MIDLOTHIAN INTEGRATION JOINT BOARD

Annual Performance Report

2016-17

Draft Version
To be ratified by IJB on 24th August 2017

Foreword

Integration is important but hard to do well. At its heart is the need to ensure that people who use our services get the right care and support whatever their needs, at any point in their care journey. In our first year as Midlothian Integration Joint Board (IJB), we have been getting to grips with this work.

- We have improved our understanding about the needs of our communities;
- We are reviewing our services so we can identify the potential for re-design and start to make changes that will have a positive impact on people's health and wellbeing.

Finances, population and workforce challenges mean that the transformational change required is considerable but necessary.

'Integration' for us is about transforming services and how we work, so that we have high quality care that is community-based, puts the person's needs at the centre and is accessible. It means investing in prevention to encourage peer support and self-management to keep people well. This is the right emphasis to have as it is estimated that 40% of our spending is currently accounted for by interventions that could have been avoided by prioritising a preventative approach. We must work in partnership across organisations, not just in health and social care, but more widely with other services as well as communities and individuals to recognise the importance that housing, finance, and employment has on our health and wellbeing. What we have been charged with doing requires change but it will also take courage. Put simply, staying still and doing more of the same is not an option open to us. The formation of Midlothian Integration Joint Board (IJB) has enabled us to approach the challenges we are faced with in different ways from before.

For example:

- Develop a local Primary Care Strategic Programme, which allows us to focus on the demands our teams face and work on solutions together with staff and patients
- Taking responsibility for developing a deeper understanding of how people in Midlothian use our acute hospitals like the Royal Infirmary and the Western General. Working with our hospital colleagues should result in a shift in resources so that we can do more for people locally to avoid hospital admissions as well as get people home more quickly
- Acting more quickly as opportunities arise to plan and provide services jointly that meet the needs of our local population and address health inequalities
- Maintaining our commitment, despite the financial pressures to focus on prevention so that we make the best use of the resources available

Without the formation of the IJB, some of these things may not have happened at all, or the pace of change would have been slower - important points to highlight. These are early days and there is still much to do. In this first annual report, we have reported on our progress against the national outcomes that all IJBs are measured against, but we have also tried to explain who we are as an organisation and share the stories of the successes and challenges over 2016/17. Our thanks to you all who contribute so much to the work we do.

Eibhlin McHugh, Chief Officer Midlothian IJB

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Section 5 Our Strategic Plan
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Section 6 Locality Planning and Integration Principles
This documents how we work as an organisation and with examples, shows how we are following the principles of integration.

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The annual report shows some of the highlights as well as the challenges of planning and delivering services across Midlothian. Throughout you will see other reports and strategies referenced. For more detailed reading, please see Appendix 1 for a list of these additional documents.

2. EXECUTIVE SUMMARY

As we reflect on our first full year of operation as Midlothian Integration Joint Board (IJB), the words that come to mind are transformation and partnership. We are working in a challenging financial environment, but close joint working with NHS Lothian and Midlothian Council has allowed the IJB to successfully deliver on a range of outcomes and manage our delegated financial resources. The financial pressures facing Midlothian Council and NHS Lothian mean that we must accelerate our programme of change in coming years.

We have seen successes and made progress, but have experienced challenges too, as we have taken on full responsibility for health and social care services for adults as well as services for offenders.

Successes in terms of working differently, always with the person at the centre of our plans as well as in partnership so that we can better meet people's needs- the Wellbeing Service and the Mental Health Access Point offering two excellent examples. Our challenges include the increasing demands on our services brings as our population grows and we all live longer. The on-going workforce issues that we have seen in Primary Care and Care at Home services amongst others have brought difficulties that we have not yet been able to resolve and we are very aware of the impact this has had on people living in Midlothian.

Colleagues across health and social care are working hard to integrate service delivery for the benefits of patients as well as the public purse. We have committed to a way of working which considers the whole person and our 'House of Care' approach can be seen across a range of services for the benefits of people with a long term condition, including cancer and mental health problems.

Change is also underway as we work with our hospital colleagues to shift care and resources from hospitals into the community, which is of particular relevance to our increasing number of older people. Of particular note is our MERRIT Team (Midlothian Enhanced Rapid Response and Intervention Team) whose range of health and social care expertise helps support older people to stay in their homes and to return home from hospital as soon as possible. While partnership working is not new, we are keen to look at opportunities to bring colleagues together and Midlothian's Joint Dementia Team is an excellent example of how working together across health and social care services can improve the quality of care.

More detail can be seen in our Strategic Plan, which sets out the journey we want to make over the next two years and how we intend to redesign services. This includes supporting people to stay healthy and enabling people to recover or live well with their long-term condition. We will give a strong emphasis to helping people to manage their own health, recognising the uniqueness of each individual. We will also pay particular attention to addressing the unfair health inequalities in our communities which are often linked to poverty and unemployment.

The pace will not be easy and a joined up approach to strategic and financial planning will be key as we aim to deliver services that are accessible and of a high quality to everyone in Midlothian, within these challenging financial times.

Some of our key achievements in our first year are:

- The Community Planning Partnerships and area targeting work which brings services and communities together across Midlothian to tackle inequalities and create solutions for local health and care needs.

- Developing our House of Care approach across a range of services for people with mental health problems, people affected by cancer, vulnerable communities and people with long term conditions. All of these services give people time and space to think about what matters to them.

- Investing in joint teams that have an impact on hospital admissions and delayed discharges, like MERRIT.

- Bringing services closer to home with the move of rehab services from Liberton Hospital to Midlothian Community Hospital.

We will publish an Annual Performance Report each year to share with you what we have achieved as well as our challenges and the impact these have for everyone in Midlothian.

3. INTRODUCTION – OUR VISION

Midlothian Integration Joint Board brings together NHS Lothian, Midlothian Council, third sector partners and communities to plan and provide services to meet the needs of our population. Our 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 want everyone living in Midlothian to be as healthy and well as possible and respect that people should have control over their lives. However, when help is needed, our services and the care and treatment we provide should be of a high standard, easy to use and accessible.

In terms of how we measure impact, our Strategic Plan sets out how we will deliver on the nine national health and wellbeing outcomes for integration. This Annual Report describes our progress against them and to help illustrate where we think we have made a difference, some key areas of work are highlighted.

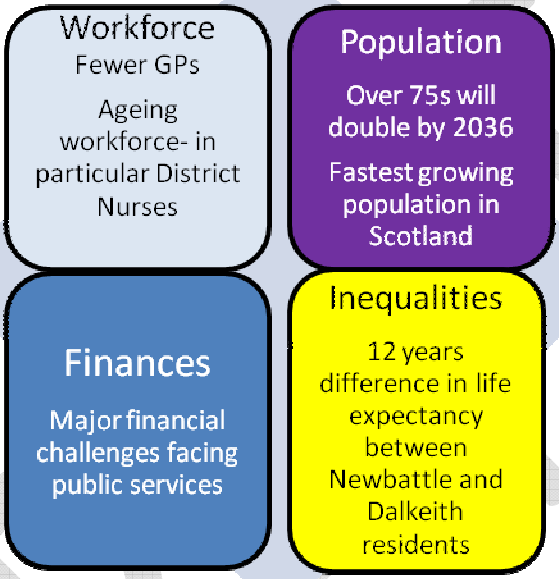
National Health and Wellbeing Outcomes

1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	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
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
7	People using health and social care services are safe from harm
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

Scottish Government identified 23 indicators that were felt evidenced the nine national health and wellbeing outcomes and these are set out in Section 3. In addition, the IJB agreed on two additional 'weather vane' indicators- the rate of over 75s admissions and delayed discharges (over 3 days).

The Strategic Plan sets out how we want to re-design services and engage with our communities as part of this journey. Put simply, there are neither the finances nor the staff to keep providing services the way we have been doing and so change, collaboration and innovation are required for us to meet the challenges ahead. Our 'Realistic Care Programme' will help us make the shift to care models that are sustainable, fair and provide better outcomes for all.

Our challenges



As our population grows and gets older, people have more complex health and social care needs and so our services must change. We also need to work in ways that make the best use of our resources. Finally, we need to pay particular attention to addressing the unfair health inequalities in our communities which are often linked to poverty and unemployment.

We are fortunate in Midlothian to have a wide network of user groups who have already influenced the Strategic Plan. We will continue to listen to our communities, developing trust and respecting each other's perspectives, as we build on the good work which has taken place in recent years in neighbourhood planning. For our staff, we will support them to have the skills and confidence to work in a more holistic way and in partnership with other agencies and with the unpaid family carers whose role cannot be overestimated.

Looking wider than Midlothian, the re-organisation of our health and social care systems mean that there is complex work going on 'behind the scenes' with our colleagues in hospitals and other IJBs across the Lothians to ensure that we make the best use of resources to meet the needs of our communities.

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. Key to our financial strategy is ensuring that we are rebalancing services by shifting spend from hospital and other institutional care to more robust and responsive services in the community.

In this, our first annual report, we want to look back over the work from 2016/17. We describe what the IJB has achieved against the health and wellbeing outcomes as well as some of the main areas we have been working on and the difference this has made.

In brief, you will find examples that focus on:

- Older People
- Primary care
- Hospitals
- Health inequalities
- Long term conditions

Our work is set out more fully in our Strategic Plan and Delivery Plan. Please see Appendix 1 for a list of links to key documents and reports.

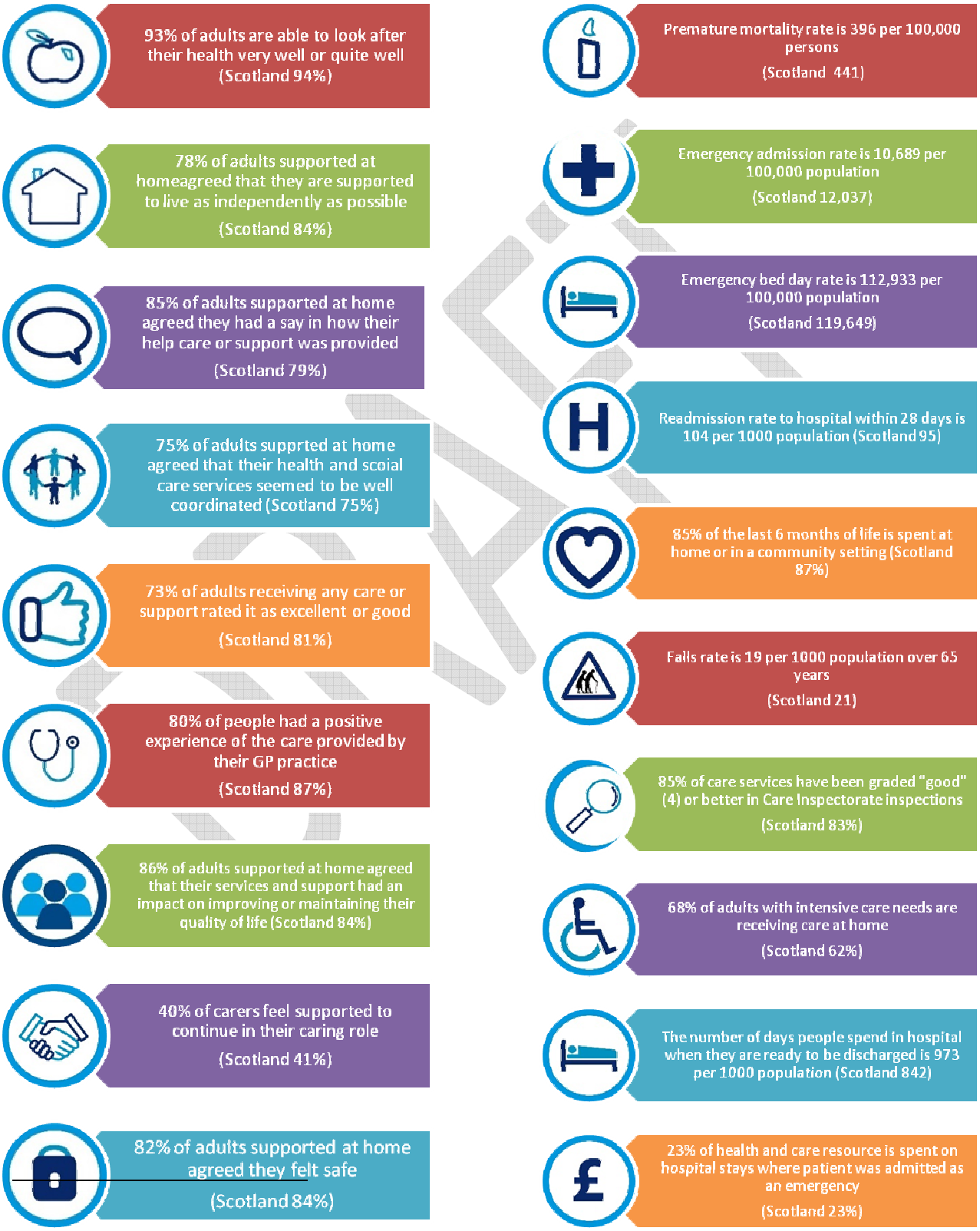
The annual report offers an opportunity to reflect on what went well, but also to acknowledge the challenges we have faced and how, as an organisation we have chosen to respond to difficult circumstances and learn from these experiences.

4. NATIONAL HEALTH AND WELLBEING OUTCOMES-OUR PERFORMANCE

The following indicators evidence the nine National Health and Wellbeing Outcomes.

2016 /17 Performance at a glance[1]

[1]ISD (June 2017) Midlothian 2016/17 Performance Core Suite of National Health and Wellbeing Outcome Indicators



4 (a)

Outcome 1- Improved health and wellbeing
People are able to look after and improve their own health and wellbeing and live in good health for longer

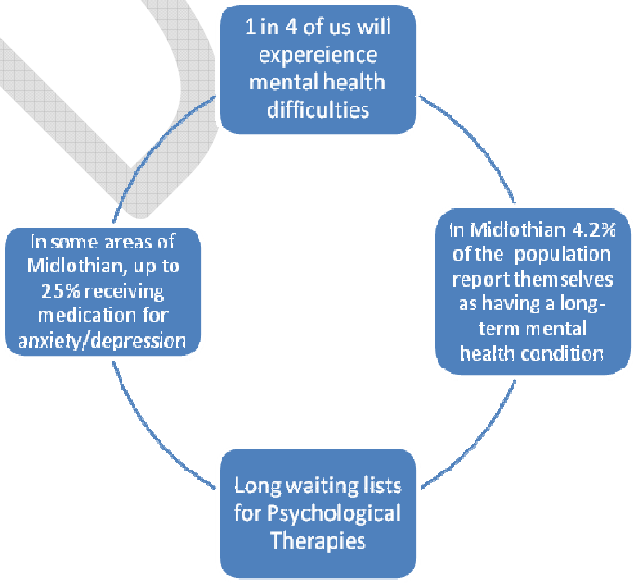
Indicator
93% of adults are able to look after their health very well or quite well (Scottish rate 94%)

Supporting people to stay healthy is not new, but encouraging people to live well needs a range of approaches, services and amenities. For example, being more active is easier if there are safe streets, cycle paths and affordable leisure services. Eating well includes access to affordable fruit and vegetables. Our partnership working with the Food Alliance, Council Services such as Leisure and Recreation and the voluntary sector are crucial to these issues.

Our emphasis on prevention can only work if we have strong relationships in place so that we can support people in a holistic way. We know that lives are complex and that the challenges people are dealing with such as unemployment, money worries and managing long-term health conditions all have an impact on mental and physical health and the ability to make choices that help us to live well. If we have confidence to look after ourselves and have more control in our lives, this enhances our sense of wellbeing, but we recognise that for some people in our communities, this is difficult, so finding ways that we can support people to do this is important.

We know that mental health issues are common reasons why people see their GP. But quite often, because of the many different issues that contribute to someone's difficulties, GPs are not always the best placed to help. We wanted to develop services that could offer a different approach from prescribing medication and had the time and skills required to support individuals to find the solutions that felt right for them.

The Challenges:



Progress in 2016/17

Wellbeing Service – in partnership with the Thistle Foundation

The Wellbeing Service has grown and is now available in eight of our GP practices. It gives people time and space to consider what is going on in their lives and to develop their own ways to feel better. The 'good conversation' demonstrates our 'House of Care' approach to seeing the whole person.

The top issues reported are:

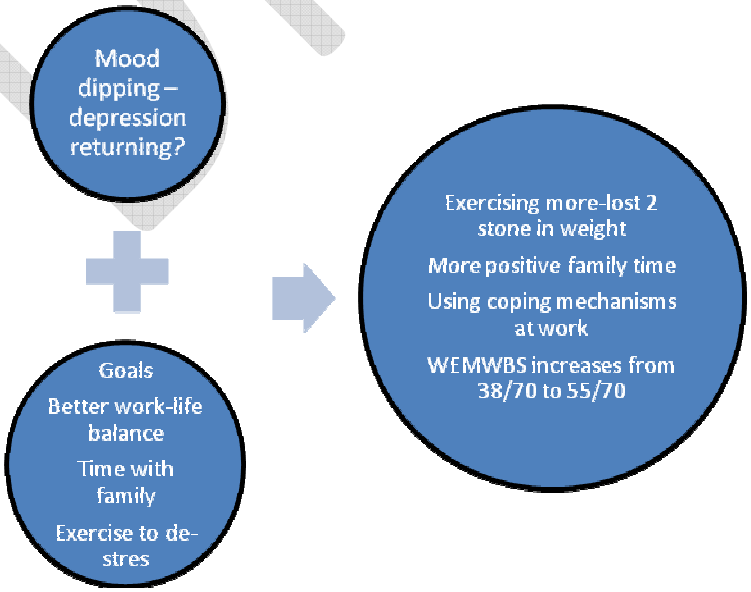
- Family
- Relationships
- Money worries
- Housing issues
- Long term mental health issues

Data to end March 2017 identified that:

- 809 people referred – more likely to be living in an area experiencing multiple deprivation than the population of Midlothian as a whole.
- 508 people supported via 1648 appointments
- There is a significant increase in people's WEMWBS over time (this measures general wellbeing). On average, people have moved from a score of 35 at first appointment to 49 on discharge. This is just over the population average score.

Health Economics work is on-going as part of the full evaluation which will cost outcomes such as weight loss, in terms of saved GP appointments and impact on prescribing.

Case Study - John's story. 52 years old and has lost a close family member

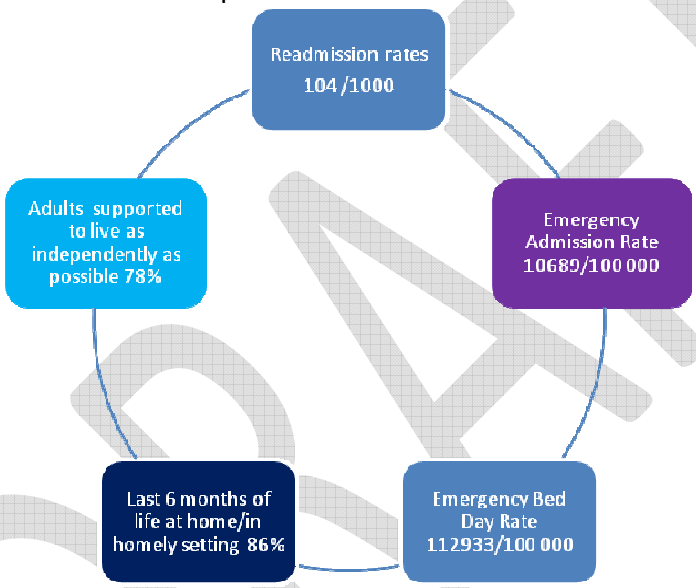


4 (b)

Outcome 2- Support to live in the community
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

Although services are working hard to support people in their own homes, or as close to home as possible, some areas have been challenging for Midlothian and some of our performance indicators are below the Scottish average.

Emergency admission and bed day rates are both lower than the Scottish average, however the readmission rate is higher. The number of days people spend in hospital when they are ready to be discharged is also higher than the Scottish rate. Our plans to address unscheduled care and to ensure people are discharged within the 72 hour target remains a top priority for the Partnership.



Progress in 2016/17

Whilst the lack of capacity in 'care at home' services is a major problem, we further invested in the **Midlothian Enhanced Rapid Response and Intervention Team (MERRIT).**

This aims to prevent avoidable admissions to hospital, help achieve a speedier discharge home, provide an intensive rehabilitation service either in the home or within the intermediate care unit at Highbank, and provide an alternative to hospital admission for older adults in Midlothian.

With extra investment, the "Hospital at Home" service now operates 7 days per week. In addition, a new post to support people with advanced Chronic Obstructive Pulmonary Disease (COPD) so they avoid hospital admission is in place. These developments mean that more people can be looked after at home. It also means more people can leave hospital quickly. As a result Midlothian has a low rate of people who are unable to leave hospital because the necessary care is not in place.

4 (c)

Outcome 3 – Positive experience and treated with dignity

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

Feeling involved in your own healthcare is important. In Midlothian, 85% of people agreed that they had a say in how their care was provided, which is higher than the Scottish average. However, ratings for health and care services and the care provided by GP practices were lower than the Scottish average. Finding it hard to see a GP has been raised by people across Midlothian and probably contributes to our lower than average score.

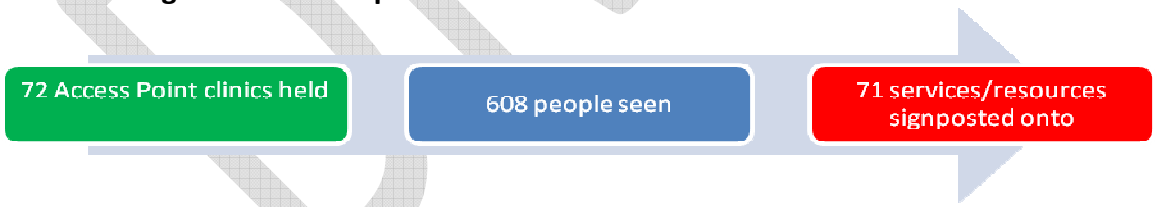
We also recognise that many people in Midlothian experience difficult times, struggling with addictions, mental health problems or are at risk of offending. Approaches focusing on peer support, such as the Recovery Cafe and SPRING are part of our commitment to having the appropriate support and pathways in place for those at particular risks. Communities also benefit from Unpaid Work projects undertaken as part of community based sentencing.

Progress in 2016/17

Access Point – in partnership with Health in Mind

We are aware that it takes courage to seek help and that long waits for services such as Psychological Therapies can create barriers to people coming forward. As a Partnership, we wanted to offer a responsive and accessible service and in mid-2016, launched the Midlothian Wellbeing Access Point. The service operates as a drop-in, so no referral is needed. This is an important feature, as the service is available when the person feels ready to seek help and it takes away the delay usually associated with accessing a service. Based at the Midlothian Community Hospital and Eastfield Health Centre, the service offers time with a Nurse Therapist to help people decide what they need to increase their mental wellbeing – reducing low mood, feelings of stress; increasing confidence and self-esteem.

Between August 2016 and April 2017:



Common themes emerging from the Access Point

- Referrals to Psychological Therapies more appropriate
- Higher percentage attending assessment appointments and a higher percentage of men attending who have not used mental health services before
- People signposted / referred onto services that were not known to them

What people said….

"Worker was very kind and took time to really listen to my situation."

"Range of options for help. Felt listened to and acknowledged"

"Able to offer me another appointment quickly to go into what I needed."

4 (d)

Outcome 4- Improved quality of life
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

The Performance Indicators relating to maintaining quality of life (84%) and the percentage of service graded 'good' or better by the Care Inspectorate (85%) were both higher than the Scottish average.

Progress in 2016/17

- **Highbank Care Home** provides 27 intermediate care beds. These beds are for people leaving hospital but not yet ready to go home or people who would otherwise have needed to go to hospital. After a stay at Highbank, 80% of people have higher independence and 53% are able to return home instead of going to a hospital or care home

- Midlothian now has an integrated **Dementia Team** who provide an immediate response to emergencies for people with dementia.

- **Midlothian Active Choices (MAC)** supports people with mental health, obesity or long-term health conditions. Alongside this, the **Ageing Well** programme, with its bank of volunteers offers a range of activities that enables older people to stay active and is now available in care homes and sheltered housing complexes

- 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

4(e)

Outcome 5- Reduced health inequalities
Health and social care services contribute to reducing health inequalities

It is well recognised that vulnerable individuals and those from a disadvantaged background are more likely to suffer from ill health, complex health issues, and require greater resources to keep them healthy. The core integration measure of premature mortality among people aged 75 and under is lower than the Scottish average. This shows positive progress over the last 5 years from 414 to 396 deaths per 100,000 population over 5 years.

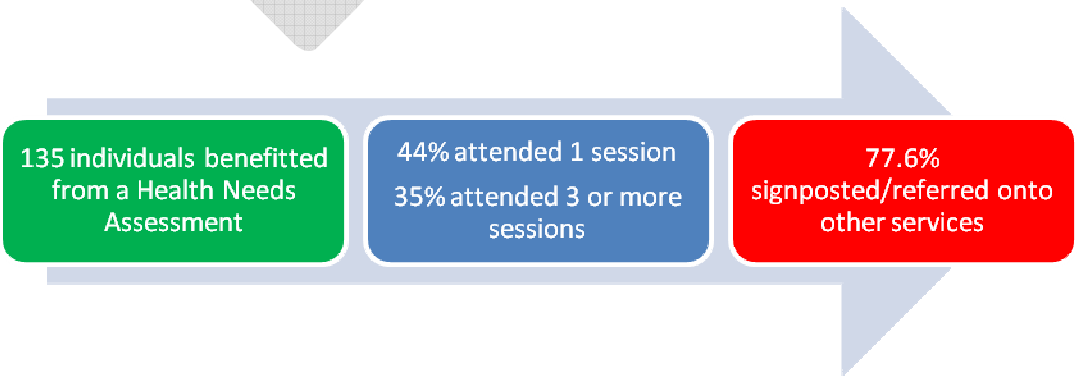
Investment by the IJB in services for offenders and for people with mental health and substance misuse problems reflects that reducing health inequalities is a priority for the IJB and the Community Planning Partnership. The Community Planning Board has developed a set of indicators that tell us whether we are making progress in reducing health inequalities and this work has been recognised as good practice in other parts of Scotland.

Progress in 2016/17

The IJB elected to include services for offenders in its scope to strengthen the local approach to addressing the health and care needs which are often the root causes of offending behaviour. **SPRING** supports women with complex needs who are at risk of or have been involved in offending. **Fresh Start** engages with individuals at the point of arrest and links them into relevant services such as substance misuse and mental health services.

The **Community Health Inequalities Team (CHIT)** launched a new service back in March 2016. Vulnerable individuals, such as carers, veterans and people experiencing homelessness have an opportunity to meet with a nurse for up to an hour to discuss what matters to them and what they would like to happen to help them lead healthier lives. The team also run a pre-diabetes programme for anyone at high risk of developing type 2 diabetes. Analysis of where people live demonstrates that the service is reaching people from more deprived areas.

Between April 2016 and March 2017:



4 (f)

Outcome 6- Support for carers
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

As a Partnership, we could not do what we do without the contribution made by unpaid carers. We estimate that @10% of our population have some form of caring role. In the national indicators, 40% of carers feel supported to continue in their caring role (Scottish rate 41%)

Financial security, physical health and emotional wellbeing are key issues. We have worked in partnership with VOCAL (Voices of Carers Across Lothians) and CAB to develop targeted services to meet these needs.

Progress in 2016/17
VOCAL has partnered with local agencies to develop peer support groups, monthly carer health surgeries and counterweights classes at the Midlothian Carers Centre. It has also assisted carers in receiving over £227,000 through advocacy for PIP (Personal Independence Payments) and ESA (Employment Support Allowance) assessments.

A Respitality scheme for carers to access hospitality sector opportunities for short breaks.
The providers make a 'gift' to a carer (plus companion) so they can have a short break away from the often heavy demands of their caring responsibilities, to recharge their batteries and have some 'me time'

Links between VOCAL and Health and Social Care services
Primary care and VOCAL Midlothian have been undertaking a pilot project in Dalkeith Health Centre in an attempt to support GPs in the service they offer to unpaid carers, helping them address issues which may be due to their caring role.

A multi-agency led Power of Attorney (POA) promotional campaign ran in November 2016 and resulted in a number of local people applying for POA and most people receiving a beneficial discount or access to Legal Aid to cover the costs. VOCAL runs monthly Power of Attorney surgeries for carers to create POAs for carers and the person that they care for – in the last year 120 carers received support to set up a POA.

The Community Health Inequalities Team (CHIT) provide surgery appointments to unpaid carers to discuss their health needs and find ways to address issues which may be affecting their health and wellbeing.

4 (g)

Outcome 7- Safe from harm
People using health and social care services are safe from harm

Good joint working is strongly associated with supporting people to be safe from harm, as well as helping prevent avoidable risks. The East Lothian and Midlothian Public Protection Office involves health, social care and Police working together to support and protect adults and children who may be at risk of harm.

On the core integration indicators performance is positive with 82% of people supported at home feeling safe (Scottish average 84%) and the falls rate among people aged 65+ has reduced from a high of 23 in 2012/13 to 19 in 2016/17, which reflects the well-established falls pathway we have in Midlothian.

Progress in 2016/17
We will provide support to help keep people safe. Specific examples include:

Ensuring Midlothian services have a better understanding of domestic violence. Midlothian has the sixth highest rate in Scotland, but our services are becoming more aware. This issue comes up frequently with the new Wellbeing Practitioners based in eight of our Health and can often be the starting point people need to take positive steps.

We have worked in partnership with Women's Aid and Midlothian Council to increase refuge capacity within Midlothian. An additional flat was secured that we can specifically use to meet the needs of women with co-occurring substance misuse and domestic abuse. The substance misuse project worker will work closely with the accommodation team workers in developing our capacity to support women with complex needs within this unit.

Telecare is an important element of our strategy to support older people for as long as possible in their own home, maintaining independence, managing risk and reassuring families. Discrete sensors are placed around the home that can create automatic alerts or the individual can press a button to signal that there is a problem like a fall.

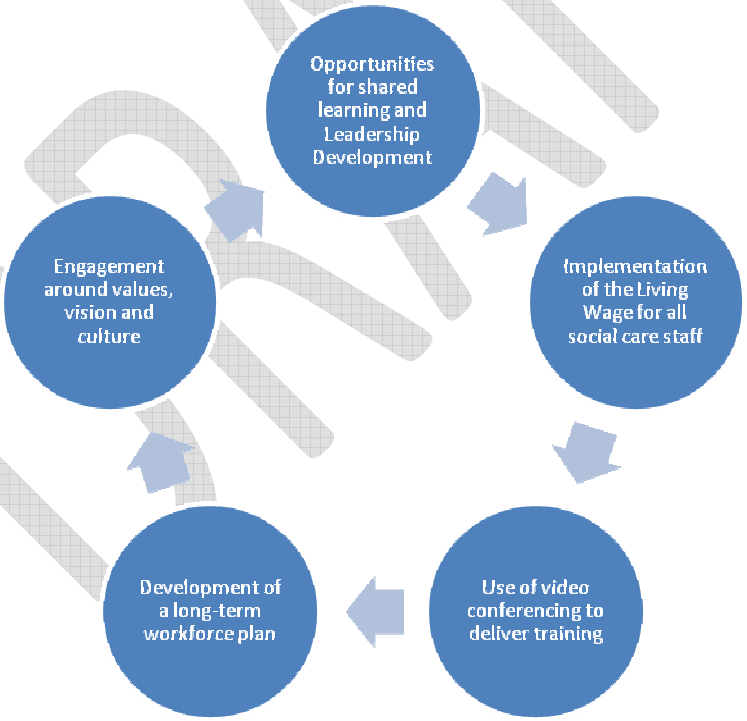
4 (h)

Outcome 8 – Engaged and supported workforce
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

To support the changes we want to see happen in Midlothian, our staff are crucial. Integration brings opportunities for professionals to work more closely together and is also critical to addressing staff shortages. Our staff need support too and opportunities to learn together so that they have the skills and confidence to work in a more holistic way is important.

In terms of staff surveys, iMatters is being rolled out to all Health and Social Care Partnership staff for the first time this year, so will include social care staff.

Progress in 2016/17



4 (i)

Outcome 9- Efficient and effective use of resources
Resources are used effectively and efficiently in the provision of health and social care services

In 2016/17, we have achieved a balanced budget position.

At 23% the level of health and care resource spent on emergency hospital care is the same as the national average. 85% of people spend the last 6 months of life at home or in a community setting, rather than in hospital, which is lower than the national average of 87%.

Prescribing is the main pressure which had an overspend of £1.3m in the year. Medication is vital in helping people recover and keeping people well. However the costs are high; almost £17m of the total £86.7 million budget for NHS Services in Midlothian is spent on prescribing. Considerable effort is being made to reduce these costs safely whilst developing alternatives.

Successful implementation of the Social Care (Self Directed Support) (Scotland) Act 2013 has resulted in growth in Self Directed Support which promotes more individual choice and control over how services are delivered

5. OUR PROGRESS AGAINST THE STRATEGIC PLAN 2016-2019

Our key priorities for change were as set out in our Strategic Plan were:

We said that we would provide services differently so that:

People are treated as individuals and have the confidence to look after themselves where they can

- Technology is used to help efficiency
- They are more easily accessible
- People know what services are available and have access to good information
- We help people to think about their future needs

Acknowledging the challenges of finances, the changes in our demographics and the persistent inequalities that exist, the Partnership's approach has centred on re-framing our expectations of the health and social care system and as part of this, testing out new ways of working. The Partnership issued its Directions, which sets out the things that we said Midlothian Council and NHS Lothian must undertake and these map onto the Strategic Plan. For a link to the Strategic Plan, please see Appendix 1.

The following section highlights some key areas of work.

Key Area 1 Older People

Directions 1, 2 and 5
What we wanted to do:
Have more services delivered locally
Prevent unnecessary hospital stays, especially for people with complex needs such as dementia

Over the next 20 years, the number of people aged over 75 will double in Midlothian. Many older people live well and remain independent, as well as making a significant contribution to Midlothian through volunteering or as informal carers for family and friends. But we know that there can often be issues such as feeling lonely that can impact on people's sense of wellbeing.

Reducing isolation and ill health- our services support people to stay active and encourage social interaction, like Ageing Well and Midlothian Active Choices (MAC) and a new day centre in Woodburn, one of our most deprived communities- Grassy Riggs – brings people together to tackle isolation.

For those who need input as they get older, we want to be able to care for more people at home, or in a homely setting, rather than in hospital. The skills and expertise of our health and social care teams, working in partnership with the voluntary sector and unpaid carers, means that we can do this. But to provide community-based alternatives, we also need to develop a better understanding of how the Midlothian population uses acute hospitals.

- Admission Prevention

We are giving priority to developing services which reduce the need for people to go into hospital, like 'Hospital at Home' (part of the MERRIT service).

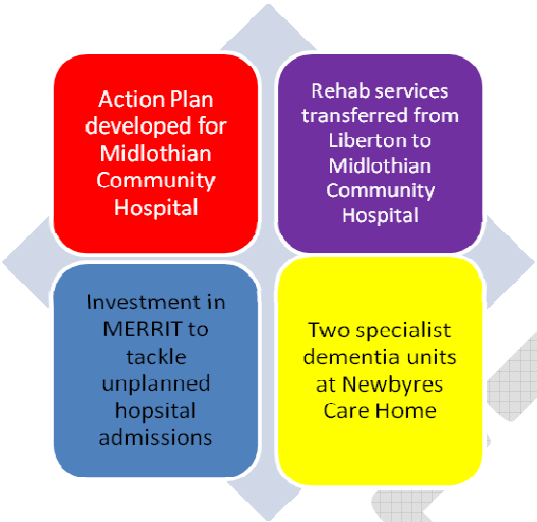
- Facilitating Early Discharge

Delayed discharge, even for a day is in no-one's interests and while Midlothian has consistently met national discharge targets in recent years, we should be working towards the complete elimination of delays in hospital. Our performance in relation to repeat emergency admissions, whilst improving, remains relatively poor. We are taking further action to reduce unnecessary admissions including more intermediate care beds.

Our 'Care at Home' service has faced significant difficulties over the last year. Home carers play a vital role in terms of day to day tasks as well as responding to emergency situations such as falls and across Midlothian provide 820 hours of care each day. But we have faced great difficulties in recruitment, while at the same time, knowing that more people need the service. This has led to people having to wait to receive care at home, which is very distressing. The situation has also impacted on other services, such as Re-ablement and caused pressures in the system so that people are unable to come home from hospital. As a result, we have taken steps to improve the situation, such as making sure care is given to

those who most need it and looking at how to attract more people to work for Care at Home services.

What we did:

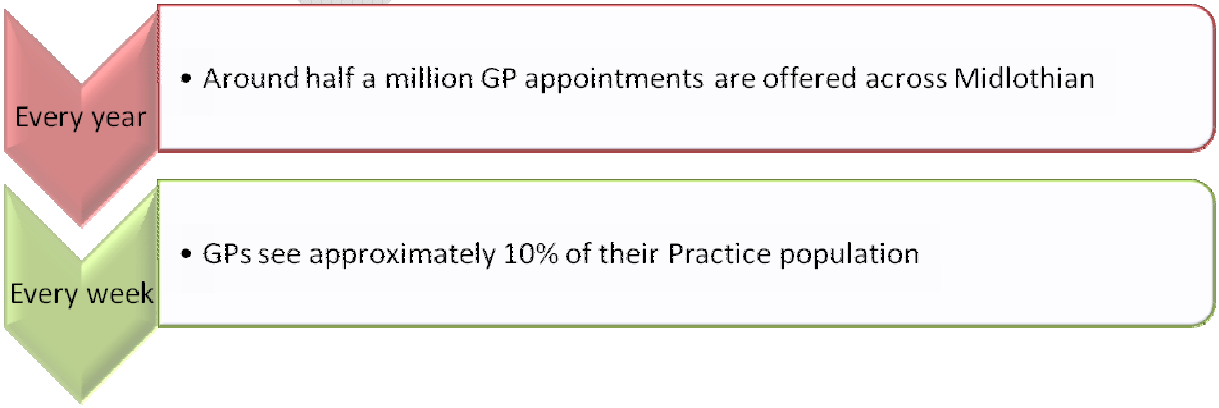


Our Older People's Strategy sets out our plans for 2016-2019 and can be found here:

https://www.midlothian.gov.uk/download/downloads/id/2249/the_joint_strategy_for_older_people.pdf

Key Area 2 Primary Care

Direction 4
What we wanted to do
Ensure that General Practice is sustainable and is resilient to current and future demand. We also wanted to deliver better care for individuals and populations at a lower per capita cost.



We know that our practices are under pressure and that there is more demand on services. We also recognise that our workforce is changing.

The move to restricted lists for several of our practices was something we did not expect to happen on the scale it did and managing the demand on primary care has been and remains a challenge.

It has focused our minds to come up with solutions that will increase capacity in the system, by investing in premises, looking at the workforce in terms of training and new roles, such as extending pharmacist input into five practices across Midlothian.

We are also working with our partners in planning at Midlothian Council so that we take a pro-active approach to the impact housebuilding will have on services.

We know that 80% of GP visits and 60% of all hospital admissions related to long term conditions and we wanted to be able to respond in a better way to people's needs. The Wellbeing Service is currently delivered in 8 GP practices (as of January 2017). They provide intensive person centred support to people who are identified by GPs and others across the system as being in need of support to improve aspects of their health and wellbeing.

Monitoring data indicates a 'highly significant' improvement noted in scores related to WEMWBS (a tool that measures general wellbeing). Further evaluation will bring in health economics expertise to value other outcomes, so for example, if as a result, a person loses weight, how much money does this save, in terms of GP visits and prescribing?

Key Area 3 Prescribing

Prescribing- Direction 6
What we wanted to do
Take measures that support a reduction in spend

Five pharmacists are 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.

Key Area 4 Substance Misuse Services

Direction 9
What we wanted to do
Take measures that support a reduction in spend

Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) is an integrated service with a focus on prevention, early intervention and recovery. Since April 2016, funding that from 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 service. Funding has been agreed to extend the GP peer support pilot into 6 additional practices for a 1 year period.

Work is continuing to develop a recovery hub within Dalkeith where both health and social care staff across Mental Health and Substance Misuse Services can be co-located and jointly managed.

Key Area 5 Health Inequalities

Focus on Health Inequalities- what we wanted to do
Change deep-seated, multigenerational deprivation, poverty and inequalities

There are unfair and avoidable differences in people's health across Midlothian. Although health is improving for most people, it is not improving fast enough for the poorest and most disadvantaged sections of our society. This is known as *health inequalities*. Put simply, those who have lower incomes, poorer housing and less access to paid work experience poorer health. It also means that when difficulties come along, they may feel less able to cope, both physically and emotionally. When we look at the information across Midlothian, we can see that there are clear inequalities related to health, educational

achievement, pay and employment. For example, there is a 12 year difference in life expectancy between Newbattle and Dalkeith, a very is a stark reminder of the unfairness that exists.

Midlothian Community Planning Partnership (CPP) made a commitment to tackle these inequalities as its priority for three years (2016-2019). In addition, addressing health inequalities is a priority for the IJB.

This is a long-term challenge and needs action and decisions across areas such as employment, education, health, early years services, welfare support and housing as part of the relevant strands of the Community Planning Partnership.

Work has been undertaken to develop a set of indicators which will help us monitor changes to the gaps between the most and least deprived communities in Midlothian. These include life expectancy, prescribing rates for anxiety and depression, primary school attendance and working age population in receipt of benefits. What we want to see is this gap between the most and least deprived communities get smaller. A full list of indicators can be seen in See Appendix 2.

What we did:
Area targeting is an approach to target the three areas in Midlothian with the highest levels of deprivation in terms of educational attainment, income, health, and access to services. The aim is to reduce the life outcome gaps for residents in Gorebridge, Mayfield, and Dalkeith/Woodburn. See Section 3 for more information on this and the Community Planning Partnership.

Our ambition to deliver person-centred integrated care is captured in our 'House of Care' model. This concept is based upon creating space for people to have "a good conversation" about what is important to them and delivering a plan that will help people to live well.

We wanted to establish person-centred and accessible services for our most vulnerable communities including unpaid carers, the homeless and people with mental health problems. Services such as the Access Point and the Community Health Inequalities Team (CHIT) are designed to proactively engage people who might not attend their GP practice and are at most risk of having poor health outcomes.

Key Area 6 Hospitals

Focus on Hospitals- what we wanted to do
Reduce avoidable use of hospital beds
Understand more about how people in Midlothian use our acute hospitals

In seeking to change the model and balance of care, we wanted to understand how the Midlothian population is using acute hospitals like the Royal Infirmary and the Western General, so that we can plan safe and effective community-based alternatives.

In particular, we wanted to strengthen our capacity to provide community based services out of hours and at weekends.

We recognise that there is no one 'silver bullet', but rather a range of evidence-based interventions that have a cumulative effect of ensuring people can be cared for in their own home or community setting wherever possible. In addition, that we can ensure that people can come home from hospital when they are ready to do so.

What we did:

- Further investment made in the Hospital at Home Service-increasing capacity to supporting 15 patients at any one time.

- 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.

- 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.

6. PERFORMANCE – LOCALITY PLANNING AND INTEGRATION PRINCIPLES

Community Planning and Area Targeting

Midlothian is small, both geographically and in population terms and overall, has lower than Scottish average levels of social exclusion and deprivation.

We have formally established two localities- East and West, but as these are newly defined, many national data sources cannot provide data at this level.

However, we do know that East Midlothian has three areas of multiple deprivation, particularly in Dalkeith & Woodburn, Mayfield & Easthouses, and Gorebridge. In addition, individuals and smaller groups who suffer from deprivation are spread throughout the small towns and villages in Midlothian.

Area Targeting is an approach to target the three areas in Midlothian with the highest levels of deprivation in terms of educational attainment, income, health, and access to services. The aim is to reduce the life outcome gaps for residents in Gorebridge, Mayfield, and Dalkeith/Woodburn.

This work requires a Community Planning Partnership approach if we are to improve the outcomes for these communities. Midlothian Health & Social Partnership contributes to this work; both in the planning and targeted delivery of certain services, for example the Wellbeing Service is now available to residents of all three areas.

Involving People

If we are to successfully redesign health and care services, the Partnership needs the support and participation of the public. We look to our local communities to find ways to work with them, recognising the key role they play, not only in helping us to plan services, but also the resources they offer that support wellbeing. We seek as a partnership to embed community engagement in the foundations of our organisation, so that working with the community is business as usual.

In order to engage with people at the right time, in the right place we undertook a variety of activities in 2016-17. We have long-established relationships with “communities of interest” such as unpaid carers, older people, and people with disabilities and we work closely with them to identify priorities, develop action plans and deliver projects.

In 2016-17 we held a large event to launch the older people’s strategy attended by 60 older people. Another event was held to launch the physical disability directory in February 2017. We also engage with groups in an ongoing way – for example the TCAT patient advisory group has met 8 times throughout the course of 2016-17. We fund collective advocacy for both mental health and learning disabilities. As an illustration of this work People First held 94 community group meetings across Midlothian. In creating our new autism strategy “Two Trumpets” we held 4 workshop events. This process of engagement is now being continued as the strategy is delivered.

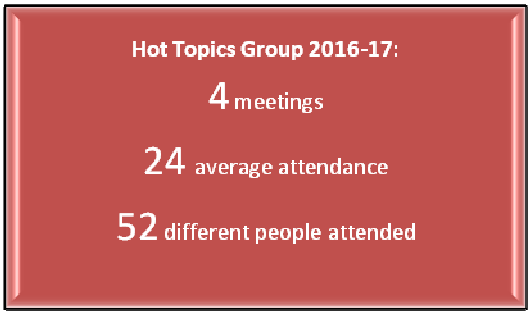
We have also established an open forum for dialogue between our management team and community members, the Hot Topics Group, which meets regularly to debate key issues. In 2016-17 the Hot Topics group met 4 times with an average attendance of 24 people.

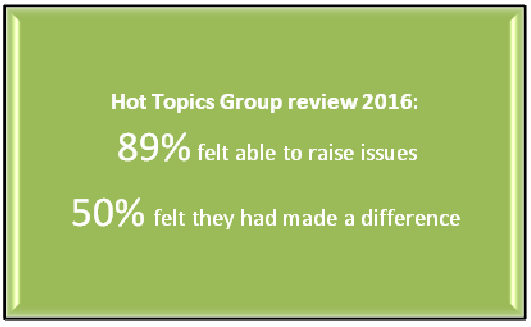
In addition we regularly seek feedback from service users via surveys and other mechanisms. The annual social work service user and carer survey was carried out in February 2017 in which a total of 199 service users participated.

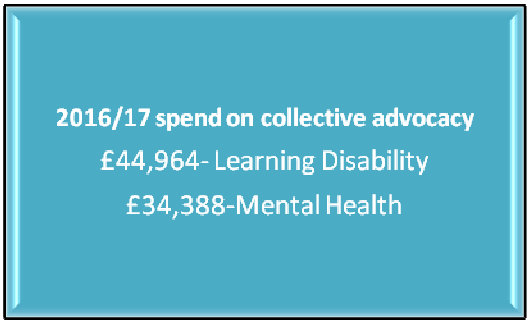
The Community Planning Partnership supports the development of strong links with geographical communities through a process of neighbourhood planning, and we are actively participating in work to improve outcomes in Midlothian's three areas of multiple deprivation – Woodburn, Mayfield and Gorebridge.

One of the big messages that came out of our engagement with communities was that services should support people to live well with long term conditions and that we need to work with the whole person. These aspects are encompassed in the 'House of Care' approach we have adopted. Other stand out issues reported to the IJB in August 2016 included access to primary care, home care and home adaptations, access to community space, physical activity and financial inclusion. The Health and Social Care Partnership are taking action to address these issues and this will be reflected in the updated Strategic Plan.

All of this work contributes to getting to know our communities and the uniqueness that exists across different parts of Midlothian. By understanding issues and needs on an area by area basis we can design services in a locally responsive and inclusive way.







Integration Principles

This is 'how we do things round here'. It is not easy to get this right. It is about the culture of the H&SCP and *how* we do things being more important then *where* we get. It would be easier for us to plan services from our perspectives, to put new services in place and be pleased with the result without really knowing what we did was the best we could do – if this is *how* we do things round here then we will get it wrong.

Culture change happens a conversation at a time. Good conversation and listening is fundamental to make the right changes and ones that will work.

We are actively doing the following in Midlothian to help us listen and understand.

- Listening and talking with 'natural communities'. The Community Planning Partnership is developing strong links with local communities through neighbourhood planning groups.
- Thinking about service planning from the perspective of localities
- Trying to see people in terms of not just their health issues, but as a whole person, part of a family or community with complex lives and that our services work hard to understand 'what matters', rather than 'what is the matter' to help people live well
- Bringing people together to share their perspectives and work together to find solutions.

No one service or individual can make these shifts to how we work or re-design what we offer, so partnership is central- with individuals, families and communities, as well as our colleagues across health and social care and the voluntary sector.

As an organisation, we want to be outward looking and listen to our communities and our staff. We are committed to using information intelligently to help us make the best decisions, to work proactively and respond to challenges and changing needs.

7. FINANCE

Background and Summary

The first year that funding was transferred to the IJB was 2016/17. The IJB undertook a detailed financial assurance process in March 2016 to review the Midlothian Council proposition along with the working proposition from NHS Lothian. The IJB then undertook a further financial assurance process – including a review of the in-year 16/17 financial information from both partners – on receipt of the NHS Lothian proposal. NHS Lothian did not set a budget formally until June 2016- three months after the IJB was established.

There were significant financial challenges in both budget offers. The IJB was keen to progress with the delivery of its strategic plan and to further the transformation process and accepted these budgets contingent on a financial risk sharing agreement with Midlothian Council and NHS Lothian.

The IJB agreed a financial risk sharing arrangement for 2016/17 with NHS Lothian and Midlothian Council, which meant that any overspends incurred in the delivery of the delegated functions by both NHS Lothian and Midlothian Council would be covered by both NHS Lothian and Midlothian Council.

The IJB was overspent by c. £1.5m in 2016/17, but additional resources were made available by the partners.
The actual position was as follows :-

	MLC	NHSiL
	£m	£m
Opening Budget	37.25	78.69
Social Care Fund		3.59
Add'n budget in year	0.41	4.41
2016/17 budget	37.66	86.69
NCL		8.70
Additional n/r Support	0.74	0.86
Net charge to IJB	**38.24**	**96.25**
Total	**£134.49 million**	

The charges made by Midlothian Council to the IJB are the net direct costs incurred in the delivery of social care services in Midlothian. The health services managed by the Joint Director are charged to the IJB directly. Charges for services not managed by the Joint Director are estimated using the Health Budget Setting Model. Midlothian's charges are generally 10% of the Lothian spend.

The pressures driving the overspends (before the non-recurrent support) fall into three broad areas:

- Overspend in social care services for adults.
- Overspend in the GP prescribing budget.
- Incomplete delivery of planned recurring savings by NHS Lothian and Midlothian Council.

2016/17 Financial Performance

The table below lays out more of the details behind the financial performance in 2016/17 :-

	Budget £000's	Actual £000's	Variance £000's
Older Peoples Services	24,789	24,497	292
Children's Services *	1,322	1,473	-151
Learning Disabilities	15,150	16,319	-1,169
Physical Disabilities	4,127	4,731	-604
Mental Health	8,738	8,607	131
Primary Care**	41,094	42,225	-1,130
Other	14,850	13,742	1,108
Acute Set Aside***	19,315	19,390	-74
Integrated Care Fund	3,505	3,505	0
Non-Recurrent Support	1,597	0	1,597
Total IJB spend	**134,488**	**134,488**	**0**

*	children's services are health visitors managed by the partnership
**	Primary care expenditure covers all of the programmes above and includes: GPs Opticians (where there may be patient charges) Community Pharmacy Dentists (where there may be patient charges) Prescribing by GPs
***	Acute set-aside - mostly in-patient bed costs but there is a small element of out-patient services depending on how the delegated function is delivered. This includes the Accident and Emergency service at the RIE

The IJB's expenditure in 2016/17 for both services delivered by Midlothian Council and by NHS Lothian has been split into programmes as far as is possible. Another way to look at our spend is as follows (see Figure 1 overleaf):

	£m
Hospital Services for In-patients	22.69
Expenditure on health services excluding above	73.56
Expenditure on social care services on care homes or adult placement	16.60
Direct expenditure on social care services to support Carers*	0.30
Other Social Care Expenditure	21.34
Total	**134.49**

*It should be noted that support to Carers is a thread that runs through most services, there is not a specific carers budget not expenditure identified. The value above is the contract with VOCAL.

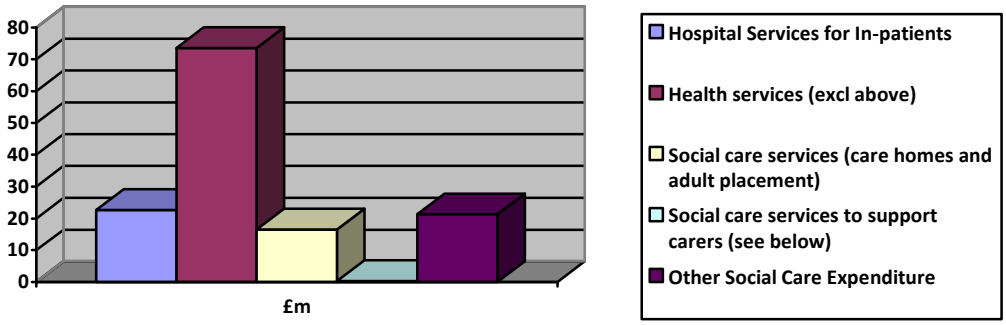


Figure 1

Social Care Fund

In 2016/17, the Scottish Government announced an 'Integration Fund' of £250m nationally which was to be directed by Integration Authorities to develop social care. Half of this fund was to be used to underpin existing pressures including the delivery of the living wage to be paid to all staff who delivered social care regardless of who employs them and half to deliver additionality – that is to be invested in delivering further social work capacity and supporting the transformation of the delivery of the service. Midlothian IJB's share was £3.59m and this was used per the Scottish Government's ambitions. The IJB has been developing, in line with the Act and its regulations, two localities within Midlothian. However, this work is at an early stage and it would not be meaningful to provide any financial analysis at a locality level for 2016/17.

2017/18 – Financial Challenges and expectations

In March 2017 IJB undertook a financial assurance process to review the budget propositions for 2017/18 from Midlothian Council and NHS Lothian. Again this process identified significant challenges but the IJB has accepted this budget although is clear that a financial risk sharing agreement similar to that in 2016/17 will not be possible. NHS Lothian has identified in its financial plan for 2017/18 (as at April 2017) a significant budgetary pressure for which there are, currently, no final plans to manage.

As part of the financial planning process for 2017/18, the financial issues identified above in 2016/17 have been addressed – NHS Lothian has uplifted the GP Prescribing baseline to the 2016/17 expenditure level and the social care management team has developed a clear plan to rebalance the budget for learning disabilities services. That said, the financial assurance exercise identified pressures within the IJB of c. £4.4m of which there are clear plans to deliver £2.8m with further plans being developed to balance the budget.

The challenge is, in financial terms, 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 an outline financial strategy and this will be developed further into a detailed multi year financial strategy which will lay out how the IJB will deliver its strategic plan.

The IJB continues to develop a multi-year financial plan that will clearly articulate how the resources available to the IJB will be used to deliver the ambitions of the Strategic Plan.

8. SUMMARY OF INSPECTIONS OF SERVICES

The Care Inspectorate undertook both scheduled and unscheduled inspections across a range of IJB services during 2016/17. The overall quality of care as assessed as good or better in 19 out of 27 services for the reporting period.

4 of our community-based services were rated adequate or lower as were 3 of our Care Homes.

Overall, 85% of care services graded 'good' (4) or better in Care Inspectorate inspections (Scottish rate 83%)

See Appendix 3 for a comprehensive list. Full reports can be viewed at http://www.careinspectorate.com/index.php/care-services

The Mental Welfare Commission undertook two inspections within mental health inpatient facilities during 2016/17.

Rossbank Ward, Midlothian Community Hospital
26th May 2016 (Unannounced)

Glenlee Ward, Midlothian Community Hospital
12th January 2017 (Unannounced)

Full reports can be viewed at:
http://www.mwcscot.org.uk/publications/local-visit-reports/nhs-lothian/

The Care Inspectorate was commissioned by Scottish Government to undertake validated self-evaluation of Drug and Alcohol Partnerships (ADPs) against the Quality Principles in 2016. This included MELDAP (Midlothian and East Lothian Drug and Alcohol Partnership) which was given feedback on its performance in terms of its strengths and areas for improvement. The local Peer Support Project was highlighted as an area of good practice.

9. INTEGRATION FUNCTIONS AND SIGNIFICANT GOVERNANCE DECISIONS –

The Board and its committees have engaged in matters relating to good governance through consideration of reports and decisions on a wide variety of issues e.g.

April 2016
- Directions to Midlothian Council and NHS Lothian
- Code of Conduct
- Risk Register

June 2016
- Equality Outcomes and Equality Mainstream Reports

August 2016
- Public Engagement Plan

October 2016
- Financial Strategy

March 2017
- Delivery Plan Health and Care 2017-18
- Performance Targets for IJB

Appendix 1 List of Key Documents and Reports

Midlothian Health & Social Care Partnership

- **Delivery Plan (2017)**
- **Strategic Plan and Strategic Plan-Easy Read version (2016-2019)**
- **Newsletters:**

https://www.midlothian.gov.uk/info/200276/strategies_policies_and_campaigns/200/health_and_social_care_integration

- **Joint Strategy for Older People In Midlothian (2016-2019)**

https://www.midlothian.gov.uk/info/200276/strategies_policies_and_campaigns/490/joint_strategy_for_older_people

- **Community Planning in Midlothian**

https://www.midlothian.gov.uk/info/200284/your_community/214/community_planning_in_midlothian

Appendix 2 Summary of Gap Inequality Indicators

Theme	Proposed Midlothian Indicator	Explanation
Health		
Life Expectancy for Males and Females		How long children born in a specified year can expect to live. Looking at the gap between the least and most deprived people across the Midlothian population.
16-75 years Mortality Rate (*or 0 – 75yrs)		Early deaths are linked to socioeconomic position
16-75 years Preventable Admissions		Hospital admissions that might have been avoided by preventive care in the community.
Type 2 Diabetes prevalence		Good example of a chronic disease with a socioeconomic gradient and is influenced by life circumstance and lifestyle factors. Can be delayed or prevented – investment in appropriate support can be influential.
(Mild to moderate) mental health prescriptions		Investigating use of prescription data
Education		
27-30 month check – language acquisition		Measure of early years development. We are particularly interested in language acquisition.
PIP Entry Score		Measure of readiness for school. Links to early years development.
Primary School Absence		Education (adults and children) has the potential to transform lives - attendance can vary according to socio-economic gradient and can be related to home circumstances.
S4 Average Tariff Score		This illustrates the variance in academic achievement by secondary school pupils in S4. Socioeconomic gradient is evident.
Adult Qualifications		Adult learning can transform lives – of the learner and their family. Impact on health, income, economic circumstance, etc
Employment and Income		
Unemployment % (ONS model-based method)		Impact on individuals, families and communities. Socioeconomic gradient.
Household income less than 60% median		Living on low income
Gross weekly pay		Inequality exists by gender at present. Also, in Midlothian weekly pay is lower than other LA areas. Poverty and income impact on health, learning and economic circumstance - well documented.
Percentage of Population Income Deprived		Gradient exists between intermediate zones in Midlothian.

Appendix 3 List of Inspections 2016/17

		Care & Support	Environment	Staffing	Management & Leadership
Extra Care Housing	Cowan Court	5		4	5
	Hawthorn Gardens	5		5	5
Community Based	Midlothian Homecare	3		3	3
	Carewatch	2		2	2
	Mears Homecare West	1		2	1
	Mears Homecare East	3		4	4
	McSence	5		5	5
	Carr Gomm	4		4	5
	Places for People	5		5	5
	Link Living	5		5	5
	Aspire	1		2	2
	St Joseph's	5		5	5
	St Joseph's Circle 1	5		5	5
	St Joseph's Circle 2	5		5	5
	St Joseph's Circle 3	5		5	5
	Elcap	5		5	
Care Homes	Nazareth House	3	3	4	4
	Springfield Bank	2	3	2	2
	Thornlea	5	5	4	4
	Drummond Grange	3	3	3	3
	Pittendreich	3	3	3	3
	Aaron	4	4	3	4
	Archview Lodge	5	5	5	6
	Highbank	5	5	5	5
	Newbyres Village	4	4	4	4
	Rosehill	5	5	5	5
	Pine Villa	4	4	5	4