Notice of meeting and agenda

Midlothian Integration Joint Board

Venue: **Conference Room, Melville Housing,**
The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ

Date: **Thursday, 16 March 2017**

Time: **14:00**

Eibhlin McHugh
Chief Officer

Contact:
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Further Information:

This is a meeting which is open to members of the public.

1 Welcome, Introductions and Apologies

2 Order of Business

Including notice of new business submitted as urgent for consideration at the end of the meeting

3 Declarations of Interest

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

4 Public Reports

4.1	Finance Paper (To Follow)	
4.2	2017-18 Delivery Plan for Health and Social Care	**3 - 58**
4.3	IJB Directions 2017-18	**59 - 132**
4.4	Measuring Performance under Integration - Agreeing the IJBs Performance Measurements	**133 - 144**
4.5	Chief Officer Report	**145 - 148**

5 Private Reports

No private business submitted for this meeting.

6 Date of Next Meeting

The next meetings of the Midlothian Integration Joint Board will be held on:

- 20 April 2017 at 2 pm - Midlothian Integration Joint Board
- 25 May 2017 at 2 pm – Development Workshop
- 15 June 2017 at 2 pm - Midlothian Integration Joint Board

Midlothian Integration Joint Board

Thursday 16th March 2017 at 2.00 pm

2017-18 Delivery Plan for Health and Social Care

Item number:	**4.2**

Executive summary

The report introduces and seeks approval for the attached 2017-18 Delivery Plan. This Plan is based upon the Strategic Plan 2016-19 providing an update on progress in 2016-17 and the key actions planned for 2017-18

Board members are asked to:

1. *Approve the Delivery Plan and the proposal to compile and circulate summary version.*

2. *Note the link to the accompanying report on the agenda relating to Directions for 2017-18*

Report

2017-18 Delivery Plan for Health and Social Care

1. Purpose

1.1 The report summarises the development of 2017-18 Delivery Plan. This Plan reports on the progress made in implementing the 2016-19 Strategic Plan and summarises the specific actions planned in 2017-18.

2. Recommendations

2.1 To approve the 2017-18 Delivery Plan

2.2 To agree to the preparation of a summary version.

3. Background and main report

3.1 **Development of Strategic Plan 2016-19**

3.1.1 Stakeholder Engagement: During 2014 an extensive programme of consultation and engagement was undertaken with the public; staff; the voluntary sector; and independent providers of health and social care. This programme sought to gather opinions about the quality and design of local services.

3.1.2 Assessment of Need: A Joint Strategic Needs Assessment was developed using a variety of expert opinion, routinely available data and comparison with other areas, to build up a picture of the health issues affecting the Midlothian population

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3.1.3 Strategic Planning Group: The regulations prescribe the need for the IJB to establish such a group with wide representation. The Midlothian group meets regularly and is chaired by Professor Alex McMahon Director of Strategic Planning in NHS Lothian.

3.1.4 Content of Plan: The Plan covers a wide range of issues and services and is inevitably quite lengthy. It was not possible to cover in depth the plans to develop or redesign these services but specific plans exist which can be accessed for more detailed information on issues such as services for older people or for unpaid carers.

3.1.5 Implementation: Finding ways of translating the Plan into tangible changes is crucial. The Midlothian IJB issues a set of Directions to NHS Lothian and Midlothian Council in March 2016. A progress report was considered by the Board at its October 2016 meeting. New Directions will be issued for 2017-18 and these are outlined in a separate report. Alongside this a senior level Transformation Board was established to oversee the wide range of service work being undertaken.

3.2 Development of a 2017-18 Delivery Plan (see Appendix1)

3.2.1 Purpose: The development of a 2017-18 Plan is intended to ensure that whilst the overall direction of the Strategic Plan is still appropriate, our redesign plans are being adjusted in light of new challenges and opportunities.

3.2.2 Layout: The Delivery Plan is written in such a way as to be stand alone; it does not require the reader to go back to the overarching Strategic Plan. A brief summary of levels of need and key policies is provided section by section. There is then a summary of the progress made in 2016-17 followed by a brief account of the main actions planned during this coming year.

3.2.3 Key Issues: The Plan covers a wide range of issues and all the planned actions are intended either to improve the quality of life of service users or make better use of limited resources. The issues of greatest priority are:

i. Increasing the capacity and managing the demands upon Primary Care
ii. Reducing the use of acute hospitals particularly in relation to delayed discharge and preventable admissions
iii. Improving mental health wellbeing given the high levels of prescribed medication and the links to offending and substance misuse
iv. Reducing the cost of Learning Disability services
v. Strengthening the multi-agency approach to Health Inequalities

4 Policy Implications

4.1 The Public Bodies (Joint Working) Act requires the IJB to prepare a Strategic Plan laying out how it plans to deliver the key health and care outcomes for the Midlothian population.

5 Equalities Implications

5.1 One of the key sections and main objectives of the Plan is to address, more effectively, the Health Inequalities experienced by people in Midlothian. A rapid impact assessment will be undertaken in March to consider how best to ensure the implementation of the Plan in a way which ensures there are no unintended adverse implications for equality groups

6 Resource Implications

6.1 The delivery of the Strategic Plan is not dependent on new resources but rather a redistribution of the total resources available to the partnership-approximately £111m per annum. However it must be acknowledged that shifting resources from hospital and care home provision to community based services and placing more emphasis on prevention will be even more challenging in light of the financial constraints facing health and social work. Nevertheless the IJB has been given the responsibility of bringing about a transformation of services to ensure that in the longer term the needs of the growing and ageing population can be met.

7 Risks

7.1 There is a risk that, as a result of the financial pressures facing both NHS Lothian and Midlothian Council, the capacity to support preventative services will be jeopardised. Similarly the continuing pressures on the Acute Hospital services will make it very challenging to shift resources from there to strengthen community based services.

8 Involving People

8.1 The development of this Plan has taken account of feedback from the public through such forums as the Hot Topics Group and from the Strategic Planning Group and Joint Planning Groups involving users, carers and the voluntary sector.

9 Background Papers

Appendix 1 2017-18 Delivery Plan

AUTHOR'S NAME	Tom Welsh
DESIGNATION	Integration Manager
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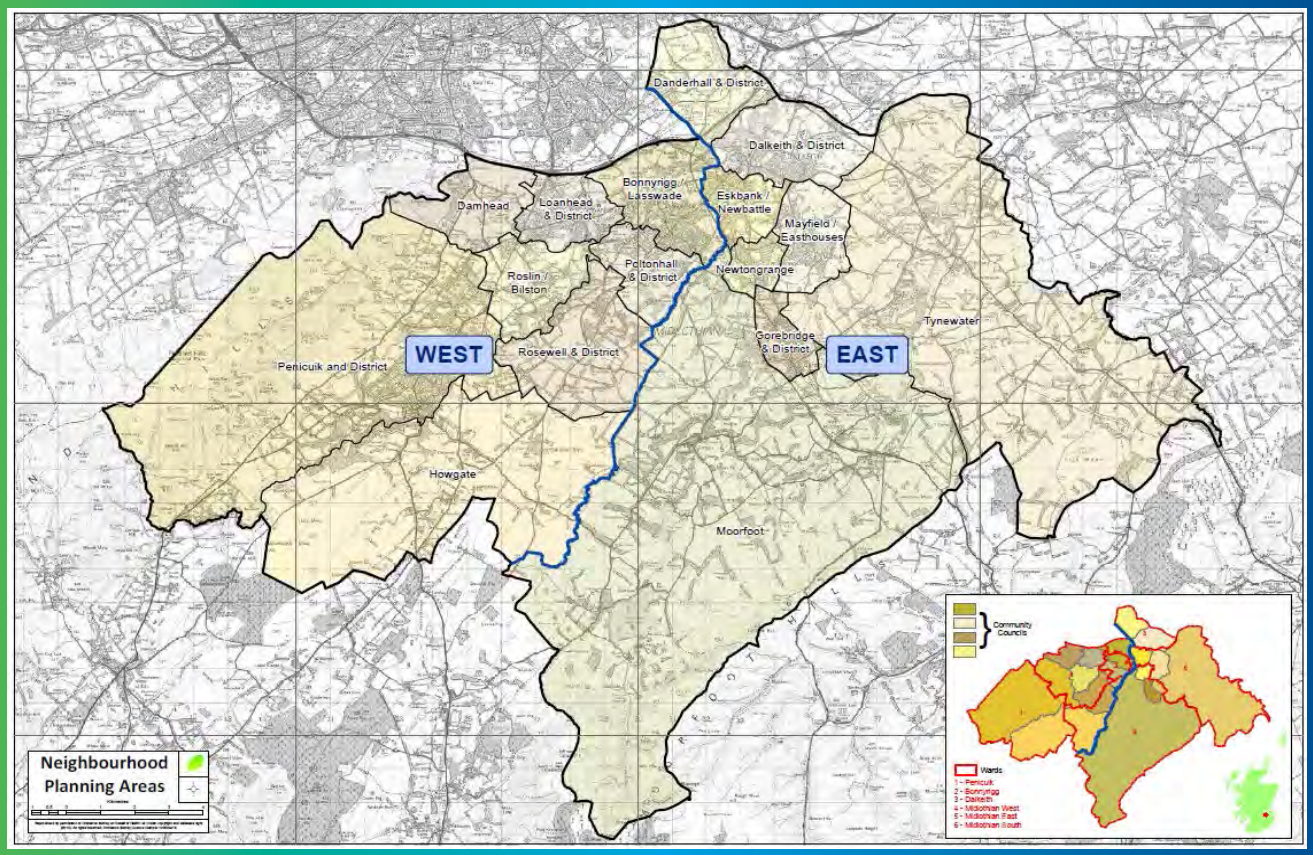
DATE	3/3/2017

Midlothian

NHS Lothian

Midlothian's Health and Social Care **Delivery Plan** 2017-18



Content

Improving Health and Wellbeing

A New Approach to Health and Social Care Delivery

Due to new legislation in 2014, a new Health and Social Care Partnership, the Midlothian Integration Joint Board (IJB), is now responsible for planning the delivery of health and care services in Midlothian.

In March 2016, the IJB published its three-year Strategic Plan.

The Plan recognised the need for detailed work to develop more clear actions to improve health and care services.

This **2017-18 Delivery Plan** sets out how the Partnership will provide services during this period. It takes into account progress made during 2016-17 and seeks to address challenges that emerged during the past year.

Understanding People's Needs in Midlothian

As a result of a major house-building programme and people living longer, the population is likely to rise from 86,670 to approximately 92,800 in 2020, continuing to grow up to 2024 to a predicted level of 101,000. Faced with this growth in population, we must continually review what this means for delivering health and care services.

We based the 2016-19 Strategic Plan on an in-depth Joint Needs Assessment (insert hyperlink). It also incorporated our understanding of the views and concerns of the public.

An ongoing conversation with service users takes place through forums such as the Hot Topics and Older People's meetings.

This plan, developed by Midlothian Strategic Planning Group, continues to include User and Carer representation. We will continue to develop, shape and oversee its delivery.

More detailed actions and investments are contained in plans compiled by local Joint Planning Groups. These consider the needs of particular user groups such as the Older People's Planning Group.

For more information, contact Tom Welsh, Integration Manager:
0131 271 3671 tom.welsh@midlothian.gov.uk

Content of the Plan

The IJB is responsible for the full range of community health and care services for adults, including some acute hospital-based services.

Midlothian Council elected to include services for offenders in the scope of the Integration Joint Board (IJB). This helps address the health and care needs that are often the root causes of offending behaviour. Developing ways of reducing offending remains the remit of the new **Community Justice and Safety Partnership.**

While it is vitally important that we develop strong links between adult and children's services, strategic planning for children's services remains the responsibility of **Getting it Right for Every Midlothian Child** group **(GIRFEMC)**.

The new IJB is not responsible for overseeing arrangements that protect people at risk of harm. This remains the responsibility of the **East and Midlothian Public Protection Committee (EMPPC)**. However, the services commissioned by the IJB have a crucial role in safeguarding people from harm and taking decisive steps to ensure we support and protect anyone considered at risk of harm.

This one-year plan summarises the key steps planned in our main service areas and describes the continuation of work with all partners and local communities to transform health and care services.

Although the very significant reductions in public spending make service redesign essential, we genuinely believe there are many changes we can make for the better, despite these financial pressures.

How the Plan is Making Differences

By redesigning our services, we are better placed to deliver the key national outcomes. These include:

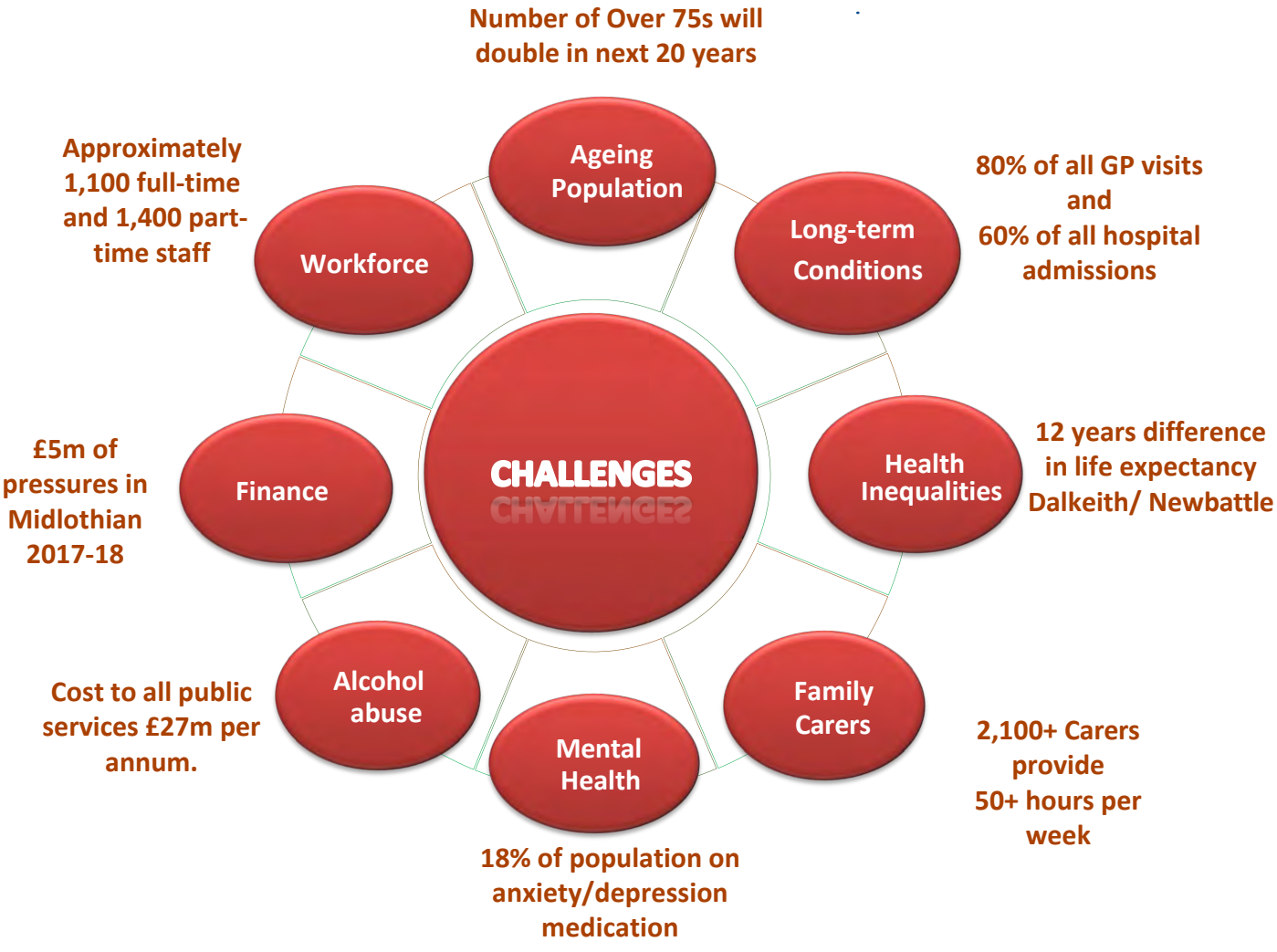
- people are being supported to remain at home for longer issues
- people are only going to hospital when necessary
- there is a real reduction in health inequalities.

The Partnership will publish an annual performance report on the impact that health and social care integration is having on the health and wellbeing of the Midlothian population.

The report will inform people on how the Partnership is using its resources and how it responds to the needs of localities within Midlothian.

Main Challenges

- More people who are frail or have dementia live for longer at home
- People are living longer with multiple long-term conditions
- Little progress is being made in reducing health inequalities
- All our services are under pressure



Our Vision

The creation of a new Health and Care Partnership provides an opportunity to make significant change in how we deliver health and care services.

'People in Midlothian will lead longer and healthier lives by getting the right advice, care, and support, in the right place, at the right time.'

We aim to achieve this ambitious vision by changing the emphasis of services, placing more importance and a greater proportion of our resources on the approaches described on the right hand side.

'We are fully committed to the principles of reducing inequalities, promoting opportunities and eliminating discrimination in line with the Equality Act and Human Rights legislation.'

Shifting Focus

Failure demand i.e. not getting it right	Prevention – Good physical and mental health:
Treatment and support	Recovery and reablement
Professional care	Self management and peer support
Reactive	Anticipatory care and planning for emergencies
Hospitals & care homes	Community based services e.g. Hospital at Home
Working in silos	Team working at local level
Opportunity costs	Improving quality and access
Health & care focus	Community planning i.e. *housing, income, transport*

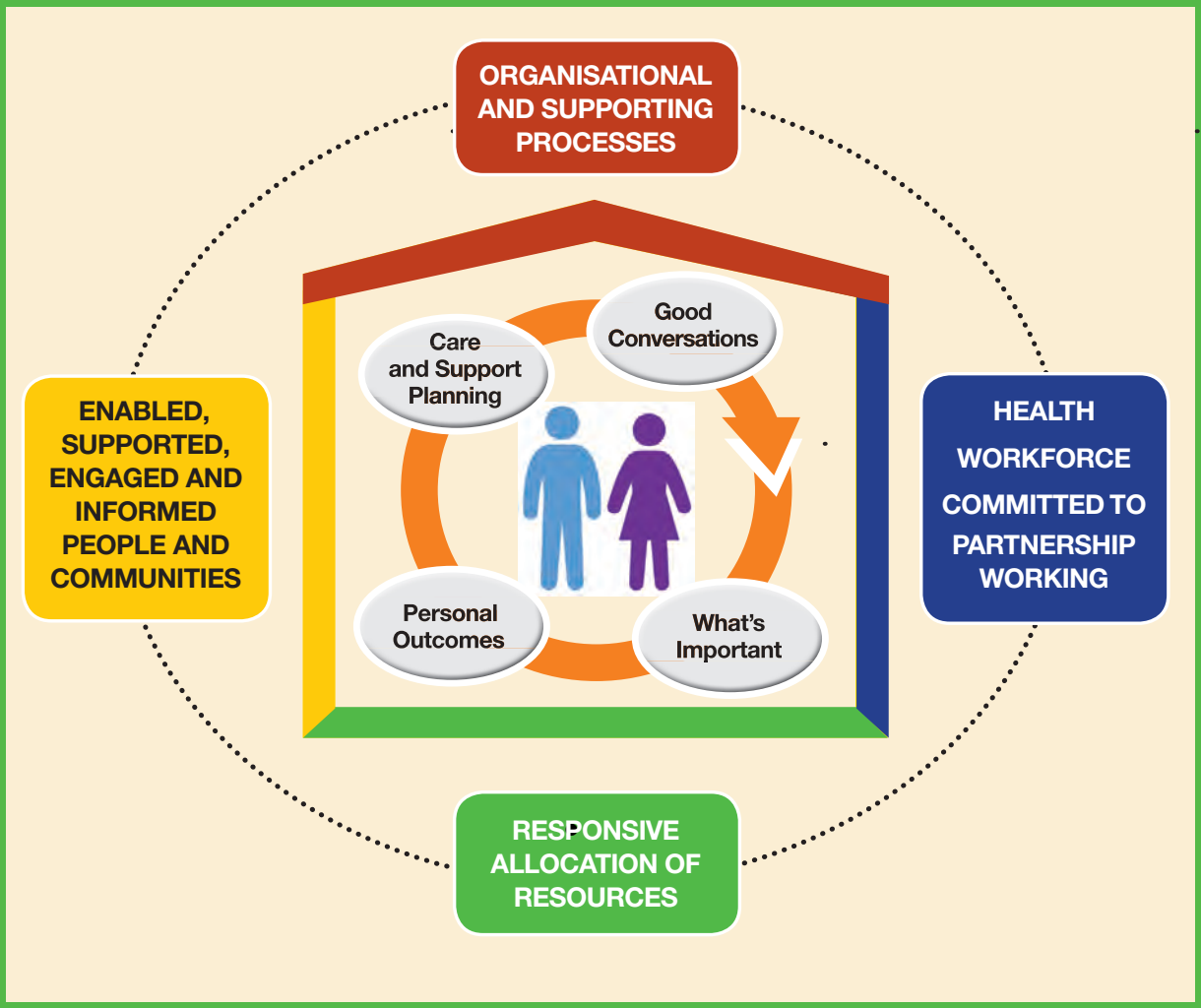
The Whole Person

We need to think differently about health:

- Focusing on the whole person not only the disease

- Recognising the importance of physical, mental and social wellbeing
- Recognising the role which families, carers and communities have in helping people to stay well

House of Care



The model we are adopting for delivering person-centred, integrated care is called the House of Care. This is about creating space for people to have 'a good conversation' on what is important to them and helping people recover or live well with their health conditions.

The Importance of Partnership Working

Organisational changes in the establishment of Health and Social Care Partnerships are important and already paying dividends.

We will only achieve major change in the health and wellbeing of the population through strong partnerships with other agencies and natural communities.

Staying healthy needs support and advice on issues such as exercise, smoking, alcohol consumption and managing stress.

A growing concern is the increase in obesity. This now accounts for **80% of people who develop 'type 2' diabetes** and with it, the long-term risk of a range of health problems.

To help combat this, we will work with networks such as the "Food Alliance" and the "Physical Activity and Health Alliance"; Council Services such as Leisure and Recreation; and the Voluntary Sector generally.

Avoiding accidents or illnesses also requires strong partnership working. For example, the Fire Service helps reduce the likelihood of fire and other accidents such as falls in the home.

Pharmacists are an invaluable source of advice in managing illness, help with giving up smoking and immunisation against flu.

Social isolation closely links to physical and mental health problems. Creating opportunities through activities, groups and befriending are important. Social inclusion also depends upon having a decent income, having a job or being a volunteer, and being able to get about -transport can be a real barrier.

Staying warm is vital for older people. There is strong evidence that living in fuel poverty exacerbates health risks and that addressing fuel poverty can reduce winter deaths; injury and falls; improve mental health; and reduce respiratory illness and circulatory disease.

We need to increase awareness and develop stronger working relations with Changeworks and other third sector partners.

A third of people (31%) in Midlothian live in fuel poverty.

Key Approaches

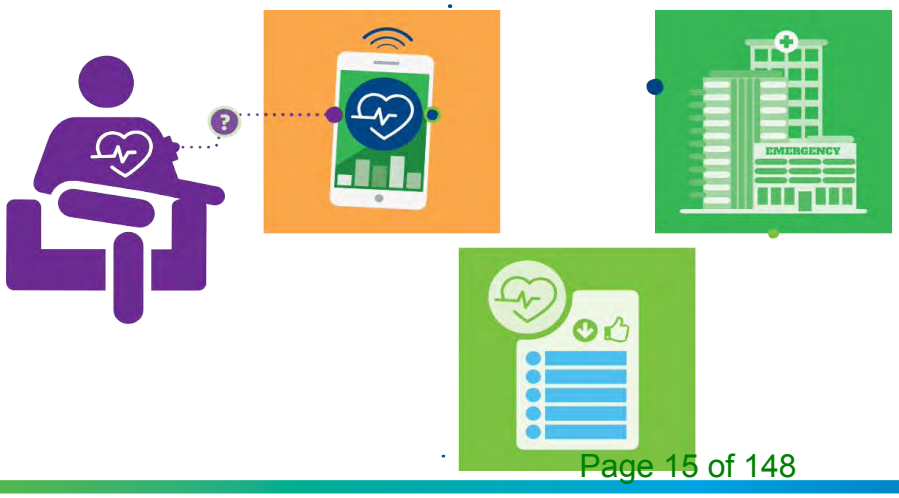
Recovery

In recent years, our ambitions for recovery increased greatly. This is now the main goal in working with people who experience mental ill-health difficulties or the consequences of substance misuse.

Recovery involves helping people to regain a normal life by making it easier to gain employment, get about, have an adequate income, maintain social contacts ad coping with the challenges they face.

Technology

As in all lifestyles, we will support the transformation of our health and care services by making effective use of technology in work and with service users. New technology is likely to have a particular role in enabling people to manage their own health conditions better.



Information

There are a number of well laid out and comprehensive websites and directories available in Midlothian. However, users, carers, and even our staff, do not always know where to look or how to find information when faced with a change in life circumstances.

We must continue to invest in communication to ensure people are getting the right information and advice that enables them to look after their own health and well-being as far as possible.

Planning Ahead

Many people develop and live with long-term conditions such as cancer, heart disease or dementia.

We must find better ways of supporting them, their families and their carers by providing clear and concise information and developing individual anticipatory care plans (ACPs) - planning for the future to help people manage as their condition changes.

Unpaid carers are telling us that they could manage crises more effectively if there was a methodical and widespread approach to planning for emergencies - particularly when the carer is suddenly unable to provide support.

We will promote the benefits of having a Power of Attorney to ensure that families have the legal power to act on behalf of their relatives when they are not capable of making their own decisions - for instance as a result of dementia.

Key Approaches

Self- Management and Peer Support

Supporting people to manage their own health conditions reduces the demands on health services and social care, whilst giving them greater confidence and a sense of control. We will only strengthen self-management if we invest in providing support and education.

Within social care, the implementation of Self-Directed Support is enabling people to be more in control of their own care arrangements and to develop more creative ways of receiving support. This is a significant change and we are still learning lessons on providing services that are equity and sustainability.

Peer support is highly valued by people who are unpaid carers or who are coping with a particular health condition(s) such as mental health, physical disability or long-term illness. Powerful local examples of groups supporting one another include the Recovery Café for recovering drug users in Dalkeith.

Public Protection

Helping people live independently at home for longer involves making sure that they are also safe from abuse. The East Lothian and Midlothian Public Protection Office involves health, social care and police staff working together to support and protect adults and children who may be at risk of harm - be it physical, sexual, psychological and financial abuse. This approach also strengthens our capacity to respond to the impact of traumatic events on the lives of many victims of abuse.

For more information on Public Protection, visit

http://emppc.org.uk/home/

Violence against women

An issue that needs more attention is Domestic Abuse. Domestic abuse is not confined to gender-based violence but includes so called 'honour' based violence, female genital mutilation and forced marriage. Nor is domestic abuse confined to one gender or ethnic group. The statistics are shocking: for example 1 in 3 women will experience gender-based violence in their lifetime.

Midlothian has a particularly bad record - the sixth highest rate in Scotland during 2015-16. Our services are becoming more aware and alert to the impact of previous trauma in people's lives such as childhood sexual abuse. This issue comes up frequently with the new Wellbeing Practitioners based in eight of our Health Centres.

Giving people time to share their real concerns through good conversations is often the first step in tackling the issue. We must increase awareness and understanding of domestic abuse in all its forms amongst all staff including district nurses, care staff and GPs.

Prevention

The increasing numbers of people with Type 2 Diabetes requiring hospital admission; the number of older people admitted to hospital following a fall; and the high cost to all public services (approx £27m per year in Midlothian) of alcohol misuse are examples of the scope to reduce demands on the health service by focusing more on prevention.

And of course avoiding ill health where possible is good for people as well!

National Guidance

In relation to health and social care, community based care, anticipatory care and prevention are highlighted as the approaches required to ensure our services are sustainable.

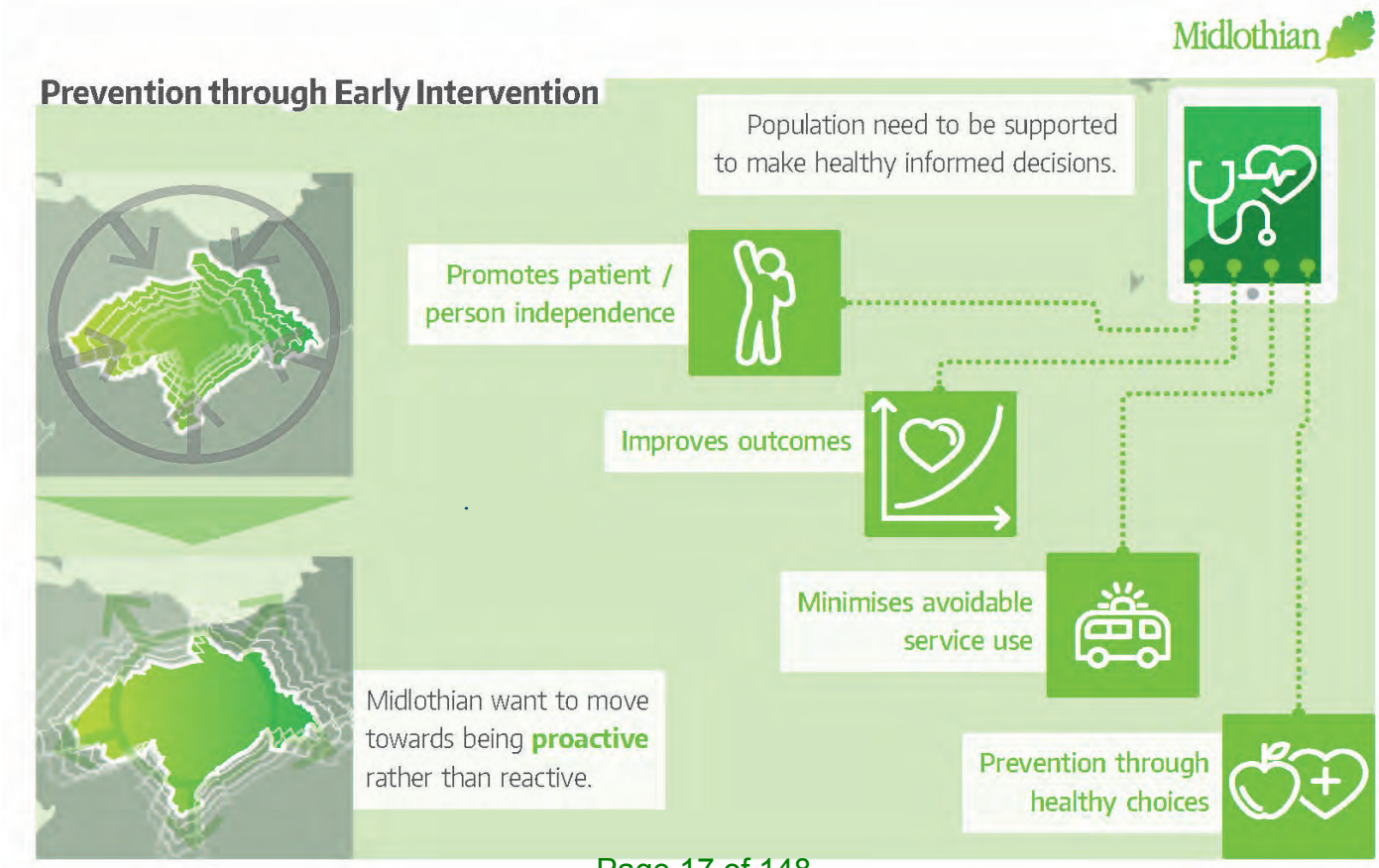
The Commission on the Future of Public Services (C Christie 2011) highlighted the importance of:

"prioritising expenditure on public services that prevent negative outcomes from arising".

New Service Challenges

There is a wide spread acknowledgement that prevention makes more sense than dealing with the problem after it occurs.

Nevertheless the financial pressures on public bodies are such that continuing to fund preventative approaches becomes more challenging.



Prevention

Progress in 2016

- We must acknowledge the work of Midlothian Leisure Services in supporting people with mental health, obesity or long-term health conditions. Alongside this, the Ageing Well programme, which harnesses local volunteers, enables many older people to stay active whether through walking, football, yoga or dance - and this programme is now available in care homes and sheltered housing complexes.
- Low income is a key factor in people's ability to stay well, whether having a warm home, eating well or being able to get out. As well as the more general support and advice available, there were three specific areas where we sought to increase people's income: working with people with mental health needs; supporting people with cancer; and providing income advice to unpaid carers.
- Through local Health Centres and national campaigns, we continue to promote preventative measures such as flu vaccination and encouraging take up of the bowel-screening programme.
- Work is underway by the Midlothian Food and Health Alliance to promote a more comprehensive approach to healthy eating including the Toot for Fruit Service; continuation of food banks; local growing projects; and the small grants programme in Mayfield, Gorebridge and Woodburn.

Key Actions for 2017-18

- Continue to develop our application of new technology to enable us to know that people are in need of support – whether in a crisis through telecare or through early detection of their health beginning to deteriorate.
- Build upon the work of the local Leisure Service to help implement a physical activity strategy to help improve people's health, reduce weight and take up new interests.
- Develop a stronger approach to creating employment opportunities, working with the council employability service, pursuing funding through the Big Lottery to address disability issues and making better links with specialist services such as for people with cancer or people who are deaf.

Working with Communities

In the implementation of the legislation and guidance on Integration, we are placing a great deal of emphasis on recognising the key part played by natural communities.

The Community Planning Partnership is developing strong links with local communities through neighbourhood planning groups.

In Health and Social Care, we are actively participating in the development of local services in the areas of deprivation - parts of Woodburn, Mayfield and Gorebridge.

This work focuses on addressing inequalities in line with the Community Planning Partnership's key objective during the period 2016-19.
We believe we are making good progress in public engagement generally, with regular topic based meetings on health and social care issues through the Hot Topics Forum. Alongside this, we continue to work closely with "communities of interest" such as family carers, older people and people with physical disabilities.

We now need to develop stronger links at a local level between staff working in local communities - GPs, District Nurses, Home Carers and staff in voluntary organisations.

New Guidance

Part 2 of The Community Empowerment Act 2015 came into force in December 2016.

This requires Community Planning Partnerships to involve community bodies at all stages of community planning and to produce "locality plans" for areas experiencing particular disadvantage.

Key Actions for 2017-18

1. Our next step is to pilot work in one locality that strengthens our support services to housebound people. The national Collaborative Leadership Programme and NHS Education Scotland support this initiative.

2. Continue to improve our understanding of need and use of resources, area by area, such as the numbers of older people admitted to hospital on an emergency basis. This will help us design services that are more responsive to local needs.

Health Inequalities

The term 'health inequalities' describes the poorer health experienced by some of our population in comparison with their neighbours.

Those who experience social disadvantage because of:

low income,
gender,
ethnic origin,
age or disability

are likely to have poorer physical and mental health than the rest of the population.

By far the most common reason for people to experience health inequalities is low income and the poorest in society die earlier with higher rates of disease.

Inequalities are often associated with geographical areas of high need -particularly parts of Dalkeith / Woodburn, Gorebridge and Mayfield / Easthouses. For example, a man living in Dalkeith is likely to **live 9 years less** than a man living in Newbattle and Dalhousie.

National Guidance

Scottish Government reinforced its commitment to addressing inequalities through Fairer Scotland Action Plan 2016 with a strong emphasis on addressing poverty.

What we really want to do is change deep-seated, multigenerational, deprivation, poverty and inequalities.

New Service Challenges

Through the national refreshing of the Scottish Index of Relative Deprivation it has emerged that:

one area of Loanhead now falls within the lowest **20%** of deprivation

We will consider how to channel our resources in response to this new challenge.

Health Inequalities

Progress in 2016

- The Community Planning Board developed a set of indicators that tell us whether we are making progress in reducing health inequalities.
- Resources secured to enable the continuation of the Community Health Inequalities Team working with people who are vulnerable such as unpaid carers and people who are homeless.
- A new mental health service – the Mental Wellbeing Access Point - established in Penicuik and Midlothian Community Hospital to enable people to obtain quick advice about appropriate sources of support.
- The Community Justice Authority introduced an advice and wellbeing service for people arrested or subject to a tagging order.
- The Spring support service for women offenders strengthened.
- The Wellbeing Service in place in two health centres, extended to a further six health centres. This service targets people with long-term health conditions and common health and social difficulties.
- MYPAS (Midlothian Young People's Advice Service) now provides a specific service in Dalkeith for LGBT Young People.
- A sexual health drop-in service, run by school nurses and MYPAS, established in Newbattle Community Centre.
- A new service for older people in Woodburn established – The Grassy Riggs - helping reduce isolation.
- Through the Coalfield Trust, a number of small locally managed programmes implemented in Woodburn.
- An additional recovery cafe for people with substance misuse problems established in Mayfield.
- An NHS funded community development worker helped support the establishment of the Mayfield In It Together initiative designed to improve the local quality of life, with town centre plans their top priority.

Key Actions for 2017-18

Much of the work started in 2016 needs continued support to ensure it is well organised and in a strong sustainable position:

- We will work with the Royal Infirmary to develop a stronger pathway to local services and support for young adults attending the hospital.
- We will develop ways of supporting people with disabilities or unpaid carers to gain or sustain their employment, working with the Council Employability Service and other specialist agencies.
- NHS Lothian and Midlothian Council will work together to provide a range of Food Programmes.
- We will strengthen the priority given by all staff to addressing poverty including closer working with specialist income maximisation services.
- Weight Management Programmes to be introduced to help address and prevent obesity and type 2 diabetes.
- We will work with specialist acute hospital staff to develop more locally based, preventative-focused services in the field of diabetes.
- We will work with Council Leisure Services to finalise and implement a local physical activity strategy.

Cancer

In the region of 2,140 people in Midlothian have had cancer.

This figure is predicted to rise due to the increased occurrence, as people get older.

People are increasingly surviving for longer following treatment for cancer with 50% of us now surviving cancer for 10 or more years.

National Guidance

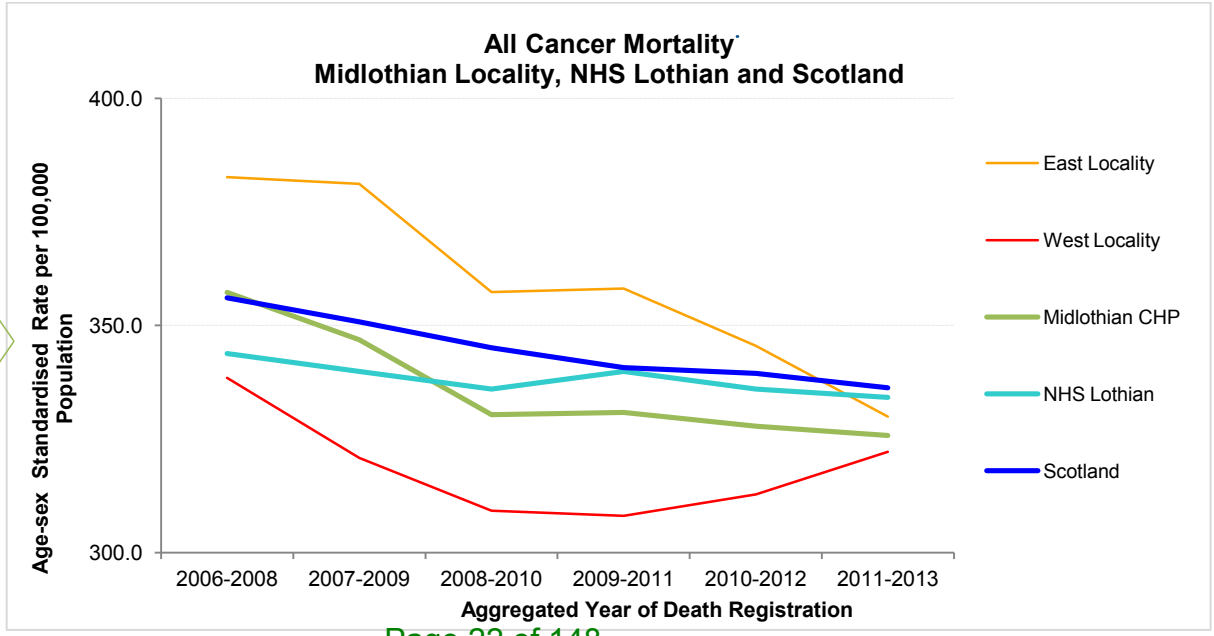
A new national Cancer Strategy Beating Cancer: **Ambition and Action** launched in March 2016. This comes with investment to tackle cancer by improving prevention, detection, diagnosis, treatment and after care for those affected.

In December 2016, the Health and Care Delivery Plan 2017-18 for IJBS included the expectation that the provision of palliative care at home will double by 2020 (see Palliative Care Section).

New Service Challenges

The national funding for the local Transforming Care after Treatment (TCAT) programme Funding ends in November 2017.

Death rates from cancer are falling



Cancer

Progress in 2016

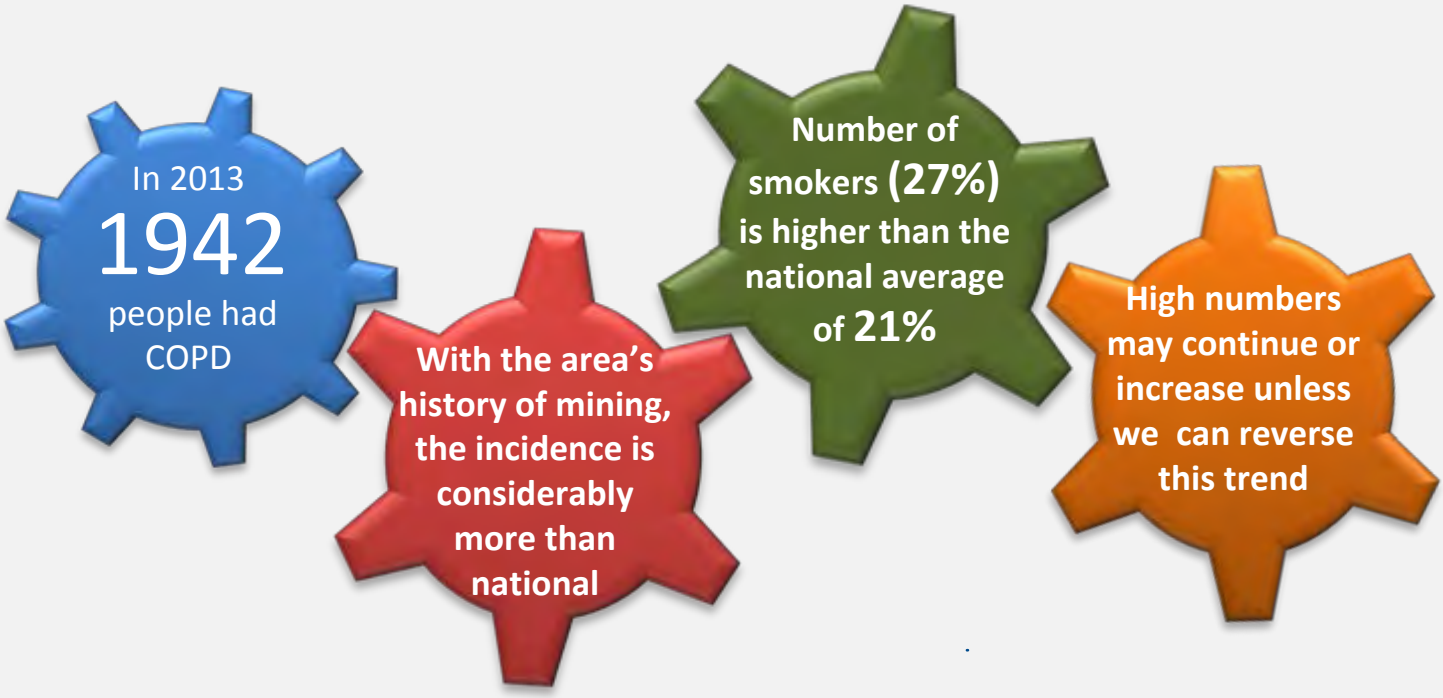
- We established the local TCAT project (Transforming Care After Treatment) to test a new and transformative approach to service delivery based on holistic needs assessment. The service is based in Lasswade Library and the community hospital where two Macmillan Rooms are established.
- Specialist services include Occupational Therapy, access to the specialist employment service based within the NHS Lothian's Work Support Services. Closer working relationships have been developed with VOCAL and the community health inequalities teams. Five members of the Council Leisure Service have undertaken specialist training in safe exercise for people with cancer.
- The specialist Macmillan Welfare benefits service generated an additional £400k (annualised £1.6m) income for people with cancer in quarter one of 2016-17. An evaluation of such services by Scottish Collaboration for Public Health Research and Policy concluded, "Few medical interventions can claim to have such a lasting and measurable impact on the lives of people."
- The local GP Cluster was successful in its application to use the Macmillan Quality Toolkit to improve quality of care for cancer patients.

Key Actions for 2017-18

- The Project Officer will promote the uptake of the TCAT project by holding regular sessions in the Western General Hospital. The implementation of the Quality Toolkit in Primary Care should also help raise the profile.
- We will pursue the introduction of a voluntary Complementary Therapy Service in response to the feedback from service users on pain management.
- We will consider plans to maintain a service to people with/treated for cancer beyond the life of TCAT as part of the broader approach to Health and Wellbeing work.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is a long-term lung disease that causes cough and breathlessness.



The rates of hospital admissions due to COPD related illness is also higher than national rates.

Progress in 2016

- The Pulmonary Rehabilitation (PR) Programme, a Lothian-wide physiotherapy led service continues to provide an exercise-based programme to people in Midlothian.
- Midlothian Active Choices (MAC) continues to promote and develop integrated pathways with NHS partners including Healthy Living Groups and the Wellbeing Team.

Key Actions for 2017-18

- Continue to explore how best to use technology to assist people in managing their own conditions.
- New post established in the MERRIT (Rapid Response and Hospital at Home Team) to work with people with advanced COPD and support them to remain at home rather than be admitted to hospital.

Neurological Conditions

Having a neurological condition is the most likely reason for experiencing complex and physical disability for people less than 65 years.

One in **97** people are affected by epilepsy

One person in every 500 has Parkinson's - estimate of 170 in Midlothian

Around **20** people living locally have Huntington's disease, an inherited condition that causes brain damage

The prevalence of Multiple Sclerosis is high whilst the number of those with Parkinson's Disease is increasing with an ageing population.

National Guidance

The Neurological Care Improvement Plan 2014-17 to improve care and outcomes for people with a neurological condition, describes this as:

'The missing millions experiencing disadvantages of complex disability at a young age with fragmented and inconsistent service provision across the public sector as a whole and within health and social care systems'

Progress in 2016

Specific developments in Midlothian intended to improve the lives of people with neurological conditions include:

- The Midlothian Community Physical Rehab Team (MCPRT) continues to provide long- term rehabilitation.
- The Scottish Huntington's Association provides specialist advice and support to those with Huntington's disease.
- A support and advice group for people with Multiple Sclerosis meets monthly supported by a Council Occupational Therapist.

New Service Challenges

The Joint Planning group for Physical Disability is the local planning forum that addresses issues arising from having a disability. There is a gap in addressing specific issues arising from having a neurological condition. We are now considering which of these issues could be addressed locally rather than on a Lothian wide basis.

Key Actions for 2017-18

- Strengthen local links with NHS Lothian forums addressing specific neurological conditions.
- The Physical Disability Planning Group to consider what role it can play in planning more effective services for people with neurological conditions.

Heart Disease

An estimated **7.8%** of men and **4.7%** of women are living with coronary heart disease (Scottish Health Survey 2014). The mortality rates for cardiovascular disease show a downward trend across Midlothian since 2006 for people less than 75 years similar to the national trend.

New Service Challenges

The increase in obesity brings an increased risk of heart disease; within the Lothians an estimated **27% of the adult population are obese** (2011). Those with heart disease may also be at risk of diabetes.

National Guidance

The Scottish Government and National Advisory Committee Heart Disease published a Heart Disease Improvement Plan in 2014. The Plan identifies **six priority areas for improvement** including prevention, rehabilitation and addressing the mental health needs of people affected by heart disease. There is also a shift towards a more patient-centred community based model of support.

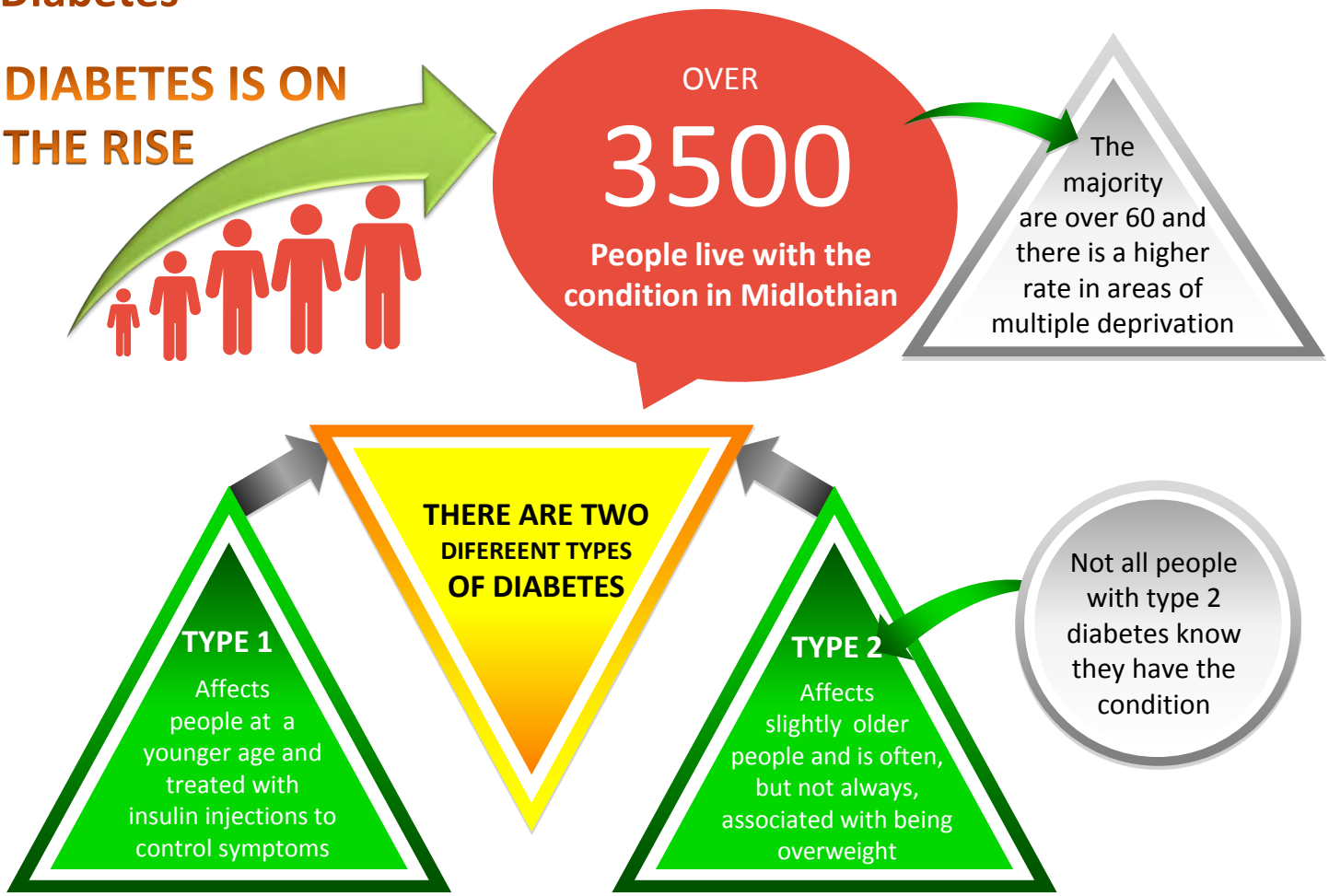
Progress in 2016

While there are no new initiatives in Midlothian this past year to address heart disease specifically, the promotion of physical activity and weight management programmes contribute to the prevention of heart disease. We met with British Heart Foundation representatives to consider how they might support the development of services in Midlothian.

Key Actions for 2017-18

- Review our links to the NHS Lothian Heart Disease Strategy Programme Board and consider the scope to improve detection and management of hypertension.
- Improve our detection of possible heart disease with inequality groups through the work of the Community Health Inequalities Team.
- Consider the adoption of the British Heart Foundation House of Care work currently piloted elsewhere in Lothians.
- Review our health screening of people with learning disabilities to ensure early detection of heart disease.

Diabetes



National Guidance

'Diabetes Action Plan' and **'Diabetes Improvement Plan'** provide the national guidance for preventing and treating diabetes. The growing concern about obesity is reflected in the Government's 2016 publication - *It takes all of us to build a fairer Scotland.*

New Service Challenges

Diabetes UK describes diabetes as the fastest growing health threat of our times and an urgent public health issue. Since 1996, the number of people living with diabetes has more than doubled.

Diabetes

Progress in 2016

There is a lot of work going on to improve access for weight management:

- Working with leisure services and responding to direct referrals from acute hospitals with support provided both on an individual and group basis within Lasswade Leisure Centre and at Midlothian Community Hospital Gym
- Introduction of new and innovative motivational texting using FLORENCE. This also encourages self- monitoring weight changes
- Encouraging self-management through more active promotion of My Diabetes My Way
- The Community Health Inequalities Team piloted a Healthy Living Programme (a six session structured-education course) designed to promote health behaviour change in individuals identified as having pre-diabetes and therefore at high-risk of developing Type 2 diabetes.

Key Actions for 2017-18

a) Proactive work with people identified at risk of diabetes (pre-diabetes) to be implemented through key staff such as Health Inequalities Nurses-paying particular attention to people from minority ethnic groups at higher risk of diabetes

b) Identify and work with housebound people who are overweight and at risk of diabetes

c) Further promotion and implementation of the new Weight Management Pathway

d) Work with key staff in the Community Planning Partnership to implement a new Physical Activity Strategy to both prevent obesity and support weight management

e) Improved data/intelligence around Type 2 diabetes in Midlothian

f) Explore a further shift of care and support for people with type 2 diabetes from secondary to primary care. If possible, this would include a single Midlothian consultant providing an outpatient service in Midlothian working closely with the GPs in envisioning and planning future diabetes services.

Stroke

The numbers people who have experienced stroke discharged to their own homes (not including care homes) in Midlothian is around 110 per year.

Although cardiovascular disease (CVD) is largely preventable, stroke remains the third biggest killer in Scotland and the leading cause of disability.

Obesity, high alcohol intake and high blood pressure can all make a stroke more likely. When someone has a stroke, urgent intervention is important in helping reduce the long-term impact. Treatment has improved in recent years and the number of deaths of people under75 has reduced significantly. According to Scottish Health Survey 2015, there has been no significant reduction in strokes since 2003.

Progress in 2016

- Midlothian Community Physical Rehabilitation Service and the Reablement Team (approximately 25 per year) continue to provide follow up support to patients discharged from hospital.
- Midlothian Active Choices (MAC) is a physical activity referral service for people with health conditions including those who have had a stroke. The MAC co-ordinator completed **Exercise after Stroke** training, strengthening the service's capacity to support those with stroke and seeing around 100 people in 2016-17.

National Guidance

Scottish Stroke Improvement Plan launched in 2014.

The Plan places strong emphasis on improving the quality of care in hospital. It recognises the scope to improve the transition back to the community and the quality of life of people who have suffered a stroke.

New Service Challenges

The creation of the Royal Infirmary Integrated Stroke Unit, whilst creating a more specialist and coherent hospital service, resulted in shorter lengths of stay that places more responsibility of community services to provide follow-up rehabilitation.

Key Actions for 2017-18

- Continue to promote prevention through blood pressure screening, weight management activity and alcohol education.
- Review our approach to community based rehabilitation and intermediate care for stroke patients. There may be increased community resource opportunities following the transfer of resources from Liberton Hospital and the review of intermediate Highbank care services.
- As part of our broader approach to strengthening self-management, we will explore options for the application of technology as well as promoting self help advice (such as the self help website: http://selfhelp4stroke.org/).

Palliative Care

NHS Lothian describes palliative care as aiming to:

'Improve the quality of life of patients and their families facing the problems associated with any life-limiting illness, through the prevention and relief of suffering by means of early identification and careful assessment and treatment of pain and other problems, physical, psychosocial or spiritual'.

National Guidance

New guidelines and standards are being developed both locally and nationally, including the Palliative and End of Life Care Strategy and a Strategic Framework for Action on Palliative and End of Life Care 2016-2021.

New Service Challenges

The national Health and Social Care Delivery Plan (December 2016) includes a requirement to double the end of life provision in the community by 2021 and reducing the numbers of people dying in hospital.

Progress in 2016

We reviewed the arrangements for planning and delivering palliative care in light of the establishment of IJBs.

In Midlothian, we established a new Palliative Care Group, chaired by the Chief Nurse and developed a local action plan.

Specialist hospital and hospice care is still provided on a Lothian basis and Midlothian is represented on both the Managed Clinical Network and the Pan-Lothian Steering Group.

Key Actions for 2017-18

- Develop a local approach to raising awareness through initiatives such as To Absent Friends and Dying Matters.
- Strengthen partnership working between local nursing services and Marie Curie.
- Strengthen care provided in care homes through involvement in a research-based staff training programme and the adoption of a systematic approach to receiving feedback from families.
- Review and seek to strengthen bereavement support available within Midlothian.
- Review the support being provided locally to carers responding to reports such as Under Pressure produced by Macmillan.
- Increase capacity to provide community based care, in 2012-13 the percentage of last 6 months spent in a community setting was 92.6% above the national average of 91.2%.

Older People

14,700

The approximate number of people are over the age of 65 years in Midlothian

1/6th

of Midlothian's population

By 2035, this proportion will grow to one quarter of the population with those over 75 years expected to double over this 20-year period.

The majority of older people live independently without any formal support. Many make a very significant contribution as volunteers, helping run local organisations, participating in local government, providing unpaid carer or being supportive grandparents.

Old age does not come alone. There is a greater likelihood of developing long-term health conditions.

People over 85 years are at significantly greater risk of living with dementia with the incidence projected to rise to 1400 to 2800 by 2035.

We estimate that between 2,700 and 4,200 people are living with frailty in Midlothian, a distinctive health state related to the ageing process resulting in multiple body systems gradually losing their inbuilt reserves.

National Guidance

Reshaping Care for Older People (2011) continues to be the main reference point. The emphasis of this is on the need to provide much stronger community based care and reduce reliance on hospitals and care homes. We are making significant progress in Midlothian in this regard.

A new national strategy for dementia is under development and focuses on issues such as diagnosis, post diagnostic support and dementia friendly communities.

New Service Challenges

During 2016-17, the big challenge was the delivery of reliable good quality care at home services. One provider's contract was terminated whilst another has had difficulties in meeting its contractual obligations.

This not only had an impact on people who rely on this support, it also caused considerable pressure in other parts of the system including delays in hospital and waiting times for reablement services.

Older People

Progress in 2016

- Whilst the lack of capacity in 'care at home' services is a major problem,we further invested in Reablement, Rapid Response and Hospital at Home. This should strengthen our ability to prevent hospital admissions and promote people's recovery.

- In relation to dementia:
  - Joint work undertaken with Scottish Ambulance Service to prevent avoidable hospital admissions.
  - Joint dementia team now provide an immediate response to emergencies for people with dementia.
  - Worked with the Council's building services to provide more dementia friendly housing including through the Maintenance Programme.

- A new post created to provide specialist dementia support to care homes, complementing the existing nurse adviser post.

- We transformed Newbyres with a new staffing structure, including nursing staff, intended to enable the Home to support more people with advanced dementia.

- Tackling isolation remains a high priority. We made some improvements to day care with a new service established in the Community Hospital and a redesigned day care service- the Grassy Riggs - provided in Woodburn.

Key Actions for 2017-18

A programme of work is underway to develop more extra care housing. This includes new build in Dalkeith and the redesign of some existing sheltered housing schemes.

The expansion of provision of intermediate care in Highbank continues. Planning needs to take place for more suitable premises for this service.

Local GPs are leading work to identify people who are living with frailty with a view to providing earlier support.

The transfer of the rehabilitation service in Liberton Hospital to the Community Hospital and enhanced community services will take place in April.

Mental Health

One in four of us will experience mental health difficulties sometime in our lives.

National estimate is that mental health issues account for 45% of all illness.

In Midlothian 4.2% of the population report themselves as having a long-term mental health condition

Poor mental health is not distributed evenly across the population and there is evidence of mental health inequalities across Scotland.

Mental health affects those more deprived disproportionately.

In some Midlothian areas up to 25% receive medication for anxiety and/or depression compared to 18% as a whole.

National Guidance

A new national mental health strategy, with a focus on such issues as prevention, self-management; supporting mental health in primary care; and improving physical health, was the subject of consultation in 2016.

New Service Challenges

Increasingly recognised is the high incidence of mental health issues addressed through Primary Care.

Alongside the heavy reliance on medication, the uptake of new services (described below) confirms the priority that must be given to improving 'Good Mental Health for All'.

Lengthy waiting lists for Psychological Therapies also exist and we must develop alternative approaches to minimise the length of time people, in distress, wait to receive support.

Mental Health

Progress in 2016

Through new funding for mental health in Primary Care, we set up an Access Point in Penicuik Health Centre and Midlothian Community Hospital to enable people to access appropriate support services.

Using a range of short term funding sources, we established a Wellbeing Service in two health centres. We rolled out to a further six in January 2017. A large proportion of the referrals made by GPs have a strong mental health dimension.

Key actions for 2017-18

- Continue planning work for the delivery of the acute and specialist services in the Royal Edinburgh Hospital. To ensure effective working between acute and community based staff, it is important to ensure, as far as possible, we treat patients from Midlothian in the same ward.
- Develop stronger joint working between substance misuse services and mental health services through the provision of a recovery hub. This places particular emphasis on promoting peer support.
- Strengthen rehabilitation by redesigning local services and ensuring access to the specialist NHS Lothian service.
- Develop a local strategy for ensuring quick access to appropriate support, including psychological therapies, building on the experience of the new Access Point and Wellbeing Services.
- Participate in the Maxout programme that seeks to transform the approach to employment, promotion of resilience, rehabilitation and interpersonal therapy.
- To ensure that people in crisis get quick access to the right type of support, including a place of safety, a joint approach agreed with the local police service, which is often the first agency to respond.

Physical Disability

The Equality Act (2010) defines disability as a physical or mental impairment that has a 'substantial and long-term adverse effect on people's ability to carry out day to day activities'.

Around 4,800 people between the ages of 16-64 years in Midlothian with a significant physical impairment.

This number includes those born with impairment, those who have been disabled through injury and those whose disability developed because of an illness.

Estimated 1200 people are wheelchair users in Midlothian.

There is national evidence that people with disabilities are more likely to experience health inequalities because they are more likely to live in poverty and disabled people experience discrimination in accessing and securing health services.

National Guidance

In December 2016, Scottish Govt announced A Fairer Scotland for Disabled People laying out a delivery plan through until 2021.

Although it covers all disabilities it is the first time there has been a national policy that covers people with physical disabilities.

New Service Challenges

Welfare Reform continues to be a major cause of concern for disabled people.

The devolution of powers to the Scottish Parliament includes:

- Disability Living Allowance
- Carer's Allowance
- Attendance Allowance
- Personal Independence Payment

It is too early to assess the impact on disabled people but the uncertainty over income entitlement is unsettling.

Physical Disability

Progress in 2016

In 2016, we focused on the development, approval and circulation of a new three-year plan. The plan continues to adopt a social model of disability aimed at removing barriers inhibiting everyday life.

There continues to be a strong emphasis on working across agencies, recognising that suitable housing, an adequate income, finding and keeping a job and being able to get about through accessible transport are critical to people's sense of wellbeing.

More specifically, we reflected on the importance of having good information about services and support in the development of a new Directory of Services, due for launch in February 2017.

Key Actions for 2017-18

- Development of plans to increase access to employment for people with disabilities including an application to the Big Lottery.
- Development of plans for a coordinated system for accessing good information in health and social care.
- Implementation of a more coordinated approach to housing for people with disabilities involving Adult Social Care, Housing and Melville Housing Association.
- Strengthen transport information in relation to taxis, buses and trains.
- Support local disabled people to apply to be part of the proposed 'experience panels', which will help shape the new devolved welfare benefits system

Sensory Impairment

An estimated 50% of sight loss is preventable or treatable.

In Midlothian, the 2011 census revealed that

5,656

people experienced some hearing impairment.

National estimate is that

1 in 6

of the population has a hearing loss.

Significant sight loss affects

1 in 30

In Midlothian, through the 2011 census,

1913

reported having sight loss impairment.

National Guidance

See Hear, published in 2014, is the national strategy developed to address sight and hearing impairment. This requires all Partnerships to produce and implement a local action plan.An Act is in place to improve access to British Sign Language services by all publicbodies in Scotland.

New Service Challenges

The link between Midlothian social work staff and those working for the specialist agencies - RNIB and Deaf Action - are not as strong as they could be. One factor is the absence of agreed access to shared information systems.

Sensory Impairment

Progress in 2016 - A number of small yet tangible improvements including:

Awareness raising through workshops and the work of the five local sensory impairment champions.

Basic sensory loss checks undertaken in care homes.

Council access to live sign language support through technology.

Increased uptake of hearing aid batteries provision in libraries and preparatory work with Audiology towards the provision of repairs and maintenance clinics utilising local volunteers.

Key Actions for 2017-18

As part of the Midlothian Community Hospital review, the option of Audiology and Ophthalmology clinics being held there to be fully assessed.

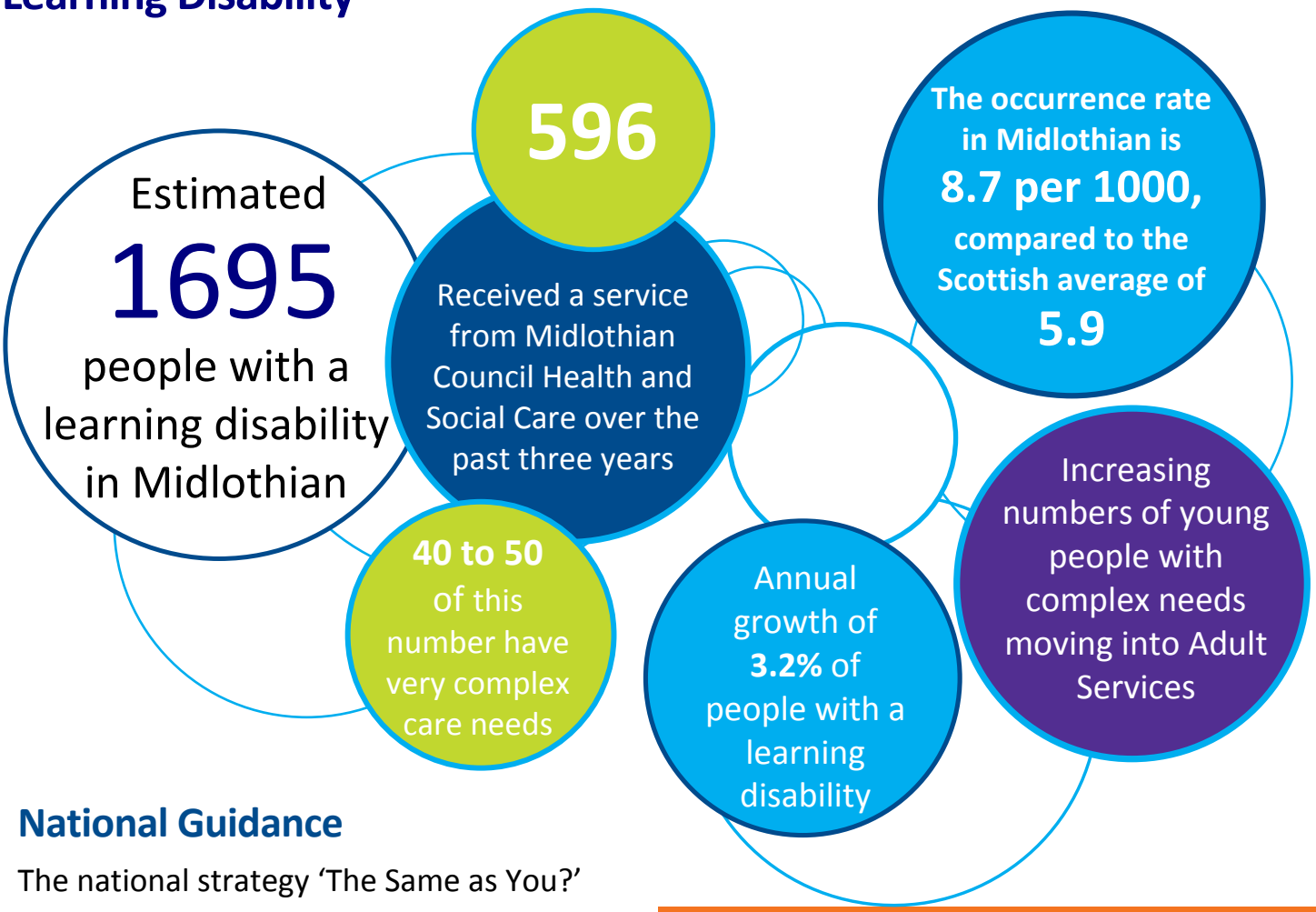
Launch of hearing aid maintenance and repair clinics in at least three libraries.

Sensory loss checks to be undertaken in social care settings such as day centres.

The application of technology to be promoted e.g. portable loop systems and the use of Contact Scotland (BSL interpreting service) in other public services.

Identify solutions for better information sharing between social work and specialist agencies.

Learning Disability



National Guidance

The national strategy 'The Same as You?' focused on ensuring services are as inclusive and community-based as possible. The more recent national strategy Keys to Life (2013) places an emphasis on human rights and tackling health inequalities.

New Service Challenges

Over recent years, expenditure in learning disability increased by over £2m per annum.

This is likely due to a strong commitment to providing individualised care packages alongside the numbers of young people moving through transition and needing high cost care packages.

The current approach is not financially sustainable. We are developing new approaches that ensure people's needs are met through more cost effective service design.

Progress in 2016

We developed new services including respite care provision in Woodburn; day services in Mayfield; and networks of mutual support in Dalkeith and Penicuik.

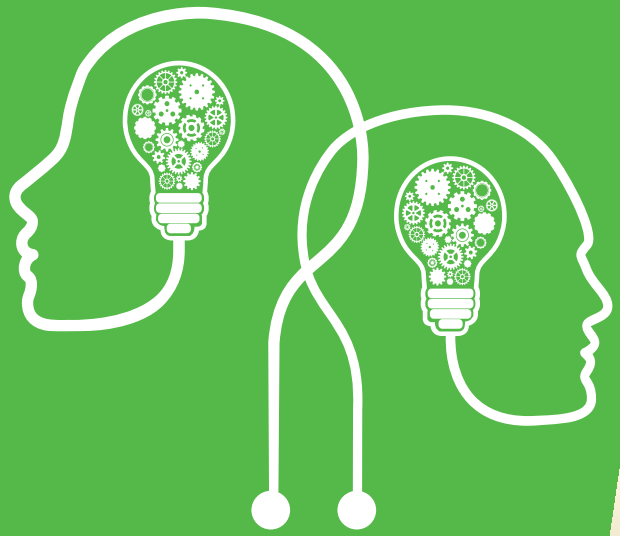
In view of the higher incidence of sensory impairment for people with learning disability, we are undertaking sensory checks in settings such as day centres.

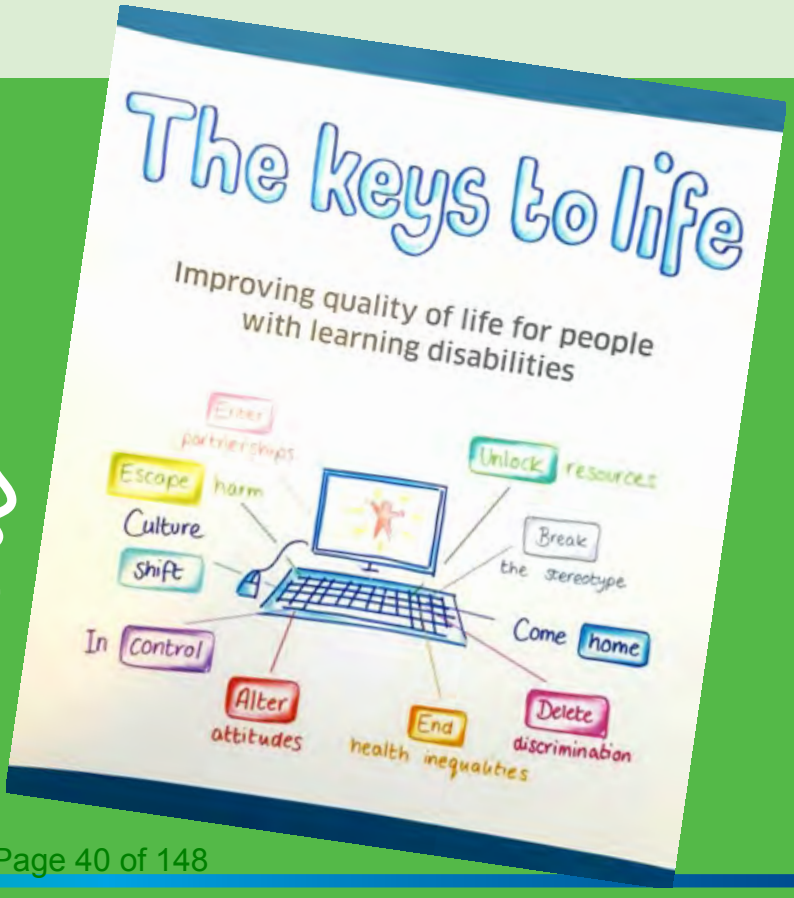
On a Lothian wide basis, plans are in place to enable the move towards more localised, community-based approaches to the delivery of specialist health services.

Learning Disability

Key Actions for 2017-18

- Finalise arrangements for the management of the community health team as a first step towards a more integrated and local approach.
- Strengthen the community team through the application of Midlothian's share of resources in the NHS Lothian Challenging Behaviour Team as well as those planned for the NHS Lothian 12 person unit.
- The 12 person complex care unit in Penicuik becomes operational.
- Review Day Services to ensure an appropriate balance of locally provided services including centre-based; community based; and opportunities for inclusion. If possible, we will reduce reliance on people travelling outside Midlothian to receive appropriate services.
- Strengthen arrangements for people moving from Education and Children's Services to Adult Services either through more effective interagency working or though the establishment of a single service.
- The three people still living in hospital settings to move to community based settings.

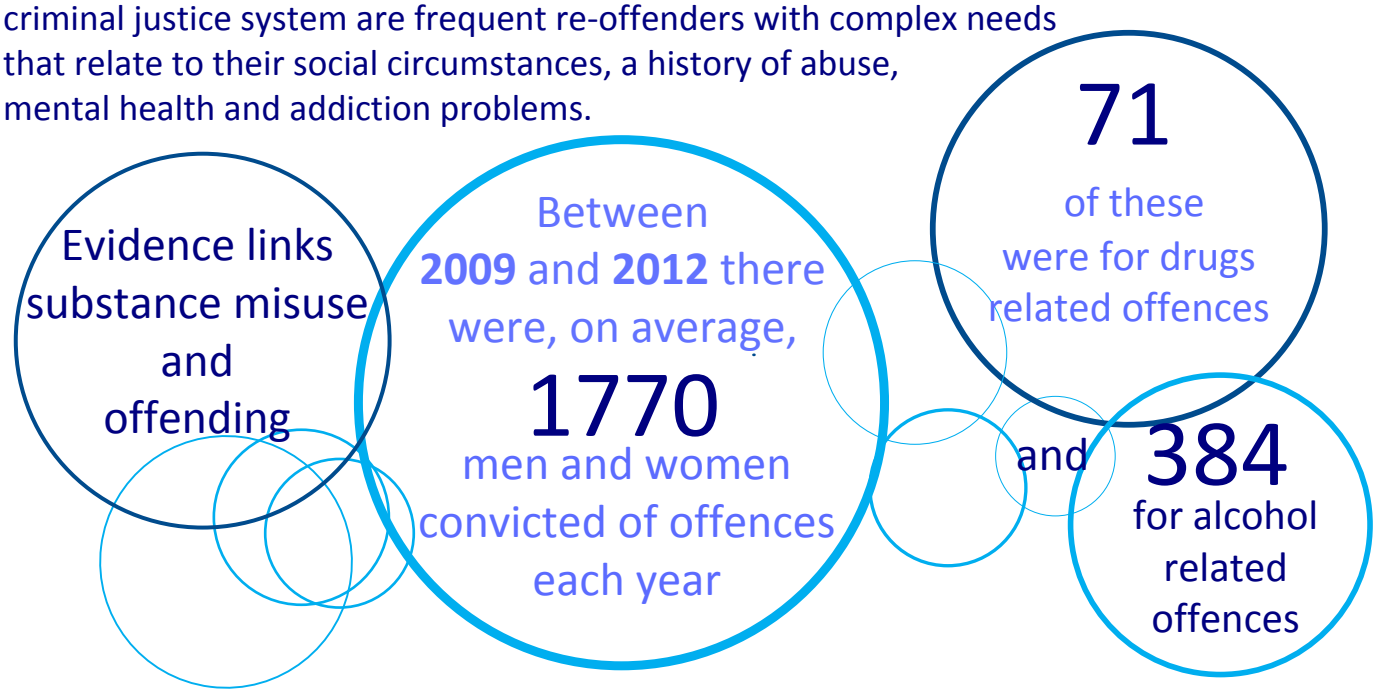




Offenders

People who offended, or are at risk of doing so, are much more likely to experience multiple and complex health issues.

The Commission on Women Offenders Report 2012 highlighted that many women in the criminal justice system are frequent re-offenders with complex needs that relate to their social circumstances, a history of abuse, mental health and addiction problems.



Information from a full year's data from the main Criminal Justice Social Work risk assessment tool (LSCMI) indicated that between January 2012 and January 2013 at the point of assessment.

65% reported an alcohol problem at some point
34% reported a current alcohol problem
60% had a drug problem at some point
31% indicated a current drug problem

National Guidance

The new arrangements in the Community Justice (Scotland) Act 2016 take effect on 1st April 2017. These place stronger emphasis on partnership working including addressing health and wellbeing concerns recognised as significant in preventing further offending. The new structure is predicated on no one agency being able to reduce reoffending, and every health board is a statutory partner in the new arrangements.

New Service Challenges

The creation of the new Midlothian Community Safety and Justice Partnership will, by raising the profile, increase the demands on services to become more effective in meeting the health and social care needs of offenders.

It is important that all agencies, which can have an impact on the issues related to reoffending, are aware of the role they can play and willing to work in partnership to achieve the outcomes in the improvement plan. This includes mental and physical health services and drug and alcohol agencies.

Offenders

Progress in 2016

The **Spring** service, aimed at women with complex needs who have been involved in or at risk of offending now includes a social worker post to support women on a one to one basis to prepare for Spring and maximise the benefits of attendance. Spring now also includes an Occupational Therapist as part of the staff team. This post is being very helpful in the Reaching In, Reaching Out part of the programme, increasing participation in meaningful activities and occupations, whether these be daily living, targeted specific homemaking occupations, supported parenting, leisure activities or skills development for future employment.

A new service, **Fresh Start**, is engaging with individuals at the point of arrest to link them into relevant services, particularly in relation to substance misuse and mental health.

Spring

A service for women in Midlothian

Information for Women

Key Actions for 2017-18

The new Community Justice arrangements include the development and implementation of a Local Outcomes Improvement Plan and this will include actions planned to address health care needs.

The relationship between previous trauma events and offending is increasingly recognized. Options for strengthening support and counselling to be considered.

Midlothian has a high incidence of domestic abuse. We will explore options to improve or reduce domestic abuse and to work effectively with women and children. We will also explore options of working effectively with perpetrators.

Substance Misuse

The misuse of alcohol and drugs impacts, in a number of ways, on the lives of individuals, families and communities.

920

Estimated number individuals with problematic drug misuse (opiates)

1800+

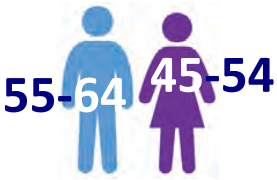
Children's lives affected in some way by parental substance misuse

473

In 2015, this was the amount of alcohol related hospital stays

4.33

The average number of drug related deaths for the period 2013-15



The highest rates alcohol related hospital stays were in these age groups

While cannabis is by far the most common illicit drug used, there is the growing problem with the misuse off prescribed medications such as opiate painkillers, tranquillisers and anti-depressants.

It is Midlothian's most deprived communities where the harmful effects of substance misuse are greatest. Rates of alcohol-related hospital admissions were nearly 7 times higher for people living in the most deprived areas compared with the least deprived.

National Guidance

The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem (2008) and Changing Scotland's Relationship with Alcohol: A Framework for Action (2009) remain the two cornerstone strategic documents.

New Challenges

Since April 2016, funding that Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) receives from the Scottish Government was reduced by 23%. We established a partnership group to make recommendations on how to make these savings while protecting the integrity of the Recovery Integrated System of Care (ROSC) that successfully developed a point noted in the Care Inspectorate report:

'Despite the complex challenges facing the ADP, it had successfully worked in partnership to re-align a large proportion of their budget to post treatment and recovery focussed services evidencing agility and an ability to jointly meet changing priorities.'

Substance Misuse

Progress in 2016

- The final MELDAP report noted 24 strengths of the partnership. These included:
  - MELDAP had consistently exceeded the three-week referral to treatment HEAT standard. In some cases, services were achieving 100% success rates indicating that overall the ADP was delivering effective access to services for individuals who required support.
  - It was evident that service users were offered high quality, evidence informed treatment, care and support interventions.
- Work started on the development of a Recovery Hub, bringing together substance misuse and mental health services.

Key actions for 2017-18

MELDAP will continue to implement the priorities set out in its Delivery Plan 2015-18. These include:

- Develop integrated Recovery Hub involving staff from substances misuse services, mental health services, council staff and third sector partners.
- Deliver actions to address areas for improvement noted in the Care Inspectorate report.
- As a member of the Midlothian Licensing Forum, work with the Licensing Board to produce a new Statement of Licensing Policy and oversee its implementation.
- Achieve balanced sustainable budget.

Primary Care

GPs

The demand for GP appointments is high with an estimated 0.5 million appointments offered each year in Midlothian. GPs are seeing approximately 10% of the Practice population every week. With recruitment difficulties and additional demands to support the frail elderly at home, in care homes and in-patient continuing care and step up/ down facilities, the pressure on GPs is increasing.

Community Nursing

With a shift from hospital care to care at home, community-nursing services provide care for people who are housebound, or who are unable to access their GP surgery. The services aim to support patients manage their conditions as independently as possible, and where appropriate, to avoid hospital admission. In line with the Lothian Palliative Care Strategy, we are increasingly managing people receiving palliative care, up to and including end of life care, within their own home or care home.

Medication

Medication is vital in helping people recover and keeping people well. The costs are high; Midlothian is spending almost £17m on prescribing out of the total health (including some hospital services) and care budget of £122m.

Dentistry

There is good access to an NHS dentist for people living in Midlothian with 84% of adults registered with a dentist (87% in Scotland, March 2015). Older people and people experiencing health inequalities are less likely to see a dentist compared with other areas in Scotland.

Sexual Health

Focus on reducing teenage pregnancy and unintended pregnancies for those over 20 years of age is growing; raising the uptake of LARC (long-acting reversible contraception); and increasing access to early abortion services.

Continence

We are implementing the main objectives of the report, **Promoting Continence in Lothian**, in Midlothian through a local coordinating group. We are also introducing protocols to improve support to people in their own homes and to care home residents.

Out of Hours

The role of Lothian Unscheduled Care Service (LUCS) is to provide urgent primary medical care services across Lothian in the evenings and weekends as well as on Public Holidays. We will consider the outcome of the national review before determining the best way forward in collaboration with the other Lothian IJBs.

Primary Care

National Guidance

- The national 2020 Vision for Scotland's Health Service is clear about the need to strengthen the role of primary care to keep people healthy in the community for as long as possible.
- In 2016-17, Scottish Government made £13m available to help deliver projects across Scotland that trial new ways of delivering health care in the community including addressing mental health issues.
- A National Review of Primary Care Out of Hours Services continues to consider how best to deliver out of hours services.

New Service Challenges

- Some Practices struggled to meet the standard of offering telephone advice or an appointment within 48 hours.
- During 2016-17, six GP Practices moved to restricted lists, limiting the number of new registrations.
- Raised public concerns through a range of open forums about access to their GP.
- The population in Midlothian is growing rapidly.
- The workload for community nursing teams is increasing alongside difficulties in recruiting district nurses.

Progress in 2016

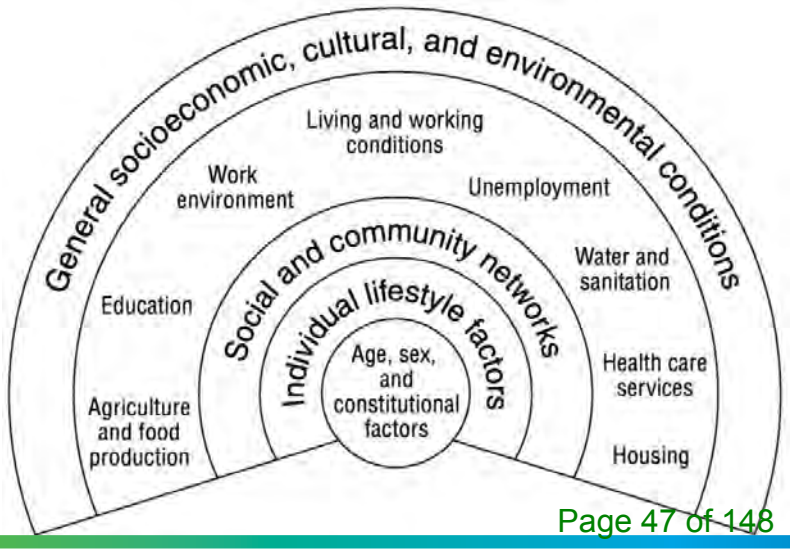
- A number of discussions held with the public e.g. Hot Topics, Older People and Community Councils.
- A number of new services introduced to Health Centres including the MW Access Point in Penicuik and Midlothian Community Hospital; the Wellbeing Service across eight Health Centres; and a Carers' Advice Service in Dalkeith Health Centre.
- Five pharmacists now working with Health Centres in East and Midlothian to support GPs on issues such as reviewing medication of patients discharged from hospital.
- We developed a local Prescribing Action Plan to manage the expenditure on medicines (approximately £17m per annum) within the allocated budget.
- An information leaflet **Do I need to see a GP?** published and distributed.

Primary Care

Key Actions for 2017-18

- A new Health Centre being built in Loanhead and will open late 2017-18 within the Community School campus.
- Continue to work on a Pan-Lothian basis to train and deploy nurses and physiotherapists trained to an advanced level to strengthen the skill mix in Health Centres.
- Work with GPs, social care staff and local voluntary organisations in Penicuik to pilot new ways of working with people who are housebound.
- Develop closer relationships with key specialist staff in the acute sector to provide more seamless services between hospital and home GPs.
- Upgrade of Health Centre premises in Newbyres.
- Open a new GP Practice in existing refurbished premises in Newtongrange.
- Work with the newly established GP Quality Cluster to help improve the quality of all health and care services.
- In line with the national review of 'out of hours' services, we will review our local arrangements on a multi-disciplinary basis.
- Contribute to the development of a new model of emergency health care such as out of hours care hubs across Lothians.
- Develop a local plan in collaboration with NHS Lothian Oral Health to improve the uptake of dental services by those groups less likely to do so i.e. people involved in offending.

The Determinants of Health



Care Packages

The number of people likely to need care packages in the future is difficult to predict.

While the number of older people and the number of children surviving with complex needs is growing the emphasis on prevention, rehabilitation and recovery is likely to reduce demand.

Nevertheless the major financial challenge facing public bodies combined with growing workforce shortages in social care mean it is critical that we review our approach to the delivery of care packages.

Approximately

2000

adults are in receipt of some form of care package

Total social care 2016-17 budget iin the region of

£39m

National Guidance

The report by the Chief Medical Officer - Realistic Medicine – has prompted a similar reflection on our approach to social care in Midlothian.

New Service Challenges

The model of social care is changing, shifting to a more person-centred approach in seeking to address individual need and improve the person's outcomes. The implementation of Self-Directed Support enabled many people to exercise more control over their care arrangements. However, we need to pay more attention to overseeing care arrangements to ensure that we are as efficient as possible with our limited resources, whether this be in providing transport, day care or overnight support.

We must also be alert to more cost effective ways of meeting people's needs, such as making full use of local voluntary resources and new technology. Our goal is to retain this more person-centred approach to providing care services in ways that are realistic.

Care Packages

Progress in 2016

- Internal policies and processes reviewed to ensure we are providing services in a way that is both equitable and affordable.
- Staff development training programmes put in place to take more account of management of risks and for identifying the most cost effective way of meeting people's needs.
- The costs and efficiency of Council and external care services are in the process of being reviewed

Key Actions for 2017-18

- Develop stronger partnership working with health services and external providers.
- Continue to examine any opportunities to enable people to manage more independently with the support of new technology.
- Develop a communication strategy that ensures the public and our partner agencies understand and can support the changes we are putting in place.

Our Realistic Care, Realistic Expectations programme aims to provide services over the next three years within a reduced budget

Hospitals

National Guidance

The Ministerial Strategic Group for Health and Community Care agreed that for 2017/18 they will track the progress of Integration Authorities:

- Unplanned hospital admissions
- Occupied bed days for unscheduled care and A&E performance
- Delayed discharges
- End of life care
- Balance of spend across institutional and community services

This demonstrates that a very high priority is attached to reducing avoidable use of acute hospital beds.

New Service Challenges

There is a need to reduce our use of Acute Hospital beds. A new national target is to reduce unscheduled care beds by 10% across Scotland. Patient safety reasons recognises that across the UK, at any one time, occupancy rates should not exceed 85%.

We have major challenges in the provision of care at home services. This led to delays in the availability of the Reablement Service and consequently arranging discharges form hospital. As a result, for a period during the year, our performance on delayed discharge deteriorated.

Our analysis of health inequalities identified a high incidence of preventable admissions from areas of multiple deprivations.

Hospitals

Midlothian Community Hospital (MCH)

New Challenges

The requirement to reduce use of acute hospital beds alongside the public's wish for services to be locally available means that we must make the maximum use of our local Community Hospital.

Progress in 2016

- **Out-patients clinics:** We worked with NHS Lothian Out-Patient Board and individual services such as Audiology to determine which services could be provided in this way without incurring significant additional costs.
- **Rehabilitation:** Plans are in place for the transfer on the 1st April 2017 of 24 post-acute rehabilitation beds for older people from Liberton Hospital to MCH.
- **Day Services:** We replaced the provision of day hospital services in MCH with a Day Care service, transferred from Highbank and Woodburn Day Care. This is a medium term arrangement until we can secure more suitable day care accommodation.

Key Actions for 2017-18

Outpatients clinics: Continue to explore opportunities for providing outpatient clinics in MCH and this may include the application of new technology for video conferencing.

Acute Hospitals

- Further investment made in the Hospital at Home Service-increasing capacity to supporting 15 patients at any one time.
- Nursing support to care homes also increased including the establishment of a nursing team in Newbyres Care Home.
- We continue to develop joint work with the Ambulance Service for people who have fallen and those with dementia.
- A new Physiotherapy post created to support people with advanced respiratory illness (COPD) and manage their condition without needing hospital admission.
- To ensure people are discharged quickly, we strengthened the In Reach Team.
- We maintained the Assisted Discharge Service provided by Red Cross.
- A Single Point of Contact in Midlothian for acute hospital staff established.
- In relation to younger people who attend the hospital regularly, some work undertaken to ensure a proactive approach to addressing their needs such as contact with the Homelessness Service.
- The joint dementia team increased its capacity with an additional social worker and introduced a duty system that works in partnership with Merrit to enable GPs to phone directly when there is a crisis/emergency. This is to avoid going to the Community Care duty team and ending up on a waiting list.

Hospitals

Acute Hospitals

Key Actions for 2017-18

- The rehabilitation pathway (24 beds) provided in Liberton Hospital will transfer to Midlothian Community Hospital in April.
- Midlothian has a high incidence of people admitted to hospital because of a fall, so we will focus more on developing a falls prevention strategy.
- Review the reasons why people admitted to hospital with conditions that in theory do not require hospital admission. This will enable us to understand better what services or support people need to avoid this happening.
- Implement a new approach to identifying people who are frail so that we can provide support at an earlier stage and help prevent some crisis admissions.
- Consider the local implications of the NHS Lothian Acute Hospital Plan proposals and what these will mean for the Midlothian population so we can make necessary adjustments to local services – for example more locally available out patient appointments.
- Review the provision of out-of-hours of Midlothian health and care services in light of the Ritchie review, and use this to improve provision and inform the Lothian-wide development of OOH provision.

Housing

Changes to the organisation of health and care focused on services provided by the NHS and Council Social Care services. However, we recognise the critical role played by housing providers through the need for the inclusion ofa Housing Contribution Statement in our Strategic Plan.

The main objective of health and care reform is the reduction on the reliance on institutional care and hospitals. As we age, staying at home is a viable option for most of us. This depends on our home's location, accessibility, size, energy efficiency and proximity to local amenities.

National guidance encourages new build housing to incorporate design features that enable people to remain in their homes longer or easily adapt them.

National Guidance

The Scottish Government will work to increase the supply of affordable housing in Scotland to deliver at least 50,000 affordable homes, of which 70 per cent will be for social rent.

New Challenges

The pace of house building impacts services and communities as the population grows. More specifically the Handyperson scheme providing a small repairs service ceased to trade leaving a gap locally.

Progress in 2016

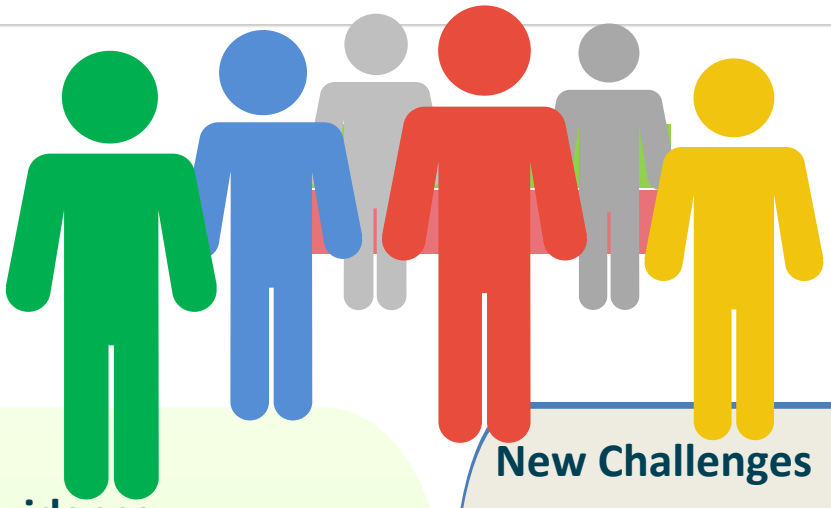
- The new Penicuik accommodation for people with complex needs is near completion and ready for use in Spring 2017.
- Council agreed an Extra Care Housing policy including a commitment to build a new facility in Dalkeith.
- A Social Landlord Register started the process of reshaping a sheltered housing complex in Mayfield to become an extra care facility.
- We put in place stronger joint working between social care and housing through the development of a Housing Options Policy that ensures we achieve the best choices for people in unsuitable accommodation.
- In relation to homelessness the new Health Inequalities services (CHIT) is seeking to address the health needs of people who are without suitable accommodation.

Key Actions for 2017-18

- Draw up detailed plans for new extra care facilities in Dalkeith and in Gore Avenue, Gorebridge.
- The up and running of new Complex Care Housing development.
- Implement a new initiative supporting young frequent attendees at the Royal Infirmary, with prevention of homelessness being a key objective.
- Explore options for replacing the Handyperson Service.

Workforce

We want to support the people of Midlothian to maintain healthy, independent lives and have access to services and community resources that support their health and wellbeing. To do this we need to nurture a high quality, skilled, courageous and compassionate workforce that promotes dignity, safety and respect, taking a strengths-based approach to supporting the people of Midlothian. Successfully implementing this plan provides a consistent and positive step towards meeting that commitment and our ambition.



National Guidance

Scottish Government states that we can only deliver health and social care services with the full engagement and contribution of a valued and skilled workforce. At the heart of the National Transformation agenda is a broader, more integrated, highly skilled, supported, and engaged workforce.

The Scottish Government published a consultation paper - National Health And Social Care Workforce Plan – this aims to support the development of a workforce planning system that progresses this agenda for use in each IJB partnership. This Workforce planning system is due for completion this spring 2017.

New Challenges

Recruitment of care workers across the sectors made more uncertain due to:

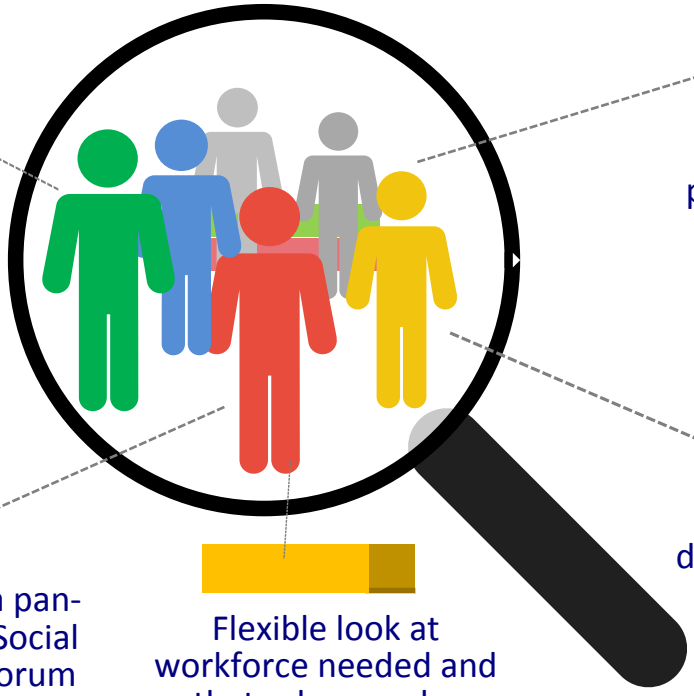
- Plans for Britain to leave EU and increasing reluctance of EU Nationals to seek work in Britain
- Increases in SSSC registration fees and pay being comparable with working in a supermarket

Releasing staff for training in order to 'up-skill' the workforce in more complex practice with service users in the community who have increasing levels of need.

New SSSC requirements for registration e.g. workers in a housing support services (probably 2017), which will require the workforce to acquire qualifications, and released from work to do so
Increasing workforce pressures in Primary Care with significant shortages of District Nurses.

Workforce

Progress in 2016



Delivery of programme of engagement with staff around culture, values and vision

Provision of a range of team development programmes for specific operational teams

Development of a detailed understanding of the workforce across NHS, Council and external sector in Midlothian as the basis for the production of a long term workforce plan

Establishment of a pan-Lothian Health & Social Care Workforce Forum and engaging with developments at a national level

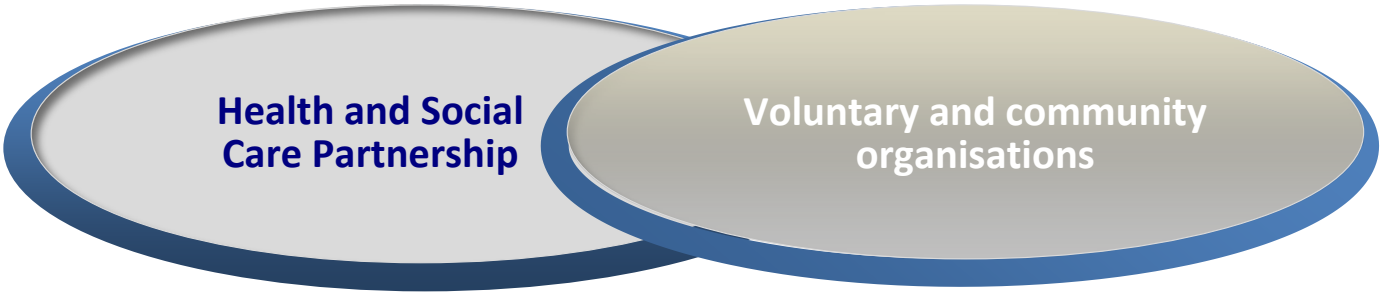
Flexible look at workforce needed and that roles may be different and/or new.

Key Actions for 2017-18

- **Induction:** Establish a shared approach to introduction to the Midlothian Health and Social Care Partnership including induction for Care at Home workers across Council, Third and independent Sector provision.
- **Team Development:** Seek opportunities to apply the Lothian Toolkit with our Third and Independent Sector providers.
- **Leadership:** Develop opportunities for leadership development at the Team Leader and operational frontline levels.
- **Health Inequalities:** Deliver a continuous programme for bite-sized workshops for all staff focusing on Health Inequalities.
- **Locality:** Focus on communities and shaping the workforce around their needs.
- **Recruitment and Retention:** In response to the challenging elements of recruitment and retention across the Partnership, continue to develop approaches to attract staff to caring roles across all agencies, focusing on the voluntary and independent sectors.
- **Roles:** Confirm the range and scope of the redesign of roles for the future, incorporating the roles the voluntary and private sector play in delivering services and support.
- **Workforce Plan:** Produce a Midlothian Health and Social Care Partnership Workforce Plan in line with Midlothian Integration Joint Board and Scottish Government requirements.

Voluntary Sector

Voluntary and community organisations play a critical role in the provision of social care services in Midlothian. They are the major provider in delivering services to people with learning disabilities and people with mental health needs. They are also central to helping reduce isolation in the provision of lunch clubs, day centres, buddy schemes, local area coordination services and peer support.



National Guidance

The Community Empowerment Act reinforced the central role that the Voluntary Sector plays and strengthened the requirement for their inclusion in decision making generally in community planning.

Progress in 2016

- **The Voluntary Sector has representation on the IJB and the Strategic Planning Group as well as on client group specific planning groups.**
- **Increasingly the Voluntary Sector is working in closer partnership through co-location with statutory agencies in areas such as primary care, substance misuse, mental health, dementia and rapid response.**
- **Midlothian Voluntary Association (MVA) established and administers a development fund to promote Peer Support.**

Key Actions for 2017-18

- The Third Sector Reference Group to develop a strategy proposing how it can play a stronger role in the Health and Social Care Partnership in helping address the dual challenges of increased demand and reducing financial resources.
- Third Sector partners enabled to contribute at an operational level in designing new models of care in response to both financial and workforce pressures.

Technology-Enabled Care

The traditional service model for health and social care will not be able to cope with the financial pressures and the ageing population. We must find new ways of supporting people and enabling them to stay well that are sustainable. Increasingly this will include redesigning services to embed and incorporate the right technologies to support new care models. This approach is in line with the wider impact of new technology in our day to day lives.

The possibilities offered by new technology have grown considerably in recent years. Technology Enabled Care is about realising the potential of technology as an integral part of a person's care and support plan to enhance quality and/or improve efficiency across health, social and independent care as well as what is available in the market-place.

National Guidance

There is a National Telehealth and Telecare Delivery Plan and a £30million TEC fund. Midlothian is benefitting from additional funds to develop new approaches.

It is not simply about finding the right 'kit' but about finding how the right care can be supported by the technologies available, some of which have become everyday. For example the delivery of better care can be facilitated by helping family members share information about the person for whom they are caring with one another as well as with health and care staff (health and social care staff); a simple smartphone or computer can support this but fundamentally the focus is supporting good communication.

Interagency Informaiton Exchange will support client/patient informaiton sharing between health and social care

Business intelligence and data visualisation development to support greater real-time insight

Developing a TEC and Digital Health and Social Care Strategy Group within the partnership

Technology-Enabled Care (TEC)

Progress in 2016

- **Videoconferencing:** Care Homes care for people who are particularly frail and vulnerable. Ensuring care home staff has the skills and knowledge needed is challenging as it can be difficult to release staff for training. We introduced videoconferencing to all Midlothian so that staff can receive training without having to leave the premises. We are also using videoconferencing to enable deaf people to access real time interpreting support.

- **Dementia:** To encourage families and staff to consider using technology, we established an 'At Home Hub' in Midlothian Community Hospital. This provides an opportunity to learn about the possible use of equipment, resources and environmental adaptations.

- **Malnutrition Management:** Dieticians are now using Health Call – an automated telephone system to support people with their weight management plans.

Key Actions for 2017-18

- **Realistic Care, Realistic Expectations:** Find new sustainable ways of supporting people and enabling them to stay well. This means setting realistic expectations while achieving our statutory obligations as a needs-led service. We will review how we can enable new models of support through the adoption of technology in practice e.g. overnight care in learning disabilities.

- **Interagency Information Exchange** introduced. This enables health and social care staff to access information about the needs and services provided by agencies to people they are working with.

- **eFrailty:** People who are frail account for a significant proportion of those admitted to hospital. To shift away from crises care we will explore how best to use technology to identify people at most risk and provide support at an earlier stage to avoid crises arising

- **Information Hub:** We will continue to explore affordable sustainable solutions to the challenge of providing easily accessible information - an issue regularly raised by the public.

- **Mobile Working:** In order to find new models of care, we must find ways of working differently and more efficiently. Paperwork and travel time to process and file field activities are areas for improvement.

Thursday 16th March 2017 at 2.00 pm

IJB Directions 2017-18

Item number: **4.3**

Executive summary

This report introduces a draft version of the 2017-18 Directions to be issued by the IJB to Midlothian Council and NHS Lothian. These Directions are intended to provide greater clarity about the key changes which need to be made during 2017-18 in the delivery of health and care services in Midlothian. These Directions should be considered alongside the Strategic Plan 2016-19 and the 2017-18 Delivery Plan.

Board members are asked to:

1. Approve the content of the Directions.
2. Agree that a summary paper be provided to ensure there is no dubiety about the key changes which need to be made

IJB Directions 2017-18

1. Purpose

This report introduces the proposed Directions to be issued to NHS Lothian and Midlothian Council for action in 2017-18.

2. Recommendations

Agree the content of the Directions and remit to the Joint Director to finalise the detail in terms of financial information and performance data related to each Direction..

3. Background and main report

3.1 **Midlothian Strategic Plan**: The Midlothian Strategic Plan 2016-19 outlines the direction of travel for the development of health and social care services in Midlothian. In many areas the Plan was described at a high level to allow further work to be undertaken with key partners about how to achieve the desired changes outlined in the Plan e.g. to reduce reliance on Acute Hospitals and Care Homes through strengthening Primary Care and Care at Home services. In light of new challenges and opportunities the Strategic Plan has been updated in the form of a Delivery Plan for 2017-18 (See separate item on the agenda)

3.2 **Legislation**: The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on Integration Authorities to develop a Strategic Plan for integrated functions and also to issue Directions to NHS Lothian and Midlothian Council highlighting specific changes which need to be put in place to implement the Strategic Plan.

3.3 **Midlothian Policy**: Midlothian IJB approved its Directions Policy on10th December 2015. This policy stipulates that Directions will be issued for all the functions that have been delegated to the IJB and that these will show the disposition of all the resources allocated to it.

3.4 **A Partnership Approach**: The clarity to be achieved through the issuing of Directions is important in ensuring there is no dubiety about how delegated health and care services are to be provided including major service redesign objectives. The IJB has previously noted that the success of the new Integration arrangements is wholly dependent upon effective joint working between the IJB, Midlothian Council and NHS Lothian. Thus whilst Directions must be issued by the IJB to NHS Lothian and Midlothian Council, these should be considered and enacted in a genuine spirit of partnership.

3.5 **Directions 2016-17**Following consideration at previous meetings of the IJB, formal Directions were issued on 31st March 2016 to NHS Lothian and Midlothian Council. Direction 5 relating to community services for older people was subsequently amended to require the Council to undertake a full review of Care at Home following consideration of report taken in private on 18th August. A progress report on Directions was considered by the IJB on 27 October 2016.

3.6 **Key Issues to be addressed through 2017-18 Directions**

Principles: In developing Directions for 2017-18 there are a number of emerging principles which should inform the redesign of services. These include:

1. A stronger emphasis on prevention being adopted by all services.
2. The development of a shared approach to risk across services
3. An increased emphasis on people being supported and treated at home
4. A move towards more Realistic Medicine and Realistic Care
5. A move towards more open access and seeking to reduce waiting lists
6. Diagnosis and treatment only being provided in hospitals where these can only safely be provided in hospital settings

Key areas for consideration include: The Directions are attached at Appendix 1. The main areas for consideration include:

Primary Care Continuation of developments to increase capacity and reduce demands upon Primary care Services

Diabetes The development of a more community based approach

Substance Misuse A continued emphasis on a recovery-based approach despite the significant service reductions required following the 23% cut in Scottish Government resources.

Learning Disability A full redesign of services is required to ensure their financial sustainability

Health Inequalities Despite the financial pressures it is vital that the Council and NHS Lothian continue to give this issue the highest priority.

Acute Hospital An acceleration of redesign is needed to reduce reliance upon acute hospitals in relation to both delayed discharge and preventable admissions.

4. Policy Implications

4.1 The requirement to issue Directions was considered and agreed by the IJB on the 10th December 2015 when a local policy was agreed.

5. Equalities Implications

5.1 The Strategic Plan has as one of its key objectives a commitment to address health inequalities. The Strategic Plan itself was subject to an Equality Impact Assessment on the 8th February 2016 and further changes were made to the Strategic Plan as a consequence.

6. Resource Implications

6.1 The resource implications of the Direction will be specified within the individual template outlining the details of each Direction

6.2 It is acknowledged that the financial context is both complex and challenging. The budgets for 2017-18 are not yet finalised. The process for decision- making about the allocation of hospital (set-aside) and hosted services to each of the Lothian IJBs is complex and not yet complete. More generally the challenges facing both NHS Lothian and Midlothian Council in trying to meet increasing demand with reducing budgets will be equally felt by the IJB in planning how to deliver health and social care services in Midlothian.

7 Risks

7.1 There are a range of risks associated with the establishment of the IJB and these are considered in a separate report on the agenda. The risk attached to the Directions issued by Midlothian IJB, are that they are not yet specific enough to ensure delivery. This risk will be managed through the Strategic Planning Core Group which will monitor closely the progress being made in these care areas of service redesign.

8 Involving People

8.1 The development of the Strategic Plan was underpinned by an extensive consultation and engagement programme with both staff and the public. The Directions flow from the Strategic Plan and have not been subject to a further process of 'involving people.

9 Background Papers

None

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DESIGNATION	Integration Manager
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DATE	06/03/2017

MIDLOTHIAN INTEGRATION JOINT BOARD:

DIRECTIONS TO MIDLOTHIAN COUNCIL AND NHS LOTHIAN 2017-18

31 March 2017

MIDLOTHIAN INTEGRATION JOINT BOARD:

DIRECTIONS TO MIDLOTHIAN COUNCIL AND NHS LOTHIAN 2017-18

1. POLICY CONTEXT

National Guidance: The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on Integration Authorities to develop a Strategic Plan for integrated functions and budgets under their control. In February 2016 Scottish Government issued a "Good Practice Note" about the application of Directions. This note confirmed that Directions must include detailed information on the financial resources that are available for carrying out the functions that are the subject of the directions. This requirement is reflected in the accompanying Directions issued to NHS Lothian and Midlothian Council.

Midlothian Policy: Midlothian IJB approved its Directions Policy on 10th December 2015. This policy stipulates that Directions will be issued for all the functions that have been delegated to the IJB and that these will show the disposition of all the resources allocated to it. It was also noted that monitoring systems for the delivery of Directions will be required by the IJB and by NHS Lothian and Midlothian Council.

Midlothian IJB's Approach to Directions 2017-18: The clarity to be achieved through Directions is important in ensuring there is no dubiety about how health and care services are to be provided including major service redesign objectives. The success of the new Integration arrangements is dependent upon effective joint working between the IJB, Midlothian Council and NHS Lothian and it is important that these Directions be considered and enacted in a genuine spirit of partnership. There is a clear commitment by the IJB not to create financial turbulence and instability in the delivery of direct services and during 2016-17 the Partnership has sought to work in close collaboration with both NHS Lothian and Midlothian Council to ensure that Directions are delivered without unintended consequences for other parts of the system. Nevertheless the IJB is moving into its second year of its existence and must now exercise clear and more decisive leadership in reshaping health and care services. This requires greater clarity and specificity about the changes to be made in the design and delivery of health and care services. As a general rule where economy of scale and clinical governance allows, the IJB intends to continue to move towards local management and local delivery of health services.

2. MIDLOTHIAN STRATEGIC PLAN

The Midlothian Strategic Plan 2016-19 outlines the direction of travel for the development of health and social care services in Midlothian. In many areas the Plan remains at a high level to allow further work to be undertaken with key partners about how to achieve the desired changes outlined in the Plan i.e. to reduce reliance on Acute Hospitals and Care Homes through strengthening Primary Care and Care at Home services. NHS Lothian and Midlothian Council are asked to develop and implement action plans which will enable the direction of travel outlined in the Strategic Plan to be realised with a particular emphasis on all services seeking to address Health Inequalities. The Council and NHS Lothian are also asked to fully engage in the development of approaches to realise the ambition of much stronger locality working, initially with a focus on services to older people.

Midlothian Integration Joint Board (IJB) must ensure that mechanisms are in place to action the Strategic Plan. A Transformation Board has been established to oversee a high level action plan. The other key mechanism takes the form of binding Directions as outlined below from the Integration Joint Board to one or both of NHS Lothian and Midlothian Council.

3. NHS LOTHIAN HOSPITAL PLAN

The key objective of integration- to shift the balance of care from hospital and care home provision-requires careful planning with the Acute Sector in collaboration with the other three IJBs operating within the area. As these plans are developed the IJB will require a better understanding of Midlothian's use of all set-aside resources (beds and outpatient facilities). Following this, new or updated Directions will be issued. This iterative approach should help to maintain the stability of service delivery and coherence about how the provision of acute hospital services develops across NHS Lothian working together on the finalisation and implementation of the Hospitals Plan.

4. NHS HOSTED SERVICES

Developing more locally responsive services which are currently hosted will demand a variable approach. Good progress has already been made in identifying opportunities to reorganise to enable more local, and more integrated management arrangements for some services such as Substance Misuse. For services which, on the grounds of economies of scale, such an approach is not considered viable, arrangements will be developed which strengthen a whole system approach within Midlothian. As these arrangements are developed, further Directions will be issued as appropriate. Until a greater degree of specificity has been developed NHS Lothian Hosted Services are asked to take due account of the general direction of travel described in the Strategic Plan.

5. FINANCIAL CONTEXT

The financial context for 2017-18 is a very challenging one with both NHS Lothian and Midlothian Council facing major financial pressures. It is also recognised that the initial proposals as to how best to allocate the Set Aside and Hosted Services budgets will require more detailed work to ensure parity but also take account of significant differences in need and in the availability of local resources. A key direction of travel will be to disinvest in institutional care including bed-based hospital care and care homes for older people.

6. PROVISION OF DIRECTIONS

These Directions are issued to provide as much clarity as possible about the changes which need to take place in the design and delivery of our services. As further plans are developed and funding allows, new or revised Directions will be issued during 2017-18. For those services which are not covered by a specific Direction the expectation is that NHS Lothian and Midlothian Council will continue to provide high quality services within current budgets, endeavouring to meet national and local targets and following the strategic objectives laid out in the Strategic Plan

All directions issued by the IJB are pursuant to Sections 26 to 28 of the Public Bodies (Joint Working) Act 2014 and the appropriate element of the Integration Scheme as detailed below:

- The IJB is constituted under Local Government regulations and, as such, under the Local Government in Scotland Act 2003, has a duty to make arrangements to secure best value – that is continuous improvement in the performance of functions. It is expected that NHS Lothian and Midlothian Council will deliver the functions as directed in the spirit of this obligation.

- The financial values ('budgets') attached to these Directions (see summary on pages 68-69) are based on the offers made to the IJB by NHS Lothian and Midlothian Council in March 2017. It is understood that the finalisation of the 2017/18 financial plans by both partners continues and that the totality of these budgets include efficiency schemes which are being developed. At this time, it is recognised that financial plans for 2018/19 are not yet available. That said, and, not withstanding the indicative nature of these budgets, the IJB cannot sanction expenditure in excess of these amounts without further discussion.

Direction 1:	Midlothian Community Hospital
Direction 2	Liberton Hospital
Direction 3:	Unscheduled care
Direction 4:	Primary Care
Direction 5:	Community Services to Older People
Direction 6:	Prescribing
Direction 7:	Learning Disability services
Direction 8:	Community-based Mental Health Services
Direction 9:	Substance Misuse Services
Direction 10:	Services to Unpaid Carers
Direction 11:	Utilisation of I.C. Fund; Delayed Discharge and Social Care Funding
Direction 12	Resource Transfer Funds
Direction 13	Social Care services
Direction 14	Other Core and Hosted NHSL Services
Direction 15	NHSL Services through Set-Aside Funds
Direction 16	Diabetes Services
Direction 17	Health Inequalities
Direction 18	Palliative Care
Direction 19	Public Engagement

7. IMPLEMENTING THE DIRECTIONS

The Transformation Board will maintain an overview of progress with the implementation of the Directions. If either Partner has difficulty in implementation of any Direction they must inform the Chief Officer as soon as possible. It is critical that lead operational managers take responsibility for the development of implementation plans and these should be submitted to Eibhlin McHugh Chief Officer by 15th May 2017.

Midlothian IJB

Direction 1 – Midlothian Community Hospital (MCH)

1	Date	1st April 2017
2	Reference number	MHSCPD1
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	Extend the services provided in MCH to improve local access. These services will include the relocation of services from Liberton (see Direction 2) and may also include the provision of more outpatient clinics, day treatment and the reduction of delays in acute hospitals
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes –Direction 1 2016-17
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	NHS (Scotland) Act 1978
10	What is to be done?	1 Plan the relocation of Liberton Hospital services (see Direction 2) 2 Review with the NHSL Outpatient Board which services could be provided in MCH including through video conferencing. 3. Develop closer working relationships between MCH and Newbyres Care Home.
11	How is it to be done? (Reference to services?)	The relocation of services from Liberton Hospital will be managed by the pan-Lothian Steering Group. The development of enhanced community services

		will be planned by the Joint Older People's Management Group
12	For integrated functions, who is to do it (council, health board, both)?	Led primarily by Midlothian Health Manager and NHS Lothian. Some collaboration will be required with Midlothian Council for any developments in relation to rehabilitation, day care etc.
13	If given to both, who does what? Singly or together?	n/a
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Local Access Promotion of Recovery Coordinated Care
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	

18	The information to be provided back and when	Progress to be reported to Strategic Planning Group and IJB
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	While the primary objective is to improve access and joint working at a local level the expectation is that any changes implemented will not result in increased costs.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	The availability of clinics in MCH may be of use to people in both East Lothian and South East Edinburgh.

Midlothian IJB

Direction 2 – Liberton Hospital

1	Date	1st April 2017
2	Reference number	MHSCPD2
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	Move resource associated with 24 beds in Liberton Hospital to health and social care services managed operationally by the Midlothian Partnership
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes Direction 2 2016-17
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Hospital set-aside
9	**Function(s) concerned, including statutory reference(s)**	Inpatient hospital services relating to the following branches of medicine— (a) general medicine; (b) geriatric medicine; (c) rehabilitation medicine;
10	What is to be done?	20 East Lothian beds in Midlothian Community Hospital transferred in to ELIJB Services. 20 beds in Liberton to be transferred to MCH Resources transferred from Liberton to Midlothian Partnership to replace 24 beds in Liberton

11	How is it to be done? (Reference to services?)	To be managed by pan-Lothian Group with a clear effective 'Communication Strategy' for Primary Care, Acute Hospitals and the Public
12	For integrated functions, who is to do it (council, health board, both)?	While primarily a transfer of health services from Liberton to Midlothian there will be some need to strengthen social care services to support patients who will receive rehabilitation in their own homes rather than in Liberton.
13	If given to both, who does what? Singly or together?	The re-provision of beds to Midlothian Community Hospital will be managed by the Midlothian Health Management Team. The strengthening of community services will be undertaken jointly by NHSL and Midlothian Council
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Promotion of Recovery Coordinated Care Local Access

17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress to be reported to Strategic Planning Group and Project Plan to be reported to IJB
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	The expectation is that the total cost of the combined model of community based and inpatient service will be less than the cost of providing this service in Liberton Hospital.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	Lothian wide implications and therefore being managed through a Project Board involving Edinburgh, East and Midlothian and NHS Lothian

Midlothian IJB

Direction 3 – Unscheduled Care

1	Date	1st April 2017
2	Reference number	MHSCPD3
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	In keeping with the primary objective of integration- to shift the balance of care away from hospitals- any further investment in Unscheduled Care should not be progressed without discussion with the Midlothian IJB. There may be more effective ways available to community and hospital services to utilise the existing budgets. In this regard Midlothian Council and NHS Lothian are asked to review the recent (2013-2015) investments made by the Unscheduled Care Board to determine whether the resources could be applied to better effect to reduce further the numbers of patients from Midlothian being admitted to acute hospitals on an emergency basis.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes-Direction 3 2016-17
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan and for NHS Lothian in being able to manage the demands on the hospital system
8	Type of function (integrated function or hospital set-aside)	Hospital set-aside
9	**Function(s) concerned, including statutory**	Inpatient hospital services-general, accident and emergency, geriatric, rehabilitation, respiratory and therapies

	reference(s)	
10	What is to be done?	**1** Review the services financed through Unscheduled Care funds and report back to the IJB. The objective is to identify additional funding to expand the MERRIT Service **2** Develop clear plans to deploy more AHPs from Acute Settings to the community to support hospital discharge **3** Consideration should be given to the possible case for reducing the provision of acute medical receiving services to one Unit for Edinburgh East Lothian and Midlothian This will entail reviewing different models including the development of an ambulatory care model in the RIE. The IJB does not support the recent proposal for the expansion of beds in the AMU in light of the Partnership's commitment to reduce unscheduled beds. **4** Midlothian H&SCP and NHS Lothian should work together to explore the feasibility and benefits of developing a locality based admission policy for frail elderly patients. The intention of this work is that a new pathway is established for Midlothian frail elderly patients who would receive care just in the RIE instead of the RIE and the WGH and this would improve patient experience and outcomes and improve patient flow in hospital'
11	How is it to be done? (Reference to services?)	NHS Lothian and Midlothian Council to provide evaluation reports on services funded during the period 2014-16 through Unscheduled Care monies to evidence impact and identify any alternative options for providing more effective service responses
12	For integrated functions, who is to do it (council, health board, both)?	Led primarily by Midlothian Head of Health Services Manager and NHS Lothian.
13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

		Resources are used effectively and efficiently in the provision of health and social care services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Local Access Promotion of Recovery Coordinated Care
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress to be reported to Strategic Planning Group Project Plan to be reported to IJB
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	While the primary objective is to improve access and joint working at a local level the expectation is that any changes implemented will not result in increased costs
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	Any changes in hospital based services will need to be planned in a way which has minimal impact upon services planned by other IJBs

Midlothian IJB

Direction 4 – Primary Care

1	Date	1st April 2017
2	Reference number	MHSCPD4
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The current pressures on Primary Care alongside the additional demands arising from a rapidly growing and ageing population mean it is essential that both the Council and NHS Lothian invest in and develop new approaches to the provision of primary care services. The over-riding objective of integration to "Shift the Balance of Care" is very dependent on our collective capacity to strengthen community based health and wellbeing services.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes –Direction 4 2016-17
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	District nursing services Allied Health Professions services General dental services Primary medical services

		General ophthalmic services General pharmaceutical services
10	What is to be done?	Wellbeing Services should be fully established and evaluated across 8 GP Practices Skill mix should be enhanced with a particular emphasis on pharmacy A Public Education Programme should be delivered to ensure the public "use services wisely" building on the work undertaken in 2016-17 The GP Cluster arrangements should be fully implemented. The new GP Practice in Newtongrange should be fully established The Midlothian Primary Care Strategy should be finalised (May 2017) and then implemented The development of Anticipatory Care Planning should be prioritised The Partnership will develop a plan to utilise the additional monies ring-fenced for developments in Primary care by NHS Lothian and any other monies provided by Scottish Government
11	How is it to be done? (Reference to services?)	The changes should be managed by the GP Management Group working closely with local Practice Forum. The development of Wellbeing Services should be coordinated by the local *House of Care* Steering Group
12	For integrated functions, who is to do it (council, health board, both)?	Both
13	If given to both, who does what? Singly or together?	Together

14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Local Access Promotion of Recovery Coordinated Care Self Management Community Based Care
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	

19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	While the primary objective is to improve access and joint working at a local level the expectation is that any changes implemented will not result in increased costs.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	Any changes in hospital based services will need to be planned in a way which has minimal impact upon services planned by other IJBs and enable the Acute Hospital Services to remain stable during the period of transition to community based services.

Midlothian IJB

Direction 5 – Community Services to Older People

1	Date	1st April 2017
2	Reference number	MHSCPD5
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	In order to accelerate the shift in the balance of care there is a need to develop community based services to strengthen the capacity of the voluntary sector, care at home services; intermediate care; and care home provision. It is also essential that work be undertaken to revise our approach to commissioning care homes alongside the full establishment of the redesigned Newbyres and the development of extra care housing
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes
7	Is it considered to be significant and outside the SP, or within?	Managing the impact of demographic changes is the key driver for integration and a major issue in the Midlothian Strategic Plan.
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	Social Work (Scotland) Act 1968 District Nursing Services Services provided outwith hospital to geriatric medicine
10	What is to be done?	1. Midlothian Council is asked to continue to reshape Newbyres Care Home to ensure it is able to meet the shift towards providing care services to people at the more advanced stages of dementia and end

		of life care. This will require the support of NHS Lothian in the provision of nursing and specialist support services. 2. Midlothian Council and NHS Lothian are asked to continue to give high priority to the strengthening of the intermediate care facilities in Highbank Care Home including the possibility of capital works being required. 3. Rehabilitation and Reablement are critical to supporting the emphasis on prevention and reducing unnecessary dependency on health and care service. The Reablement Services should be reviewed to determine what scope there is to improve its effectiveness through investment in capacity and/or redesign of processes. 4. Midlothian Council and NHS Lothian should make tangible progress in developing strong partnership working at local levels. 5. The approved policy on extra care housing should be progressed as quickly as possible 6. A full review of our approach to care homes should be undertaken within the wider national context 7. The work commenced in 2016-17 to review of how care at home services are commissioned and delivered should be completed. This should result in services which deliver high quality of care, long term sustainability and areable to fully participate in a multi-agency locality based approach.
11	How is it to be done? (Reference to services?)	These changes will be managed by the Joint Older People's Management Group and the Newbyres Project Board
12	For integrated functions, who is to do it (council, health	Both

	board, both)?	
13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Makes the best use of the available facilities, people and other resources Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Local Access Promotion of Recovery Coordinated Care
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress to be reported to Strategic Planning Group

19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	While the primary objective is to improve access and joint working at a local level the expectation is that any changes implemented will not result in increased costs
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	Any resulting changes in hospital based services will need to be planned in a way which has minimal impact upon services planned by other IJBs.

Midlothian IJB

Direction 6 – Prescribing

1	Date	1st April 2017
2	Reference number	MHSCPD6
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The continuing financial pressures on the prescribing budget are a major concern to the IJB. Midlothian should receive its appropriate share of the additional £2m in the NHS Lothian budget to develop prescribing schemes and de-prescribing initiatives. The Partnership should implement its local Prescribing Plan
6	Does it supersede or amend or cancel a previous Direction? If so, specify	No
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan given the financial risks.
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	
10	What is to be done?	NHS Lothian should implement measures which will support the reduction is spend. These will include “Script Switch”; the promotion of improved self-management through Wellbeing Services; the strengthening of pharmacy support in Health Centres and the provision of better information to patients

		on the efficacy of drugs.
11	How is it to be done? (Reference to services?)	The work will be led by a local Management GP in conjunction with the Clinical Director and Head of Health and supported by the Lothian Prescribing Forum.
12	For integrated functions, who is to do it (council, health board, both)?	Both
13	If given to both, who does what? Singly or together?	Singly for direct work on prescribing and together for Wellbeing services
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Promotion of Recovery Coordinated Care

17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress to be reported to the Practice Reps Forum
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	The primary objective is to find approaches which help control expenditure given the very high resources used in this area and the fact that it is a demand-led budget.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	In view of the risk sharing arrangements which apply in this area of expenditure all IJBs have a strong interest in the effectiveness of measures introduced in Midlothian

Midlothian IJB

Direction 7 – Learning Disability Services

1	Date	1st April 2017
2	Reference number	MHSCPD7
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The high costs of existing services and growing numbers of children with complex needs moving into adult services means it is critical we design service models which are financially sustainable. Much work is already underway to develop new housing models and the planned opening of the Complex Care Development in Penicuik The key task now is to focus on how best to design services for people with high levels of need with some 37 individuals, accounting for over £5million, currently supported in single intensive care packages in the community. These services must be high quality, financially sustainable and creates the environment that ensures social care staff are appropriately supported to deliver quality care.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	No
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated Function

9	**Function(s) concerned, including statutory reference(s)**	Social Work (Scotland) Act 1968
10	What is to be done?	**1.** The establishment of a fully integrated Midlothian Learning Disability Service to strengthen the capacity of services to support people with complex needs through the development of new models of care and improvements in the planning and co-ordination of care delivery. This will include professionals working together with a focus on designing and implementing person centred models of care and ensuring sustainability by making more effective use of assistive technology and working with service providers to better support the social care workforce. **2.** A programme of case review to support the implementation of new models of care and ensure an equitable and sustainable allocation of resources across people who use services. **3.** Plans will also be implemented to resettle the remaining 3 patients in learning disability hospital care with the commensurate transfer of resources to community services. **4.** 4. Midlothian will need access to 2 beds in the NHSL assessment and treatment service. Community Team management and budget should shift to Midlothian by April 2017 to include nursing and AHPs. The preference is that local professional leadership should sit within Midlothian but there is recognition that further dialogue is needed; psychiatry for instance should remain a pan Lothian team within the MCN. **5.** The Midlothian share of the pan Lothian Challenging Behaviour Team should be used to augment the Community Team. **6.** There is a need to maintain pan Lothian approach to Forensic Team, Epilepsy Team and Acute Hospital Liaison team. The Midlothian share

		of the housing support element of the Forensic Service should be transferred to the Partnership's budget. **7.** We are unclear how Mental Health Liaison Service benefits Midlothian patients and are minded to seek the transfer of Midlothian's share of the resource to the Partnership **8.** Midlothian is about to open its own complex care unit in Penicuik and therefore do not wish to pursue the pan Lothian proposal for the development of a 12 person complex unit. Midlothian's share of the NHS funding identified to support this development should be made available to strengthen local services to manage the needs of people whose needs are complex. **9.** Primrose Lodge which is located in Loanhead should be considered for possible development of services for PMLD coming through transition. This would enable Midlothian to develop a local service utilising its share of Murray park resources. **10.** There should be no change to Midlothian's indicative share of the NHSL Learning Disability budget without discussion with the local Partnership **11.** As the current institutional Learning Disability Services are decommissioned a clear and transparent mechanism will require to be put in place to transfer the appropriate proportion of the budget to the Partnership.
11	How is it to be done? (Reference to services?)	Local developments will be managed by the Joint learning Disability Planning Group while links will be maintained with the Lothian wide Collaborative Group
12	For integrated functions, who is to do it (council, health board, both)?	Both

13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Makes the best use of the available facilities, people and other resources Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Local Access Promotion of Recovery Coordinated Care
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	To be managed by the Joint learning Disability Management Group and reported to the Strategic Planning Group

19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	This is one of the highest risk areas in relation to spend. A primary objective is to bring more control and greater emphasis on cost effective models of care
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	Use of NHSL Assessment Beds will require cooperative working across the 4 IJBs.

Midlothian IJB

Direction 8 – Mental Health

1	Date	1st April 2017
2	Reference number	MHSCPD8
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The primary objective for improving services in Mental Health is to strengthen access to a wide range of psychological support to improve prevention and in recognition of the high numbers of people with common mental health problems (In total 17.8% of the population are on medication for anxiety/depression/psychosis). Greater emphasis should be given to improving access through the development of the *Gateways* approach, by extending social care supports, and by reviewing and reshaping the delivery of psychological therapies.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes –Direction 8 2016-17
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	Mental Health (Care and Treatment) (Scotland) Act 2003

10	What is to be done?	**1.** The new services introduced in 2016-17 should be evaluated. These include services funded through the Innovation Fund, the 3 streams of the National Mental Health Fund and monies applied for through Primary Care Transformation alongside the Wellbeing Services introduced through the House of Care and the Community Health Inequalities Team which are contributing to the support network for people with low level mental health problems. Specifically the development of the Mental Wellbeing Access Point should be evaluated as part of our strategy to improve access to community based health and care services including psychological therapies . **2.** There is a need to develop a more robust approach to responding to people in crisis particularly out of hours, building on the work already undertaken with the Police **3.** Alongside this alternative approaches to speeding up access to Psychological Therapies should be introduced. This activity should be led and managed by the local Joint Mental Health Strategic Planning Group through a service transformation programme that provides access to a full range of timely interventions to the local population. **4.** While services are already well integrated further work is needed to strengthen joint work with substance misuse services. This is not just a matter for health and social work; the third sector is critical. Co-location will be helpful to this objective if this can be achieved. **5.** There is also a need to develop a more robust approach to responding to people in crisis building on the work already undertaken with the Police. **6.** In relation to acute services there is a pressing need to review the placement of Midlothian patients in the Royal Edinburgh; it is vitally

		important that hospital and community staff work effectively together and this is best achieved if Midlothian patients are treated in the Midlothian/East Lothian ward. Currently this is not being consistently achieved. There is also a need to review Midlothian's use of rehabilitation beds and other specialist services in light of the RE Hospital. **7.** More broadly mental health is a major feature of our strategic direction and service delivery in Midlothian. As a consequence, planning service redesign will be managed by the local Partnership whilst working with other IJBs to design and implement new approaches to specialist pan-Lothian services including the Royal Edinburgh. Midlothian will not be participating in the development of a pan-Lothian *Sense of Belonging 2* Strategy. Midlothian's share of strategic resources for mental health should be directed to the Partnership during 2017-18
11	How is it to be done? (Reference to services?)	These changes should be managed through the local Joint Mental Health Planning Group
12	For integrated functions, who is to do it (council, health board, both)?	Local NHS Lothian Services, NHS Psychology Service and Midlothian Council
13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users 6Improves the quality of the service

		Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Local Access Promotion of Recovery Coordinated Care
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress to be reported to Strategic Planning Group Project Plan to be reported to IJB
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	While the primary objective is to improve access and joint working at a local level the expectation is that any changes implemented will not result in increased costs.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	Any changes in Psychology Services will need to be planned in a way which has minimal impact upon services planned by other IJBs.

Midlothian IJB

Direction 9 – Substance Misuse Services

1	Date	1st April 2017
2	Reference number	MHSCPD9
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The priority being given to "recovery" should be maintained through progress being made in establishing Recovery Hub(s). Alongside this Midlothian Council and NHS Lothian should move towards more integrated and locally managed arrangements for specialist community based services involving the Third Sector providers as appropriate.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes –Direction 9 2016-17
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	Services provided outwith a hospital in relation to an addiction or dependence on any substance Social Work Scotland Act 1968
10	What is to be done?	**1.** In light of reducing budgets for Substance Misuse the IJB supports the plans as laid out by MELDAP. **2.** It is vital that despite this difficult climate that services which support

		recovery are strengthened. This will include rolling out existing models of peer support through both the recovery network model and work being undertaken in Health Centres. **3.** Integration should be pursued to ensure key services work effectively together. This is not just a matter for health and social work; the third sector is key and links with the mental health services are vital. Co-location will be helpful to this objective if this can be achieved. **4.** Midlothian's pro-rata share of funds relating to substance misuse will be used to redesign the Substance Misuse Directorate services moving service delivery into the Partnership and reducing the use of "central" bed-based services such as the Ritson Clinic. ➢ The capacity of community substance misuse services to deliver community based detox should be strengthened. ➢ An increased proportion of resources will be directed towards prevention –including harm-reduction and recovery-based services. **5.** Midlothian Council and NHS Lothian should work together to support the establishment of a Community Recovery Hub and the co-location of integrated mental health and substance misuse services
11	How is it to be done? (Reference to services?)	The redesign and rebalancing of services will be undertaken by MELDAP and reported to the Strategic Planning Group. Operational integration will be designed and led by Heads of Service
12	For integrated functions, who is to do it (council, health board, both)?	Both

13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services People using health and social care services are safe from harm
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Local Access Promotion of Recovery Coordinated Care
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Report on realigned budget back to the Strategic Planning Group and to

		MELDAP. Report on developments in relation to recovery reported back to MELDAP and to the Strategic Planning Group Options in relation to co-location to be managed through Joint Management Team
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	We know that too high a proportion of our resources are spent on treatment. A stronger focus on both prevention and promotion of recovery should in the long term be a more cost effective approach.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	No impact

Midlothian IJB

Direction 10 – Services for Unpaid Carers

1	Date	1st April 2016
2	Reference number	MHSCPD10
3	Date of IJB meeting at which Direction was authorised	31st March 2016
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	Unpaid Carers are the cornerstone of our health and care system. Identification and support must be a priority for all our services. The new Carers Legislation should be a catalyst for Midlothian Council and NHS Lothian to review and strengthen their focus on unpaid care without which the objective of "Shifting the Balance of Care" will not be realised.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes –Direction 10 2016-17
7	Is it considered to be significant and outside the SP, or within?	Key issue in the Midlothian Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	Community Care and Health (Scotland) Act 2002 Social Care (Self-Directed Support) (Scotland) Act 2013
10	What is to be done?	The new local Carers Strategy should be implemented addressing key issues such as income, employment and health and wellbeing. A system of emergency planning for carers should be designed and

		implemented ensuring that all key agencies- GPs, Social Workers, specialist teams e.g. Dementia, MERRIT-and Acute Hospital staff. Links should be made as appropriate with existing Anticipatory Care Planning systems. An implementation plan for the new Carers legislation should be developed and put in place.
11	How is it to be done? (Reference to services?)	The development will be led by the joint Carers Strategy Group and then implemented through operational teams.
12	For integrated functions, who is to do it (council, health board, both)?	Both
13	If given to both, who does what? Singly or together?	
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services People using health and social care services are safe from harm
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from	Coordinated Care

	the Strategic Plan	
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Report on numbers of carers identified System of managing emergency planning
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	If unpaid carers are supported and empowered to be an active partner in the provision of health and care services then there is evidence that this will reduce emergencies and enable carers to fulfil their caring role for longer. This in turn supports the move to reduce unnecessary dependency on statutory services.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	No direct impact on other IJBs

Midlothian IJB

Direction 11 – Utilisation of Specific Funding Streams-Delayed Discharge; Integrated Care Fund; Social Care

1	Date	1st April 2017
2	Reference number	MHSCPD11
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The Government has allocated new monies to enable the process of transformation. These include Integrated Care Fund and the Delayed Discharge Fund introduced in 2015 and more recently Social Care monies and funding to facilitate the transformation of Primary Care. Plans for the utilisation of these monies have been agreed and are in various stages of implementation. These monies are the vehicle for supporting the redesign of health and care services. In this regard it is recognised that there will need to be fluidity to allow opportunities to learn and adjust these developments. Midlothian Council and NHS Lothian are asked to ensure that the monies continue to be applied with the objectives of reducing delayed discharge; addressing the needs of people with long term health conditions; and strengthening preventative service delivery. This will require both organisations to take an active role in monitoring and adjusting the application of these monies in light of experience and new opportunities.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	No

7	Is it considered to be significant and outside the SP, or within?	These monies are critical to the success in implementing the Midlothian Strategic Plan.
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	All functions
10	What is to be done?	The Partnership should develop detailed plans about the proposed utilisation of these funds
11	How is it to be done? (Reference to services?)	The Strategic Planning Core Group has been recast as the Health and Social Care Transformation Board and will have primary responsibility for ensuring these monies are applied to best effect. It is recognised that Scottish Govt. has issued clear instructions about the use of the Social care monies in relation to such burdens as meeting the Living Wage objective.
12	For integrated functions, who is to do it (council, health board, both)?	Both
13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services People using health and social care services are safe from harm

15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Transformation; Community based care Local Access Promotion of Recovery Coordinated Care Self-Management
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	A systematic approach to regular monitoring of all services funded through new monies will be required. This will be particularly important for those services which are not yet established as effective and key components of the local health and social care system.
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	Many of these services will be provided through arms length organisations and will therefore be subject to the established approaches to contract monitoring. The same vigilant approach must be applied to all services funded through new monies and decisive action taken to redirect monies as required.
21	Relevance to or impact on other Lothian IJBs and/or	For the most part the developments are local and therefore of minimal impact on other IJBs. However those services intended to have an impact upon our

	other adjoining IJBs	use of Acute Hospitals will need to be managed in such a way as to avoid any unnecessary complications for hospital staff working to very different approaches across the 4 Lothian IJBs.

Midlothian IJB

Direction 12 – Resource Transfer Funds

1	Date	1st April 2017
2	Reference number	MHSCPD12
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	Resource Transfer monies were provided by NHS Lothian to enable community based services- particularly social care services- to be strengthened and thereby enable the reduction on the reliance of long stay inpatient services. The Council remained accountable to NHS Lothian for its application of Resource Transfer monies. The new context of the Council and NHS Lothian providing services under the direction of the Integration Joint Board means this transactional relationship is no longer appropriate.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes Direction 12 -20216-17
7	Is it considered to be significant and outside the SP, or within?	Outside the Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated
9	**Function(s) concerned, including statutory reference(s)**	Wide range of functions relating primarily to older people, dementia, learning disability and mental health

10	What is to be done?	Accountability for the application of these monies should now be treated in the same way as the use of all other resources deployed by the Council and NHS Lothian on behalf of Midlothian IJB. i.e.: • They should be utilised in ways which are consistent with the Strategic Plan. • Every effort should be made to identify potential savings through more efficient ways of working.
11	How is it to be done? (Reference to services?)	n/a
12	For integrated functions, who is to do it (council, health board, both)?	Council and NHS Lothian
13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	All National Outcomes are relevant
15	Relevant Integration Delivery Principles	All Integration Delivery Principles are relevant
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	The Strategic Plan should be treated as the context for the delivery of Council Social Care Services
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress to be reported to Strategic Planning Group
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	While this Direction removes the need for formal accountability between Midlothian Council and NHS Lothian, it remains vital that these monies are subject to a rigorous scrutiny to ensure that the Public Pound is maximised and every opportunity for efficiencies are pursued.

21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	No impact anticipated

Midlothian IJB

Direction 13 – Social Care Services

1	Date	1st April 2017
2	Reference number	MHSCPD13
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	Midlothian Council is asked to provide or commission effective and high quality social care services to all service users and carers in Midlothian. These services should be provided in a manner which meets the objectives and ways of working outlined in the Midlothian Strategic Plan In view of the continuing critical pressures on Social Care budgets the model of social care must be reframed as a matter of urgency. This will include more fully empowering and enabling service users and families to manage independently and gain access to community based services and supports. This will entail re-visting the approach to Self-Directed Support; Risk assessment; and Eligibility Criteria. The application of new technology and the role of the voluntary sector will be strengthened.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes Direction 13 2016-17
7	Is it considered to be significant and outside the SP, or within?	While some services will not be specified within the Strategic Plan these should nevertheless be provided in a way which is consistent with the philosophy and approaches described in the Plan.
8	Type of function (integrated function or hospital set-aside)	Integrated

9	**Function(s) concerned, including statutory reference(s)**	The functions are outlined in the Midlothian Integration Scheme Annex 2. The services to which these functions relate are as outlined below: • Social work services for adults and older people • Services for adults with physical disabilities and learning disabilities • Mental health services • Drug and alcohol services • Adult Protection and Domestic Abuse • Carers support services • Community Care assessment teams • Support services • Care home services • Adult placement services • Health improvement services • Aspects of housing support, including aids and adaptations • Day services • Local area co-ordination • Respite provision • Occupational Therapy services • Re-ablement services, equipment and telecare • Criminal Justice Social Work services
10	What is to be done?	Services should be provided in accordance with legislation, policies and procedures.
11	How is it to be done? (Reference to services?)	Unless specified in accompanying Directions services should continue to be

		provided to the same standards and volumes as has been the case in 2015-16 within the available budgets. However all services should seek to adopt the philosophy and key principles outlined in the Strategic Plan.
12	For integrated functions, who is to do it (council, health board, both)?	Council
13	If given to both, who does what? Singly or together?	Single – although every opportunity should be sought to strengthen partnership working in all areas of activity.
14	Relevant National Health & Well Being Outcomes	All National Outcomes are relevant
15	Relevant Integration Delivery Principles	All Integration Delivery Principles are relevant
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	The Strategic Plan should be treated as the context for the delivery of Council Social Care Services.
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress in service redesign to be reported to the Strategic Planning Group
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	In addition to the savings targets which apply to Council Services, every effort should be made to secure Best Value and secure efficiencies-given the general financial context and outlook.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	No direct impact is envisaged on other IJBs

Midlothian IJB

Direction 14 – Other Core and Hosted NHSL Services

1	Date	1st April 2017
2	Reference number	MHSCPD14
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	NHS Lothian is asked to provide effective and high quality health services to all service users and carers in Midlothian. These services should be provided in a manner which meets the objectives and ways of working outlined in the Midlothian Strategic Plan. All services should provide information on activity and outcomes for Midlothian patients.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	Yes Direction 14 2016-17
7	Is it considered to be significant and outside the SP, or within?	While some services will not be specified within the Strategic Plan these should nevertheless be provided in a way which is consistent with the philosophy and approaches described in the Plan.
8	Type of function (integrated function or hospital set-aside)	Integrated
9	**Function(s) concerned, including statutory reference(s)**	The functions are outlined in the Midlothian Integration Scheme Annex 1. The relevant services, including hosted services are as outlined below – these exclude services covered by more specific Directions 1.Primary medical services during out-of-hours (East Lothian) (see Direction 4)

		2.Geriatric medicine services provided outwith a hospital 3. Palliative care services provided outwith a hospital.(see Direction 18) 4.Continence services provided outwith a hospital. 5.Kidney dialysis services provided outwith a hospital. 6.Services provided that aim to promote public health.(see Direction 17) 7.Health Visiting 8.School Nursing 9.Dietetics (Midlothian) 10. Art Therapy (Midlothian) 11. Integrated Sexual and Reproductive Health service (Edinburgh) 12. Continence Services (Edinburgh) 13. Public Dental Service (West Lothian) 14. Podiatry (West Lothian) 15. Orthoptics (West Lothian) 16. SMART Centre (Edinburgh) 17. Royal Edinburgh and Associated services (See Direction 8) 18. Specialist Substance Misuse Services-LEAP, Ritson Clinic and Harm Reduction (See Direction 9)
10	What is to be done?	Services should be provided in accordance with legislation, policies and procedures.
11	How is it to be done? (Reference to services?)	Unless specified in accompanying Directions services should continue to be provided to the same standards and volumes as has been the case in 2015-16 within the available budgets. However all services should seek to adopt the

		philosophy and key principles outlined in the Strategic Plan.
12	For integrated functions, who is to do it (council, health board, both)?	NHS Lothian
13	If given to both, who does what? Singly or together?	Single – although every opportunity should be sought to strengthen partnership working in all areas of activity
14	Relevant National Health & Well Being Outcomes	All National Outcomes are relevant
15	Relevant Integration Delivery Principles	All Integration Delivery Principles are relevant
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	The Strategic Plan should be treated as the context for the delivery of NHS Lothian Services to the people of Midlothian.
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	Progress in the delivery of service redesign should be reported to the Strategic Planning Group.
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	In addition to the savings targets which apply to NHS Lothian Services, every effort should be made to secure Best Value and seek out efficiencies-given the general financial context and outlook.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	No direct impact is envisaged on other IJBs

Midlothian IJB

Direction 15 – NHSL Set-Aside Services except Unscheduled Care

1	Date	1st April 2017
2	Reference number	MHSCPD15
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	NHS Lothian is asked to provide effective and high quality health services to all service users and carers in Midlothian. These services should be provided in a manner which meets the objectives and ways of working outlined in the Midlothian Strategic Plan.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	n/a
7	Is it considered to be significant and outside the SP, or within?	While some services will not be specified within the Strategic Plan these should nevertheless be provided in a way which is consistent with the philosophy and approaches described in the Plan.
8	Type of function (integrated function or hospital set-aside)	Set-Aside
9	**Function(s) concerned, including statutory reference(s)**	The functions are outlined in the Midlothian Integration Scheme Annex 1. The services to which these functions relate are as outlined below and exclude services which relate to Unscheduled Care: 1.General medicine 2.Geriatric Medicine (see Direction 3) 3.Rehabilitation Medicine 4.Respiratory Medicine

		5.Psychiatry of Learning Disability (see Direction 7) 6.Palliative Care provided in Hospital 7.Services provided in a hospital in relation to an addiction or dependence on any substance 8.Mental health services provided in a hospital except secure forensic mental health services (see Direction 8)
10	What is to be done?	Services should be provided in accordance with legislation, policies and procedures.
11	How is it to be done? (Reference to services?)	Unless specified in accompanying Directions services should continue to be provided to the same standards and volumes as has been the case in 2015-16 within the available budgets. However all services should seek to adopt the philosophy and key principles outlined in the Strategic Plan.
12	For integrated functions, who is to do it (council, health board, both)?	NHS Lothian
13	If given to both, who does what? Singly or together?	Single – although every opportunity should be sought to strengthen partnership working in all areas of activity
14	Relevant National Health & Well Being Outcomes	All National Outcomes are relevant
15	Relevant Integration Delivery Principles	All Integration Delivery Principles are relevant
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	The Strategic Plan should be treated as the context for the delivery of NHS Lothian Services to the people of Midlothian.
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	

18	The information to be provided back and when	Progress in the delivery of service redesign should be reported to the Strategic Planning Group.
19	Anything else considered necessary or desirable	n/a
20	Principles of Following the Public Pound	In addition to the savings targets which apply to NHS Lothian Services, every effort should be made to secure Best Value and seek out efficiencies-given the general financial context and outlook.
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	These services are shared by adjoining IJBs so service redesign must be planned in a coordinated way.

Midlothian IJB

Direction 16– NHSL Set-Aside Diabetes Services

1	Date	1st April 2017
2	Reference number	MHSCPD16
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	A community based approach should be developed drawing on best practice elsewhere. In the first instance a full analysis of current usage of Acute Hospital Services should be provided to inform the redesign of services towards a community based model.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	No
7	Is it considered to be significant and outside the SP, or within?	Within the Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Hospital Set -Aside
9	**Function(s) concerned, including statutory reference(s)**	
10	What is to be done?	Clinics should be undertaken in Midlothian and will require consultants to become more community-based. As 16% of acute hospital beds are occupied by people who have diabetes it

		should be possible to reduce bed numbers as preventative actions take effect. Resources should be redirected from Acute Hospital to community based services.
11	How is it to be done? (Reference to services?)	
12	For integrated functions, who is to do it (council, health board, both)?	NHS Lothian
13	If given to both, who does what? Singly or together?	
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources

16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Prevention Local Access Coordinated care Improved support for people with long term health conditions
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	
19	Anything else considered necessary or desirable	
20	Principles of Following the Public Pound	
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	

Midlothian IJB

Direction 17 – NHSL Health Inequalities

1	Date	1st April 2017
2	Reference number	MHSCPD17
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	NHS Lothian and Midlothian Council
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	It is vital that we sustain and where possible invest more resources in addressing health inequalities which is one the key priorities both of the IJB and the Midlothian Community Planning Partnership. The continuation of the Community Health Inequalities Team (CHIT) work in Midlothian (annual cost of approx £120k) is critical to improving performance in addressing inequalities in areas such as mental health, substance misuse and homelessness
6	Does it supersede or amend or cancel a previous Direction? If so, specify	No - new Direction
7	Is it considered to be significant and outside the SP, or within?	Key objective of IJB to address inequalities
8	Type of function (integrated function or hospital set-aside)	Integrated Function
9	**Function(s) concerned, including statutory reference(s)**	Public Health
10	What is to be done?	.A range of coordinated work will be undertaken with Community Planning Partners to address Inequalities. More specifically:

		• Community Services will work with the Royal Infirmary to develop a stronger pathway to local services and support for young adults attending the hospital. • Weight Management Programmes will be introduced to help address and prevent obesity and type 2 diabetes • Community Services willl work with specialist acute hospital staff to develop more locally based, preventative-focussed services in the field of diabetes • The Partnership willl work with Healthcare Improvement Scotland to evaluate the impact of the Wellbeing Service and the Community Health Inequalities Teams
11	How is it to be done? (Reference to services?)	The appropriate proportion of the NHS Lothian *Preventative Spend* budget should be allocated to the IJB to reflect the resources required to deliver this delegated function. The IJB will direct its share of these resources to support the CHIT team.
12	For integrated functions, who is to do it (council, health board, both)?	Council Services have a key role in addressing Inequalities. This Direction relates specifically to NHS Lothian in regard to prioritising spend
13	If given to both, who does what? Singly or together?	Both
14	Relevant National Health & Well Being Outcomes	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and

		social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Addressing Inequalities Transformation; Community based care Local Access Promotion of Recovery Self-Management
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	
19	Anything else considered necessary or desirable	
20	Principles of Following the Public Pound	
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	

Midlothian IJB

Direction 18 – Palliative Care

1	Date	1st April 2017
2	Reference number	MHSCPD18
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	Both
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The overall objective remains that of improving the quality of life of patients and their families facing the problems associated with any life-limiting illness, through the prevention and relief of suffering. This Direction is focussed upon the strengthening of community based palliative care in line with national requirement to double home based palliative care by 2020
6	Does it supersede or amend or cancel a previous Direction? If so, specify	No-new Direction
7	Is it considered to be significant and outside the SP, or within?	Priority of Strategic Plan although now has an increasing profile at a national level
8	Type of function (integrated function or hospital set-aside)	Integrated
9	**Function(s) concerned, including statutory reference(s)**	
10	What is to be done?	Strengthen partnership working between local nursing services, Marie Curie and care at home staff

		Strengthen care provided in care homes Strengthen bereavement support available within Midlothian Review the support provided to family carers
11	How is it to be done? (Reference to services?)	Delivery of local strategy through the Midlothian Palliative Steering Group and through close working with the Lothian Managed Clinical and Care Network
12	For integrated functions, who is to do it (council, health board, both)?	Both
13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are integrated from the point of view of service-users Improves the quality of the service
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	Care at Home Coordinated Care Support from carers
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	
19	Anything else considered necessary or desirable	
20	Principles of Following the Public Pound	

21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	

Midlothian IJB

Direction 19 – Public Engagement

1	Date	1st April 2017
2	Reference number	MHSCPD19
3	Date of IJB meeting at which Direction was authorised	31st March 2017
4	**To whom? (council, health board, both)**	Both
5	Purpose - a general statement and description of reasons/logic to give context and help understanding	The financial pressures on Health and Social Care are such that it is vital we develop much stronger collaboration with service users and communities to develop new solutions and more effective ways of working. There has been a strong tradition of public engagement: we must build on this and ensure that user involvement becomes a central plank of the redesign of health and care.
6	Does it supersede or amend or cancel a previous Direction? If so, specify	No-new Direction
7	Is it considered to be significant and outside the SP, or within?	Central Issue in Strategic Plan
8	Type of function (integrated function or hospital set-aside)	Integrated
9	**Function(s) concerned, including statutory reference(s)**	
10	What is to be done?	Design and Develop a Public Engagement Strategy
11	How is it to be done? (Reference to services?)	Planning Officers, Service Managers, and Communications Staff working in collaboration with the Communities Team and MVA should develop a plan for consideration and approval by the IJB

12	For integrated functions, who is to do it (council, health board, both)?	Both
13	If given to both, who does what? Singly or together?	Together
14	Relevant National Health & Well Being Outcomes	Resources are used effectively and efficiently in the provision of health and social care services Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
15	Relevant Integration Delivery Principles	Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care) Makes the best use of the available facilities, people and other resources
16	Relevant priorities, strategies, outcomes, PIs, etc., from the Strategic Plan	• Prevention • Self-Management • Good information • Early Intervention
17	How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.)	
18	The information to be provided back and when	
19	Anything else considered necessary or desirable	
20	Principles of Following the Public Pound	
21	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	

Midlothian Integration Joint Board

Directions Summary

	Indicative Budget 2017/18 £000's	Direction	Function(s)
Adult & Social Care			
Addictions			
Assessment and Care Management			
Criminal Justice			
Learning Disability Services			
Management and Administration			
Meldap			
Mental Health Services			
Non Specific Groups			
Older People			
People with AIDS/HIV			
Performance and Planning			
Physical Disability Services			
Public Protection			
Service Management			
Strategic Commissioning			
Health Services			
Core			
Community Hospitals			
Mental Health			
District Nursing			
Health Visiting			
Community AHPS			
GMS			
Prescribing			
Resource Transfer			
Delayed Discharge			
Social Care Fund			
Integrated Care Fund			
Other Core			
Hosted			
Sexual Health			
Hosted AHP Services			
Hosted Mental Health			
Rehabilitation Medicine			
Learning Disabilities			

Substance Misuse
Oral Health Services
Hosted Psychology Service
Complex Care
Lothian Unsched. Care Serv.
Other Hosted
Strategic Programmes

Set Aside
A & E (outpatients)
Cardiology
Diabetes
Endocrinology
Gastroenterology
General Medicine
Geriatric Medicine
Infectious Disease
Rehabilitation Medicine
Respiratory Medicine
Therapies/Management
Other

Total IJB

Midlothian Integration Joint Board

Thursday 16th March 2017 at 2.00 pm

Measuring Performance under Integration: Agreeing the IJBs Performance Measurements

Item number: 4.4

Executive summary

Board members are asked to:

- ***Consider and inform the emerging objectives for the Midlothian IJB to monitor progress using the indicators agreed by the Ministerial Strategic Group for Health and Community Care***

Report

Measuring Performance under Integration: Agreeing the IJBs Performance Measurements

1. Purpose

To present to the IJB the emerging draft objectives for the IJB to monitor progress against the indicators agreed by the Ministerial Strategic Group for Health and Community Care.

2. Recommendations

Discuss and agree the proposed objectives

3. Background and main report

3.1 The IJB received a short paper in February 2016 outlining the indicators that should be used by all IJBs to track progress. The Ministerial Strategic Group for Health and Community Care agreed that in 2017/18 progress by IJBs will be tracked across the following:

(1) Unplanned admissions;

(2) Occupied bed days for unscheduled care;

(3) A&E performance;

(4) Delayed discharges;

(5) End of life care; and

(6) The balance of spend across institutional and community services

3.2 IJBS have been asked to set local objectives for each indicator and to describe expected performance per quarter during 2017/18.

3.3 The IJB needs to consider its ambition for change across the system and ensure this is reflected in its objective for each target: An unambitious objective may fail to keep up within increasing demand on services from an ageing population but an overambitious objective may be impossible to deliver within system constraints. It is also important to consider the ownership of the objective because system-level change will require all parts of the system to be working towards this goal and share ownership of it.

3.4 Appendix one contains more detail on the proposed objectives for the Midlothian IJB and a presentation will be available at the IJB meeting to aid the discussion.

3.5 In summary the following objectives are proposed for the IJB to consider:

Reduce emergency admissions by 5% by September 2018
Reduce occupied bed days for adults for unscheduled care by 15% by April 2019
Increase performance in the 4 hour target to 87% for patients who are subsequently admitted into hospital by April 2018
Maintain current number of patients using A&E
Reduce by 11%* the delayed discharge bed days per month by September 2017 and have no patients in the RIE or the WGH with a delayed discharge of over 72 hours
Reduce the delayed discharge beds by 30% (deadline TBD) compared to the baseline
Reduce by 10% in the RIE and WGH the number of occupied bed days in the last six months of life
Reduce the % of patients aged 75+ who are in a large hospital from 1.7% to 1.5% (the Average in Scotland) by TBD
Reduce the % of people added 75+ who are in a care home from 6.9% to XXX by TBD

4. Policy Implications

4.1 These objectives should be seen alongside the IJB's Strategic Plan and its Directions. The objectives describe the pace that change will be happen across the system, the strategic plan describes our direction of travel and the directions describe how the changes will be made. Consequently these objectives have significant implications for IJB policies

5. Equalities Implications

5.1 There are no equalities implications from this report.

6. Resource Implications

6.1 There are resource implications to achieve these objectives. They will require new investment in community based services and will dictate the level of resource that can be transferred from hospital as use of hospital-based services reduces.

7 Risks

7.1 There is a risk that the IJB fails to set suitably ambitious objectives

8 Involving People

8.1 The trajectories and indicators will be developed by the Joint Management Team and will be discussed with the Strategic Planning Group

9 Background Papers

Appendix 1: Detail on the objectives

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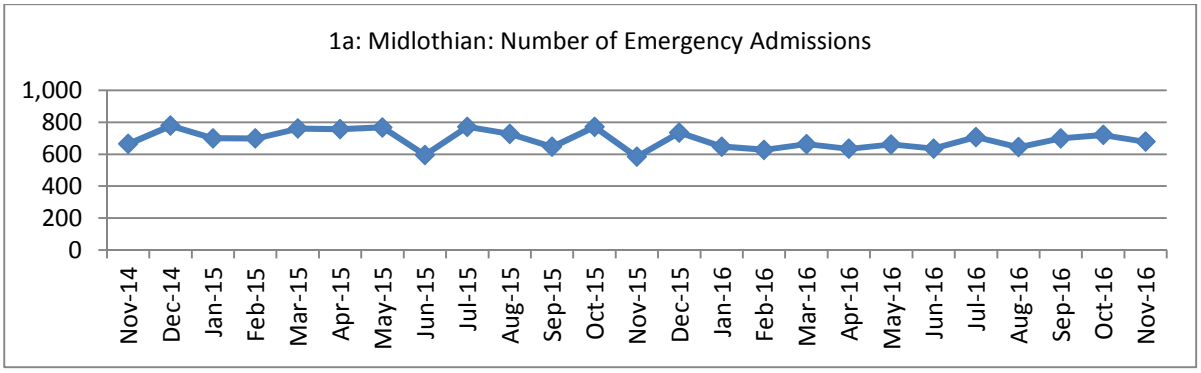
DATE	26/1/17

1. Unscheduled Admissions

1. Unscheduled Admissions (all adults admitted in to an acute hospital for an unplanned emergency admission)	Median performance reduced by 5% by September 2018 and demonstrated by control chart	Reduce emergency admissions by 5% by September 2018
Actions at IJB Level: 1. Reduce A&E attendances and admissions from Care Homes 2. Reduce out-of-hours admissions from LUCS through development of Out-of-hours services as per Ritchie 3. Reduce preventable admissions specifically for patients with COPD and Type 2 Diabetes 4. Reduce admissions relating to falls 5. Reduce admissions relating to frailty through improved anticipatory care supported by the efrailty project 6. Maximise capacity of the Hospital at Home service by 50%		

What this means for Midlothian?

There were 695 admissions per month on average per month in the last two years. A 5% reduction in this requires 35 fewer admissions per month.



Has this been achieved in the past?

There were five months in the last two years where the goal-level was attained (Jun 15, Sep 15, Nov 15, Feb 16, Jun 16).

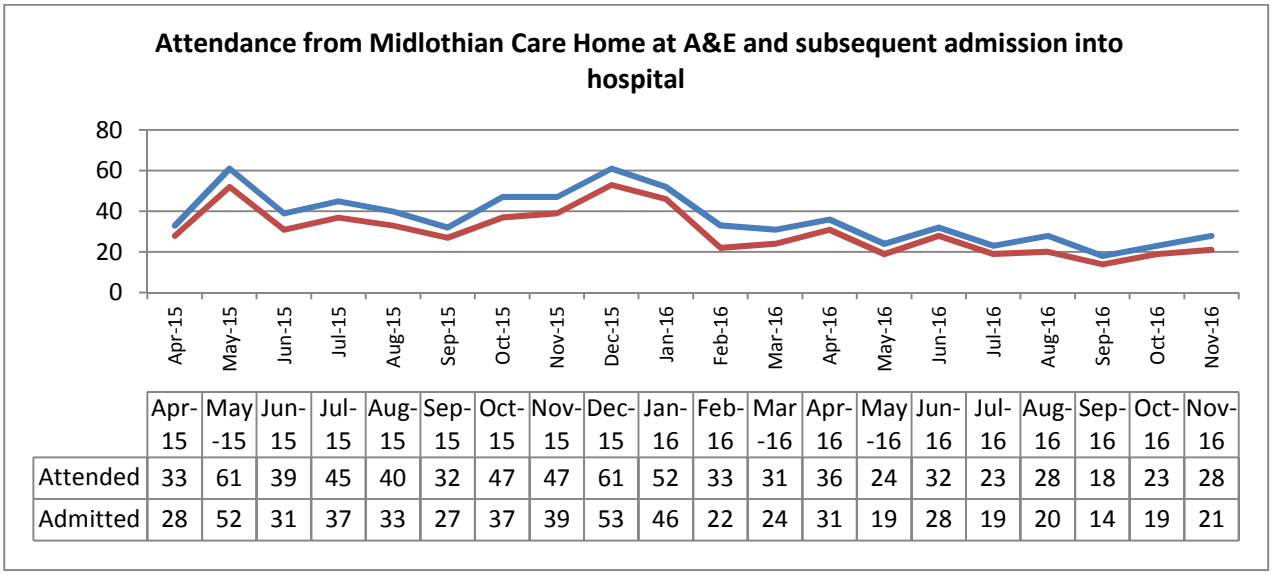
How achievable is this goal?

The population in Midlothian is increasing with the new house building so the potential number of admissions could be higher because there is larger population. However admissions are more likely from patients who are older and/or have multiple long term condition and this group is also increasing in number. Without action it should be expected that admissions will increase.

There are some identified patient groups where action is expected to reduce the number of hospital admissions:

Reduce A&E attendances and admissions from care homes.

The current data on A&E attendances and subsequent admission from a care home in Midlothian shows that on average there were 30 admissions per month from April 15 to Nov 16 (a similar time period to the benchmarking data provided by Scottish Government). There should be opportunity to reduce this by 5-10 admissions per month on average because some of the admissions could have been avoided if there was alternative support for the patient.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Attended	33	61	39	45	40	32	47	47	61	52	33	31	36	24	32	23	28	18	23	28
Admitted	28	52	31	37	33	27	37	39	53	46	22	24	31	19	28	19	20	14	19	21

Potentially Preventable Admissions

ISD Scotland provides detail on the number of potentially preventable admissions. In Midlothian for April 15 to March 16 there were 1682 admissions (source: DISCOVERY) which is on average 140 admissions each month. This is based on 19 ambulatory-care sensitive conditions that include asthma, diabetes complications and COPD.

A 20% reduction on PPA from Midlothian would reduce monthly admissions by 28.

Reducing admissions due to falls

ISD Scotland provides detail on the number of admissions dues to a fall. In Midlothian the average number of admissions per annum due to a fall was 531 (between 2013 and 2015) . This is an average of 44 admissions per month.

A 20% reduction in admissions due to a fall would reduce monthly admissions by 8 patients

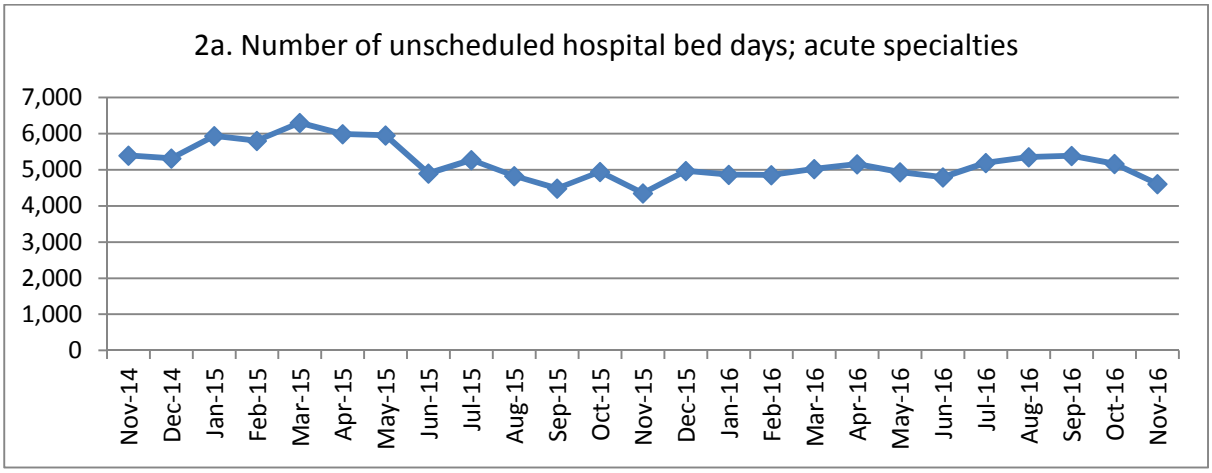
2. Occupied Unscheduled Care Bed Days

2. Occupied Bed Days Unscheduled Care (adults)	Median performance is reduced by 10% and demonstrated by control chart	Reduce OBD for adults for unscheduled care by 15% by April 2019
Actions at IJB Level: 1. Achieve a 5% reduction in emergency admissions as per objective 1 2. No delayed discharge in an acute hospital bed 3. Reduce the LOS for patients on an acute site through actions including locality-based admission policy for frail older patients and development of community services and facilities at Highbank and MLCH		

What this means for Midlothian?

There were 5,192 unscheduled occupied bed days on average per month over the last two years for Midlothian patients. This equates to 170 beds occupied per day by Midlothian patients.

A 15% reduction means there will be on average 770 fewer occupied bed days per month or 25 fewer occupied beds each day. It is a goal that is more ambitious than the Scottish Government's target of a 10% reduction across Scotland



Has this been achieved in the past?

No. Midlothian performance has not achieved the potential goal in any month in the last two years.

How achievable is this goal?

It is an ambitious goal for the IJB but a reduction is required if activity and resource are to transfer from hospital to community. Specific actions identified may reduce the daily occupied beds by 14.

There are some identified patient groups where action is expected to reduce the number of occupied bed days.

Actions that reduce unscheduled admissions

All actions described in the previous section will reduce the number of occupied bed days but some are difficult to quantify because information on OBD is not available at present (e.g. occupied bed days as a result of an admission from a care home – although this will be provided by the LIST team).

Potentially Preventable Occupied Bed Days

ISD Scotland provides detail on the number of potentially preventable occupied bed days. In Midlothian for April 15 to March 16 13,800 OBD (source: DISCOVERY) which is on average 1150 OBD each month. This is based on 19 ambulatory-care sensitive conditions that include asthma, diabetes complications and COPD.

A 20% on PPA from Midlothian may reduce monthly OBD by 230 OBD or 7 beds.

Delayed Discharge & expanding the Hospital at Home Service

A combination of expanding the capacity of the MERRIT hospital at home service and limiting delays in an acute hospital to under 72 hours is estimated will reduce OBD by 230 beds per month or 7 beds.

3. Accident and Emergency Performance

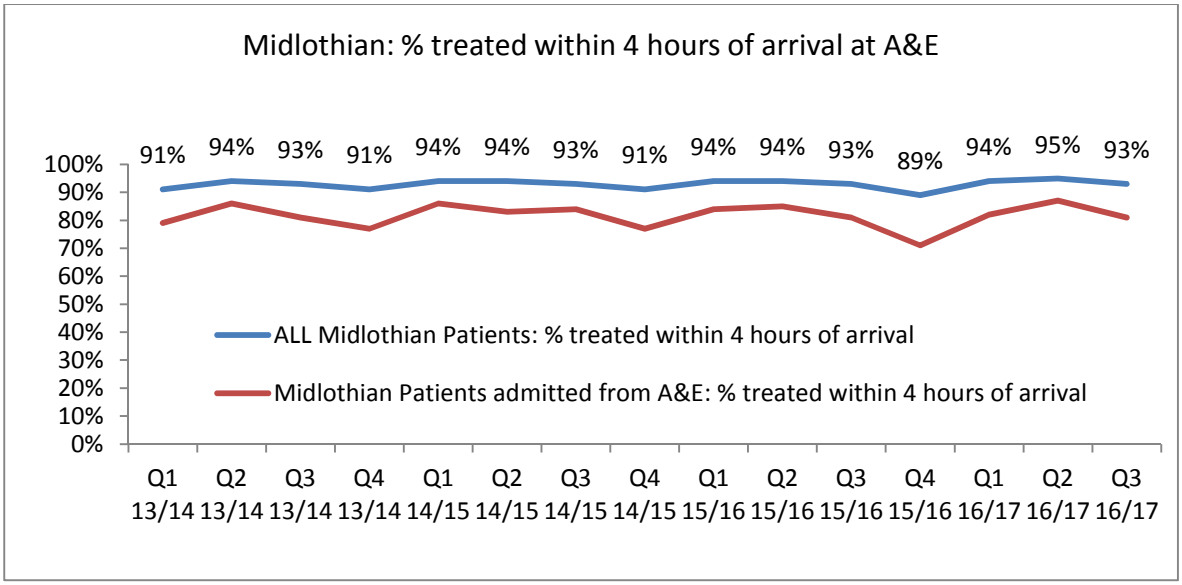
3a. Accident and Emergency Performance	Median performance is increased by 5% and demonstrated by control chart	Increase performance in the 4 hour target to 87% for patients who are subsequently admitted into hospital by April 2018
To improve performance against the 4 hour target for patients subsequently admitted into hospital. Current average performance for this cohort is 82% treated within 4 hours.		
Actions at IJB Level: 4. Achieve a 5% reduction in emergency admissions as per objective 1 1. Make progress towards achieving the 10% reduction in OBD as per objective 2 2. Increase access to General Practice through the Midlothian General Practice Strategic Programme to reduce inappropriate use of A&E 3. Develop a process between RIE A&E and General Practices in Midlothian to redirect patients at the A&E front door whose condition can be treated within General Practice 4. Develop media and social media campaign to change behaviour in population 5. Reduce inappropriate A&E attendances by patients with care homes 6. Joint work between MELDAP and the RIE Alcohol Liaison Service to reduce inappropriate use on A&E by patients with problematic substance use 7. Better use of Anticipatory Care Planning		
3b. Accident and Emergency Performance	Median activity is maintained and demonstrated by control chart	Maintain current number of patients using A&E
A&E activity by Midlothian patients is increasing and there have been significantly significant increases in the median monthly patient number using A&E.		
Actions at IJB Level: 1. Actions as per objective 3a		

What this means for Midlothian?

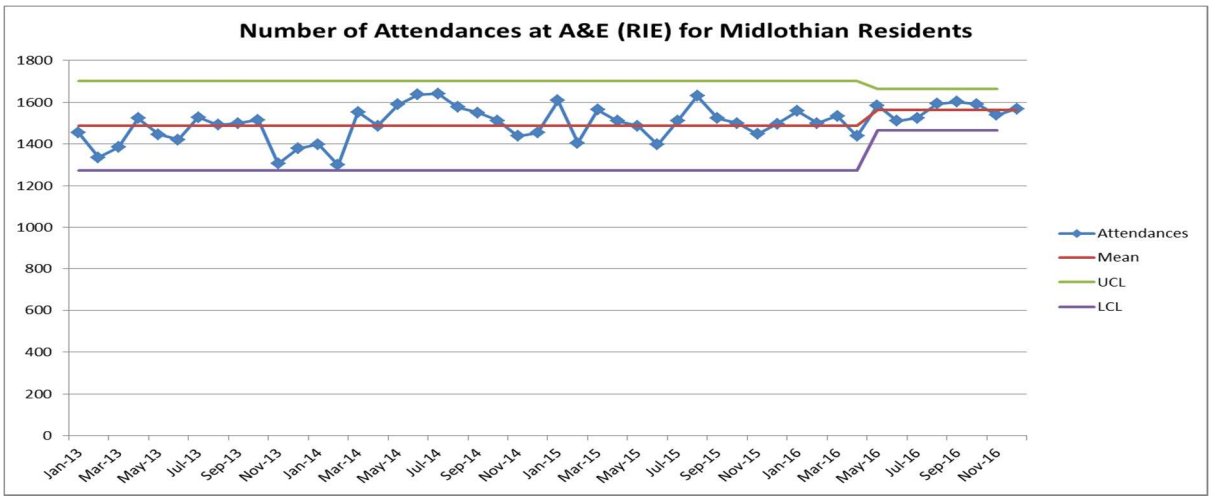
There is an established HEAT target that 95% of patients are treated by A&E within 4 hours of arrival. This is not routinely achieved in Lothian. The following graph shows the performance for Midlothian patients each quarter since April 2013.

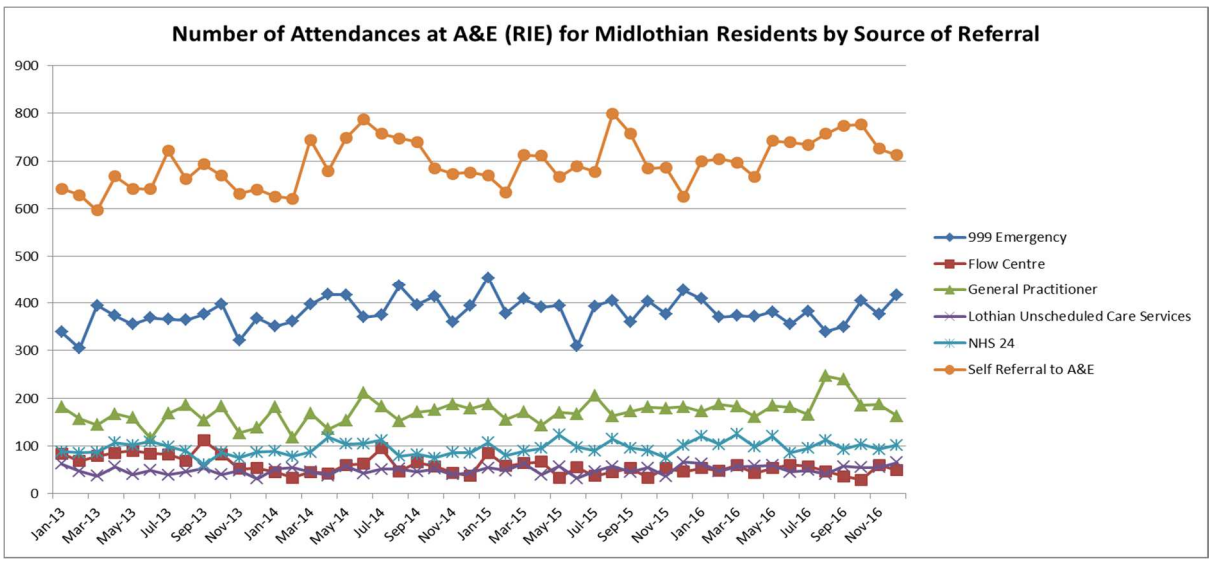
What is suggested though is that instead of focussing on the A&E performance for all patients the IJB instead focuses on the performance for those patients who were subsequently admitted from A&E. The average performance against the 4 hour target for all patients since April 2013 was 93%. The average performance of those who were subsequently admitted into hospital was 82%. The overall performance masks a lower performance for patients who need to use A&E services.

The rationale for focusing on patients who were subsequently admitted as a performance indicator is because there is an issue of people choosing to use A&E instead of accessing their GP.



Source: Discovery





Has this been achieved in the past?

How achievable is this goal?

4. Delayed Discharge Bed Days (all ages including mental health and code 9s)	September 2017	Reduce by 11%* the delayed discharge bed days per month by September 2017 and have no patients in the RIE or the WGH with a delayed discharge of over 72 hours Reduce the delayed discharge beds by 30% (deadline TBD)*
*compared to average performance from Nov 14 to Dec 16		
Actions at IJB Level: 1. Develop responsiveness of community services including MLCH and Highbank		

5. End of Life Care – proportion of time in large hospital in last 6 months of life	TBD	Reduce by 10% in the RIE and WGH the number of occupied bed days in the last six months of life
The data provided by Scottish Government is derived from the old method of identifying bed days using SMR01. This method excludes activity on sites including Liberton and Midlothian Community Hospitals. The new method uses data from SMRO1. SMRO4 and GLS. This increases the number of bed days recorded by around 100%. Using this data a potential objective to use is to focus on reducing on acute sites the number of bed days in the last six months of life.		
Actions at IJB Level: 1. Reduce admissions from care homes 2. Further actions to be identified		

6. Balance of Care	TBD	Reduce the % of patients aged 75+ who are in a large hospital from 1.7% to 1.5% (the Average in Scotland) by TBD
Further work required to identify the reduction of bed days required to achieve this change		
Actions at IJB Level: 1. Actions as per objective 1 2. Actions as per objective 2 3. Actions as per Objective 5		

Thursday 16th March 2017 at 2.00 pm

Chief Officer Report

Item number: **4.5**

Executive summary

This report has three sections. One describes the progress being made on integration. The second describes some of the significant pressures being faced by health and care in recent months. The third highlights some recent or forthcoming key service developments.

Board members are asked to:

1. *Note the issues raised in the report*

Chief Officer Report

1. Purpose

1.1 This report provides a summary of the key issues which arisen over the past two months in Health and Care.

2. Recommendations

2.1 To note the issues outlined in the report.

3. Background and main report

3.1 **Progress on Integration**

3.1.1 **Community Learning Disability Team**
All specialist NHS Lothian Learning Disability Services are currently managed on a pan lothian basis within the Royal Edinburgh Hospital. The Midlothian Health and Social Care Partnership will take on the management of the NHS Community Learning Disability Team on the first of April 2017. This is the first step towards creating a fully integrated learning disability service that will strengthen the capacity of all services to support people with complex needs through the development of new models of care.

The new service will will work in close partnerships with commissioned service to support the social care workforce. Increasingly professionals will focus on the design of person centred packages of care and support of family carers in order to secure more sustainable service delivery and respond to the increasing population of people with learning disabilities whose needs are complex.
The service will continue to have access to hospital beds based in the Royal Edinburgh Hospital as well as some specialist services such as forensic and epilepsy services that will continue to be provided on a pan lothian basis.

3.2 **Service Pressures**

3.2.1 **Improving Access to Midlothian Council Social Work and Occupational Therapy Services**
For people in need of social work support timely access is vital. Over the past year waiting times for both social work support and occupational therapy support for aids and adaptations have both increased significantly. These increases were contributed to in part by increasing numbers of adult protection referrals. All referrals are assessed by the duty team, urgent referrals are responded to immediately so that critical needs are dealt with while others are prioritised.
More recently with the use of improvement methodology waiting times have been reduced in the occupational therapy pathway for people requiring adaptations with reductions from twenty to twelve weeks from referral to assessment. One of the key changes that has made a difference is providing

people with better information at an earlier stage of the process on the range of options that are available to them. A similar exercise is now being undertaken with social work referrals and we are beginning to see improvements.

3.3 Service developments

3.3.1 Complex Care Unit in Penicuik

Plans are now well underway for the opening of the new unit in Penicuik to meet the needs of people with learning disabilities whose needs are complex. The new project is part of Midlothian Council's Phase 2 housing development project. It provides 12 purpose built tenancies that are designed to provide the best possible living environment for people with learning disabilities whose behaviours challenge services. The built environment minimises risks to tenants and allows them to be supported in a model of care that is respectful of their dignity.

The service will also include provision of a "safe house" for people in crises or whose care package are at risk of breakdown thus avoiding the use of high cost emergency care packages that have exposed the partnership to very severe financial risks over the past two years.

The service will include a multi-disciplinary approach embedded in the staff team and accessible support and skills development for social care staff. This will significantly enhance the working environment for staff and ensure more sustainable services.

This new model will replace the current model whereby individuals with very complex needs are supported intensively often on a twenty four basis with two members of staff in single tenancies without easy access for staff to management support.

The Richmond Fellowship has been appointed as the service provider. Assessments are underway to identify those individuals who will be prioritised for the new service.

3.3.2 Liberton Hospital Site

The Midlothian Health and Social Care Partnership has been working towards the reprovision of post-acute rehabilitative care for older people, both general and orthopaedic, from Liberton Hospital to Midlothian Community Hospital. This is a collaborative project involving East Lothian and Edinburgh Health and Social Care Partnerships as well as the Acute Hospital in support of the wider work to deliver care closer to home.

We have now reached the final stage of the transition with the planned reduction of Midlothian patients in Liberton Hospital from 24 beds in 2016 to the current 6 beds in March 2017. From 1 April 2017, no further Midlothian patients will be admitted to Liberton Hospital for post-acute rehabilitative care. This development allows us to strengthen the delivery of community services and marks an important milestone in achieving our aim of rebalancing care from acute to community settings.

4. Policy Implications

4.1 The issues outlined in of this report relate to the integration of health and social care services and the delivery of the policy objectives IJB's Strategic Plan.

5. Equalities Implications

5.1 There are no particular equalities issues arising from this report.

6. Resource Implications

6.1 The development of an integrated learning disability service and the new complex care service for people with learning disabilities whose needs are complex aims to support the implementation of new models of care that are sustainable and promote better outcomes for people who use services.

7. Risks

7.1 The risks for service users and social care staff arising from the single tenancy model of care for people with complex needs will be mitigated through the development of a new model of care in the Penicuik complex care service development.

7.2 The provision of a "safe house will also mitigate risks that arise in crises situations when emergency care packages need to be secured for individuals.

8. Involving People

8.1 New models of care outlined in this report have been developed close collaboration with professionals and service providers and have been informed by the experiences of service users and social care staff.

9. Background Papers

None

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