Midlothian
Health & Social Care

Midlothian Integration Joint Board

Annual Performance Report

2021/22

Contents

Executive Summary

The Midlothian Integration Joint Board (IJB) plan and direct health and social care services for the people of Midlothian. We are a planning and decision-making body responsible for the integrated budget from Midlothian Council and NHS Lothian.

We are responsible for monitoring progress towards the National Health and Wellbeing Outcomes and the objectives in our Strategic Commissioning Plan 2019 to 2022. During this time we worked to ensure people had the right advice, care and support in the right place, at the right time to be able to lead long and healthy lives. We focused on prevention, recovery, independence, choice and control, equalities, supporting the person not just their condition, and high quality and coordinated care that is evidence based and provided locally.

The pandemic did not stop us planning and delivering services but it reduced our capacity for implementing some planned redesigns of services. In many respects it accelerated change by creating opportunities to work together in new ways and strengthen our community connections.

Considering the impact of all our services and supports is a complex exercise and involves a wide range of data. The Scottish Government measure our performance towards nine Health and Wellbeing Outcomes using data collected from Scottish Health and Care Experience (HACE) Survey and Scottish Government's Ministerial Strategic Group (MSG) targets for hospital admissions.

The challenges we faced

We continued to face a number of challenges in 2021/22 including an ageing population, inequalities in health, a national workforce shortage, increasing reliance on unpaid carers and growing pressures on acute hospitals. There was an increase in demand for community services as the way people accessed planned and unscheduled care changed and we were supporting people when they had to wait longer for planned services with increasingly complex needs.

More people are living in Midlothian than ever before, and this has meant changes to the average age of our population and typical household size. This may explain why some services are more in demand despite the gains we are making in quality and improvements.

Our progress towards the National Outcomes

In 2021/22, our priority continued to be the health and wellbeing of our communities and our workforce. Supporting people effectively and safely was more important than ever and services responded to evolving circumstances. Services provided face-to-face support where this kept people safe and well. However, in line with national guidance and restrictions, the way people accessed many of our services changed. During this time, most people surveyed continued to feel safe; felt enabled to look after their own health and wellbeing, and felt they had a say in how their services and support were provided.

In 2021/22 the number of people under 75 who died prematurely in Midlothian reduced. Cardiovascular disease and cancer are strongly linked to deprivation and addressing the impact of poverty remained central to our work. We increased opportunities and access to employment

alongside work to address drug and alcohol problems, and links to violence. By ensuring good mental wellbeing support, increasing educational attainment, and promoting healthier physical and social environments we anticipate that premature mortality will continue to reduce.

We have improved our services to help people live as independently as possible at home or in a homely setting within their community. This includes reducing the number of days people have to stay in hospital when they are ready to return home and increasing the number of adults who have intensive care needs that are supported to live within their community.

It is important that people see the right professional from the very first conversation and so we expanded the teams that work in our GP practices and in the community. There are now more specialist services including Physiotherapists, Primary Care Mental Health Nurses and Wellbeing Practitioners, Pharmacists, Advanced Nurse Practitioners for minor illness, Phlebotomists and Community Treatment & Assessment Clinic (CTAC) located in practices than ever before. People could usually access the care that they need directly from these professionals without needing to see a GP first.

Respect and dignity are central to our values, and we made progress embedding a Human Rights approach across our services. Despite the ongoing challenges facing health and social care, the support delivered by Midlothian Health and Social Care Partnership helped improve the quality of life for 81% of the people who responded to the HACE survey, an increase of 13% from the previous year. Understanding the different types of support people need to achieve what matters to them continues to be an important part of our self-management approach.

Health inequalities result in poorer outcomes for some people and communities. 1 in 4 children live in poverty in Midlothian. We continued to commit to having Good Conversations and using this approach to help addresses the impact of inequality. Good Conversations is an approach to change our culture and working with people's life circumstances, supporting self-management, choice, and control. People say this approach is meaningful and makes a difference in their lives.

The HACE survey highlighted that we must improve how we support unpaid carers. The work of our local voluntary organisations continues to be invaluable and the feedback they receive is generally more positive. However, we know that there are many carers who are 'hidden', may not recognise themselves as carers, and do not access any support. We must continue to reach out to them. We must also recognise that the pressures on our 'care at home' services over the past year have contributed to an even greater reliance on families, neighbours, and friends. There are no quick solutions but improving support to unpaid carers will be a key task for the Partnership over the coming year.

Our services and supports aim to keep people safe from harm and prevent avoidable risks. In 2021/22, we received 674 Adult Protection referrals. This was an increase of 49% than the previous year. In the past year 64% of people referred for Adult Support and Protection were over 65yrs old, 53% were females and the main reason for referral was neglect. Where it was feasible to reduce face-to-face contact, teams changed how services were delivered in line with national guidance and continued to see people face-to-face where this kept them safe and well. Voluntary organisations also worked hard to find safe ways of supporting vulnerable people.

We still have work to do to improve. This includes better workforce planning to ensure our workforce has the knowledge and skills to meet the needs of people and communities. Feedback told us that accessing the right care at the right time was difficult for some people who needed support.

The national indicators were implemented by the Scottish Government Ministerial Steering Group. We met 4 out of the 8 local targets we set against these national key indicators. Based on these targets, while the numbers of patients delayed in hospital remained high, the length of these delays were reduced by half as measured by delayed discharge bed days. This is, at least in part, due to our Home First philosophy and improving flow through the work of a range of services including the local Flow Hub and the Discharge to Assess Team.

The quality of the services people received was rated as high by 78.6% of those surveyed and demonstrated a considerable increase in quality from the previous year. This was also reflected in the grades awarded to several social care services by the Care Inspectorate.

Our budget and spending.
Ensuring we make best use of our resources is a complex task. We had a total budget of £178m and ended the financial year with a small underspend of £10.5m. This underspend is made up of an underspend on the IJBs operations of £1.1m and earmarked funding, predominantly for COVID not spent in year of £9.7m.

In 2021/22 there was an increase in the IJB spend within the community services. This is in line with our ambitions to develop health and social care services locally and away from hospital and highlights our ongoing commitment to transformation health and social care. However, the pressure on acute hospital remains very high. We continued to support people to improve their own health and all our services promote preventative action and early intervention.

Future plans.
Looking forward, we expect to face a number of opportunities, risks and uncertainties in the coming years. We recognise the scale of these, but also that services need a period of stability to recover and address the areas where waiting times have increased over the past 2 years.

Our future direction and ambitions are set out in our 3-year Strategic Commissioning Plan. Over the last year many services have revaluated how best to meet the needs of people and their communities and are at the start of a new and exciting transformational change programme.

We have set a balanced budget and will invest in key areas of prevention as well as make recommendation for how to use our reserves to support innovative practice and accelerate priority areas of transformation. The funding gap in future years and the potential for additional savings requirements creates significant uncertainty in relation to our ambitions.

Evaluating how what we do changes outcomes for people and communities depends on many factors. We will develop our use of Outcome Mapping to help us record, analyse, and understand our performance towards our strategic aims of supporting people and communities look after and improve their health and wellbeing for longer.

Foreword

Welcome to our 7th Annual Performance Report which reflects on our progress and performance from 1st April 2021 to 31st March 2022.

In introducing this report, it is important to acknowledge how the pandemic has continued to dominate our work over the past 12 months. Covid-19 continues to impact everyone and will have a long-term impact on our services and communities.

New and evolving challenges have increased demand and sustained pressure across the whole system. Supporting people with Covid-19, delivering vaccinations, keeping people safe and helping people manage their health and wellbeing have been our priorities. We have adapted our services to meet the needs of individuals, working together where this has required a different type of support.

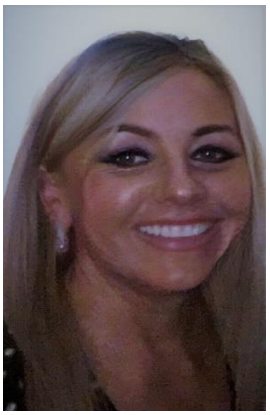
This Annual Report explains our performance; how well we have provided the right care, at the right time. Giving priority to responding to the pandemic has limited our capacity to deliver some core services.

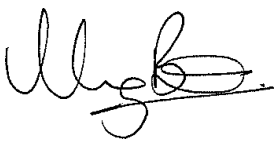
Our staff remain our greatest asset and I would like to thank all staff for their commitment and professionalism to keep people safe. Supporting staff remains a high priority and our new Wellbeing Lead has supported staff to remain safe and well. We will continue in our efforts to retain our staff and provide support and advice on health and wellbeing.

As our recovery programme continues, we must reshape health and social care with a stronger emphasis on prevention and early intervention. We will listen to people and involve communities in how we design and deliver services. A community powered approach will ask 'what makes us healthy?' rather than 'what makes us ill?' and see communities, health and social care, housing, sport and leisure, welfare rights, employment services and the voluntary sector all playing a role in maintaining good health. We will strengthen our support for carers as we recognise their essential and valued role. Throughout the pandemic their contribution has been, and remains, critical.

As Chief Officer, I am proud to lead health and social care, alongside our independent and third sector partners, to provide high quality care with professionalism and dedication, even in the most of challenging times. I look ahead with an increasing sense of optimism as we take forward our Strategic Commissioning Plan and redesign services based on views of our staff, people who have experienced our services, and our communities.

Together we will improve our service and supports that help people live the lives they choose.





Morag Barrow
Chief Officer, Midlothian IJB

Introduction

This report gives an overview of our performance in planning and carrying out integrated functions. It looks at the progress we made over 2021/22 to deliver the key priorities of our 2019/22 Strategic Commissioning Plan.

Who we are

The Midlothian Integration Joint Board (IJB) plan and direct health and social care services for the people of Midlothian. We are a planning and decision-making body created by Midlothian Council and NHS Lothian. We are responsible for the integrated budget (received from Midlothian Council and NHS Lothian) and allocate this in line with our objectives in the Strategic Commissioning Plan.

Our responsibilities and legal duties are outlined in the Public Bodies (Joint Working) (Scotland) Act (2014). The IJB meets regularly and includes members from NHS Lothian and Midlothian Council, the Third Sector, staff and people who represent the interests of people and communities, patients, service users and carers.

What we are trying to achieve

The Scottish Government measure our performance based on Health and Wellbeing Outcomes.

	National Health & Wellbeing Outcome	
1		**Health & Wellbeing** People are able to look after and improve their health and wellbeing and live in good health for longer.
2		**Living in the Community** People are able to live, as much as possible, independently and at home or in a homely setting in their community.
3		**Positive Experiences & Dignity** People who use health & social care services have positive experiences of those services, and have their dignity respected
4		**Quality of Life** Health & social care services help to maintain or improve the quality of life of people who use those.
5		**Health Inequalities** Health & social care services contribute to reducing health inequalities.
6		**Support for Carers** People who provide unpaid care are supported to look after their health and wellbeing.
7		**Safe from Harm** People using health & social care services are safe from harm.
8		**Workforce** Staff are engaged with their work and are supported to continuously improve the information, support, care and treatment they provide.
9		**Use of Resources** Resources are used effectively and efficiently.

Our Strategic Commissioning Plan 2019 - 2022

Our vision in the Strategic Commissioning Plan was for everyone in Midlothian to have the right advice, care and support in the right place, at the right time to be able to lead long and healthy lives. We focused on prevention, recovery, independence, choice and control, equalities, supporting the person, not just their condition and high quality and coordinated care that is evidence based and provided locally.

This report shows our progress and performance in the final year of this plan. While the pandemic did not stop us planning and delivering services, it reduced the capacity for implementing some planned redesigns of services. In many respects the crisis accelerated change and created opportunities to work together in new ways and strengthen our community connections.

Integration, Quality, Best Value – ways to improve

We think about how we can improve what we do in three ways; integration, quality, and Best Value. In this report we have detailed what we have done and how this has improved outcomes for people and communities. We have used the icons below to show good examples of integration, quality, or Best Value.

Integration is about how we work with all our partners to ensure everyone gets the right care, at the right time, and in the right setting.

Quality is about 6 key areas of services – are they safe, effective, efficient, timely, person centred, equitable.

Best Value is about ensuring resources are well managed improving services that deliver the best possible outcomes for people and communities.

How do we know if we are achieving this?

You can see the details of our performance in the Data Appendix at the end of this report. We used a range of feedback to see how well we are doing. This included:

- **Feedback from people- who use our services, their families and carers**
  We used a range of methods to gather feedback including surveys, compliments and complaints systems like Care Opinion, group events like the Older People's Assemblies, and representation at planning groups. We also take into account information from Third Sector services such as VOCAL Carer's survey.

- **Scottish Government Data - The National Performance Indicators**
  These indicators include information gathered by the Scottish Health and Care Experience (HACE) Survey posted to a sample group of people in Scotland at the end of 2021. It asks about their experiences of health and social care services over the previous 12 months. 1,772 people responded from Midlothian. This is less than 2% of Midlothian's population. The National Records of Scotland recorded Midlothian's population was 93,150 on 30th June 2020.

- **Scottish Government's Ministerial Strategic Group (MSG) targets**
  These targets are for hospital admissions. Updated targets for 2021/22 were developed by Midlothian Health and Social Care Partnership, agreed by the IJB and submitted to Scottish Government in June 2021. Our targets are measured against a baseline from 2017/18.

Understanding how we contribute to people's outcomes

The services we plan and direct must, by law, aim to improve outcomes for people who use our service, their carers and families. It is hard to evaluate how what we do changes outcomes as this depends on many factors. To try and better understand this, we have developed our use of Outcome Mapping to help us record, analyse and understand our impact on people and communities.

Developing our performance framework

We began to develop a Performance Management Framework to improve how we assess our performance. We reviewed our data sources, measures and metrics, checked the quality of our data and identified gaps.

We are improving how we collect and present our data to show how we are meeting our aims and making best use of our resource. This will improve our ability to report on our performance for legislative and statutory requirements, local and national policy, best practice, professional guidance and evidencing the impact of integration.

We have worked with other Health & Social Care Partnerships, Integration Joint Boards and external partners and explored opportunities to innovate using digital tools.

The main challenges of 2021-22

The IJB was set up in 2015 to develop local solutions to improve health and care services. We still face some of the same issues such as an ageing population, inequalities in health, a national workforce shortage, increasing reliance on unpaid carers and growing pressures on acute hospitals. This year there have been a number of additional challenges including:

- **Covid-19 and the impact on the workforce**
  Covid-19 increased the pressure on our already stretched workforce. Illness and absence reduced the number of available qualified staff, many of whom had increased demands through additional services such as mass vaccination programmes.

- **Increasing Demand**
  The demand for community services increased due to changes in the how people accessed planned and unscheduled care. Continuing to support people when they had to wait longer for planned services further increased this pressure.

  In addition, higher numbers of people with increasingly complex needs who receive the support they needed in the community increased the pressure on many of our local services. This impacted on both our delegated service and the two Pan Lothian services hosted by Midlothian HSCP; the Adults with Complex and Exceptional Needs Service and Dietetics.

- **Wider Changes to Health and Social Care Planning**
  The 2021 Feeley Independent Review of Adult Social Care brought uncertainty about how the Scottish Government might review the provision of care services.

- **Population Changes**
  There have been changes to the overall size of our population, the number of older people living in Midlothian, and the number of single person households

  Population size
  Midlothian is one of the fastest growing areas in Scotland. By 2028 Midlothian's population is projected to have grown by faster than anywhere else in Scotland.

  Population age
  The number of people over 75 is increasing. By 2028 the number of people over 75 is projected to increase by 41%.

  Household size
  More people are living alone with a third of all households having just 1 person. Older people are now more likely to live alone or in smaller households and older women are most likely to live alone. The Health Foundation found out that, when compared with people who live with others, people aged over 65 who live alone are more likely to have three or more long term conditions, go to their GP and A&E more and are at higher risk of being admitted to hospital. This helps to explain why some services are more in demand despite the gains we are making in quality and improvements.

- **Health Inequalities**
  Covid-19 and the rising cost of living impacted people in unequal ways and the health gap between the richest and the poorest widened. During the year we had to focus on our crisis response to Covid-19 which meant some preventative programmes did not take place.

- **Unpaid Carers**
  During the pandemic many people became carers for the first time. Covid-19 affected the way service offers and support could be delivered. Not all services and supports were able to work at full capacity due to restrictions and people had to take on tasks which the Care at Home services were unable to provide. Additionally, more people recognised they carried out a caring role and the demand for support for unpaid carers increased.

How did we do?

How we are reporting this data

The information we use to measure our progress comes from several sources and is displayed in a way that makes it clear where we have done well and where we still have room to improve. The answers provided by Midlothian respondents to the HACE Survey are organised under the National Performance Indicators.

In 2020 the Scottish Government made changes to the survey for National Performance Indicators 1-9. Some questions were added, some were amended, and some were removed (the full list of these changes is in the Scottish Government Technical Report). These changes mean it is difficult to compare our performance with previous years and, in some cases, means we only have data from 2020. We have provided the following data:

- For Indicators 1-9 the data for 2021/22 is compared with 2019/20 only.
- For Indicators 11-20 the data for 2021/22 in compared with the previous 4 years.

1,772 people responded from Midlothian. This is less than 2% of Midlothian's population and the response rate increased with age and was highest in the 65+ age group (44%). This is compared to a response rate of 10% for those aged 17-34.

In the Data Appendix we have provided more information about our progress over time and our position in comparison to the rest of Scotland.

For some National Indicators the number of responses from each locality were too small to be published.

We have designed the report to look at each of the Health and Wellbeing Outcomes alongside the National Performance Indicators used to measure each one. All National Performance Indicator data for Midlothian against the national average is in the Data Appendix

The National Indicators

- Our performance has improved compared to last year.
- There hasn't been a significant change in performance compared to last year.
- Our performance has worsened compared to last year.

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.	92%	
2	Adults supported at home agreed that they are supported to live as independently as possible.	73%	
3	Adults supported at home agreed they had a say in how their help, care or support was provided.	70%	
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated.	64%	
5	Adults receiving care or support rated it as excellent or good.	79%	
6	Adults had a positive experience of the care provided by their GP practice.	62%	
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life.	81%	
8	Carers feel supported to continue in their caring role.	27%	
9	Adults supported at home agreed they felt safe.	79%	

	National Indicator	Our result	Our Progress
11	Premature Mortality Rate (People under 75)	**407** per 100,000	
12	Emergency Admission Rate	**11,568** per 100,000	
13	Emergency Bed Day Rate	**106,360** per 100,000	
14	Readmission to hospital within 28 days.	**105** per 1,000	
15	Proportion of the last 6 months of life spent at home or a community setting.	**88%**	
16	Falls Rate (People over 65)	**25%**	
17	Care services graded Good or better in Care Inspectorate Inspections.	**78%**	
18	Adults with intensive care needs are receiving care at home.	**64%**	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	**520** per 1,000	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	**23%**	

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1 Health & Wellbeing

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

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.	92%	
11	Premature Mortality Rate (People under 75)	407 per 100,000	
12	Emergency Admission Rate	11,568 per 100,000	

Right care, right place, right time

Our services aim to support people to look after their own health and wellbeing. We see ourselves as 'facilitators' and not 'fixers' and promote self-management through services and supports including welfare advice, and advice and support for people who are managing difficult circumstances.

One example of this is the Community Respiratory Team who help people manage lung conditions like Chronic Obstructive Pulmonary Disease (COPD). They encourage self-management through promoting physical activity and signposting people to community services for health and wellbeing. They supported people in their own homes which often meant people didn't need to go to hospital. Over the past year the team have helped prevent over 80 admissions to hospital and supported over 100 people leave hospital sooner to help them recover in their own home.

Improving mental health support in the community.

Over 90% of people requesting support from the Community Mental Health Team received support within 18 weeks.

The Team worked with the Intensive Home Treatment Team to support people at risk of being admitted to hospital to receive care at home instead of on an acute mental health ward. They also worked with Psychological Therapy Services and Adult Services to redesign how people with Autism Spectrum Conditions were assessed and diagnosed. This reduced the waiting list time from 56 weeks to under 18 weeks.

To improve the health and wellbeing of the population we needed to focus on the underlying causes of poor health and inequalities. Poor health can be the result of several factors, including diet, smoking, cultural factors and the sense of control people feel they have in their lives.

Prevention and early intervention for type 2 diabetes

The dietetics service supported people with, or at risk of developing, type 2 diabetes. People shared experiences and gained confidence to look after their own condition.

- Over 250 people accessed support from weight management programmes
- 125 people were referred for Physical Activity support
- 90 people completed face to face group weight management programmes
- 65 people were referred to the 'Let's Prevent Diabetes' programme in McSence and Newbattle, with additional virtual support

Activities were available for anyone living in Lothian giving choice about where and when people wanted to take part.

Scotland has the highest rates of premature mortality in the UK. More than 20,000 people aged under 75 die each year, with a disproportionate number of these in the most deprived areas. In 2021/22 the number of people under 75 who died prematurely in Midlothian increased.

Midlothian has a higher number of people with respiratory illness than the Scottish average. We suspect that there may be a connection between the number of people who prematurely died in 2021/22, the impact of COVID-19, and this vulnerable group.

Cardiovascular disease and cancer are strongly linked to deprivation. Addressing the impact of poverty and increasing opportunities and access to employment is vital alongside work to address drug and alcohol problems, and links to violence.

By ensuring good mental wellbeing support, increasing educational attainment, and promoting healthier physical and social environments we anticipate that premature mortality will reduce.

2 Living in the Community

People are able to live, as much as possible, independently and at home or in a homely setting in their community.

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
2	Adults supported at home agreed that they are supported to live as independently as possible.	**73%**	
3	Adults supported at home agreed they had a say in how their help, care or support was provided.	**70%**	
12	Emergency Admission Rate	**11,568** per 100,000	
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15	Proportion of the last 6 months of life spent at home or a community setting.	**88%**	
16	Falls Rate (People over 65)	**25%**	
18	Adults with intensive care needs are receiving care at home.	**64%**	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	**520** per 1,000	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	**23%**	

Right care, right place, right time

The indicators used in this section relate to the experience of people when they receive care in hospital. In 2021/22 there are good examples where we have improved our services including reducing the number of days people have to stay in hospital when they are ready to return home and increasing the number of adults who have intensive care needs that are supported to live within their community.

Learning Disability Services worked with our partners to improve how people with complex care needs were supported to live well in their local community.

Supporting people to lives good lives

We know that people with learning disabilities often spend far longer in hospital than those without a learning disability.

One local resident had spent nearly 17 years in hospital because appropriate housing and support had not been available locally to meet their needs. However, with local supported living facilities and integrated working across health, social care, social work, housing and the Richmond Fellowship Scotland, they are now living as independently as possible in their own community. They recently reported 'The world is now my oyster!'

People want to live independently in their own homes for as long as possible. Living well in good quality housing that meets people's support needs is the foundation of good health. In 2021 we arranged 174 adaptations to people's homes, providing 2,092 telecare packages, and increased the number of care at home hours by 7.8% to 17,000 hours per week.

Weight management support was delivered to people in their own homes using the online platform "Near Me". Over 80% of people who received support in this way reported that they would choose to continue with this as they liked being in their own home and not having to travel.

Ensuring people who are housebound received vaccinations

The Housebound programme supported over 1,000 people whose health records indicated they were housebound and immunosuppressed. Telephone calls and Good Conversations to discuss people's needs identified around 200 people who said they were able and willing to come into a clinic to be vaccinated. The remaining 800 patients were vaccinated at home.

During the pandemic we worked with independent and Third Sector partners to support people stay safe and well at home during periods of lockdown, shielding, or self-isolation and expanded our support to help people get back home from hospital promptly and receive the right care at home.

Preventing admissions to hospital for Chronic Heart Failure

Pathhead Medical Practice worked with consultants at the Royal Infirmary to identify a small group of people with chronic heart failure who met the criteria for 'medication optimisation'. This ensured they were offered the most effective medication to reduce their risk of needing to go to hospital.

Digital skills for older people

Volunteer Midlothian ran 'Connect on Line' classes for older people to develop skills and confidence to book appointments and tests, get vaccine certificates, complete the census, order online shopping, and use websites for price comparisons. Over 20 volunteers supported 51 older people to attend group sessions to learn new skills, 23 people received home visits, and many more were signposted to online safety, security, and energy workshops.

The service purchased tablets, upgraded laptops, and gave out devices through their lending library. iPads and mobile Wi-Fi were obtained through the Scottish Government 'Connecting Scotland' scheme. Connect on Line also successfully applied to the National Databank scheme and received 30 phone sim cards for people experiencing data poverty.

3 Positive Experiences & Dignity

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

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
3	Adults supported at home agreed they had a say in how their help, care or support was provided.	70%	
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated.	64%	
5	Adults receiving care or support rated it as excellent or good.	79%	
6	Adults had a positive experience of the care provided by their GP practice.	62%	
14	Readmission to hospital within 28 days.	105 per 1,000	
15	Proportion of the last 6 months of life spent at home or a community setting.	88%	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	520 per 1,000	

Right care, right place, right time

GP are independent contractors, and we continue to work closely together. The HACE survey covers elements of services that are delivered by GP independent contractors, and elements that are delivered by the HSCP.

Over a third of patients were concerned about the arrangements for accessing advice and support from local health centres but four of the 12 local practices rated consistently higher than the Scottish averages. 62% of people said they had a positive experience of the care provided by their GP practice. This is lower than in 2020/21 (67%) and is lower than the average in Scotland (67%, reduced from 79% in 2020/21).

However, 88% of people said they had a positive experience when needing to see a GP urgently. This is a small increase from 2020/21 and is higher than the average for Scotland (85%). At least in part, we think more positive results are due to our Good Conversations approach and changes that increased opportunities to quickly assess urgent problems.

Initial Primary Care medical assessment is now available by telephone, video, and email in some practices. Demand for GP appointments continued to increase with up to an estimated 10,000 patient contacts with a member of the primary care team in Midlothian each week.

It is important to see the right professional from the very first conversation. To try and get this right more often all reception teams were trained in 'Care Navigation' conversations to make sure people are directed to the most appropriate community professional or service. We also expanded the teams that work in our GP practices and in the community.

There are now more specialist services located in practices than ever before. People can usually access the care they need from Physiotherapists, Primary Care Mental Health Nurses, and Wellbeing Practitioners directly from these professionals without needing to see a GP first. Pharmacists, Advanced Nurse Practitioners for minor illness, Phlebotomists and Community Treatment & Assessment Clinic (CTAC) are also available at GP practices.

Each GP practice in Midlothian has a tailored model of delivery to meet the needs of its own population. As a result, there is flexibility in the range and number of professionals available at each practice and how people contact the practice team. Future work includes addressing variation in the digital support available and improving access to consultations using online systems.

Being seen quickly by the most appropriate professional leads to better outcomes and experiences. For example, or latest data shows that the MSK-APP service across all practices in Midlothian has freed up 2307 hours (61 days) of GP time since it started in 2019. This has resulted in 93% of people not requiring further GP input for their musculoskeletal issue after seeing a physiotherapist.

Our own services work closely with hosted services in other areas of Lothian, for example, the Speech and Language Therapy Home First Team. They helped people with communication or swallowing difficulties and provided targeted support in people's homes to avoid them having to stay in hospital or to help them get home from hospital more quickly.

Helping people stay at home

The Day Hospital were concerned about man attending the service who had experienced swallowing difficulties and significant weight loss. A number of professionals were considering admitting him to hospital. The Day Hospital suggested that the Home First Speech and Language Therapist (SLT) could help. The SLT reviewed how the man was swallowing and provided advice and strategies to help then followed up with a home visit.

"The advice for my swallowing really helped. I am drinking more and not coughing nearly so much. It was so helpful for you to come to the house as getting out is difficult. You are a real brick, thank you!"

The Midlothian Community Treatment and Care (CTAC) Service worked alongside specialist teams, to improve outcomes for people with chronic long-term wounds. People said this improved their mood, motivation, and participation in activities previously limited by the challenges of long-term wound care including getting out and about locally, meeting friends and planning family visits.

The CTAC team provided individualised care and supported over 20 people who now no longer need to visit health centres and GP practices for long-term wound management.

Continuity matters and that an appointment with a GP adds best value to care where there is a need to investigate persistent or progressive symptoms of concern, or manage complex chronic illness, frailty, or palliative care. We saw this in 2021/22 where potentially preventable admissions for people with heart failure were reduced by 50% and avoided an unnecessary hospital stay.

Improving care at the end of life

The Midlothian District Nursing service supported people with life limiting illnesses live at home at the end of their life. Staff teams tried to stay consistent to build relationships and provide emotional support. Our palliative care feedback project told us that families valued staff continuity and that those relationships helped them cope in difficult times.

Over the past 2 years, the service increased the number of visits by 62% and increased the average time for each visit. Visits for symptom management were recognised as vital to ensure people were supported well at home and these visits increased by 142%.

The Community Respiratory team supported people at the end of their COPD journey by focusing on shared decision making, individual choice, anticipatory care planning and quality end of life care as close to home as possible.

4 Quality of Life

Health & social care services help to maintain or improve the quality of life of people who use those.

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
★★★★★ 5	Adults receiving care or support rated it as excellent or good.	**79%**	
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life.	**81%**	
13	Emergency Bed Day Rate	**106,360** per 100,000	
14	Readmission to hospital within 28 days	**105** per 1,000	
16	Falls Rate (People over 65)	**25%**	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	**520** per 1,000	
£ 20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	**23%**	

Right care, right place, right time

The support delivered by Midlothian Health and Social Care Partnership helped improve the quality of life for 81% of the people who responded to the HACE survey, an increase of 13% on the previous year.

Cherry Road Day Centre used collaborative models of community support for people with complex care needs. Over 60 people with learning disabilities took part in creative workshops, educational activities and vocational opportunities. These reflected individuals' interests and helped develop a better understanding of what matters to each person and what a good life means to them. People

designed their own environments and daily activities. Everyone's contribution was valued equally and added to our understanding of different ways of seeing and experiencing the world. Weekly workshops supported meaningful activities in local community spaces included sensory sound sessions, product design, live music, and textiles.

Understanding the different types of support people need to achieve what matters to them continues to be an important part of our self-management approach.

Supported Self-Management

The Thistle Foundation provided supported self-management and carer support for people with long-term health conditions or facing challenging life situations. 1,400 people were referred for one to one support and group courses. 75 people attended online Lifestyle Management and Mindfulness courses to support them to feel more able to return to the activities that matter in their lives.

One participant said, "In the first lockdown I couldn't get out the door, I'd be crying, shaking and panicking. … I'm meeting friends again, and even going on the bus. One of the other ladies in the group and I support each other by video calling and saying 'you go to your front door, and I'll go to mine...' I used to have high blood pressure stressing about going out. Because my blood pressure is coming down it makes my doctor happy – which makes me happy!"

Our services for older people adapted to people's needs and offered support in new ways. Our Intermediate Care Community Teams partnered with the Red Cross to help people come home from hospital earlier and stay at home for longer. In the first 6 months, 95 people were supported to return home and live independently through advice with welfare benefits, assessments of the home and referrals for adaptations and equipment, referrals for social activities, and help with Power of Attorney applications.

Physical activity plays a key role in both our physical and mental wellbeing and maintaining an active lifestyle is even more important as we get older. By helping people to remain active the risk of falls that result in a trip to hospital can be reduced. Our work to improve access to sport and leisure supported older people and those living with long term conditions.

Improving access to Sport & Leisure

Sport & Leisure provided support and opportunities for physical activity for people at risk from poor health outcomes related to inactivity across the pandemic.

- 18,394 people aged over 50 took part in Ageing Well activities
- 3,966 people with long-term conditions were supported by Midlothian Active Choices

Respect and dignity are central to our values, and we made progress embedding a Human Rights approach across our services. Our new contracts with care at home providers specify how the service should promote human rights. We secured funding to deliver training to staff to support them to embed a human rights-based approach within our care homes. For people with learning disabilities a Human Rights Panel was established, led by 'People First Midlothian', and held human rights sessions focussing on supported decision-making.

Training and further education

The Midlothian Unpaid Work team develop and promote training pathways, further education and employment opportunities to support people with a previous pattern of offending. Workplace Health and Safety training was incorporated into inductions providing the opportunity to gain this SQA recognised qualification. First Aid at Work and Emergency First Aid courses are also regularly delivered by the team.

In partnership with Midlothian's Communities, Lifelong Learning and Employability team and local Higher Education providers, 83 courses have been completed with 55 individuals gaining qualifications in courses including the Construction Skills Certificate Scheme (CSCS) card, Rural Skills Course, and Adult Achievement Awards.

5 Health Inequalities

Health & social care services contribute to reducing health inequalities

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
11	Premature Mortality Rate (People under 75)	**407** per 100,000	
12	Emergency Admission Rate	**11,568** per 100,000	

Right care, right place, right time

Health inequalities result in poorer outcomes for some people and communities. 1 in 4 children live in poverty in Midlothian. Adults living in areas of deprivation are more likely to be prescribed medication for anxiety or depression or go to hospital for a preventable reason than people living in affluent areas. People in areas of deprivation are more likely to die, on average, 9 years earlier than people living in more affluent areas.

Vaccinations in the right place to reduce inequalities

Pop-up vaccination clinics in Newbattle, Penicuik & Dalkeith vaccinated over 800 people in areas where we knew the number of people with vaccinations was low.

The No.11 Service in Dalkeith supported the vaccination team to reach people known to be at risk of health inequalities within the Criminal Justice System and people recovering from substance use. Our Health Inclusion nurse vaccinated nearly 50 people living in hostels.

We have an obligation under the Equality Act 2010 to positively promote equality. We must advance equal opportunities and foster good relations between different people when carrying out our activities. As part of our responsibilities to consider how our services and supports might affect different groups in different ways and avoid unintended consequences, we completed 8 Integrated Impact Assessments to inform our planning and ensure our services and supports met the diverse needs of our communities.

'Good Conversations' is an approach to changing our culture, seeing ourselves as 'facilitators', 'not 'fixers', understanding and working with people's life circumstances, and supporting self-management, choice, and control. Good Conversations addresses the impact of inequality. 19 services redesigned how they welcome people and treating people as experts in their own lives. People said this approach was meaningful and made a difference in their lives.

"My appointments with people with a long-term condition have got shorter. I asked a person with chronic pain to talk about the day she coped and what she did and encouraged her to do more of the same."

General Practitioner

"I used to spend most of the appointment with a patient who has diabetes talking about their diet. On this occasion I asked what mattered and she said she was scared. This meant we discussed this and helped her to understand what would help her manage her condition."

Practice Nurse

"I felt really listened to. It was nice to take my time about things"

We work with people as equal partners and focus on what matters to them with a 'whole person' approach.

Reducing A&E attendance

The Health Inclusion Team supported 11 people under the age of 55 who had attended Accident and Emergency more than 3 times in a year.

They supported people using 'Good Conversations' there was a 64% reduction in visits by the group.

6 Support for Carers

People who provide unpaid care are supported to look after their health and wellbeing.

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
8	Carers feel supported to continue in their caring role.	27%	

Right care, right place, right time

In 2021/22 many people became carers for the first time or may have found their caring role significantly changed. Covid-19 affected the way services and support could be delivered, and people's care needs changed. Not all services and supports were able to work at full capacity due to restrictions and people had to take on tasks which the Care at Home services were unable to provide. Restrictions in the availability of some support services accessed by carers, e.g., residential respite for older people, led to alternative solutions being piloted.

Additionally, more people recognised they carried out a caring role and the demand for support, information and advice for unpaid carers increased. The last census told us that over 2,000 people in Midlothian provide substantial care of more than 50 hours per week. We continue to try and reach everyone who provides a caring role. We know that many unpaid carers are not actively known to our services.

Perhaps the most concerning aspect of the HACE survey feedback is how poorly our unpaid carers feel supported. 19% of respondents (336 people) described themselves as having carer responsibilities.

Although 60% of people who responded felt they had a good balance between caring and other things in their life, the Midlothian VOCAL carers survey found this to be much lower at 28%. This is particularly relevant as carers who are in contact with VOCAL are seeking support, information, and advice with their caring role, perhaps including how to manage their caring and health & wellbeing.

Midlothian achieved slightly higher (40%) than the national average (39%) in the HACE survey when asking carers if they felt they had a say in the services provided for the person they care for. This was significantly higher (54%) in the VOCAL survey and likely due to the work of VOCAL to provide support and promote self-advocacy with carers.

Increased carer support

We awarded new and increased contracts to local organisations to support carers. The British Red Cross, Dalkeith Citizens Advice Bureau, and VOCAL increased capacity to support carers with financial advice and grants as well as improving earlier identification of those in a caring role.

More carers were supported by VOCAL in 2021/22 with 1,130 people completing Adult Carer Support Plans, 198 people accessing a Wee Breaks grant, and 500 people going on a day-attraction break.

We developed our Carers Strategy alongside a review of carers support and services. It aims to improve both the experience for carers and how caring is viewed and valued within our services and communities. Priority aims included:

- Carer identification and Carer involvement
- Access to Support, Information and Advice
- Health & wellbeing (including breaks from caring)
- Planning ahead and financial support

We undertook a self-evaluation to help us understand how we can be more successful supporting unpaid carers in ways that are meaningful to them. We know that carer support is about the whole system working better together and have become more aware of the impact that capacity pressure on care at home, respite, and day services has on carers. We will continue to take a whole system approach to improve the support available and experience of unpaid carers.

"Getting the desired information/service quickly from one main contact point has reduced stress and uncertainties of finding and getting appropriate support"

"I feel I am not alone. I know that in my day to day caring and when big decisions have to be made, I can access support"

"The support from Wee Breaks was invaluable to us and kept us going"

"I was torn to bits by it all and VOCAL gave me a steadying hand when I most needed it"

7 Safe from Harm

People using health & social care services are safe from harm.

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
9	Adults supported at home agreed they felt safe.	**79%**	
12	Emergency Admission Rate	**11,568** per 100,000	
13	Emergency Bed Day Rate	**106,360** per 100,000	
14	Readmission to hospital within 28 days.	**105** per 1,000	
16	Falls Rate (People over 65)	**25%**	
17	Care services graded Good or better in Care Inspectorate Inspections.	**78%**	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	**23%**	

Right care, right place, right time

We received 674 Adult Protection referrals. This was an increase of 49 %, with 221 more than the previous year. In the past year 64% of people referred for Adult Support and Protection were over 65yrs old, 53% were females and the main reason for referral was neglect.

Training staff on Adult Protection

Adult Protection services delivered Adult Protection Council Officer training to social workers who carry out specific duties under Adult Protection legislation to protect vulnerable adults.

86 multi-agency staff in Midlothian and East Lothian attended a course on protecting adults at risk of financial harm.

We supported people at risk of abuse from close family members. We worked with families to search for solutions or, in rare cases used legal proceedings to protect people. In 2021/22, two people were assessed as being at risk of harm from people close to them. The safest solution in both these cases was to seek a Banning Order through the courts.

We worked with the police in reducing violence against women and girls. 'Women's Aid East and Midlothian' provided support and refuge accommodation to women, children and young people who experienced domestic abuse. They remained fully operational and provided support to 306 women and 208 children and young people including refuge accommodation for 29 families.

Supporting women affected by complex trauma

The Spring service supported women affected by histories of complex trauma and substance use, mental health and/or offending behaviour to access support for all of their needs under one roof.

The Spring service worked collaboratively with Women's Aid East and Midlothian, Access to Industry, Health in Mind, Occupational Therapy, the Health Inclusion Team, and Justice Social Work. The 'Stepping Stones' programme was redesigned to integrate emotional regulation and distress management in all sessions, and renamed 'Stepping Forward'.

Women who have experienced trauma frequently report low self-esteem and low feelings of trust and hope. 83% of women who accessed the Spring service reported improvements in 'identity and self-esteem' and 'trust and 'hope'.

Our services and supports aim to keep people safe from harm and prevent avoidable risks. In 2021/22, where it was feasible to reduce face-to-face contact, teams made a number of changes to how services were delivered in line with national guidance. However, teams continued to see people face-to-face where this kept them safe and well. Third sector organisations also worked hard to find safe ways of supporting vulnerable people.

We worked to ensure people could access information and know where to turn to for help. The 'Older People's Newsletter' was printed and delivered to people who may have found it hard to find the information online.

Digital poverty and variation in digital access became even more important to address in 2021/22 as we increased our use of technology to support people in the community. Working with The Connecting Scotland scheme and our Third Sector colleagues, we jointly distributed 116 iPads and digital devices to people.

Our work to keep people safe and well at home also includes the use of telehealth equipment. During 2021/22 there were 25,175 responses to alarms within the home for Midlothian Residents. The majority of alarms were responded to by health and social care staff (65%) with family members providing support where appropriate (35%).

Keeping people safe in their own homes

Our community alarm systems help keep people safe and well in their own homes. We provided a range of sensors including community alarms, smoke and CO2 detectors, a bed sensor, a door sensor and a falls detector. These are linked to a call centre who can respond if someone doesn't respond to the alarm. This helps people feel able to remain in her own home and feel safe.

We provided support for people leaving hospital such as falls alarms to ensure help was at hand quickly when needed.

8 Workforce

Staff are engaged with their work and are supported to continuously improve the information, support, care and treatment they provide

National Indicators used to measure this outcome.

These are no National Indicators to measure our progress towards this outcome and we use staff surveys to evaluate our performance.

Right care, right place, right time

iMatter staff survey

Over half of the workforce (700 staff) responded to our annual survey. Despite the pandemic resulting in some of the most challenging times in our working lives, staff rated the level of support from the HSCP in relation to their health and wellbeing as constant with previous years.

More flexible and home working, staff vaccinations and personal protection equipment helped staff feel safe and valued but 27% of staff told us there was room for improvement. We recognised the importance of easy access to support and appointed a Wellbeing Lead to listen to staff, provide the right resources, and offer access to coaching.

Health and wellbeing

Our staff and partners in every sector showed an enormous commitment to supporting people and communities in 2021/22 as we continued to feel the impact of the pandemic. Supporting our staff to perform well, feel safe, and properly valued so they can continue to deliver high quality services was identified as one of our five top priorities and a *'Spotlight'* area in 21/22.

Supporting our staff to rest, refuel and recover

Reduced access or closure of local premises meant it was often difficult for staff to find somewhere to eat or drink, rest, or use a toilet while working in the local community.

We identified 21 Midlothian Council and NHS Lothian buildings with suitable areas to rest, refresh, and refuel. Our staff co-created a logo, promotional materials and a map.

National recruitment crisis
Scotland saw a significant drop in workforce over the past two years and much of this was due to the impact of COVID-19. Chronic illness, long covid, increasing difficulties with mental health and well-being, people taking on a new caring role or choosing early retirement, adjusting working patterns and reducing working hours to manage new commitments all impacted on the choices people have made in relation to their working lives.

Finding recruitment solutions
We want Midlothian to be a place where people chose to work and be part of health and social care within their community. In 2021/22 the NHS and the Council workforce in Midlothian grew by 11% to 1,090 whole-time equivalent staff. This figure is more than double when we also consider our independent and third sector partners. Despite this, the impact of the pandemic continued to be felt across services nationally, and pressure on existing staff was amplified by recruitment difficulties.

Care at home services and care homes experienced significant recruitment challenges and this impacted on the number of staff who completed SVQ training. Where staff were historically supported to gain SVQ qualifications while working, having more new staff in the workforce than usual meant the proportion of staff who had completed all the relevant SVQ qualifications dropped from 85% to 60%.

A new Clinical Educator post was created at Midlothian Community Hospital to address recruitment challenges by supporting staff to develop into new roles. This helped to develop and assess competences, consolidate new skills, and provide support for learning and improvement.

Training staff

In 2021/22 we secured premises to provide local training and wellbeing support, with plans to open our training suite in Hardengreen in 2022/23. Training and staff development opportunities were available to all staff although this was constrained by the capacity of services to release staff.

The Midway approach offered all staff training in areas such as trauma and health literacy, 287 participants went on Bitesize training and 91 staff have been trained on improving their skills in Good Conversations to support self-management.

Initiatives to address staff shortages were put in place including career pathways for nursing posts; foundation courses and modern apprenticeships in the community hospital; increased capacity for SVQ programmes; and increased capacity to train social work students.

Training and staff development opportunities are readily available to all staff both online and face to face. Ongoing training is important to keep staff safe and maintain registration and we continued to support the capacity of services to release staff wherever possible.

Quality Improvement Team

Staff benefited from opportunities for reflection and learning together to continuously improve the information, support, care, and treatment they provide. Quality Improvement Teams were one way we support our staff to engage in continuous improvement of experiences and outcomes of care. These teams used data to identify and prioritise areas where we could improve, try new ideas, and share learning.

Quality improvement to improve outcomes

The Intensive Home Treatment Team identified that a brief crisis intervention would reduce the risk of admission to hospital for some people experiencing mental health difficulties.

The team found that by creating the 'Crisis Intervention and Monitoring Pathway, people in crisis but without a known diagnosis could see significant change with only require a short period of intervention and benefit from recommended supports. This will be piloted within the Mental Health and Resilience Service and outcomes reviewed in 2022/23.

9 £ Use of Resources

Resources are used effectively and efficiently.

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated.	64%	
12	Emergency Admission Rate	11,568 per 100,000	
15	Proportion of the last 6 months of life spent at home or a community setting.	88%	
16	Falls Rate (People over 65)	25%	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	520 per 1,000	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	23%	

Right care, right place, right time

Ensuring we make best use of our resources is a complex task. We continued to prioritise our work on prevention, early identification, and early intervention.

In 2021/22, we continued to invest in our work in the community so more people were treated at home and avoid a hospital admission. For example, the Discharge to Assess Team recruited 36 health care assistants to enable people to return home as soon as they were fit to do so. Our continued investment in Home First services and the implementation of the Primary Care Improvement Plan are examples of increased investment in community services and our commitment to reduce our reliance upon hospitals.

However, the pressure on acute hospital remained very high. We continued to support people to improve their own health and all our services promote preventative action and early intervention. Our work on reducing the incidence of diabetes as a partner in the South East Scotland Diabetes Strategy is an example of this. We must also help people stay as well as possible when they have long term conditions and the Improving Cancer Journey programme in collaboration with Macmillan is an example of this.

The emphasis given nationally and locally to vaccinating against COVID reflects the importance of prevention wherever possible. We performed better than the Scottish average for all 3 doses with 100% of people having their first dose. Our overall performance on vaccination rates compares well to elsewhere in Scotland demonstrating our resilience and ability to adapt and deliver service in new and innovative ways.

Successful vaccination programme

As part of one of the most effective vaccination programmes in Scotland, Gorebridge Leisure Centre was transformed into a local and accessible vaccination centre. As a result, vaccination uptake significantly improved in 2021-22

The Flu vaccination team designed clinics in response to views about the convenience of location and times. The pre-school vaccination team opened a telephone helpline for queries, created more flexible clinic times at a variety of accessible locations, and offered drop-ins rather than set appointments. The team increased capacity at every clinic by improving the process and reducing appointment times from 20 minutes to 15 minutes. Weekend and Friday afternoon clinics proved to be very popular.

Sport and Leisure staff provided support including helping people maintain social distancing whilst queuing and answering questions for people attending. Positive and effective working between NHS Lothian, Sport and Leisure staff, St Johns Ambulance and volunteers ensured around 9000 vaccinations a week were safely delivered.

How We Spent Our Money (2021/22 subject to audit)

The IJB had a total budget of **£178m** and ended the financial year with a small **underspend of £10.5m**. This underspend is made up of an underspend on the IJBs operations of £1.1m and earmarked funding, predominantly for COVID not spent in year of £9.7m. For more information see our Annual Accounts.

Direct Midlothian Services	**Budget**	**Spend**	**Variance**
Community AHPS	£2,707,000	£2,788,000	-£81,000
Community Hospitals	£5,715,000	£5,891,000	-£176,000
District Nursing	£5,923,000	£5,875,000	£48,000
General Medical Services	£33,882,000	£33,859,000	£23,000
Health Visiting	£2,233,000	£2,221,000	£12,000
Mental Health	£2,950,000	£2,825,000	£125,000
Other	£1,275,000	-£4,875,000	£6,150,000
Prescribing	£19,101,000	£19,253,000	-£152,000
Resource Transfer	£7,172,000	£7,172,000	£0
Older People	£22,842,000	£19,001,000	£3,841,000
Learning Disabilities	£16,548,000	£16,528,000	£20,000
Mental Health	£1,177,000	£1,387,000	-£210,000
Physical Disabilities	£3,537,000	£4,086,000	-£549,000
Assessment and Care Management	£3,378,000	£2,987,000	£391,000
Other	£3,113,000	£2,361,000	£752,000
Midlothian Share of pan-Lothian			
Set Aside	£20,548,000	£20,698,000	-£150,000
Mental Health	£2,662,000	£2,715,000	-£53,000
Learning Disabilities	£1,415,000	£1,427,000	-£12,000
GP Out of Hours	£3,144,000	£3,102,000	£42,000
Rehabilitation	£879,000	£791,000	£88,000
Sexual Health	£696,000	£676,000	£20,000
Psychology	£846,000	£855,000	-£9,000
Substance Misuse	£375,000	£363,000	£12,000
Allied Health Professions	£1,622,000	£1,494,000	£128,000
Oral Health	£1,853,000	£1,822,000	£31,000
Other	£1,438,000	£1,210,000	£228,000
Dental	£5,855,000	£5,855,000	£0
Ophthalmology	£1,742,000	£1,742,000	£0
Pharmacy	£3,795,000	£3,795,000	£0
	£178,423,000	**£167,904,000**	**£10,519,000**

Financial Challenges During 2021/22

COVID-19 Financial Impact

COVID-19 disrupted patient journeys and service delivery and delayed access to secondary care treatment which might otherwise reduce care requirements for individuals. We remain committed to supporting our partners (Midlothian Council and NHS Lothian) during this very difficult time but we anticipate that, as the impacts of the pandemic become more manageable, we will be able to return to a more 'business as usual' position.

During the financial year, we spent around £5,488,000 to support the additional costs of health and social care generated by the COVID-19 pandemic. This was funded through our COVID-19 reserve along with additional funding from the Scottish Government. In addition, we continued to support NHS Lothian with its remobilisation plan as part of the overall recovery of services from the pandemic.

Social Care

There was an overspend within adult services, specifically for clients with physical disabilities. This was offset by a significant underspend in services for older people.

Health

Although there were operational overspends within Community Hospitals, as a result in the changing environment and nature of patients these were offset by vacancies across the system and slippage of programmes. For our Hosted and Set Aside services the areas with continued pressures being experienced Mental Health Inpatient services with additional capacity being required in year to cope with high demand and the increased demand on the community equipment store.

The main pressure for Set Aside services in this financial year lies within Gastroenterology Services and the ongoing pressure with drug costs for the treatment of long-term gastroenterology conditions. Junior Medical pay pressure also continued during this year, where additional staffing was required to fill gaps in rotas and where there were service pressures. The Junior Medical position has improved significantly from previous years but still remains a pressure.

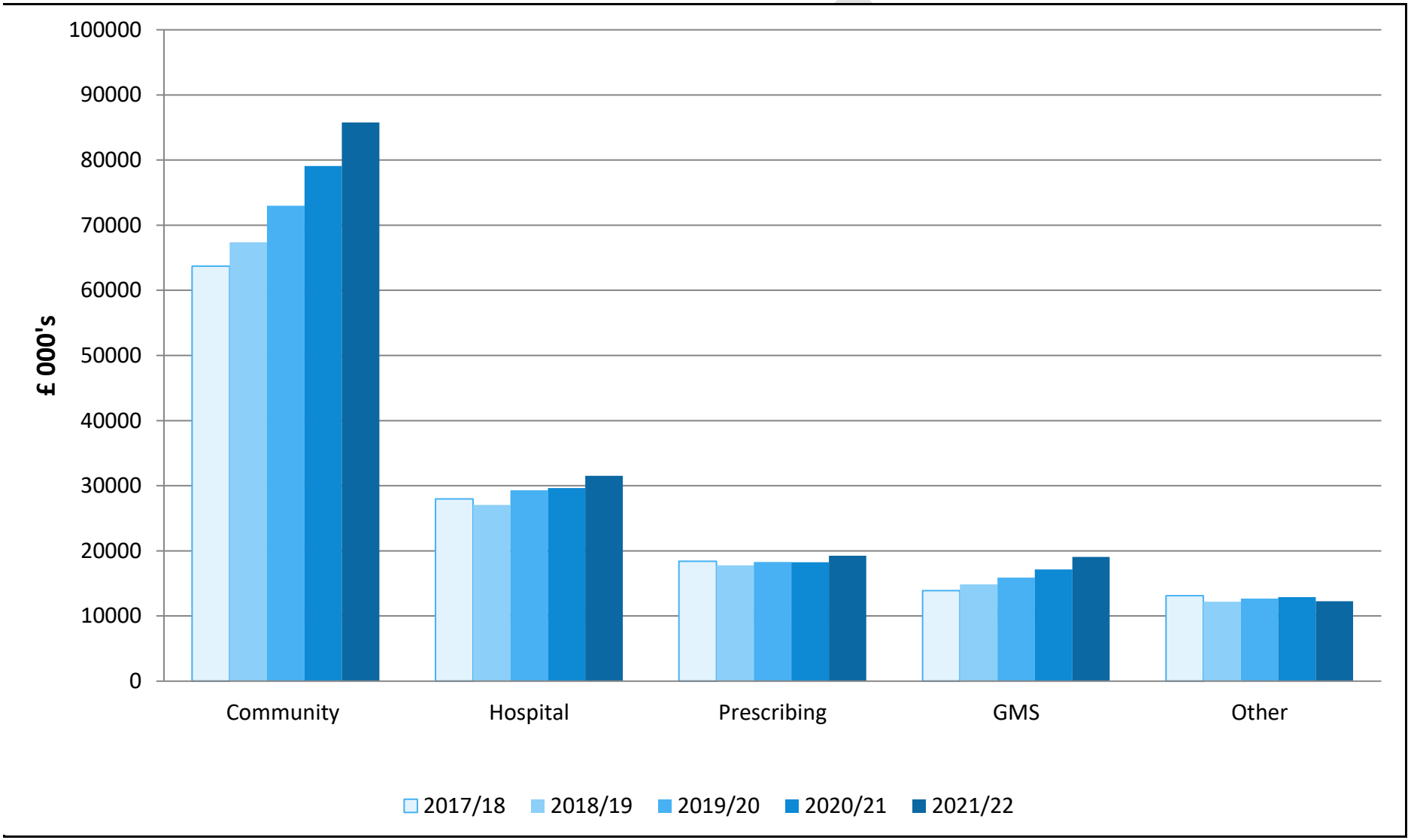
The Scottish Government released funding to cover the impact of COVID costs on NHS Lothian's position and that funding has been allocated to delegated and set aside services to offset additional expenditure incurred. With COVID funding being allocated across the IJBs set aside specialities to cover additional costs incurred around extra staffing to cope with COVID-19, the overall position on set aside is much improved compared to previous years.

We have a duty under the Local Government Act 2003 to make arrangements to secure Best Value. Best Value includes aspects of economy, efficiency, effectiveness, equal opportunity requirements, and sustainable development.

In 2021/22 there was an increase in the IJB spend within the community services. This is in line with our ambitions to develop health and social care services locally. Examples of this are our home first model, the development of intermediate care services locally, including discharge to assess and hospital to home.

Main Areas of Spend (2017/18-2021/22)

The graph below compares our spend trends for the past 5 years. We are unable to report on spend by locality as we do not hold data in this form.



Working with our Communities

The Public Bodies Act requires that each Integration Authority area is split into at least two localities. The data from the HACE Survey is included in an appendix to this report. However, the number are often too small to be reported.

There is no natural split into two or more areas nor is the population large enough to make a locality approach viable for commissioning services. As the smallest mainland authority in Scotland, we do not consider this is a meaningful approach.

Instead, we work with the local Community Planning Partnership and Neighbourhood plans to work with 16 natural communities to identify what is working well and plan areas for development. The voluntary sector has strong roots in local areas and supports a system wide understanding of community intelligence that is invaluable. Our ongoing partnership with the third sector is at the core of our work in communities.

This approach has been particularly effective during civil emergencies such as extreme weather conditions and, more recently, the pandemic.

Delivering local services

- **Local Care & Treatment Centres**
  Three Care and Treatment Centres were established in 2020/21 and they continued to support people this year. We also expanded local multidisciplinary primary care teams to provide local access to services such as physiotherapy, pharmacy and wellbeing.

- **Cash in your Pocket**
  Through targeted leafleting and the provision of local advice, Cash in Your Pocket was a multi-agency approach to increasing uptake of benefits entitlement for older people involving the Citizens advice Bureau (CAB), Housing Associations, Voluntary Organisations, and the HSCP. Over a three-month period, these agencies supported people to access an additional £531,645 in their pockets. This coordinated campaign saw an increase of approximately 25% on the same period in the previous year.

- **Local support for local need**
  In partnership with Midlothian Voluntary Action, the Mental Health Foundation distributed £297,000 of new investment to address isolation, recovery from Covid-19 and support suicide prevention. There were 27 successful applications based in local communities including a men's club in Pathhead and activities for older people in Cousland.

- **Easily Accessible services**
  New initiatives provided local services – for example to increase the uptake of benefits and prevent diabetes through weight management and physical activity groups.

- **Vaccinations**
  The vaccination programme was delivered in localities to ensure easy access and reduce the need to use public transport. This included working with popular local commercial partners like IKEA to reach as many people as possible.

- **Planning for the future**
  Plans have been developed to address the growing needs for local health centres in areas such as Shawfair, and developments have progressed well to establish extra-care housing in Dalkeith, Gorebridge and Bonnyrigg.

- **Supporting vulnerable people through the lockdowns**
  Statutory services worked alongside community councils and volunteers to support vulnerable people with food, shopping, prescription and isolation. Voluntary organisations such as Red Cross, Thistle Foundation and Grassy Riggs supported vulnerable people in areas of deprivation including Mayfield, Dalkeith and Gorebridge. The approach to more proactive work in areas of deprivation will be revisited as part of the broader 'area targeting' activities led by the Community Planning Partnership in 22-23.

Supporting local communities

During periods of national restriction, the Grassy Riggs drop-in café closed but the staff continued to support the local community in a variety of ways. Staff and volunteers carried out regular welfare phone calls and delivered steak pies and soup every week to 21 local people who were vulnerable or unable to leave the house.

By keeping in touch with people, staff and volunteers were able to provide support and direct people to other services. Common issues were support for carers, wellbeing and wellness, and bereavement. The Grassy Riggs staff supported older people who were anxious and worried about their health and more vulnerable to Covid-19.

A small number of people who have not felt confident to return since the Café reopening in May 2021 continue to benefit from telephone support

Despite the continued pressures of the pandemic the commitment to maintain and strengthen work with the Third sector was evident through the programme of Third Sector Summits that continued online to ensure that staff across sectors were equipped to recognise and address the impact of health inequalities.

Looking forward

We expect to face a number of opportunities, risks and uncertainties in the coming years. We recognise the scale of these, but also that services need a period of stability to recover and address the areas where waiting times have increased over the past 2 years.

Our future direction and ambitions are set out in our 3-year Strategic Commissioning Plan. This recognises our ability to progress transformational change was severely restricted by the impact of the pandemic as well as what can realistically be achieved within a one or two-year timeframe. Over the last year many services have revaluated how best to meet the needs of people and communities and are at the start of a new and exciting transformational change programme.

We set a balanced budget and will invest in key areas of prevention as well as make recommendations for how to use our reserves to support innovative practice and accelerate priority areas of transformation. The funding gap in future years and the potential for additional savings requirements creates significant uncertainty in relation to our ambitions.

Finance

In March 2022 we undertook part of the annual financial assurance process to review the budget offer for 2022/23 from Midlothian Council and NHS Lothian. This identified financial challenges, but we accepted the budget as it passed the two tests of 'fair' and 'adequacy'. It should be noted that this was a challenging settlement for the IJB, and any further reduction will undoubtably impact on service delivery. We must ensure Best Value by continuing the transformation of health and social care to deliver are safe, effective, efficient, person-centred, timely and equitable services.

Covid-19

The coronavirus pandemic remains a significant challenge with uncertainty around further waves and outbreaks. This will remain at the forefront of our planning.

Community Growth

More than 12,000 new houses will be built in the next 3 years. This will pose challenges for our services and change the face of some local communities. As people live for longer many more people will be living at home with frailty and/or dementia and/or multiple health conditions. An increasing number of people live on their own, and for some this will bring a risk of isolation.

Primary Care and Community Services

Recruitment and retention is a growing problem in health and social care. There is a shortage of GPs; a significant proportion of District Nurses are nearing retirement; while care at home providers find it difficult to attract and keep care at home workers despite measures such as the living wage and guaranteed hours. The aging population means these pressures will almost certainly increase.

The Acute hospitals that support the population of Midlothian (The Royal Infirmary of Edinburgh and the Western General Hospital) remain under significant pressure and exist, as do other social

care and health services, in a financially challenging environment. We will continue to invest and develop community-based alternatives that will minimise avoidable and inappropriate admissions.

Introduction of a National Care Service Bill

The National Care Service (Scotland) Bill was introduced to Parliament on 20 June 2022 and Scottish Government have committed to establishing a functioning National Care Service by 2026. This will mean changes to governance and delivery of health and social care. We will work in close collaboration with Scottish Government to try and ensure that gains in integrated working and more closely integrated services continues to progress.

Improving Quality of Services and Outcomes for People

We need to continue to develop our ability to deliver high quality services through a quality programme. Alongside this we need to develop ways of understanding the impact these services have on people's own personal goals in relation to their health and wellbeing.

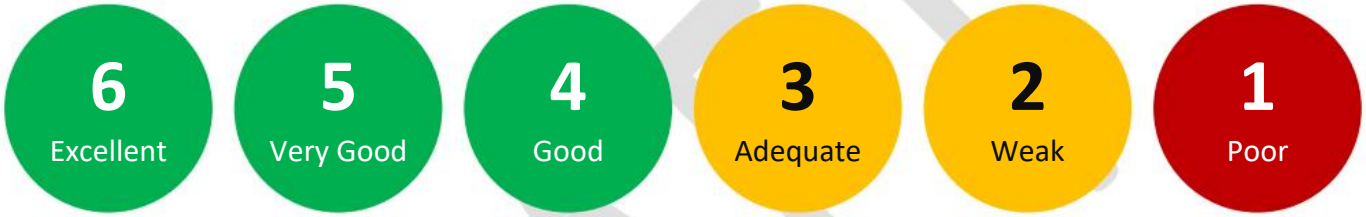
We have committed to an ambitious programme of self-evaluation, quality management and outcome mapping to become a more responsive and effective provider of health and social care services. In addition, the capacity to provide local training and wellbeing support across the partnership will be enhanced during 22/23 with the acquisition of a training suite in Hardengreen.

Improving Reporting of Hosted Services

As we develop our own performance measures, we have become even more aware of how important it is to be able to report well to other areas of the system that depend on our data and receive quality data in return. An example of this is the services that are delivered on a pan Lothian basis but hosted within one of the four HSCP across Lothian. All four HSCPs are working together to ensure that these hosted services can provide accurate and meaningful local performance data for each HSCP area in the future.

Inspections

The Care Inspectorate inspect care homes and care at home services to check the quality of care. The majority of care homes in Midlothian are not managed by the HSCP. Read the full reports at the Care Inspectorate website



Care at Home Services

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning	Care & support during COVID
Call In Homecare	01/12/2021	4 Good	5 Very Good	-	-	-	4 Good
Cera Midlothian	01/06/2021	4 Good	-	-	-	-	
Midlothian Council	Various	4 Good	4 Good	-	-	-	4 Good

Recommendations and Areas for Improvement (if any)

Name	Recommended Improvement
Call in Homecare	People should be reassured that their care and support plans contain the most current and up to date information.
Cera Care Midlothian	Ensure improvement in the oversight, recording and reporting systems to ensure these comply with legal responsibility. The management team should review client care plans on a regular basis

Care Homes for Older People

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning	Care & support during COVID
Nazareth House	Various	2 Weak	2 Weak	2 Weak	3 Adequate	-	3 Adequate
Pitendriech	22/11/2021	4 Good	-	-	-	-	3 Adequate
Guthrie House	28/02/2022	4 Good	-	-	-	-	4 Good
Springfield Bank	Various	3-Adequate	3-Adequate	-	-	-	3 Adequate
Drummond Grange	18/06/2021	4-Good	-	-	-	-	3 Adequate
Archview Lodge	01/06/2021	4 Good	-	-	-	4-Good	4-Good

Recommendations and Areas for Improvement (if any)

Name	Recommended Improvement
Nazareth House	Care records reflect care given. People should have confidence that their needs and wishes are met. Staff must appropriately support service users who are experiencing stress and distress. Service users experience a service which is well led and managed, which results in better outcomes for service users. Staff are able to support service users to receive care that meets their health, safety and wellbeing needs and enables them to experience respectful, personalised and compassionate care**.**
Springfield Bank	People should be respected and treated with dignity. People should have confidence that their needs and wishes are met. People should experience care and support that is right for them. People should be able to eat and drink well.
Drummond Grange	People should experience a clean environment that reduces the risk of any cross infection. People should feel they are kept as safe as possible from the risks of cross infection.
Archview Lodge	Personal plans record all risk, health, welfare and safety needs, in a coherent manner, which identifies how service user needs are to be met.

Intermediate Care Homes

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning	Care & support during COVID
Highbank	05/07/2021	4 Good	-	-	-	-	4 Good

Recommendations and Areas for Improvement (if any)

Name	Recommended Improvement
Highbank	People should feel confident they will receive the care and support they need. Staff should follow the 'Open with Care' guidance on visiting. Staff should be aware of the legal framework that supports adults with incapacity to ensure their rights are met. People experiencing care who are at risk of falling should be cared for in ways that promote their safety and independence.

IJB Business

Communication and Engagement

We undertook a large-scale consultation as we were developing our 3-year Strategic Commissioning Plan. We consulted people who use our services, staff and members of the public on services they use and their views on how we plan our services as a whole. This process took many months, and we did it in several stages. You can read a full report on our website.

Developing our vision, values, and strategic aims

Our vision and values were discussed with senior staff and 6 strategic aims were developed with staff, planning leads, planning groups and community partners.

Developing our 3-year plan

Our plan is divided into different areas of work, each led by a planning lead. Each planning lead was asked to work with partners and front-line staff to gather the views of people who use their services. They did this though surveys, focus groups, interviews and Question and Answer sessions. They also used consultation findings such as the Citizen's Panel and recommissioning information. **Over 3,000 people's views were included** and helped shape draft plans for each area.

Consulting on our draft ideas

Once we had our draft plan, we asked people if they thought it was an equitable and effective use of resources. We put a copy of it in every library and online, posted it on social media and sent a postcard to every household in Midlothian to let people know about it. Key stakeholders including neighbouring IJBs, NHS Directors, the Integration Joint Board, the public and third sector organisations all commented on it.

The Midlothian Learning Disability Planning Group was supported by 'Expert Panels' to draw together experts, including people with lived experience, to develop solutions in partnership for the areas of our Strategic Plan that affect people with a learning disability, their families, and carers.

We consulted with members of staff and third sector organisations using an 'integrated impact assessment'. This helped us avoid negative impacts on different groups of people including those with protected characteristics, and on human rights, sustainability, and the environment.

What we found out – people value services centred around the person.

There were a few common themes throughout the consultation including:

- **Flexible support**. People spoke of how services could be improved to offer more flexible and joined up support.
- **Feeling heard and valued.** People spoke of the need to feel safe, welcome, and heard. This included not having to repeat your story, and not feeling processed, judged, or rushed.
- **Supported Self-Management**. People told us we need to support the fabric that keeps them well through better information on what is available and being able to access services directly.

Integration Functions and Governance Decisions

Scheme of Integration

The Integration Scheme is the document which outlines the establishment, governance, scope, and operation of the Midlothian Integration Joint Board. Legislation requires the Health Board and the Council to jointly agree the scheme and then carry out a review within five years of Scottish Government approval. The Midlothian Integration Joint Board was established on 27 June 2015. A review of the Integration Scheme should have been completed in 2020 but was delayed until 2021 due to the challenges brought by the pandemic.

In light of the continuing pressures on health and care and the proposed establishment of a National Care Service, the review focused on agreeing a consistent approach to be taken in all four Lothian Integration Schemes and rather than a full review of delegated services. The proposed revised Scheme of Integration was approved by Midlothian Council and by NHS Lothian Board in June 2022 before submission to Scottish Government for consideration and final approval.

Strategic Commissioning Plan

Following a substantial programme of consultation and the updating of the Joint Needs Assessment, the Strategic Commissioning Plan for 2022-25 was developed and approved by the IJB.

Directions

A revised approach to managing progress was agreed on 17th June 2021 and a six-monthly review of progress was considered by the IJB on 9th December 2021. New Directions were included within the Action Plans supporting the new Strategy.

IJB Voting Members

Carolyn Hirst and Patricia Donald, both NHS Board members, were reappointed to the IJB

Key Decisions Taken by the Integration Joint Board in 2021/22

- **Finance**
  NHS Lothian Budget Offer 2021/22 Accepted 8th April 2021
  Audited Annual Accounts Approved 9th September 2021
  IJB Outline Budget 2022/23 Agreed 17th March 2022
- **Strategic Planning**
  Strategic Plan 2022-25 Approved in principle 17th March 2022
  Directions Performance Management Agreed 17th June 2021
  Directions Progress Report Noted 9th December 2021
- **Governance**
  Local Code of Corporate Governance Approved 8th April 2021
  Audit and Risk Annual Report 2020/21 Approved 26th August 2021
- **Performance**
  Amended Improvement Goals Approved 8th April 2021
  Performance Management Structure and Additional Resources Approved 26th August 2021

Improvement Goals and an Outcome-based Approach Progress noted 26th August 2021
Annual Performance Report Contents Approved 14th October 2021

- **General**
  Public Engagement Strategic Statement Approved in Principle 8th April 2021
  Equality Outcomes 2021-25 and Mainstreaming Report Approved 8th April 2021
  Draft IJB Complaints Handling Procedure Approved 8th April 2021
  Workforce Development Plan Approved for Implementation 17th June 2021

Copies of the relevant reports can be found in the committee reports on the Midlothian Integration Joint Board pages of the Midlothian Council website

COMMUNICATING CLEARLY

We are happy to translate on request and provide information and publications in other formats, including Braille, tape or large print.

如有需要我們樂意提供翻譯本，和其他版本的資訊與刊物，包括盲人點字、錄音帶或大字體。

Zapewnimy tłumaczenie na żądanie oraz dostarczymy informacje i publikacje w innych formatach, w tym Braillem, na kasecie magnetofonowej lub dużym drukiem.

ਅਸੀਂ ਮੰਗ ਕਰਨ ਤੇ ਖੁਸ਼ੀ ਨਾਲ ਅਨੁਵਾਦ ਅਤੇ ਜਾਣਕਾਰੀ ਤੇ ਹੋਰ ਰੂਪਾ ਵਿੱਚ ਪ੍ਰਕਾਸ਼ਨ ਪ੍ਰਦਾਨ ਕਰਾਂਗੇ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਬਰੇਲ, ਟੇਪ ਜਾਂ ਵੱਡੀ ਛਪਾਈ ਸ਼ਾਮਲ ਹਨ।

Körler icin kabartma yazilar, kaset ve büyük nüshalar da dahil olmak üzere, istenilen bilgileri saglamak ve tercüme etmekten memnuniyet duyariz.

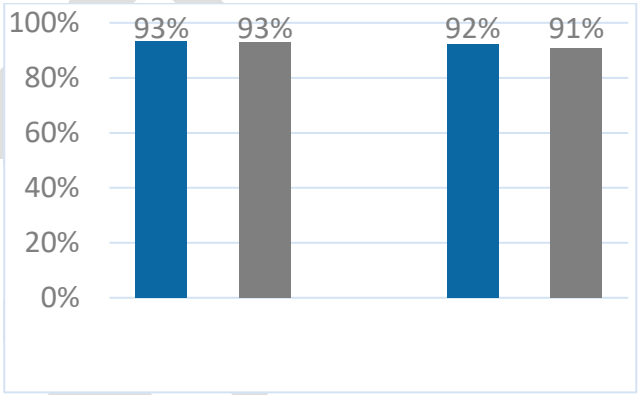
اگر آپ چاہیں تو ہم خوشی سے آپ کو ترجمہ فراہم کر سکتے ہیں اور معلومات اور دستاویزات دیگر شکلوں میں مثلاً بریل (نابینا افراد کے لیے اُبھرے ہوئے حروف کی لکھائی) میں، ٹیپ پر یا بڑے حروف کی لکھائی میں فراہم کر سکتے ہیں۔

Contact 0131 270 7500 or email: enquiries@midlothian.gov.uk

Data Appendix

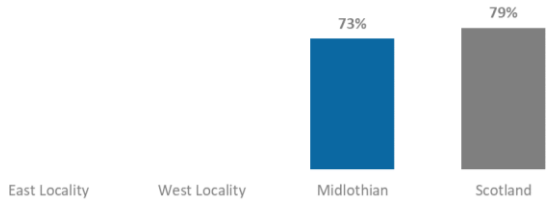
	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.	92%	

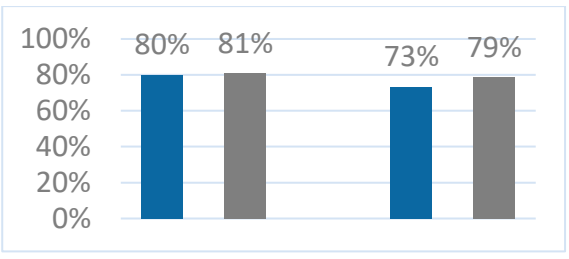
In 2021-22, Midlothian's performance was the **same** compared to 2020-2021.
Overall performance across Scotland got **worse** by 2 percentage points.
Midlothian's performance was **better** than across Scotland.
We are doing **well** in relation to national performance.



	National Indicator	Our result	Our Progress
2	Adults supported at home agreed that they are supported to live as independently as possible.	73%	

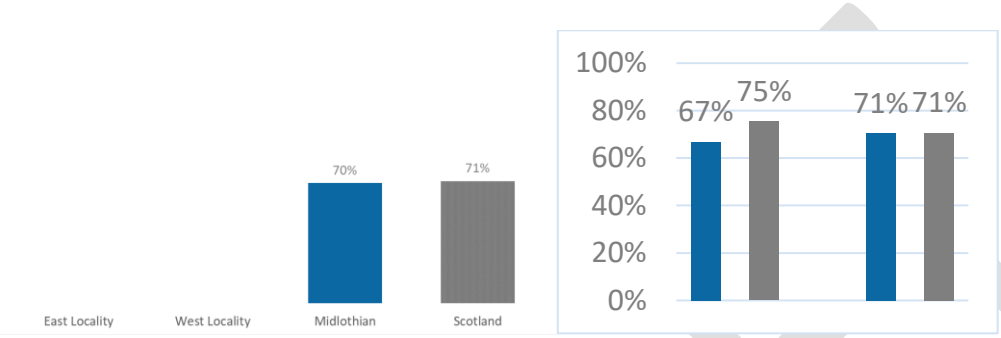
In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 7 percentage points.
Overall performance across Scotland got **worse** by 3 percentage points.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.





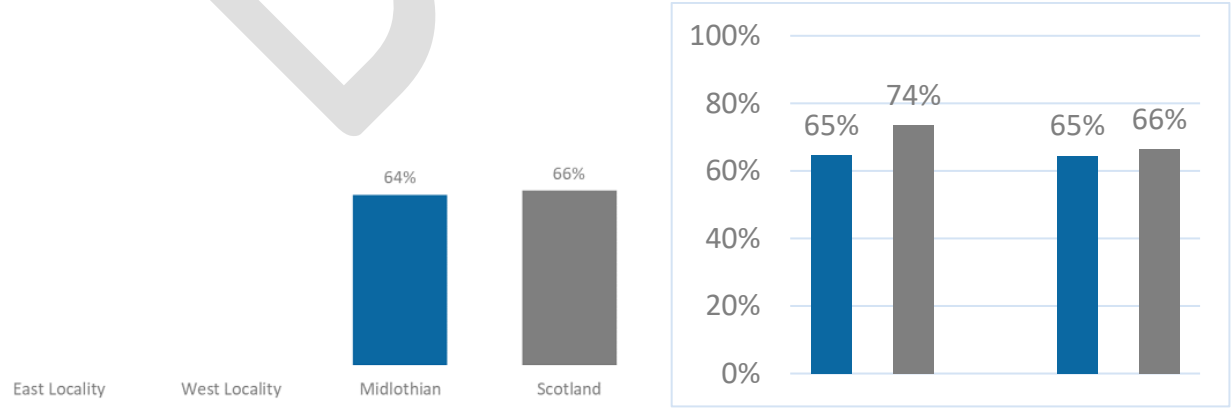
	National Indicator	Our result	Our Progress
3	Adults supported at home agreed they had a say in how their help, care or support was provided.	70%	

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 4 percentage points.
Overall performance across Scotland got **worse** by 4 percentage points.
Midlothian's performance was the **same** as across Scotland.
We are **doing well** in relation to national performance.



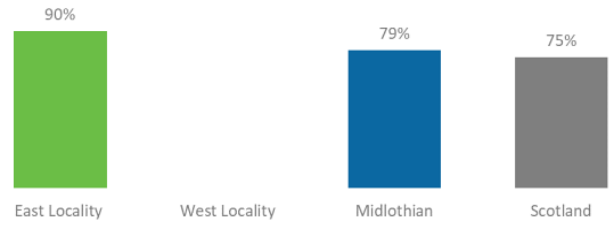
	National Indicator	Our result	Our Progress
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated.	64%	

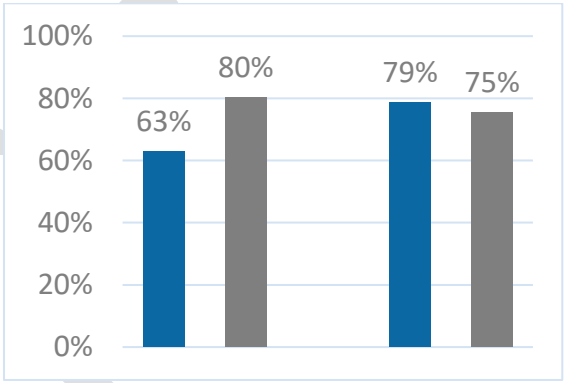
In 2021-22, Midlothian's performance stayed the **same** compared to 2020-2021
Overall performance across Scotland got **worse** by 8 percentage points.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.



	National Indicator	Our result	Our Progress
★★★★★ 5	Adults receiving care or support rated it as excellent or good.	79%	

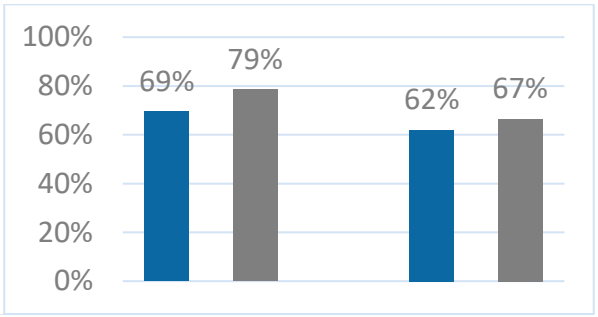
In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 16 percentage points.
Overall performance across Scotland got **worse** by 5 percentage points.
Midlothian's performance was **better** than across Scotland.
We are **doing well** in relation to national performance.





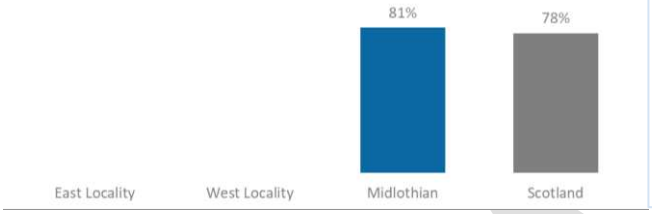
	National Indicator	Our result	Our Progress
6	Adults had a positive experience of the care provided by their GP practice.	62%	

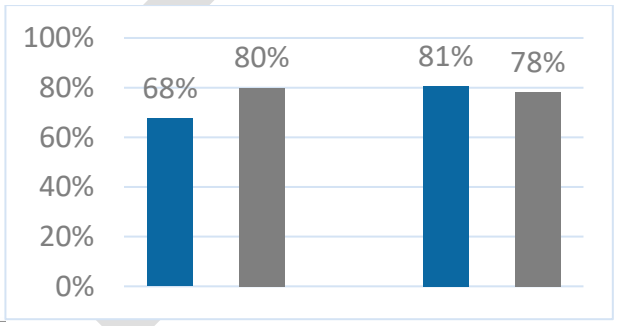
In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 7 percentage points.
Overall performance across Scotland got **worse** by 12 percentage points.
Midlothian's performance was **worse** than across Scotland.
There is **more work** to do in relation to national performance.



	National Indicator	Our result	Our Progress
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life.	81%	

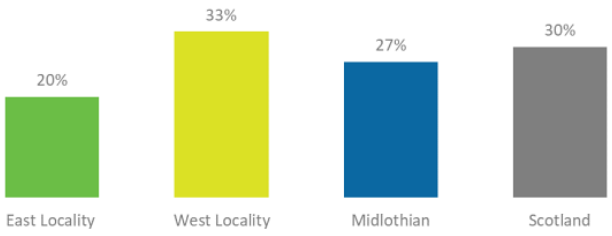
In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 13 percentage points.
Overall performance across Scotland got **worse** by 2 percentage points.
Midlothian's performance was **better** than across Scotland.
We are **doing well** in relation to national performance.

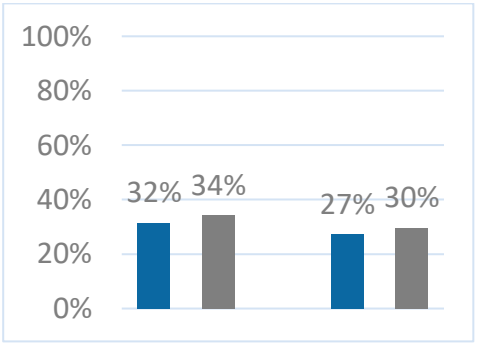




	National Indicator	Our result	Our Progress
8	Carers feel supported to continue in their caring role.	27%	

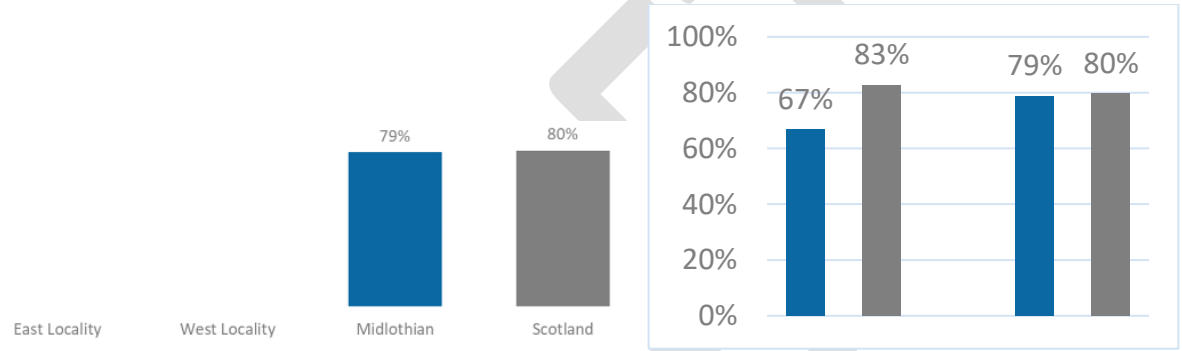
In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 5 percentage points.
Overall performance across Scotland got **worse** by 4 percentage points.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.





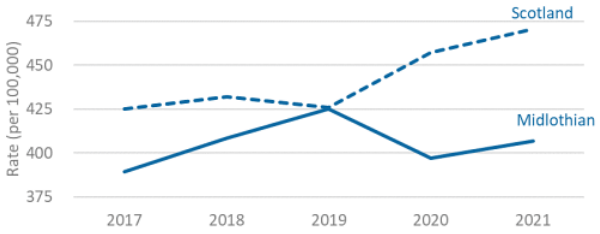
	National Indicator	Our result	Our Progress
9	Adults supported at home agreed they felt safe.	**79%**	

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 12 percentage points.
Overall performance across Scotland got **worse** by 3 percentage points.
Midlothian's performance was the **same** as across Scotland.
We are **doing well** in relation to national performance.



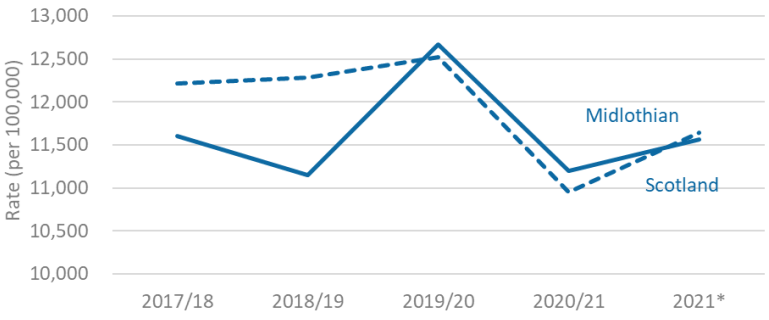
	National Indicator	Our result	Our Progress
11	Premature Mortality Rate (People under 75)	**407** per 100,000	

In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 3%.
Overall performance across Scotland got **worse** by 3%.
Midlothian's performance was **better** than across Scotland.
We have **more work** to do in relation to national performance.



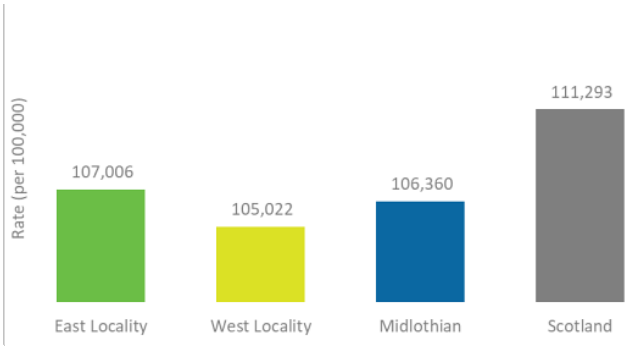
	National Indicator	Our result	Our Progress
12	Emergency Admission Rate	**11,568** per 100,000	

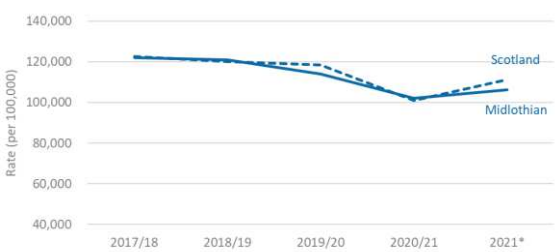
In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 3% i.e., the number of people who needed to be urgently admitted to hospital increased.
Overall performance across Scotland got **worse** by 6%.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.



	National Indicator	Our result	Our Progress
13	Emergency Bed Day Rate	**106,360** per 100,000	

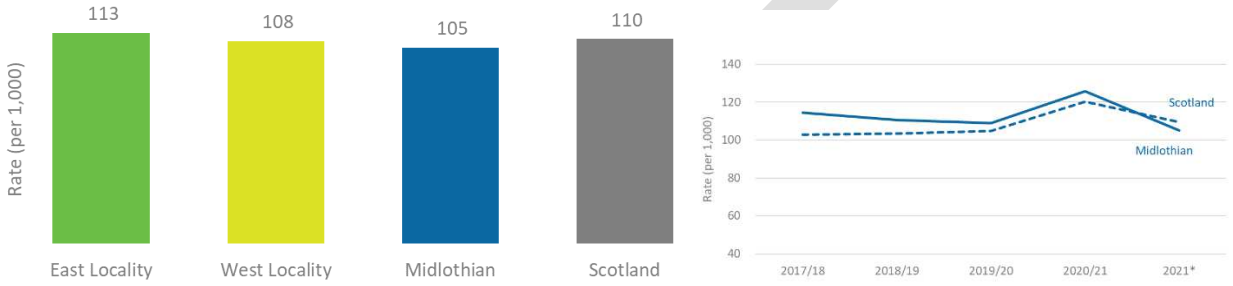
In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 4% i.e., people spent more days in hospital as part of an emergency admission.
Overall performance across Scotland got **worse** by 8%.
Midlothian's performance was **better** than across Scotland.
We have **more work** to do in relation to national performance.





	National Indicator	Our result	Our Progress
14	Readmission to hospital within 28 days.	**105** per 1,000	

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 17%.
Overall performance across Scotland got **better** by 8%.
Midlothian's performance was **better** than across Scotland.
We are **doing well** in relation to national performance.

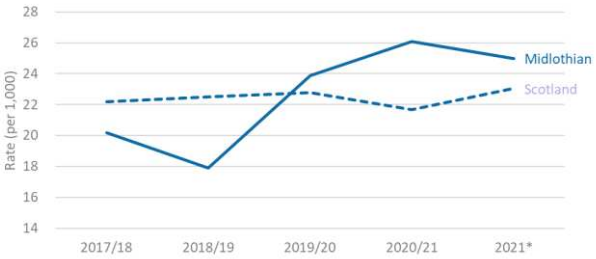


	National Indicator	Our result	Our Progress
15	Proportion of the last 6 months of life spent at home or a community setting.	**88%**	

In 2021-22, Midlothian's performance stayed the **same** compared to 2020-2021.
Overall performance across Scotland stayed the **same**.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.

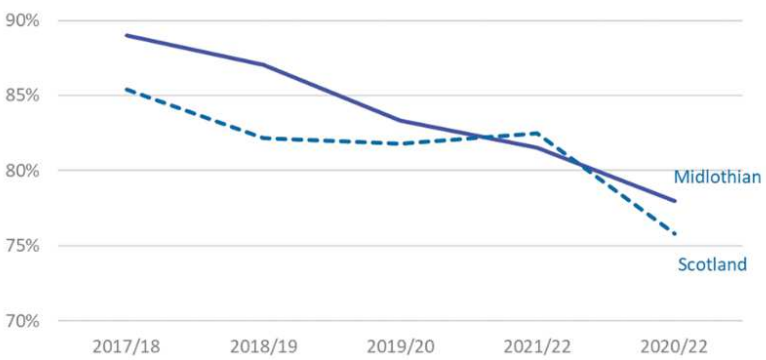
	National Indicator	Our result	Our Progress
16	Falls Rate (People over 65)	25%	

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 4%.
Overall performance across Scotland got **worse** by 5%.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.



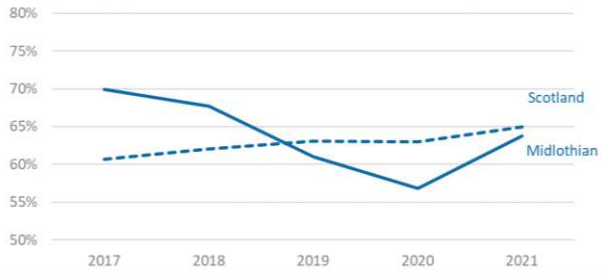
	National Indicator	Our result	Our Progress
17	Care services graded Good or better in Care Inspectorate Inspections.	78%	

In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 4 percentage points.
Overall performance across Scotland got **worse** by 6 percentage points.
Midlothian's performance was **better** than across Scotland.
We have **more work** to do alongside national performance.



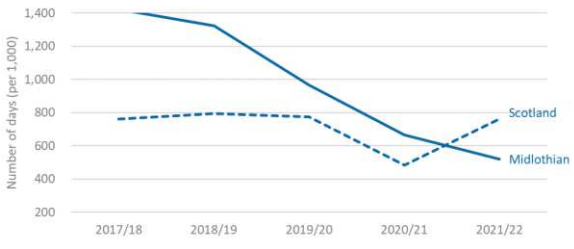
	National Indicator	Our result	Our Progress
18	Adults with intensive care needs are receiving care at home.	64%	

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 7 percentage points.
Overall performance across Scotland got **better** by 2 percentage points.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do to match national performance.



	National Indicator	Our result	Our Progress
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	520 per 1,000	

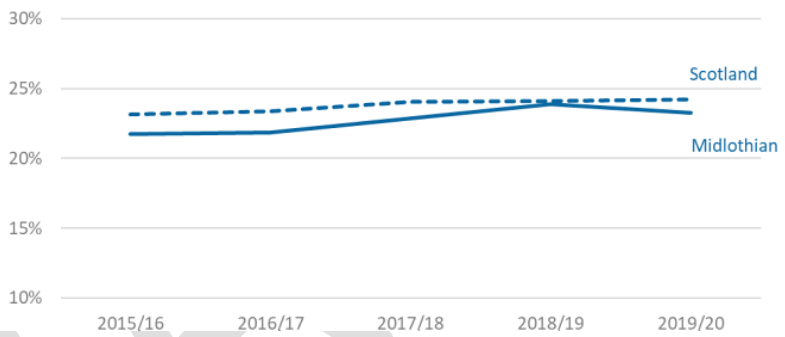
In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 22%.
Overall performance across Scotland got **worse** by 57%.
Midlothian's performance was **better** than across Scotland.
We are **doing well** in relation to national performance.



	National Indicator	Our result	Our Progress
£ 20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	23%	

This data is no longer collated and not current.

NHS Boards were not able to provide detailed cost information for 2020/21 due to changes in service delivery during the pandemic. As a result, PHS have not provided information for indicator 20 beyond 2019/20. PHS previously published information to calendar year 2020 using costs from 2019/20 as a proxy but, given the impact of the COVID-19 pandemic on activity and expenditure, PHS no longer consider this appropriate



Ministerial Steering Group Targets

Updated targets for 2021/22 were developed by the HSCP, agreed by the IJB and submitted to Scottish Government in April 2021. Our targets are measured against a baseline from 2017/18.

MEASURE	2017-18	2018-19	2019-20	2020-21	2021-22	STATUS
Reduce emergency admissions into hospital from Midlothian by 5% (all ages)	9,028	8,841	10,966	9,207	9,287*	Not achieved
Reduce number of unscheduled hospital bed days: acute specialties by 10% (all ages)	63,019	62,372	59,798	57,459	55,275*	Achieved
Decrease in the use of unscheduled geriatric long-stay beds (all ages)	12,734	13,551	12,806	12,802	14,367**	Not achieved
Decrease in the use of unscheduled mental health beds (all ages)	14,843	15,162	13,708	12,511	10,624	Achieved
Maintain Emergency Department Attendance at baseline level (all ages)	29,382	29,688	33,319	26,390	31,295	Not achieved
Maintain Delayed Discharge Occupied Bed Days below 40% of the 2017/18 activity	12,295	12,934	10,412	7,150	6,135	Not achieved
Reduce the percentage of time people spend in a large hospital in their last six months of life	8.7%	9.8%	9.1%	7.4%	7.9%	Achieved
Maintain the proportion of people over the age of 65 who are living in the community at 97% or higher	96.4%	96.5%	96.7%	97%	No data	Achieved

SOURCE: Public Health Scotland Integration Performance Indicators Sep 2022

Notes

*Where noted the calendar year 2021 is used as a proxy for 2021/22 due to the national data for 2020/21 being incomplete. We have done this following guidance from Public Health Scotland.

**Where noted the data is provisional.

Figures presented will not take into account the full impact of the precautionary measures that were in still place due to COVID-19 during early 2021.