Team Manager post will also be appointed to manage the service during the development of phase 1 and expansion of the service during 2021.

The three practices involved have all received support to allow them to release senior GP time to develop the new model. There is a shared ambition to make greater use of technology for remote monitoring of chronic conditions

3.5.7 Link Workers

The Wellbeing Service was operating in 75% of Midlothian Practices at the start of the PCIP and was extended to all practices in Year 1. The service moved to a telephone-based service during COVID-19 response.

During COVID-19 response the British Red Cross changed their service model to provide a service for all patients identified with moderate and severe frailty. These vulnerable people were contacted and offered additional support through a range of measures dependant on their individual needs. In Midlothian 11/12 practices shared patient contact details with the Red Cross which led to 2630 people being contacted

3.5.8 Urgent Care

- **COPD**

Midlothian HSCP has worked with General Practitioners in Midlothian to establish a Community Respiratory Team to improve management of COPD. By March 2020 demand was above the capacity of the service and the service is under review. There is an increased demand in all respiratory conditions, which has been enhanced due to COVID-19. The service will work alongside the Scottish Ambulance service to implement respiratory pathways for Midlothian in the prevention of hospital admission during 2020/21

- **Frailty**

This programme uses data to identify people with frailty, understand service utilisation and identify improvements across the frailty system of care. The programme initially focussed on General Practice and the interface with community services.

During the COVID-19 response the key new development in the programme was the Red Cross Welfare Call service where over 2700 people estimated to have moderate or severe frailty were contacted and supported (issues identified including hearing aid battery replacements, social isolation, shopping, and prescriptions).

As Scotland moves out of the national lockdown the Red Cross are making a second round of calls as the support needs of people with frailty are changing.

Since COVID-19 a new development has seen the Penicuik Frailty Multidisciplinary meeting move to meeting online and the practice using Near-Me for extended appointments. Initial assessment of this has shown an increased level of attendance as the meeting requires less time commitment from staff without the need to travel.

The General Practice Learning Collaborative has also started meeting online with the first meeting focussing on the Red Cross service. The work in the programme over the rest of 2020 is to continue the substantive pilots in the programme, consolidate the learning and focus on how the analytics produced from this work can support improvements in other parts of the frailty system of care.

3.5.9 **Primary Care Mental Health Services**

The Primary Care Mental Health Nurse service was developed during Year 2 of the PCIP. Initially this was fully funded by the PCIF but as the service has expanded the additional posts have been funded from Scottish Government Action 15 funding. The service will be operational in all 12 practices by September 2020. There are 10 nurses working in the services (8.8 WTE). During COVID-19 response the service was pulled back from practices at their request but is now being reintroduced. Some practices are piloting direct patient booking via the reception team to reduce GP contacts. The model of service provision has been refined and feedback is positive.
The Nurses have strong links and pathways with practices and also the Joint Mental Health Team meaning that care can be managed in the Primary Care setting where appropriate but also very easily escalated to specialist services when required.

3.6 Health Visiting

Midlothian HSCP continues to implement the Health Visiting Universal Pathway. Currently there are 4 wte Health Visitor vacancies which when filled will take Midlothian HSCP to the Scottish Government agreed establishment of 27.8 wte. Due to this vacancy the Health Visitors still require the support of the skill mix team to provide the full Universal Pathway visits. The next cohort of newly qualified Health Visitors is due in December.

As for other services, COVID-19 has challenged the ability to continue to provide services and necessitated different ways of working. Early in the Pandemic laptops were introduced, secure global desktop accessed and smart phones purchased to allow staff to work from home and continue to provide a service in a safe socially distanced way. This also allowed shielding staff to work from home and reduced the numbers of staff actually working in the bases.

The Scottish Government issued guidance detailing which aspects of the pathway should be prioritised for face to face visiting. Other contact continued through use of technology. Recent Q1 data shows that Midlothian HV are still achieving a good number of visits and a good standard of data recording.

In February/March 2020 Healthcare Improvement Scotland carried out a joint inspection of services for children and young people in need of care and protection within Midlothian HSCP. The inspection focussed on 5 questions:

1. How good is the partnership at recognising and responding when children and young people need protection?
2. How good is the partnership at helping children and young people who have experienced abuse and neglect stay safe, healthy and recover from their experiences?
3. How good is the partnership at maximising the wellbeing of children and young people who are looked after?
4. How good is the partnership at enabling care experienced young people to succeed in their transition to adulthood?
5. How good is collaborative leadership?

The Draft Inspection Report was issued 6th July 2020. Currently all areas evaluated as **GOOD**. (Good = Important strengths and some areas for improvement) Final report is due 1st September 2020.

Midlothian HSCP have created a 0-5 Immunisation Team from the Band 5 Community Staff Nurses originally working within the Health Visiting teams. This team will continue to work closely with the Health Visiting teams to ensure good communication and follow-up of families with poor attendance/uptake of immunisations.

Midlothian School Nursing Service continues to be hosted in East Lothian.

3.7 Hosted Service

3.7.1 Dietetics

NHS Lothian hosted Dietetic Service reports into Midlothian HSCP through the Joint Management Team, and the Head of Dietetics is directly responsible to Head of Older People and Primary Care. In addition, NHS Lothian Director of AHP seeks assurance of professional activities.

The focus over the last 12 months has been on reaching out to areas of highest deprivation and, introducing clinical services in each locality rather than centralised in hospitals e.g. Paediatric Dietetic clinics decentralised and there continues to be a development of service provision with a community and more patient-centred focus.

The service continues to pursue technology as part of patient pathways, with a digital first approach. E.g. the TEC project using Health Call which is a patient remote reporting system for weight, appetite and use of oral nutritional supplements, was completed and a new contract signed for this system to be embedded within the malnutrition care pathway. The test of change for Irritable Bowel Syndrome (IBS) care pathway includes a video for first line treatment.

The Weight Management Team Lead has been seconded to Scottish Government to lead on the Type 2 Diabetes Framework – prevention, early diagnosis and intervention. All community based Dietetic staff have mobile technology (laptops and mobile phones).

There has been an increase in temporary and permanent staffing levels over the last 12 months due to greater awareness of the lead role Dieticians can take in specific pathways. The service is working with national, regional and board level developments.

The National Inherited Metabolic Diseases service, funded through National Services Division, has been introduced for children and adults. A national Dietetic clinical lead, along with an additional training post (Band 6) has also been introduced in this highly complex specialty. The East Regional Diabetes Early Adopter funding has supported the tiered model of care with Tier 2 as a Service Level Agreement with local leisure services for both children and adults. Demand remains high (150 referrals per month Lothian-wide) and waiting times exceed 18 weeks for weight management in Tier 3. A secure digital solution is being explored at national level to provide virtual group programmes. Dieticians led the Tests of Change in Coeliac Disease for children and adults funded from Scottish Government Modern Outpatient Programme and from September 2019, NHS Lothian funded this on a recurring basis.

NHS Lothian Primary Care prescribing funding is supporting additional Dieticians to implement the Scottish Government Oral Nutritional Supplement Recommendations (2018) with a focus on quality of care in treating disease-related malnutrition and financial savings on prescribing budgets. As of June 2020, targeted patient review in approximately 70 (58%) of Lothian GP Practices resulted in 70% reduction (range 14-94%) in oral nutritional supplements spend within those GP Practices. 60% of patients reviewed by the project team had the supplements stopped and 11% had supplements reduced.

Financial Year	Total Spend on Adult ONS Items	Number of Patients
2016/17	£1,831,829.94	6620
2017/18	£1,671,746.88	6447
2018/19	£1,668,156.54	6198
2019/20	£1,363,688.45	5532

These developments in service provision are scrutinised through quality improvement reporting. E.g. Oral nutritional supplement project reports to NHS Lothian Prescribing Forum, Scottish Government and East region, reporting on Diabetes Prevention Framework and Weight Management services, Test of change for GI conditions report through NHS Lothian Steering Groups into the Modern Outpatient Programme.

Dietetics have fully implemented recording all interventions on TRAK and are now paperlite, giving much improved access to the MDT on care provided by the service and opportunities for performance reporting. Work continues in collaboration with the Lothian AHP Informatics Group to establish a dashboard of performance

measures which are accurate, valid and transparent, based on using TRAK. Dietetics has contributed to a pilot template for AHP Governance which is now being extended throughout Lothian to demonstrate assurance on clinical care.

3.7.2 Adults with Complex and Exceptional Needs Service

The Adult with Complex and Exceptional Needs Service (ACENS) provides care for people assessed as having exceptional healthcare needs, who have a package of care agreed through the NHS Lothian ACENS Review Group. Care needs are assessed using the agreed Decision Support Tool and are funded by the relevant HSCP where the patient resides.

This Pan Lothian service supports packages of care within the NHS Lothian area in a variety of community settings including the patient's home and any respite setting they access.

The service works in partnership with the patient and/or their family, carers and other care giving agencies, including the Education Department, Social Work Department and respite facilities. The service provides up to 24 hours, 7 days a week care for patients and ultimately support for their family and carers.

The patients have varied individual care needs, many being dependent on technology to maintain their airway, and may have life limiting conditions. All patients have an individual package of care and the aim is to provide high quality, consistent and continuous care and therefore help the patient and their family live as normal a life as possible.

Over the past two years there has been a focus to improve governance arrangements within the service. Systems and processes have been developed to support patient and staff safety and actions taken to reduce the need for use of nursing agency staff. There are currently nine packages supported across Lothian HSCPs with a total budget of almost £1.2million.

This year has seen the development of a new referral process and associated paperwork. Laptops are now in place within each patient's home, giving staff access to online support while working in the patient's home. An Intranet site is being developed for the service and will be promoted across NHS Lothian – there has been a delay due to COVID-19. The nursing team are now using TRAK to record patient interventions where possible, improving communication and continuity of care should the patient be admitted to hospital as an emergency.

The key risks continue to be linked to the need to access Nursing Agency to cover last minute absence. Actions taken to mitigate this include:

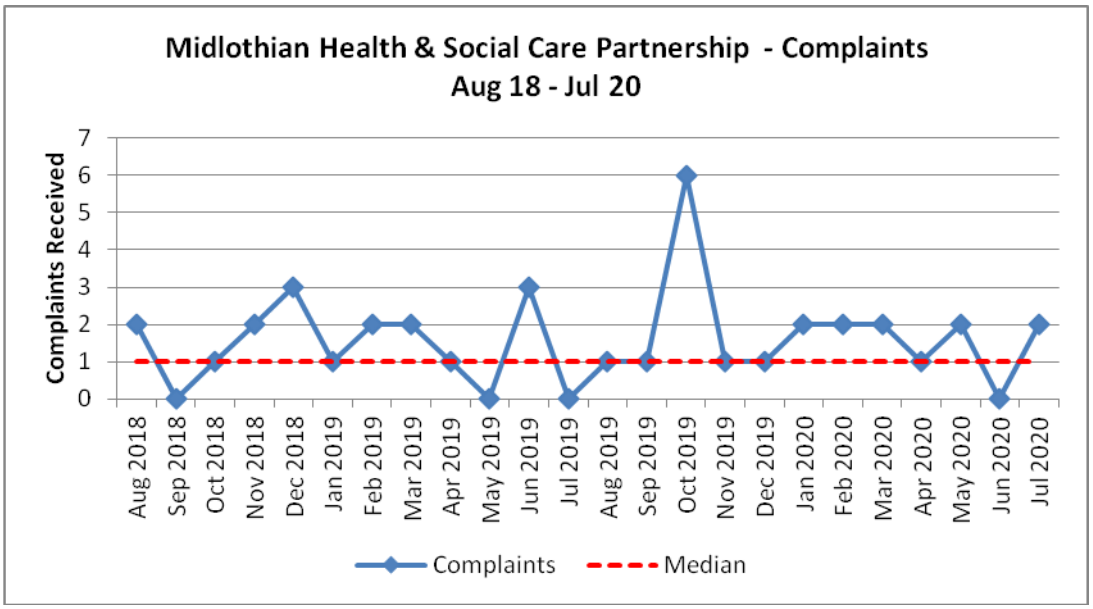
- Working with NHSL Staff Bank to increase their members with the necessary skills to work within the service.
- Addressing staff absence, recruitment and retention issues as they arise
- Introduction of eRoster
- Improving support for existing staff: Orientation programme; Training passports; Competency programme; Shift co-ordinator contact; Lone working procedures; use of Microsoft Teams.
- Escalation procedures
- Improved communication

A contingency plan was put in place due to the expected COVID-19 related issues; however the impact has been limited. Absence levels have reduced and fewer staff have moved on to other posts reducing the amount of recruitment required. This has led to improved continuity and better team working within the service. This has also led to a reduction in Agency use.

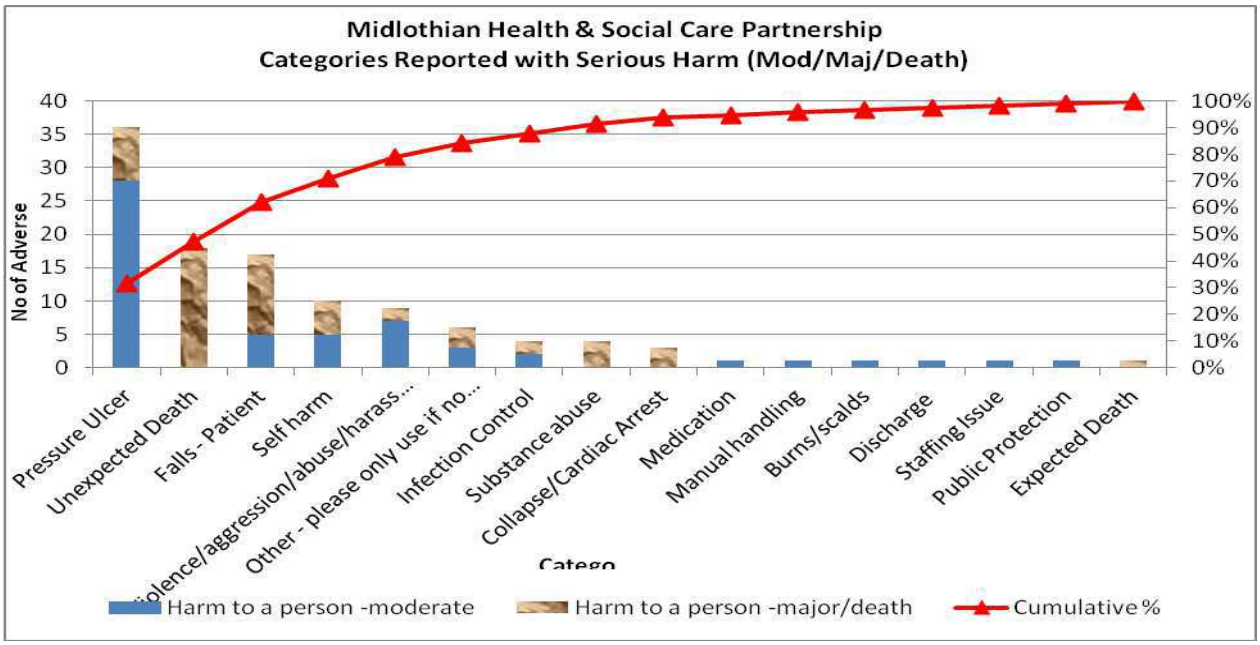
3.8 Clinical and Care Governance Group

Within Midlothian HSCP, a Clinical and Care Governance Group has been established for a number of years, drawing together health and social care services. The group is co-chaired by the Chief Nurse, Clinical Director and the Chief Social Work Officer. New structure of Quality Improvement Teams has been established within the areas of: Mental Health/Substance Misuse; Midlothian Community Hospital; Community Services; AHP; Learning Disabilities; Community Residential including care homes. These QITs report in to the Clinical and Care Governance Group. The remit of the groups is to provide appropriate governance and assurance on health and social care services in Midlothian.

3.8.1 Midlothian continues to receive relatively few complaints, as outlined in the table below, but learning from all complaints is discussed within the Clinical Care and Governance Group and within individual service areas.



3.8.2 Similarly, the reporting of issues relating to serious harm is also reviewed by the Clinical and Care Governance Group and further information is set out below:



4 Risk and Mitigation

The Midlothian HSCP Risk Register identifies and manages a number of risks and the key risks are noted below, which are all supported by agreed measures in which to mitigate and manage the risks effectively. These risks are managed at both Service level and HSCP Management Team level, and are also reported into the Audit and Risk Committee within the Integrated Joint Board (IJB).

The IJB Audit and Risk Committee maintains a strategic risk profile which is regularly monitored. Key risks and the actions undertaken to manage these risks are reviewed and updated quarterly, and presented at the Audit and Risk Committee.

Midlothian HSCP also inputs into the corporate risk register which sits within NHS Lothian Board.

Key risks for Midlothian HSCP are:

4.1 Capacity of service to meet increased demand due to increasing population, age, and frailty. Primary Care sustainability linked to this. Being addressed through the Primary Care Improvement Plan.

4.2 Lack of availability of staff with appropriate qualifications or skills, including: GP; Advanced Nurse Practitioners; Advanced Physiotherapy Practitioners; District Nurses; Health Visitors; Carers. This may impact on the Midlothian HSCP timescales to implement some of the developments planned and is being addressed through the HSCP Workforce Framework.

4.3 Ongoing risks related to COVID-19, substantial risk mitigation and management required to ensure services are able to reinstate safely and to meet demand. Several working groups are in place to plan how to prioritise the re-mobilisation of services while ensuring the safety of our staff and patients.

4.4 Risk management of Midlothian Care homes, with increased measures in place to ensure safe delivery of service and additional workforce requirements to ensure safe ways of working in a Covid environment. This is being managed through the Care home Assurance Group at both Midlothian HSCP level and NHS Lothian Board level.

4.5 Emergency admissions and Delayed Discharges, and the use of unscheduled care facilities, including Emergency Department, have greatly reduced as a result of COVID-19. Services to support people who have a long term condition to stay well at home have continued to operate in order to support as many people as possible to avoid hospital visits. Many services continued to operate, whilst reducing face to face contact with telephone and digital tools being employed. It is the intention of the HSCP to review the different models of service provision employed during the pandemic with a view to maintaining certain practices longer term.

4.6 Major incident planning, risk mitigation and resilience across HSCP continue ensuring risks are managed in an integrated way.

5 Impact on Inequality, Including Health Inequalities

5.1 Midlothian HSCP remains committed to tackling inequalities and to investing in preventative work. There is a particular focus on people who are more vulnerable to health inequalities whether as a result of poverty, age, disability or long term health conditions.

5.2 During 2019, the Community Planning Partnership sponsored whole-system Type 2 Diabetes Prevention Strategy was progressed. The tier 2 weight management service was increased by 50% in Midlothian. £60,000 was secured to support diet and healthy weight community development approach in local communities. This work will progress in 2020-21. In addition, Midlothian delivered the first regional weight stigma programme. This was delivered to a total of 16 participants working in a variety of roles within health, social care and third sector. Feedback included *"this weight stigma training has shown me how negatively obesity is depicted in the media and society. It's very easy to see how it can go unnoticed until it's pointed out."*

5.3 Ageing Well and Midlothian Active Choices (MAC) continue to support a large number of people to be active and socially connected, in particular people with a long term condition. This also included delivering tier 2 weight management programmes and increasing the number of people being referred to participate in weight management services. In 2019-20 499 people were referred and triaged across tier 2 and tier 3 weight management services in Midlothian. These services represent a positive partnership with Sport and Leisure Services.

5.4 Community Health Inequalities Team nurses increased support to people living in homeless hostels and those attending substance misuse services. They also participated in the Inclusion Health Evaluation Programme (ongoing) being led by Public Health along with substance misuse service colleagues in Midlothian HSCP. One nurse has completed a sexual health qualification to allow outreach

sexually transmitted infections testing and other support around sexual health and blood borne viruses. In 2019-20 the service supported a total of 181 people with complex needs.

5.5 The Welfare Rights Service continued to provide effective support to people receiving a service from Children & Families and/or Adult Health and Social Care. In 2019-20 the welfare rights team secured a total of £4,411,105 for Midlothian citizens. The team works closely with community based welfare rights services such as the Citizen Advice Bureaus in Midlothian.

5.6 Work has been progressed to provide additional support to women who smoke during pregnancy. This involved Sure Start, income maximisation and smoking cessation support. The next step for the work is the recruitment to the smoking in pregnancy cessation worker role.

6 Duty to Inform, Engage and Consult People who use our Services

6.1 Communication and engagement play a crucial role in supporting Midlothian HSCP to achieve its aims for the integration of health and social care in Midlothian. It is also a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014, the legislative framework for the integration of health and social care services in Scotland.

6.2 There was extensive consultation with staff, stakeholders and members of the public in 2018-19 about services delivered and what could be improved. This influenced the direction of the IJB Strategic Plan 2019-22 and thereby local planning groups.

6.3 The Partnership is developing a strategic approach to community and stakeholder engagement in service planning and review. A draft strategy is in development with the intention is to schedule patient/service user, care and staff consultation activity throughout the year, linked to current service development or review where possible.

6.4 During 2019-20 staff and carers of people with dementia were asked their views on community supports. Funding was secured to begin a programme of consultation around palliative care involving families and staff. VOCAL undertook a survey of unpaid carers. A mental health advocacy group and a local mental health service both gathered views and feedback from people around local provision or plans. Patients and GPs were surveyed on the community service for people with COPD. An autism group conducted an online survey for people with autism and their families. People who use substances and/or have mental health difficulties were consulted on the development of a new multi-agency hub that opened in 2019.

6.5 A number of consultations are planned for 2020. These relate to:

- Frailty – for the TEC pathfinder project
- Unpaid carer service redesign
- Mental Health in the Community Service redesign
- Community Treatment And Care Pilot site

- Care at Home service evaluation
- Extra care housing consultation for planning approval

7 Resource Implications

7.1 There are no direct resource implications arising from this report.

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