Midlothian
Health & Social Care

Midlothian Integration Joint Board

Annual Performance Report

2022/23

Contents

Executive Summary

The Midlothian Integration Joint Board (IJB) plan and direct health and social care services for the people of Midlothian. We are a planning and decision-making body responsible for the integrated budget from Midlothian Council and NHS Lothian.

We are responsible for monitoring progress towards the National Health and Wellbeing Outcomes and the objectives in our Strategic Commissioning Plan 2022 to 2025. We provide services and supports to ensure people have access to the right advice, care, and support in the right place, at the right time to be able to lead long and healthy lives. We focus on prevention, recovery, independence, choice and control, equalities, supporting the person not just their condition, and high quality and coordinated care that is evidence based and provided locally.

In 2022/23 we focused on understanding how local communities' needs had changed before making decisions about how to improve and build the right support. This has helped us prepare for a challenging 2023-24 financial position with transformation initiatives that can assess and adapt to change.

The services we plan and direct must, by law, aim to improve outcomes for people who use our services, their carers, and families. Considering the impact of all our services is a complex exercise and involves a wide range of data. The Scottish Government measure our performance towards nine Health and Wellbeing Outcomes using data collected from Scottish Health and Care Experience (HACE) Survey and Scottish Government's Ministerial Strategic Group targets for hospital admissions. We have continued to develop our use of outcome mapping to better understand how services contribute to progress towards our strategic aims and outcomes that matter to people.

The challenges we faced

Some of the challenges services face today have emerged due to COVID-19, and some are due to wider change in the health and care system. How people want to experience health and social care, the cost-of-living crisis, and environmental issues have impacted on how we need to respond.

We must focus more on prevention and early intervention to prevent ill or worsening health, meet people's needs in times of crisis and support them to take action. This includes working with partners to ensure there is a range of appropriate, good quality accommodation that supports people to thrive.

Some people are waiting longer for planned care which means they needed more support at home and in the community, and more people are choosing to spend the last days of their lives at home. Advances in digital technology means more services can be provided online and we must ensure we continue to meet everybody's needs.

Our progress towards the National Outcomes

In 2022/23, our services continued to support people to look after their own health and wellbeing. By seeing ourselves as 'facilitators' and not 'fixers' we promoted self-management and 92% of people in Midlothian said they were able to **look after and improve their health and wellbeing** and live in good health.

The rate of emergency admissions to hospital for people living in Midlothian reduced in 2022/23, but **the number of days they need to stay in hospital** increased. This is partly because Midlothian has fewer nursing home beds than other areas and people who needed more care than could be provided in their own home couldn't be discharged from hospital. The overall number of days people stayed in hospital when they were ready to go home reduced in 2022/23, but people aged 75 and over were more likely to be delayed in hospital when they were ready to go home than other age groups. Fewer people in Midlothian were **readmitted to hospital within 28 days** of being discharged than the year before.

We believe people are the experts in their own lives. We have been having 'Good Conversations' in Midlothian for over a decade and our commitment to the 'Midway' has helped us work alongside people to achieve the things that matter most to them. 120 staff have undertaken 'Good Conversations' training this year.

We continued to work with our GP colleagues. People were concerned about getting appointments when they need them. GP activity has returned to pre-COVID-19 levels in Midlothian and GPs had more contact with people than other areas across Lothian. 45% of people have seen the same GP for repeat consultations over the last 6 months. For adults who are 65 years and older this rises to between 50-65%. We have continued to increase the number of specialist services located in GP practices including Community Treatment & Assessment Clinics (CTAC) in all GP Practices.

We worked with a range of partners to continue to create opportunities that improve health, wellbeing, and quality of life for people and communities in Midlothian. For example, our Older People's Service provided more than 230 online, outdoor, and creative opportunities each month for older people to connect with each other and have worked alongside ArtLink to support people with disabilities enjoy participating in the Arts.

We invested in a Volunteer Coordinator to expand and coordinate local volunteers. People who volunteer tell us that their mental health and wellbeing has improved (92%), as well as their physical health and wellbeing (85%). 69% of volunteers report increased motivation and activity levels. More than half (54%) experience a reduction in loneliness, and more engagement in their community (31%).

We developed better services for people experiencing poor mental health by working closely across health and social care, housing, and the Third Sector. In 2022/23 our teams supported 34 people into employment, education or volunteering and increased people's opportunities to succeed.

Where we are born, live and work can impact our health and wellbeing. While not everyone living in a deprived area will experience high levels of deprivation, there is a link between deprivation and poorer health outcomes. Diabetes, ischaemic heart disease, Chronic Obstructive Pulmonary Disease

and dementia are all long-term conditions that contribute to premature death in Midlothian more frequently than across Scotland as a whole.

We have continued to invest in our Health Inclusion Team who work with the people most affected by health inequalities to improve their quality of life. In 2022/3 the team found new ways to reach and support people who find it difficult to access health care e.g., people affected by homelessness, substance use, domestic abuse, or people with caring responsibilities.

In our last Annual Performance Report, we noted we had work to do to **better support carers**. We listened to carers, people who receive care, a range of staff, and other partners as we developed the Midlothian Carers Strategy for 2022-25. People told us that the priorities in the strategy were highly relevant to provide the support they needed.

Our services and supports aim to keep people safe from harm and prevent avoidable risks. In 2022/23 we received 929 Adult Support and Protection referrals compared to 674 the year before. The main type of harm investigated was financial harm, commonly for women at risk (67%), and adults aged 65 and over (52%). Nearly 80% of **adults supported at home agreed they felt safe**.

In 2022/23 we saw a reduction in the number of people aged 65 and over being admitted to hospital as a result of a fall. Despite this, falls remain in the top ten reasons for people in Midlothian being admitted to hospital. Our Frailty Programme explored and defined the falls pathway across Midlothian to understand where improvements could be made in the care we provide, and our community alarm systems help kept people safe and well in their own homes. During 2022/23 there were 26,694 responses to alarms within the home for Midlothian Residents. This is an increase of 6% compared to last year.

We worked to **improve the experience of our workforce** and develop our workforce planning capacity skills. In 2022/23 we published the first Midlothian Health and Social Care Partnership Integrated Workforce Plan 2022/25, developed our staff Communication, Engagement and Experience Delivery Plan, and introduced a range of staff wellbeing supports including the 'Changing Gear' programme to help staff leave work each day and focus on other parts of their life.

During 2022/23, the Care Inspectorate completed 18 inspections in Midlothian. The majority of services inspected were given a rating of adequate, good, or very good.

Our budget and spending

Ensuring we make best use of our resources is a complex task. In 2022/23, we had a total budget of **£173m** and ended the financial year with an **overspend of £10.3m**. This included an underspend on our operations of £0.4m and the use of earmarked reserves funding during the year, predominantly for COVID-19. Our health services were overspent, and NHS Lothian provided the IJB with additional one-off funding of £1.4m to break even against these budgets.

In March every year, Midlothian Council and NHS Lothian make a budget offer to the IJB, based on levels of funding set by Scottish Government. This year Midlothian Council did not offer to pass over the agreed amount in full and the IJB has explored options to mitigate this reduction in funding supported by a multi-year financial plan for how the resources available to the IJB will be used to deliver the ambitions of the Strategic Plan. Despite financial challenge, the IJB has

prioritised supported an increase in wages in line with the living wage and asked services to ensure fair working by offering guaranteed hours.

Looking ahead

The years ahead will be some of the most challenging that health and social care have ever faced. We will need to better understand how peoples' and communities' needs change and build the right offers of support, with the resources we have available. The IJB will continue to invest in population health and improve community alternatives to hospital-based care.

Integrated workforce planning is new for health and social care, and we will develop our skills in this across 2023/24. The needs of our workforce are changing and dependent on many new factors. Our Integrated Workforce Plan focuses on the 5 pillars of workforce planning set by Scottish Government to support recovery, growth and transformation of health and social care.

People and communities have valuable skills and experience to design and improve the health and care services that matter to them. We want to work with communities to ensure that we are planning and developing the right local health and care services. As we better understand the changing needs of communities, we need to be clear about when we are implementing change, and when we need to think in much bigger terms about transformation. We will continue to take a transformational approach with a range of related and dependent initiatives then do whatever it takes to ensure that learning can be spread across the whole system at scale and at pace.

We recognised health and social care does not have the infrastructure to share data in the way we need and asked our partners to put in place mechanisms that allow safe and integrated data sharing. Our ambitious digital plan was launched in 2022 and will provide innovative solutions to some of our most complex challenges. In 2023/24, we have asked NHS Lothian and Midlothian Council to ensure we can access data by Health and Social Care Partnership area. This will help us to identify and address equality issues, meet different needs, and encourage participation. We will have to make better use of existing technologies and provide people with access to accurate information and services.

We need to provide information about how well our hosted services are performing to the other Lothian Health and Social Care Partnerships and NHS Lothian. We have worked hard in 2022/23 to make sure our hosted services can provide the right information in a consistent way and are leading the way in the development of this approach for Hosted Services in 2023/24.

In 2023/24 we also need to plan for and start writing our next Strategic Commissioning Plan for 2025 to 2028. Our planning and performance team will ensure the consultation, review, and governance around our most important piece of planning is done well and includes everyone that wants to be involved.

Foreword

Welcome to our 8th Annual Performance Report which reflects on our progress and performance from 1st April 2022 to 31st March 2023

In 2022-23 Midlothian Integration Joint Board (IJB) and Midlothian Health and Social Care Partnership (HSCP) have delivered care, support and treatment that contributes to improved outcomes for people and communities. This Annual Report explains our performance; how well we have provided the right care, at the right time, in the right place through early intervention and prevention, support and treatment.

This has been an important year for Midlothian Integration Joint Board as we set out our vision for a new future in our Strategic Commissioning Plan for 2022-25. During the first year of this plan, services made significant progress in improving how we plan and deliver care, found opportunities to work together in new ways, and strengthened our community connections.

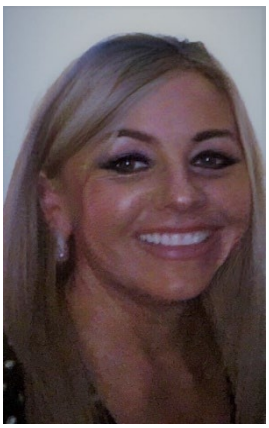
As I reflect on the contribution of integrated health and social care over the past year, we made good progress in how we support people in communities to live good lives. Understanding local communities, what makes people healthy, and how we support good health and wellbeing has supported more people to live the lives they choose.

We have learned that before we can make decisions about how we should improve, we must be prepared to do things differently. Simple changes can have significant consequences. Much of 2022-23 has focused on understanding how local communities' needs have changed and building the right support. This has helped us prepare for a challenging 2023-24 financial position with transformation initiatives that can assess and adapt to change.

This year also saw the publication of our first Integrated Workforce Plan 2022-25. We have increased our capacity to plan our workforce to meet our duties in relation to the Health and Care (Staffing) (Scotland) Act. We have worked with staff across the partnership, listened to each other, and worked together to support staff to remain safe and well.

We continue to depend on our strong relationships with local communities and delivery partners who work alongside statutory services. Improving outcomes is only possible when everyone's contribution is valued. This takes teamwork and true partnership to succeed, and I am delighted we have invested in developing ways to describe and learn from how we work together by telling our story and progress through outcome mapping.

I would like to sincerely thank everyone who has contributed to improving outcomes for local communities over the past year. I am proud to lead health and social care in Midlothian and know that together we can support everyone in our communities in health, wellbeing, and good lives, lived well.



Morag Barrow
Chief Officer,
Midlothian IJB

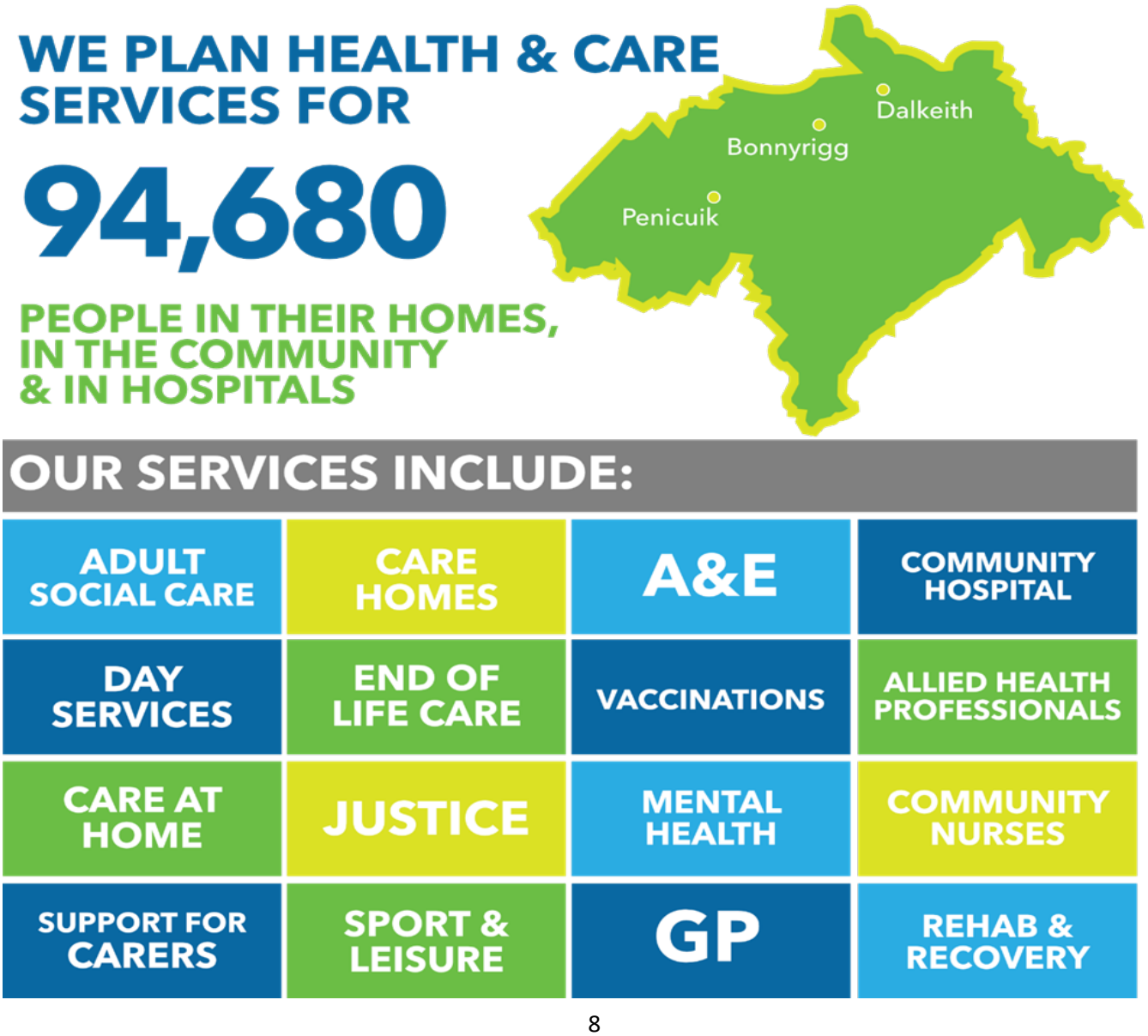
Introduction

Who we are

The Midlothian IJB plan and direct health and social care services for the people of Midlothian. We are a planning and decision-making body created by Midlothian Council and NHS Lothian. We are responsible for the integrated budget (received from Midlothian Council and NHS Lothian) and allocate this in line with our objectives in the Strategic Commissioning Plan.

Our responsibilities and legal duties are outlined in the Public Bodies (Joint Working) (Scotland) Act (2014). We meet regularly and include members from NHS Lothian and Midlothian Council, the Third Sector, staff, and people who represent the interests of people and communities, people who experience our services, their families, and carers.

Midlothian Health and Social Care Partnership oversees more than 60 services on behalf of Midlothian IJB. This includes two hosted services, Dietetics and Adults with Complex and Exceptional Needs, who deliver care to people across the whole Lothian region for the four Health and Social Care Partnerships - Midlothian, East Lothian, West Lothian, and City of Edinburgh.



What we are trying to achieve

The Scottish Government measure our performance based on Health and Wellbeing Outcomes.

National Health & Wellbeing Outcome

1		**Health & Wellbeing** People are able to look after and improve their health and wellbeing and live in good health for longer.
2		**Living in the Community** People are able to live, as much as possible, independently and at home or in a homely setting in their community.
3		**Positive Experiences & Dignity** People who use health & social care services have positive experiences of those services, and have their dignity respected
4		**Quality of Life** Health & social care services help to maintain or improve the quality of life of people who use those.
5		**Health Inequalities** Health & social care services contribute to reducing health inequalities.
6		**Support for Carers** People who provide unpaid care are supported to look after their health and wellbeing.
7		**Safe from Harm** People using health & social care services are safe from harm.
8		**Workforce** Staff are engaged with their work and are supported to continuously improve the information, support, care, and treatment they provide.
9		**Use of Resources** Resources are used effectively and efficiently.

Our Strategic Commissioning Plan 2022-2025

We also measure our performance against our objectives in our Strategic Commissioning Plan. This directs the Midlothian Health and Social Care Partnership to transform services, with the resources available, so that people in Midlothian live longer and healthier lives.

We want to work with people as partners in their own health and social care and we want to provide more support, treatment, and care for people in their homes and communities.

We have asked the Midlothian Health and Social Care Partnership to ensure they offer services in a timely way at every stage of someone's care and treatment:

- Preventing ill health and providing support early,
- Ongoing support and treatment,
- In times of crisis and emergency

Our Strategic Aims

Our Strategic Commissioning Plan has six main aims:

1. Increase people's support and opportunities to stay well, prevent ill or worsening health, and plan ahead.
2. Enable more people to get support, treatment and care in community and home-based settings.
3. Increase people's choice and control over their support and services.
4. Support more people with rehabilitation and recovery.
5. Improve our ability to promote and protect people's human rights, including social and economic rights and meet our duties under human rights law through our services and support.
6. Expand our joint working, integration of services, and partnership work with primary care, Third Sector organisations, providers, unpaid carers, and communities to better meet people's needs.

Our Values

We aim to provide the right support in the right place at the right time.

We think about how we work, and how we can improve, in three ways:

- **Integration** is about how we work with all our partners to ensure everyone gets the right care, at the right time, and in the right setting.
- **Quality** is about 6 key areas of services – are they safe, effective, efficient, timely, person-centred, equitable.
- **Best Value** is about ensuring resources are well managed improving services that deliver the best possible outcomes for people and communities.

How do we know if we are achieving this?

Understanding how we contribute to people's outcomes

The services we plan and direct must, by law, aim to improve outcomes for people who use our services, their carers, and families. It is hard to evaluate how the work we do contributes to improvements in the health and wellbeing of people and communities. This is because so many factors influence peoples' lives, what difference each factor makes, and the impact it has in their life.

We use Outcome Mapping as a way to understand how our services contribute to our strategic aims and the outcomes that matter to people. This approach allows us to describe what we do, who with, what people learn and gain as a result, how this makes them feel and the difference this makes in their lives. This helps us make more targeted, locally informed decisions about how to commission services.

We used a range of feedback to inform our outcome mapping including:

- **Feedback from people who use our services, their families and carers**
- **Scottish Government's Ministerial Strategic Group (MSG) targets**
- **Scottish Government Data - The National Performance Indicators**
  The National Indicators 1-9 are taken from the Health and Care Experience Survey (HACE) which is conducted every 2 years. 2022/23 is not a reporting year for the HACE Survey so there is no update from the data reported in the Annual Performance Report 2021/22.

  In November 2021 the survey was posted to a random sample of people registered with a GP in Scotland based on information available on 6 October 2021. People were asked about their experiences during the previous 12 months - accessing and using their GP practice and Out of Hours services; aspects of care and support provided by local authorities and other organisations; and caring responsibilities and related support. 1,772 people responded from Midlothian - less than 2% of Midlothian's population. The response rate increased with age and was highest in the 65+ age group (44%). This is compared to a response rate of 10% for those aged 17-34.

  In 2020 the Scottish Government updated the survey, some questions were added, some were amended, and some were removed (the full list of these changes is in the Scottish Government Technical Report). These changes mean it is difficult to compare our performance with previous years and, in some cases, we only have data from 2020.
    - For Indicators 1-9 the data for 2021/22 is compared with 2019/20 only.
    - For Indicators 11-20 the data for 2021/22 in compared with the previous 4 years.

  You can see the details of our performance in the Data Appendix at the end of this report.

The main challenges of 2022-23

The IJB was set up in 2015 to develop local solutions to improve health and care services. We still face some of the same issues such as an ageing population, inequalities in health, a national workforce shortage, increasing reliance on unpaid carers and growing pressures on acute hospitals.

Some of the challenges services face today have emerged due to COVID-19, the cost-of-living crisis, and environmental issues and some are new as the wider system of health and care has changed and people have changed how they want to experience health and social care.

Shifting the balance of care

Our Strategic Commissioning Plan focuses on early intervention and prevention, support and treatment, and support in times of crisis and emergency. It has been a challenge to find the right balance between meeting people's needs in times of crisis while also supporting them to take action to prevent ill or worsening health in the future. Whole population programmes of prevention and early intervention will reduce pressure on emergency services in the future. However, it has been difficult to distribute and prioritise resources for more community services because we need to keep people safe in times of crisis.

The foundations of good health and wellbeing

We are concerned that the lack of available specialist accommodation for people with mental health needs led to people being delayed in hospital. We need a better range of accommodation that can provide the right support for people to thrive. This is particularly true for people who also use substances.

Policy and funding restrictions

National policies or the ring-fencing of funding for specific care and support made it difficult for services to provide support in other areas. For example, it can be difficult to help people who need support with alcohol use alongside other substances as the funding was primarily provided for substance use.

Transitions from children services to adult services for people with Learning Disabilities

When people move from children's services to adult services, differences in funding and services can make the transition difficult.

Cost of Living Crisis

Higher costs-of-living impacted the health and wellbeing on people, families, and young children.

Longer waiting lists

Some people waited longer for planned care which means they needed more support to cope at home. The impact of waiting longer meant people became more unwell, and some needed more support. This meant some people reached a crisis where it could have been avoided.

Changes to end of life care

More people choose to spend the last days of their lives at home - including people with young families and younger people, who are very unwell with cancer, needing care in our community hospital.

Increase in support for the menopause

Our GP colleagues supported an increase in women to manage the symptoms of the menopause.

Integrating digital systems

Advances in digital technology meant more services could be provided online and we must ensure we have a range of offers and supports to meet everybody's needs. While the number of technologies and apps to support service delivery increases, Health & Social Care do not share technology.

Workforce

Recruitment and retention, staff engagement and staff wellbeing continued to be a national and local challenge.

How did we do?

How we are reporting our data

The information we use to measure our progress comes from several sources and shows where we have done well and where we have room to improve.

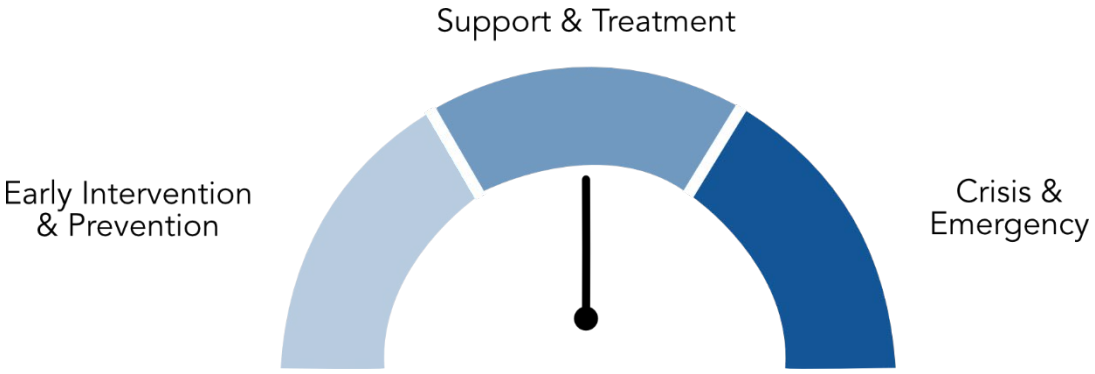
We have designed the report to look at each of the Health and Wellbeing Outcomes alongside the National Performance Indicators used to measure each one. All National Performance Indicator data for Midlothian against the national average is in the Data Appendix.

In the Data Appendix we have provided more information about our progress over time and our position in comparison to the rest of Scotland.

For some National Indicators, the number of responses from each locality were too small to be published.

We want people who live in Midlothian to take action to stay well, prevent ill or worsening health, plan ahead, and live healthier, longer lives. We think about how we do this in three ways: early intervention and prevention; support and treatment; and crisis and emergency.

For each Health and Wellbeing Outcome we have described the impact of what we do for the people who live in Midlothian. We have used the icon below to show good examples of:



The National Indicators

- Our performance has improved compared to last year.
- There hasn't been a significant change in performance compared to last year.
- Our performance has worsened compared to last year.

The National Indicators 1-9 are taken from the Health and Care Experience Survey (HACE) which is conducted every 2 years. 2022/23 is not a reporting year for the HACE Survey so there is no available update or change in the data from the Annual Performance Report 2021/22.

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.	92%	
2	Adults supported at home agreed that they are supported to live as independently as possible.	73%	
3	Adults supported at home agreed they had a say in how their help, care or support was provided.	70%	
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated.	64%	
5	Adults receiving care or support rated it as excellent or good.	79%	
6	Adults had a positive experience of the care provided by their GP practice.	62%	
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life.	81%	
8	Carers feel supported to continue in their caring role.	27%	
9	Adults supported at home agreed they felt safe.	79%	

	National Indicator	Our result	Our Progress
11	Premature Mortality Rate (People under 75)	**428** per 100,000	
12	Emergency Admission Rate	**9,788** per 100,000	
13	Emergency Bed Day Rate	**112,579** per 100,000	
14	Readmission to hospital within 28 days.	**99** per 1,000	
15	Proportion of the last 6 months of life spent at home or a community setting.	**88%**	
16	Falls Rate (People over 65)	**18.9%**	
17	Care services graded Good or better in Care Inspectorate Inspections.	**78%**	
18	Adults with intensive care needs are receiving care at home.	**60%**	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	**784** per 1,000	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	**23%**	

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1 Health & Wellbeing

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

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.*	92%	
11	Premature Mortality Rate (People under 75)	428 per 100,000	
12	Emergency Admission Rate	9,788 per 100,000	

* There is no update to the national data for 2022/23 in relation to this indicator.

Our services aim to support people to look after their own health and wellbeing. By seeing ourselves as 'facilitators' and not 'fixers' we promote self-management through services including welfare advice, and information and support for people who are managing difficult circumstances. 92% of people in Midlothian said they are able to look after and improve their health and wellbeing and live in good health.

Premature mortality is defined as deaths occurring before the age of 75. This indicator is measured using the European Age-Standardised mortality rate for people aged under 75. The methodology was updated in 2013, allowing for comparisons over time. Since 1997, the rate of premature mortality decreased every year until 2015 when there was an increase. It then remained relatively stable until 2020 where there was a further increase, largely due to COVID-19 deaths. During 2022/23, the premature mortality rate increased in Midlothian and is now almost at the average rate across the whole of Scotland.

The rate of emergency admissions to hospital during 2022/23 matches what we would expect to see based on the number of people living in Midlothian. This is also the case for the other Health and Social Care Partnerships across the NHS Lothian area.

Inclusive vaccinations – flexible services and information

Vaccination teams improved how they share information with people. The team worked with community groups including the Midlothian Ukrainian Coffee Morning and held vaccination clinics at No11 in Dalkeith so people with mental health and substance use issues were able to get their vaccinations in a familiar environment, without needing to travel.

The Preschool Immunisation team supported 1,800 young children to get a flu vaccination at a range of convenient locations including leisure centres, libraries, specialist nurseries and working men's clubs. They offered twilight sessions, drop ins, and joint appointments for siblings. Parents were able to give consent over the phone, which meant other family members could bring children along.

Improving dental health in Care Homes

Some people find it more difficult to keep their mouth and teeth clean. This can be due to a physical difficulty from a stroke, arthritis, or arm injury, be caused by medicines that cause a dry mouth, or due to difficulties accessing dental care.

The Caring for Smiles Team supported 10 nursing and care homes with a Dental Health Support Worker who visits every 8 - 10 weeks.

They assisted care staff to ensure that every resident has an oral health risk assessment and daily oral care plan. Staff training was offered, and all care staff were encouraged to undertake accredited oral care training at SCQF level.

The team also offered denture marking and signposted people if they needed urgent dental care with a general dental practitioner or the specialist special care oral health service.

Supporting people with Chronic Obstructive Pulmonary Disease

The Community Respiratory Team supported people at home with Chronic Obstructive Pulmonary Disease. When people become unwell, the team arranged treatment and support. This could mean talking to the GP or a team prescriber to get the right medicine that could prevent an unnecessary trip to hospital. They provided reassurance to people and gave guidance to them, to GPs, and to carers.

By providing specialist treatment and support at home 189 unnecessary stays in hospital were avoided. This is a 12.5% increase compared with 2021/22, and accounts for 1,134 hospital bed days.

2 Living in the Community

People are able to live, as much as possible, independently and at home or in a homely setting in their community.

National Indicators used to measure this outcome.

The indicators used in this section relate to the experience of people when they receive care in hospital.

	National Indicator	Our result	Our Progress
2	Adults supported at home agreed that they are supported to live as independently as possible*.	73%	
3	Adults supported at home agreed they had a say in how their help, care or support was provided*.	70%	
12	Emergency Admission Rate	9,788 per 100,000	
13	Emergency Bed Day Rate	112,579 per 100,000	
14	Readmission to hospital within 28 days	99 per 1,000	
15	Proportion of the last 6 months of life spent at home or a community setting.	88%	
16	Falls Rate (People over 65)	19%	
18	Adults with intensive care needs are receiving care at home.	60%	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	784 per 1,000	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	23%	

* There is no update to the national data for 2022/23 in relation to this indicator.

There is no update for the national data that describe how well adults feel they are supported at home or if they were involved in decisions about their care or support. Care Opinion is an online platform that people can use to give us up to date feedback about the care and support they receive. In the past year this has included experience of care provided by Midlothian Community Hospital, Hospital at Home, and GP services.

The national data tell us that we are supporting 88% of people to spend the last 6 months of their life at home or in a homely setting. This data does not include information about whether this was someone's preferred option, however our community services report they are seeing an increase in the number of people who choose to be cared for at home at the end of their life.

In 2022/23, the number of people in Midlothian being admitted to hospital in an emergency reduced. However, the number of days they need to stay in hospital increased. This is partly because Midlothian has fewer nursing home beds than other areas and people who need more care than can be provided in their own home cannot be discharged from hospital. This reduced the number of available hospital beds for people who needed to be admitted.

Our local data tell us that people aged 75 and over are only a small number of attendances at A&E, but often spend longer there than younger age groups. Three-quarters of 75-year-olds in the UK have more than one long term condition and often need more time for the right assessment, treatment, and care. This is even higher for people aged 85 and over. The two most likely reasons that people aged 75 and over need to go to A&E are confusion (delirium) and hip fractures. This age group accounts for about half of emergency admissions to hospital, and three-quarters of people who experience a delay in their discharge from hospital are aged 75 and over.

In 2022/23 the overall number of days people stayed in hospital when they were ready to go home reduced. However, this was not the same for all age groups. People aged 75 and over were more likely to be delayed in hospital when they were ready to go home than other age groups. The number of days people aged 75 and over were in hospital when they were ready to be discharged (per 1,000 population) increased in Midlothian by 51%.

Longer stays in hospital could be due to people being admitted to hospital in an emergency being more unwell than in the past. This is called 'acuity' and there is no agreed national measure for this, but we are trying to better understand this by using what we know about people's health, e.g. the number of health conditions a person is managing.

In 2022/23 fewer people in Midlothian were readmitted to hospital within 28 days of being discharged than the year before. It is important to note that the rate of readmission applies to hospital stays and does not include 'virtual wards' like the Hospital at Home service.

Volunteers building stronger communities

One of the ways we can support people living in communities is by supporting volunteers.

In Midlothian in 2022/23, when people went home from hospital, more of them remained well at home. People who were discharged from hospital were often supported by volunteers who helped them get used to new equipment, make connections in the community, ask for support and build confidence and independence.

We invested in a Volunteer Coordinator to expand and coordinate local volunteers. Volunteers supported people to attend the gym, join the library, visit community cafes, join craft classes, go to the cinema, attend cooking lessons, go walking, visit Dalkeith country park, use public transport, visit Edinburgh, attend fayres, gain confidence with mobility aids, and connect with neighbours. Supporting people to enjoy these activities built friendships and new connections, helped people access support and resources, establish positive routines, and created a new sense of community. People told us that volunteers helped them make new connections and be more active in their community, which improved their mental and physical wellbeing.

Regaining independence after hospital

The Rehabilitation Garden at Midlothian Community Hospital was co-designed and created in partnership with the NHS Lothian Charity, the Conservation Volunteers, the Cyrenians, and the Community Payback team. Officially opened in June 2022, the garden provides outside space for people to work towards their rehabilitation goals, while taking part in practical activities they enjoy and improving their sense of wellbeing.

The garden created opportunities for practical activities, for example walking and moving around on different surfaces and gardening that support rehabilitation. These activities increased skills and confidence with balance, hand dexterity, mobility, memory, working with others.

People are often more engaged and motivated when working outdoors. This provides an opportunity for people to be more confident about going home, as the garden is a place where people can practise their everyday skills.

Supporting people to live well with a cancer diagnosis

Cancer can have a huge impact on people and their families. People told us their most frequent concerns are money, anxiety, fatigue, and uncertainty about the future. The Improving the Cancer Journey programme supports people to focus on what matters most to them and to live as well as they can with a cancer diagnosis.

This year, they increased the number of people they supported by 26%. They worked with 74 people with a cancer diagnosis and 20 carers or family members affected by cancer. 40% of people were given extra support with welfare rights and benefits advice. They also provided help with housing, blue parking badges, and support from food banks.

3 Positive Experiences & Dignity

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

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
3	Adults supported at home agreed they had a say in how their help, care or support was provided*.	70%	
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated*.	64%	
5	Adults receiving care or support rated it as excellent or good*.	79%	
6	Adults had a positive experience of the care provided by their GP practice*.	62%	
14	Readmission to hospital within 28 days.	99 per 1,000	
15	Proportion of the last 6 months of life spent at home or a community setting.	88%	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	784 per 1,000	

* There is no update to the national data for 2022/23 in relation to this indicator.

People are the experts in their own lives. We have been running Good Conversations courses in Midlothian for over a decade to work alongside people to achieve the things that matter most to them. Over the past 12 months this has gained momentum and became a core part of the HSCP's system-wide approach called the Midway. The Midway is how Midlothian HSCP welcomes people into services, how staff work alongside them, and how we contribute to them achieving their personal outcomes. 120 staff have undertaken the training this year.

For people with one or more long term condition, the Midway approach supports them to manage their health and wellbeing effectively. Good Conversations help staff connect people with the right services to get the right help at the right time. Our 'no wrong door' approach has contributed to improved outcomes for people.

Coordinating care and better outcomes

The Physical Disabilities team focused on what matters to the people they support using the 'Good Conversations' approach. This helped them connect people to services quickly.

An example of this is when the team supported someone with several physical health conditions who was struggling to manage everyday tasks in the home. They shared that they were experiencing difficulties with their mental health. The team provided equipment and adaptations needed to help the person at home and connected them with Mental Health Services.

By listening to what mattered, the team supported the person to access the right help for both their physical and mental wellbeing. The person told us this helped them be more confident and independent.

GPs are independent contractors, and we continued to work closely together. The HACE survey covers elements of services that are delivered by GP independent contractors, and elements that are delivered by the HSCP. There are now more specialist services located in practices than ever before. People do not usually need to see a GP first to access the care they need from Physiotherapists, Primary Care Mental Health Nurses, and Wellbeing Practitioners. Pharmacists, Advanced Nurse Practitioners for minor illness, Phlebotomists and Community Treatment & Assessment Clinic (CTAC) are also available at GP practices.

Individualised and flexible treatment and care

Community Treatment & Assessment Clinics (CTAC) are one of the ways we ensure people are able to see the right person, at the right place, and at the right time. There is a CTAC service in all Midlothian GP Practices, run by highly skilled nursing staff. Services include blood tests and blood pressure checks requested by the GP, removal of stitches or staples after an operation or injury, wound care, injections, ear irrigation, Doppler scans, catheter care, and long-term condition monitoring. On average CTAC teams offer over 2,000 appointments each week, and provide information, treatment, and support that helps people better understand their condition, manage, and recover.

The CTAC team provided specialised person-centred care, by giving people the information they need to make decisions about their care. The service helped a young person regain their confidence, reconnect with friends and family, return to work, and enjoy what matters most to them, by helping them better manage their condition leading to recovery.

Ulcers on both legs had contributed to the person becoming isolated and being unable to work or travel. The CTAC team arranged flexible, individualised appointments with the same nurse over 6 months, who explained the condition and the treatment options. The person was supported to set personal goals and was involved in decision-making to agree the right care. As a result of working together, within 6 months the person had returned to work and was able to travel abroad.

Each GP practice in Midlothian has a tailored model of delivery to meet the needs of its own population. As a result, there is flexibility in the range and number of professionals available at each practice and how people contact the practice team.

Improving support for the menopause

Nurse-led reviews for women taking Hormone Replacement Therapies helped people improve their health and wellbeing.

Changes in how we talk about the menopause mean that more women are coming forward for treatment and support. Our GP colleagues recognised an urgent need to do things differently, so that women get better access to the information and medicines that are right for them.

Comments from women include:
"I was using my patches wrongly", "I felt able to ask questions about my HRT", "I did not realise I needed contraception with HRT as I was still in my 40s", "I've never had a review before and found it beneficial to have a chat about my HRT".

We know that people are concerned about seeing their GP and getting appointments when they need them. When we talk about 'GP activity' we mean the number of contacts GPs have with people, e.g., appointment, telephone call, eConsult. In Midlothian, GP activity has returned to pre-COVID-19 levels. This year, GPs in Midlothian have consistently had more contact with people than other areas across Lothian.

Our data tell us that GPs in Midlothian are completing between 10,500 – 16,300 clinical contacts each week. We have seen a change in the number of people who need appointments urgently for medical advice or assessment. People who see a GP on the day they contact the surgery are approximately 50% of all GP appointments.

In December 2022, the demand for GP appointments increased by 82% in Midlothian. This was due to an increase in throat infections and press reports raising public concerns that this could lead to a more serious and life-threatening infection known as invasive group A streptococcal disease. GP services worked hard to keep people safe and avoid them going to hospital unnecessarily.

Local data tell us that on average 45% of people have seen the same GP for repeat consultations over the last 6 months. For adults who are 65 years and older this rises to between 50-65%.

Changes to seeing the GP

GPs have made a number of changes to improve access and communication, and the Midlothian HSCP Digital Programme is supporting 3 more practices to improve access by using eConsult. Most practices have increased their use of social media and some use SMS texting to relieve pressure on the phonelines.

GP Practice teams have improved how people get their medicines. All practices now offer online repeat prescription ordering. One practice has now reduced the turnaround time to one day.

The GP management of Danderhall Practice has changed in 2022-23. Midlothian HSCP worked with them to help ensure a smooth transition. GPs are providing more support in Danderhall with the number of appointments continuing to increase. The Practice team can now book people a same-day appointment at the minor ailment clinic, and routine face to face appointment capacity has increased. Early data tell us that fewer people from Danderhall are going to A&E for conditions that a GP could manage. Easier access to the practice building, and removing the buzzer and intercom system may have contributed to this change.

Crisis and Emergency

In 2022/23, we reviewed how we involve older people in planning and making decisions about their care if they become very unwell. Anticipatory Care Planning is a person-centred, proactive approach to help people think ahead, consider what matters to them, and plan for future care.

Thinking ahead can help people feel more in control of their health and wellbeing. Having good conversations and creating an Anticipatory Care Plan ensures people's wishes are known. This reduces stress if people become very unwell, allowing health and care staff to confidently act on people's preferences. For people who live in care homes, this can reduce the number of people who are admitted to hospital when their preference is to stay at home.

We worked with the British Institute of Human Rights, Care Homes, health and social care practitioners and GP practice teams to improve the way care home residents, families, carers, and staff work together to create meaningful anticipatory care plans.

More people who live in care homes avoided an unnecessary stay in hospital when their anticipatory care plan was clearly written. The person's preferences within the plan are used to ensure all decisions made in an emergency situation are person-centred.

More than 154 care home staff were trained in anticipatory care planning and reported feeling more confident in having the skills to support anticipatory care planning.

4 Quality of Life

Health & social care services help to maintain or improve the quality of life of people who use those.

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
★★★★★ 5	Adults receiving care or support rated it as excellent or good*.	79%	
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life*.	81%	
13	Emergency Bed Day Rate	112,579 per 100,000	
14	Readmission to hospital within 28 days	99 per 1,000	
16	Falls Rate (People over 65)	18.9%	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	784 per 1,000	
£ 20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	23%	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2022/23, we worked with a range of partners to continue to create opportunities that improve health, wellbeing, and quality of life for people and communities in Midlothian.

Our Older People's Service provided more than 230 online, outdoor, and creative opportunities each month for older people to connect with each other. Our Care at Home service has been reviewed to ensure it is sustainable and fit for the future.

Tramway

In partnership with Cherry Road Day Services for people with Learning Disabilities, Midlothian HSCP sponsored the multi-sensory 'Human Threads' exhibition at the Tramway contemporary arts venue in Glasgow, from May - August 2022. The celebrated the common threads that make connections between people with complex disabilities and the wider world.

The exhibition represented many years of work between Artlink and Cherry Road Learning Centre which supports people with profound and multiple developmental disabilities and their carers. The exhibition was a large scale, multi-sensory, interactive landscape which invited audiences on a journey of light, sound, touch, and smell, providing the opportunity to look at who we are through a completely different lens.

People who attended Cherry Road thought this was a positive experience and enjoyed creating national artwork.

Volunteering plays a critical role in improving quality of life. People are motivated to volunteer for a number of reasons, including the opportunity to gain knowledge and skills, to give back to their community and help others, to gain the experience they need to move into studies or employment, and following support they themselves had in the past.

We know volunteering has positive health outcomes, and volunteers have shared their experiences of feeling more motivated, skilled, and confident. Volunteers have opportunities to develop new skills in health and social care, and many use these skills to go on to study or get a job.

The data tell us that retired and unemployed people who volunteer are often healthier than people who do not. Volunteers from lower income households are often much healthier than those who do not from similar households. The evidence also suggests that young people in particular benefit from volunteering.

We have developed better services for people experiencing poor mental health, by working closely across health and social care, housing, and the Third Sector. In 2022/23 our teams have supported 34 people into employment, education or volunteering and increased people's opportunities to succeed.

Improving personal outcomes through volunteering

People who volunteered told us that their mental health and wellbeing improved (92%), as well as their physical health and wellbeing (85%). 69% of volunteers reported increased motivation and activity levels. More than half (54%) experienced a reduction in loneliness, while over a third reported increased confidence (38%) and more engagement in their community (31%).

Improving support for people with neurological conditions

Midlothian HSCP worked with partners including the Thistle Foundation, ArtLink and Cerebral Palsy Scotland to better understand the needs of people with neurological conditions.

Supported by Scottish Government funding and in partnership with Cerebral Palsy Scotland we improved the pathway for people living with Cerebral Palsy. By working together and sharing information, this project will keep the views of people at the centre of decisions when future services and support are designed.

We worked alongside ArtLink to support people with neurological conditions to tell the story of how they experience of health and social care.

Improving quality of life for Adults with Complex and Exceptional Needs

The Adults with Complex & Exceptional Needs Service (ACENS) supports people over the age of sixteen who have been assessed as having exceptional healthcare needs and their families at home, and in the community.

Most people receiving care from the ACENS team have a life-limiting condition and require specialist care, equipment, and technology in their own environment. This highly skilled team tailors support to each person's individual needs and supports them to continue to live at home, build relationships, and participate in the activities that matter to them.

5 Health Inequalities

Health & social care services contribute to reducing health inequalities

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
11	Premature Mortality Rate (People under 75)	**428** per 100,000	
12	Emergency Admission Rate	**9,788** per 100,000	

The Scottish Index of Multiple Deprivation (SIMD) is how the Scottish Government identifies deprivation in Scotland. SIMD data is organised into 10 data zones, from the most to the least deprived. In Midlothian, approximately 31,522 people live in a zone that is considered to be the most deprived. People living in the most deprived areas are 30% more likely to need a prescription for anxiety or depression, and 24% of children live in poverty. We know families that include a person with a disability are more likely to be financially disadvantaged than other families.

Where we are born, live and work can impact our health and wellbeing. While not everyone living in a deprived area will experience high levels of deprivation, we know there is a link between deprivation and poorer health outcomes. This means people who live in the most deprived communities are more likely to die before the age of 75 (premature mortality) compared to those living in the least deprived areas. People living in remote rural areas have the lowest premature mortality rates, with higher premature mortality in large urban areas.

There are a number of long-term conditions that contribute to people dying earlier, as well as reducing the number of years people live in good health. Diabetes, ischaemic heart disease, Chronic Obstructive Pulmonary Disease and dementia are all long-term conditions that contribute to premature death in Midlothian more frequently than across Scotland as a whole. More people in Midlothian have their health affected by lower back and neck pain, headache disorders, anxiety disorders, and diabetes than across Scotland as a whole. We cannot assume that deaths related to substance use occur only in people under the age of 75.

A small proportion of premature deaths in Midlothian will be related to substance use. For 2022, the number of deaths related to substance use has reduced by 82% on the previous year. This is, in part, due to more people being known to services and accessing the right support. The evidence tells us that people who are known to services are much less likely to die from substance use.

We know that stopping smoking increases your chances of living a longer and healthier life. People who can stop smoking reduce their risk of heart disease, stroke, respiratory disease, and cancer. Stopping smoking can lead to improvements in the symptoms of smoking-related diseases, and also improve mental

health and wellbeing. The Scottish Government and NHS Boards agreed to work towards a smoke free Scotland by 2034. To do this, we worked to help people successfully stop smoking, especially in our most deprived areas.

Reducing smoking during pregnancy

Fewer people smoking also reduces the risk of people being exposed to second-hand smoke (passive smoking). This benefits the development of babies and children in particular. We also know that if parents stop smoking, it is less likely their children will become smokers. Children living with parents or others who smoke are much more likely to start smoking themselves.

We offered 1:1 sessions in community venues across Midlothian with information and support for pregnant women and their partners.

In Midlothian 12.6% of pregnant women smoked at their first midwifery appointment. The Health Improvement Team worked with midwives, health visitors, and family nurse partnerships to improve training and information. A 'smoking in pregnancy' training module was developed for NHS staff and Midwives had equipment and training to offer carbon monoxide monitoring.

We saw a 300% increase in the number of women who made a quit attempt with the Smoking Cessation service.

Improving access to health and care

Our Health Inclusion Team worked with the people most affected by health inequalities including people affected by homelessness, substance use, domestic abuse, or people with caring responsibilities.

The team offered support in local settings including temporary accommodation, food banks, and community groups. In 2022/23 they supported over 120 people with a wide range of health needs. This included blood borne virus testing, physical checks, cervical screening tests, immunisations, weight management support, substance support, support to access services and registering with a GP or Dentist.

Supporting people with Learning Disability

Our Day Services provided opportunities for people to learn new skills and connect with each other. We worked in partnership with Thera Trust to increase our ability to provide integrated care and support.

Our Expert Panels delivered change that mattered most to people. The Complex Care Expert Panel's financial recommendations for Community Change Fund spending priorities were approved. This included recruiting a new Transition Development Worker, making improvements to Day Service venues for people with complex needs, developing a Positive Behavioural Support Training Programme, and supporting grants to Third Sector organisations. The Human Rights Expert Panel created its first programme of activity. Bi-monthly meetings will oversee work to ensure we are promoting and protecting peoples' human rights and our duties under human rights law.

Supporting people with the cost of living

The rising cost of living is affecting people who are struggling to pay energy bills and buy enough food. More people are having to choose between eating and staying warm.

The British Red Cross provided practical support, such as food vouchers, slow cookers, and recipes, to help people enjoy warm, healthy, affordable meals and pay energy bills. This support has contributed to a number of the most vulnerable people in our communities remaining safe.

6 Support for Carers

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

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
8	Carers feel supported to continue in their caring role*.	27%	

* There is no update to the national data for 2022/23 in relation to this indicator.

In our last Annual Performance Report, we noted we had work to do to better support carers. Midlothian achieved slightly higher (40%) than the national average (39%) in the 2021/22 HACE survey when asking carers if they felt they had a say in the services provided for the person they care for. This was significantly higher (54%) in the VOCAL survey and likely due to the work of VOCAL to provide support and promote self-advocacy with carers.

The VOCAL survey also provided us with local insight into what matters most to people who undertake a caring role. Information and support helps people to provide care for as long as they are willing and able to do so. 17% of carers did not feel they had a say in the services provided for the person the look after. This was greater for those caring for someone due to substance use (31%) or visual impairment (26%) and those caring for people aged 16-25 (26%). More than a third of carers (38%) did not feel services were well coordinated and described additional stress caused by having to interact with several agencies.

Nearly a quarter of carers (24%) told us there were no services available to provide care whilst they take a break. Additionally, 39% of carers told us there was nobody else to provide care, and 27% reported that the person they care for will not accept care from others.

33% of carers in Midlothian told us that would like to see more services in their local communities at a time that suits them and was provided in one place. 40% of carers wanted help to understand legal rights and entitlements, and 36% wanted help to contact statutory agencies like health, social care, or education.

Providing the right support

In 2022/23 we increased the number of Adult Carer Support Plans by 150%. We focused on listening to carers, our partners, people, and communities to ensure that we use all our available resources in ways to make the biggest difference. We have collaboratively developed a range of supports to improve the experience of carers including plans for a Midlothian Community Care Cooperative.

People told us that the priorities in our Carer's strategy were highly relevant to provide the support they needed:

- Identifying carers, and helping people recognise when they are providing a caring role,
- Improving access to support, information, and advice,
- Supporting health and wellbeing (including breaks from caring),
- Planning ahead,
- Financial support, and
- Involving carers in care decisions and designing services and supports for the future.

The Midlothian Carers Strategy 2022-25 was published in 2022.

Carer Relief Companion scheme

Our Carer Relief Companion scheme is a programme where volunteers support families by spending time with the person they care for doing their preferred activities, whether playing dominoes or reminiscing over old photographs. For a few hours each week, volunteers give carers the opportunity to look after their own health and wellbeing by offering companionship to the person they are caring for while they take a short break.

"I would like to record my thanks …. This was to provide a companion service to my father (who)…has been diagnosed with Alzheimer's Dementia. The provision of the companion service enabled him to have additional contact with someone other than me. Whilst he did not realise it, I think he was becoming quite lonely on his own.

…the companion service team … took time to listen and understand my father and my circumstances and to seek to identify someone suitable to provide the companion service. The companion who was identified really made the service easy as she clearly understood the circumstances and was very accommodating in terms of my father's increasingly acute memory loss - often the conversation would need to start from square one again and the volunteer was patient.

I would have no hesitation in recommending the companion service to others. It gave me real peace of mind knowing that someone else was looking in on my Dad and providing that extra interaction for him at a much-needed time".

7 Safe from Harm

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

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
9	Adults supported at home agreed they felt safe*.	**79%**	
12	Emergency Admission Rate	**9,788** per 100,000	
13	Emergency Bed Day Rate	**112,579** per 100,000	
14	Readmission to hospital within 28 days.	**99** per 1,000	
16	Falls Rate (People over 65)	**18.9%**	
17	Care services graded Good or better in Care Inspectorate Inspections.	**78%**	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	**23%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

During 2022/23, the Care Inspectorate completed 18 inspections in Midlothian which is an increase of 80% compared with last year. The majority of services inspected were given a rating of adequate, good, or very good. A summary of the key findings can be found later in this report. Over two-thirds of Health and Social Care Partnerships across Scotland saw a reduction in this national indicator.

We received 929 Adult Support and Protection referrals in 2022/23, compared to 674 the year before. This is an increase of 225 referrals (37.8%) and an 100% increase over two years. The main type of harm investigated was financial harm, most commonly for women at risk of harm (67%), and adults aged 65 and over (52%).

Safe use of medicines

A way to help people stay safe at home is to make sure their medicines are well managed. This includes ensuring carers understand how to give, and keep clear records of, medicines.

The practice learning and development team developed medication training, supported by the NHS Pharmacy facilitator and the Midlothian HSCP Clinical Pharmacist, for our Care at Home Management team. The training was well-received.

When people leave hospital, their medicines have often changed. These changes need to be communicated to GPs and community pharmacists quickly and accurately. This is called 'Medicines Reconciliation'. The national Scottish Patient Safety Programme target is to complete this within 48hrs of the GP receiving a hospital discharge letter.

The Medicines Reconciliation Hub reviews the medicines for people in Midlothian who are discharged from hospital. The hub is led by highly skilled pharmacy technicians and all 12 GP practices in Midlothian have access to the hub. We have increased staffing within the hub, which has led to medicines being reviewed within 48 hours over 80% of the time.

We continue to improve the number of ways people can access the right information at the right time. Self-management approaches focus on supporting people to take action to prevent ill or worsening health. We know that people are more likely to take positive action in relation to their health and wellbeing when information is easy to find, including online resources.

Online support for mental health

Midspace is the online resource for mental health and wellbeing information in Midlothian Nearly 15,000 people in Midlothian have accessed Midspace for information and support. A further 723 people have accessed the integrated mental health team through social media. A newsletter also provided information for the whole community.

In 2022/23 we have seen a reduction in the number of people aged 65 and over being admitted to hospital as a result of a fall. Falls remain in the top ten reasons for people in Midlothian being admitted to hospital. Reducing falls and reducing how many people need to go to hospital will help people stay well, improve wellbeing, and reduce pressure on the wider system. For older people, we know that falls can be associated with being unwell. However, falls should not be considered as an inevitable consequence of getting older.

This indicator is based on information about people aged over 65 who are admitted to hospital after a fall. The good work we are doing to prevent people falling or providing personalised care for people who have fallen in their homes to prevent going to hospital, is not described by this indicator.

We also know that falls are often not reported. Even when falls are reported, the systems we use to record information are not well connected, and do not consistently identify opportunities to prevent falls in the future. We have worked to better understand how we can contribute to reducing the risk of older people falling, and we will continue to work with all our partners in Midlothian.

In 2022-23 our Frailty Programme explored and defined the falls pathway across Midlothian to understand where improvements could be made in the care we provide. This work highlighted opportunities for prevention and early intervention, and combined with our 'Good Conversations' approach, these changes improved our ability to provide high quality, person-centred care in the right place at the right time.

Our work to keep people safe and well at home also includes the use of telehealth equipment. Our community alarm systems help keep people safe and well in their own homes. We provide a range of sensors that are linked to a call centre. This helps people feel able to remain in her own home and feel safe. During 2022/23 there were 26,694 responses to alarms within the home for Midlothian Residents. This is an increase of 6% compared to last year.

Supporting people who use substances

The Substance Use team provided information, advice, and support to people and their families. We developed supports, treatment, and care including new medical treatments and increasing the safe use of needles.

Scotland has the highest drug death rate in the UK. Across Scotland, there were 797 suspected drug deaths during the first nine months of 2022. The average age of a drug death has increased from 32 in 2000 to 44 in 2021. Overall numbers are falling but still remain high. People living in the most deprived areas are 15 times as likely to have a drug-related death as those in the least deprived areas.

Accidental overdose is a common cause of death among people who use heroin, morphine, and similar drugs. Naloxone is a drug that reverses the effects of an overdose. Administration of naloxone provides time for emergency services to arrive and for further treatment to be given.

The Substance Use team provided training on the use of naloxone kits for people at risk of opioid overdose, for their friends and family, and for our workforce.

In 2022/23, 168 kits were replenished by Midlothian and East Lothian Drugs, the Substance Use Service, and peer workers.

8 Workforce

Staff are engaged with their work and are supported to continuously improve the information, support, care, and treatment they provide

National Indicators used to measure this outcome.

These are no National Indicators to measure our progress towards this outcome, so we use staff surveys to evaluate our performance.

Staff experience

iMatter is an annual survey sent to all employees across health and social care in the Lothians. In 2022, 48% of the workforce in Midlothian HSCP completed the survey. This is a small decrease (2%) on the previous year. Staff are asked about their work and their wellbeing including 'effective team working', 'health and wellbeing', and 'being involved in decisions'.

The Employee Engagement Index is the overall score given to the organisation. The five key areas of this measure how well staff feel they are:

- Informed,
- Appropriately trained & developed,
- Involved in decisions,
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued, and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients, and the wider community.

The maximum score is 100, and in 2022 Midlothian scored 78. This is an increase compared to last year.

A recent staff survey was completed by 90 social care staff. Approximately 85% described a positive experience of supervision, leadership, and training opportunities. Staff also reported improvements in strategic and locality planning, commissioning, and how we measure our performance.

Communication, Engagement and Experience Delivery Plan

In 2022/23 all staff across the partnership were invited to take part in a 4-month consultation on how we could improve the experience of working in Midlothian. Over 200 staff provided feedback, and this fed into the vision, aims and objectives of our Communication, Engagement and Experience Delivery Plan. Surveys, forums, team meetings and workshops shaped the language, aims, and actions in the plan. Midlothian HSCP will listen to staff as we deliver, review, and reshape the workplace experience.

Bringing people together

The 'Soup Stop' at Midlothian Community Hospital brings staff together, take a break with some healthy food and chat with our Senior Management and Executive Management in an informal and relaxed atmosphere. Staff have told us this has built a better sense of working together and improved staff wellbeing.

Working in health and social care is a rewarding career but can be challenging physically and emotionally. Our staff have told us that competing demands can make it difficult to 'switch off.' We introduced the 'Changing Gear' programme to help staff leave work at the end of the day and focus on the other parts of their life. The programme is delivered over four 30-minute sessions and aims to teach simple techniques for the body and mind. Yoga, simple exercises, mindfulness, and worry management have been funded through a small grant provided by NHS Lothian charity. All staff who have taken part would recommend the course to others and 92% of staff rated the programme as very good or excellent.

The environment can have a significant impact on our mental health. It can create a sense of social support, provide comfort, and increase motivation and creativity. Following successful funding bids, the NHS Lothian charity supported Midlothian HCSP and the Dalkeith Guerrilla Gardeners to create two wellbeing spaces with the Haven and staff wellbeing room at Midlothian Community Hospital, and the garden at Number 11, St Andrews Street. In 2023/24, we are hoping to provide more wellbeing spaces for our workforce in Penicuik, Bonnyrigg, and Dalkeith.

Midlothian HSCP Integrated Workforce Plan and Workforce Development

In December 2022 we published the first Midlothian Health and Social Care Partnership Integrated Workforce Plan for 2022-2025. This plan recognises local and national challenges, how we are responding to ongoing pressures, and ensure we have a workforce fit for the future.

We must do more to support our workforce. This means investing in the wellbeing, training, and development of our workforce, including our Third Sector partners and unpaid carers.

We know our workforce is our greatest asset, and we must ensure we have the right staff, in the right place, at the right time. Good Workforce Planning will ensure that our workforce has the knowledge and skills to deliver health and care in the future. We must invest in developing a skilled, flexible, and adaptable workforce.

In 2022/23 we progressed plans to establish a Workforce Governance Board to oversee the delivery of our Integrated Workforce Plan. Our two main areas of focus will be workforce planning, and workforce engagement. We will ensure we have reliable and accurate information about workforce demand, vacant posts, and recruitment times. This will include the development of workforce planning tools, and a review of operational workforce planning opportunities. As we develop our workforce planning skills, we will plan in partnership with NHS Lothian, Midlothian Council, Higher Education Institutions, and the Third and Independent Sectors to ensure we have an integrated workforce, fit for the future, that puts people at the heart of all we do.

We have highly skilled and experienced teams in Midlothian HSCP. However, we faced staff retention challenges, particularly in relation to nursing, care at home staff, and mental health officers. In addition to our work on staff engagement and experience, we are increasing staff development opportunities. A new local Career Development Toolkit will be developed in 2023/24, to ensure staff have a clear route to develop and progress.

Bright Futures for staff at Midlothian Community Hospital

Midlothian Community Hospital reviewed its staffing model to ensure that staff had the right skills and the right support to provide the highest quality care.

- All Health Care Support Workers took part in a development programme with a combination of formal and informal training. There are 13 clinical competencies matched to the areas people work and include record keeping, vital signs, ordering of specimens, and simple wound management.
- A range of Nursing Assistant roles were available including nursing assistants in training, qualified nursing assistants, and student nurse assistant practitioners. All staff undertook training in person-centred care planning, and leadership skills.
- Newly qualified nurses were offered a supportive environment with a structured 2-day induction, and support by the new Clinical Facilitator to continue to learn and develop in areas like medicine management and leadership skills. They also took part in formal structured courses including NHS Lothian's Newly Qualified Nurse programme and the Flying start programme. All student nurses received a welcome pack and were supported by the Clinical Facilitator with all aspect of nursing care. Weekly education sessions were available to students of any visiting professional.

9 £ Use of Resources

Resources are used effectively and efficiently.

National Indicators used to measure this outcome.

	National Indicator	Our result	Our Progress
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated*.	64%	
12	Emergency Admission Rate	9,788 per 100,000	
15	Proportion of the last 6 months of life spent at home or a community setting.	88%	
16	Falls Rate (People over 65)	18.9%	
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	784 per 1,000	
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	23%	

* There is no update to the national data for 2022/23 in relation to this indicator.

We allocate the integrated budget we receive from Midlothian Council and NHS Lothian.

Our Strategic Commissioning Plan sets out an overall plan for our delegated services every three years. We asked services to prioritise a number of outcomes. Financial planning allocated funding to each service to ensure the health and care needs of the people of Midlothian were met. This involved considering the best way to use available resource to provide the highest quality of care.

Midlothian Health and Social Care Partnership directly managed this funding and made decisions about how services use the money they received. Resources have been stretched due to salary increases for our staff and our commissioned services, and a larger population with more complex needs.

All services have a duty to ensure we deliver Best Value. This means we ensure resources are well managed, to improve services, and deliver the best possible outcomes for people and communities.

Reviewing medication

By working closely with GP Practices, the Pharmacy team worked to make sure that people take the safest, most effective medicines. This included carrying out polypharmacy reviews, where a person's medicines are looked at to make sure they are all still needed.

Preventing hospital admissions

Some of our community teams provided care to prevent admission to hospital. In 2022/23 we developed an electronic data dashboard to tell us when someone from Midlothian is in A&E. This information helped community teams work alongside A&E colleagues and avoid admission where possible.

The dashboard was also used by the Flow Team to coordinate the care of people while they were in hospital, and when they were ready to go home. The dashboard provides up-to-date information, so planning for people to be discharged from hospital is done as early as possible.

Better integrated collaborative working to continue to achieve best value

The Dietetic Prescribing Support Team worked with people who were discharged from hospital, and people living in Care Homes. The team made sure these people have the right nutritional support, which may include Oral Nutritional Supplements. The team worked closely with GP practices to promote the updated Malnutrition Care Pathway and training.

Working alongside Care Home staff, a more efficient referral process was jointly developed. Communication between teams improved. As a result, the team saw people earlier, by ensuring that care home residents saw a dietitian at the right time, we spent less despite the increased cost of supplements.

How We Spent Our Money (2022/23)

We had a total budget of **£173m** and ended the financial year with an **overspend of £10.3m**. This included an underspend on our operations of £0.4m and the use of earmarked reserves funding during the year, predominantly for COVID-19. For more information see our Annual Accounts.

	Budget	Spend	Variance
Direct Midlothian Services			
Community AHPS	2,234,069	2,101,440	132,629
Community Hospitals	6,205,539	6,563,225	-357,686
District Nursing	6,085,440	5,858,168	227,272
General Medical Services	17,275,583	17,511,583	-236,000
Health Visiting	2,397,793	2,505,868	-108,076
Mental Health	3,030,656	2,849,066	181,590
Other	1,383,805	7,597,473	-6,213,668
Prescribing	19,660,453	20,328,369	-667,916
Resource Transfer	7,112,274	7,109,434	2,840
Older People	26,304,227	25,552,368	751,859
Learning Disabilities	18,228,653	18,983,957	-755,304
Mental Health	1,134,041	1,188,778	-54,737
Physical Disabilities	3,829,016	3,846,579	-17,562
Assessment and Care Management	3,616,499	3,583,197	33,302
Other	3,499,315	7,367,121	-3,867,806
Midlothian Share of pan-Lothian			
Set Aside	21,494,976	22,586,023	-1,091,046
Mental Health	2,802,063	3,050,666	-248,603
Learning Disabilities	1,338,475	1,353,181	-14,706
GP Out of Hours	1,327,876	1,396,803	-68,927
Rehabilitation	947,650	782,937	164,713
Sexual Health	758,821	773,731	-14,910
Psychology	1,282,550	1,183,509	99,041
Substance Misuse	517,656	497,070	20,586
Allied Health Professions	1,780,607	1,657,908	122,699
Oral Health	1,355,200	1,304,536	50,665
Other	3,825,622	3,716,635	108,987
Dental	6,347,653	6,347,653	0
Ophthalmology	1,743,994	1,743,994	0
Pharmacy	3,829,726	3,829,726	0
	171,350,233	**183,171,000**	**-11,820,767**
Non recurring funding support from NHS Lothian	1,480,000		1,480,000
	172,830,233	**183,171,000**	**-10,340,767**

Subject to audit

Financial Challenges during 2022/23

COVID-19 Funding

During the pandemic, Midlothian, in line with Scottish Government guidance, stepped up a range of services to support a system wide response to COVID-19.

The cost projections associated with these services were reported to us through the Scottish Government Local Mobilisation Plan. During the 2020/21 to 2022/23 financial years the associated costs were funded by designated COVID-19 funding.

The Scottish Government confirmed the funding would not be available in the 2023/24 financial year. In response, we assessed and reprioritised funding streams to ensure both clinical and financial sustainability of these services.

Social Care

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

Health

There were operational overspends within Community Hospitals because of workforce challenges and overspend within the prescribing and general medical services budgets.

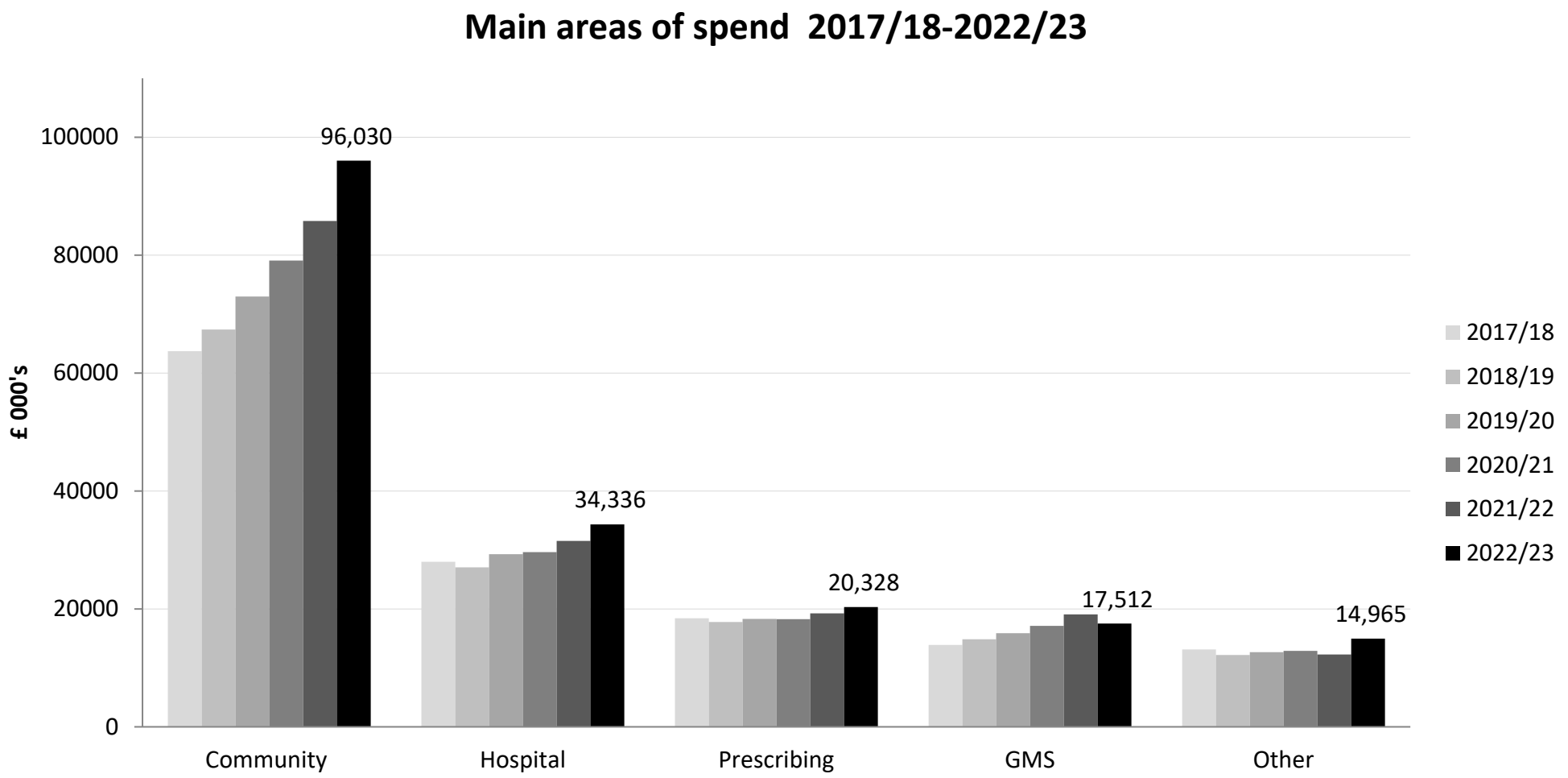
Our Hosted and Set Aside services continued to experience a number of pressures. Mental Health Inpatient services required additional capacity to meet high demand. There were also increased requirements for equipment provided by the Community Equipment Store.

The main pressure for Set Aside services was within Gastroenterology Services and the ongoing pressure with drug costs for the treatment of long-term gastroenterology conditions. Junior Medical pay pressure also continued, where additional staffing was required to fill gaps in rotas and where there were service pressures. The Junior Medical position has improved significantly from previous years but continued to be a pressure.

The health arm of the IJB was operationally overspent and NHS Lothian provided the IJB with additional one-off funding of £1.4m to support break even against these budgets.

Main Areas of Spend (2017/18-2022/23)

The graph below compares our spend trends for the past 6 years. We are unable to report on spend by locality as we do not hold data in this form.



Budget challenges in Midlothian

In March every year, Midlothian Council and NHS Lothian make a budget offer to the IJB, based on levels of funding set by Scottish Government. The IJB then review these offers and accept or reject them as part of its annual financial assurance process. This year Midlothian Council did not offer to pass over the agreed amount in full, and the IJB voted not to accept this offer.

The Council's position did not change, and the IJB has continued to explore options to mitigate this reduction in funding. This includes developing a multi-year financial plan to support how the resources available to the IJB will be used to deliver the ambitions of the Strategic Plan.

It became clear across 2022/23 that the financial situation had become more difficult as we better understood the impact of events since March 2020. Despite this, the IJB supported an increase in wages in line with the living wage and asked services to ensure fair working by offering guaranteed hours.

The years ahead will be some of the most challenging that health and social care have ever faced. This means we will need to better understand how peoples' and communities' needs have changed and build the right offers of support, with the resources we have available. The IJB will continue to invest in population health and improve community alternatives to hospital-based care.

Working with local Communities

Community Planning is a way of organisations working together, and with local communities, to use resources to improve people's lives. There are 32 Community Planning Partnerships across Scotland - one for each council area. These Partnerships bring together key organisations, both statutory and Third Sector, to plan services that will deliver better outcomes for people.

Midlothian Integration Joint Board and Midlothian Health and Social Care Partnership are part of the Midlothian Community Planning Partnership. By working together, we want to see people leading healthier, safer, greener, and successful lives. This involves including the people who use our services, their families, and carers in developing and improving the care and support we provide.

In 2022/3 we reviewed how we could most effectively contribute to the 'Single Midlothian Plan' and work with the Community Planning Partnership members, to achieve more together than health and social care can do alone. We will lead the 'Midlothian will be Healthier' thematic area with 4 multi-sector projects:

- Midlothian Care and Support Community Co-operative
- Falls prevention and support
- Digital self-management platform
- Early identification and support for people living with frailty.

The Third Sector has strong roots in local areas and supports a system-wide understanding of our communities that is invaluable. Our ongoing partnership with the Third Sector is at the core of our work in communities.

The Community Planning Partnership annual conference took place in November 2022, where the results of the Midlothian Citizen's Panel Survey were presented. Over 1,000 people were asked their views on what matters most to them in their communities and what they think we should be focusing on. 565 people replied to a questionnaire and the three priorities people wanted the health and social care to focus on to 'Make Midlothian Healthier' were:

- Support the health needs of a growing and ageing population
- Provide support to vulnerable people
- Improve wellness and support

We worked closely with the Midlothian Community Planning Partnership to develop the contribution from health and social care. The work to develop a new plan for 2023/27 has been based on the wishes of people and communities and explored opportunities to work with more of the partners in our Community Planning Partnership.

Communication & Engagement

We constantly involve people who use our services, their carers, and people who support them develop and deliver our services. This year we consulted people to ask for their views on a range of services including:

Palliative End of Life Care Project

We were one of two pilot sites chosen to take part in a project, funded by the Scottish Government and Marie Curie, to explore ways to capture feedback from bereaved family members about palliative and end of life care. We spoke to 61 people including family members, community district nurses and staff from Midlothian Community hospital. Key themes that emerged were:

- The importance of relationships and being treated as a whole person in a good death
- The importance of being able to make choices in a good death
- Getting help needed when it is needed
- The importance of specialist advice and care, especially at the very end of life

Neurological conditions

We worked with Artlink to listen to people with a neurological condition and understand their experiences, to help us make sure everyone can get the care and support they need to live well. We commissioned an author and speaker on disability, social inclusion, and empowerment to interview people and present her findings.

Additional funding for carers

As part of the process for allocating additional funding from the Scottish Government to support carers we consulted with 40 stakeholders and unpaid carers on the services we deliver, gaps and what could be improved or developed. We asked about:

- Carer Identification
- Information, support, finances, and breaks
- Carer Health and wellbeing
- Planning ahead

Community justice

We undertook a variety of consultations including the Citizens Panel; individuals in care at HMP Edinburgh; individuals allocated to Justice Social Work or engaging in groups including Unpaid work as part of Community Payback Orders. Key themes from these consultations included:

- A need to redesign our exit questionnaires for all individuals on Community Payback Orders.
- Development of an effective, person-centred, and trauma informed Restorative Justice pilot that promotes and prioritises the voice of survivors. We are one of the first local authorities in Scotland to take forward this ground-breaking, innovative, and partnership-led work and consultation, engagement, research and training and development all contributed to the design of the project.

Transitions for people with learning disabilities.

The Transition Forum looked at how we plan and provide support for people aged 14-25 who require additional support as they make the transition to young adult life. Over 30 people replied to our online questionnaire. The main themes were:

- People said they wanted support for mental health, independent living and social activities
- People felt they could be better supported for planning in the future
- People felt they were unsure of the support available to them during transitions

Looking forward

To meet the needs of people and communities we will need to deliver on the strategic priorities of all our partners. We have identified themes and priorities that we must work together to achieve:

- Provide more preventative care
- Understand how peoples' and communities' needs have changed and build the right offers of support
- Ensure effective and efficient services while also maintaining quality
- Improve socio-economic, health, wellbeing, and personal outcomes

We must develop a whole-system approach to how we design and deliver our services. We must share decision making and share responsibility for outcomes and use proactive and consistent approaches to improve our performance.

Working with communities

People and communities have valuable skills and experience to design and improve the health and care services that matter to them. We want to work with communities to ensure that we are planning and developing the right local health and care services.

We want to be confident that all our delegated services are committed to quality community engagement and be able to describe how well they are working with communities. To do this, we will undertake a self-evaluation using the Health Improvement Scotland Quality Framework for Community Engagement and Participation across 2023-24. This will complement our outcomes-focused approach by prioritising outcomes over activity, describe the impact of our partnership working, describe the changes made as a result of feedback, and how potential impact is being monitored.

In 2023/24, we will ensure we have identified and supported engagement activity in 4 ways:

- We will work with communities to complete the Health Improvement Scotland self-evaluation and identify key areas for improvement
- We will be clear on how we expect all our delegated services work with communities
- All our delegated services will report on the specific engagement activities relating to service planning and design
- We will be able to describe our internal governance systems for community engagement activities

Designing our services

As we better understand the changing needs of communities we will continue to assess, adapt, and innovate to ensure what we offer is what people need. We need to be clear about when we are implementing change, and when we need to think in much bigger terms about transformation.

Change is when we modify our actions to achieve better results or to meet changing targets or resources. This usually involves implementing well-defined shifts in activity. Transformation involves bigger reinvention, sometimes in profound ways, can often involves rethinking our core beliefs and patterns of long-term behaviour.

We will continue to take a transformational approach with a range of related and dependent initiatives then do whatever it takes to ensure that learning can be spread across the whole system at scale and at pace.

Workforce

Integrated workforce planning is new for health and social care, and we will develop our skills in this area across 2023/24. This includes our preparations to deliver the requirements of the Health and Care (Staffing) (Scotland) Act.

The needs of our workforce are changing and dependent on many new factors. Our Integrated Workforce Plan focuses on the 5 pillars of workforce planning set by Scottish Government to support recovery, growth and transformation of health and social care.

As we transform our services, we will continue to work with partners from all sectors to develop an integrated workforce that is fit for the future.

Data, Digital and Technology

We recognised health and social care does not have the infrastructure to share data in the way we need and asked our partners to put in place mechanisms that allow safe and integrated data sharing. Our ambitious digital plan was launched in 2022 and will provide innovative solutions to some of our most complex challenges.

Outdated IT and limitations around data sharing are barriers to helping us transform at the speed and scale that we need to. Efficiently linking information to how we plan our services does not just improve care and save money, it also frees up time to let our services and teams do their best work. Starting this work has helped us understand our success is dependent on releasing the data we need from individual services and using this in an integrated way.

We also know that data alone does not make better decisions. People and communities are expecting a new standard of care to support social and health needs. We must respond with a fast, joined up data-informed approach, analysed by connected systems and highly skilled teams.
In 2023/24, we have asked NHS Lothian and Midlothian Council to ensure we can access data by HSCP area. This will help us to identify and address equality issues, meet different needs, and encourage participation. We will have to make better use of existing technologies and provide people with access to accurate information and services.

Hosted service reporting

We need to provide information about how well our hosted services are performing to the other Lothian Health and Social Care Partnerships and NHS Lothian. We have worked hard in 2022/23 to make sure our hosted services can provide the right information in a consistent way and are leading the way in the development of this approach for Hosted Services in 2023/24.

Planning ahead

In 2023-24 we also need to plan for and start writing our next Strategic Commissioning Plan 2025-28. Our planning and performance team will ensure the consultation, review, and governance around our most important piece of planning is done well and includes everyone that wants to be involved.

Inspections

The Care Inspectorate inspect care homes and care at home services to check the quality of care. The majority of care homes in Midlothian are not managed by the HSCP. Read the full reports at the Care Inspectorate website.

Care at Home – Support Services

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
St Joseph's Services - Circle of Best Practice 1 - Care at Home	10/02/2023	5 Very Good	5 Very Good	4 Good	-	5 Very Good
St Joseph's Services - Circle of Best Practice 2 - Care at Home	10/02/2023	5 Very Good	5 Very Good	4 Good	-	5 Very Good
St Joseph's Services - Circle of Best Practice 3 - Care at Home	10/02/2023	5 Very Good	5 Very Good	4 Good	-	5 Very Good

Recommendations and Areas for Improvement (if any)

Name	Recommended Improvement
St Joseph's Services - Circle of Best Practice 1 - Care at Home	1. The service should ensure that staff are appropriately trained and receive refresher training as and when required to meet the care and support needs of people. This should also be reflected in robust training records, so the care provider is confident that its workforce is appropriately skilled
St Joseph's Services - Circle of Best Practice 2 - Care at Home	1. The service should ensure that staff are appropriately trained and receive refresher training, as and when required, to meet the care and support needs of people. This should also be reflected in robust training records, so the care provider is confident that its workforce is appropriately skilled.
St Joseph's Services - Circle of Best Practice 3 - Care at Home	1. The service should ensure that staff are appropriately trained and receive refresher training, as and when required, to meet the care and support needs of people. This should also be reflected in robust training records, so the care provider is confident that its workforce is appropriately skilled.

Care Homes for Older People

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Aaron House	17/03/2023	4 Good	-	4 Good	-	-
Aaron House	26/07/2022	3 Adequate	4 Good	3 Adequate	4 Good	4 Good
Aaron House	21/12/2022	3 Adequate	-	3 Adequate	-	4 Good
Drummond Grange	16/05/2022	4 Good	4 Good	4 Good	4 Good	4 Good
Guthrie House	15/11/2022	3 Adequate	4 Good	-	-	-
Nazareth House	04/05/2022	3 Adequate	3 Adequate	3 Adequate	-	-
Nazareth House	24/11/2022	4 Good	4 Good	4 Good	4 Good	4 Good
Newbyres Village	29/04/2022	4 Good	-	-	-	-
Newbyres Village	16/09/2022	3 Adequate	3 Adequate	3 Adequate	4 Good	4 Good
Pittendriech	01/11/2022	3 Adequate	3 Adequate	3 Adequate	3 Adequate	3 Adequate
Rosehill	28/10/2022	3 Adequate	3 Adequate	3 Adequate	4 Good	3 Adequate
Springfield Bank	07/12/2022	4 Good	4 Good	4 Good	3 Adequate	4 Good

Recommendations and Areas for Improvement

Name	Recommended Improvement
Drummond Grange	1. To ensure that people are receiving regular interactions and engagement from staff is important. This should include encouragement and availability of resources to undertake activities for people who are supported in their bedrooms. 2. To ensure that people experience high quality care and support that is right for them, all staff should undertake further equality and diversity training. The training should be reflective and include discussion on how to put learning into practice. 3. To improve the environment of the home the provider should continue to develop a refurbishment plan, specifically for Pentland and Kevok. This should include, but not be restricted to, improving bedrooms and corridors, ensuring timely repairs and replacement of items. The plan should detail the timescales for refurbishment and repairs/maintenance to take place and be reviewed on a regular basis. 4. People should be helped to live well right to the end of their life. The manager and staff should develop with people their anticipatory care plan. This should include information received both from the person and those important to them, which ensures staff know what they should do if a person's health deteriorates.
Guthrie House	1. People should be able to maintain and develop their interests and activities in a way that is meaningful for them. People who choose not to, or are not able to, participate in group activities, should have opportunities for social activities and be supported to pass their time in meaningful ways. To support this, the provider should ensure that people are supported with individual social opportunities in line with their choices and preferences This could include the deployment of activity staff and involvement of care staff in order to be able to offer social opportunities for people on a regular basis. 2. People should be confident that their personal plans reflect things that are important to them and how their needs and wishes are to be met. 3. People should be able to enjoy a positive dining experience that is as free from intrusive noise and interruptions as possible. 4. The provider should ensure that any treatment or intervention that residents receive is safe and effective.
Nazareth House	1. Personal plans should accurately reflect the care provided. 2. To ensure people are actively encouraged to be involved in improving the service, family, friends, and people supported should be given feedback on how quality assurance processes have led to improvements based on their feedback and suggestions.

Name	Recommended Improvement
	3. All staff should undertake the relevant level of training to promote their understanding and skills relating to supporting people with dementia. The training should reflect the promoting excellence framework for people with dementia, at a minimum of skilled level. 4. To improve the environment of the home the provider should continue to develop a refurbishment plan. This should include, but not be restricted to redecoration, repairs, equipment replacement and improving the garden area. The plan should detail the timescales for refurbishment to take place and be reviewed on a regular basis. 5. Six monthly reviews of support, as good practice, should give detail on discussions and reflect all aspects of care, including outcomes and activities. Outcomes of what people want from their life in the home (including relatives' views) should be reflected in the review of care. 6. People should have choice about getting involved with activities and interests important to them, both in the care home and their community. The provider should continue to develop opportunities for people to participate in meaningful activities. This is to enable people to get the most out of life and options to maintain and develop their interests, activities, and what matters to them. This includes opportunities to connect with family friends and the local community, in different ways. People with specific communication needs or cognitive impairment should also be supported to participate in a meaningful way and those important to them involved in planning activities and evaluating how meaningful they were. The recording and monitoring of this should help to promote positive outcomes for all.
Newbyres Village	1. The provider should ensure that care staff are appropriately trained to meet the moving and handling needs of people and that this is delivered in a safe manner. This practice should also be underpinned through observation of practice by management. This is to support the ongoing development of staff, ensuring they are competent, skilled, and able to reflect on their practice to continue to meet people's needs. 2. The provider should ensure that there is a structured team meetings and support and supervision system in place for staff (which incorporates observations and reflections of practice). This is to support the ongoing development of staff, ensuring they are competent, skilled, and able to reflect on their practice to continue to meet people's needs. 3. The provider should ensure people's care planning documentation is reviewed on a regular basis and the systems and processes used by staff reflect this in a consistent way.
Pittendriech	1. People who need help to take their medication should have confidence that they will receive it safely from appropriately skilled staff.

Name	Recommended Improvement
	2. To ensure people are supported appropriately in a meaningful way, all staff should be consistent in their approaches to people who exhibit stress and distress. This would include de-escalation techniques, what leads to the person becoming upset, and in what circumstances to administer prescribed medication. All of which would be recorded in their personal plan. 3. To ensure people are kept safe, the provider should implement appropriate procedures for the control and prevention of infection. 4. To ensure that people's needs are fully met as agreed in their personal plan, including medication, all documentation should be consistently and accurately recorded.
Springfield Bank (7 December 2022)	1. Personal plans should accurately reflect care provided and give clear instruction to all staff including agency staff. 2. To ensure people are supported appropriately in a meaningful way, all staff should be consistent in their approaches to people who exhibit stress and distress. This would include de-escalation techniques, what leads to the person becoming upset, and in what circumstances to administer prescribed medication. All of which should be recorded in their personal plan. 3. All staff should receive training on meaningful engagement with people living in a care home. This would give staff the knowledge, skills, and confidence to initiate meaningful interactions with residents out with direct care tasks. 4. Observation and reflection of staff practice should become a regular part of staff development. This would enable staff to reflect on their practice and evidence how training undertaken enhances staff skills and knowledge.
Springfield Bank (23 May 2023)	1. To ensure people are supported appropriately in a meaningful way, all staff should be consistent in their approaches to people who exhibit stress and distress. This would include de-escalation techniques and what leads to the person becoming upset. All of which should be recorded in the personal plan and reviewed. To support staff, observed practices and self-reflection of how the techniques were put into practice should be part of their development. 2. All staff should receive training on meaningful engagement with people living in a care home. This would give staff the knowledge, skills, and confidence to initiate meaningful interactions with residents out with direct care tasks. 3. To improve the environment of the home the provider should develop a full refurbishment plan. This should include a full inventory of any, furniture, fittings, or equipment which is need of replacement. The plan should detail the timescales for refurbishment to take place and be reviewed on a regular basis. 4. People should have choice about getting involved with activities and interests important to them, both in the care home and their community. The provider should continue to develop opportunities for people to participate in

Name	Recommended Improvement
	meaningful activities. People with specific communication needs or cognitive impairment should also be supported to participate. 5. in a meaningful way and those important to them involved in planning activities and evaluating how meaningful they were. The recording and monitoring of this should help to promote positive outcomes for all. An assessment of the number of health and wellbeing workers should be undertaken to ensure each person has the opportunity to engage in activities meaningful to them.

Care Homes for Adults with a Learning Disability

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Dougall Court	09/05/2022	3 Adequate	3 Adequate	4 Good	2 Weak	-
Dougall Court	02/09/2022	4 Good	-	-	3 Adequate	-

No recommendations and Areas for Improvement.

Care Homes for Adults with a Learning Disability and Autism

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Parkside Court	19/05/2022	4 Good	3 Adequate	-	-	-

No recommendations and areas for improvement

Housing Support Service

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Bluebird Care	02/03/2023	4 Good	4 Good	4 Good	-	4 Good

Recommendations and Areas for Improvement

Name	Recommended Improvement
Bluebird Care	1. To ensure people are kept safe and limit the spread of infectious diseases, (including but not limited to COVID-19) the care provider should ensure that staff are trained to have the knowledge and application of guidance from the Infection Prevention and Control Manual. 2. To ensure people are kept safe and limit the spread of infectious diseases (including but not limited to COVID-19) the care provider should work closely with people to develop person-centred care plans and risk assessments which reflect the Scottish Government and Health Improvement Scotland guidance. 3. To ensure that people are supported in a consistent way and do not feel rushed, the provider should improve on current scheduling practices. 4. To safeguard people who use the service and meet legal requirements the provider should not employ any person in the provision of a care service unless that person is fit to be employed. Policy and practice must take account of the Adult Support and Protection (Scotland) Act (2007).

Support Service

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Cherry Road Resource Centre	14/03/2023	4 Good	4 Good	-	3 Adequate	5 Very Good

Recommendations and Areas for Improvement

Name	Recommended Improvement
Cherry Road Resource Centre	1. To ensure people are kept safe and limit the spread of infectious diseases, (including but not limited to COVID-19), the care provider should ensure that staff are trained to have the knowledge and application of guidance from the Infection Prevention and Control Manual. 2. To ensure people get the most out of life and experience positive mealtime experiences the provider should engage with people, their relatives, and staff to explore if or how a balance could be agreed which is reflective of the Keys to Life Strategy.

IJB Business

Integration Functions and Governance Decisions

Integration Functions

1. Equality in Midlothian

Everyone should be treated equally. No-one should have worse opportunities because of where they were born, how they identify, what they believe or whether they have a disability. We take steps to ensure equality is at the heart of what we do and the work of our partners. This includes the way we make decisions, the way we and people who work alongside us behave, how we decide how we spend money, and how we improve our services.

By law, we must report on the progress towards mainstreaming equality by publishing a Mainstreaming Equality Report every 4 years and provide a progress update midway through the plan. Midlothian Health and Social Care Partnership is the organisation delivering services to the community, and working to further equality in its work, but the IJB must publish the report on its actions.

In 2022/23, we reviewed and published the progress update on our Mainstreaming Equality Report Update (for 2021/23) and Action Plan (for 2023/25). This report details the progress we have made with our mainstreaming equality work alongside our NHS and Local Authority partners and set out our ambitions and action plan for 2023/25.

In 2022 we worked with the Equality and Human Rights Commission to develop a better understanding of our duties as a Public Body and help us ensure that improving equality is at the centre of our decisions. We developed a process to help identify, complete, review and monitor the impact of our decisions for all new and revised strategies, policies and plans, provisions, practices, and activities.

In Midlothian, we complete Integrated Impact Assessments (IIAs) to consider how our work might impact equality issues, health inequalities, socio-economic inequalities, needs assessments for care experienced people, human rights, and the environment. Completing an IIA should highlight how we can avoid discrimination against groups of people and to remove or minimise disadvantage where possible.

In 2022/23, we completed IIAs for the following new or revised strategies, policies and plans, provisions, practices, and activities.

- Midlothian HSCP Staff Wellbeing Delivery Plan
- Midlothian HSCP Establishment of the Midlothian Mental Health and Resilience Service
- Midlothian HSCP Chest, Heart and Stroke, Scotland (CHSS) Long COVID Service

2. Developing a new approach to Directions

Directions are the mechanism by which we set out our main priorities for the services delegated to us and how we instruct NHS Lothian and Midlothian Council on how to approach this and allocate financial

resources. In 2022/23 we improved how progress is measured to recognise the individual and collective contribution made by our partners in a number of ways:

- **A log of Directions**
  This was created to ensure compliance with the Statutory Guidance from the Scottish Government and review progress against our current Directions.
- **A review of how to set Directions**.
  This looked at ensuring control around strategic planning, financial allocation, performance monitoring and review of priority actions. The Board reappraised the value of issuing high numbers of operational Directions and decided to move towards a more strategic approach for 2023-24.
- **A series of workshops for officers of the HSCP and Board members**
  These supported the development of a strategic set of Directions that reflected the Board's best hopes for the people and communities of Midlothian, and gave operational services the ability to explore, design, and create the transformation required.
- **Six monthly updates on Midlothian IJB Performance**
  The Midlothian Performance Framework sits alongside the Midlothian HSCP Performance Framework and brings together the strategic ambitions of the organisation with operational activity captured in the Midlothian HSCP Governance and Assurance Framework.

Looking forward, our Directions for 2023/24 are aligned to the nine National Health and Wellbeing Outcomes and share the overarching strategic vision of the Lothian Strategic Development Framework, the Midlothian Council 5-Year Plan, and the ambitions of the Midlothian Community Planning Partnership. This integrated approach is designed achieve the greatest change in the shortest time possible to improve the outcomes that matter most to people and communities. Directions for 2023/24 were issued on 30th March to the chief executives of NHS Lothian and Midlothian Council.

3. Developing new Performance Framework

Our new Performance Framework has been produced to support strategic measurement for 2023/24. This will sit alongside the Midlothian HSCP Performance Framework and bring together the strategic ambitions of the organisation with operational activity captured in the Midlothian HSCP Governance and Assurance Framework.

Following development by the Performance, Assurance and Governance Group, the Board were presented with a first draft of the Performance Framework on 13th October 2022 and approved the new framework on 9th February 2023.

4. Outcome mapping and the OutNav software

In 2021/22 we worked with Matter of Focus to develop a framework to describe how we work with people and communities to improve outcomes. In 2022/23 we focused on ensuring we are able to tell our story consistently and meaningfully about supporting people to achieve the things that matter most to them. This included designing a whole system approach that helps us examine and review our Activity (governance) and Experience (population information), alongside Outcomes.

Based on the learning from 2021/22, we designed and developed a single, common approach for all services and our commissioned partners to tell their story. This allowed us to describe the contribution we make to changing outcomes and transformed the way we talk about data. We have not simply taken old processes and made them electronic, we have provided a meaningful way for services to describe their

contribution to population change and directly contribute to how we are measuring progress towards our 6 strategic aims. We tested our new approach in autumn 2022. This helped us make further improvements and include more service areas in OutNav. We are confident this work will help us move towards a truly outcomes-focused approach, while still meeting our statutory reporting requirements for service activity and output data. We currently have approximately 40% of our service areas on the system and all areas have been asked to record outcomes in this way by January 2024.

Governance Decisions

1. IJB Membership

- Patricia Donald, Non-Executive NHS Board member, left the Board in June 2022
- Carolyn Hirst, Non-Executive NHS Board member, left the Board in August 2022, also stepping down as Chair
- Dr Johanna Simpson was reinstated as a non-voting Board member in August 2022
- Dr Rebecca Green was appointed as a new non-voting Board member in August 2022
- Val De Souza, Non-Executive NHS Board member, was appointed to the Board in August 2022, also being appointed Chair
- Councillor Kelly Parry was appointed to the Board in August 2022
- Councillor Colin Cassidy was appointed to the Board in August 2022, also being appointed Vice Chair
- Jock Encombe, Non-Executive NHS Board member, stepped down as a voting Board member in February 2023
- Andrew Fleming, Non-Executive NHS Board member, was appointed as new voting Board member in March 2023

2. Model Schemes

- Code of Conduct approved on 16th June 2022
- Standing Orders approved on 9th February 2023
- Register of Interest updated August 2022
- Scheme of Integration presented on 15th December 2022 and approved by Scottish Government on 15th May 2023. Please note this is an NHS Lothian and Midlothian Council Scheme

3. Finance

- Audited Annual Accounts 2021-22 approved 15th September 2022
- Medium-term Financial Plan 2022-23 – 2026-27 noted 15th December 2022
- Funding Agreed for Equalities Lead post 9th February 2023

4. IJB Performance

- Annual Performance Report approved on 13th October 2022
- Annual Performance Report published on 31st October 2022

5. Directions

- Directions 2023-24 approved on 16th March 2023
- Directions 2023-24 issued on 30th March 2023

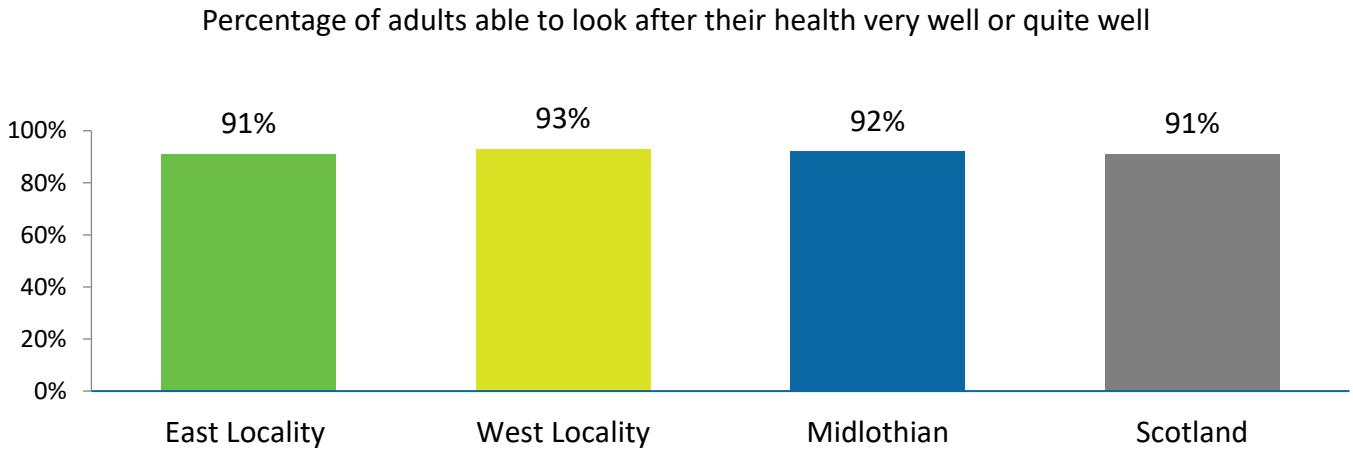
Copies of the relevant reports can be found in the committee reports on the Midlothian Integration Joint Board pages of the Midlothian Council website.

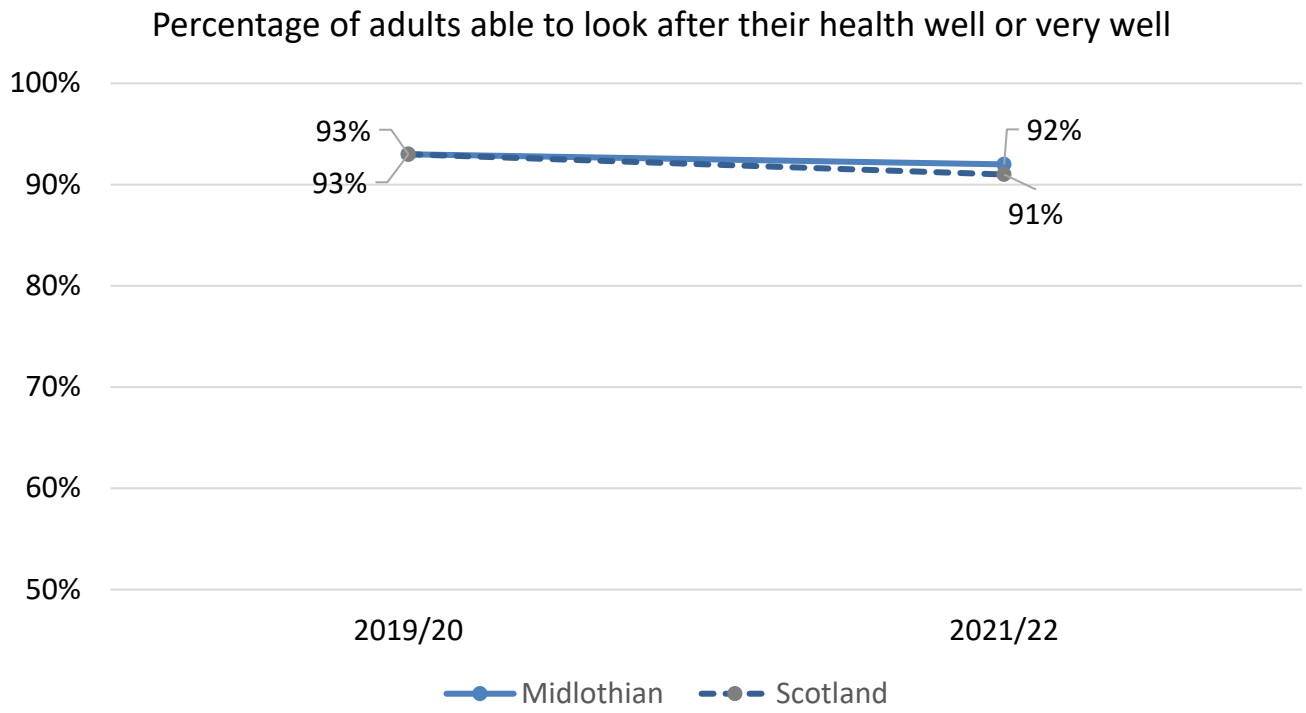
Data Appendix

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well*.	**92%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance was the **same** compared to 2020-2021.
Overall performance across Scotland got **worse** by 2 percentage points.
Midlothian's performance was **better** than across Scotland.
We are doing **well** in relation to national performance.

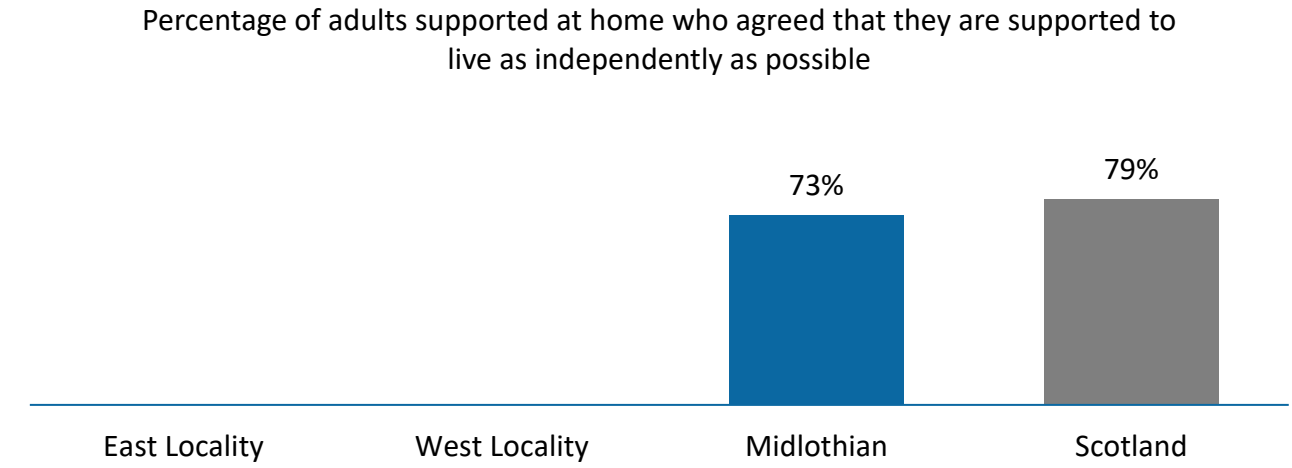




	National Indicator	Our result	Our Progress
2	Adults supported at home agreed that they are supported to live as independently as possible*.	**73%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 7 percentage points.
Overall performance across Scotland got **worse** by 3 percentage points.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.



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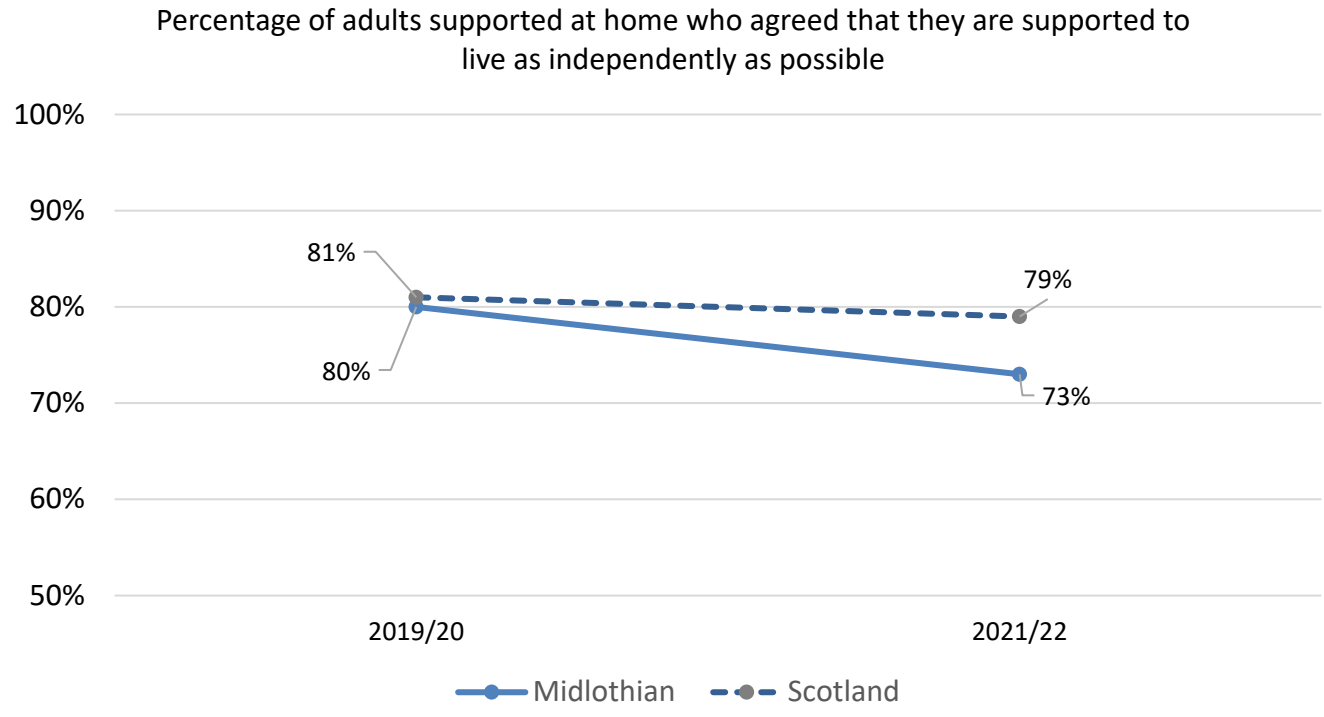
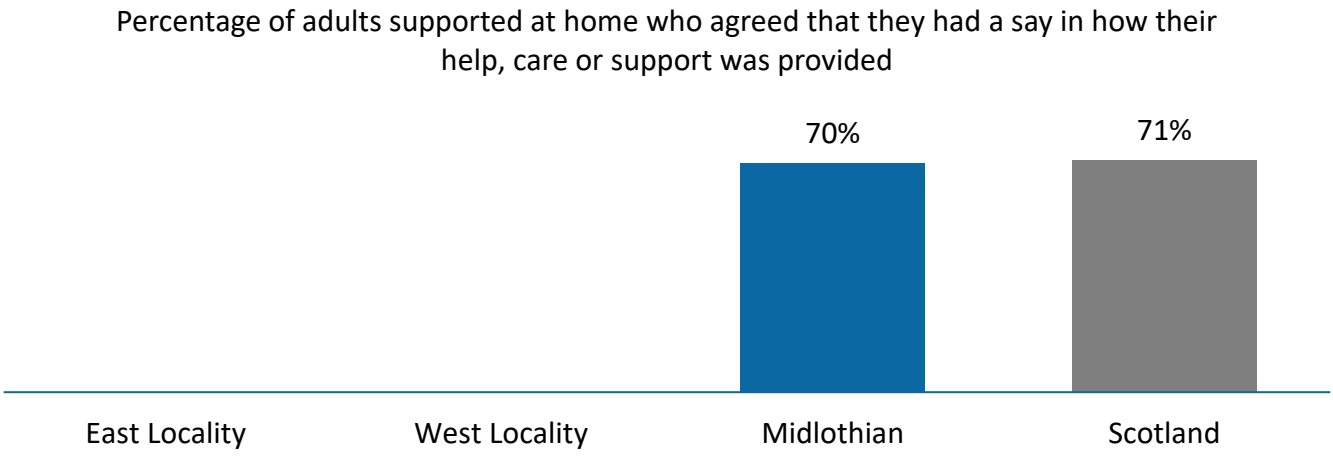


	National Indicator	Our result	Our Progress
3	Adults supported at home agreed they had a say in how their help, care or support was provided*.	**70%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 4 percentage points.
Overall performance across Scotland got **worse** by 4 percentage points.
Midlothian's performance was the **same** as across Scotland.
We are **doing well** in relation to national performance.



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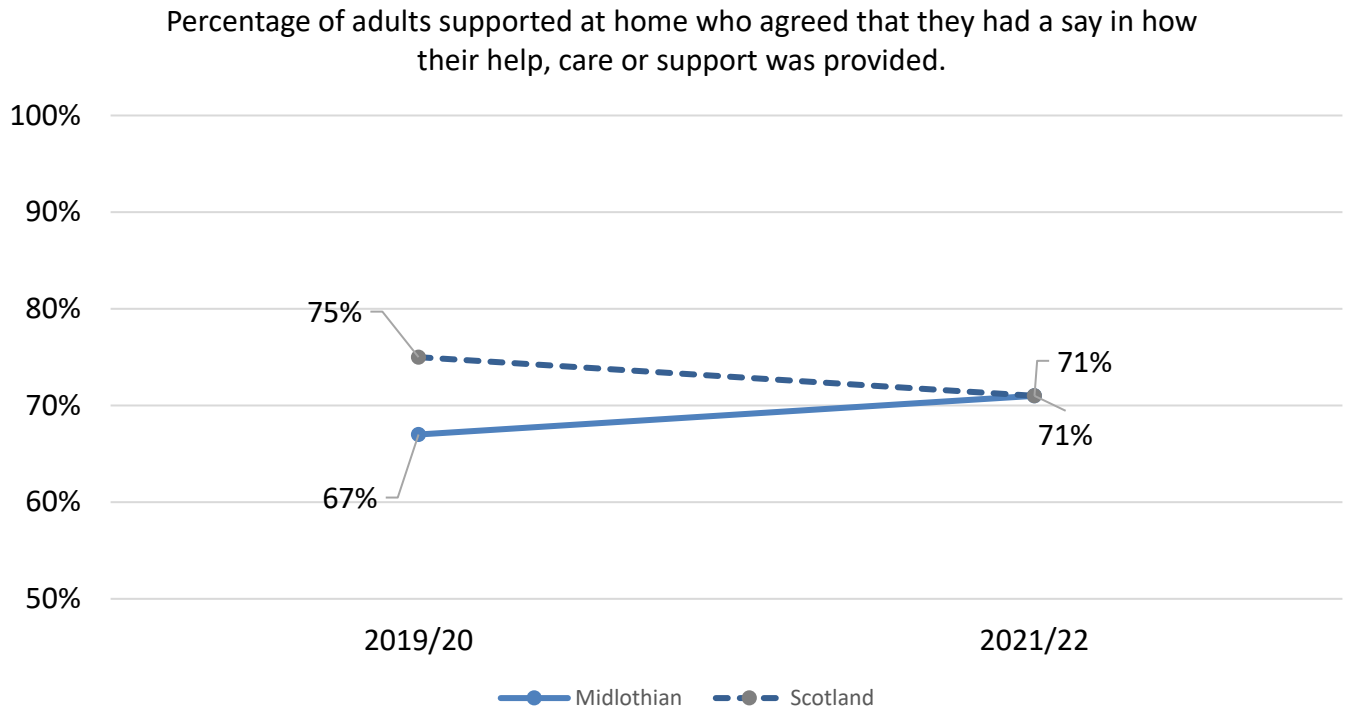
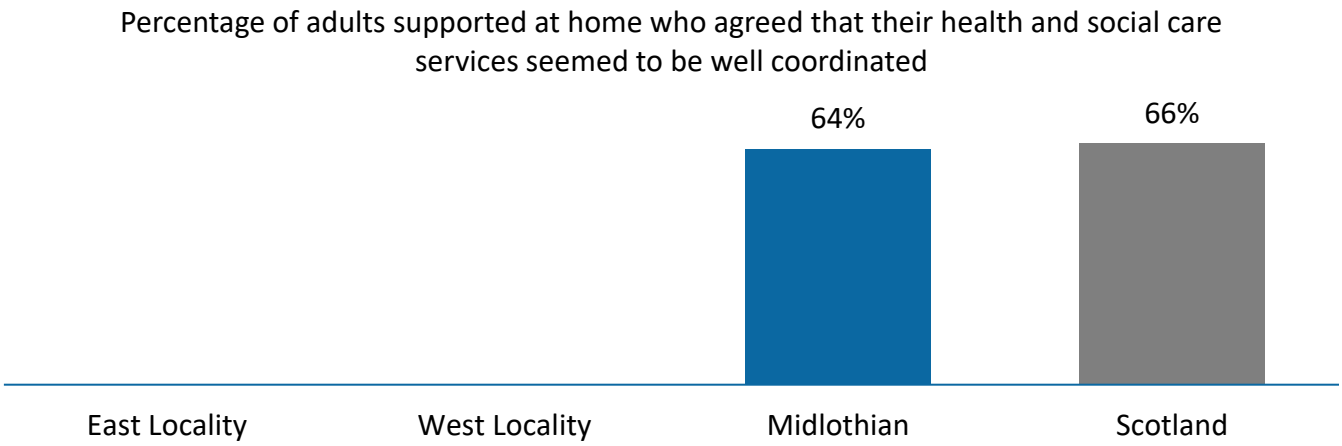


	National Indicator	Our result	Our Progress
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated*.	**64%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance stayed the **same** compared to 2020-2021
Overall performance across Scotland got **worse** by 8 percentage points.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.



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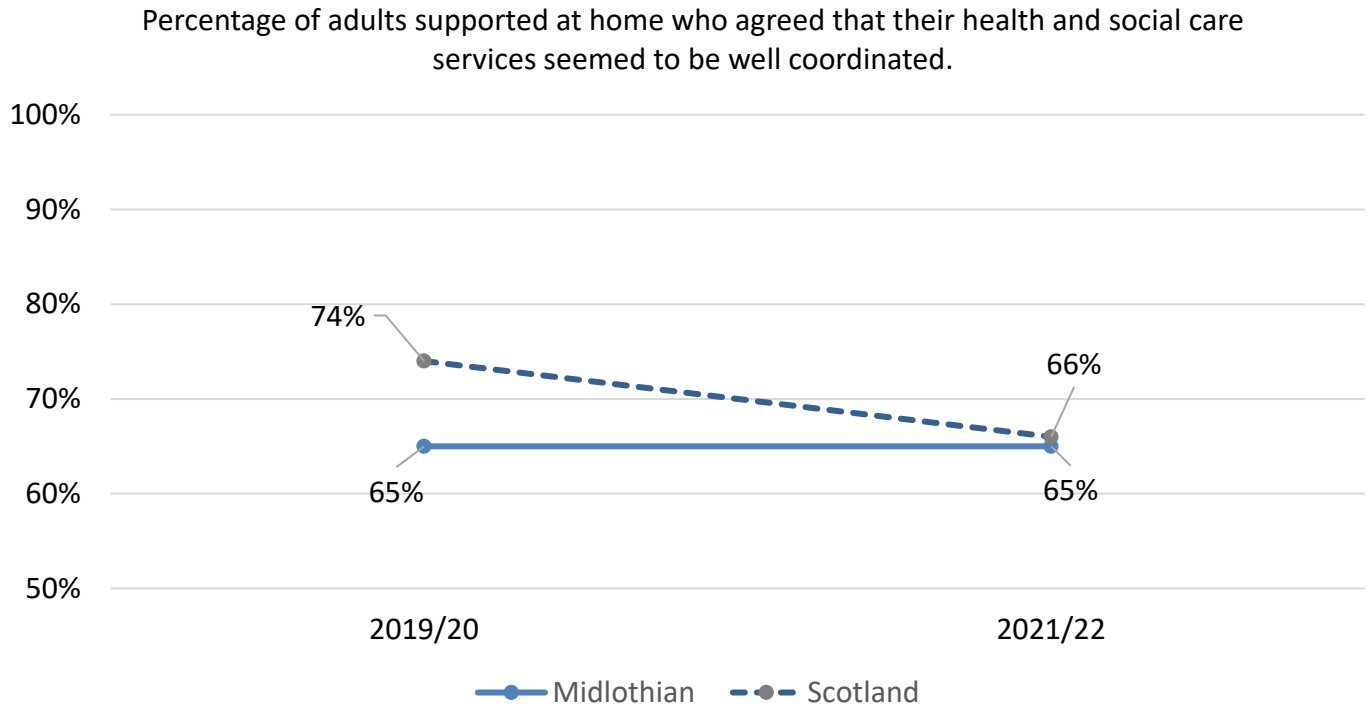
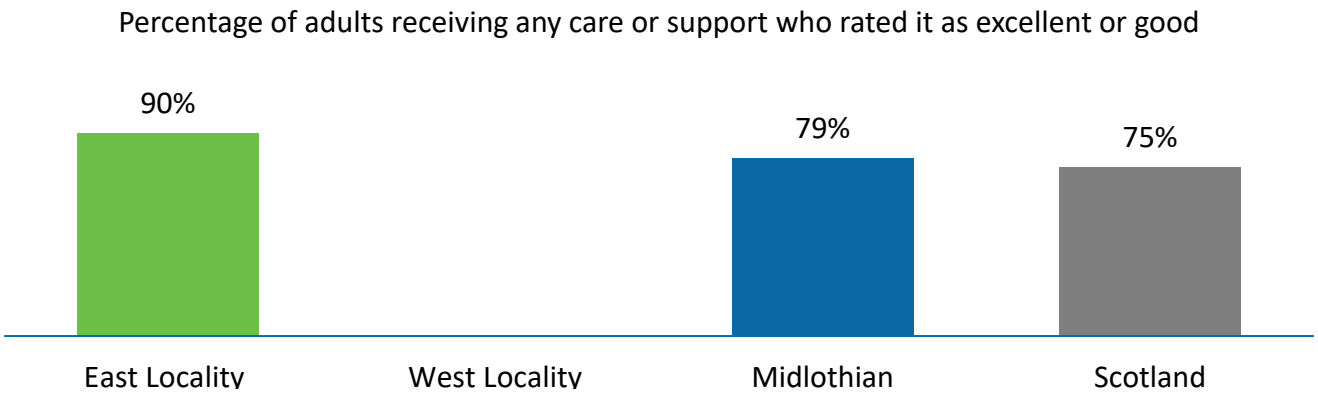


	National Indicator	Our result	Our Progress
★★★★★ 5	Adults receiving care or support rated it as excellent or good*.	**79%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 16 percentage points.
Overall performance across Scotland got **worse** by 5 percentage points.
Midlothian's performance was **better** than across Scotland.
We are **doing well** in relation to national performance.



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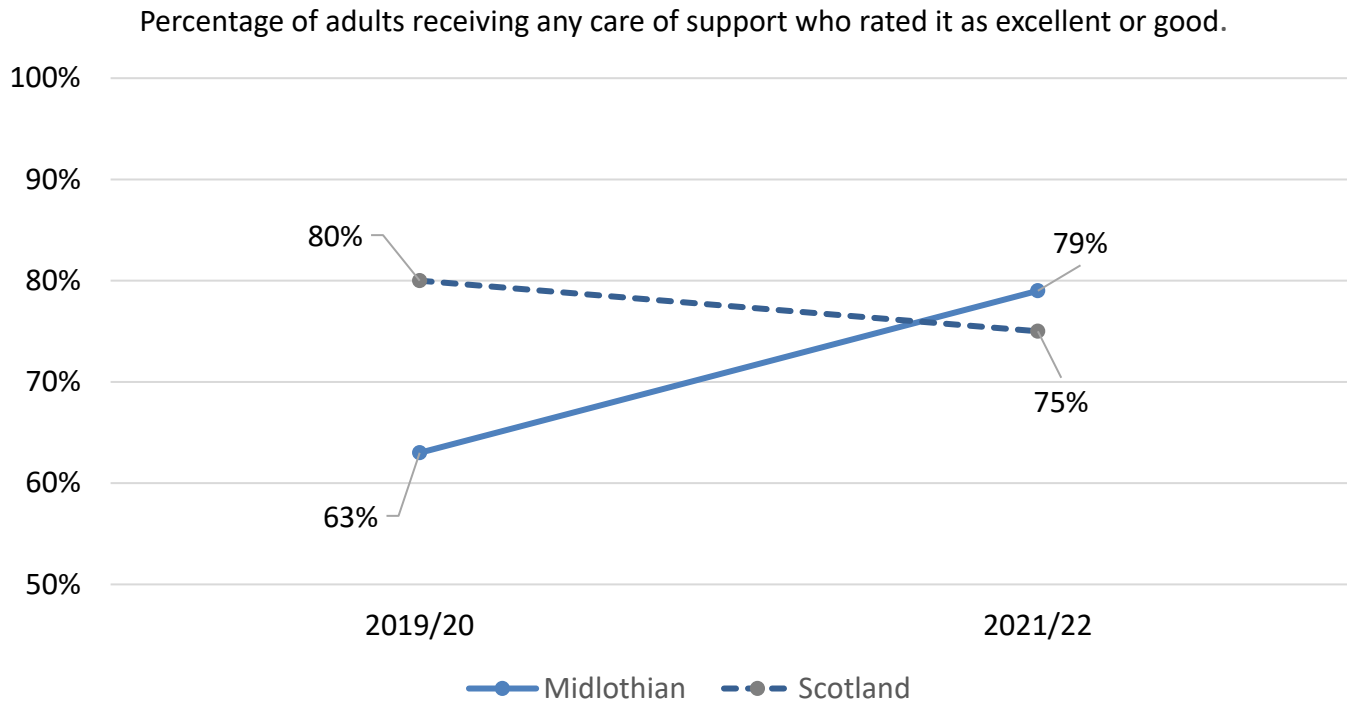
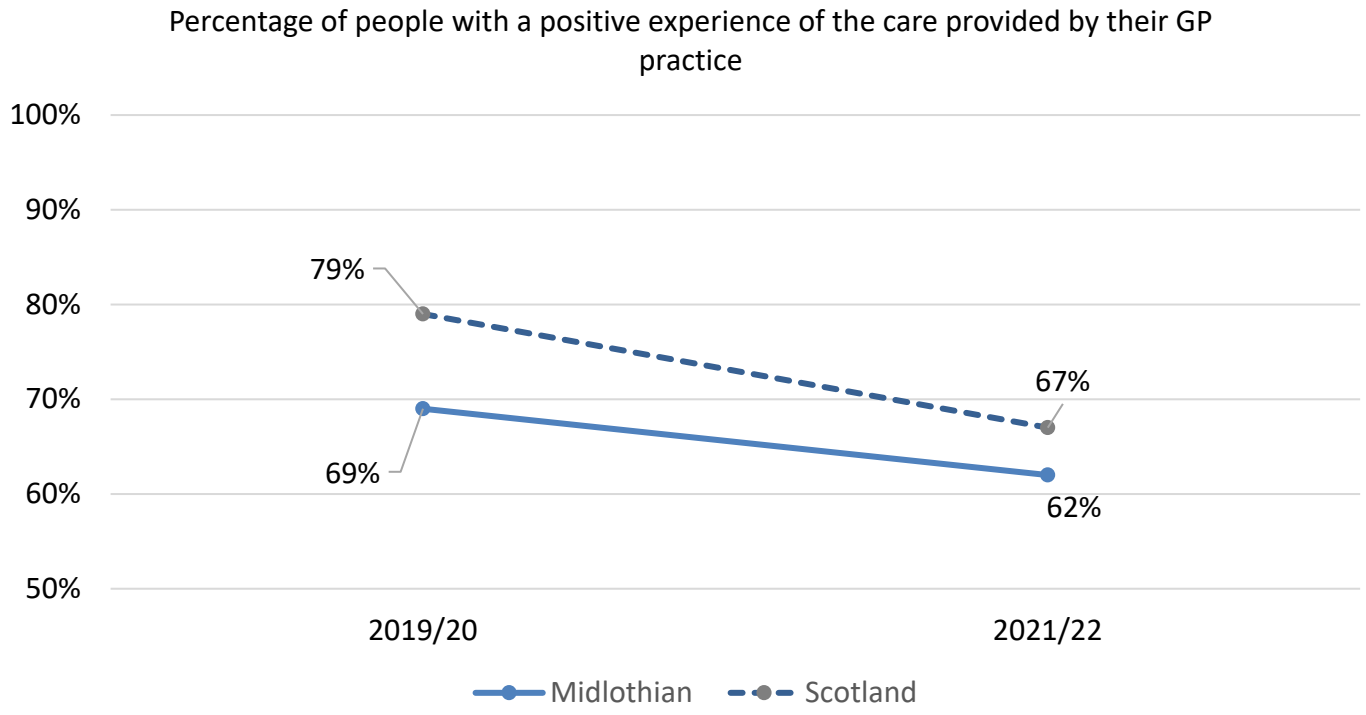


	National Indicator	Our result	Our Progress
6	Adults had a positive experience of the care provided by their GP practice*.	**62%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

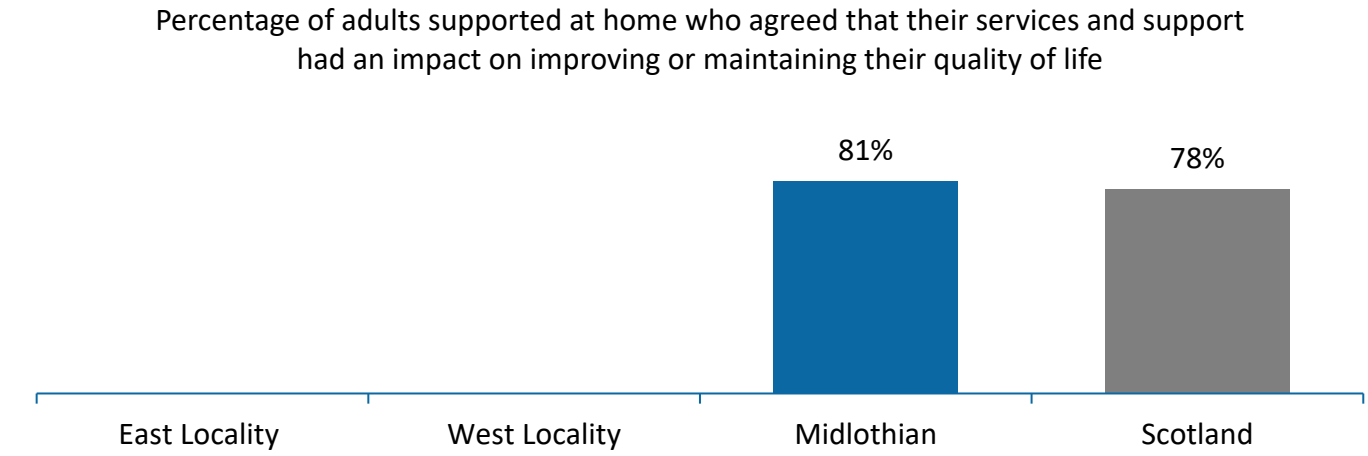
In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 by 7 percentage points.
Overall performance across Scotland got **worse** by 12 percentage points.
Midlothian's performance was **worse** than across Scotland.
There is **more work** to do in relation to national performance.



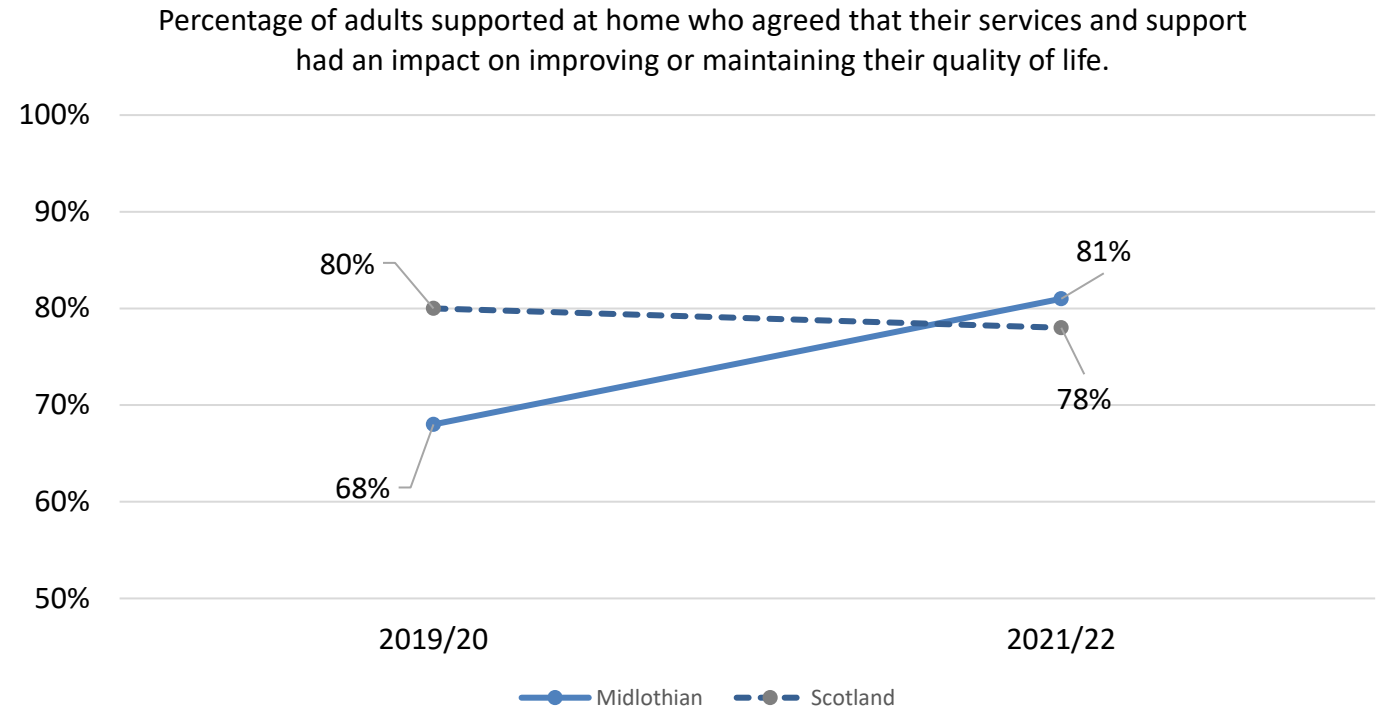
	National Indicator	Our result	Our Progress
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life*.	**81%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 13 percentage points.
Overall performance across Scotland got **worse** by 2 percentage points.
Midlothian's performance was **better** than across Scotland.
We are **doing well** in relation to national performance.



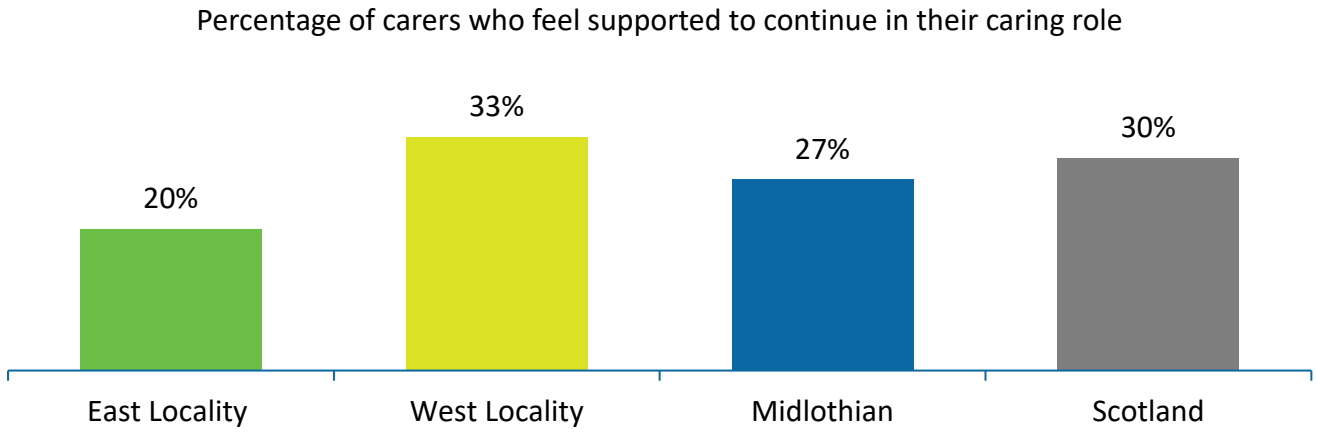
Locality numbers have been suppressed due to low response rate.

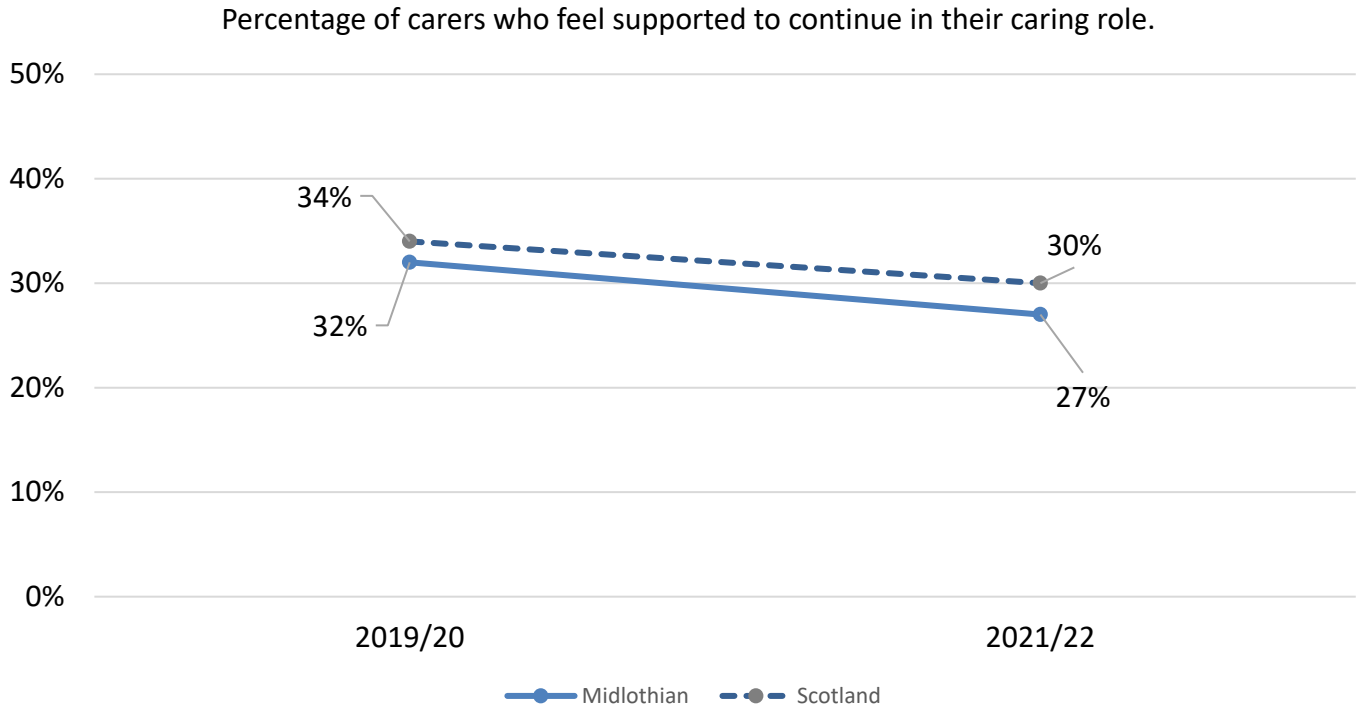


	National Indicator	Our result	Our Progress
8	Carers feel supported to continue in their caring role*.	**27%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance **worsened** compared to 2020-2021 5 percentage points.
Overall performance across Scotland got **worse** by 4 percentage points.
Midlothian's performance was **worse** than across Scotland.
We have **more work** to do in relation to national performance.

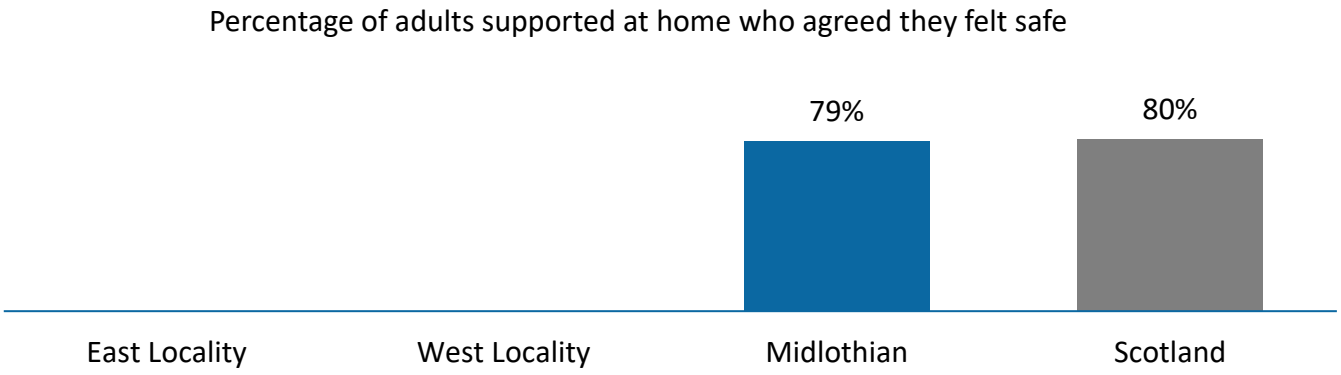




	National Indicator	Our result	Our Progress
9	Adults supported at home agreed they felt safe*.	**79%**	

* There is no update to the national data for 2022/23 in relation to this indicator.

In 2021-22, Midlothian's performance **improved** compared to 2020-2021 by 12 percentage points.
Overall performance across Scotland got **worse** by 3 percentage points.
Midlothian's performance was the **same** as across Scotland.
We are **doing well** in relation to national performance.



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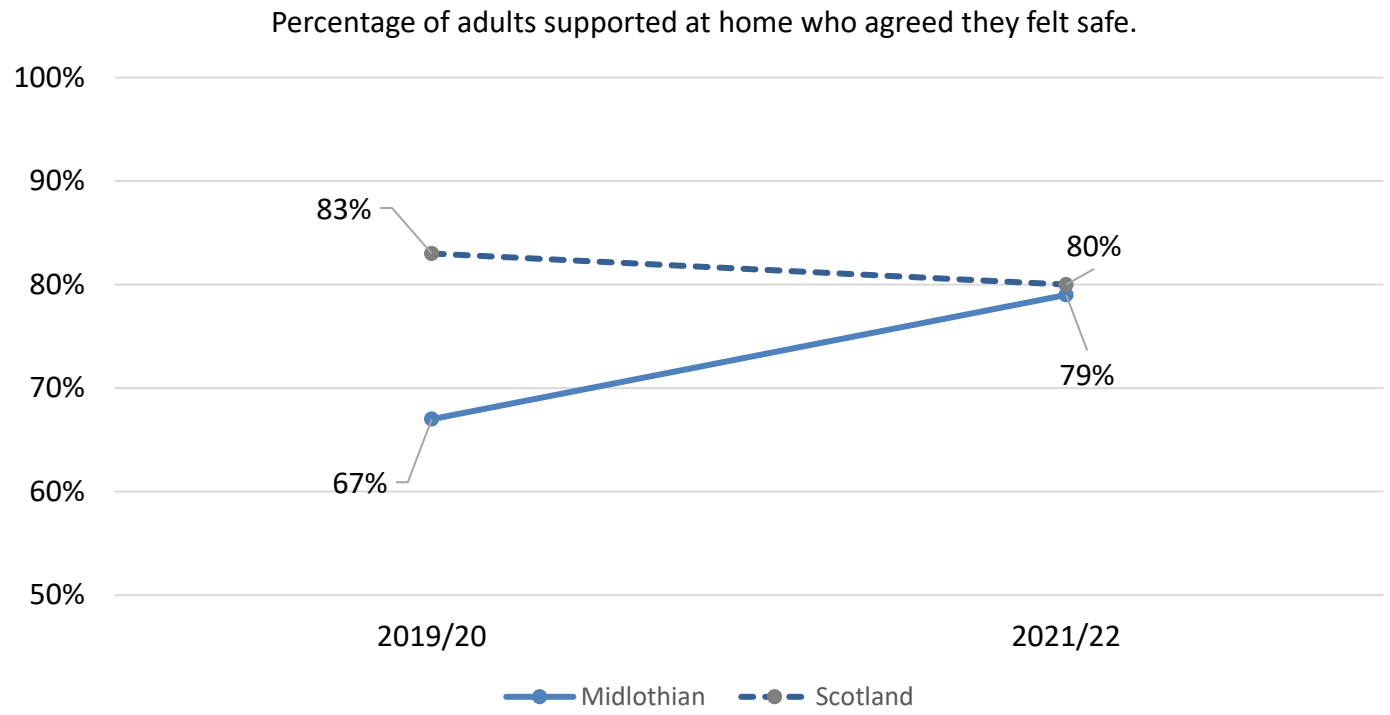
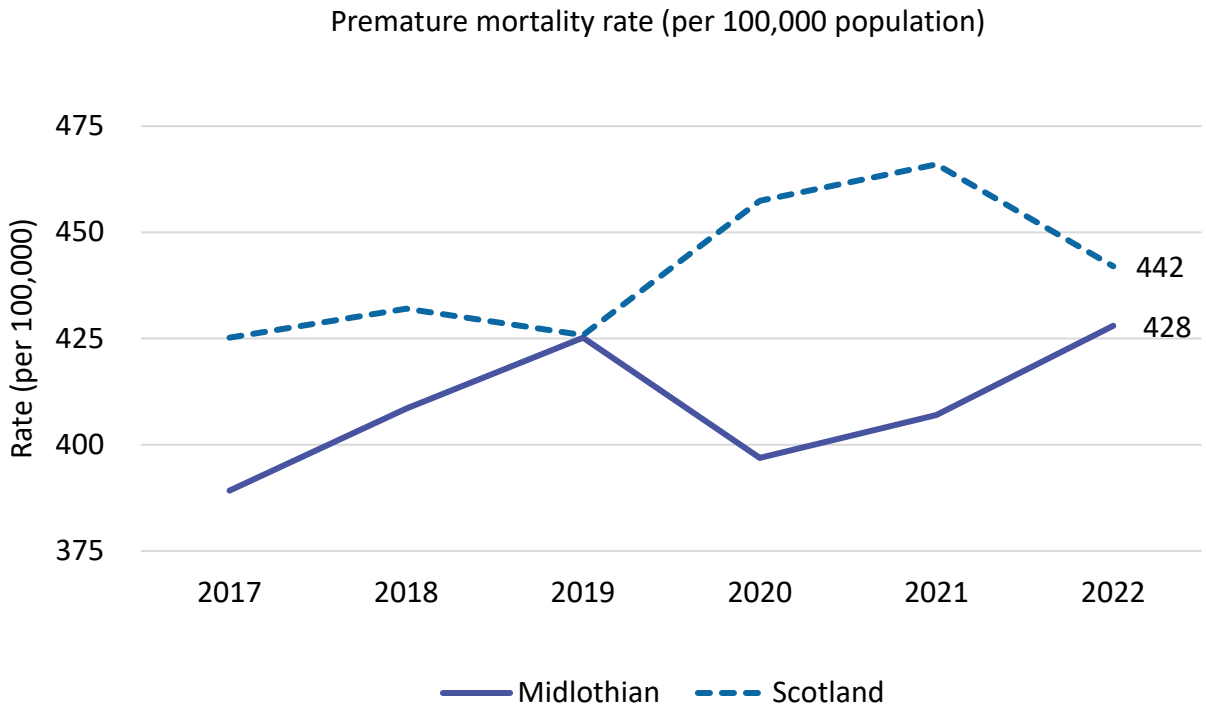


	National Indicator	Our result	Our Progress
11	Premature Mortality Rate (People under 75)	**428** per 100,000	

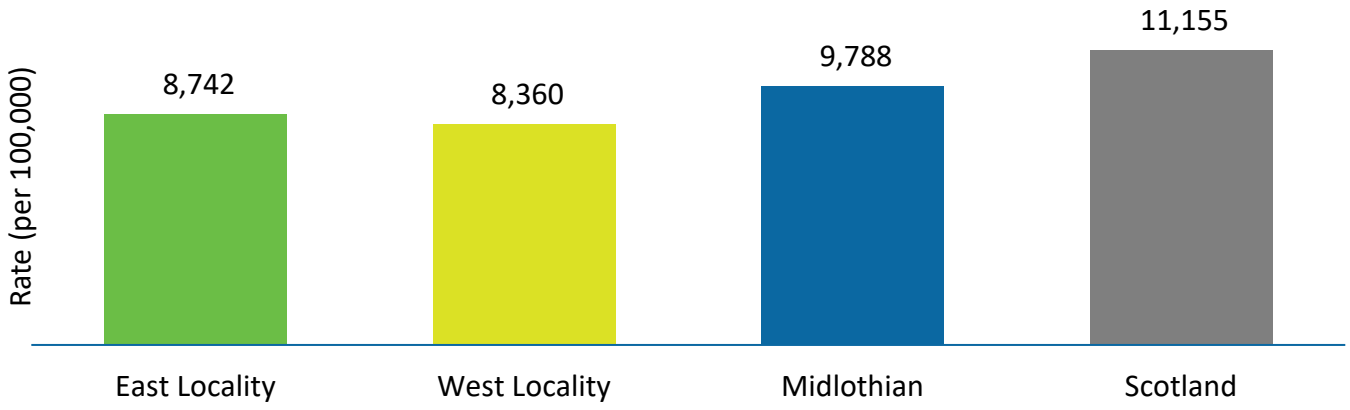
In 2021-22, Midlothian's premature mortality rate increased compared to 2021-2022 by 5%.
Overall premature mortality rate across Scotland decreased by 5%.
Midlothian's rate was lower than across Scotland.
We are doing well in relation to national performance.



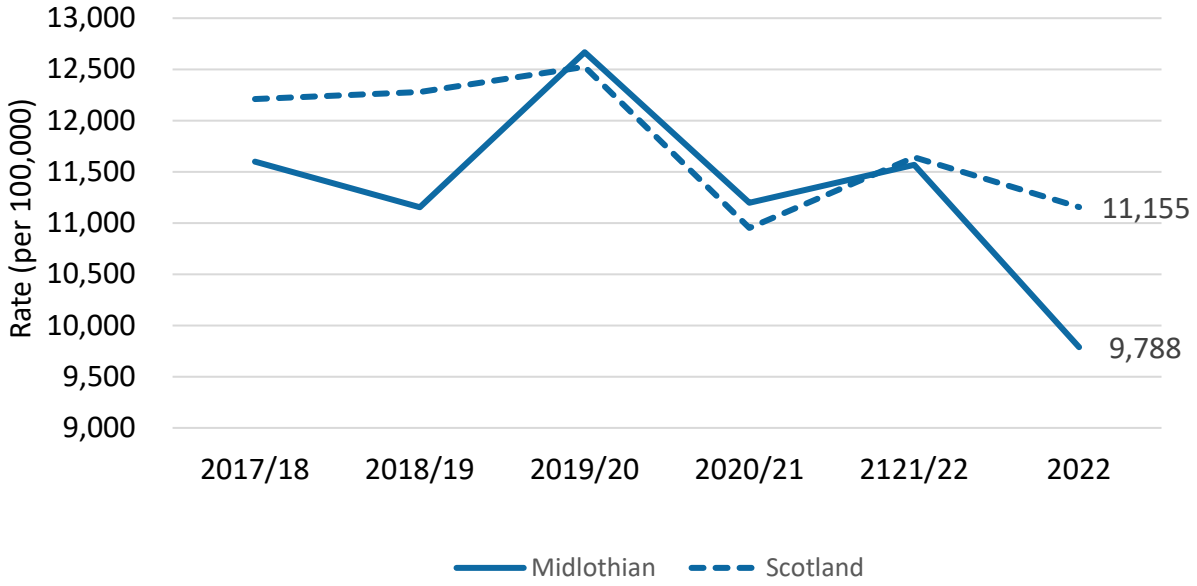
	National Indicator	Our result	Our Progress
12	Emergency Admission Rate	**9,788** per 100,000	

In 2022-23, Midlothian's emergency admission rate **reduced** compared to 2021-2022 by 15% i.e., the number of people who needed to be urgently admitted to hospital decreased.
The emergency admission rate across Scotland reduced by 4%.
Midlothian's rate was **lower** than across Scotland.
We are doing well in relation to national performance.

Rate of emergency admissions for adults 2022* (per 100,000)



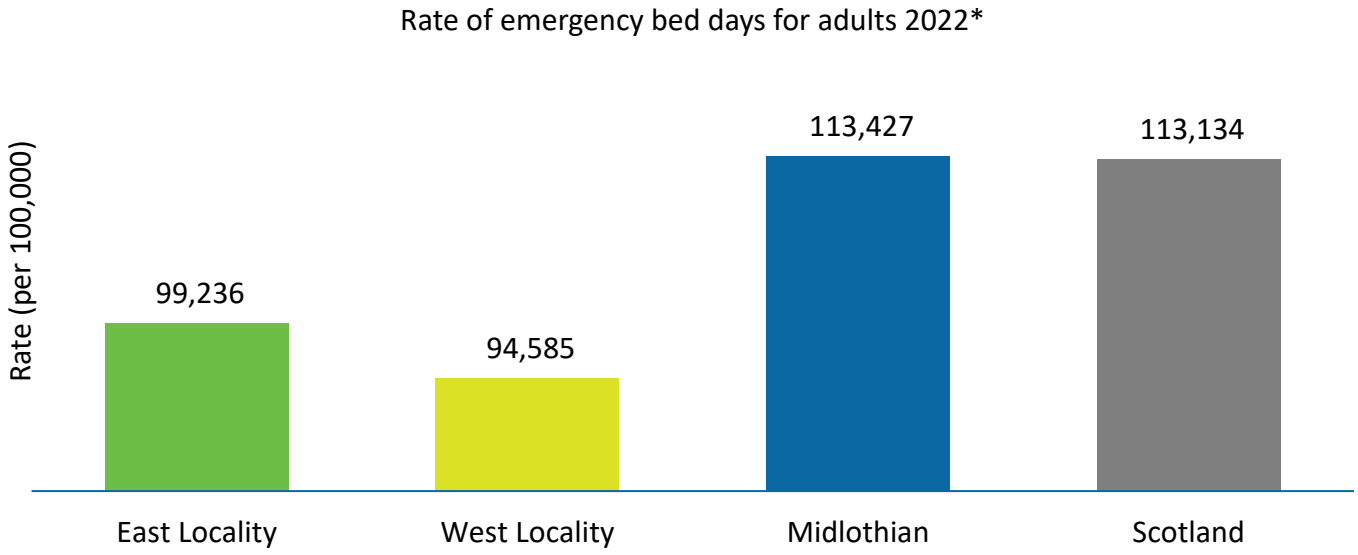
Rate of emergency admissions for adults 2022* (per 100,000)

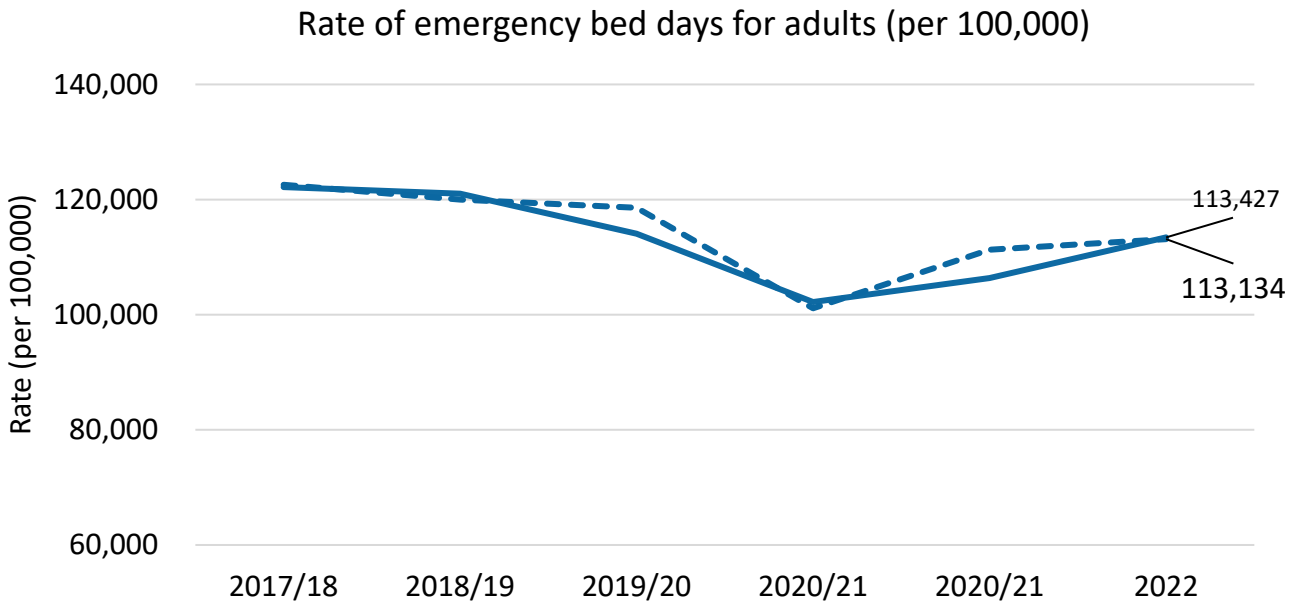


*Where noted the calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance from Public Health Scotland.

	National Indicator	Our result	Our Progress
13	Emergency Bed Day Rate	**113,427** per 100,000	

In 2022-23, Midlothian's emergency bed day rate **increased** compared to 2021-2022 by 7% i.e., people spent more days in hospital as part of an emergency admission.
The emergency bed day rate across Scotland increased by 2%.
Midlothian's rate was **higher** than across Scotland.
We have **more work** to do in relation to national performance.



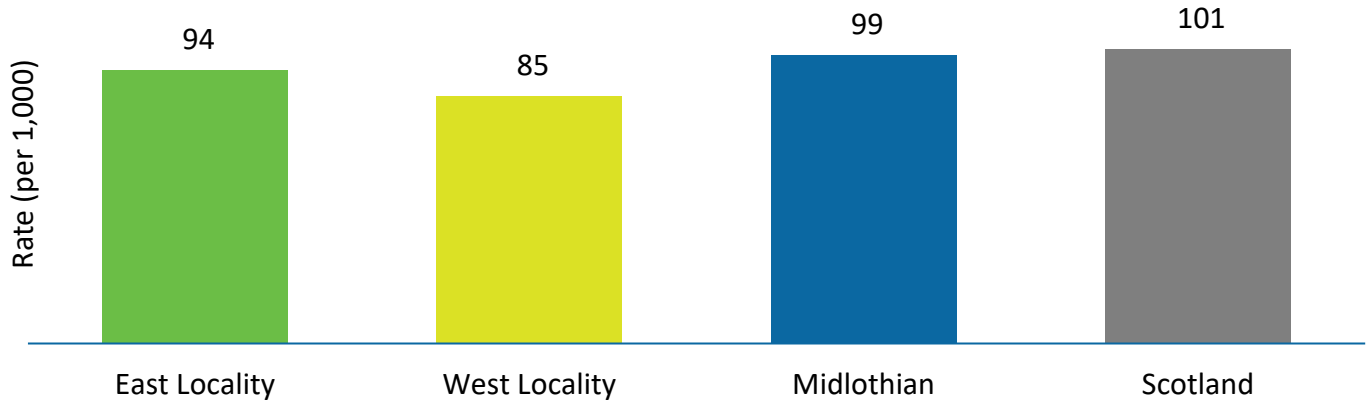


*Where noted the calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance from Public Health Scotland.

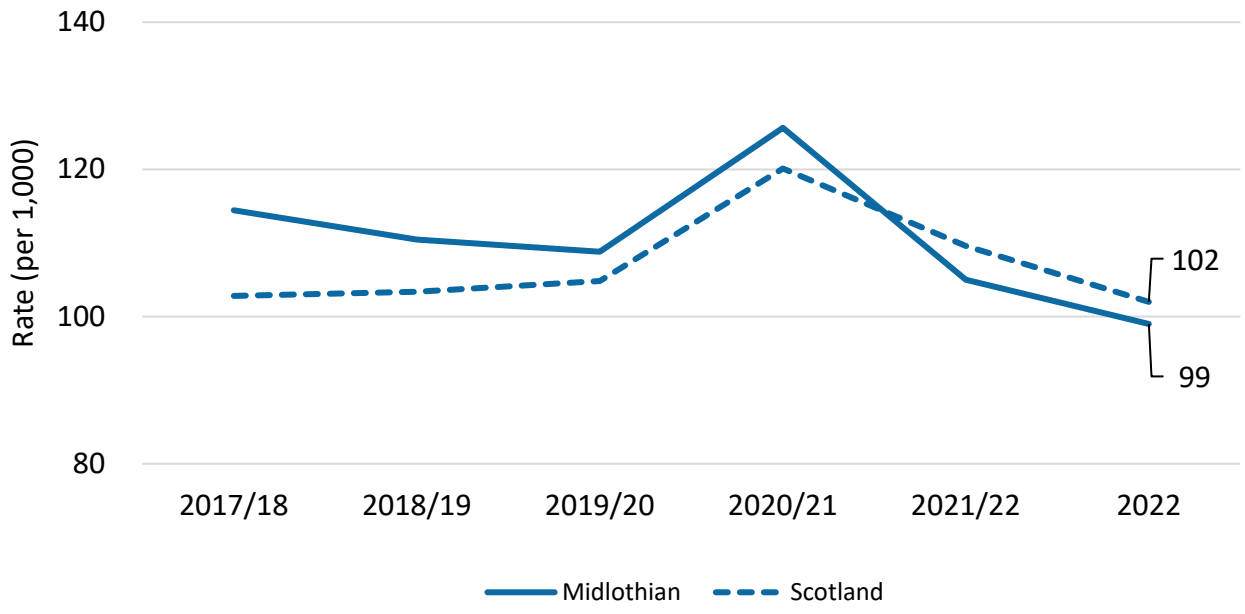
	National Indicator	Our result	Our Progress
14	Readmission to hospital within 28 days.	**99** per 1,000	

In 2022-23, Midlothian's readmission rate **reduced** compared to 2021-2022 by 6%.
Overall readmission rates across Scotland **reduced** by 8%.
Midlothian's rate is **lower** than across Scotland.
We are **doing well** in relation to national performance.

Rate of readmissions to hospital within 28 days of discharge per (1,000 admissions) 2022*



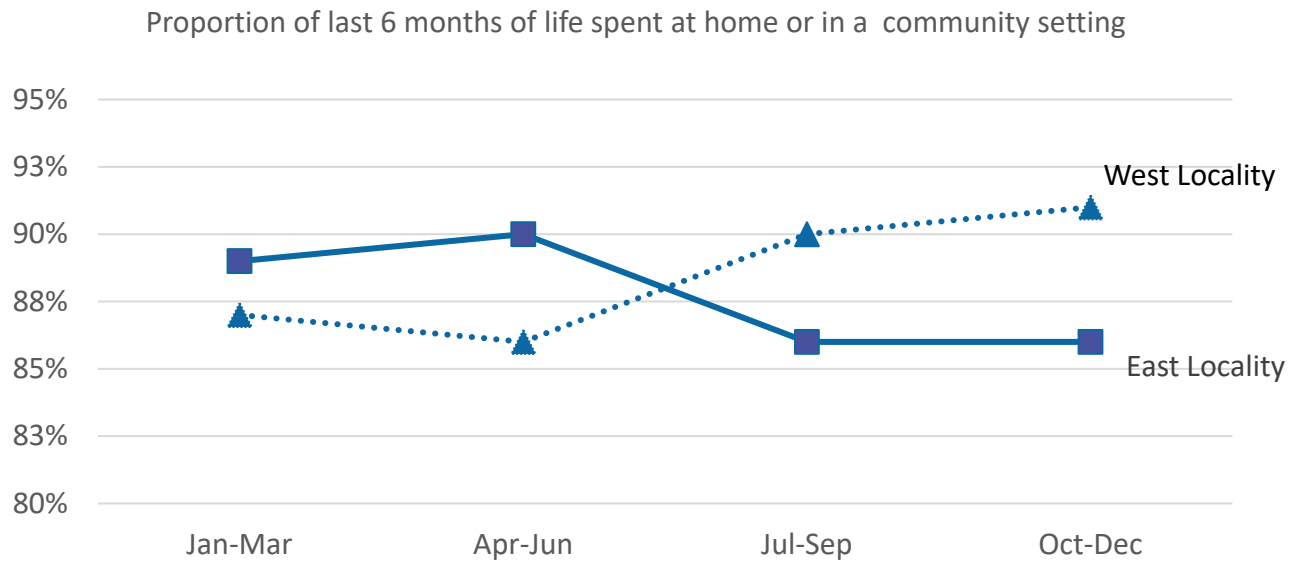
Readmissions to hospital within 28 days of discharge (per 1,000 admissions)

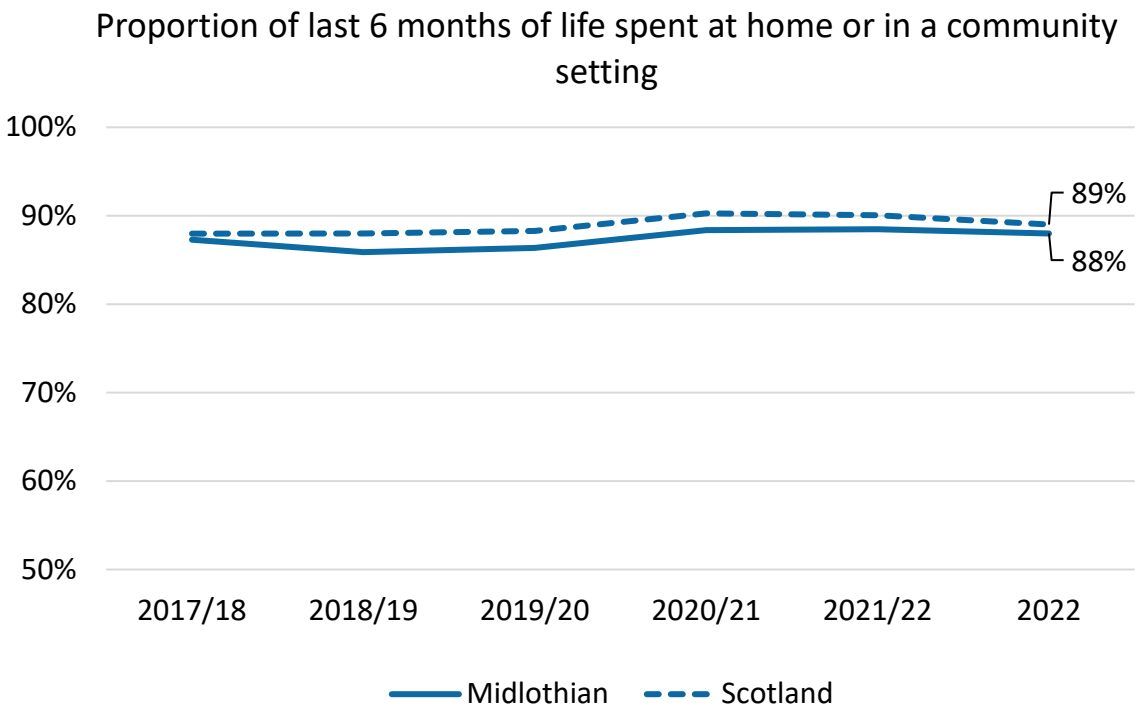


*Where noted the calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance from Public Health Scotland.

	National Indicator	Our result	Our Progress
15	Proportion of the last 6 months of life spent at home or a community setting.	**88%**	

In 2022-23, Midlothian's performance stayed the **same** compared to 2021-2022.
Overall performance across Scotland **reduced** by 1%.
Midlothian's performance was **lower** than across Scotland.
We have **more work** to do in relation to national performance.

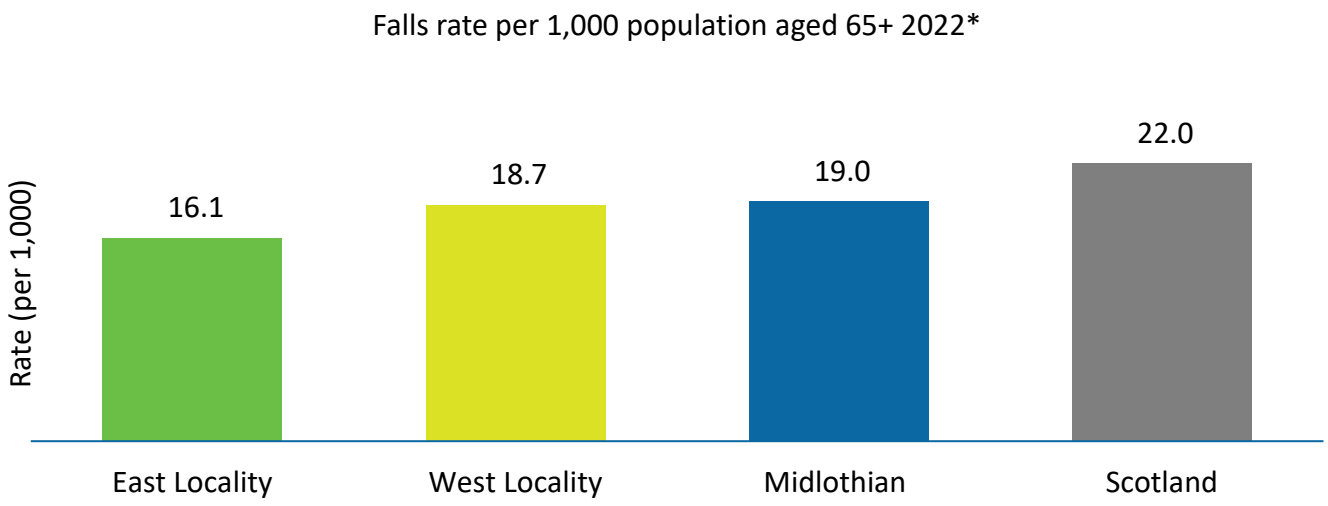


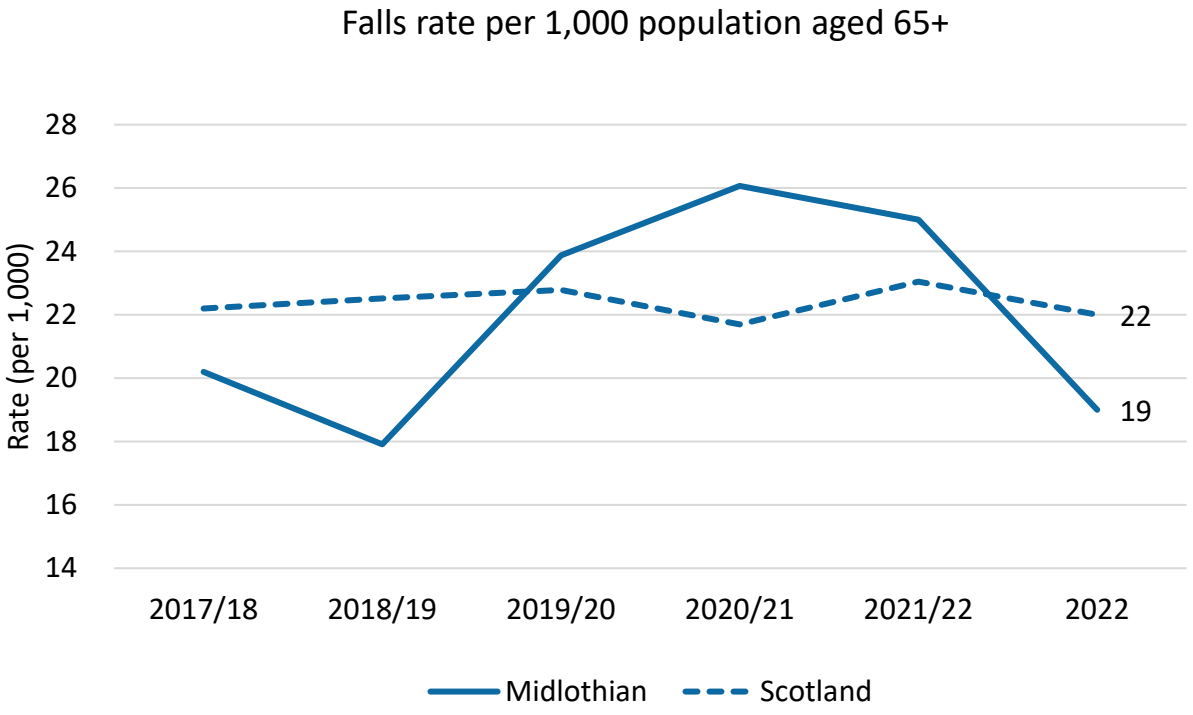


*Where noted the calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance from Public Health Scotland.

	National Indicator	Our result	Our Progress
16	Falls Rate (People over 65)	**19%**	

In 2022-23, Midlothian's falls rate **reduced** compared to 2021-2022 by 6 percentage points.
Overall falls rate across Scotland **reduced** by 1 percentage point.
Midlothian's rate was **lower** than across Scotland.
We are doing well in relation to national performance.

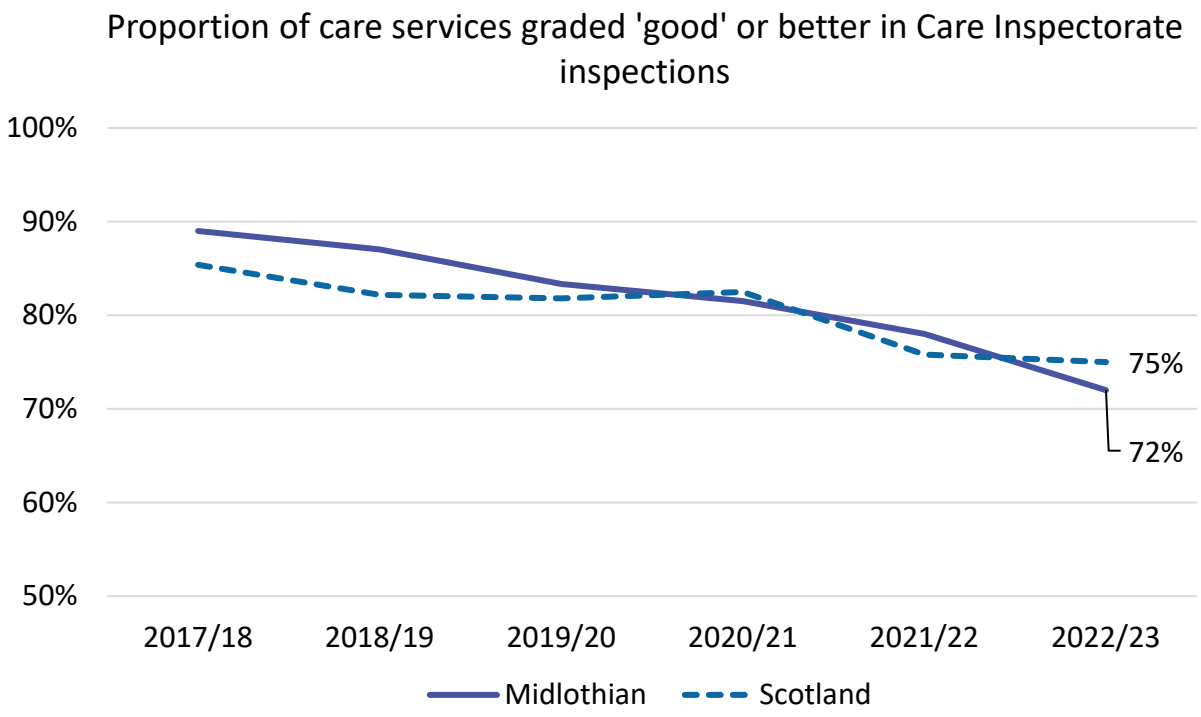




*Where noted the calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance from Public Health Scotland.

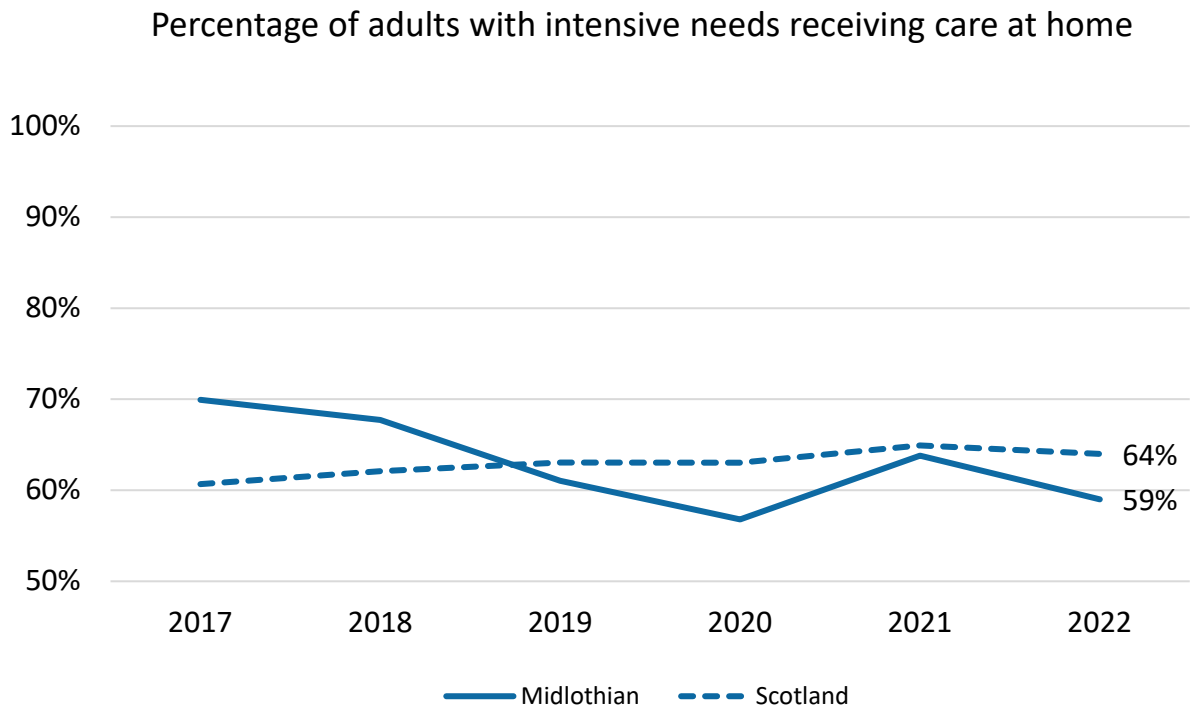
	National Indicator	Our result	Our Progress
17	Care services graded Good or better in Care Inspectorate Inspections.	**72%**	

In 2022-23, Midlothian's performance **worsened** compared to 2021-2022 by 6 percentage points.
Overall performance across Scotland worsened by 1 percentage point.
Midlothian's performance was **lower** than across Scotland.
We **have more** to do in relation to national performance.



	National Indicator	Our result	Our Progress
18	Adults with intensive care needs are receiving care at home.	**60%**	

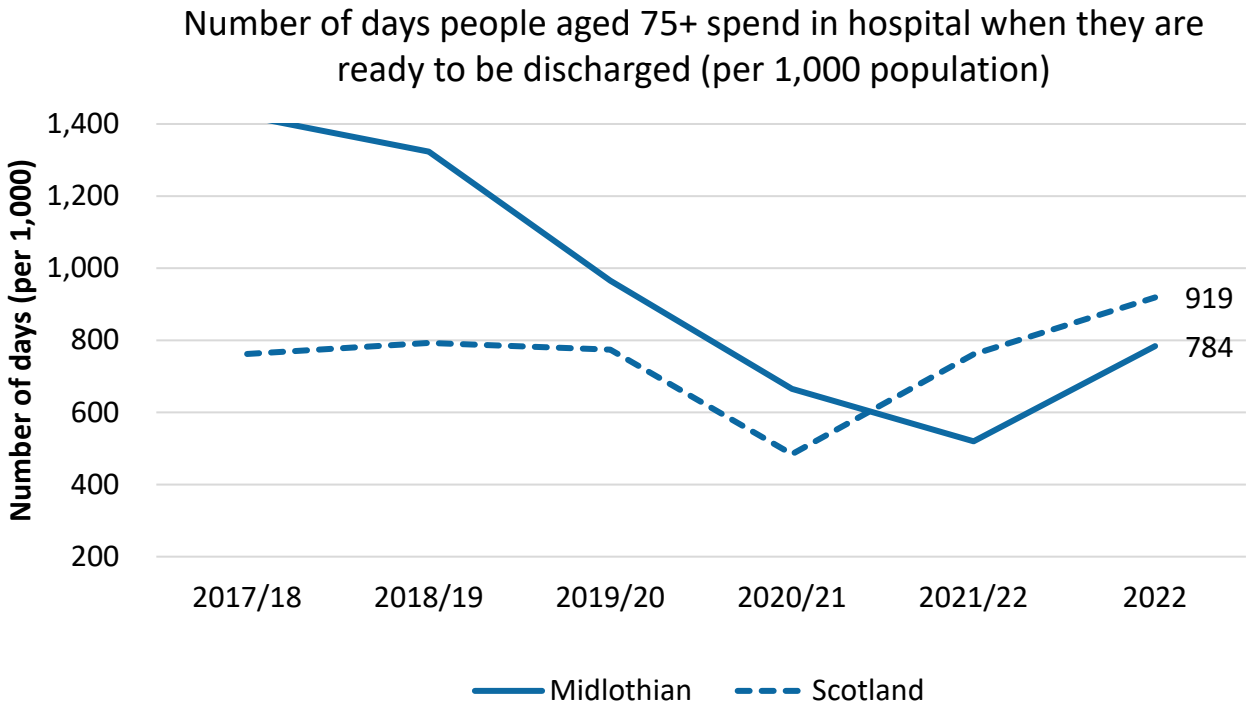
In 2022-23, Midlothian's performance **decreased** compared to 2021-2022 by 5 percentage points.
Overall performance across Scotland decreased by 1 percentage point.
Midlothian's performance was **lower** than across Scotland.
We **have more** to do in relation to national performance.



*Where noted the calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance from Public Health Scotland.

	National Indicator	Our result	Our Progress
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.	**784** per 1,000	

In 2022-23, Midlothian's performance **worsened** compared to 2021-2022 by 51%.
Overall performance across Scotland got **worse** by 21%.
Midlothian's performance was **better** than across Scotland.
We are **doing well** in relation to national performance.

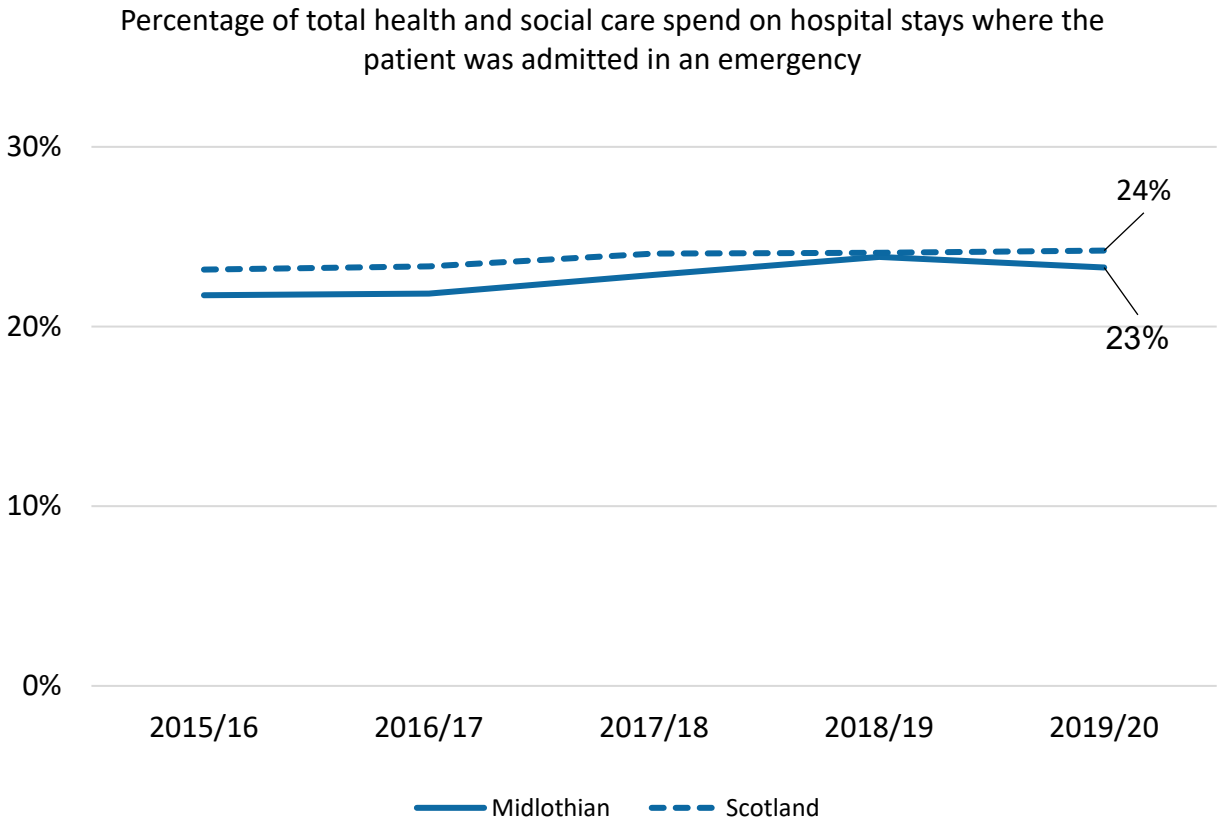


*Where noted the calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance from Public Health Scotland.

	National Indicator	Our result	Our Progress
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.	**23%**	

This data is no longer collated and not current.

NHS Boards have not been able to provide detailed cost information since 2019/20 due to changes in service delivery during the COVID-19 pandemic. As a result, PHS have not provided information for indicator 20 beyond 2019/20. PHS previously published information to calendar year 2020 using costs from 2019/20 as a proxy but, given the impact of the COVID-19 pandemic on activity and expenditure, PHS no longer consider this appropriate.



Ministerial Steering Group Targets

Updated targets for 2022/23 were developed by the HSCP, agreed by the IJB, and submitted to Scottish Government in June 2022. Our targets were set to prioritise an increase in system stability.

MEASURE	2018-19	2019-20	2020-21	2021-22	2022-23	STATUS
Maintain emergency admissions into hospital from Midlothian at or below 767 / month	8,841	10,966	9,207	9,606	***8,458***	Achieved*
Maintain number of unscheduled hospital bed days: acute specialties at or below 5,074 / month	62,372	59,798	57,459	57,394	***60,452***	Achieved*
Maintain the use of unscheduled: • geriatric long-stay beds (all ages) • mental health beds (all ages) at or below 2021/22 levels	13,551 15,162	12,806 13,708	12,802 12,511	16,638 11,934	***16,747*** ***12,345***	Not achieved*
Maintain Emergency Department Attendance (all ages) at or below (2,629 / month)	29,688	33,319	26,390	33,155	33,233	Not achieved*
Maintain Delayed Discharge Occupied Bed Days at or below 820 / month	12,934	10,412	7,150	6,135	12,608	Not achieved*
Reduce the percentage of time people spend in a large hospital in their last six months of life	9.8%	9.1%	7.4%	7.9%	*No data*	N/A
Maintain the proportion of people over the age of 65 who are living in the community at 97% or higher	96.5%	96.7%	97%	97%	*No data*	N/A

SOURCE: Public Health Scotland Integration Performance Indicators June 2023

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