# Midlothian Integration Joint Board

## 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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