Midlothian
Health & Social Care
Partnership

ANNUAL PERFORMANCE

2019/20

FOREWORD

It was an honour to be appointed as Chief Officer of Midlothian Integrated Joint Board in October 2019 following Allister Short's move to West Lothian. This report shows how we have worked towards our long-term objectives through the continuing dedication and skill of our staff; our partners in the voluntary and independent sectors; and all the informal carers and neighbours upon whom the health and care system is entirely dependent. My very sincere thanks for all their work during 2019-20.

New services and approaches to improve health and wellbeing.

We have focused on making sure people are only in hospital when they need to be through the "Discharge to Assess" Team and the "Hospital at Home" Service. We have improved services for people with mental health needs, substance misuse and offending behaviour in our new *Number11* in Dalkeith. Staff have been trained to have a 'Good Conversation' and help people identify their health outcomes, based on their strengths and assets. We are looking at 'outcomes mapping' to improve how we measure performance to provide a meaningful picture of how we are delivering health and care services.

The third sector continues to be a crucial partner and we will continue to work in partnership with this strong and innovative sector.

Some services under pressure

Some of our services remain under pressure such as Care at Home and General Practice. We will strengthen these and support people to remain well by investing in prevention and early intervention.

Plans for next year

We will continue to reshape our services to support people to stay well and at home as far as possible. Good housing is crucial. We will work with the Council and Third Sector partners to develop housing for people with learning disabilities and build extra care housing for older people and disabled people. As part of the European Scirocco Programme we hope to learn how to improve our services from health and care developments in other European countries.

Whilst not within the time frame of this report I must acknowledge the challenges in March 2020 due to COVID-19. Our services were quick to take action and positive relationships with our partner care providers helped to ensure a robust response. While COVID-19 presented many challenges, there will be developments as a result of the pandemic that we will sustain. I have been proud and humbled by the dedication of staff and volunteers - and saddened by the impact of the virus on our residents.

Morag Barrow,
Chief Officer
Midlothian Integrated Joint Board

NATIONAL HEALTH & WELLBEING OUTCOMES

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

People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

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

Health and social care services contribute to reducing health inequalities.

People who work in health and social care services are engaged with their work and improve information, support, care and treatment they provide.

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Resources are used effectively and efficiently.

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

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

HOW DID WE DO?

NATIONAL INDICATORS
OUR RESULTS

2019/20 survey results will be published later than planned due to the COVID-19 pandemic. Below are the latest figures available from the 17/18 national survey

Adults can look after their health well or very well

13/14	15/16	17/18	19/20
94.0	95.0	93.0	
94.9	93.5	91.7	

Adults live as independently as possible

13/14	15/16	17/18	19/20
83.0	83.0	81.0	
82.6	78.0	86.3	

Adults had a say in their help, care or support

13/14	15/16	17/18	19/20
83.0	79.0	76.0	
84.9	84.4	79.7	

Adults thought services were coordinated

13/14	15/16	17/18	19/20
78.0	75.0	74.0	
76.8	71.3	70.8	

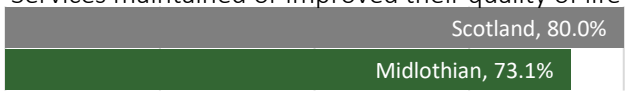
Adults rated services as good or very good

13/14	15/16	17/18	19/20
83.0	81.0	80.0	
83.5	73.1	71.3	

Adults had positive experiences at the GP

13/14	15/16	17/18	19/20
85.0	85.0	83.0	
77.7	78.6	75.8	

Services maintained or improved their quality of life

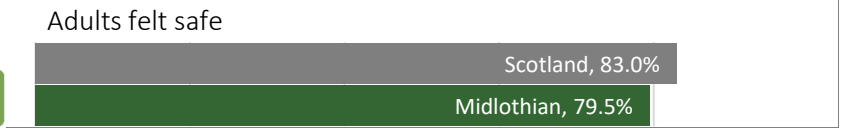


13/14	15/16	17/18	19/20
85.0	83.0	80.0	
80.2	82.3	73.1	

Carers felt supported in their role

13/14	15/16	17/18	19/20
43.0	40.0	37.0	
44.5	39.4	32.1	

Adults felt safe



13/14	15/16	17/18	19/20
85.0	83.0	83.0	
76.8	80.7	79.5	

HOSPITALS

Emergency Admission rate per 100,000 of the population

	15/16	16/17	17/18	18/19	19
Scotland	12,295	12,229	12,210	12,275	12,602
Midlothian	11,602	10,923	11,599	11,153	12,561

Emergency Bed Rate per 100,000 of the population

	15/16	16/17	17/18	18/19	19
Scotland	128,541	126,891	123,383	120,177	117,478
Midlothian	122,943	122,994	123,180	121,587	115,308

Readmission into hospital within 28 days

	15/16	16/17	17/18	18/19	19
Scotland	98	101	103	103	104
Midlothian	104	109	114	110	108

Number of days of people aged 75+ spend in hospital when ready to be discharged per 1,000 population

	15/16	16/17	17/18	18/19	19/20
Scotland	915	841	762	793	793
Midlothian	835	971	1,422	1,323	1,002

% health and care resource spent on hospital stays after emergency admission

£

	15/16	16/17	17/18	18/19	19
Scotland	23	23	24	24	23
Midlothian	22	22	23	23	22

COMMUNITY

% of the last 6 months of life spent at home or in a community setting

	15/16	16/17	17/18	18/19	19
Scotland	87	87	88	88	89
Midlothian	85	86	87	86	86

Falls rate per 1,000 of the population aged 65 or over

	15/16	16/17	17/18	18/19	19
Scotland	21	21	22	23	23
Midlothian	21	19	20	18	22

Care services rated good or better by the care inspectorate

	15/16	16/17	17/18	18/19	19/20
Scotland	83	84	85	82	82
Midlothian	85	76	89	87	83

% Adults with intensive care needs receiving care at home *(2019 data available Sep 2020)*

	2015	2016	2017	2018	2019
Scotland	61	62	61	62	
Midlothian	63	69	70	68	

Premature Mortality Rate per 1,000 people

	2015	2016	2017	2018	2019
Scotland	441	440	425	432	426
Midlothian	396	400	389	409	425

HOW THE INDICATORS LINK TO THE OUTCOMES

Outcome:	
Health and wellbeing	
Living in Community	£
Dignity	
Quality of Life	£
Health inequalities	
Carers	
Safe from harm	£
Workforce	
Resources	£

- Adults are able to look after their health very well or quite well
- Adults supported at home agreed that they are supported to live as independently as possible
- Adults supported at home agreed they had a say in how their help care or support was provided
- Adults supported at home agreed that their health and social care services seemed to be well coordinated
- Adults receiving any care or support rated it as excellent or good
- Adults had a positive experience of the care provided by their GP practice
- Adults supported at home thought services and support improved or maintained their quality of life
- Carers feel supported to continue in their caring role
- Adults supported at home agreed they felt safe

- Premature Mortality Rate
- Emergency Admission Rate
- Emergency Bed Day Rate
- Readmission rate into hospital
- Last 6 months of life spent at home/community
- Falls Rate
- Care Services rated good or better
- Adults with intensive care needs supported at home
- Number of days delayed in hospital
- £ Health and care resource

DISCUSSION

Every two years, the Scottish Government asks 100,000 people across Scotland about their experience of health and social care services. In 2017/18, **1,977 people** from Midlothian contributed to this Scottish Health and Care Experience Survey (a response rate of 26%). Survey results for 2019/20 were due to be published in April 2020, but due to the COVID-19 pandemic, the most recent results were not available at time of writing.

In addition to this survey data we have also included data related to quality of life and service use. For some indicators, the data has not been published for 2019/20 so we have included data from Jan – Dec 2019 as a substitute. This means results are not directly comparable but Public Health Scotland recommends this to improve consistency between all Health and Social Care Partnerships.

We are committed to increasing the number of people who stay well at home, and receive treatment or care in their own community if they need it. We have good local *care services* (83% rated good or above by the Care Inspectorate) and while our figure for *adults with intensive care needs who are supported at home* remains above the Scottish average we would like to it be greater. While our figure for the *last six months of life in the community* is 86% it is worth noting that this does not include time spent in our community hospital, thereby missing this cohort of people cared for in their local community.

Our *emergency admission rate* and the *emergency bed rate* remain higher than we would like although they are below the national average. Our *readmission to hospital* rate is slightly higher than the national average.

Midlothian people spend too long in hospital after they are ready for discharge. Our figure for *days in hospital when ready to be discharged* is higher that the Scottish average and reducing this is a key priority for the partnership. Delays occur for a range of reasons including the availability of care at home support. Additional days in hospital contribute to the *cost of hospital stay* – while our rate is below the Scottish average we intend to reduce it further.

The response for unpaid *carers feeling supported in their role* has been lower than the national average for the last two surveys and remains a challenge. In response to this, we are working with our carer support services to provide enhanced emotional, practical and financial support where feasible. In addition, work continues within our own services and with partner agencies to improve the early identification of carers in order to offer appropriate support, especially in our deprived areas where carers provide more hours of care per week. Unpaid carers who receive a service from our local carer organisation, VOCAL, report more positively on their feeling of support in their role.

Work is underway to support people who are considered frail and those living with long term conditions. By providing proactive, local and accessible person-centred support people will hopefully live well at home for longer. Our *falls rate* continues to be lower than the national average.

People in our most deprived areas have poorer health outcomes. Our *premature death rate* remains under the national average but has increased from the previous year. People in poverty are more likely to develop some long–term diseases such as COPD and diabetes and people with these conditions are twice as likely to be admitted to hospital and have a longer length of stay.

WHAT DID WE DO?

HEALTH & WELLBEING

Empowering communities and individuals to manage their health and wellbeing can be particularly challenging because of some of the difficulties people face, including poverty and health conditions.

We use data and technology to help us make it easier for people to get timely access to information about their health.

20 years of Ageing Well

Ageing Well celebrated its 20th birthday. It started with two volunteers running one walking group. Today over 50 volunteers run 44 groups with over 600 people taking part each week.

Volunteers run a wide range of activities including health walks, singing, new age kurling, badminton, indoor bowls, table tennis and walking sports football, rugby and netball. They also organise annual events such as Walk the Line and the Senior Olympics for Care Homes and Sheltered Housing. Happy Birthday!

Support with medicines

We spend £18 million a year on prescription drugs – nearly 15% of the whole Health and Social Care budget. We have tried new ways to support people to manage their medicines.

We have a number of teams helping people learn about their medicines, checking they are taking the right ones and answering questions. We also have a pharmacy team in all GP practices.

MMCC

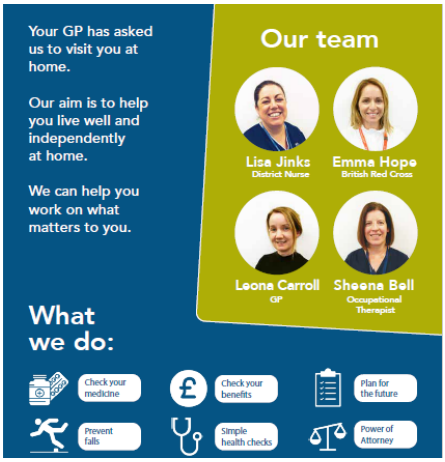
Diabetes prevention

People from black, Asian and other minority ethnic groups are disproportionately affected by Type 2 Diabetes in comparison to white populations. We worked in partnership with Midlothian's Muslim Community Centre to set up a weekly walking group, a fitness class and a programme of with speakers which included a pharmacist, a community nurse and a dietitian.

Around 9 women of Indian, Pakistani and Bangladeshi heritage attend the fitness class and walking group.

LIVING IN THE COMMUNITY

People want to live at home for as long as they are able to do so. Our Midlothian Flow Hub has helped coordinate care, treatment and therapy in patients' own homes preventing admission into acute hospitals. A range of services including Hospital at Home and Discharge to Assess enable people to avoid inpatient care or reduce the time spend there.



Support for people with frailty

The winter frailty team is made up of a GP, Occupational Therapist, District Nurse and Local Area Coordinator from the Red Cross. They work with 3 GP Practices to support people with frailty. Frailty is a recognised long term health condition

Many of the people they have supported have reduced their medication, been supported to prevent falls and all have created anticipatory care plans. Some are receiving benefits, going to social activities and have Power of Attorney arrangements.

Housing solutions

Occupational Therapists and staff from Housing have trained frontline staff to help them support people to live in suitable , accessible housing.

People's needs change over time and this training supports staff to feel confident talking to people about their options and plan ahead. Over 60 people from housing, NHS, Housing associations, Social Care, Third Sector and carers have been trained.

Learning Disabilities

The right quality environment, particularly good quality housing, is one of the fundamental building blocks for our local services.

The Learning Disability Strategy group continued to work with Housing Department on a programme of housing developments designed with the needs of people with a Learning Disability in mind. 12 flats at Teviot Court in Penicuik have already been built and plans have been made for further developments in Bonnyrigg, Dalkeith, and Gorebridge.

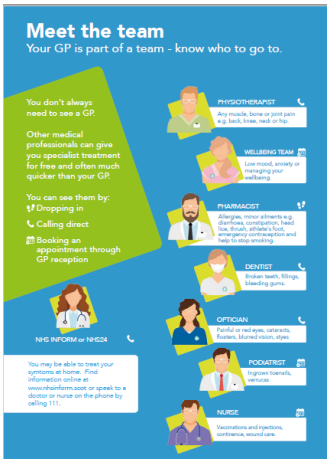
POSITIVE EXPERIENCES & BEING TREATED WITH DIGNITY

People want timely, accessible and good quality care. We have more GP practices with open lists than in previous years so it is easier for people to register and access primary care services. We have developed new ways of providing earlier support to people who are diagnosed as being frail reducing crises and emergency admissions.

Online Consultations

One Medical Practice has moved to online consultations. Patients enter their symptoms online and a GP can then assess them once the surgery opens and offer advice over the phone, make referrals and/or appointments.

This system means the phone lines are clear for vulnerable patients. Most patients can submit their request for an appointment 24/7 and will be contacted when the surgery opens for advice or to be directed to the most appropriate service.



Meet the Team

GPs are just one of a range of people who can support you. We are making it easier to see the right person, at the right time in the right place by working in multi disciplinary teams in GP surgeries.

We now have a range of people working from local GP practices including Physiotherapists, Pharmacists, Primary Care Mental Health Nurses and Wellbeing workers.

Hearing aid clinics

Hearing aids can be a lifeline to staying independent but they can sometimes need a little attention. Whether the battery is flat, it needs re-tubed or people just need some advice, we ran 23 clinics to offer people advice and practical help.

The clinics in Dalkieth and Penicuik are coordinated in partnership with volunteers, Deaf Action and Audiology. They have been so popular that we are planning a third clinic in Gorebridge.

IMPROVED QUALITY OF LIFE

People are living longer lives, however there is a high number living with long term conditions.

By working in partnership across services, people are able to be seen by the right person at the right time resulting in a lower emergency bed admission rate in acute hospitals.

Midlothian Works
Individual Placement and Support service

Supported employment

We supported people with severe and enduring mental health conditions who want to work but experience significant barriers to accessing mainstream employment.

6 people have had job outcomes including working as a nursery assistant, in pet care, events steward, retail assistant, after school club support and mail deliveries.

Care home support team

A team of nurses, social workers and occupational therapists have been supporting staff in care homes to improve support for people with dementia.

They will look at ways to reduce unnecessary admissions to hospital and share good practice – including Namaste Care at Newbyres Village care home. This project brings residents together to stimulate the senses in a soothing atmosphere.

Help for muscles, bones or joints

Every GP surgery in Midlothian has a specialist physiotherapist who can give people an assessment, exercises and advice on how to manage their muscle, bone or joint pain better.

People can ask at their surgery for an appointment. The physiotherapists can make a diagnosis, refer people for further physiotherapy or investigations or to another specialist.

REDUCED INEQUALITY

Inequalities are avoidable and unfair differences in people's health across social and population groups.

People who live in our most deprived communities are more at risk of lower life expectancy and overall poorer health. A number of activities to tackle health inequalities are focussed in our most deprived communities where there is the most need.

Supporting people leaving prison

The services working in our new No 11 hub meet every fortnight to support people leaving prison.

They work with the Scottish Prison Service to meet people in prison to build relationships and then offer them support to link them into services and agencies in the community including housing, recovery communities, peer support and skills development.

Women's Social Supper

A partnership project with Social Bite, Children 1st and No 11 has supported between 20 – 30 women and children every week with a free women's only drop in supper.

It runs every Thursday between 16:30 – 18:00 at the new recovery hub in Dalkeith for women who are facing challenges in their lives. Women are part of a safe space and can access free food, support and advice, clothing and toiletries.

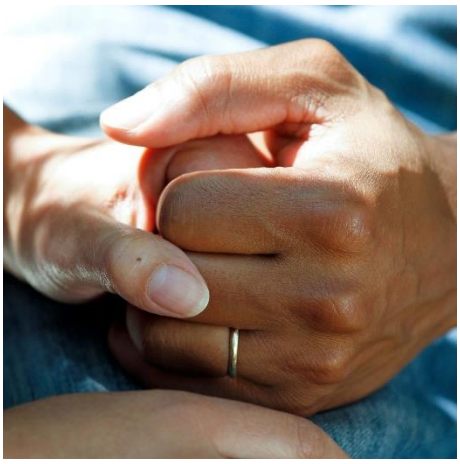
Supporting those who are homeless.

A nurse from the Community Health Inequalities team has been joined by a Community Psychiatric Nurse from the Substance Misuse Team to support people living in homeless hostels. They provide a direct nursing service and support to access medical services, food banks, peer support and other opportunities.

They have also worked with staff to develop the Housing First model – which will focus on offering permanent housing and support to people who are homeless.

SUPPORT FOR CARERS

Midlothian has approximately 9,000 unpaid carers and it is crucial we recognise the significant impact and effect their caring role can have on them, and offer support to sustain their role as long as they wish to do so. Many of these carers are not actively known to our services and we continue to try and reach these hidden carers. We have worked alongside VOCAL and other services that have contact with carers to ensure carers are represented into ongoing service design to improve services to meet the needs of carers and those who they care for.



A single point of contact

Carers were part of our consultation to improve community support for people with dementia.

Nearly everyone we spoke to, including the dementia team, third sector providers, sheltered housing and carers mentioned the need to provide more support to carers. We are now looking into creating a single point of contact – so carers have a named person who can offer support and guidance for a number of years.

Financial Advice

Citizen's Advice Bureau has been working in partnership with VOCAL to offer outreach clinics to offer benefits advice.

VOCAL hosted twice weekly welfare benefit and advice surgeries where carers could ask staff from Penicuik CAB advisers questions on a range of topics including welfare benefits; debt; employment; and transport.

Monthly Dementia Surgeries

Alzheimer Scotland's Dementia Advisor held a specialist surgery at VOCAL to provide practical and emotional support for 18 carers of someone living with dementia.

Carers could follow up any questions or queries after the surgery as the condition of the person they care for, and their role as a carer, changed. VOCAL and Alzheimer Scotland also ran joint information sessions for carers.

SAFE FROM HARM

All services must aim to keep people remain safe from harm and prevent avoidable risks. We have increased our recruitment of Allied Health Professionals, including Occupational Therapists, who have helped people reduce their risk of falls to below the Scottish average.
There is a strong link between substance misuse, community justice and mental health and the newly formed Number 11 hub in Dalkeith improves collaboration between these services.

Support for neurological conditions

Midlothian Council and the NHS Lothian's Lanfine service started to work more closely to support people with progressive neurological conditions at home. The Council also commssioon the specialist services of the Scottish Huntington's Association.

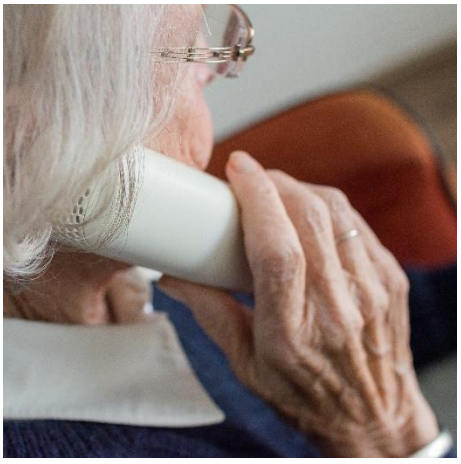
This will bring together a range of professionals such as Medical and Nursing staff, Social Workers, Physiotherapists, Occupational Therapists, Speech and Language Therapist, Neuropsychologist, Dietitian, Therapy Support Workers and support for carers.

Low threshold prescribing

MELDAP
MIDLOTHIAN & EAST LOTHIAN DRUGS & ALCOHOL PARTNERSHIP

Every week people at risk of drug related over dose and death have been accessing support at a café style clinic.

They can access a prescprition for opioid substitution treatment, peer support workers, housing and benefits advice, mental health referrals, health checks, and clean needles or overdose-reversing naloxone kits. This style of support has increased attendance in this group from under 30% to more than 90%.



Adult Support & Protection

A team leader, 3 social workers and a Community Care Assistant support adults at risk.

Last year they received **245** referrals in relation to issues such as financial and psychological harm, in particular in older people.

The majority of referrals were referred to other health and social care services for longer term support.

EFFICIENT & EFFECTIVE USE OF RESOURCES

We continue to strengthen our community based support to provide an alternative to hospital admission for many. Teams like our Rapid Response Service prevent many from an unwanted stay in hospital and many more people with intensive care needs are receiving care at home higher than the national average. Our GP practice teams have expanded with more specialist services located in practices such as physiotherapists, pharmacists and mental health nurses which allows people to be seen quicker and have a better experience.

Helping you home after hospital

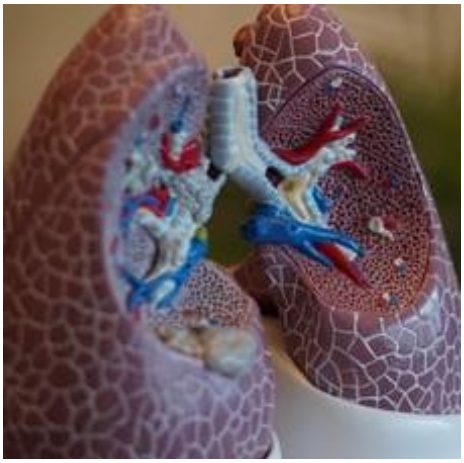
The Discharge to Assess team consists of occupational therapists, physiotherapists, community care assistants and clinical support workers who support patients after a stay in hospital.

They have supported 430 patients since they started in early 2019. They assess a patient's needs once they are back at home so they don't have to wait for their assessment in hospital. This has saved 3,390 unnecessary days for the hospital.

Hospital at Home Team

The team provides acute care to up to 15 patients in a virtual ward – with an average length of stay of 6 days.

Most of the patients are over 65. The majority are referred by their GP through the Flow Centre but around 25% are from the "Front Door" of the acute hospitals. Patients have a range of conditions e.g. infections, musculoskeletal problems, limited functional abilities and delirium and/or dementia.



Supporting people with COPD

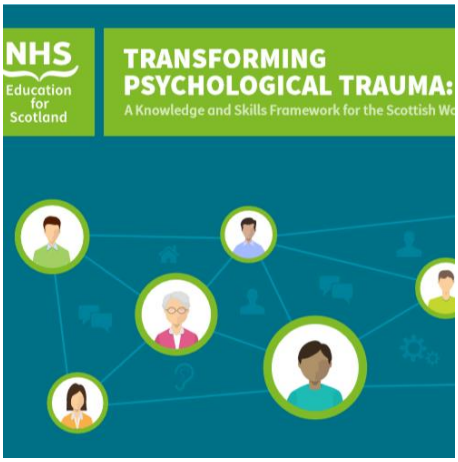
The Community Respiratory Team was expanded, working with more patients with COPD to try and prevent admission to hospital, or facilitating quicker discharge when a patient is admitted to hospital.

In the year 19/20 217 admissions were avoided and 96 facilitated discharges took place, resulting in a 1686 reduction of days in hospital overall.

STAFF

Our staff are our greatest and most valuable resource.

We have developed a comprehensive staff training programme which allows staff to have a "Good Conversation" with people to support self management and direction. The Midlothian Way includes training in trauma, health inequalities and health literacy.



Training in trauma

Midlothian Council recieved funding from the Scottish Government to train staff across the whole system.

21 people can now deliver training to reception staff, teachers and health visitors to give them a better understanding of the needs of children and adults who have been affected by traumatic experiences.

Good Death, Good Grief

The death of someone close can be overwhelming. Relatives, friends or neighbours can offer support but there are also organisations to help guide you through what to do and talk through your feelings.

As part of the festival of remembrance 'To Absent Friends' we supported staff to have good conversations about death and promoted organisations on www.midlothian.gov.uk/bereavement.

Voluntary Sector Summit

We have contracts with around 40 voluntary organisations accounting for 33% of the total Adult Social Care budget.

The Voluntary Sector is a key partner in the planning and delivery of health and social care. Leaders from voluntary sector organisations and the management team of the HSCP met 3 times to discuss and explore how we could work collaboratively to make best use of the available resources.

LOCALITY PLANNING

EAST & WEST MIDLOTHIAN

A locality is 'a smaller area within the borders of an Integration Authority'. We have two – East and West and this helps us plan services that suit local communities. We also use "Area Targeting" to support communities. Areas of Dalkeith/Woodburn, Mayfield/Easthouses and Gorebridge (in the East) and parts of Bonnyrigg, Loanhead and Penicuik (in the West) are areas of deprivation.

Each community council area has a neighbourhood plan that allows residents and Community Planning Partners to identify areas to work on together - using assets, activities and resources, from the public, voluntary and private sectors and local communities. These plans are based on local data, lived experience and community engagement and are at various stages of maturity . Some local priorities include

- Preventing Isolation and establishing community groups for local support
- Improving Physical Activity and access to community sport
- Supporting the Workforce
- Maximising income
- Reducing Health Inequalities
- Supporting people to live at home

TAILORED SUPPORT FOR COMMUNITIES

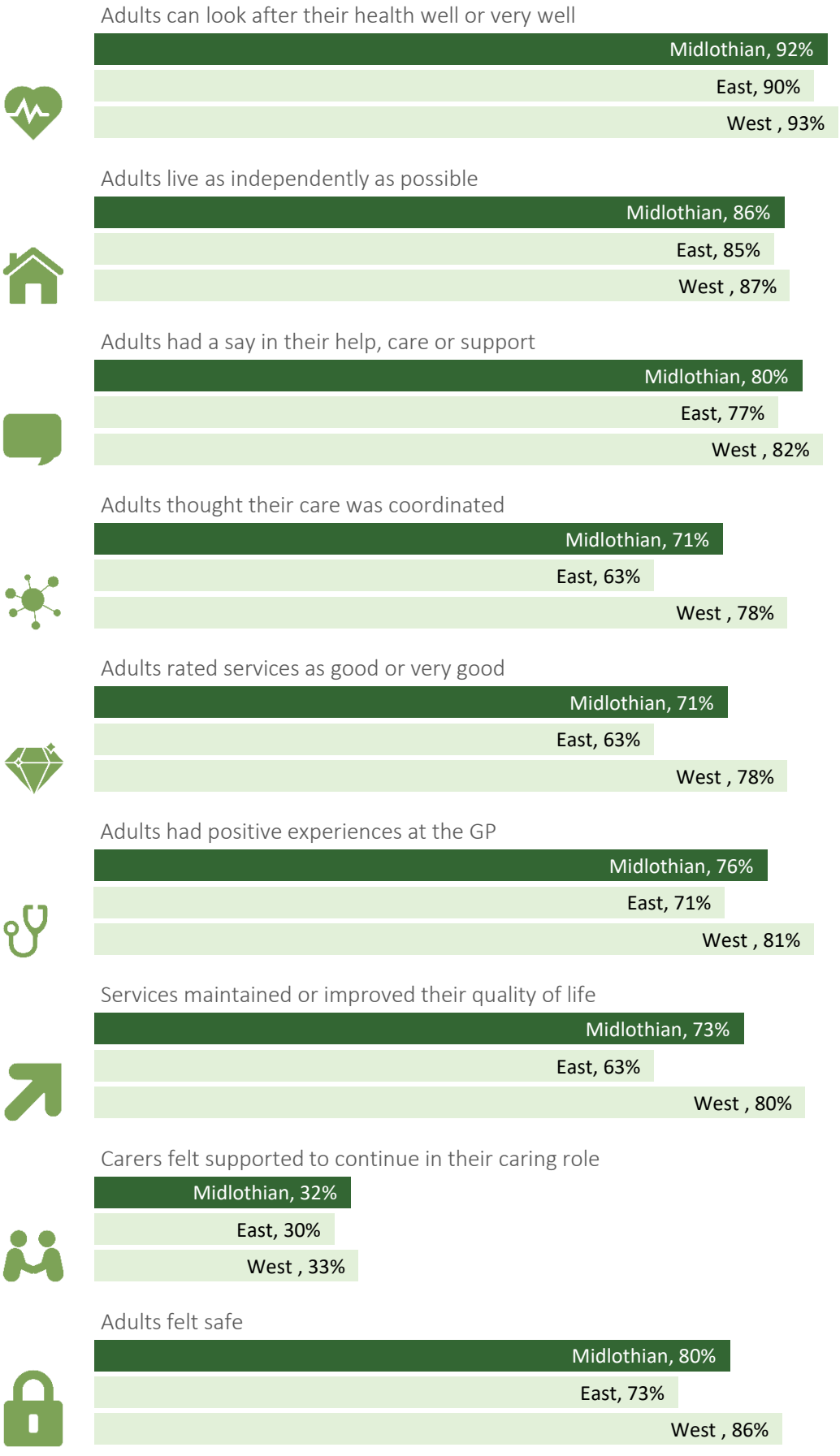
Homecare

Our Homecare service continues to improve the quality of care provided to vulnerable individuals in their own home. The service has been split across the two localities (East and West) and again into six smaller areas to ensure continuity of care, flexibility and creates additional capacity. These changes have already shown improvement, with almost as many new packages of care being provided in the first months of 2020, as were provided in the whole of 2019. A family member said *"Without your team of carers my mum wouldn't be able to live at home"*

Newbattle – More than Food project

Using Scottish Government funding, we worked with Midlothian Council, families and schools to deliver activities in the summer holidays to improve the health and wellbeing of families. Activities included resilience workshops for kids, healthy eating sessions, sport activities and informational sessions by Community Health Inequality nurses and Health in Mind. Watch a video here.

INDICATOR DATA BY LOCALITY



HOSPITALS

Emergency Admission Rate (2019) – 12, 561 per 100,000
East 13,208 per 100,000 West 11,981 per 100,000

Emergency Bed Rate (2019) – 115,308 per 100,000
East 122,277 per 100,000 West 109,055 per 100,000

Readmission to hospital within 28 days (2019) - 108 per 1,000 discharges
East 113 per 1,000 discharges West 104 per 1,000 discharges

No. of days in hospital when ready to be discharged
No data by locality

£

% resource on hospital stay after emergency admission
No data by locality

COMMUNITY

% of the last 6 months spent at home or community (18/19) – 86.1%
East 84% West 88%

Falls rate (65+) (2019) – 22.2 per 1,000 population
East 24 per 1,000 West 21 per 1,000

Care services good or better (Care Inspectorate)
No data by locality

Adults with intensive care needs receiving care at home
No data by locality

Premature mortality rate (2019)
No data by locality

FINANCE

HOW WE SPENT OUR MONEY (2019/20)

The Integrated Joint Board had a total budget of **£149m** and ended the financial year with a small **underspend of £0.743m**. For more information see our Annual Accounts and Financial Strategy.

	Budget	Spend	Variance
Direct Midlothian Services			
Community AHPS	2,153,000	2,021,000	132,000
Community Hospitals	5,556,000	5,665,000	-108,000
District Nursing	3,489,000	3,343,000	147,000
General Medical Services	15,750,000	15,885,000	-134,000
Health Visiting	1,991,000	1,699,000	292,000
Mental Health	2,607,000	2,422,000	185,000
Other	10,718,000	10,252,000	466,000
Prescribing	18,368,000	18,305,000	63,000
Resource Transfer	5,197,000	5,187,000	9,000
Older People	18,352,000	16,646,000	1,706,000
Learning Disabilities	13,598,000	16,214,000	-2,617,000
Mental Health	869,000	845,000	24,000
Physical Disabilities	3,381,000	3,736,000	-355,000
Assessment and Care Management	3,146,000	2,806,000	340,000
Other	3,247,000	2,412,000	835,000
Midlothian Share of pan-Lothian			
Set Aside	18,705,000	19,082,000	-378,000
Mental Health	2,244,000	2,352,000	-108,000
Learning Disabilities	1,350,000	1,499,000	-149,000
GP Out of Hours	1,208,000	1,287,000	-79,000
Rehabilitation	792,000	695,000	97,000
Sexual Health	640,000	643,000	-3,000
Psychology	761,000	779,000	-17,000
Substance Misuse	467,000	441,000	26,000
Allied Health Professions	1,362,000	1,307,000	55,000
Oral Health	1,738,000	1,707,000	31,000
Other	2,449,000	2,166,000	283,000
Dental	5,111,000	5,111,000	
Ophthalmology	1,702,000	1,702,000	
Pharmacy	2,924,000	2,924,000	
	£149,875,000	**£149,133,000**	**£743,000**

MAIN AREAS OF SPEND (£000)

CHALLENGES

Social Care

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

Health

The main financial pressure was within set aside budgets (NHS Lothian services within the acute hospitals - Royal Infirmary of Edinburgh, the Western General Hospital and St. John's Hospital) which are delegated to the IJB e.g. Accident and Emergency, Geriatric Medicine, Rehabilitation Medicine and Respiratory Medicine.

- Junior Medical Staff – due to additional staffing requested to cover rotas for sickness; maternity and vacancies.
- General Medicine – due to challenges with recruitment and bed pressures across all sites
- Infectious Diseases - due to drug expenditure being higher than budgeted

The Scottish Government new monies to support integration received by the IJB this year has supported its aims of delivery of the living wage, the Carers Act and Franks Law in line with Scottish Government's guidance.

The IJB also has a duty under the Local Government Act 2003 to make arrangements to secure Best Value and does this through continuous improvement in the way in which its functions are exercised. Best Value includes aspects of economy, efficiency, effectiveness, equal opportunity requirements, and sustainable development.

Challenges & expectations next year

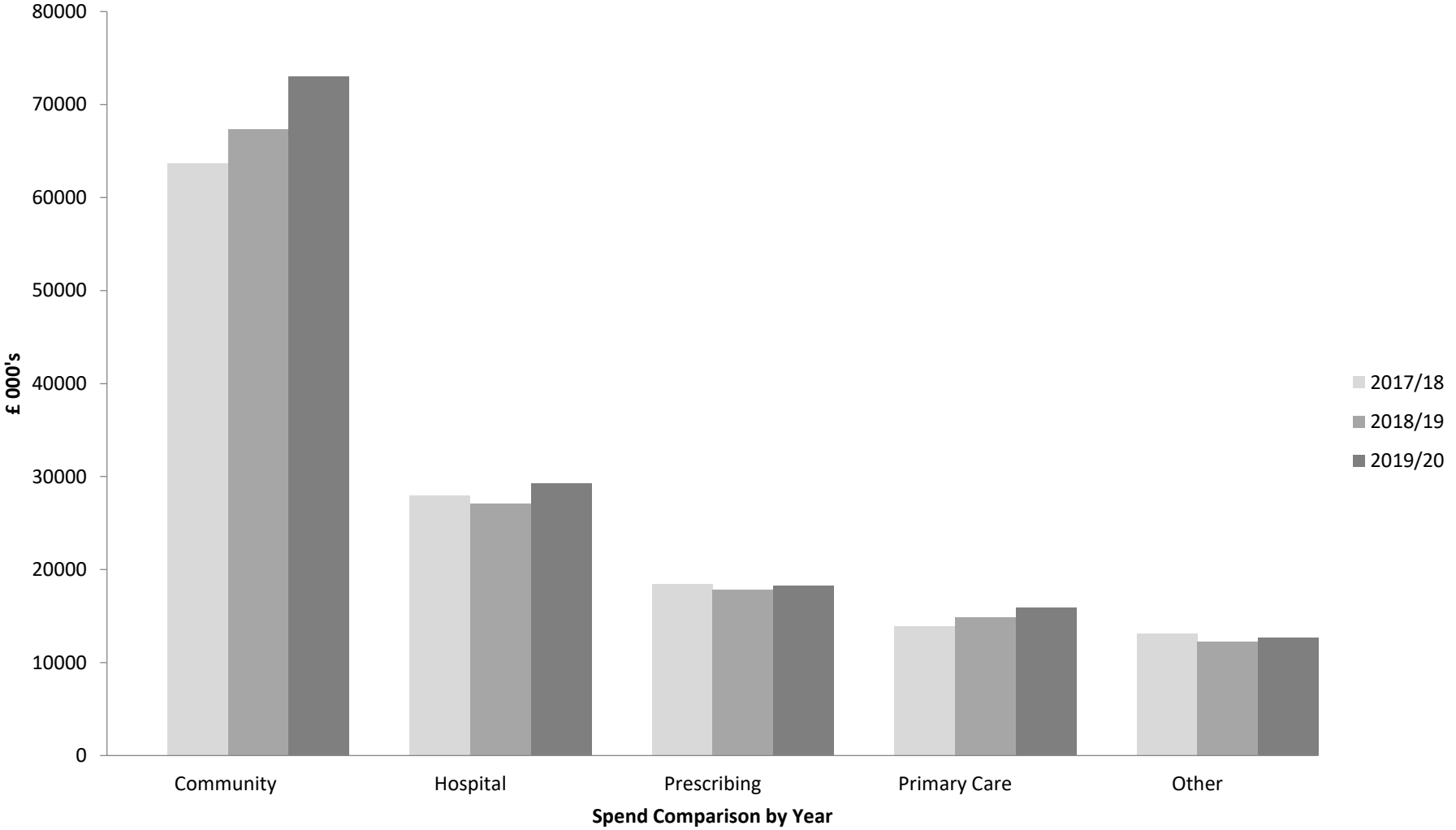
In February 2020 the IJB undertook part of its annual financial assurance process to review the budget offer for 2020/21 from Midlothian Council. Again this process identified financial challenges but the IJB has accepted this budget as it passed the two tests of 'fair' and 'adequacy'. It should be noted that this was a challenging settlement for the IJB and any further reduction would have an impact on service delivery. The IJB at their April 2020 meeting also accepted the budget offer from NHS Lothian for 2020/21 having undertaken the same approach regarding financial assurance and "fair and "adequate" test.

As part of the financial planning process for 2020/21, NHS Lothian has uplifted the baseline budget by 3% and Midlothian Council also uplifted the base budget and passed through the additional social care monies from the Scottish Government (£96m nationally).

The challenge is to continue the transformation of the services that deliver the IJB's delegated functions whilst continuing to deliver high quality health and social care to the population the IJB supports. The IJB has developed a financial strategy and a medium term financial plan which was presented to the IJB at its meeting in June 2019. The IJB continues to develop this multi-year financial plan to support how the resources available to the IJB will be used to deliver the ambitions of the Strategic Plan

MAIN AREAS OF SPEND (2017-2020)

The graph below compares our spend trends for the past 3 years. We are unable to report on 2016/17 or previous data the same way. We are also unable to report on spend by locality as we do not hold data in this form.



CHALLENGES & DECISIONS (2020/21)

Key transformation programmes:

- **Reshaping unscheduled care** – by working with acute staff and Lothian IJBs to reduce admissions to acute care, increase rehabilitation and offer local services by reshaping Midlothian Community Hospital.
- **Developing a Home First model** - by redesigning intermediate care services; developing our Care at Home services and improving support for people with Frailty.
- **Improving Housing options** – by working with the council to develop housing for people with learning disabilities and build extra care housing for older people and disabled people.
- **Improving our services** – by learning from other European countires as part of the Scirocco Programme
- **Redesigning support for Unpaid Carers**.
- **Redesigning mental health supports – by recommissioning community mental health services and developing an Older Peoples Mental Health ward in Midlothian Community Hospital**
- **Tackling health and income inequalities.**

Key Risks, Challenges and Uncertainties

We face huge challenges due to the coronavirus pandemic but the crisis also created an opportunity to build on existing and newly forming community connections.

A growing and aging population
12,000 new houses will be built in the next 3 years. Many more people will be living at home with frailty, dementia and/or multiple health conditions. An increasing number of people live on their own, and for some this will bring a risk of isolation.

Higher Rates of Long-Term Conditions
Midlothian has a higher incidence than the national prevalence of cancer, diabetes, depression, hypertension, chronic obstructive pulmonary disease and asthma.

High rates of mental health needs
Approximately 18% of the population are on medication for anxiety and depression.

Financial Pressures
Public Finances face severe challenges. The Council continues to face significant reductions in its overall budget but has sought to protect social care budgets from the level of cuts required in other services. The financial position for the UK and Scotland remains uncertain.

Workforce Pressures
Recruitment and retention is a growing problem in health and social care. There is a shortage of GPs; a significant proportion of District Nurses are nearing retirement; while care at home providers find it difficult to attract and keep care at home workers. The aging population means these pressures may increase.

Acute Hospitals
We need to invest in community based alternatives that will minimise avoidable and inappropriate admissions and facilitate earlier discharge.

Health Inequalities
People living in some Midlothian communities are living in poorer health and are likely to die younger with higher rates of cancer, stroke, diabetes and heart disease. People with disabilities are more likely to have lower educational achievements, higher rates of poverty and poorer health outcomes.

INSPECTIONS

The Care Inspectorate inspects our care homes and care at home services. They look at the quality of care to ensure it meets high standards. Where they find that improvement is needed, they support services to make positive changes. Read the full reports here.

Here are the services that have had an inspection with a written report in the last year.

HOMES:

	Wellbeing	Leadership	Staffing	Setting	Planning
Dougall Court (LD)	4	4	3	3	4
Richmond Fellowship (LD)	5	5			
Parkside Court (LD)	4				4
Highbank	3	4	3	3	3
Nazareth House	3	3	4	3	3
Springfield Bank	3	4	4	4	3
Pittendreich	3	4	4	3	4
Newbyres	5	4	3		4

*LD = Learning Disability

Areas for improvement:

- **Pittendreich -** No areas of improvements.
- **Nazareth House**
  - The provider should improve the way they deal with feedback.
  - The provider must provide dementia training.
- **Highbank**
  - The manager should identify areas for improvement recorded under each of the five key questions.
- **Springfield Bank -** No areas of improvements.
- **Newbyres Village**
  - The provider should ensure appropriate opportunities are in place for staff to feel supported in their roles and able to influence further improvement and development within the service, including reflecting on their own practice.
  - The provider should ensure that resident's needs are fully met by having the right number of people to care for them.
  - The provider should ensure falls prevention guidelines, risk assessments and support plans are in place.

COMMUNITY:

Areas for improvement

- **Shared Lives Midlothian**
  - Ensure people's care and support needs are reviewed to ensure their needs are continuing to be met.
- **SCRT East**
  - Ensure that the service is provided at the agreed times, and in such a way that it meets the needs of the service user as recorded in the support plan.
  - Ensure that service users are fully involved in developing their support plans.
  - Ensure that staff are competent in the administration and recording of medication.
- **Mears – Edinburgh & Midlothian**
  - The service should ensure people receive the care and support required in the agreed timescale.
  - The service should ensure that appropriate risk assessments and guidelines are in place for people who may have reduced mobility and rely on various equipment like walking aids for assistance.
- **Cowan Court -** No areas of improvements.
- **McSence -** No areas of improvements.
- **St Joseph's Services - New Lodge -** No areas of improvements.
- **St Joseph's Services - Circle of Best Practice 1 - Care at Home**
  - The service should ensure that staff are appropriately trained.
- **St Joseph's Services - Circle of Best Practice 2 - Care at Home**
  - The service should ensure that staff are appropriately trained.
- **St Joseph's Services - Circle of Best Practice 3 - Care at Home -** No areas of improvements.
- **Thera (Scotland)**
  - The provider should improve their training records and monitor staff registration requirements.
- **Bluebird Care -** No areas of improvements.
- **Health In Mind Support from Home - Visiting Support** - no recommendations
- **Penumbra Housing Support Service – Wayfinder Park Cottage –** no recommendations
- **ELCAP –** no recommendations

INTEGRATION FUNTIONS & GOVERNANCE DECISIONS

The Scheme of Integration was due to be reviewed by NHS Lothian and Midlothian Council by June 2020. Due to the COVID-19 pandemic this was delayed.

All Midlothian HSCP documents can be found online..

COMMUNICATING CLEARLY

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

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

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

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

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

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

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