APRIL 2018

FINANCIAL STRATEGY

Midlothian Health and Social Care Partnership

1. Purpose

The IJB and its partners face a significant financial challenge over the next few years. This is driven by a mixture of increasing demand and expectations for health and social care along with a reduction in real terms in the financial resources available. This financial strategy lays out the principles and mechanisms through which the IJB will reduce its cost base whilst managing increases in demand for the care that it delivers.

The IJB will develop a three year financial plan will articulate in financial terms how the IJB will deliver its Strategic Plan and will be based on this overarching financial strategy. It is clear that if no changes are made to the current health and social care delivery model then the cost increase will significantly outstrip any increases in financial resources – this strategy lays out how that financial gap will be managed.

Our Vision

The Midlothian Health and Social Care Partnership's vision is that people 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.

The IJB will continue the process of full integration of the services delivery teams, not just between NHS and Council delivered services but also moving pan-Lothian services into the locally managed and locally delivered services. This will generate operational and managerial synergies and should reduce costs, however this will be a step in the redesign of services into the establishment of multi-disciplinary teams delivering care in a community based setting.

Key Changes in Our Use of Resources

2. Prioritising the Allocation of Resources

The IJB will make decisions by reviewing the resources available and prioritising them to achieve the agreed outcomes. Guidance on this process has been issued by the Scottish Government and the themes laid out in this guidance are those that flow through this paper (see appendix 2). These themes are based on a fundamental review of the current use of resources in order to support the redesign of the overall health and social care system. The move of resources should reflect the key strategic aims of the IJB. The key principles guiding this movement are outlined in this report, along with some specific plans which are being developed to achieve the required shifts in expenditure:

3 Making More Efficient use of Resources

There are immediate pressures on the IJB which require action to bring the expenditure in line with the monies now being made available by the Council and NHS Lothian

Social Care: The *Realistic Care Realistic Expectations* Programme is intended to identify significant savings through more efficient and more equitable ways of providing social care services. This is being overseen by the Council Business Transformation Group

Prescribing: In response to major pressures upon the local prescribing budget GPs and the Pharmacy Service are implementing a series of changes to reduce expenditure

Service Integration: The social care and health teams within the Partnership are being joined together into one overall team with a single management structure. This will generate operational synergies and stop 'double doing' – for example multiple assessments etc.

4 Public Engagement

The emerging financial challenges facing the partners, and therefore the budgets likely to be available to the IJB, require a concerted programme of public engagement. Transforming health and care services will only succeed if the people of Midlothian understand the changes being considered; are able to influence these; and are prepared to support them. With this in mind a communications and engagement plan is now being developed. A Communication and Engagement Plan in relation to Realistic Care has been developed and is now being implemented. The overall objectives of this communication and engagement plan are to:

- *Inform: People understand the current pressures on social care services in Midlothian and action being taken in response*
- *Inform: Service users and carers understand the specific pressures relating to services they receive*
- *Engage: Social care services understand the experience of service users, carers, the public and partner organisations and what is important to them*
- *Engage: We identify ways to work better together and make changes to our approach*
- *Effective communication and engagement reduces pressure felt by frontline staff*

4 Key Shifts in Our Use of Resources

The financial strategy is based upon the premise that redesigning services as laid out in the Strategic Plan can be funded by moving resources from one model of care to another. Additionally, in time, these shifts in emphasis will result in less costly services.

Move from Failure Demand to Prevention. It has long been accepted that prevention programmes can deliver significant benefits to patients and to the utilisation of health and social care resources. Further development of the prevention principle will be a key part of the IJB's strategy. Much preventative activity is delivered by partners within the broader Community Planning Partnership including employability support services, housing and leisure services. This reflects the findings of the Christie Commission on the future of public services.

Move from Hospital or Care Homes to Community Based Services People wish to remain at home for as long as possible and only go into hospital where it is absolutely necessary. There is considerable scope to provide more services in the community which could lead to significant savings. The IJB has committed to a reduction in occupied bed days of 10% which if achieved should enable a significant transfer of resources to community services.

Move from Treatment and Support to Recovery and Reablement There is a growing commitment to providing more intensive support to enable people to recover as far as possible. Emphasising recovery is reflected clearly in areas such as mental illness and substance misuse while a more proactive approach to rehabilitation is being adopted in areas such as stroke and in the delivery of care at home services more generally

Move to Improved Quality and Access Providing high quality services and enabling quick access to services is likely to lead to reduced costs across the system. People awaiting access to treatment for addiction or to psychological therapies are vulnerable to deteriorating further. People delayed in hospital are more likely to lose their independence skills

Move from Working in Silos to Team Working In order to provide holistic care we need to strengthen our approach to team working. This will be reflected in stronger working arrangements across health, social care and voluntary organisations through joint teams. We will also seek to create more effective working relations between based in local communities

Move from Reactive to Anticipatory Care Planning People with long term health conditions and disabilities need to be supported to plan ahead in response to their condition or their life circumstances changing significantly. This includes Power of Attorney arrangements, emergency planning and anticipatory care planning.

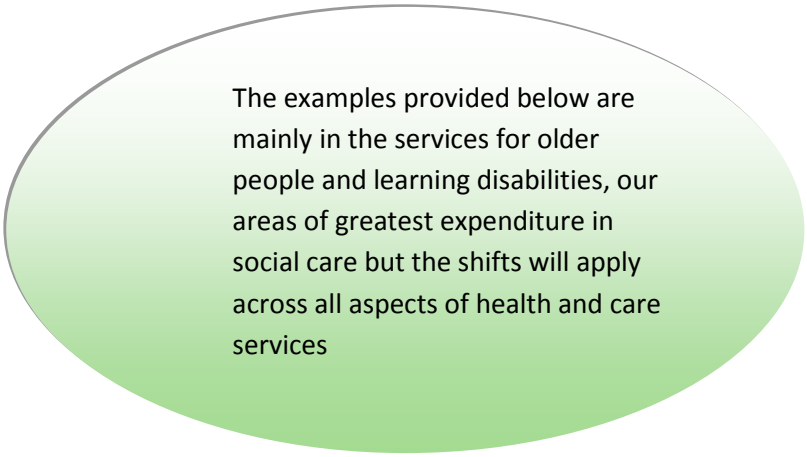
5 Workforce

The Midlothian Health and Social Care Workforce Framework is essential to the successful implementation of the Health & Social Care Strategic Plan. The framework will provide a bedrock for the full Workforce Plan, made up of individual Service Plans. This Framework for Workforce Planning will:

- be primarily future-focused
- be integrated with strategic and financial planning
- be dynamic and responsive to the complex, changing and shifting landscape
- support the understanding of the need to link service outcomes and the workforce required to deliver these
- be relevant to all people who work across health and social care and provide the focal point for staff to develop their skills within the context of transformation
- involve planning and modelling sustainable, affordable approaches to support health and social care integration for the future

6 How the Key Shifts will Work in Practice

These plans are being continually developed and strengthened as we explore with staff and with the public about how these changes can be achieved and in a way which ensures long term sustainability. The following are examples of the redesign of health and care services which if implemented effectively will be better for service users whilst also being more realistic than the current models of care both in terms of reducing finances and workforce availability.



Move from Hospital or Care Home Based to Community Based Services

Learning Disability:

Strengthening and improving access to community based services such as Local Area Coordination rather than the default of formal day services by improving access to universal services such as Further Education and Employability.

Older People:

Preventing ill health depends upon strengthening access to opportunities and services which enable people to stay healthy physically and mentally. Working with and in communities is being piloted in Penicuik through the Housebound Project. Stronger partnership working with the voluntary sector will be critical. A key issue in supporting older people is strengthening the opportunities for people to remain socially engaged given the health risks associated with loneliness.

Move from Hospital or Care Home Based to Community Based Services

Long Term Health Conditions

Diabetes services delivered by consultant led teams within the RIE, significant elements of which could transfer to GP practices and community services

Respiratory services being supported and delivered through physiotherapists and anticipatory care nurses, avoiding the need for admission to hospital in managing conditions such as COPD

Learning Disabilities

As Midlothian reduces its reliance upon inpatient beds and other specialist services there will be scope to strengthen community based services to people with complex needs.

Older People

The reliance upon care home services has reduced in recent years, their focus being increasingly on palliative care and dementia. It is vital that alternatives continue to be developed, particularly extra care housing.

The reduction in the reliance upon hospital beds depends upon strengthening services which avoid admission. This in turn requires the release of some resources tied up in acute settings.

Primary Care and the Community Hospital

In order to shift diagnosis and treatment out of hospital into the community there will be a need to strengthen primary care services. The development of Community Nursing, Physiotherapy and Wellbeing services will help reduce the demand upon GPs allowing this shift to take place. There are also opportunities to maximise the facilities at the Community Hospital and this work is underway with the outpatient board. This will be dependent upon developing a better understanding of Midlothian's use of acute hospitals both for inpatient services and treatment clinics and thereafter developing affordable and clinically safe models of care in Midlothian.

Move from Treatment and Support to Recovery and Reablement

Substance Misuse

The shift from treatment to recovery services is most developed in substance misuse and mental health services. Within substance misuse the development of recovery focused services including the Recovery Cafes and the Recovery College have made an important contribution to improved outcomes for individuals There has also been investment in peer support initiatives which recognises the unique contribution of peers and social inclusion in the journey of recovery.

Care at Home

The Reablement service focuses on helping home care clients to regain their daily living skills and reduce their ongoing dependency on care services. At present this approach is confined to a particular group of staff but there is considerable scope to extend this philosophy to all care at home services.

Learning Disabilities

Challenging Behaviour leads to a significant draw upon health and social care resources. Greater investment is needed to support staff to work more effectively with people who present challenging behaviour at home and in day services. This will include achieving a more integrated approach with the NHS Lothian specialist services.

There are a number of people with mild learning disabilities who with support could reduce their reliance upon formal supports through further education, travel training and employability support

Improve Quality and Access

Delayed Discharge
The models of care can result in an inefficient use of resources. One of the most pressing examples is delayed discharge. Delayed discharge consumes resources in the system and delivers no benefit at all to the patients trapped in this process. Work on anticipatory care and hospital at home should support admission avoidance which will strike at some of the root causes of delayed discharge.

Learning Disabilities
Developing new approaches to supporting high levels of need will help ensure the most effective use of both money and workforce. Examples of these include overnight care and one to one support within day services. This work will be underpinned by the Fair Access to Care policy and will, for instance, lead to the development of more shared tenancies working to a set financial cap on care packages.
A number of people are provided with day services in Edinburgh. This wastes money on non-productive transport. Services should wherever possible be provided locally. Some people with mild learning disabilities are supported in expensive services such as Cherry Road. Steps will be taken through individual reviews to ensure people are receiving services appropriate to their needs.

Older People:
The delivery of care at home services in an efficient and yet outcome focused way is challenging. Key issues include effective workforce planning to recruit and retain skilled staff. There is also to organise more efficient models of care which minimise travel time and reduce down time. In relation to care home services shortcomings in quality of care can lead to increased expenditure through Large Scale Investigations and preventable admissions to hospital

Move from Working in Silos to Team Working

This shift is a key driver of the integration agenda aiming to both improve efficiency and more seamless services to individuals

Learning Disabilities
Building on the move to local management of the NHSL Learning Disability Service work is underway to integrate this service with the relevant social work staff.

Older People
Strengthening team working is more challenging in older people's services given the range of staff and services involved. Developments such as MERRIT and the Joint Dementia Team have demonstrated the value of doing so. This must be mirrored at the primary care level, particularly between district nursing and care at home services. The Penicuik Housebound Project may provide some pointers to the way ahead with the possibility that through more efficient team working resources can be freed up.

Primary Care
There is very clear scope for reducing duplication by creating a more coherent joined up approach to the delivery of community nursing nd care at home services. This may include a move towards a more structured model of care coordination which will be tested through the Penicuik Housebound Project

Move from Reactive to Anticipatory Care Planning

Learning Disabilities
The greatest additional demand on expenditure in learning disabilities arises from children moving into adulthood. Transition is a key stage in working with service users and their families to ensure that

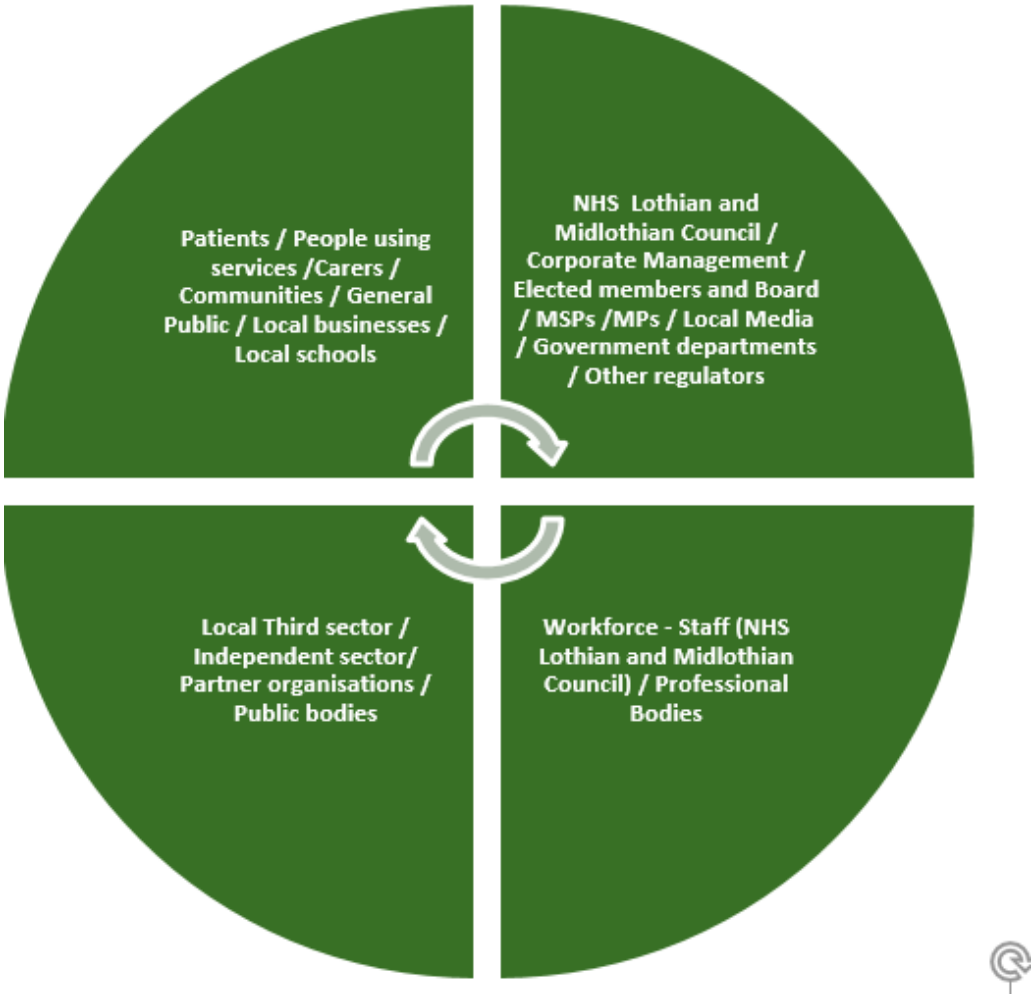
expectations are realistic and t opportunities for independence are planned and maximised as far as possible.

Older People

The value of supporting people to plan ahead has been reflected in the national profile given to developing more holistic approaches to anticipatory care planning; the importance of carers having emergency plans in place; and the promotion of the benefits of Power of Attorney arrangements.

7 Who will make this Strategy Work in Practice

The redesign of health and care services requires the development of a consensus about how we use our limited resources. Inevitably this will pose challenges for decision-makers; staff; partner agencies and people who use services but if we take the time to communicate effectively with one another we will be better placed to reshape our services effectively:



8 Impact of this Strategy if Successfully Implemented

The scale and pace of change required cannot be overestimated. However if we can be brave and think differently about health and care there are strong grounds for trusting that we all stand to benefit> We will place more emphasis upon staying healthy; on recovering; on living well in old age or with long term health conditions; and on being more confident about managing our health now and in future:

Achieving Better Outcomes