NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**2 November 2022**
Title:	**HHSCC Finance Report – Month 6 2022/2023**
Responsible Executive/Non-Executive:	**Louise Bussell, Chief Officer, Highland Community**
Report Author:	**Elaine Ward, Deputy Director of Finance**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to a:

- Annual Operating Plan

This aligns to the following NHSScotland quality ambition:

- Effective

This report relates to the following Corporate Objective(s)

Clinical and Care Excellence • Improving health • Keeping you safe • Innovating our care		**Partners in Care** • Working in partnership • Listening and responding • Communicating well	√
A Great Place to Work • Growing talent • Leading by example • Being inclusive • Learning from experience • Improving wellbeing		**Safe and Sustainable** • Protecting our environment • In control • Well run	 √ √
Other (please explain below)			

2 Report summary

2.1 Situation

This report is presented to enable discussion on the Highland Health & Social Care Partnership financial position at Month 6 2022/2023 (September).

2.2 Background

NHS Highland submitted a financial plan to Scottish Government for the 2022/2023 financial year in March 2022 and this plan was approved by the Board in May 2022. This plan identified an initial budget gap of £42.272m. A savings programme of £26.000m was planned - £3.000m of this being related to Adult Social Care. No funding source was identified to close the residual gap of £16.272m. This report summarises the Highland Health & Social Care Partnership financial position at Month 6, provides a forecast through to the end of the financial year and highlights the current savings position.

2.3 Assessment

The HHSCP continues to face significant financial challenges with a requirement to identify significant savings and cost reductions. This challenge comes against the backdrop of a Scottish Government drive to increase investment in Adult Social Care, the development of the National Care Service and the fragility of service provision due to recruitment challenges and rising costs.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	√	None	

3 Impact Analysis

3.1 Quality/ Patient Care

Achievement of a balanced financial position for NHS Highland in 2022/2023 is predicated on closing the initial budget cap of £42.272m. The impact on quality of care and delivery of services is assessed at an individual scheme level using a Quality Impact Assessment tool.

3.2 Workforce

There is both a direct and indirect link between the financial position and staff resourcing and health and wellbeing. Through utilisation of the Quality Impact Assessment tool the impact of savings on these areas is assessed.

3.3 Financial

Delivery of a balanced position presents a significant challenge to both NHS Highland and the Highland Health and Social Care Partnership.

3.4 Risk Assessment/Management

Scottish Government's covid funding package mitigated against the risk of not achieving a balanced budget position in 2021/2022. For 2022/2023 the expectation of Scottish Government is that all Boards will deliver at least the position set out in their financial plan. For NHS Highland this means delivering a financial position no more than £16.272m over

budget. A recovery plan has been developed and the mitigating actions within it are being monitored.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not applicable

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage both internal and external stakeholders where appropriate through the following meetings:

- Executive Directors Group – via monthly updates and exception reporting
- Financial Recovery Board held weekly
- Discussion at relevant Senior Leadership Team meetings
- Quarterly financial reporting to Scottish Government

3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Community SLT meetings

4 Recommendation

- **Discussion** – Committee discuss the Highland Health and Social Partnership financial position at month 6.

.1 List of appendices

- Appendix 1 – Adult Social Care Summary

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1 NHS Highland 2022/2023 Financial Plan

1.1 A one year Financial Plan for 2022/2023 was submitted to Scottish Government in March 2022. A further revision was submitted in July 2022, updated based on the quarter 1 position.

1.2 The Financial Plan submitted identifies an initial budget gap of £42.272m with a CIP programme of £26.000m – £3.000m relating to Adult Social Care - planned. This left a balance of £16.272m unfunded.

1.3 Following submission of the quarter 1 financial return to SG and follow up discussions Richard McCallum wrote to NHS Highland highlighting the expectation that, as a very minimum, NHS Highland would deliver the position set out within the 2022/2023 financial plan. This means delivering a financial position no more than £16.272m over budget. A recovery plan has been developed and the mitigating actions within it are being monitored.

2 NHS Highland – Period 6

2.1 For the six months to the end of September 2022 NHS Highland has overspent against the year to date budget by £19.294m and is forecasting an overspend of £39.922m at financial year end. This is a deteriorating position from that reported in the Month 5 Finance Report presented to the NHS Highland Board and reflects a more pessimistic forecast on savings delivery through to the end of the financial year and a lower than anticipated allocation for Scheduled Care.

2.2 The year to date position includes slippage against the CIP of £7.833m with slippage of £15.305m forecast through to year end.

2.3 A breakdown of the year to date position and the year-end forecast is detailed in Table 1.

Table 1 – NHS Highland Summary Income and Expenditure Report as at 30 September 2022 (Month 6)

Current Plan £m	Summary Funding & Expenditure	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
1,087.563	**Total Funding**	510.208	510.208	-	1,087.563	-
	Expenditure					
403.005	HHSCP	202.425	207.118	(4.693)	415.131	(12.125)
242.835	Acute Services	123.861	136.917	(13.056)	266.151	(23.315)
208.794	Support Services	69.656	70.938	(1.282)	212.802	(4.008)
854.634	**Sub Total**	**395.942**	**414.973**	**(19.031)**	**894.083**	**(39.449)**
232.929	Argyll & Bute	114.267	114.530	(0.264)	233.402	(0.473)
1,087.563	**Total Expenditure**	**510.208**	**529.503**	**(19.294)**	**1,127.485**	**(39.922)**

2.4 Whilst a Recovery Plan has been developed to reduce the forecast overspend at Period 3 the forecast presented above does not reflect the proposed actions. These will flow through to the position when there is certainty around deliverability.

3 HHSCP – Period 6

3.1 The HHSCP is reporting an overspend of £4.693m at the end of Period 6 with a year end overspend of £12.125m forecast.

3.2 The forecast position includes slippage of £5.816m against the CIP.

3.3 A breakdown across services is detailed in Table 2 with a breakdown across Health & Adult Social Care shown at Table 3. A more detailed breakdown of the ASC position is included at Appendix 1.

Table 2 – HHSCP Financial Position as at 30 September 2022 (Month 6)

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
221.790	NH Communities	110.780	115.770	(4.990)	231.660	(9.870)
44.568	Mental Health Services	22.508	22.961	(0.452)	46.037	(1.469)
139.959	Primary Care	69.525	69.407	0.118	140.036	(0.077)
(3.312)	ASC Other includes ASC Income	(0.389)	(1.020)	0.631	(2.603)	(0.709)
403.005	**Total HHSCP**	**202.425**	**207.118**	**(4.693)**	**415.131**	**(12.125)**

Table 3– HHSCP Financial Position as at 30 September 2022 (Month 6)–split across Health & Adult Social Care

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
244.552	Health	121.977	125.983	(4.006)	252.756	(8.205)
158.454	Social Care	80.448	81.135	(0.687)	162.374	(3.921)
403.005	Total HHSCP	202.425	207.118	(4.693)	415.131	(12.125)

3.4 A breakdown across services within North Highland Communities is detailed in Table 4.

Table 4– North Highland Communities as at 30 September 2022 (Month 6)

Annual Plan £m's	Detail	Plan to Date £m's	Actual to Date £m's	Variance to Date £m's	Forecast Outturn £m's	Var from Curr Plan £m's
67.750	Inverness & Nairn	33.773	34.179	(0.406)	68.877	(1.128)
47.542	Ross shire & B&S	23.665	24.510	(0.844)	48.798	(1.256)
42.980	Caithness & Sutherland	21.569	21.749	(0.180)	43.741	(0.761)
49.200	Lochaber, SL & WR	24.534	24.478	0.057	49.923	(0.723)
4.739	Management	2.389	5.888	(3.499)	10.489	(5.749)
4.552	Community Other	2.308	2.158	0.150	4.350	0.202
5.027	Hosted Services Includes Midwifery	2.541	2.809	(0.268)	5.482	(0.456)
221.790	**Total NH Communities**	110.780	115.770	(4.990)	231.660	(9.870)
70.633	**Health**	35.252	38.349	(3.097)	76.251	(5.619)
151.157	**ASC**	75.528	77.421	(1.893)	155.409	(4.252)

3.5 A year to date overspend of £4.990m is reported within NH Communities with this forecast to increase to £9.870m by financial year end.

3.6 Within the Health element of NH Communities the forecast position is being driven by:

- £2.675m of unachieved saving
- £2.700m of service pressures within Enhanced Community Services, Chronic Pain & Palliative Care

3.7 Table 5 breaks down the position within Mental Health Services.

Table 5– Mental Health Services as at 30 September 2022 (Month 6)–split across Health & Adult Social Care

		Position to Date			Forecast Outturn	
Annual Plan £m's	Detail	Plan to Date £m's	Actual to Date £m's	Variance to Date £m's	Forecast Outturn £m's	Var from Curr Plan £m's
	Mental Health Services					
21.227	Adult Mental Health	10.574	11.235	(0.661)	23.148	(1.921)
12.450	CMHT	6.180	5.921	0.259	11.880	0.570
5.918	LD	2.957	3.093	(0.135)	6.026	(0.107)
4.973	D&A	2.797	2.711	0.085	4.984	(0.011)
44.568	**Total Mental Health Services**	22.508	22.961	(0.452)	46.037	(1.469)
33.959	**Health**	17.199	18.227	(1.027)	36.469	(2.510)
10.608	**ASC**	5.309	4.734	0.575	9.568	1.040

3.8 Mental Health Services are reporting a year to date overspend of £0.452m with this forecast to increase to £1.469m by financial year end.

3.9 The overspend within the Health element of Mental Health Services is being driven by unachieved savings (£1.206m), agency costs (£0.899m) within the learning disability and dementia units and ongoing locums within Psychiatry. Ongoing vacancies are mitigating the full impact of these pressures.

3.10 The underspend within the Adult Social Care element of Mental Health is due to vacancies and reduced costs in independent sector provision.

3.11 Primary Care are currently reporting an underspend of £0.118m with this forecast to move to an overspend of £0.077m by financial year end. Underspends within the Public Dental Service, due to recruitment challenges, is being balanced by increasing locum costs in 2c practices.

3.12 ASC Central is forecasting an overspend of £0.709m with ongoing vacancies mitigating the forecast slippage on the Cost Improvement Programme of £1.285m.

4 Savings Programme

4.1 A £3.000m Cost Improvement Programme has been established within ASC. There are currently 5 schemes in the pipeline at this stage in the financial year slippage of £1.285m. This is a deteriorating position from month 5 and reflects pressures in service areas where savings delivery was previously anticipated.

4.2 The HHSCP, excluding ASC, has a CIP target of £6.360m. 35 Schemes are in development. Slippage of £4.531m against the CIP is forecast at this time.

4.3 There is a significant risk associated with the achievement of the savings targets and the month 6 forecast for NHS Highland overall has increased the slippage forecast from £12.225m at month 5 to £15.305m at month 6.

5 Non-ASC Allocations

5.1 Allocations have now been made in respect of Outcomes Framework (£3.817m), Alcohol and Drug Partnerships (£2.006m) & Primary Care Improvement Fund (£5.240m).

6 General Update

6.1 Ongoing uncertainty around allocations and the fragile position within Care Homes continues to impact on production of robust financial forecasts. The overall forecast position is based on a number of assumptions. It is assumed that earmarked recurring allocations received in 2021/2022 will be received at the same rate as last FY and an element has also been built into the forecast for enhanced support and additional costs associated with Care Home provision.

6.2 Further risks relevant to the overall NHS Highland & Highland Health & Social Care Partnership have been identified as follows:

- **Pay Award** – with the exception of Medical & Dental this has yet to be agreed. Whilst funding has been assumed this has not been confirmed.
- **Inflation** – continuing to increase with the impact on operational budgets being monitored
- **Recruitment challenges** – there is an ongoing inability to recruit to required levels in some areas which is leading to increased agency and locum costs.
- **CIP** – limiting CIP slippage to £15.305m will be challenging.

6.3 In addition to these risk a number of issues have materialised and have been built into the forecast position. The development of the Recovery Plan, referred to in para 1.3, is intended to mitigate the impact of these issues.

- **Scheduled Care allocation** – this allocation was approximately £4m less than anticipated.
- **Slippage on CIP** - £15.305m
- **Care Home/ Care at Home** – additional support/ responsibility
- **Impact on 2023/2024**

7 Recommendation

- Highland Health & Social Care Committee members are invited to discuss the month 6 and forecast financial position as presented in the paper.

Appendix 1

Category	Annual Budget £	YTD Budget £	YTD Actual £	YTD Variance £	Year End Forecast £	Year End Forecast £
Care Homes	14,776,796	7,278,933	6,843,632	435,301	14,883,796	(107,000)
Care Homes Isc	32,452,466	16,402,727	16,884,436	(481,709)	33,649,466	(1,197,000)
Older People Other Care	1,150,421	578,490	550,158	28,332	1,087,421	63,000
Older People Other Care Isc	1,206,309	603,526	571,869	31,657	922,309	284,000
People With A Learning Dis	4,413,079	2,299,197	1,735,021	564,176	3,593,079	820,000
People With A Learning Dis Isc	28,845,118	14,418,630	14,331,868	86,762	28,959,118	(114,000)
People With A Learning Dis Sds	5,586,164	2,640,126	3,037,809	(397,683)	6,158,164	(572,000)
People With A Mental Illness	519,712	259,869	146,372	113,496	308,712	211,000
People With Mental Illness Isc	7,149,345	3,575,017	3,491,135	83,882	6,890,345	259,000
People With Mental Illness Sds	740,983	358,613	376,695	(18,082)	783,983	(43,000)
People With A Physical Dis	910,908	454,476	326,831	127,645	729,908	181,000
People With A Physical Dis Isc	4,201,627	2,109,465	2,186,084	(76,619)	4,644,627	(443,000)
People With A Physical Dis Sds	2,676,821	1,321,162	1,289,577	31,584	3,043,821	(367,000)
People Misusing D & A Isc	15,905	7,991	5,065	2,926	9,905	6,000
Community Care Assessment	7,624,913	3,764,775	3,255,687	509,088	6,863,913	761,000
Statutory Consultation	518,000	258,996	258,758	238	518,000	-
Older People Care At Home	14,589,132	7,286,965	7,152,723	134,242	14,405,132	184,000
Older People Care At Home Isc	12,763,189	6,373,218	6,912,768	(539,550)	13,071,189	(308,000)
Older People Care At Home Sds	3,813,896	1,760,343	2,504,438	(744,095)	4,801,896	(988,000)
Reablement	380,075	190,062	114,294	75,768	380,075	-
Telecare	888,774	475,178	391,882	83,296	748,774	140,000
Support Services	1,730,151	862,912	759,507	103,405	1,540,151	190,000
Directorate And Strategic Plan	44,332	(77,834)	76,946	(154,780)	240,332	(196,000)
Housing Support	6,090,712	3,045,342	3,000,197	45,145	5,991,712	99,000
Budget Savings/pressures	(3,822,498)	(1,497,385)	(369,970)	(1,127,415)	(662,498)	(3,160,000)
Management And Planning	5,095,745	1,797,530	1,466,780	330,749	4,716,745	379,000
Home Care Service - Hq	-	1	-	1	-	-
Carers Support	512,445	512,445	512,445	-	512,445	-
Covid 19 Asc	3,195,173	3,195,173	3,199,452	(4,279)	3,195,173	-
Older People Older Care Isc	383,919	191,956	122,665	69,291	383,919	-
Total Adult Social Care	**158,453,611**	**80,447,898**	**81,135,124**	**(687,226)**	**162,374,611**	**(3,921,000)**

HIGHLAND HEALTH & SOCIAL CARE GOVERNANCE COMMITTEE
Report by Committee Chair

The Board is asked to:

- **Note** that the Highland Health & Social Care Governance Committee met on Wednesday 31 August 2022 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Ann Clark, Board Non-Executive Director - In the Chair
Tim Allison, Director of Public Health
Louise Bussell, Chief Officer
Cllr, Christopher Birt, Highland Council
Cllr, Muriel Cockburn, Board Non-Executive Director
Cllr, David Fraser, Highland Council (until 3pm)
Joanne McCoy, Board Non-Executive Director
Gerry O'Brien, Board Non-Executive Director
Michael Simpson, Public/Patient Representative
Wendy Smith, Carer Representative (from 2pm)
Michelle Stevenson, Public/Patient Representative
Simon Steer, Director of Adult Social Care
Elaine Ward, Deputy Director of Finance
Neil Wright, Lead Doctor (GP)
Mhairi Wylie, Third Sector Representative (until 3pm)

In Attendance:
Christopher Arnold, Area Manager, Flow & Performance, Community
Stephen Chase, Committee Administrator
Patricia Hannan, Pharmacy Services
Arlene Johnstone, Head of Service, Health and Social Care
Campbell Mair, Managing Director, Highland Home Carers
Fiona Malcolm, Head of Integration Adult Social Care, Highland Council (from 2pm)
Jill Mitchell, Primary Care Manager
Nathan Ware, Governance and Assurance Coordinator

Apologies:
Catriona Sinclair, Ian Thomson (P Hannan attended), Kate Patience-Quaite, Fiona Duncan, Pam Cremin, Jacqueline Paterson, and Tracy Ligema.

1 WELCOME AND DECLARATIONS OF INTEREST

The Chair opened the meeting at 1pm, welcomed the attendees and advised them that the meeting was being recorded and would be publicly available to view for 12 months on the NHSH website.

The meeting was quorate.

The meeting began with a short video showcase of responses from some unpaid carers who have received funding from NHS Highland through the SDS Option 1 Short Breaks Direct Payment Fund produced by the Comms Team.

2 FINANCE

2.1 Year to Date Financial Position 2022/2023 [PP.1-10]

E Ward spoke to the paper, and clarified that the month 4 position was included in the report (as opposed to month 5 as stated incorrectly in the agenda).

L Bussell noted the extent of the financial challenge facing the Directorate. Each of the Heads of Service for Primary Care, Mental Health and Community will be focusing on individual areas but also what can be done across the organisation to address efficiencies and savings targets. An additional focus will be on services which have been started as part of redesign initiatives without an identified budget source.

In discussion, the following issues were addressed,

- M Simpson asked if it was ever possible to balance the budget for the organisation.
- The Chair noted that the financial plan approved by the Board at the start of the financial year included a £16m unfunded gap which indicated that it would not be possible for the organisation to achieve balance this year. The year-to-date position is showing significant overspend against the plan and the main target is to meet the original plan.
- M Simpson asked how much NHS Highland spends on energy and if each area was responsible for its energy usage with one provider.
- E Ward responded that she could bring the information to the next committee and noted that a significant energy budget was factored in at the start of the financial year.
- It was asked if an increase in staff working part time hours was having an impact on locum/supplementary costs.
- E Ward assured that it is recruitment difficulties that are creating cost pressures.
- G O'Brien noted that other than in relation to Adult Social Care, the Directorate was reporting a significant shortfall against its savings targets and asked how this would be addressed.
- E Ward addressed the matter of operational overspend which is largely driven by difficulties with recruitment which is a national issue. Savings programs are in the early stages of development and this is being reviewed weekly. Service pressures make it challenging to allocate staff part time to develop savings plans.
- L Bussell added that areas such as procurement, use of buildings and resources was a key focus, but acknowledged that there may be some areas such as successful pilot projects which will not be continued due to cost pressures. There is a need to include teams in addressing these issues in order to best resolve problems. Some difficult decisions may be necessary.
- The Chair commented that the savings process has a quality impact assessment that has to be completed. She asked whether in making the 'difficult decisions' there would be a similar process and what the Committee's role might be.
- L Bussell answered that where local teams considered that a decision could have an impact on quality this would be escalated to the Board Finance Committee and the Medical and Nursing Director and their deputies would be part of that process. Given the timescales and practical challenges the committee's role would be one of scrutiny and assurance.

- J McCoy asked about the overspend from use of locums and agency nurses and if there were time scales for the dedicated piece of work to reduce these costs.
- E Ward answered that this was a national piece of work reviewing expenditure and agency rates across all areas with details expected to come to the Board later this year.

After discussion, the Committee:	
– **AGREED** to receive **limited** assurance from the report.	

3 PERFORMANCE AND SERVICE DELIVERY

3.1 Assurance Report from Meeting held on 29 June 2022 [PP.11-21]

The draft Assurance Report from the meeting of the Committee held on 29 June 2022 was approved by the committee.

- The Chair requested an amendment to the end of p.3 of the report where some text was missing.

The Committee	
– **Approved** the Assurance Report pending the amendments referred to, and – **Noted** the Action Plan.	

3.2 Matters Arising From Last Meeting

- Together We Care: The committee noted that information about which groups were contacted for engagement was due to be circulated.

3.8 Chief Officer's Report

The Chair requested that the CO Report be considered at this stage in the meeting.

L Bussell drew the committee's attention to the key points of the report which included information about the most recent meeting of the Joint Monitoring Committee, the first since the Highland Council elections. She highlighted the following:

- The Sexual Assault Referral Centre which had been referred to as the Forensic Medical Examination Service will be known as The Shores and based on the Raigmore site. The service still contains a forensic medical examination section. A satellite building in Caithness set up to reduce travel will be known as the Northern Shores.
- The Highland Alcohol and Drug Partnership submitted its annual report to Scottish Government on 5th August, this focussed on education, prevention, treatment and recovery, and children and young people, as the backdrop to work ongoing to improve services in Highland. National figures published in 2022 sadly show an increase in drug-related deaths in Highland in 2021 compared to 2020. The MAT standards are aimed at reducing drug-related deaths. In addition, there is a new target for OST (opioid substitution treatment) and a need to improve treatment waiting times, the target for which is 90%, with current performance sitting at 76%.
- Recruitment remains a challenge in some areas, with some pockets of good well-established teams.
- Another focus is on improving whole family support when someone faces with drug and alcohol-related challenges.
- The Chair asked if Highland is on target to submit an improvement plan regarding achievement of the MAT standards by the end of September as required by Scottish Government, and if there are particular challenges, other than recruitment, in the way of achieving the target.
- T Allison noted the complexity of governance with the HADP (Highland Alcohol and Drug Partnership) reporting to the CPP (Community Planning Partnership). The Alcohol and Drug Service (NHS Highland) delivers the MAT standards.

- The plan is to complete standards 1 to 5 by April 2024 and the remaining standards by April 2026.
- There are geographical issues which present a challenge for NHS Highland for some of the MAT standards such as ensuring that appropriate transport is available to get to the service. It is likely to be more of a challenge in our remote and rural areas.
- A Johnstone added that the national team are confident that they have gathered everything needed for the improvement plan. The non-fatal overdose team has recently seen some successful recruitment within Inverness and a venue is being sought for the team to be based in.
- M Cockburn expressed concern that the local CPPs were functioning less well in rural areas yet drug and alcohol issues exist in most villages and towns.
- T Allison responded that HADP was accountable to the HCPP and that services are delivered on the ground by a range of partners. The aim is for an equitable service across the region but it was inevitable that people may have to travel to services from some of our more remote and rural areas.
- Cllr Birt noted that the continuing high level of drug deaths is of great concern and asked what services were doing currently to address the issue of drug deaths.
- L Bussell noted that the MAT standards are the real focus (reducing deaths), and that additional funding has been made available, for example, for recruitment to new roles with an emphasis on early intervention and work with families to create a 'wrap around' service. More work with Primary Care, schools and other agencies to get a more proactive/preventative approach is the method being taken.
- T Allison commented that this is a complex societal issue for Scotland which has the highest drug-related death numbers in Europe and that many of the issues are long standing and will therefore take much time to fully address. He gave examples of preventive work such as a pilot of the 'Icelandic' model with young people. He also noted that the number of people dying from alcohol is much higher and there is a need to look at substance use in the round. When working with people we know are using substances the focus is on reducing harm. Action needs to be multi-faceted and done in partnership.

The Chair requested that a future Chief Officer Report confirms the submission of the improvement plan by the due date, and that thought be given to which indicators in terms of service improvement in relation to the Drug and Alcohol service be added to the reporting dashboard.

- L Bussell noted that, with reference to Long COVID, some recruitment was underway in relation to Occupational Therapy and Physio as part of the rehab aspect of Long COVID.
- The Committee workplan included a commitment to provide information about the development of a Care Academy. S Steer referred to different aspects of current plans to encourage recruitment and retention. These include developing an assessment and recruitment centre model to streamline the application process and foster an encouraging atmosphere with new recruits, and promoting the full range of opportunities within social care. NHSH is working closely with partners and the independent sector in this area as it is known that there is increasing pressure as staff move between sectors and to health roles for better opportunities.
- C Mair, Highland Home Carers and Scottish Care, commented on the importance of a Care Academy approach as a way of encouraging recruitment and retention, valuing staff and the care sector as a validated and important area of employment.
- He summarised the initiatives his organisation is involved with including working closely with Skills Development Scotland looking at modern apprenticeship opportunities, developing accredited qualifications to be delivered 'in house', with investment in a state of the art learning and training environment in Inverness, and finally, commissioning reforms and different approaches to culture and to relationships to move away from the thinking and the language of the funded and the funder and instead as co-investors in the national economy, to the highland economy and people's lives.

In the discussion that followed,

- It was asked what the role of the Highland Council is in terms of encouraging people into working in the care sector
- C Mair noted that in terms of governance, the council are part of the Joint Monitoring Committee, and commented that there are some good people committed to developing this work. He also noted the importance of the independent and Third Sectors having to behave as leaders in order to drive the work forward with the support of agencies such as Skills Development Scotland.
- S Steer gave assurance that NHS Highland are working with National Education Scotland, Skills Development Scotland, the Highland Council, and Highland and Islands Enterprise to develop a tactical approach and encourage skills development and support staff retention in the care sector with three-year workforce development plans. This approach is intended to work with the apprenticeship approach taken by Highland Council.

The Committee:

- **NOTED** the update.
- The Chair requested that a future Chief Officer Report confirms the submission of the MAT Standard improvement plan, and that thought be given to which indicators in terms of D&AS service improvement be added to the reporting dashboard.

3.3 Learning Disability Services Assurance Report

A Johnstone gave a presentation outlining the key points of the paper which had been circulated ahead of the meeting.

During discussion, the following areas were addressed,

- The Chair asked what the next steps would be for the Coming Home project
- A Johnstone noted that there are a number of workstreams working in the area of housing to prevent people being housed out of area and isolated from their families. This is challenging outside of cluster housing because there is less of a support network for workers especially in crisis incidents. The aim is to add two more clusters in Inverness and explore what options there are in areas such as Caithness.
- There is work underway concerning Positive Behaviour Support (PBS) which is a model for working with individuals with challenging behaviour patterns to support them to improve their interactions with workers.
- It was asked how far the service has gone in its transformation journey to ensure opportunities for people with complex needs experience a life within their own communities.
- A Johnstone noted that there are still difficulties in placing people within a community and that there can still be negative responses to news that people with complex needs may be housed nearby, but that work is ongoing to address these areas.
- It was asked how a family would become known to the service and if the support covers all age groups.
- A Johnstone answered that the majority of people with complex needs will be known to services from a very young age through children's social work services or children's paediatric services or learning disability nurses. After this point, through the transitional arrangement with Highland Council, an individual's needs are then addressed by NHS Highland's Learning Disability Service. In those instances where someone's needs have gone under the radar they are usually individuals living in remote and rural areas with an ageing family who are no longer able to support their needs. However, most individuals will be known to their GP or social worker.
- L Bussell paid tribute the work over the challenges of the last two to three years and how positive it is to see progression into new models of working and new approaches.
- A Johnstone commented on the challenges ahead with a shrinking workforce which is likely to make this work much more difficult for staff to address individual needs.

- W Smith commented that she felt, having a family member who uses these services, that the report bore little resemblance to real life experience for people who use learning disability services. W Smith referred to the Community Care Act which she felt still encourages that people live in institutional settings, and expressed disappointment at the lack of data from families using the services, and expressed a desire to see a more independent approach to gathering intelligence.
- A Johnstone responded that there is the intention to use some of the funding from Scottish Government to outsource some engagement work for future strategy to skilled consultants but that plans are at an early stage.
- W Smith offered to give some time to support these discussions.
- A Johnstone thanked W Smith for the offer and this will be followed up. She also noted the need to distinguish between consultation with users of services and with carers carried out alongside Ian Thomson's team and to fulfil the requirements of the Carers Act.
- M Cockburn requested if more information on the transition element of the service between the council and the health board could be brought to the committee to highlight the challenges in this area.
- The Chair suggested that this be added to discussions around the workplan as it may not be possible to address at the next meeting.
- The Chair asked for clarification on the difference between the new Annual Health Checks to support people with learning disabilities and those carried out pre-COVID.
- A Johnstone clarified that Scottish Government direction to NHS boards is that annual health checks will now move to primary care and that it will be for every person with a learning disability, regardless of whether they are known to the service. Clarity has been sought from government about the budget, and there are conversations to be had with primary care colleagues as to how this work is carried out in future.
- The Chair requested that an interim update come to the committee as part of the Chief Officer's Report.

The committee **noted** the ongoing strategy development work and how the service is responding to the Coming Home report.

The Committee:

- **NOTED** the ongoing strategy development work and how the service is responding to the coming home report.
- **AGREED** that more information on the transition of service between Highland Council and NHSH be added to discussions around the workplan.
- **AGREED** to accept moderate assurance from the report.

The committee held a short break.

3.4 Primary Care Improvement Plan Assurance Report

J Mitchell introduced the report and noted that the two areas that the team is focusing on currently include Community Care and Treatment. There is not yet an agreed model for this and a comprehensive survey is underway of the team's practices to ascertain what staff is available to support this as a work stream. From next year the focus will be on urgent care.

In discussion, the following issues were raised,

- N Wright commented that GPs are not yet seeing the results of the work addressed by the paper and asked what the situation was with recruiting a primary care mental health team for Lochaber.
- A Johnstone noted the challenge of recruitment and that work to explore how staff from other areas might support the Lochaber area is being undertaken, with the proviso that this would place a limit on time available in the area due to travel.

- N Wright asked why we are not yet using all the budget and suggested that there had been quite a slow start to the programme, and asked what more can be done to speed up progress.
- J Mitchell agreed that there had been recruitment challenges. Workstreams are developed in agreement with the GP Sub-committee. The approach has been to develop very practice-centric solutions. Where recruitment is not possible remote solutions are explored. The workstreams that have managed to recruit into new roles have experience different challenges including an eventual return of people recruited from Community Pharmacy to Primary Care after a couple of years. Working out how to encourage retention and development in role will be important. Scottish Government have assured NHSH that there is some latitude to use some of the underspend to work such as digitizing records and assisting with accommodation requirements.
- The Chair asked if the Primary Care Improvement Fund slippage in previous years is included in the sums held by Scottish Government on NHS Highland's behalf for use in this financial year.
- E Ward clarified that the money is part of the monies which were returned to Scottish Government to be held for NHS Highland.
- J Mitchell confirmed that the team were exploring ways of using the slippage such as training and IT developments and suggestions will be discussed with GP Sub-Committee.
- The Chair asked for confirmation that the national funding table in the papers showed that Highland is doing reasonably well compared to many boards in terms of slippage.
- J Mitchell confirmed that after a slow start to the programme, momentum had been built, and that there is now a clear direction for the programme and a move to use our fuller allocation.
- G O'Brien asked what plans have been built in to evaluate the model that has been implemented in terms of assessing how GP's time is being freed up and how they are using this time, and what the impact is as seen from the patient perspective.
- J Mitchell answered that each of the work streams are linked into a national group with a separate national evaluation team established to run alongside this work.
- M Stevenson raised a concern about the use of a third party to scan patient notes and asked whether patients' consent would be sought for this.
- J Mitchell answered that any arrangement made with the provider is on a national contract framework, but offered to provide more information about the governance and the opt in/opt out status for patients in this area.
- M Simpson asked why it appeared to be easy to recruit locums to remote areas but not a resident GP.
- N Wright noted the difficulty of recruiting resident GPs and how some doctors stay as locums because they enjoy the flexibility and it suits their career stage. He also commented that numbers of GPs are an issue across the UK.
- J Mitchell noted the difficulties of finding suitable accommodation but also that work was underway with Scottish Rural Medicines Collaborative promote the attractiveness of working in Highland, but that there is no straightforward solution to the matter.

The Chair asked J Mitchell to consider what indicators around the objectives of the programme could be developed to be included in the committee's dashboard reporting.

The Committee: • **AGREED** to accept moderate assurance from the report.	

3.5 Vaccination Strategy Update

C Arnold noted the report circulated ahead of the meeting and invited questions from the committee.

During discussion, the following points were addressed,

- The Chair thanked C Arnold for the paper and commented on the complexity of the task faced by the vaccinations team, and the progress that had been made since the start of the pandemic and the ongoing implementation of the Vaccination Transformation Programme.
- It was noted how the VTP would take vaccination duties away from school nurses in order to free them up for other advanced work. This is an area of challenge in providing a like for like service replacement in order to minimise disruption within schools. Systems would remain the same but different people would administer the vaccinations.
- It was noted that there are still a number of issues to be resolved in establishing the approved model for VTP adult vaccinations such as recruitment of staff and training. It was commented that only 50% of slots for vaccinators from the bank had been allocated. C Arnold responded that 50% is a good amount at this stage of the winter campaign given previous experience and that work is moving in the right direction to address this.
- It was noted that there are some national issues to be resolved such as the extent of temporary registrations for staff returning to vaccination work after retirement and the tax status of such staff. Conversations are ongoing on a weekly basis with Scottish Government to resolve this.
- N Wright asked what the current situation was regarding the coordination of a new IT system and childhood vaccinations. Child Health leads are leading on this work to establish an effective system. Initially, it is likely that the current paper system familiar to GPs will continue with an electronic system hoped to arrive by 2024.
- N Wright commented that the system which records COVID and flu auto populates clinical records and is an effective system for staff to use.
- L Bussell noted the challenges posed in establishing locations across the dispersed geography of Highland. It is felt that there is a good spread of locations but that it will be a different experience for the public who have previously engaged with their local GP for vaccinations.
- It was asked if it had been possible to model and set limiting factors for the distances which individuals will have to travel for vaccinations, taking into account accessibility of public transport.
- C Arnold answered that a number of different models, formulas and algorithms have been trialled. For the current vaccination plans the aim is to have a sub-fifteen minute travel time. This is an ideal and it is recognised that this is not currently possible for everyone. However, 85-87% of people are likely to have a vaccination location within this time limit.
- A particular challenge in achieving this target is the Aviemore, Kingussie and Laggan area and work is underway to find suitable locations.
- T Allison commented that whilst some people may have to travel further than we would like, especially if the appointment offered isn't suitable, every effort was being made to respond to justifiable public demand for easy access to clinic locations.
- M Cockburn asked what flexibility there was for households where partners may fall into slightly different age brackets to arrange joint appointments.
- C Arnold answered that there is a degree of eligibility flexibility afforded by government models where a household could reduce its travel by attending a vaccination appointment together.
- J McCoy asked if it was possible for people to choose not to have the flu and COVID vaccinations at the same time.
- C Arnold answered that this was technically possible. An individual in this instance would need to self-book a second appointment, however due to the pressures on the booking system it may not always be possible to book for the same location.
- Cllr Birt asked whether given the financial situation accommodating such requests might be an area for potential savings
- T Allison clarified that the vaccinations are not mandatory and that there are people who have a bad reaction to vaccines, despite lack of scientific evidence against both vaccines

being administered at same time. However, there is a balance to be struck between efficiency, improving public health by maximising take up and accommodating the wishes of individuals, and while this may not always be easy the team will try to accommodate as far as is practical.
- C Arnold asked that members raise awareness of the campaign and encourage particularly those in the 50-64 age bracket to attend their appointment.

The Chair commented on concerns in the media that people may have become a little complacent with the long duration of living with the pandemic, and that therefore communications and encouragement to attend will be important.
It was agreed that C Arnold's slide presentation would be circulated to the committee members.

The Committee:	
• **AGREED** to accept moderate assurance from the report.	

3.6 IPQR Dashboard Report [PP.76-88]

- It was agreed that this item would be discussed at the committee's development session on **29 September**.

- It was commented that some of the graphs are difficult to read due to the colour visual presentation.

3.7 Hearing and Sight Care (3rd Sector Project Board Funding Uplift) [PP.89-92]

L Bussell took questions on the paper on behalf of J Paterson.

- The Chair noted that this was the second SBAR recommending an uplift for one of the three organisations involved in delivering sensory services across Highland and that the Committee had approved an uplift for services in Lochaber at a previous meeting. She requested clarification if there would be a third SBAR and was informed this was unclear and would depend on outcome of discussions on-going with the organisation in question.
- P Macrae asked for clarification and assurance that what was being delivered was value for money.
- L Bussell noted that these contracts had not been reviewed for several years and had therefore required a number of months of dialogue to establish up-to-date figures. A new tender process is just underway for the entirety of services across Highland which aims in part to address the issues that were coming to the fore while the old contracts were still in use. The current position is a holding position for the next 18 months. There are cost pressures to the tendering process but the costs were considered to be much higher if they were to have been brought in house.
- The Chair expressed concern that there may be more issues like this to come.
- L Bussell noted that this particular contract was considered an outlier and that similar issues had not been identified with other contracts.

After discussion, the Committee:	
- **Agreed** to the uplift in support.	

3.8 Chief Officer's Report [PP.93-100]

See above.

4 HEALTH IMPROVEMENT

There were no matters discussed in relation to this Item.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Committee Annual Work Plan [PP.101-103]

The Chair noted that the workplan would be reviewed at the next agenda planning meeting in light of the fragility of the current situation, and would be presented for consideration at the next meeting.

The Committee APPROVED the Work Plan.

5.2 Review and Update of Committee Terms of Reference [PP.104-107]

The Chair noted that Governance Committees required to review their TORs on an annual basis. She invited comments or proposals for amendment to the existing TORs and none was forthcoming.

The Committee APPROVED the Terms of Reference.

6 AOCB

Proposed dates for 2023 were approved

11 January
1 March
26 April
28 June
30 August
1 November.

- M Simpson requested that there be an update on the North Coast service redesign included for the next meeting. L Bussell apologised that details had not come to the meeting due to the team being currently overstretched.

The Committee: – **APPROVED** the proposed 2023 dates.

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 2nd November 2022** at **1pm** on a virtual basis.

The Meeting closed at 4.15 pm

HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE ROLLING ACTION PLAN

Those items shaded grey are due to be removed from the Action Plan.

	Item	Action / Progress	Lead	Outcome/Update
04/09/2019	**Clinical Governance**	Agreed detailed report on ASC Clinical & Care Governance to be submitted to future meeting.	**S Steer**	Progress report to be brought to the January committee.
03/03/2021	**Staff Experience Item**	Suggestion: Team involved in savings on PMO workstreams. Other suggestions to be discussed with L Bussell's team.	**R Boydell/L Bussell**	To be included in future Development Sessions (~4 in 2023)..
08/07/2021 And 02/03/2022	**Enhanced Community Services**	Update report and assurance on progress and plans for redesign to provide enhanced community services including parity of opportunity across the region.	**R Boydell/L Bussell**	Trial to include in future cross service reports from localities from Jan 2023 (in context of ADP and Strategy).
12/01/2022	**Mental Health Report**	Update in six months; to include further information on CAMHS position	**A Johnstone/L Bussell**	Update in CO Report, with possible strategy paper Jan/March 2023.
12/01/2022	**SDS Strategy**	Consideration to be given to future report on Community Directorate implementation of NHSH Engagement Framework in redesign	**A Clark/L Bussell/I Thomson**	Committee to receive report on draft Engagement Framework at November meeting.
02/03/2022	**Children's Services Reporting**	Further discussions to be held taking into account Committee views, including with HC and update provided in CO report	**L Bussell/S Amor**	Progress report for Jan/March 2023
31/08/2022	**PCIP**	To identify potential indicators for IPQR Committee dashboard re the PCIP	**J Mitchell**	TBC
31/08/2022	**DAHP/CO**	To confirm MAT standards improvement plan submitted and indicators for dashboard report	**S Stewart/L Bussell**	CO Report
31/08/2022	**Learning Disability**	Update on progress with introduction of Annual Health Checks and Employability project in CO report	**A Johnstone/L Bussell**	CO Report

31/08/2022	**Learning Disability**	More detail requested on Transitions service. To be discussed at Agenda Planning for November meeting.	**A Clark/L Bussell**	TBC

Items addressed on an On-going basis

01/09/2021	**Chief Officer's report**	To include North Coast Redesign Update.	**L Bussell**	On-going
01/09/2021	**Chief Officer's Report**	Regular update on the progress of the NCS and how the partnership is responding and considering changes at the local level.	**L Bussell**	On-going and possible wider report on Integration issues at January 2023 meeting
02/03/2022	**COVID Update**	Chair/CO/D of PH to discuss how/when to bring information on service response to Long COVID to Committee	A Clark/L Bussell/T Allison	On-going

Items to be Followed Up Outwith Meetings

12/01/2022	**SDS Strategy**	Chair, I Thomson and L Bussell to discuss and agree timetable for future reports to Committee on Implementation	**A Clark/I Thomson/L Bussell**	Update report in Jan/March 2023
02/03/2022	**Children's Services**	Information on CAMHS referrals to be provided to N Wright	**L Bussell**	
02/03/2022	**Children's Services**	CO to hold discussions with Mhairi Whylie on inclusion of Third Sector in service redesign and decisions on additional allocations	**L Bussell/M Wylie**	On-going
31/08/2022	**PCIP**	Response to query about patient consultation re scanning of records	**J Mitchell**	
31/08/2022	**Learning Disability**	Offer from A Johnstone to W Smith to discuss commission for independent engagement work	**A Johnstone/W Smith**	

Development Sessions

	Item	Action/Progress	Lead	Outcome/Update
04/09/2019	**Chief Officer's Report**	Agreed consideration be given to inviting C Morrison to address a future meeting on Near Me.	**A Clark/L Bussell**	Development Session on technology enabled care during 2023.
08/07/2021	**Workplan**	Climate Change: consideration to be given as to how to approach the subject, e.g what commitments have been made, how might the Mobilisation Plan be affected.	**A Clark/L Bussell**	29 September

DRAFT Winter Ready Plan

NHS Highland

Together We Care

Context

Winter priorities overview

Acute priority areas letter

Winter planning checklist

“Winter Ready” task and finish group established

Accelerated planning and implementation to align with U&USC

WINTER READY PRIORITIES

THEME	ACTION	OUTCOME
Redirect	Redirect inappropriate ED attendances and signpost to appropriate services	See those that need emergency care quickly
Reduce	Reduce admissions where clinically appropriate	Support our population with the appropriate level of care
Rapid	Facilitate rapid discharge and support	Support a “home is best” approach when active treatment is complete
Respond	Respond quickly to support crisis and vulnerable population across our system	Population can remain safely supported in their own home
Restore	Restore planned care activity to optimal levels	Population who need planned care can be seen in a timely way
Reassure	Actively support and reassure our colleagues	Our colleagues who deliver our services are valued and supported

Winter Ready Plan Overview

STRATEGIC OBJECTIVES

- Improving outcomes
- Great place to work
- Working together

Communications Plan
Clear consistent messaging to our population and colleagues

Performance Indicators
Triggers for escalation and intelligence led decision making

Governance Framework
Operational, Tactical, Strategic approaches across the organisation

Resilience Plan
Support continuity and incident working collaboratively with partners

Redirect

- Promote utilisation of 111 and FNC
- Accelerate MIU access and booking
- Resilience of OOH service
- Redirection and signposting at ED
- Access to hot clinics and virtual support
- Support and pathways for falls/frailty

Reduce

- ACPAs in place for most vulnerable
- Direct support for Care Homes
- 24/7 support for MH through MHAU
- Support vaccination uptake
- Urgent dental access
- PGDs/Anticipatory Prescribing

Rapid

- Discharge by 12noon
- PDDs in place for all patients
- 7 day working with barriers understood
- Transport delays minimised
- Choice policy applied
- Sit to stand to keep mobile
- Define bed complement and definitions

Respond

- Personal contingency plans in place
- Increase CRT support
- Maximise intermediate care beds
- Support for carers (tbc)
- End of life care and support
- Ready Scotland Emergency Boxes
- Direct admissions to Community

Restore

- Protect life limiting surgery access
- Increase planned activity to pre-pandemic
- Theatre utilisation
- Diagnostics (tbc)

Reassure*

- Rapid recruitment to vacancies
- Weekly bank pay
- Real time staffing monitored
- Wellbeing available across system
- Support primary care workforce
- Before you go home
- Student nurses and medical trainees

Key Performance Indicators

Redirect

Measurement	Target
Calls to FNC & outcome	Count/tbc
Calls to OOH and outcome	Count/outcome
MIU tbc	Count
AEC attendees	Count
Flow group 2 admission avoidance	Bed days
AEC LOS	Time
Prescribing / rescue mediation	tbc
Clinical dialogue usage	tbc

Reduce

Measurement	Target
ACPAs in place (DM)	Tbc
Care home admissions	Tbc
ED performance	90%
MH assessment unit referrals	Count
Mortality in hospital (EoL)	Count
OPAT	Bed days
SAS TAT	Times

Rapid

Measurement	Target
Discharged by noon	80%
PDDs in place for all patients	80%
Choice policy applications	Count
Equal discharges by days of week	Balanced
Admissions/discharges	Balanced
Length of stay	Monitored
Readmission within 28 days	%
% discharged directly home	Monitored

Respond

Measurement	Target
Emergency admissions (care)	Count
Care home beds operating	Count
Reablement	
Ready Scotland Emergency Boxes	Count
Delayed discharges (what and where)	
Social care assessment & reason	
Long stay population	

Restore

Measurement	Target
Cancellations	<1%
Boarders across system	<10
TTG activity and demand	Count
OP activity and demand	Count
Cancer 31 and 62 day	Count
Urgent surgery times	Days

Reassure*

Measurement	Target
Vacancies across all areas	Tbc
Staffing levels	Tbc
Recruitment	Tbc
Real time staffing	Tbc

Governance Framework

Strategic	Tactical	Operational
U&USC Programme Board managing the long term planning	Weekly and daily performance intelligence to assess triggers	Check and challenge meetings to focus on flow
EDG to be updated on performance through bi-weekly reporting	Winter Oversight Group to provide overview on progress	Escalation framework applied to ensure joint understanding
Communications with our public with agreed key messaging continually through winter	Internal communications and support for our colleagues	Multi-agency assessment meeting reviewing DDs and Long stay patients across acute and community
Resilience plan in collaboration with our partners as part of current arrangements		

Communications with our Population

What you can do for yourself – self care, activity, nutrition

What you can do for others – meals, neighbours, communities

Volunteer drivers and friends and family with employers

Falls prevention working with 3rd sector

In partnership with 3rd sector, CAB, Highland Council

Calls to action focused and case studies

Column in courier about winter and realistic messaging 21/10

Opening hours for positive messaging

Next Steps

- Weekly meeting to finalise “Winter Ready” plan
- Internal engagement plan over next two weeks to penetrate the organisation
- All levels to develop understanding of targets within operational teams
- Governance on how we will manage agreed
- Aligned to U&USC plan and winter plan accelerates implementation
- Communication with public
- Key performance indicators / triggers / clinically led

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**November 2022**
Title:	**Engagement Framework**
Responsible Executive/Non-Executive:	**Fiona Hogg, Director of People and Culture**
Report Author:	**Ruth Fry, Head of Communications and Engagement**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well	x	Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	x
Perform well		Progress well					

2 Report summary

2.1 Situation

The Sturrock Report recommendations included a requirement for NHS Highland to develop an Engagement Strategy. NHS Highland is now implementing the second year of its three-year Communications and

Engagement Strategy, which sets the direction for the development of these functions in the Board, with annual action plans presenting the detailed activities required by the Communications and Engagement Team. Updates on this Strategy are reported to the Staff Governance Committee.

Argyll and Bute Health and Social Care Partnership already has an agreed Engagement Framework and reports to the IJB.

There remains a requirement, however, for a strategic-level blueprint to shape and guide engagement activity across all services. This Engagement Framework fulfils that function. We have referred to it as a 'framework' because it provides the guidance, procedures, templates and training for services to implement appropriately and proportionately. It is a set of tools for them to work with, and will be supported by advice from the Communications and Engagement Team.

The Engagement Framework will be submitted to the Board for final approval, and is reported here to the Highland Health and Social Care Committee for their endorsement.

2.2 Background

2.2.1 Developing the Framework

The Framework has been developed by a Short-Life Working Group (SLWG) which included NHS Highland colleagues with engagement experience, trusted partners such as Health Improvement Scotland, and representatives of people who use our services and carers. We also invited representation from Argyll and Bute HSCP and have worked to ensure the NHS Highland Framework sits logically alongside theirs. We thank all of the participants for their time and commitment: the Framework is stronger and more representative because of their input.

The draft Framework was shared with groups representing communities of interest and of location for comment. A summary of feedback received is included at Appendix 3.

2.2.2 The content of the Framework

The SLWG agreed Aims for the Framework, and set out what we mean by community engagement. The Framework is intended to support external engagement with people and groups affected by potential services changes:

however, its ethos and much of its content can equally be applied to internal engagement with colleagues.

We have established Engagement Values, which have already been adopted by some services and partners to guide their work, and outlined a model Engagement Cycle, based upon the national Planning With People guidance.

Key Performance Indicators are included in the Framework and it is anticipated that these will be reported to Committees.

The Framework also lists the supporting 'tools' such as training, templates and guides, available, including some already completed and some yet to be developed. The SLWG was supportive of a policy for reimbursement of volunteers to be developed, to recognise the time commitment of those with lived experience who may be called upon to support engagement, and the Framework commits to take this work forward.

The SLWG felt strongly that the Framework should allow for 'two-way' engagement and provide a structure not only for NHS Highland to ask for input on proposed changes, but also for people who use our services to suggest areas where they would like to engage, with a focus on service improvement. The Framework therefore incorporates support for community-led engagement, and proposes an annual budget of £2,500 is allocated to support such projects, which should be put forward by the Advisory Group and agreed by the Oversight Group.

2.2.3 Proposed governance arrangements

The Framework proposes a governance structure with an Oversight Group reporting to the Highland Health and Social Care Committee and Clinical Governance Committee. We are keen to hear this Committee's views on the proposed governance structure, quorum for the oversight group, and frequency and content of reporting.

The Oversight Group would be supported by an Engagement Advisory Group, which would reflect the views and input of communities, people who use our services, partners and staff.

Draft roles and remits for these groups are attached as Appendix 2.

2.3 Assessment

The Engagement Framework has been co-produced with our communities and partners. Initial drafts have been well-received and several services have already begun implementing engagement supported by the values and tools encapsulated in the Framework. We recommend the Committee ratify the Framework.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	x	Moderate	
Limited		None	

3 Impact Analysis

3.1 Quality/ Patient Care

Best practice engagement promotes the health and wellbeing of staff, patients and the wider community.

3.2 Workforce

This paper supports the Staff Governance Standard, specifically

- Well informed
- Involved in decisions

3.3 Financial

Services are required to fund their engagement activities: while the corporate Communications and Engagement Team can offer advice and support, there is no central budget for engagement. In particular, projects designated as The Volunteer Reimbursement Policy may have a moderate impact on future costs. An annual revenue budget of £2,500 is requested to support community-led engagement projects.

3.4 Risk Assessment/Management

This report relates to EDG Strategic Risk Register risk number 877: “There is a risk of services being designed and delivered in ways that make them unsuitable or inaccessible to some people; because of lack of resourcing of, or commitment to, partnership working and engagement, leading to poorer health outcomes and reduced wellbeing for people in Highland and Argyll and Bute, and damaging the performance and reputation of NHS Highland. This risk has now been removed from the Risk Register as the introduction of the Engagement Framework is a significant mitigating factor.

There remains a risk that service will not implement the Framework. This will be mitigated by ongoing training and awareness-raising, and reporting to Committee of services' KPIs.

3.5 Data Protection

Where individual projects may involve personal information advice has been sought from the Data Protection Team to ensure the correct risks have been considered and documentation completed.

3.6 Equality and Diversity, including health inequalities

The development of an Engagement Framework is a key step towards ensuring we meet our duty to engage with people with protected characteristics.

3.7 Other impacts

n/a

3.8 Communication, involvement, engagement and consultation

The Framework was co-produced with community and partner representatives and the draft has been consulted upon.

3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Engagement Framework Short-Life Working Group
- Healthcare Improvement Scotland Community Engagement
- Argyll and Bute HSCP
- Highland Council Housing and Maintenance & other departments
- Public representatives
- Unpaid carer representatives
- The wider community including:
    a. Partner organisations
    b. Third sector and community groups
    c. Community Planning Partners
    d. Community Councils
    e. NHS Boards and HSCPs from other areas
    f. National organisations such as the Alliance and Scottish Recovery Network

4 Recommendation

- **Discussion** – For input and endorsement.

4.1 List of appendices

Appendix 1: NHS Highland Draft Engagement Framework

Appendix 2: Roles and remits of governance groups

Appendix 3: Feedback received and incorporated

September 2022

WORKING TOGETHER FOR A BETTER FUTURE

2021 - 2025

Appendix 1

Engagement Framework

NHS Highland

Final draft Plan - 7th September 2022

To be reviewed April 2025

NHS Highland wants to have a consistent and meaningful approach to listening to and engaging with people who live, work and volunteer in the Highlands

We will do this by producing a framework that meets our statutory duties, moral responsibilities and core values

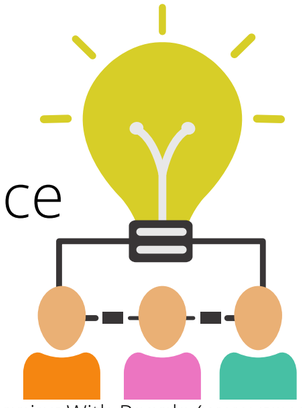
Our framework aims to:

- provide clear ways for managers and staff to engage with and empower people to inform plans, decisions, policy, practice and change
- foster partnership and values based approaches to engagement with our communities and partners
- provide assurance and accountability to communities, partners and our Board, that engagement is meaningful, leads to action and demonstrates the difference it has made

What we mean by Community and Engagement

Community refers to a group of people who share a common place, a common interest, or a common identity. There are also individuals and groups with common needs. It is important to recognise that communities are diverse and that people can belong to several at one time.

Engagement covers a range of activities that encourage and enable people to be involved in decisions that affect them. This can range from encouraging communities to share their views on how their needs are best met and influence how services should be delivered, to giving communities the power to inform decisions and even provide services.



Our Engagement Values

Friendly

engagement will be welcoming, and appealing for, individuals, communities, partners and our staff

we want people to feel safe to share their views

Inclusive

we will go to where people are and everyone will be able to engage with us in a way that best suits them

we will be open and sharing with information

Timely

early engagement and participation will take place during planning and service redesign

continuous conversations with communities will be the norm

Meaningful

lived experience and peoples views and ideas will be at the heart of our plans and decisions

feedback will be valued as a gift

Together

redesign will be needs led and co-design will be the main approach for developing plans and services

people will be true partners

Responsive

we will tell people how their contributions has informed plans and decisions

people will know the difference they have made

ENGAGEMENT FRAMEWORK

NHS Highland

How

- Develop engagement standards and processes based on guidance and good practice
- Provide training, engagement tools and templates to support staff to engage with communities
- Regularly evaluate engagement to, learn, share and improve practice
- Utilise Care Opinion to capture experience and feedback at the point of contact
- Set up governance arrangements, to make sure engagement is meaningful, follows good practice and informs decisions
- Link feedback and complaints to engagement processes & reporting

Why

- Duty to involve people in how services are planned, delivered and improved
- Plans for change should be based on experience of those most or disproportionately affected, as well as clinical and other important information
- Involving people early, leads to better decisions and quality services and helps to identify and address potential health inequalities - no one is left behind
- The benefits of change are recognised and supported by communities, staff and partners

What

- Develop different ways to communicate with individuals, groups and communities
- Build relationships with communities and trusted partners, working together on the areas that matter most to people
- Develop different ways to hear views and empower people with lived experience, to inform how we plan and deliver services
- Make sure the experience of vulnerable and disadvantaged groups and individuals are sought, valued and inform plans
- Make the most of every contact, collecting feedback and experience from patients as they connect with services

Who

- Patients, carers, people who need the health and care services we provide
- Young people and people from protected, vulnerable, disadvantaged groups and communities of experience
- People who live in remote and rural and island communities
- Trusted partners who support people who need our services
- Staff, clinicians, managers and agencies who work along side us
- Everyone who lives and works in the North NHS Highland area (Argyll and Bute HSCP has its own similar Framework)

Governance

Engagement Oversight via group or committee

Part of NHS Highland Board and Health and Social Care Partnership agendas

What does this mean to me?

Why

The Framework will help NHS Highland staff and people who work with us to understand our responsibilities and commitments to involving people in decisions that affect them.

It should also help communities to understand their rights to be involved in decisions about their care, medical treatment and plans for current and future services.

Who

The Framework applies to all NHS Highland health and social care staff at all levels.

It also relates to everyone who lives, works and volunteers in the NHS Highland area.

It is designed to help ensure that communities of experience and vulnerable and protected groups are listened to and included within plans and important decisions.

What

The framework will enable true partnership working to be adopted.

NHS Highland staff, patients and communities will work together to identify and create engagement approaches and opportunities.

People with lived experience will be valued and empowered to inform and influence plans and decisions.

How

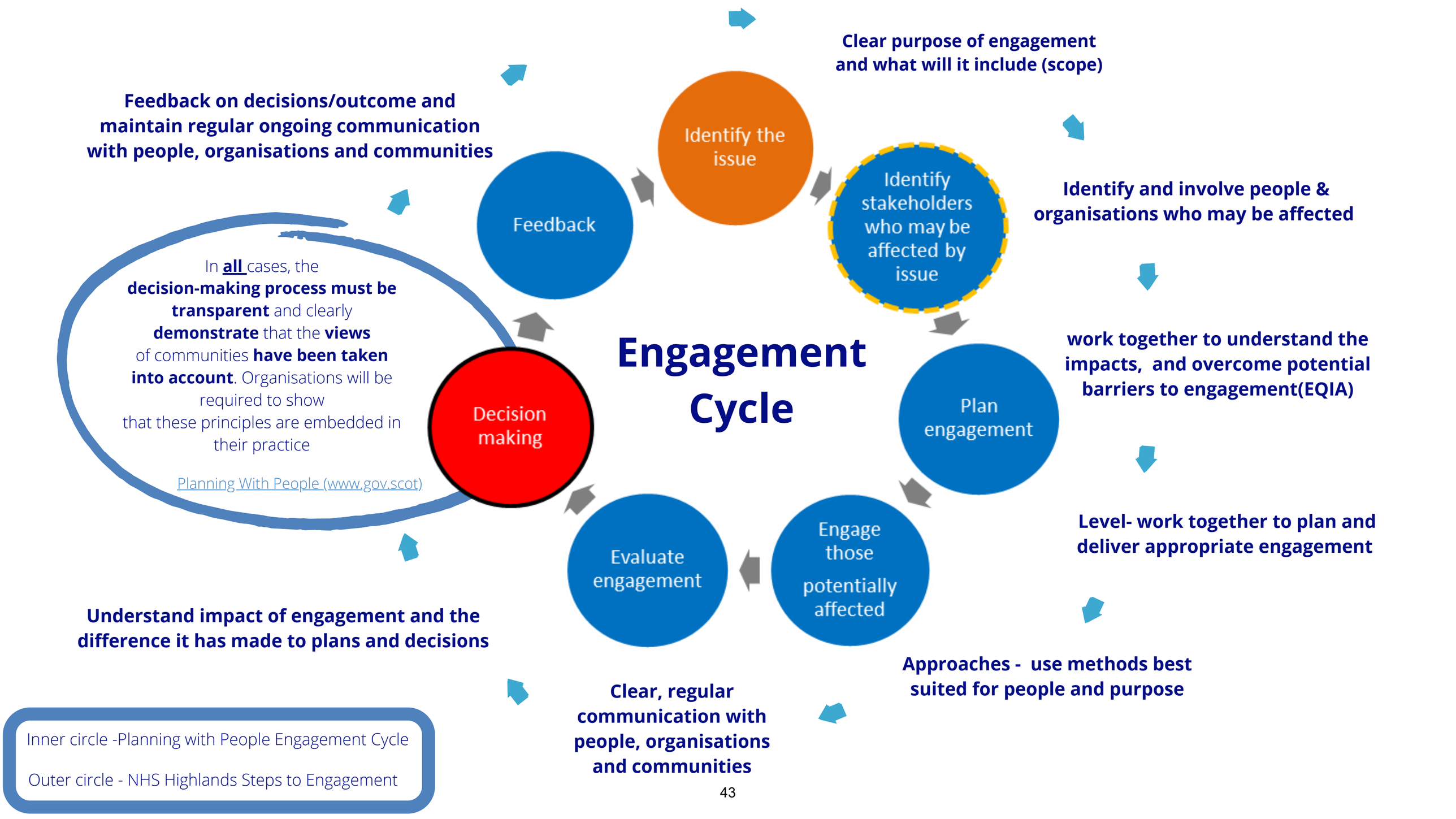
The Framework will act as a blueprint mapping different ways to meaningfully engage and involve individuals and communities in important decisions.

It will provide clear pathways and governance structures that ensure engagement is meaningful and considers relative impacts.

Training and support will be provided to all, at all levels, to make sure the framework works in practice for everyone.

Argyll and Bute Health and Social Care Partnership has its own own framework, that applies to staff who work in this area. The Argyll and Bute framework can be found at https://nhsh.scot/EngageArgyllandBute

Engagement Cycle



Clear purpose of engagement and what will it include (scope)

Identify and involve people & organisations who may be affected

work together to understand the impacts, and overcome potential barriers to engagement(EQIA)

Level- work together to plan and deliver appropriate engagement

Approaches - use methods best suited for people and purpose

Clear, regular communication with people, organisations and communities

Understand impact of engagement and the difference it has made to plans and decisions

Feedback on decisions/outcome and maintain regular ongoing communication with people, organisations and communities

In **all** cases, the **decision-making process must be transparent** and clearly **demonstrate** that the **views** of communities **have been taken into account**. Organisations will be required to show that these principles are embedded in their practice

Planning With People (www.gov.scot)

Inner circle -Planning with People Engagement Cycle

Outer circle - NHS Highlands Steps to Engagement

Levels of Engagement

NHS Highland

Inform | **Consult** | **Involve** | **Shared decision making** | **Partnership working**

Involvement → **Influence** → **Partnership**

- Newspaper and social media releases
- Public information stands and exhibitions
- Newsletters and podcasts
- Online, paper or telephone surveys
- Seeking comments on plans and recommendations
- Patient/carer representation on committees and groups
- Public or patient involvement at the start of service redesign or project
- Focus, discussion groups & conversation cafes'
- Patient stories
- Joint standing on working groups
- Citizen panels or Assemblies
- Public and community representatives active partners in ongoing service improvements
- public and partners co-creating service plans, options and strategies
- Community or Partner led intitatives
- Co-production, experience based co-design & Scottish Approach to Service Design

communication

Empowerment

IAP2 IAP2 Public Participation Spectrum - IAP2 Australasia
NHS Lothian Public Engagement - A New Framework.pdf

Proposed Governance Structure

Highland Health and Social Care Committee

NHS Highland Board

Clinical Governance Committee

Engagement Oversight Group

Engagement Advisory Group

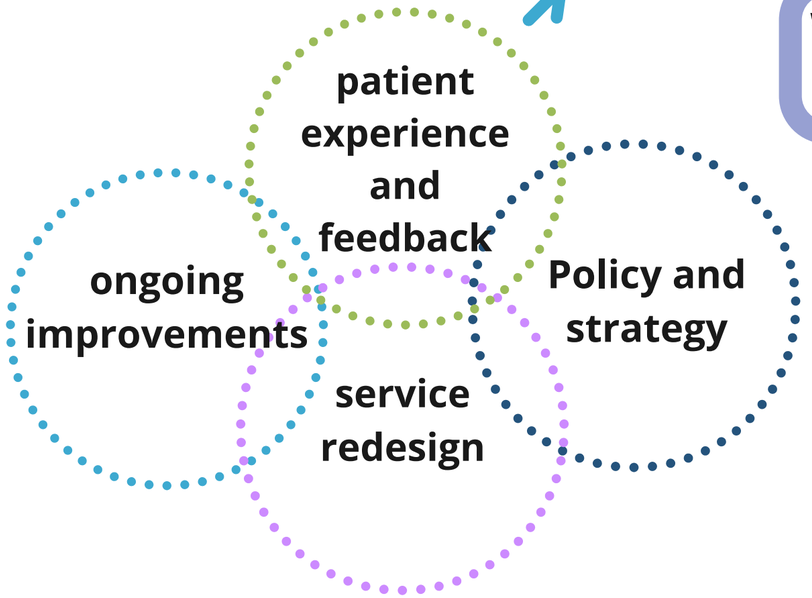
community planning groups and partnership forums

Wider Community Engagement Network & Partners Networks

Trusted partners and protected groups

Citizen/ Participation Assembly or Panel

Staff engagement and 100 Panel



Governance

Reporting

Suggested Functions

Engagement Advisory Group

Provides feedback and advice , shares good practice and Informs development of procedures, networks and training.

comments on draft engagement plans and road tests

public facing information and surveys

- Service user representatives
- Carer representatives
- Communities of interests and experience
- Young people
- Trusted partners (like HIS-CE, THC,TSI)
- Staff and service representatives

meets bi-monthly via Teams with periodic face to face meetings

Engagement Oversight Group

Provides assurance that NHS Highland meets its statutory duties, the National Standards for Community Engagement and our core values to involving people in important decisions that may affect them, the people they care for or their community.

- Sets and oversees Key Performance Indicators
- Ensures proportionate, meaningful engagement informs decision making in key projects and service redesigns, considering impacts and vulnerable/protected groups
- Ensures appropriate evaluation of engagement
- Shares engagement metrics with services for improvement purposes

meets quarterly with exception reporting, as needed

Citizen's Panels or Assembly & Staff Engagement & Panels

Population & staff representative panels to provide feedback and suggestions on key topics and themes, to support strategic planning and understanding of what is important to our population and workforce.

Digital and face to face periodic engagement, with identified members

Community Engagement and Partner Networks

An honest, transparent, two-way space, between our communities, population and our partners. Various engagement opportunities to support different interests, projects and preferred methods for engagement will exist, in partnership with others, where possible.

People and groups will share and select topics of interest for exploration and improvement, that will be community led, and supported by us. Periodic communications and 'gatherings' will take place to provide updates and sense checking that people are being heard and accurately understood.

variety of ways and frequencies for engagement

Key performance indicators

How will we know we are getting it right?

Strategic level

- Services feel more confident they are engaging well
- Service users report an improvement and say they feel their input made a difference
- Services receive a regular stream of feedback from people who access services from a range of sources
- We can show that feedback and lived experience has been used to inform strategy at the highest level

Service redesign level

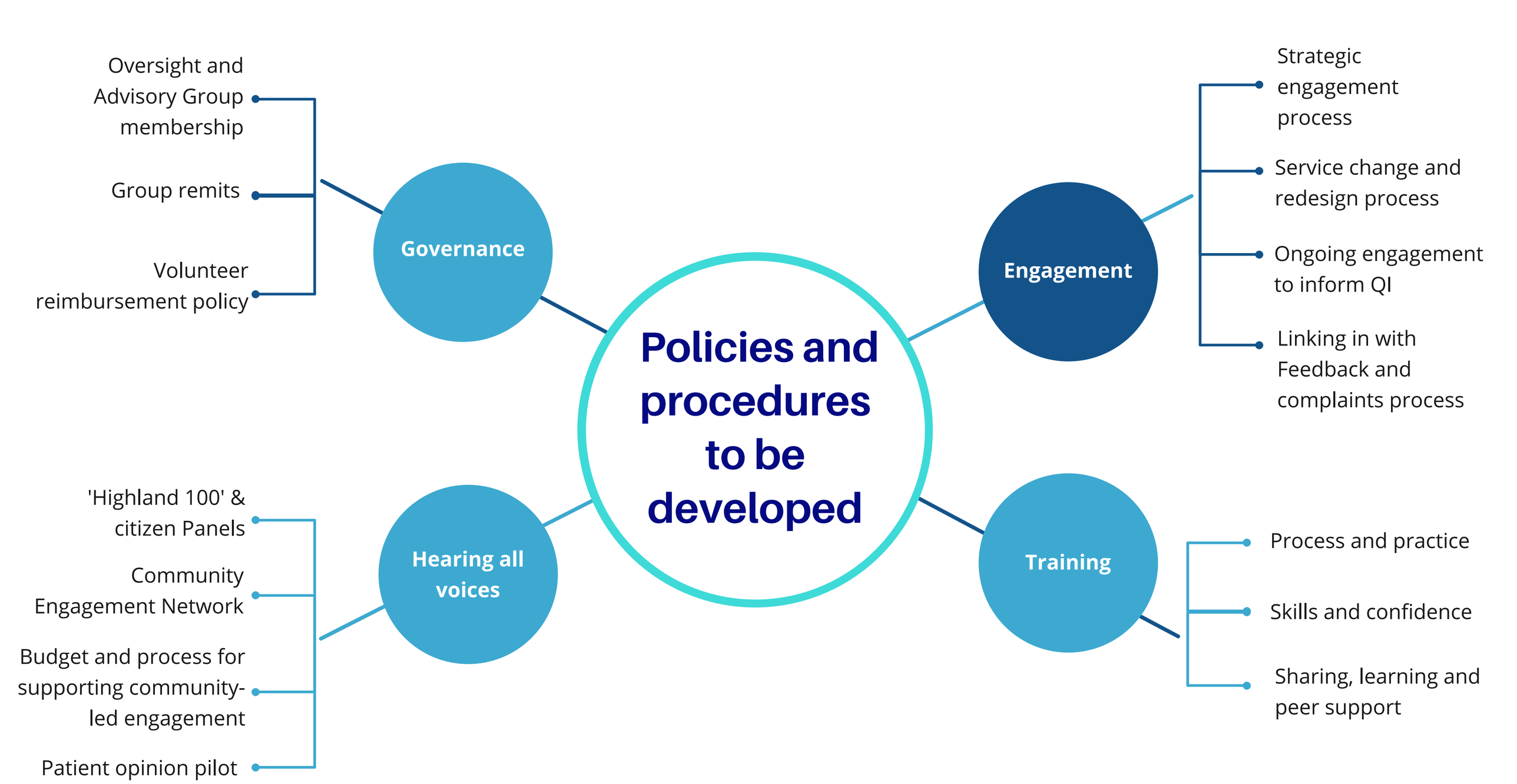
- Service redesign programmes are using the Engagement Framework and process, including required timeframes and sufficient notice, and have an appropriate, dedicated budget for engagement
- We can show that early, timely and ongoing engagement with everyone impacted by these programmes
- We can show that protected and vulnerable groups have been appropriately included *(to include numbers of people involved and support provided to enable meaningful participation)*
- We can show that feedback and lived experience has had an impact on redesign outcomes

Service improvement level

- Service improvement projects are using the Engagement Framework and process, including appropriate timeframes and sufficient notice, and have a budget for engagement
- Impact assessments will inform engagement plans and activity
- We can show that engagement, based on each project's bespoke objectives, has listened to feedback from appropriate audiences
- We can show that feedback and lived experience has had an impact on service improvement and changes made

Operational level

- Training and awareness sessions are well received, and templates and support materials well used
- Relationships with stakeholders improve and new relationships are forged
- People will be supported and empowered to share their lived experience and feedback in a range of ways
- People will be empowered and supported to identify and lead on improvement areas important to them
- Improvements are informed by ongoing, regular conversations with people, communities & partners


Policies and procedures to be developed
Governance
Oversight and Advisory Group membership
Group remits
Volunteer reimbursement policy
Engagement
Strategic engagement process
Service change and redesign process
Ongoing engagement to inform QI
Linking in with Feedback and complaints process
Hearing all voices
'Highland 100' & citizen Panels
Community Engagement Network
Budget and process for supporting community-led engagement
Patient opinion pilot
Training
Process and practice
Skills and confidence
Sharing, learning and peer support

Implementation

A three stage plan

2021- 2022
Foundations

- Start developing networks
- Start developing connections & joint working opportunities
- Establish working groups
- Agree success criteria and measurement plan
- Establish channels for regular updates
- Start developing engagement processes
- Agree governance and oversight process
- Agree central engagement channels
- Identify potential test sites

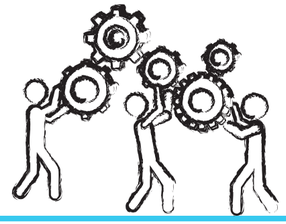
2022 -2023
Building

- Develop guidance, SOPs and mentoring approach to support tests
- Set up and test governance and reporting structures
- Test engagement processes & protocols
- Set up and test central engagement channels
- Evaluate test areas and make relevant changes
- Draft awareness raising and training materials - focusing on test examples
- Draft implementation plan
- Draft ongoing evaluation tools

2023 - 2024
Living

- Start awareness and training sessions in a tiered approach, *including; NHS Highland Board, Health & Social Care Partnerships (HSCPs), governance committees, senior managers and operational and clinical leads and project teams*
- Governance and reporting structures go live
- Process and protocols go live
- Engagement channels are in place
- Supportive structures are in place
- Ongoing evaluation and feedback mechanisms are in place

Progress so far



RESOURCES & SUPPORT

Additional staff resource

- 1x FT Engagement Manager
- 1x PT Engagement Coordinator
- 1x FT Administrator (fixed term March 23)
- 1x FT Web Manager (developing new website)

Providing ongoing & adhoc advice & support to staff (like RNI & Ruthven Ward Refurbishment)

Specialist engagement advice and support for;

- Skye, Lochaber and Maternity Redesigns
- NHSH wide Strategies (like Together We Care)
- Delivering on Anchor Well action(s) within ADP

External resources, training and support, available, like Care Opinion, Healthcare Improvement Scotland-Community Engagement (HIS-CE), Scottish Recovery Network, The Alliance & others

TRAINING & AWARENESS

- 3x engagement & EQIA in redesign (recorded)
- 2x digital inclusion (recorded)
- 1x planning with people for lay reps
- Voices training for lay reps planning for late 2022
- Sign posting to external training and resources

TEMPLATES AVAILABLE

- existing EQIA material
- engagement strategy & action plans
- Canva infographics explaining change, processes and timelines
- Sway newsletters internal & community facing
- survey templates for patients & communities
- Argyll and Bute engagement spec template

NETWORKS & CONTACTS

Building connections with

- key partners, including; HIS-CE, The Highland Council (THC), Third Sector Interface (TSI), University of the Highlands & Islands (UHI)
- vulnerable and protected groups
- internal networks
- localities to support redesign work
- developing an overarching network

Starting conversations with key contacts about approaches and ways we can work together - effectively communicate and meaningfully engage

PROCESS

- established people for short life working group to help progress elements within the framework
- gained learning and examples from successful examples
- connected with THC, TSI & Police Scotland about joint engagement opportunities
- working up and trying out engagement processes for Skye redesign and Mental Health & Learning Disability Strategy
- Collecting examples of practice and 'how to' type information to support practice
- drafting roles and remits for groups within governance process & overarching engagement network functions
- exploring how Argyll and Bute HSCP & NHS Highlands processes can align

Produced by NHS Highland September 2022

Draft for approval 29.11.2022

NHS Highland would like to thank the everyone involved in creating this document and the frameworks within. We would particulalry like to thank the individuals, groups, communities, partners and members of staff, who took the time to share their feedback and suggestions on the draft version, as part of our initial consultation.

Credit and reference goes to, Argyll and Bute HSCP, The Highland Council, NHS Greater Glasgow and Clyde, NHS Lothian, NHS Borders, Fife HSCP, East Renfrewshire HSCP, NHS Wigan, Healthcare Improvement Scotland - Community Engagement, The Scottish Recovery Network, The Alliance, and Cope Scotland, whose shared practice, learning and advice form part of our approaches and governance structures.

Special thanks goes to our short life working group members, that include Non-Executive Board members, NHS Highland staff, managers, local partners and public representatives, who helped to coproduce this framework and the suggested models within.

Community Engagement Oversight Group

Purpose
To provide assurance that NHS Highland meets its statutory duties, the National Standards for Community Engagement and Health and Social Care and our own values, to involving people in important decisions that may affect them, the people they care for or their community.

Setting and overseeing Key Performance Indicators relating to meaningful engagement, in line with current legislation, Scottish Government Guidance and recognised good practice to ensure;

- we meet our statutory responsibilities relating to engagement and involving people in decisions that affect them
- the Engagement Framework is an integral part of NHS Highlands strategic, redesign and everyday work

Membership
To ensure sufficient analysis and assurance is provided, group membership will include;

- 2 Board Non-Executive Director members,
- Senior Managers/Programme leads Health and Social Care
- 2 members of the Advisory Group
- Carer representative
- Communications and Engagement Manager/Head of
- Equality Officer/lead
- Information officer/lead
- Third Sector and partners

Meetings
Quarterly meetings will take place, to oversee live and planned processes to ensure priority projects are scrutinised promptly. An agreed set of key performance indicators will be used to measure criteria for meaningful engagement and successful sign off before projects can move to the next stage in the governance and/or redesign process.

Exception reporting could be arranged if needed.

Quorum
For a meeting to progress a quorum is needed, for this group a quorum is defined as at least 5 members. Including

- 1 Non-Executive
- 1 Communications and Engagement
- 1 Partner or Third Sector representative.
- 1 Advisory Group
- 1 Senior Manager

Remit
The group will oversee engagement processes, to check that proportionate, meaningful engagement informs decision making in key projects, strategy developments and service redesigns, considering;

- potential impacts and if an EQIA (Equality Impact Assessment) has been completed, in line with Equality Act 2010, Fairer Scotland Duty and Islands (Scotland) Act 2018,
- scale and status of change – note, major service change requires external assurance from Healthcare Improvement Scotland - Community Engagement
- transparency, accessibility, availability and frequency of information and communications with those affected, partners and local communities
- appropriate and proportionate stakeholder involvement, considering vulnerable, protected and less heard from individuals, groups and communities
- opportunities for people most affected to inform and influence plans and key decisions in decision making process
- opportunities for co-production , co-design, and innovative practice in partnership with others
- evaluation of and learning from engagement processes and activities

Shares engagement metrics and findings with services for improvement purposes

Authority
The engagement model and values have been coproduced with a short life working group, consisting of NHS Highland staff, managers, Non-Executive Board members, public and carer representatives and key partners and has been approved at Health and Social Care Partnership and NHS Board level.

Community Engagement Advisory Group

Purpose
A group of mixed stakeholders from different backgrounds and experiences, to provide feedback, advice and share good practice to inform the development of inclusive and thorough engagement plans and procedures on key projects within NHS Highland.

The group will support the development of networks and engagement related training to help embed the Engagement Framework as part of our everyday practice and procedures.

The group will also act as one of our ‘expert sources’ to;

- provide comment, advice and identify potential gaps and appropriate approaches on draft public facing information, surveys, and engagement methods

- and, reach and hear experiences from protected, vulnerable and less heard from voices within our communities

Membership
Group membership will include;

- Public representatives
- Communities of interest and/or experience representatives
- Carer representatives
- Young peoples
- Representatives from vulnerable and protected groups and trusted partners
- Equality Officer/lead
- Deaf Services & See Hear Highland Education & Learning Services [SHHELS] and Speech and Language
- Third Sector and private and statutory partners
- Healthcare Improvement Scotland – Community Engagement
- NHS Highland employees
- Communications and Engagement Manager/Co-ordinator
- Service and project leads (as needed)

Meetings
Bi-monthly meetings will take place, to provide advice and support to live and planned processes to ensure priority projects undertake early and meaningful engagement with affected individuals and communities. Documents and supporting information for agenda items will be emailed out to group members one week in advance, where possible, to allow time for people to read and prepare advice or questions in advance of meetings. Documents can be printed and posted out to members on request.

Quorum
For a meeting to take place a quorum is needed. For this group this is defined as at least 6 members, plus project or service leads requesting advice.

This should include 1 representative from:

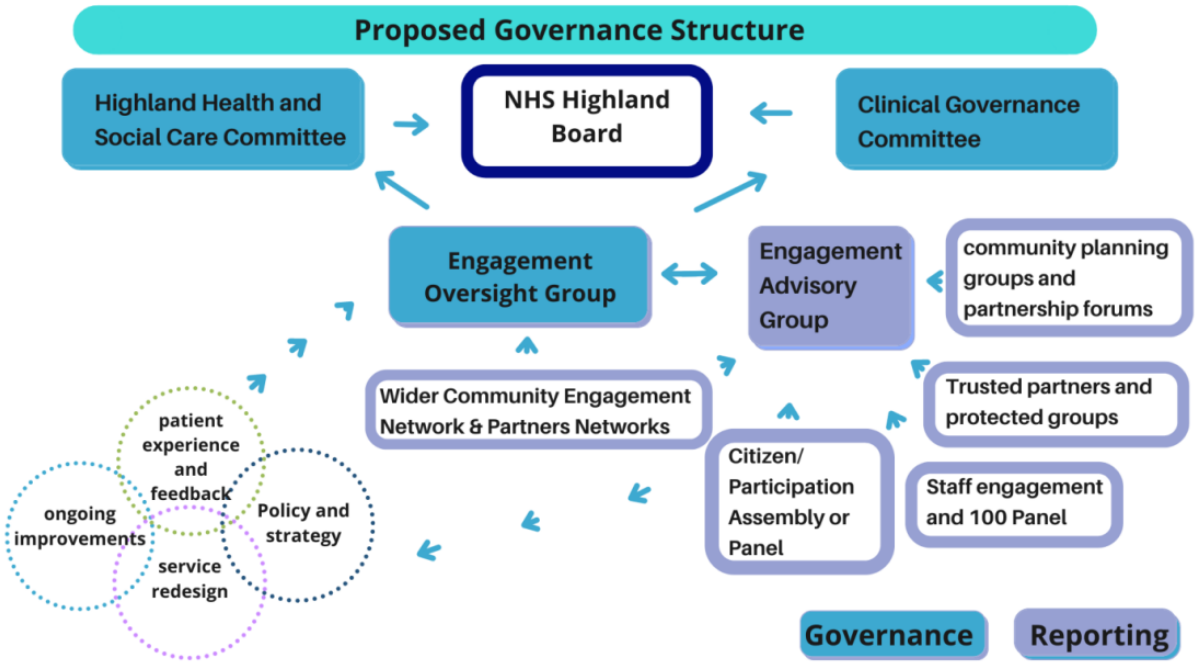
- The community
- Communications and Engagement team
- Trusted partners
- Project lead or service manager (for specific engagement advice requests)
- Community of interest/experience
- Vulnerable or protected groups
- Carer

Remit
The group will provide advice and support to inform engagement processes, to help ensure that they are inclusive, proportionate and will lead to meaningful engagement

to inform decision making in key projects, strategy developments and service redesigns, considering;

- If the people most affected have been identified in plans – this information should be part of Equality Impact Assessment on engagement plans, considering vulnerable, protected and marginalised groups identified in Equality Act 2010, Fairer Scotland Duty and Islands (Scotland) Act 2018,
- advice about accessible information and communications and best ways to share this with representative groups/communities
- advice relating to best ways to engage and involve vulnerable, protected and less heard from individuals, groups and communities – methods and connections and links to groups/communities, advice about support needed and available
- share ideas, approaches, methods and best practice for developing plans and options in partnership with others when designing plans and future services
- share examples and experience of Co-production , co-design, and innovative practice
- act as a source of advice and testing for major service change plans and approaches (note major service changes are externally assured by Healthcare Improvement Scotland - Community Engagement)
- support evaluation of and share ways to capture learning from participants to inform future engagement processes and activities

Reporting arrangements



NHS Highland Engagement Framework Summarised Feedback and linked Changes

The NHS Highland Engagement Framework has been created organically, through conversations, meetings, discussions and shared learning with many individuals, groups, organisations, including examples of already established processes and resources from other areas.

During July 2022, NHS Highland also shared a draft of the Engagement Framework with staff, communities and partners for comment, as part of the frameworks final development phase.

Feedback was captured and shared via email, one to one phone or teams and group meetings, Board Development meeting and Short Life Working Group meeting. Approximately 20 items of feedback were received from a range of sources, including, members of the public, community groups, community councils, partner organisations, third sector organisations, staff, managers and NHS Highland Board members.

Below shows a table noting the changes that have been made due to the feedback we received.

Changes made	Summarised linked feedback	Further actions
Indicators added to reflect lived experience	Verbal feedback received from partner organisation relating to indicators and adding lived experience as part of measurements	Indicators to be reviewed by Oversight group once in place
Complaints and feedback linked into the framework and the processes within	Verbal feedback from various sources relating to how framework connects and links in with NHSH established feedback and complaints process	Further thought and development of processes and procedures to enable stronger and clearer links to be made
Care Opinion trial is currently being planned and progressed by engagement team to capture and share learning. Care Opinion provides different routes to enable people to give feedback. This includes written or drawn, online via their website, on the phone	Verbal feedback from community member relating to making feedback easier for people to give	Learning from trial shared and soft roll out of Care Opinion planned and supported Developing training, tools and resources to support a wide range of ways to capture feedback from people in accessible and preferred ways
Argyll and Bute are currently conducting a review of their strategy. Updated and used	Verbal feedback from multiply sources, querying if the Framework includes Argyll and	Continue to support the review of Argyll and Bute engagement strategy and

existing Argyll and Bute planning and flow chart templates to support implementation of North Highland Framework and create consistency. Included explanation and a link to Argyll and Bute's Strategy in North Highland Framework for clarity.	Bute Health and Social Care Partnership, and if not to clarify the relationship between the two engagement strategies	explore opportunities to combine or dovetail processes, procedures and support.
No changes made	Query from staff member regarding plans to introduce portals for patients to access results and reports, similar to NHS England	Consider if this fits within the engagement framework portfolio or if it belongs a different directorate
Sources of reference and examples used added and links provided throughout document and at the end of the document Page name also changed to 'Levels of Engagement' to provide clarity	Written feedback from partner organisation about 'Our Engagement Model page 7' consultation version of the Framework – asked if a blended model from a number of sources and to provide references to any models used	None
Document written in plain language, acronyms have been removed or explained where possible. Tools and resources with clear guidance and links to policy, and resources relating to accessible information and communication, have been developed and are being tested within test sites.	Written and verbal feedback from various sources, need to improve our patient communication in general and to keep abbreviations/acronyms to a minimum, using terms in full where possible or explaining them where not	Continue to develop ways to communicate with people using methods that suit differing needs and preferences Develop training, guidance and links to existing resources, examples and requirements for accessible communication and information
Reference was linked to Voices training (Chest Heart and Stroke Scotland), link to website explanation now included	Written feedback from partner organisation, relating to the Training and Awareness box on page 13 – query if referring to the VOiCE online engagement tool or Voices Scotland training for lay representatives?	
Remote and rural added and recognised in the framework slide as 'lived experience'	Verbal feedback from a community member that living in a remote and rural area is a lived experience.	

None - lived experience is referenced and incorporated as an essential element throughout the Framework and is at the very heart of informing all of the supporting features in a variety of ways.	Verbal feedback community member, raising that internal governance slide does not mention lived experience – is this is a potential gap for decision making	
Framework updated to include more Standard Operating Procedures (SOPs) and policies to support the implementation of the framework EQIA is highlighted and noted as an essential element both within the Engagement Cycle Slide and supportive resources that have been created for staff and managers.	Verbal feedback community member suggesting Equality Impact Assessments should look at the needs of disabled people, as well as other protected groups. Making sure that the needs of people with physical, learning and neuro diverse disabilities are equally recognised and considered. Also to involve disabled people in designing engagement processes and for more policies to guide staff which will lead to better practice	Develop relevant SOP's and policies – suggest list be reviewed and updated periodically following a partnership approach EQIA training and awareness to be refreshed as part of training and awareness package, working with key partners to ensure it is sufficiently inclusive and robust
Initial training and links with Ability Net, Deaf Services & See Hear Highland Education & Learning Services [SHHELS], and British Deaf Association have been established.	Verbal feedback community, suggestion for disabled people to participate and share experience as part of staff training and awareness sessions.	To be explored in greater detail with relevant partners, as part of the next phase of developing training
Framework supportive tools have been created to support holistic views of patients, following a value based and what matters to you, approach. These have been approved by the SLWG and are currently being tested by a small number of live projects.	Verbal feedback community, engagement should capture the holistic views of patients, unpaid carers and their situations.	Approaches to be further developed in partnership, as implementation plans progress and skills, practice and contributions grow. Continue to support the formation and development of the carers union and to work with partners to ensure views of carers are heard and incorporated.
The two governance slides have been combined into one and an additional functions slide created, to describe functions and the makeup of groups within the governance structure.	Written and verbal feedback received from various sources about the clarity and functions of the groups within the proposed governance structure.	Reporting arrangements and related timescales to be agreed with HHSCC and Clinical Governance Committees and approved by NHSH Board during November 2022.

Draft role and remit documents have been created for both the Advisory and Oversight Groups.		
What does it mean to me slide, states that it applies to all NHS Highland health and social care staff at all levels.	Written feedback from staff member, querying if the term NHS staff includes primary care	Further development of processes for some areas of primary care are required, in partnership with GP practices and other affiliated practitioners and commissioned services
Resources and tools have and will continue to be developed to support staff to implement the engagement framework into their everyday and improvement or redesign work.	Written query from staff member regarding how local teams will put the framework into action and how they would select the groups and sectors in the community to engage with.	Continue to develop tools, training and resources in partnership, testing via identified test areas. Arrange training, awareness and peer support sessions to support transition to this way of working.
Training, tools and resources are being drafted to support staffs skills, understanding and practice regarding effective and meaningful engagement. The Advisory and Oversight group remits have been developed and will provide an additional source of advice and support and will be able to identify gaps and people or groups who are missing from engagement. Community Led Engagement idea was created through feedback received and will provide a way for groups and communities to identify and resource engagement meaningful to them. The governance structure has been strengthened in order to provide an additional layer of assurance that	Written and verbal feedback from various sources relating to effective, meaningful engagement not being 'easy', and can become "tick the box" by solely focusing on 'usual suspects' and those already engaged, like active/visible representative groups or organisations. Need to include vulnerable and protected groups and 'overlooked' sections of communities, as well as those who provide informal support to these groups and people. Need to also ensure investment in public/patient representatives/user led organisation and for the right staff to be there to support this to happen.	Continue; - to develop and adapt training, resources and support - Establish governance structures and groups - develop and grow networks and relationships with trusted partners and communities - develop process and means to support community lead engagement process

engagement has been meaningful and that the people who are most affected have been proportionally involved in decisions.		
Number of test sites are currently following the framework using different approaches – these will be written up as examples and used in the next phase to demonstrate different approaches in practice and sharing learning and techniques	Written feedback from partner, would be meaningful to have a slide which showed particular examples of new types of engagement working well on different projects to really demonstrate the framework in practice	Continue to develop approaches and capture learning to share. Emphasis for all is values based engagement of lived experience and partnership working, with everyone affected or involved.
Transparency, engagement informing decision-making and feedback are main features of the engagement framework. Added slide to clearly demonstrate the planning with people engagement cycle that explains decision-making and highlights feedback as a part of the process.	Written feedback from partner, not clear how people will really know that their input has made a different. How will participants get feedback (where/when will updates be circulated and in what format)? How will the public know what has changed as a result of community engagement – lessons learned or actions taken?	The establishment of communication and engagement channels to support this way of working are part of the next phase of the Frameworks development. Including - developing ways to receive and provide feedback - establishing and linking with existing networks - developing stakeholder panels and community led engagement as described within engagement framework
Engagement Cycle and NHSH steps added to create clearer process for continual engagement and conversational approach	Feedback from various sources, move to continual engagement and conversation, rather than peaks and troughs	This theme to be a reoccurring and key theme for training and support materials
NHS Highland has an established reimbursement policy and process	Feedback from various sources relating to volunteering expenses and payments and the need to ensure that people are supported and the time and contributions they give are recognised and fully valued.	To explore expenses and payments ideas and options with key partners and update or create polices and processes as appropriate.
Engagement Cycle and process flowchart has been developed to demonstrate where engagement sits within decision making	Written feedback from community member, community consultation should not become overly removed from the processes of	Development of training and awareness resources, materials and training to support understanding, skills and practice.

process.	decision making, otherwise there is a danger that some people can come to feel these processes are tokenistic.	Governance structure should also ensure engagement is meaningful and not tokenistic.
The Engagement Cycle slide and supportive resources have been created to make sure that engagement is inclusive and considers everyone who may be affected or involved.	Written feedback from community member relating to importance of any community consultation group to include people with a local voice who genuinely represent the variety of community views.	Awareness raising, training and peer support will form part of implementation. Governance and supportive structures should also help to ensure plans and processes are genuinely inclusive.
The framework aims to improve local networks and how we connect or work with local groups. Guidance and resources have been created to support local teams to move to this way of working and will be rolled out as part of implementation of the Framework.	Written feedback from community group we rarely hear proactively and directly from anyone in the NHS and would welcome that changing - whether this be through a network or us being associated with this framework.	As above
The framework aims to address inconsistency with how we involve people in important decisions and improve relationships and trust by working with people, in a partnership approach. Engagement processes have been created, and training, tools and resources are being developed to make sure and support meaningful engagement, that informs important decisions, takes place at all levels within NHS Highland.	Feedback from community member, “at present I am utterly shocked by the way our services have deteriorated over the years and feel that the voice of the community is completely ignored. I’m sorry that my response is so negative but I feel that I must be honest in my response.”	
No change but welcome sharing our ideas, practice and learning with others.	Feedback from Partner organisation, overall we feel this is an excellent document - it is well presented, easy to read and there is	Continue to develop local, national and wider peer networks to inform and improve practice.

Current guidance and good practice is at the heart of the framework. A review date for 2025 has been suggested to ensure that the framework continues to evolve, reflecting learning, emerging practice and changes. within guidance, legislation and duties.	good use of visuals to aid understanding. We are often asked to share examples of engagement frameworks and once this NHS Highland Framework is finalised we are keen to use as an example. It is clearly laid out and straightforward to follow It clearly describes and demonstrates NHS Highland's commitment to community engagement and involving people It makes useful reference to up to date Scottish Government engagement e.g. 'Planning with People' which is useful context for people reading the document	

12th October 2022

Together We Care
with you, for you

NHS Highland

Item 3.5

North Highland Health and Social Care Partnership Performance and Quality Report

2 November 2022

The North Highland Health and Social Care Partnership Performance Framework is a set of performance indicators used to monitor progress and evidence the effectiveness of the services that North Highland provides as aligned with the Annual Delivery Plan. The performance indicators should primarily be reported to the Health and Social Care Committee for scrutiny, assurance and review. A subset of these indicators will then be incorporated in the Board Integrated Performance and Quality Report.

North Highland Health & Social Care Partnership

In order to standardise the production and interpretation a common format is being introduced for all dashboards within NHS Highland. There is a need to establish targets for improvement measures and these will be developed for incorporation into the Annual Delivery Plan for NHS Highland.

It is **recommended** that:

- Committee consider and review the initial Performance Framework identifying any areas requiring further information or inclusion in future reports.
- Further development work is undertaken with ASC SLT to agree additional requirements for future inclusion within the overall partnership's performance framework.
- Committee to note that following the Development Session that the format and content has been amended for consistency throughout with further breakdowns to give more detailed information. Although the main focus is Adult Social Care, additional content on DHDs to community hospital level, Self Directed Support, including Carer Breaks, and Mental Health are included.

Development Session

In line with the NHS Highland IPQR, it is intended for this developing report to be more inclusive of the wider Partnership requirements and to further develop indicators in agreement with the Community Services Directorate, Adult Social Care SLT, and HHSCC members that will align with the new 'Together We Care' Strategy and the Annual Delivery Plan objectives.

A Development sessions was held with committee in September 2022 where the format of the report and ASC indicators were discussed in detail with discussion on possible indicators to be included in future reports.

Development Session Update:

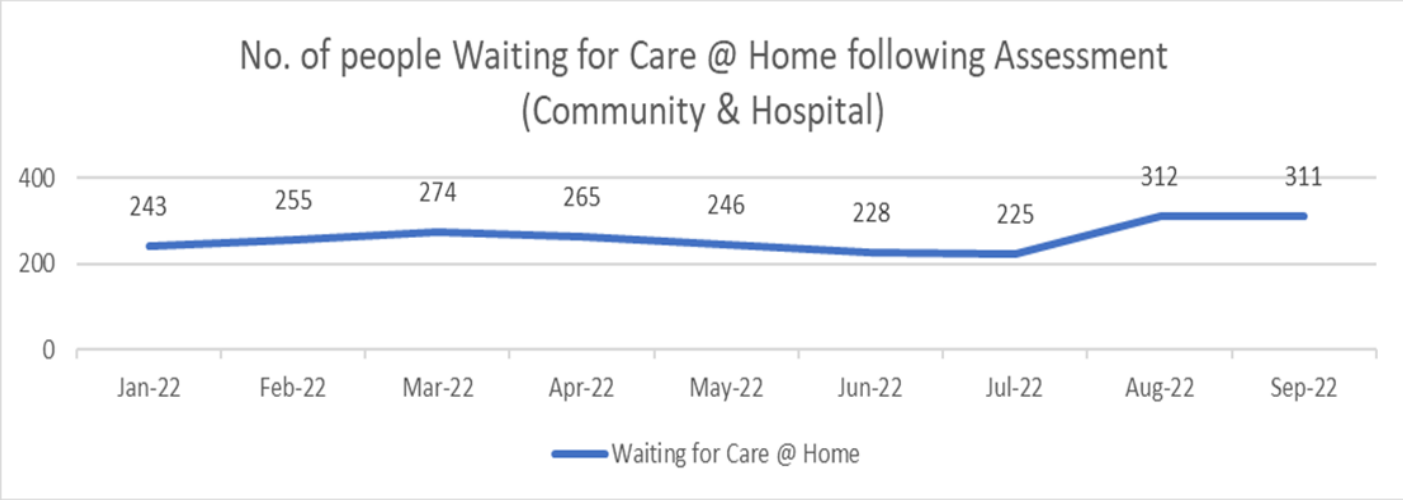
- Care-at-Home and Care Homes – further breakdown provided, 4-6 & 7-8
- Delayed Discharge – amended format now included, slides 9-10
- Self Directed Support/Carer Short Breaks – now included in report, slides 11-13
- Adult Protection included – slide 14
- Mental Health Psychological Therapies and Community Mental Health Services – slides 15-16
- Format of reporting amended for consistency
- National Integration and relevant Ministerial indicators – to be reported as an annual inclusion

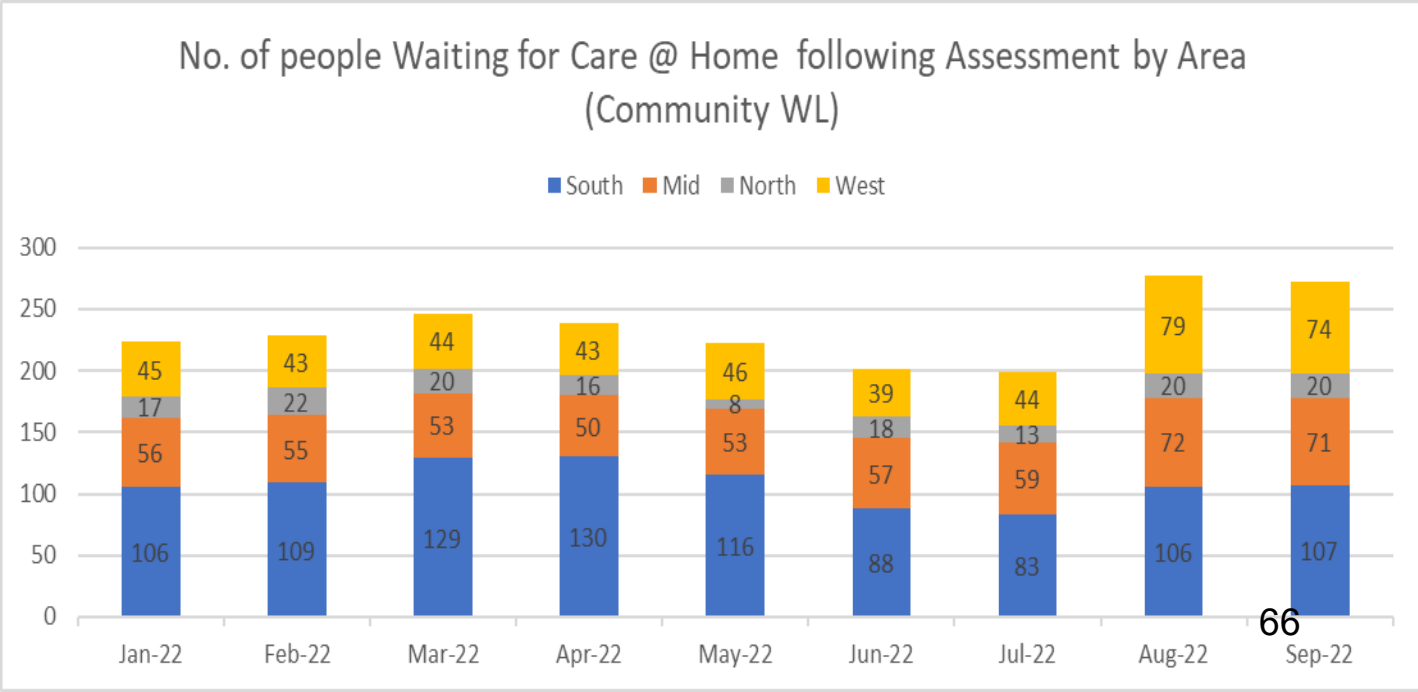
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

Priority 2 - Embed a place approach to Home Based Care & Support and care homes so that proactive care is provided tailored to the needs of the individual

Priority 9A, 9B, 9C – Work together with H & SC partners by delivering care and support together that puts our population, families and carers experience at the heart

North Highland Care at Home





Currently provided weekly as part of the PHS weekly return. This **manual** data return commenced in September 2021 and is provided by each district team weekly. Hospital DHD's are added to the community data.

It has been recognised that there is a pressing need to validate the manual weekly returns from CAH officers and support staff due to the significant fluctuation and increases since July 2022.

Graph 1 – Care at Home (Community & Hospital DHD's) – the total number of people waiting on a care at home service to commence following completion of a social care assessment.

Graph 2 – Care at Home (Area level) - the number of people waiting on a care at home service to commence following completion of a social care assessment, **community** only.

Update as at 21/10/2022

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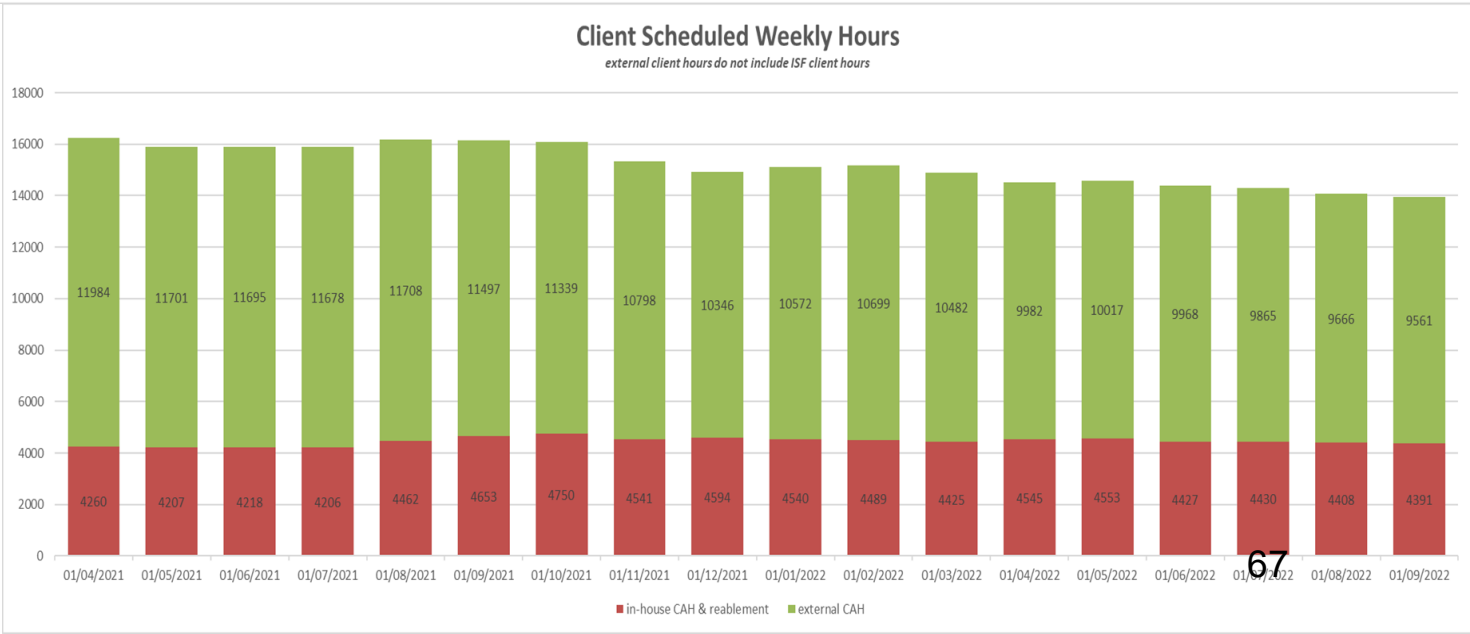

Care at Home

Significant reduction in the number of people receiving external care-at-home since April 2021 due to workers leaving employment in care. Some net growth within internal services.

Ongoing discussions with the sector to sustain services, to stimulate growth, to prepare for winter, and to release and increase capacity.

Current strategic steps/work stream activity include:
Now: Responsive capacity release, collaborative recruitment

Next:

- Strategy and ambition
- Workforce creation and development
- Contract and commissioning redesign

NHS Highland and external care providers continue to operate in a pressured environment working in collaboration with ongoing sustained staffing, and competing recruitment pressures.

Update as at 21/10/2022

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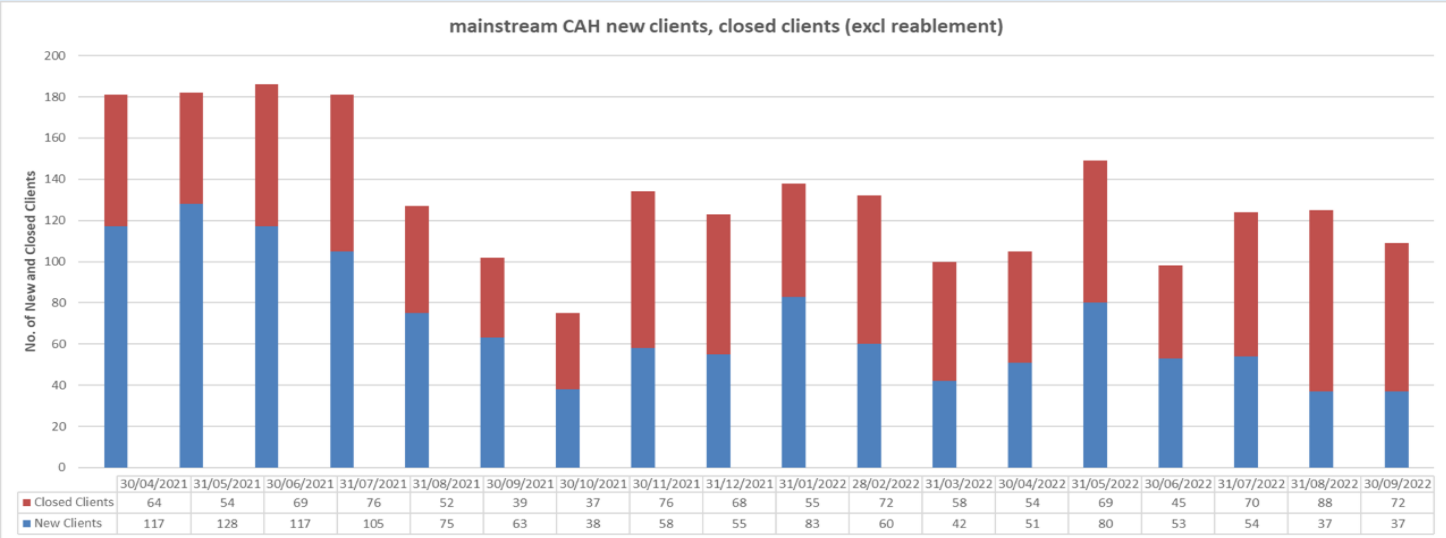
North Highland Care at Home



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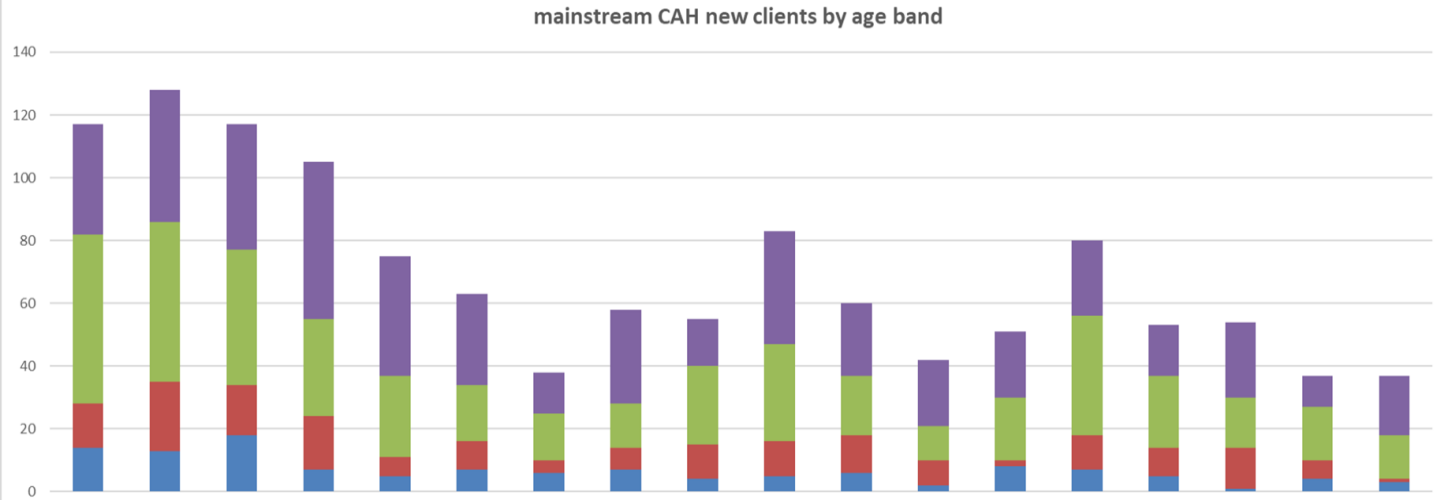
Closed Clients	64	54	69	76	52	39	37	76	68	55	72	58	54	69	45	70	88	72
New Clients	117	128	117	105	75	63	38	58	55	83	60	42	51	80	53	54	37	37



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85+	35	42	40	50	38	29	13	30	15	36	23	21	21	24	16	24	10	19
75-84	54	51	43	31	26	18	15	14	25	31	19	11	20	38	23	16	17	14
65-74	14	22	16	17	6	9	4	7	11	11	12	8	2	11	9	13	6	1
18-64	14	13	18	7	5	7	6	7	4	5	6	2	8	7	5	1	4	3

Care at Home – New & Closed Packages

Graph 1 – Shows the number of new clients and closed packages per month.

For the last reported quarter from July to September 22, please note that overall available capacity to provide a care-at-home service to new service users is challenging due to staffing related pressures in both in house and commissioned services.

Graph 2 – Shows the number of **new** care at home service users split by age band over the same period.

Update as at 21/10/2022

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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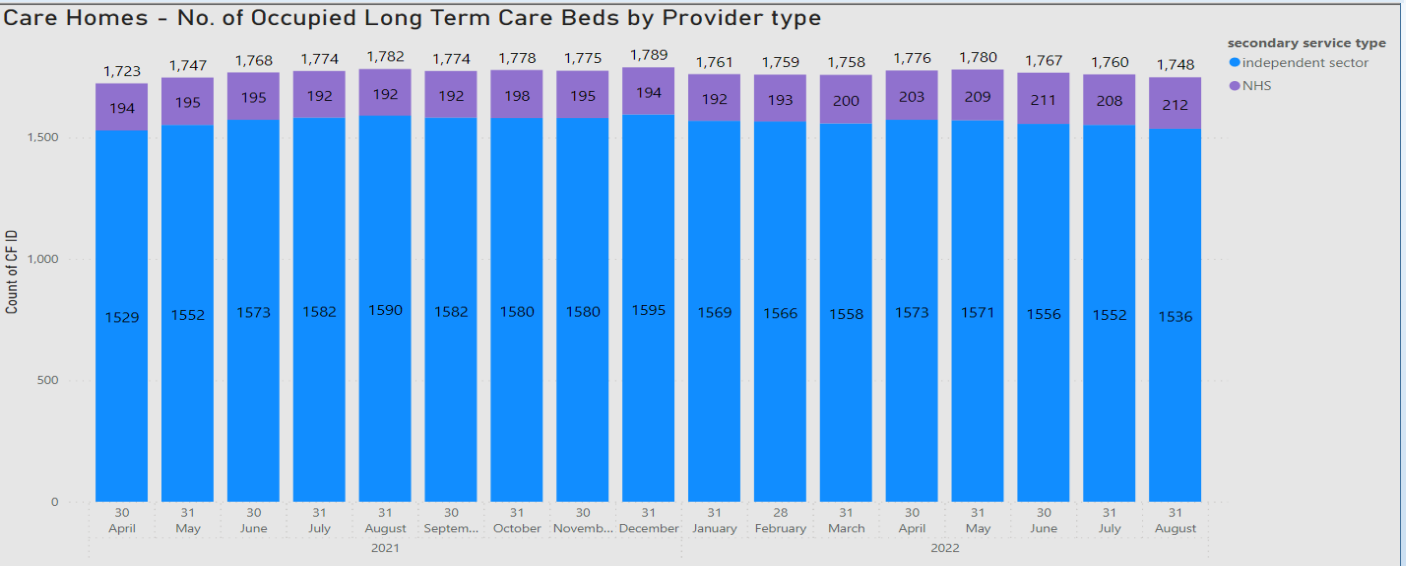
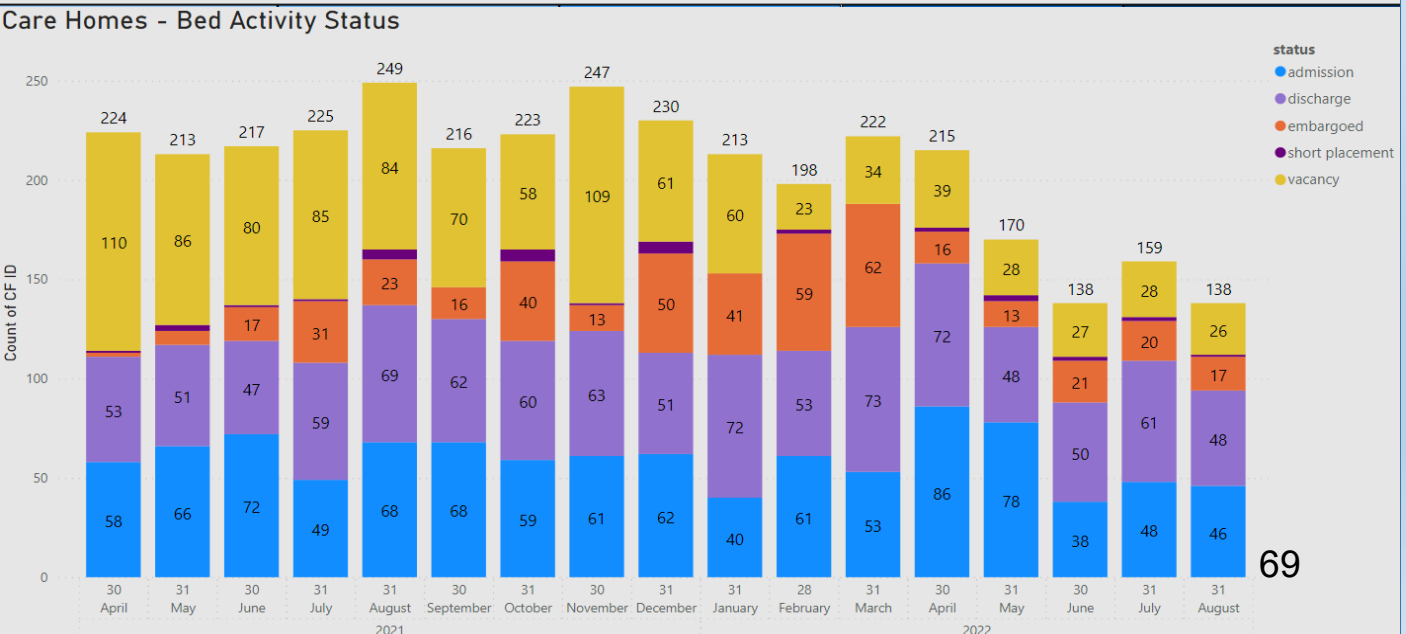
Priority 9A, 9B, 9C – Work together with H & SC partners by delivering care and support together that puts our population, families and carers experience at the heart

North Highland Care Homes





North Highland Care Homes

The care home and indeed the care at home sectors are both under significant stress and pressure. This is multi-factorial including recruitment and retention challenges, financial concerns and the remote and rural context that the services work within.

The HSCP are working closely with care home providers as the overall number of available beds continues to reduce with a number of providers leaving the sector and others expressing concerns about the future.

During 2022-23, unfortunately, 3 care homes have closed, these were Shoremill, Cromarty; Budhmor House, Skye; Grandview, Grantown on Spey. In April 2021, Eilean Dubh was registered as a new care home.

This unprecedented number of closures (usually one per annum) highlights the real challenge of supporting the care sector as various cost of living impacts, such as additional food costs, insurance, and increasing energy costs cause additional financial stress for care providers.

The HSCP are working with the Highland Council to develop a strategy for care homes and an implementation plan to span the short to longer term care environment. Development session in place for end of November.

Update as at 21/10/2022

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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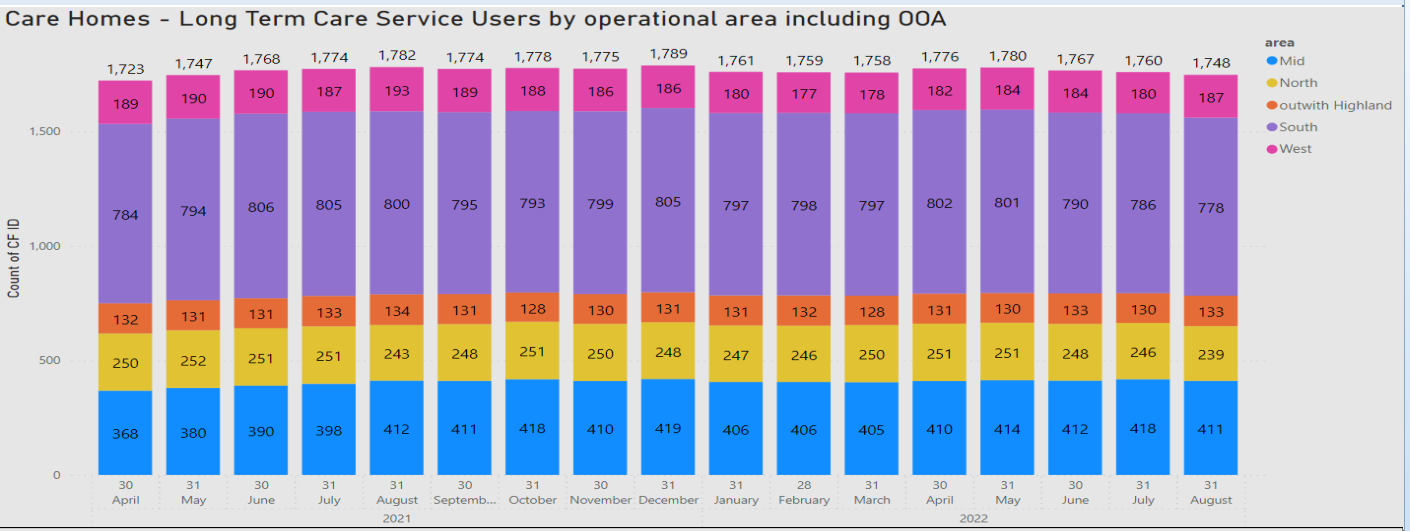
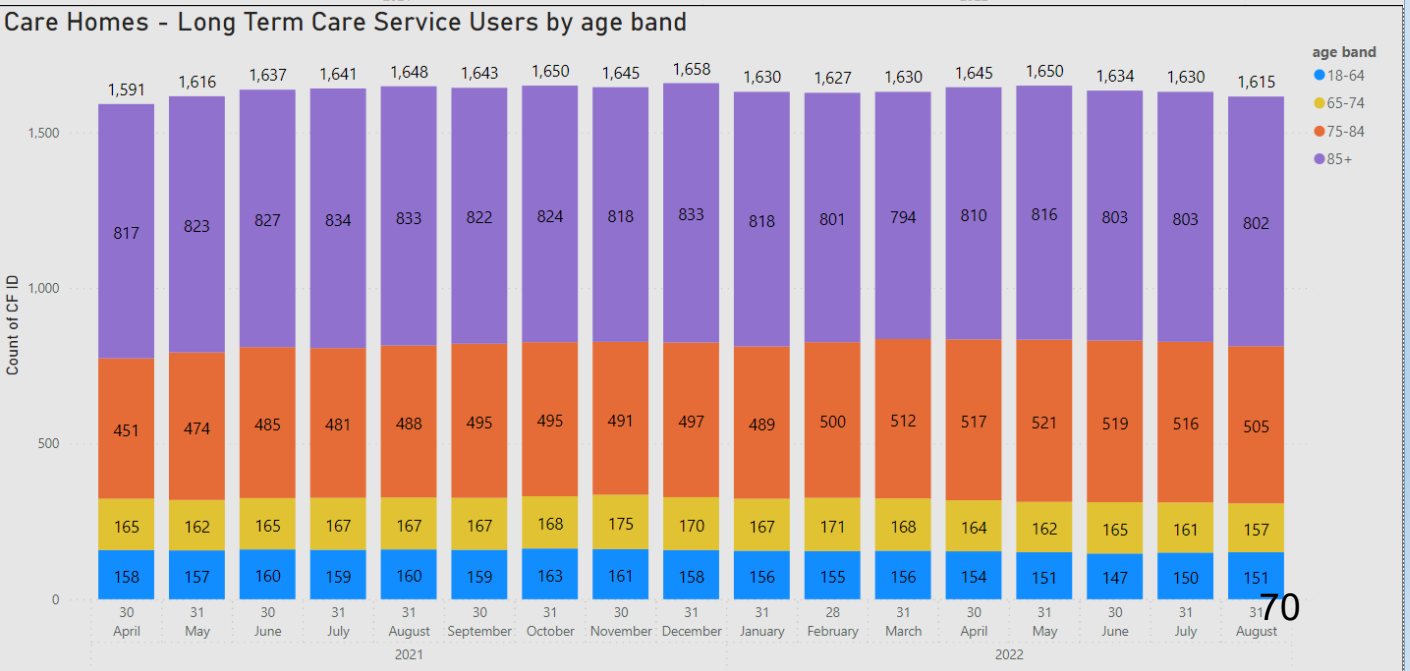
North Highland Care Homes





North Highland Care Homes

These graphs provide an overview of the occupied long term care beds for both external and NHS managed care homes by providing a breakdown by Area in North Highland (NH) and those placed out of area, but funded by NH.

South: 778 occupied care beds
Mid: 411 occupied care beds
North: 239 occupied care beds
West: 187 occupied care beds
Out of Area: 133 commissioned care beds

In addition a further breakdown is provided by the current age of those service users for North Highland only, showing 46% are currently over the age of 85 in both residential and nursing care settings.

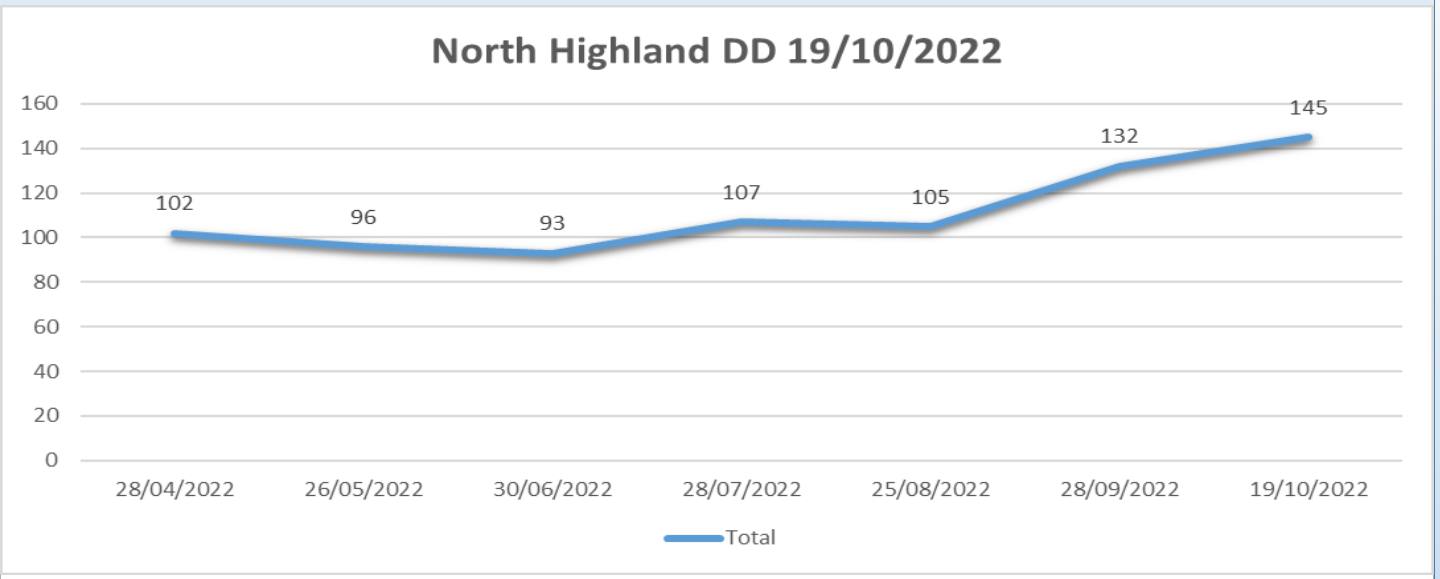
Update as at 21/10/2022

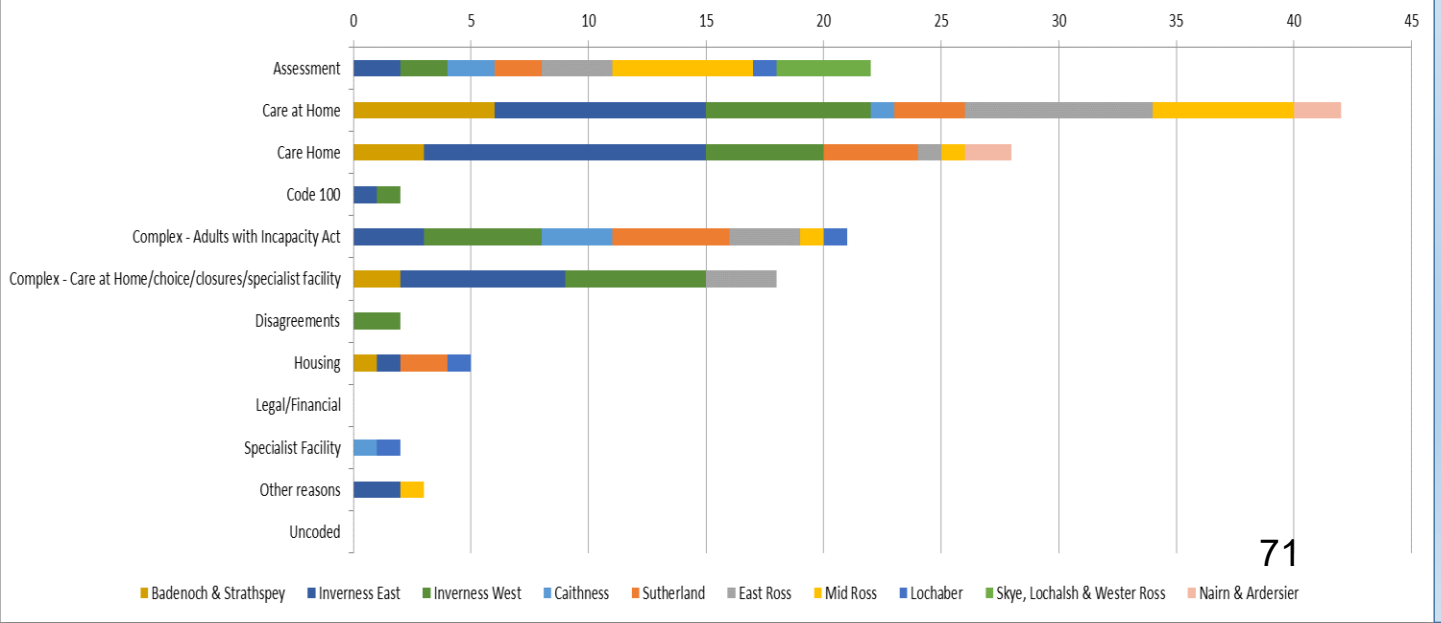
Strategic Objective 3 Outcome 11 – Respond Well

Priority 3 - Work to minimise the length of time that hospital based care is required. We will work with you, your family, and carers to adopt a "home is best" approach

Priority 11C – Ensure that our services are responsive to our population's needs by adopting a "home is best" approach

North Highland DDs





Performance Overview North Highland

There is no national target for delayed discharges but we aim to ensure we get our population care for in the right place at the right time. *145 delayed discharges in October 2022 with 21 of those are code 9 (complex). Delayed discharges across all of our sites have risen significantly since end of June. The reason for those awaiting discharge are shown across districts.*

Delayed discharges remain a concern both nationally and within NHS Highland. They are part of a bigger picture of a system under strain as well as the need to ensure we are focusing on reshaping how we work together.

There is a close relationship between the unscheduled care work required across the system and the level of delayed discharges alongside the competing challenges within acute and community services. There is a need for quality improvement work across a number of areas. This work is in progress with a number of key developments underway . This is though in the context of significant system pressure such as in adult social care and the need to effectively manage change across the organisation.

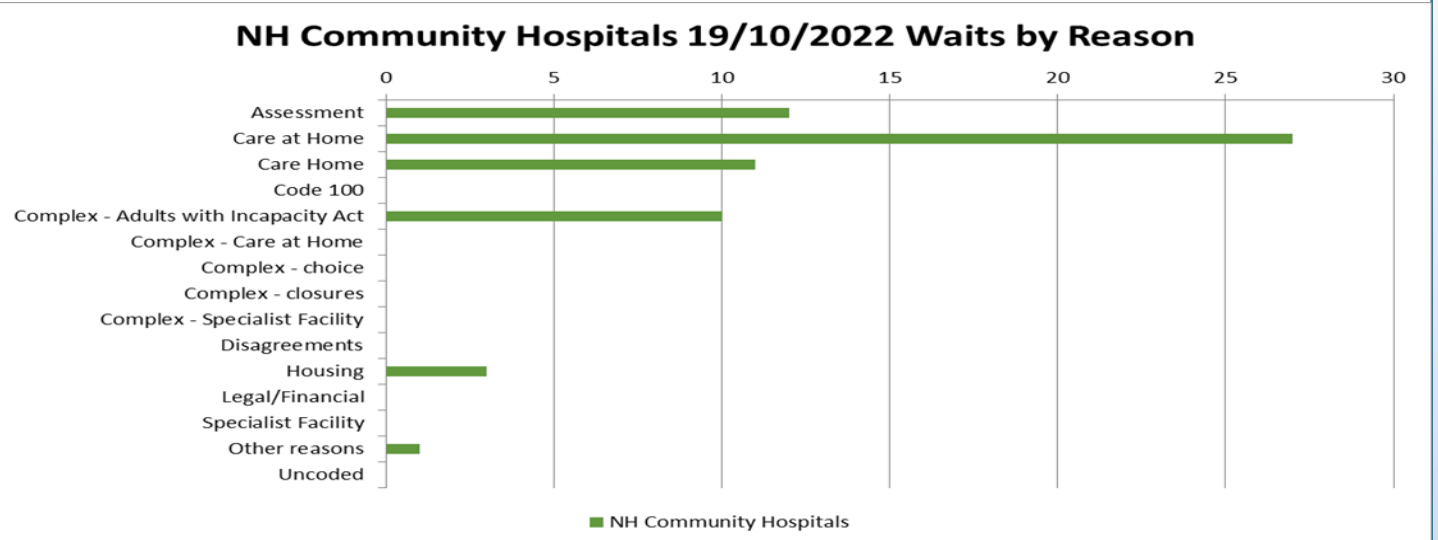
Cross system working is key to ensuring success of this work as long as benchmarking from other areas to achieve sustainable improvements.

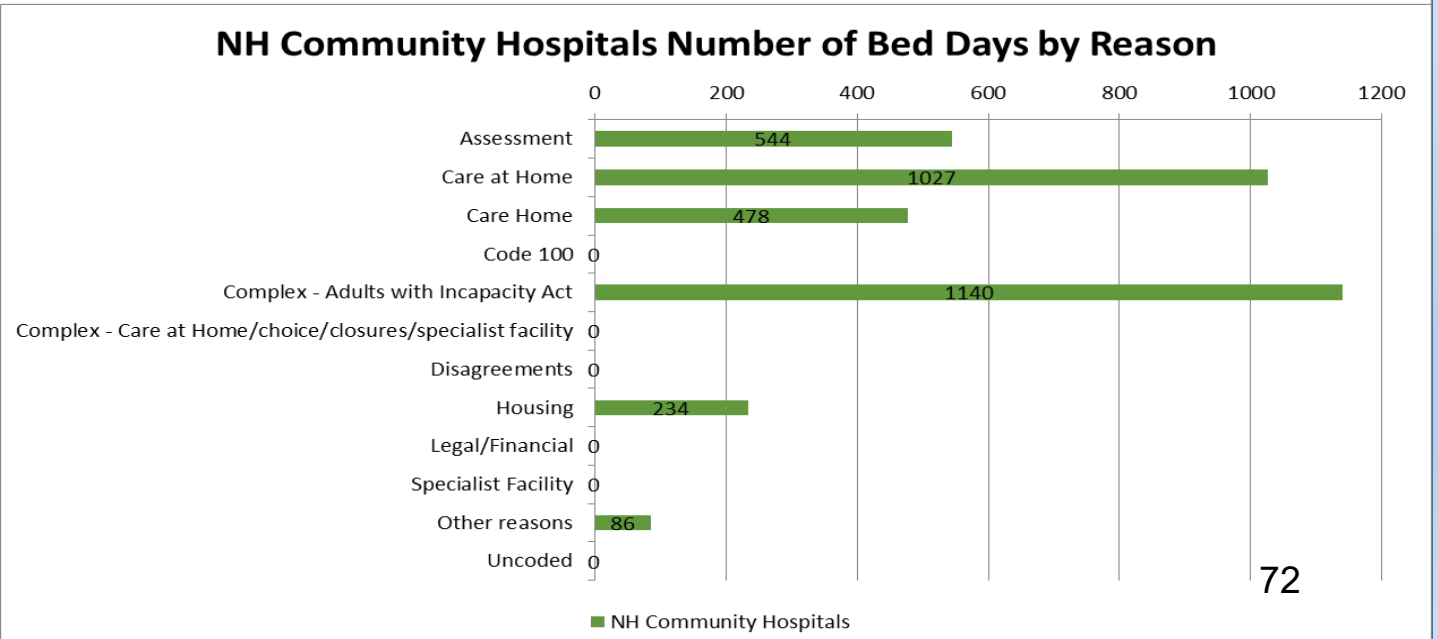
Strategic Objective 3 Outcome 11 – Respond Well & Care Well (Delayed Discharges)

Priority 3 - Work to minimise the length of time that hospital based care is required. We will work with you, your family, and carers to adopt a "home is best" approach

Priority 11C – Ensure that our services are responsive to our population's needs by adopting a "home is best" approach.

North Highland Community Hospitals DDs





Performance Overview North Highland

There is no national target for delayed discharges but we aim to ensure we get our population care for in the right place at the right time.

Of the 145 delayed discharges at 19/10/2022, 64 are in North Highland Community Hospitals. 13 are in New Craigs hospital and all other delayed discharges are in acute hospitals.

Update as at 21/10/2022

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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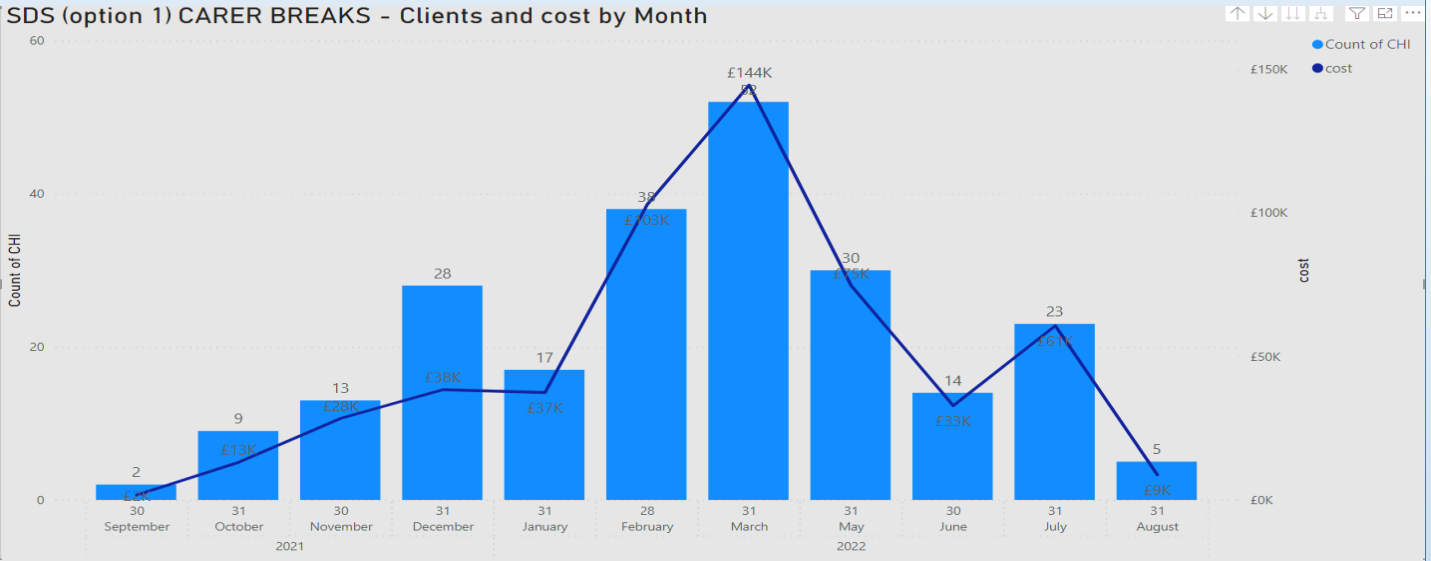
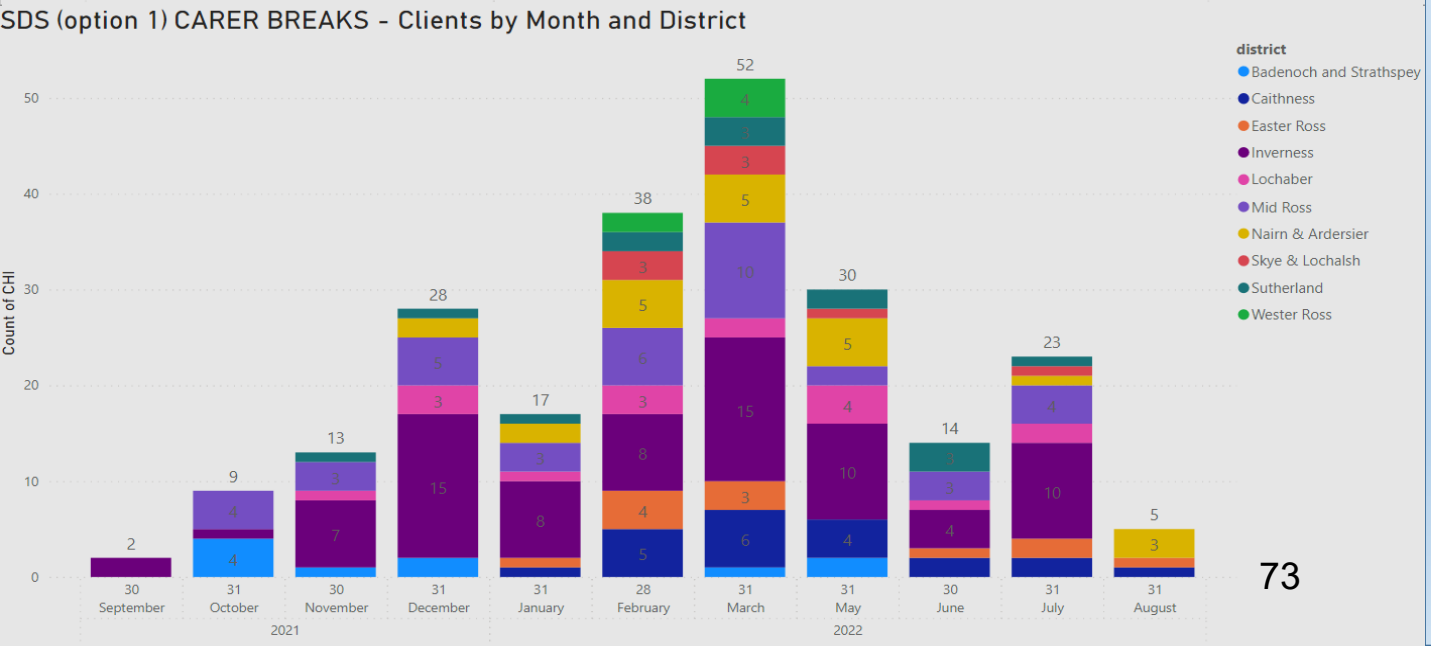
Carer Breaks – Option 1 (DP)





SDS Option 1 Carer Breaks

As reported to previous committee and included in previous Carer Programme update reports, this scheme to support unpaid carers started in September 2021 and is an integral component of a balanced "carers programme" aimed at meeting our duties under the Carers Act.

The peak of this scheme was during February to April 2022 with at the end of August, some 231 individuals benefitting.

It is the aim of NHS Highland to ensure that unpaid carers continue to access a range of services and we are committed to supporting carers, while maintaining our Option 1 short breaks scheme to increase the access of carers to flexible, personalised ways to provide them with a break.

It is well evaluated and continues to be well received by carers and their families.

Update as at 21/10/2022

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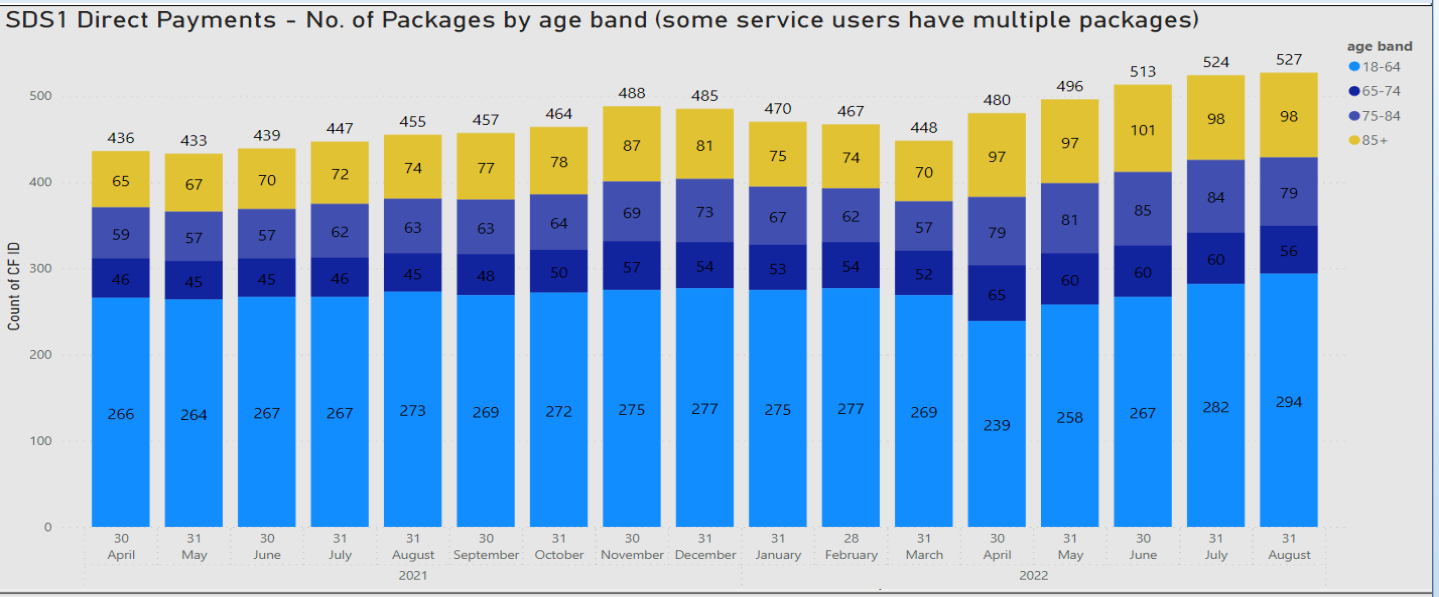
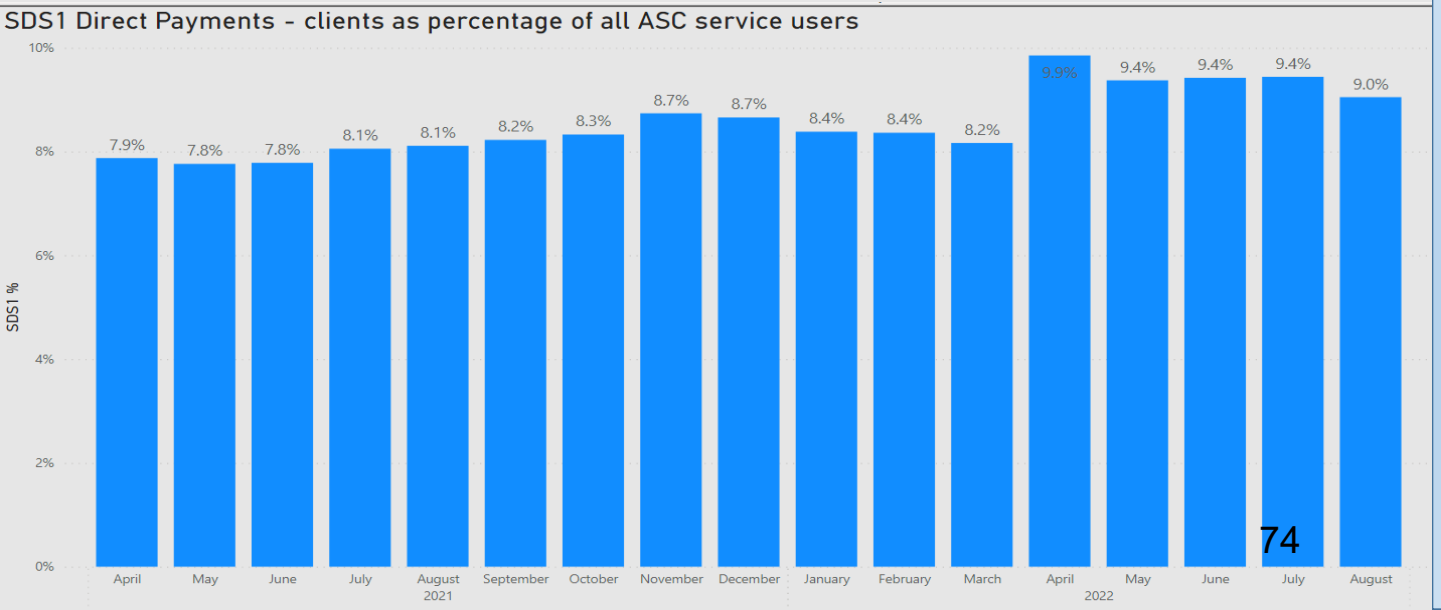
Self Directed Support – Option1 (DP)





SDS Option 1 (Direct Payments)

Demonstrable and sustained growth in Option 1 although we have seen a recent reduction since peaking in April 2022 with above average trend increases in some of our more remote and rural areas, for example, the increase in Skye, Lochalsh and West Ross could highlight the lack of alternative care options and a real market shift/resource pressure.

Our current number of active service users receiving a direct payment is 530 with a projected annual cost of £9.9m.

As an integral component of our Self Directed Support Strategy, development work continues with the SDS Peer Support Group, a group representing users of these services, and Community Contacts to design a co-produced proposal with NHS Highland which will identify and include the core cost components and move closer to identifying the "true cost" of delivering care for Options 1s.

Update as at 21/10/22

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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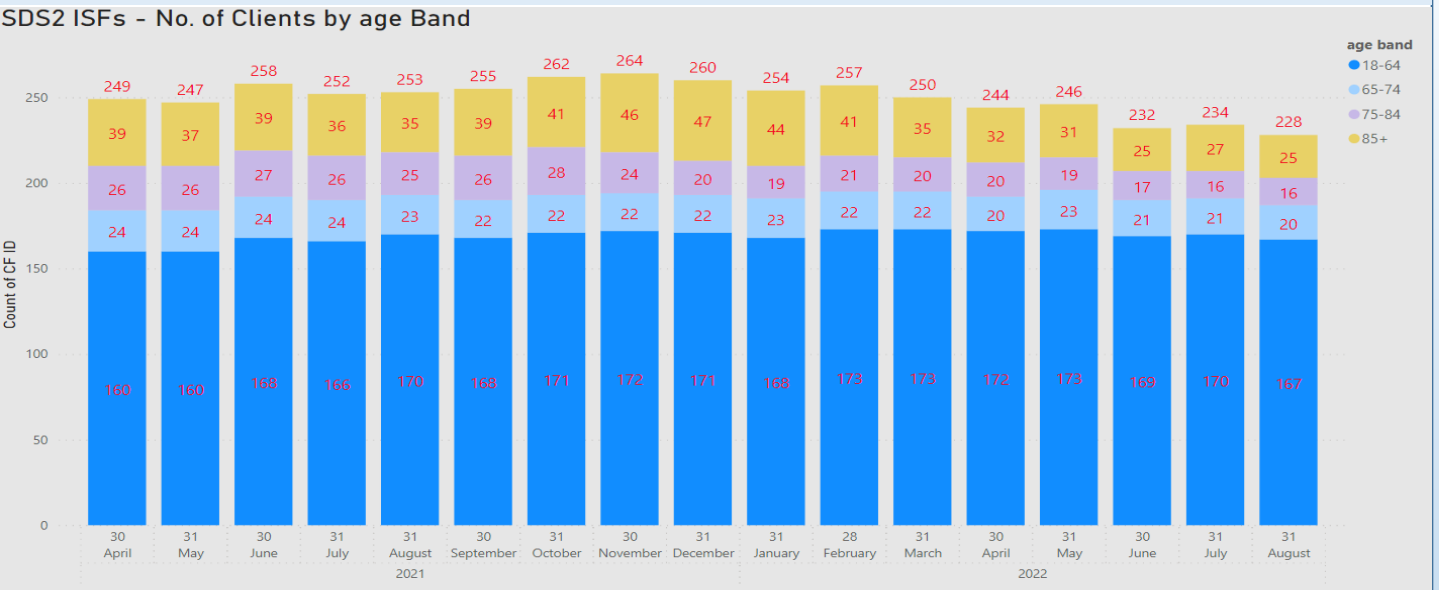
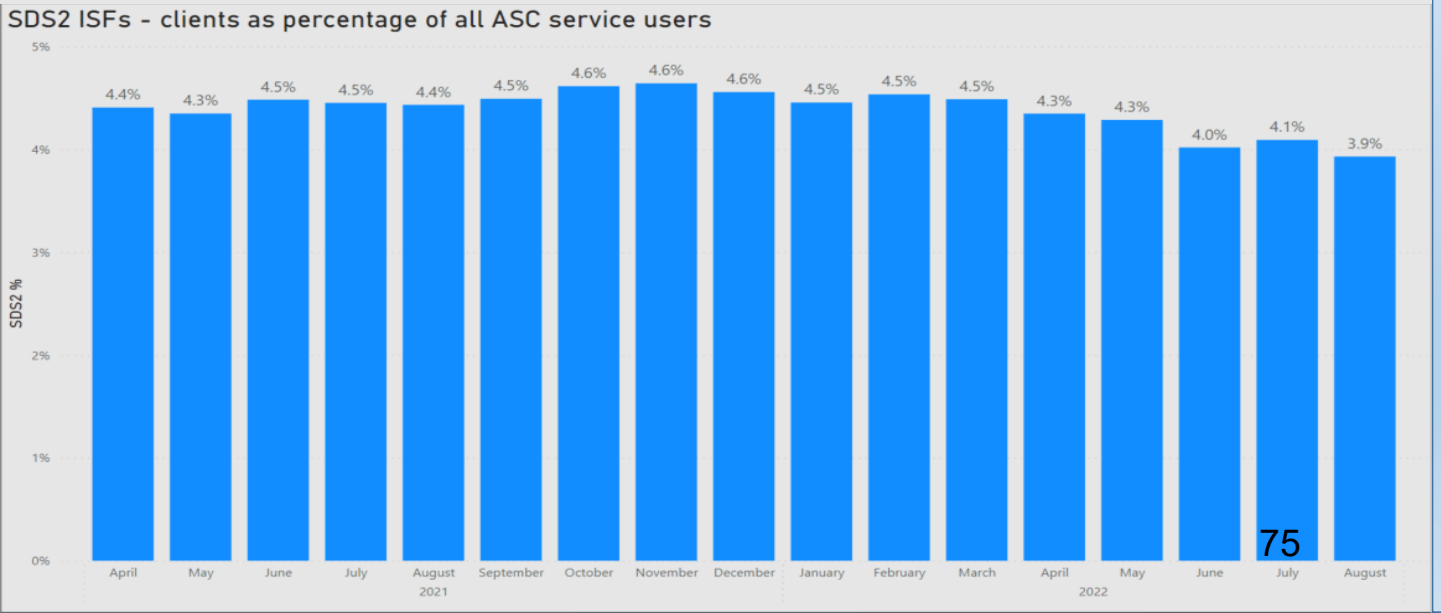
Self Directed Support – Option2 (ISF)





SDS Option 2 (Individual Service Funds)

Recent reduction in the overall net number of ISFs split by age band

Our current number of active service users receiving an individual service fund is 228 at August 2022 with a projected annual cost of £4.85m.

As a component part of our Self Directed Support Strategy, work continues in partnership with In Control Scotland as a participating site (there are 6 other partner agency sites across Scotland) to work together to better understand any barriers to ISFs.

There were **6 key** recommendations across the participating Scotland sites:

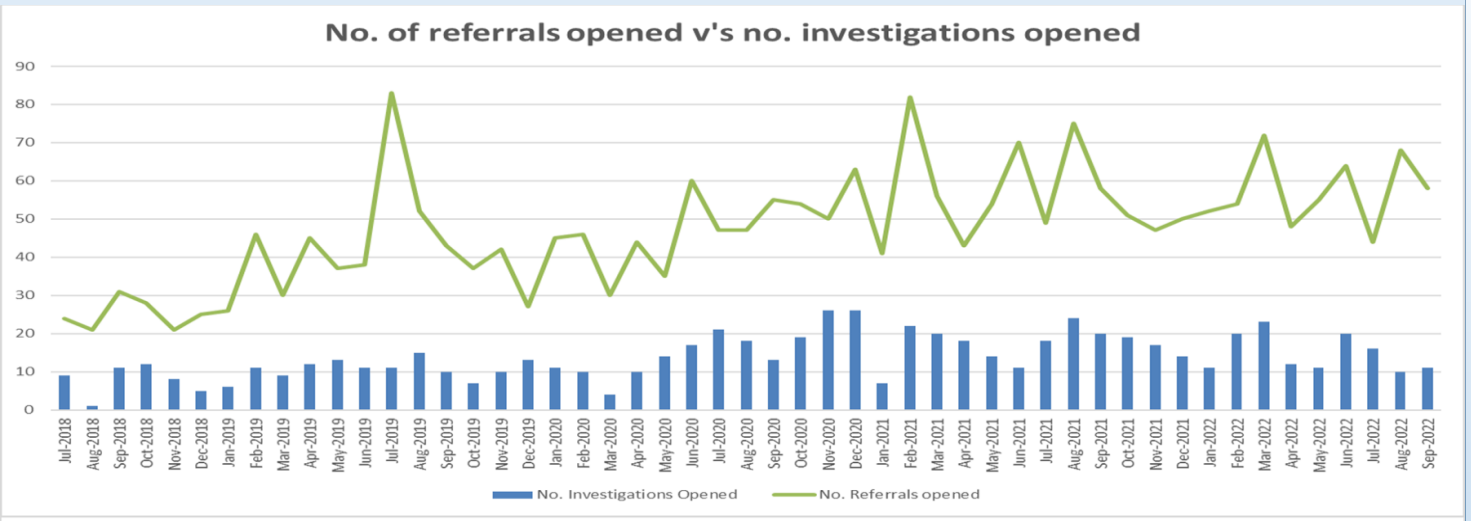
- To revisit the definition of Option 2 to reach a consistent starting point in all areas
- To proactively increase worker autonomy
- To identify and address the key blockages to real change in the commissioning landscape
- To agree a national standard in relation to whether or not ISFs should be held and managed by the local authority (not NHS)
- To positively and proactively incentivise provider engagement
- To build support plans around outcomes not units of time

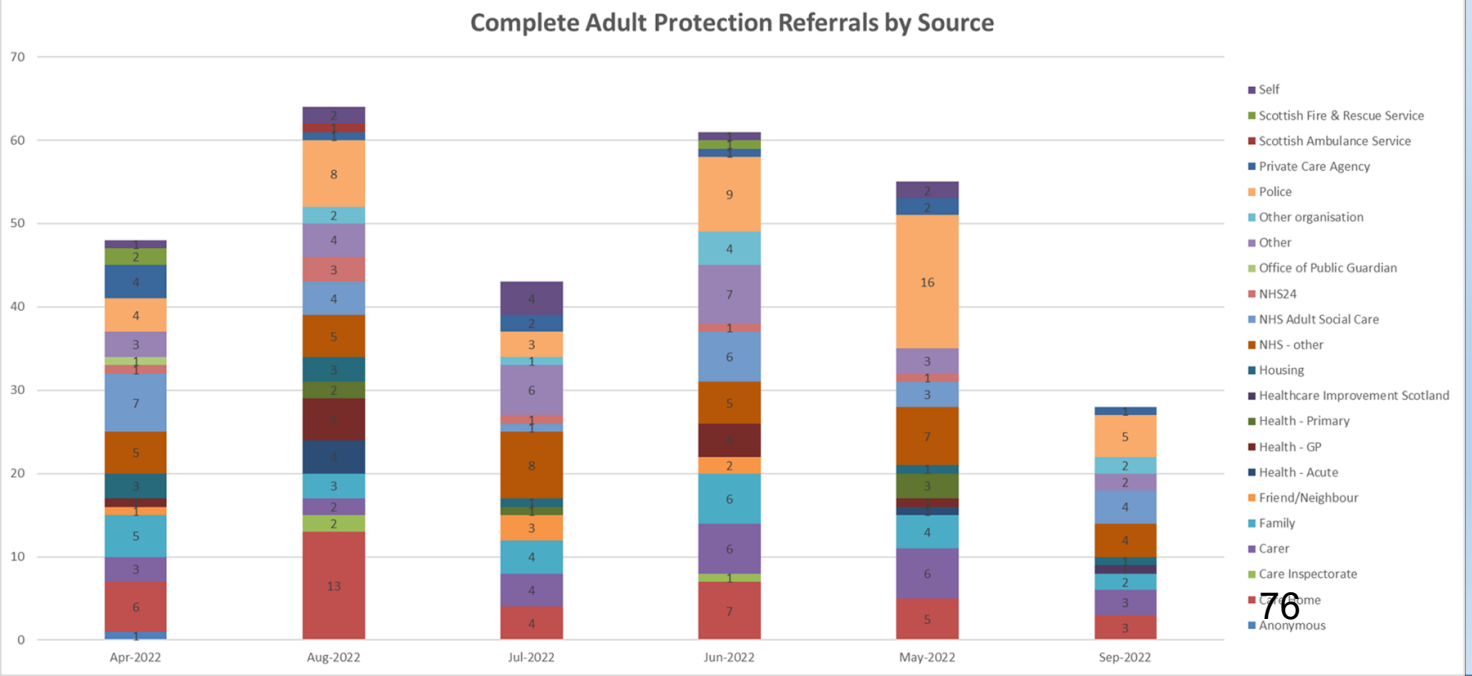
2 successful workshops were held in September 2022 with a number of actions agreed and progressing.

Update as at 21/10/22

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

Adult Protection





Adult Protection

The recent development session confirmed information on Adult Protection should be included.

Currently Adult Protection information is provided as part of an Annual Adult Protection return. The number of initial referrals and inquiries received are assessed by Community Care teams as to whether or not they meet the 3 point test and should progress to an investigation. Referrals come from multiple sources as shown on the graph, previously the main source was the police however as people have become more aware of Adult Protection the numbers of referrals have increased from other sources.

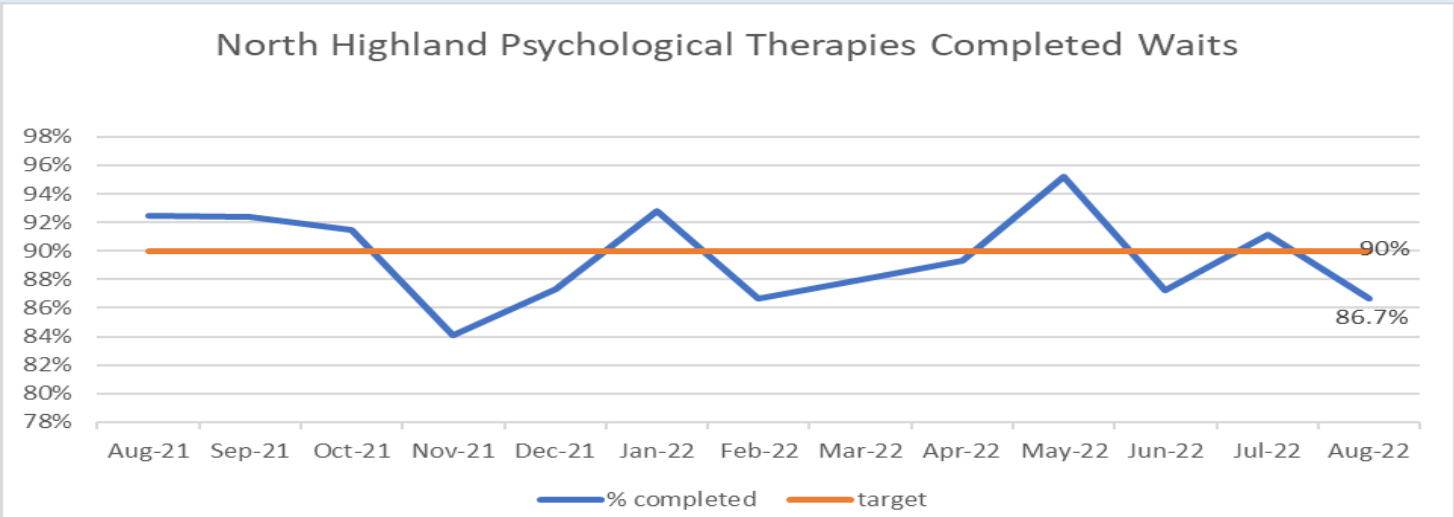
The number of referrals that progress to a full investigation following the initial inquiry is approximately 30%.

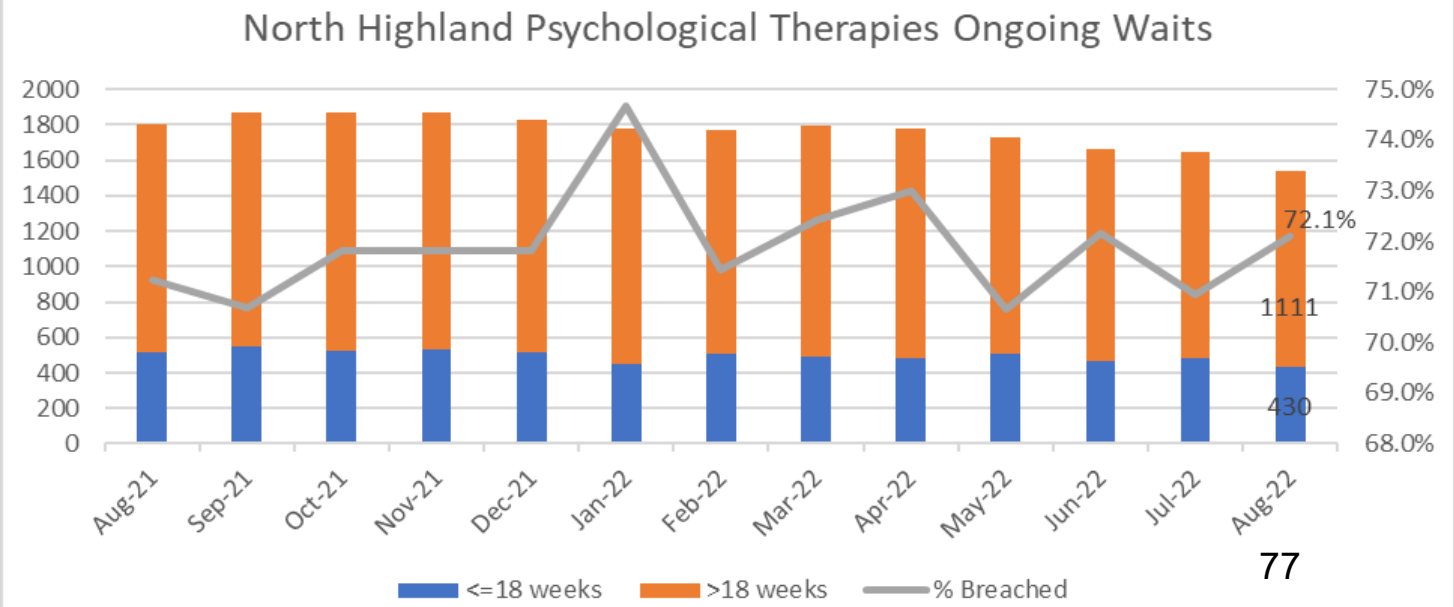
Update as at 21/10/2022

Strategic Objective 3 Outcome 10 – Live Well (Psychological Therapies)

Priority 10A,10B,10C - E*nsure that both physical and mental health are on an equal footing and reduce stigma by improving access and enabling all our staff in all services to speak about mental health and wellbeing"*

Psychological Therapies North Highland 86.7% August Performance





Psychological Therapies Performance Overview - North Highland

The national target:

90% of people commence psychological therapy based treatment wi thin 18 weeks of referral. August 2022: Current performance 86.7%

We have 1541 of our population waiting to access PT services in North Highland. 1111 patients are waiting >18 weeks (72% breached target) of which 860 have been waiting >1year. Of the 1541 waiting, 390 of those are waiting for North Highland neuropsychology services of which 368 are waiting > 1 year .

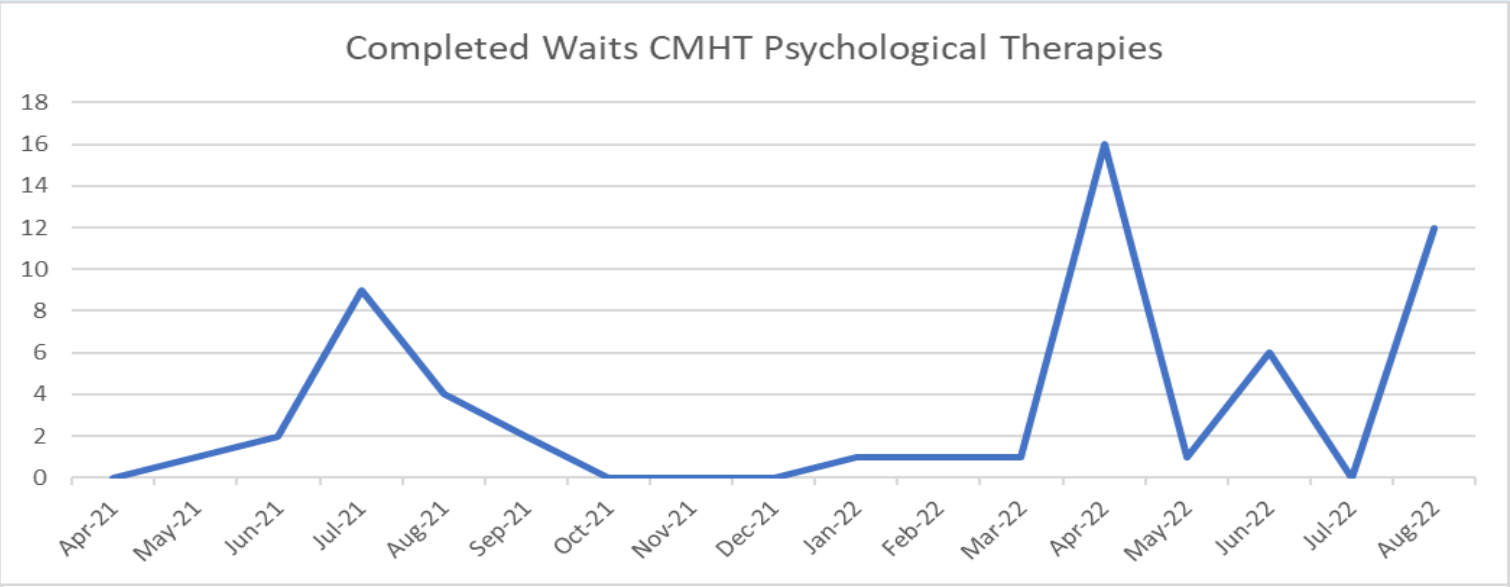
Psychological therapies services have had longstanding challenges with significant waiting times. There are a number of factors that have led to this including a lack of any other route for psychological interventions at an earlier stage. It is anticipated that the development of primary care mental health services will help to fill this gap in provision along with the targeted use of community resources and the development of CMHT colleagues to work with their psychological therapy colleagues.

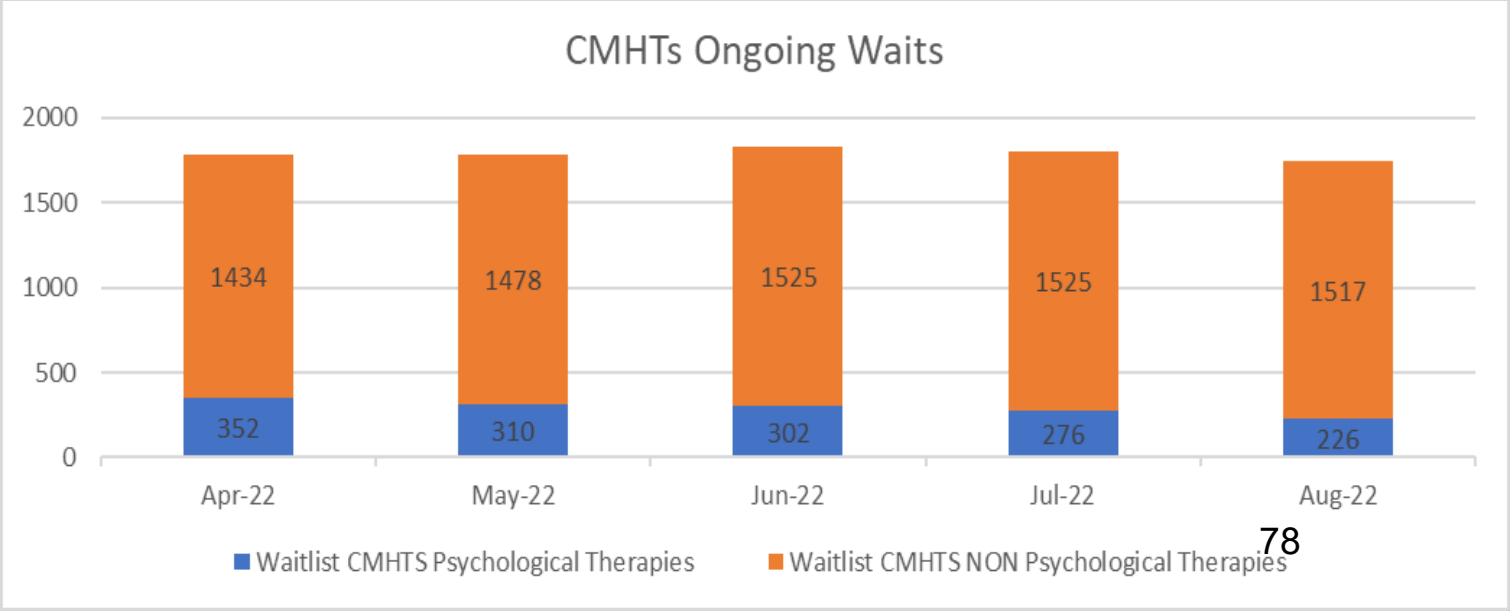
There will though always be a need for specialist services and the team are working to build a resilient model. The Director of Psychology is working closely with her team to reduce the current backlog and to build for the future. Recruitment and retention is difficult when national recruitment is taking place, however there has been some success to date and in particular we are developing our neuropsychology service which forms the majority of out current extended waits. The data provided here is already showing improvement overall with clear trajectories agreed with SG as we progress with our implementation plan.

Strategic Objective 3 Outcome 10 – Live Well

Priority 10A,10B,10C - En*sure that both physical and mental health are on an equal footing and reduce stigma by improving access and enabling all our staff in all services to speak about mental health and wellbeing"*

Community Mental Health Teams





Community Mental Health Teams

The ongoing waits for CMHTs are not currently reported unless they fit the criteria for psychological therapies such as STEPPS group therapies. The delivery of these group therapies was halted during COVID and the availability of an online method was slow to progress. This has resulted in a significant backlog in this area. There is a shortage in STEPPS trainers within the UK so we are therefore exploring a range of options for increasing NHS Highland STEPPS practitioner capacity.
There are now 2 completed groups.
There are 2 groups starting in parallel on 2nd November.

Also, in addition the PD Service are going to lead by example with an on-line STEPPS for patients across NHS Highland. Three people have been identified for the impending training.

Graph 1 – shows the number of completed waits within the CMHT PT patients waiting on group therapies.

Graph 2 – shows the ongoing waits as recorded on PMS for the last 3 months, split between PT group therapies and other patients.

15/08/2022

NHS Highland

Together We Care
with you, for you

Annual Performance Report
2021-22
October 2022 Final Draft

APR

Annual Performance Review 2021-22

Introduction from the Chief Officers	3
Introduction	4
Strategic Context	6
Delivery of Adult Social Care during 2021-22	8
National Health & Wellbeing Outcome Indicators	9
Outcome 1 People are able to look after and improve their own health	10
Outcome 2 Living independently	12
Outcome 3 People have positive experiences of services	20
Outcome 4 Services centred on improving quality of life	21
Outcome 5 Services contribute to reducing inequality	22
Outcome 6 Unpaid Carers are supported	23
Outcome 7 Service Users are safe from harm	25
Outcome 8 Workers are engaged and supported	27
Children and Families	28
Reporting on Localities	29
Inspection of Services	29
Outcome 9 Resources are used effectively	30
Finance Report	31
APPENDICES	
Finance Table	34
National Outcomes Tables	35

Introduction from Chief Officers, NHS Highland and The Highland Council

We welcome the opportunity to share our Annual Report setting out much of what we have achieved in 2021-22. The report provides us with a chance to share our achievements as well as our challenges, reflecting on the continued impact of Covid-19 and to consider our future direction.

We have been actively working with our communities to achieve good health and social outcomes for people. We are committed to ensure people's voices are heard and their needs are understood and effectively met in collaboration with partners. Everyone using our services, their families and carers, all staff and stakeholders are working hard together to improve the health and wellbeing of our local population.

Within the report you will see examples of specific services which demonstrate positive change at a local level and improved outcomes for the population. Through the year we have also been working to strengthen the partnership within the agreed Integration Agreement and the Joint Project Management Board is now well established.

We are proud of the continued commitment of our colleagues and the services they provide whilst acknowledging the ongoing challenges for our communities and the need for ongoing service redesign and development.

Providing effective support for carers is central for those being cared for and our local communities and 2021-22 saw work commencing on the co-production of a carers strategy. This will reflect the needs and priorities of our unpaid carers.

Financially, the HHSCP position at month 12 showed a year end overspend of £0.791m of which £2.355m relates to Adult Social Care (ASC) and the balance being Health expenditure.

This position includes Scottish Government funding which was provided in response to Covid-19 pressures.

Building on our developments and learning there are many opportunities for the future, not without challenge, but surmountable due to the excellent partnership approach of the communities of our local populations and service teams.

We would like to thank all of our colleagues and communities for their help and support over the past year. With strong leadership, community participation and the support of our Partnership Board, we are confident that we will continue to strengthen our partnership governance to enable continued high quality service delivery as we move into the next stage of the pandemic and consider the way ahead.

Fiona Duncan, Executive Chief Officer, Health and Social Care, Highland Council

Louise Bussell, Chief Officer Highland Health and Social Care Partnership

Introduction

This annual report for 2021-22 confirms our commitment to the health, care and overall wellbeing of our community. We aim to give every child and young person in Highland the best possible start in life; enjoy being young; and are supported to develop confidence, capability and resilience, to fully maximise their potential, ensuring our children are safe, healthy, achieving, nurtured, active, respected & responsible and included. We aim to provide the right level of service provision, support and information to our adult population to ensure they have optimum opportunities to live well working in partnership across the statutory, third sector, voluntary and independent organisations.

As a partnership, we are committed to developing our services. We have some very complex and testing decisions to make around what services will look like in the future, with development of the National Care Service plans. In response to this we commenced work on an NHS Highland 5 year *Together We Care* Strategy, looking at all ambitions of Health and Care services across our community.

We continued to make progress across many areas with a number of largely positive comparisons against National performance. The challenge for the future is to focus on delivering care in a post Covid-19 environment, to enable self support, better support carers, developing and extending home based care options and working with Highland communities to develop more local, community based provision and support.

Successes

This year has been challenging because of the reach of Covid-19 pressures, but we worked hard to continue to provide excellent health and social care services for our people, especially in Primary, Community, Mental Health, Acute Care and Adult Social Care. There are areas where performance has been positive and innovative which we aim to maintain. In those areas where there is work still to be done we are planning our next steps.

- We are focused on improving health and wellbeing as well as delivering high quality care for the people of Highland
- Moving to deliver as many of our normal services as possible, as safely as possible
- We have applied resource to specific areas for improvement and change and these initiatives, to support the national health and wellbeing outcomes by which we are measured.
- The engagement of all staff, volunteers and partners has been vital to the planning, developing and implementing of our service developments and we work hard to maintain positive relationships.
- We have listened to our partners and communities in the development of the NHS Highland strategy so we have a framework for the next 5 years.

Much redesign and development activity has been around community based services to build community capacity and further develop an anticipatory and preventative approach to care with further work planned for 2022-23. This development has included the opening of two new hospitals in Badenoch and Strathspey and Skye and the redesign of services as part of this with work progressing well in Caithness and Lochaber redesigns.

During 2021-22 the successful Covid Response Team has moved to being a sustainable service under the new title of Community Response Team This innovative model of care is established across Highland area, and are continuing to provide primary care support to a broad range of people needing care.

It is likely to be a number of years before we see the full impact of these changes. The development of the integrated children's service plan has caught the testimony and voice of children young people and their families and has supported the development of priorities for the next two years. Our initial engagement with our Community as part of the *Together We Care* NHS Highland strategy is also capturing the desire for a holistic health and social care service over the next 5 years.

Challenges and Opportunities

This year, the continued impact of Covid brought about sustained challenges and high pace of change. How to deliver services as normally as possible and ensuring we have the capacity to deal with the continuing presence of Covid were major challenges in our partnership. Recovery and redesign of services were key challenges that were regularly reported to the Scottish Government. These challenges however were balanced by our focus on remobilize, refresh and redesign with good relationships, to enable positive change. Within this report you will see evidence of this alongside forward planning work. The commitment of staff and communities is unquestionable which resulted in an many successes, albeit with work still to be done.

We thank all for the continued enormous contributions made by the people dedicated to providing care, including NHS and Council staff, Independent and Voluntary organisation staff, as well as individual volunteers and carers.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the publishing of the Annual Performance Report, assessing the performance and carrying out the integration functions for which Integrated Joint Boards in Scotland and Integration Authorities (in Highland's case) are responsible.
The Annual Performance Report 2021-22 therefore encompasses:

- Assessing Performance in relation to the National Health Wellbeing Outcomes
- Financial Performance and Best value
- Reporting on Localities and the work of Locality Planning groups and Community Stakeholders
- Inspection of services, including details of any inspections carried out in 2021-22 relating to the functions delegated to the Partnership, by scrutiny bodies
- The 9 National Health and Wellbeing Outcomes describe what people can expect from the HSCP. Performance against each outcome is analysed in the performance assessment sections, with illustrative practice examples demonstrating how local services are working to achieve the outcomes.

This report identifies the progress achieved and the work that is ongoing within our Localities, recognising the continued and unprecedented impact, challenges and opportunities of the pandemic. It also demonstrates some of the challenges for the Health and Social Care Partnership (HSCP) and highlights the significant changes that will take place to shape services that respond to future need, via our Together We Care strategic intents, when published in autumn 2022.

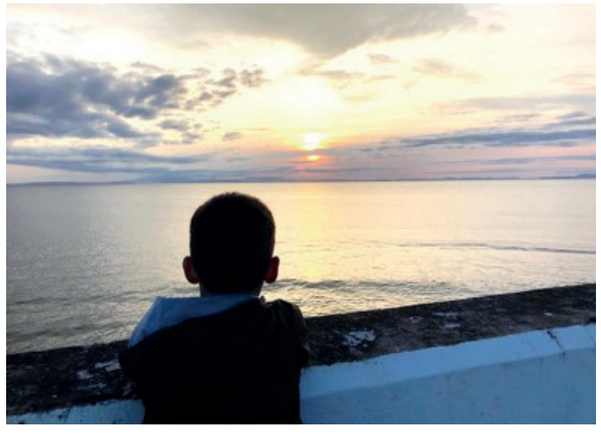
In Highland in 2021-22 our main aim during the pandemic was to maintain and deliver our wide range of health and social care services for our population, with investment made to either continue or commence development of service improvements. Additionally our aim has been to strengthen our governance arrangements within the Partnership through review of the Integration Agreement.

For NHS staff, a key aim was to develop and implement our action plan for our Culture Fit for the Future, making Highland a great place to work and to improve sustainable and resilient services.

Financially, our drive was to recover our financial position. Financially, the HHSCP position at month 12 showed a year end overspend of £0.791m of which £2.355m relates to ASC and the balance being Health expenditure. Going forward, work will continue to improve services whilst focusing on the financial position.

All of these components co-exist and as we move forward we will seek to continue to build on this good work, evolving through the identification of local needs with the aim of building sustainable high quality services.

This is a review of what we faced in 2021-22, and what we learned.



Strategic Background

Strategic Context

In 2012, The Highland Council and NHS Highland Board used existing legislation (the Community Care and Health (Scotland) Act 2002) to take forward the integration of health and social care through a lead agency Partnership Agreement. The Council would act as lead agency for delegated functions relating to children and families, whilst the NHS would undertake functions relating to adults.

"Our aim is: "Making it better for people in the Highlands".

Progress is measured through tracking work and improvement plans using key measures. This report sets out a number of important measures of progress. It also describes some of the main areas we have been working on and the difference this has made.

The Annual Performance Report is an opportunity to reflect on 2021-22 and the resilience of our workforce and partners in delivering services during the pandemic. It is also a chance to reflect on the key learning and ways we can develop, and to appreciate the presented opportunities.

Highland Health and Social Care Partnership

The Highland Partnership covers the Highland Council area. The total land mass is 25,659 square kilometres, which covers a third of Scotland, including the most remote and sparsely populated parts. We have the 7th highest population of the 32 authorities in Scotland at around 234,000, with a slightly higher percentage of children, and higher proportions in all of the age groups above 45 years.

This population is broadly equally divided across urban areas, small towns, rural areas and very rural areas. Outside Inverness and the Inner Moray Firth there are a number of key settlements around the area including Wick and Thurso in the far north, Fort William in the south west and Portree in the west. These towns act as local service centres for the extensive rural hinterland which makes up the majority of the region.

There are four coterminous managerial areas for NHS Highland and Highland Council children's services, and nine local Community Planning Partnerships.

Adult Social Care is commissioned by Highland Council from NHS Highland. Delivery of Adult Social Care is reported to Committees of both the Highland Council and the NHS Board and the governance of the partnership is managed by the Joint Monitoring Committee. With similar reporting arrangements, Children's Services are delivered with the Highland Council acting as lead agency. The Strategic Plan for Children and Young People, 'The Highland Integrated Children's Service Plan 2021 – 2023' is governed by The Integrated Children's Services Planning Board through to The Highland Community Planning Partnership Board (HCPPB). In addition to the formal reporting through the HCPPR regular updates on the progress in meeting the aspirations and oucomes of this plan are provided to The Highland Council's Health, Social Care and Wellbeing Committee, the JMC and the HHSCP.

Highland Council and NHS Highland have formal arrangements for engaging with Third Sector and Independent partners, service users and carers. These partners are represented in strategic planning and governance processes.

In 2021-22 work continued in implementing the Integration Agreement and also in considering the impact of the developing National Care Service. Within children's services we have renewed our commitment to:

Tackling Inequalities
Reducing the gap in outcomes between the most and least deprived children and young people in Highland by working to reduce child poverty within our communities and keep our children and young people safe from harm.

Love and Support for our Care Experienced Young People
Ensuring children and young people who are care experienced are loved and supported to improve their life experiences and life chances.

Good Health and Wellbeing including Mental Health
Ensuring all children and young people are supported to achieve and maintain good physical and mental health and wellbeing.

Promoting Children's Rights and Participation
Work to ensure we are delivering on the provisions of the United Nations Conventions on the Rights of the Child (UNCRC) as incorporated into Scots Law. These could affect our service delivery and also in how we report our performance in the future.

Improvement Programmes currently underway in Highland include:

- Modernisation of Primary Care
- Redesigning Mental Health
- Redesigning Unscheduled Care
- Investing in Acute and Community Care Hospitals e.g. National Treatment Centre Highland (due to open April 2023), Badenoch & Strathspey and Broadford Hospitals (opened in 2022)
- Transforming Adult Social Care
- Review of Children's' services in line with UN Rights of a Child

All of these components co-exist and as we move forward we will seek to build on this good work, evolving through the identification of local needs with the aim of building high class sustainable services. Initial engagement on the NHS Highland 5 year *Together We Care* strategy commenced with our Community in the latter half of 2021-22.

Highland tends to have a health profile that is qualitatively higher than the Scottish national average overall , although there is variation across localities:

- Above average educational attainment, employment, income
- Below average crime, homelessness, alcohol-related mortality and hospital admissions
- Average smoking rates
- Health condition prevalence rates that are similar to, and often lower than, the national average; some emergency hospital admission rates that are higher than elsewhere in Scotland?
- Geographical challenges in providing equal access to services: Low wage rates, high fuel poverty, higher numbers of older people, recruitment challenges.

Delivering on the commitments and priorities outlined in the integrated children's services plan. https://www.forhighlandschildren.org/index_70_464745328.pdf

Delivery of Adult Social Care during 2021-22

All of these components co-exist and as we move forward we will seek to continue to build on this good work, evolving our approach through the identification of local needs with the aim of building sustainable high quality services.

This is a review of what we faced in 2021-22, and what we learned.

Challenges

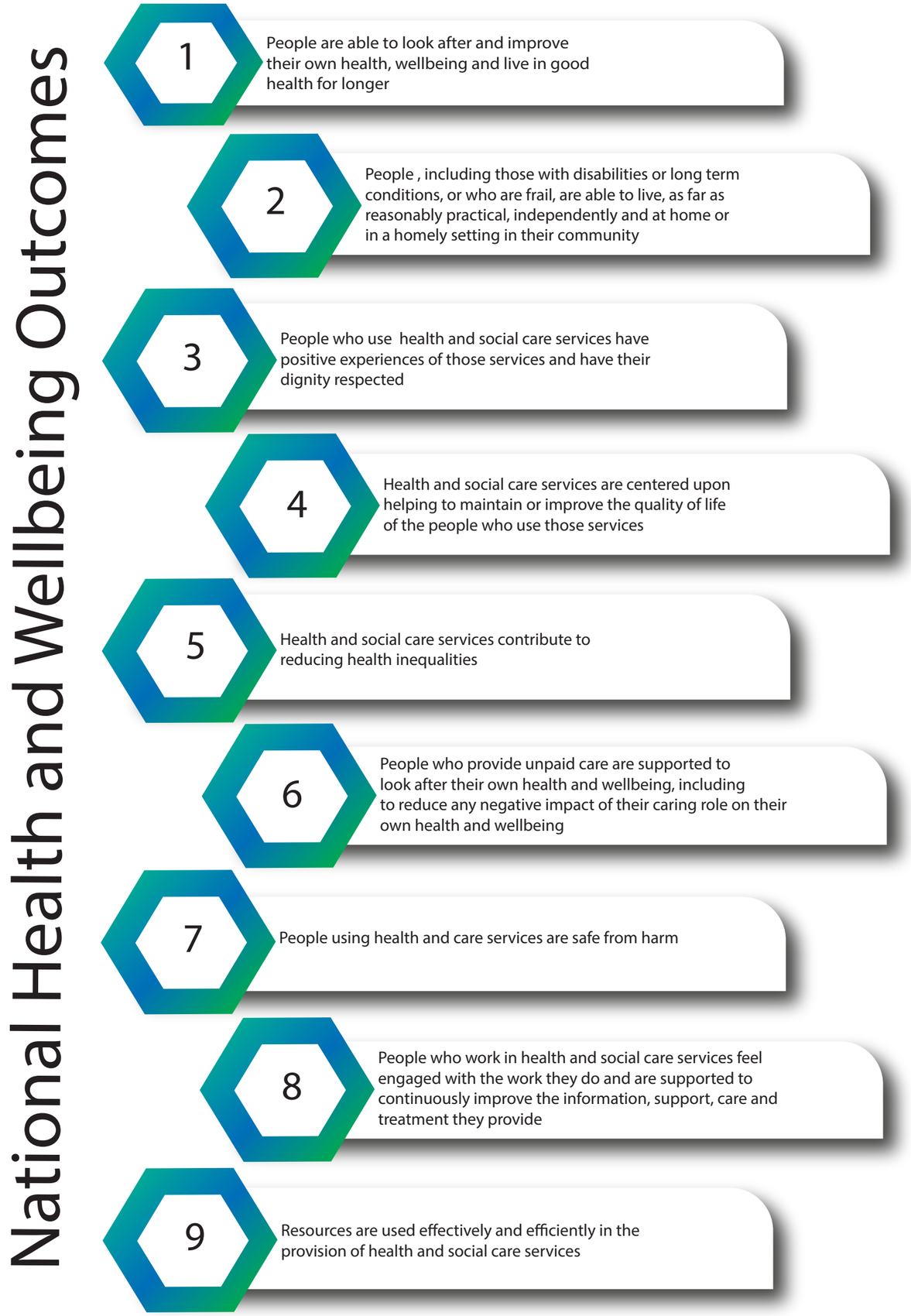
- Understanding and reacting to risk situations: i.e. respective risks being very difficult to calibrate
- Managing Services in highly dynamic policy and practice environments
- Seeking to support adult mental health in new ways – and coping with the impact on relationship based practice of social distancing and use of Personal Protective Equipment (PPE)
- Seeking to support carers with many respite services during lockdown periods
- Ongoing and increasing impact on the health and well-being of adults with mental illness
- Care Homes: maintaining warm, homely environs and maintaining Infection Prevention Control
- Maintaining good communication with dispersed workforce
- Supplying PPE and Testing routes for staff
- Working with partners in new and ways with unprecedented risk situations.
- Workforce and care facilities susceptible to Covid absences

What went well

- Staff, service users and carers working flexibly to promote welfare at almost every level: including taking on greater workloads etc.
- Increased flexibility and choice for people who access self directed support services under SDS Options 1 and 2
- Light touch monitoring of budgets under Options 1 and 2; no monies withheld although aware of some changes to PAs
- Staff (across all disciplines) continue to be cohesive and focused on a common goal
- New organisational links have been made
- Staff demonstrated bravery and commitment to provide services in spite of risks
- Streamlined processes used to expedite valued outcomes: e.g. processes fast-tracked to facilitate discharges from Hospital
- Enormous effort maintained in supporting logistical routes for PPE and Testing.
- Remote working and virtual meetings maintained
- Work with voluntary sector and ongoing strengthened community spirit

Opportunities for Development

- Traditional service models have to change; this provides us with an opportunity to reconsider our services and how we make best use of resources
- The use of technology to maintain links with service users, carers and professionals needs to be both consolidated and accelerated to improve service provision
- Delivering personal outcomes in a wider variety of ways, already required as part of our demographic challenge
- A consensus regarding the need to prioritise 'Services to Carers' to enable fast-tracking new responses to meet demand



The National Health and Wellbeing Outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. These outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using these services, carers and their families.

The following pages provide an assessment of our performance against these outcomes; and against agreed core national integration indicators linked to these outcomes. The core integration indicators provide an indication of progress towards the outcomes that can be compared across Partnerships and described at a national level over the longer term.

Performance against the National Health and Wellbeing Outcomes

Performance against each of the National Health and Wellbeing Outcomes and associated National Performance Indicators is detailed in the following pages. Where relevant, performance against associated Local Performance Indicators is also provided. The extent to which implementation of the Plan is contributing towards meeting the National Health and Wellbeing Outcomes is noted below with each associated action cross referenced within the footnotes. Comparison is also made with the initial 2015-16 baseline figure.

National Health and Wellbeing Indicators

An associated core suite of 23 National Performance Indicators has been developed, drawing together measures that were felt to evidence the 9 National Health and Wellbeing Outcomes. In addition, there are 2 Childrens Outcomes. Of the 23 indicators, 14 evidence the operational performance of Highland Health and Social Care - with the data provided by the NHS Information Services Division (ISD). The data for the remaining 9 indicators is taken from responses from the Scottish Government's biennial Scottish Health and Care Experience Survey. These tables are at the end of the document.

Currently there is a national and local review of the performance management framework and outcomes.

NHS Highland's 5 year Strategy, Together We Care, with you for you maintains a strong emphasis on self managed care which underpins all of the responses in this document.

Together We Care
with you, for you

Outcome 1

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

This indicator is intended to determine the extent to which people in Highland feel they can look after their health. It is recognised that this may be more difficult for people with long term conditions and these performance indicators provide a measure of that.

The 2021-22 Biennial Survey results showed NHS North Highland slightly higher than the national average in a number of areas with an overall client satisfaction rating higher than the national average. This is an improvement since the last Survey in 2019-20. We remain committed to working with our services and partner organisations, to achieve sustainable improvement in client and patient satisfaction.

To support our strategic outcome 'more people will live well in their communities', and the initial engagement with our community as part of the Together We Care strategy, we are committed to growing community capacity that focuses on early intervention and a preventative approach.

Within services for children, the partnership has committed to delivering on 'The Promise' which clearly identified the need to significantly upscale family support services and identified whole family support as a priority in Plan 21-24. We have developed plans to ensure children and families are able to access preventative, needs-based support when they need it, for as long as they need it. The focus of this work is to holistic support that addresses the needs of children and adults in a family, at the time of need rather than at crisis point, aims to support families to flourish and reduce the chances of family breakdown and of children entering the care system. The same preventive interventions should also support adults in a family's ability to engage with other support that helps them access the labour market, pursue qualifications, or progress in employment, thereby enabling them to improve their financial situation.

To support our strategic outcome 'more people will live well in their communities', and the inital engagement with our community as part of the Together We Care strategy, we are committed to growing community capacity that focuses on early intervention and a preventative approach. Our approach is to provide care, based on co-production principles, developing new community driven models of care, and to help people maintain their independence wherever possible.

Our relationship with the Third Sector will support us to continue the development of a Highland based third sector network focused on health and wellbeing in our communities.

Outcome 2

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

This indicator reflects whether people who need support feel that it helps them keep their independence as much as possible. This outcome is supported by national survey every 3 years and information gathered locally.

Overall, the picture is one of improving previous performance. There was a continual increase in the numbers of clients referred for, and provided with, telecare to enable them to remain at home. However, the number of days' people spend in hospital when they are ready to be discharged, per 1,000 population (75+) increased and was significantly above the national average. This most likely reflects the increased acuity and complexity of admitted patients, who perhaps were not seen during lockdown.

A key indicator in this group is the number of delayed discharges which is well above the Scottish average. Delayed discharge continues to be a challenge. A key part of the national Redesign of Urgent Care Programme 2021-22 is to improve the delayed discharge position.

The four options of Self Directed Support (SDS) are available to any adult who has been assessed as requiring social care support. An outcomes-based assessment can be requested from any NHS Highland Integrated District Team.

A personal, outcomes-focused assessment will be completed jointly by the person in partnership with one or more professionals to determine eligibility for assistance with care and support needs. Depending on the individual's circumstances, a financial assessment might also be undertaken. Assessments will normally be reviewed on an annual basis.

In adult services substantial growth in Self-Directed Support and in particular Options 1 and 2, has been seen over the last five years. Throughout North Highland, as we develop services following the pandemic, the measures as described above have led to greater involvement of supported people and their family/networks in the assessment and decision making processes and increased flexibility, choice and control in relation to meeting desired outcomes.

Addressing unscheduled care was a key driver of the national Redesign of Unscheduled Care programme for 2021-22. Through the year, we continued to develop the reach of the Flow Navigation Centre which helps to triage emergency calls and provide the most appropriate emergency care and sometimes reduces the impact on A&E. This is run in partnership with NHS24 and other national bodies.

The percentage ofadults aged 65 or over supported at home who agreed that they are supported to live as independently as possible increased to 87%, significantly above the national average of 79%.

The readmission to Hospital within 28 days (per 1,000 discharges) showed a small decrease from 2020-21 to 113, in line with the national average of 110.

Care at Home Services can be delivered via all 4 SDS options. For Option 3, service delivery is broken into three component parts. In-house enablement care, in house mainstream care and independent sector care. The independent sector makes up 69% of the total Care at Home delivery in Highland.

Care at home services have experienced a challenging period, particularly around staff recruitment and retention, and delivery of capacity required to meet current needs.

There has been significant dialogue with the sector collectively regarding plans and intentions regarding commissioned care at home services, in order to achieve first and foremost, sector stability, with a view to thereafter:

- building resilience;
- growing and releasing capacity; and
- improving efficiency / processes

A priority area is the need to identify, release and deliver additional care at home capacity is critical to addressing flow issues within the wider system.

Across North Highland, unmet need is still a real issue and the sector is finding further growth more difficult due to severe recruitment challenges that are currently facing all providers. This current issue is not unique to North Highland and is consistent with the picture at a national level but does need to be balanced against the significant additional growth seen during the pandemic. It is a multi- faceted changing situation, and Highland will continue to seek to engage collaboratively with providers as we work to build sustainable care at home services.

In terms of immediate actions to attract and retain staff, additional Scottish Government funding for care at home capacity has enabled Highland to implement, ahead of schedule, commitment of £10.50 per hour minimum wage, which was welcomed by the sector. It is noted that staff are fatigued and there is an increase in staff sickness, alongside vacancies is compounding the challenges.

There has been work in house and with care at home partners to seek to address the following identified key issues:

- Staffing crisis situations arising from significant
- recruitment / retention issues
- Increased attrition and unsuccessful recruitment
- Acute staffing availability and wellbeing issues
- Specific geographic challenges in rural / remote
- delivery
- Escalations / contingencies already deployed and service instability already experienced or anticipated

Due to significant stressors in this sector and despite the sustained efforts of both NHS Highland and our care-at-home partners as detailed above, there have been a reduction in commissioned hours per week over 2021-22 and, increasing package returns with a reduction in excess of 1,300 external hours across the whole region.

It is important to set this scheduled hour reduction in context with the many challenges described in the report as there has been an increase in the number of paid relative carers reflecting individual preferences in keeping with Scottish Government direction on self-directed support and the requirement to meet identified needs in a more flexible way, reflecting individual choice.

In addition to the early implementation of the Scottish Government's £10.50 commitment; there is implementation of block contracts for commissioned services and joint working to come together to focus on care as a career with several initiatives underway.

This sector has experienced a challenging 2 years but there is ambition about what can be achieved with and alongside the sector. There is a commitment to ensuring that care at home services have a clear and positive identity and are widely regarded as important and valued by Highland communities and that the models of care available embrace and maximise digital innovation and reflect the diversity and geography of Highland. To achieve this next steps include ongoing joint work with the sector, contract and commissioning redesign and workforce planning.

In house care at home services mirror many of the challenges faced by the external sector. This service and in house care home services work to a cycle of continual improvement. We have an updated and ratified registered services learning framework which reflects national and local priorities and reinforces statutory /mandatory learning. This is being further developed to ensure the impact of the learning is sustained and appropriate by enhancing supervision and appraisal sessions to include a noted reflection of this. The NHS Highland SSSC policy has also been updated to clearly outline the responsibilities of employer and employee in relation to achieving and maintaining registration.

Looking ahead, we are in the early stages of working with partners in exploring the possibility of a more widespread and consistent approach to modern apprenticeships. A series of bite size training resources are being developed to support staff to have the skill set required to safely undertake roles. Quality assurance processes, outcomes focussed care planning, and the new Care inspection frameworks are all priority areas.

Care at Home (CAH)

The pandemic placed significant pressure on all parts of the care sector, including care at home. The stressors for both In-House and commissioned providers of maintaining standards while addressing supply and flow issues around PPE, fluid and fast changing guidance, reporting requirements and testing, were challenging. Nevertheless, there was remarkable commitment, contribution and care provided, by all, in this extremely challenging environment.

All care at home services quickly responded to the pandemic and adapted their contingency plans to reflect current and projected needs. By identifying high priority situations the service was able to maintain a consistent support to those most vulnerable or at risk in the community.

Initial challenges in relation to PPE were addressed and teams were given extra input in relation to infection prevention control. Care at home staff displayed flexibility and professionalism and this approach assisted to keep the people they support and staff safe.

There is a need to have sustainable and available care at home capacity to assist with the discharge flow from hospital to home, and to prevent unnecessary hospital and care home admissions. Care at home capacity is sometimes only available where providers have additional capacity; this is not always at the volume or locations required across an urban, rural and remote dispersed geographical area such as Highland.

CAH Commissioned Services

It is clear that the previous commissioning approach has not delivered the necessary capacity improvements anticipated. In remote and rural areas there has been very little expansion from independent sector providers into remote/ rural areas whereas there has been significant growth in urban and some rural areas.

In order to have sustainable care at home services available, there is still a need to commission the necessary capacity in the locations required and

there is a requirement on the part of NHS Highland to encourage a range of providers to areas where additional capacity is still required. NHS Highland continues to commission high volumes of care at home from the independent sector; In house services remain in many areas, including North and West Highland.

Specialist services have been set up in Inverness such as the Enhanced Responder Service (ERS) and Overnight Service (SOS) to assist with flow from hospital and work is progressing in the North Area (Caithness and Sutherland) around service redesign for in house services. A number of block purchase commitments have been made to continue to support service certainty and improve flow.

The care at home sector adapted well to the challenges of the pandemic and continued to deliver services without significant disruption. This is testament to the commitment of our valued partners in delivering care. Several care providers have expanded their operations quickly and efficiently with demonstrable growth seen alongside the support of discharge and flow from hospitals during the pandemic.

The current contract with our external care providers was extended for a year in March 21 and there is an opportunity to review our approach, take learning from Covid and also of experiences of services such as the Enhanced Responder Services (ERS) and Overnight Service (SOS).

CAH In-House Services

Recruitment to care at home teams remain challenging within remote and rural areas and this is reflected in redesign proposals where job roles allow and encourage flexibility across services.

As with many services, the ability for staff to attend face to face training was significantly affected and this has resulted in the need for extra focus in this area. A recent training needs analysis identified priority areas and plans are in place to address the shortfalls.

The teams have demonstrated further how critical their role is in supporting communities to remain safe within their home environment. Their dedication to continue to provide a high standard of support for everyone is notable.

CAH Business Process Payment Improvement

We transitioned to our new payment arrangements which were warmly welcomed by our partners during December 2020.

Before Covid, we paid all care at home providers in arrears. Now we pay in advance which has sustained short term cash flow, introduced flexibility within our system, secured a level of payment for care delivery and an agreed known and understood payment timetable for all providers. This enabling step is intended to assist providers but it does not resolve the need for service level certainty and to have available capacity when required.

Through the period we worked in improving patient flow by reducing delayed hospital discharges and through additional surge capacity provision and ensuring continuity of social and community care.
Our staff were committed in supporting people to remain at home.

Carers

Support services to carers were increasingly important due to the ongoing impact of Covid-19. This was manifest in the suspension of many Day and Respite Services which has significantly reduced the short-breaks available to carers to support them in their role.

The Highland Carers Improvement Group agreed that interim services for carers should be sought which could demonstrate that they can provide a significant impact in one, or more, of the following areas:

- Provide highly reactive supports to help carers at times of particular stress
- Link carers to their local communities and the sources of support they contain
- Prevent carer breakdown and obviate the need for more formal services to the cared for person (including admission to residential care or hospital);
- Support carers when the person they care for is being discharged from hospital;
- Offer a range of planned and 'Covid-proof' short-break alternatives which are attractive and/ or acceptable to both carers and the cared-for person;
- Provide carers with the practical skills they need to manage their caring role; and
- Provide information and advice for carers that allow them to make informed choices about their role and supports decision making in line with Self-Directed Support principles.

A Carers Services Project Team was quickly brought together to structure a bidding process for Carers services/projects which were considered capable of mitigating the impact of Covid-19. Its work included:

- Structuring an open invitation of bids
- Setting out the parameters for applications, including evaluation criteria.

Working to an identified Implementation Budget (of which £250,000 of the earmarked £400,000k was deployed).

This work was undertaken to complement the ongoing work to identify a fully costed Carers Programme to develop good local services for carers which include; information, advice, completion of Adult Carer Support Plans and, crucially, a greater number and variety of short break opportunities.

Currently we have a great deal of work still to do to provide the tangible supports for carers that we know they need; however with the completion of our Strategy and the work to tender for services for carers that journey is now well underway.

Support Services

The support sector has adapted well to the challenges of Covid-19 and continued to deliver and maintain services for people with a learning disability and mental health issues in Highland. The sector has been meeting regularly with the Head of Service: Learning Disabilities and Autism in a huddle arranged to flag issues with regards to service delivery, PPE, and any other emerging issues. In

addition, regular meetings with individual providers have been held in order to provide additional support and oversight of services.

Since the onset of Covid-19, there has been an expectation that providers would maintain regular contact with every person that they support even if they have ceased their support for a short period. Providers were expected to complete and submit notification of change of support forms for every individual they support where a change has been made. In addition, a RAG (red/ amber/ green rating) status was set up for every person with a Learning Disability that we know in Highland which involved provider support for monitoring and overseeing. These support mechanisms have been successful in flagging any emerging issues, maintaining stability in the service and enabling a quick response to any escalation of issues.

Care Homes

Over the course of 2021-22, there has been a considerable level of care home related activity / supports within Highland, across a wide number of service areas: adult social care, nursing, health protection, infection prevention and control, vaccination, testing, community operational teams, business support (and others), all of whom have had a pivotal role in supporting or overseeing commissioned or delivered care home services.
The challenges faced by care home services have been multiple, sometimes simultaneous, fast changing and unrelenting, spanning across staffing, guidance, financial and regulatory areas.

The primary challenges have undoubtedly been in relation to staffing and Covid status, particularly around recruitment, retention and Covid impacted absences.

There were already insufficient numbers of staff in care home employment pre Covid. This has been exacerbated over the pandemic as exhausted staff seek to leave the sector for a less demanding and often better paid role.

The impact of Covid within a home can acutely and rapidly decimate staffing levels, which is, at best, significantly challenging to plan for, and highly stressful to manage and coordinate, in terms of staffing cover, along with supporting residents and their relatives during these anxious periods. These situations also have a direct and negative impact on resident experience.
Staffing issues have therefore dominated care home activity over 2021-22, mainly arising from the significant number of care homes experiencing staff or resident related Covid cases.

The highest number of care homes "closed to new admissions" at any one time, was 47 (out of 69 care homes in north Highland) on 9 January 2022. The highest number of care homes in outbreak at any one time was 29 on 24 March 2022. The knock on impact on staffing availability for care homes in these situations, was significant. Despite an expanded and expanding mutual aid support team (CRT) there has been unmet need and providers have been supported to prioritise the delivery of safe care.

During 2021-22, this area of activity has been overseen by the Care Homes Oversight Group.

Daily clinical and care huddles have enabled timely flow of information to and between relevant stakeholders, assisting fast and effective decision making. Significant efforts and energy invested in provider liaison, relationships and supporting service continuity plans. A significant level of mutual aid has been made available but not service all demands have been able to be met. There has been a necessary focus on priorities of safe care for risk mitigation. Staffing escalation protocol has not been as effective as envisaged and development of this continues.

There have been 2 care home closures in the last two months with a 3rd pending, it is a risk that there will be further unplanned short notice closures, without action / intervention.These short notice closures result in poor resident outcomes, are resource intensive to manage and require significant short notice and high level business and commercial input to support.

A decisive and proactive plan is being developed to ensure availability of and support to, care homes in identified strategically important locations.
Going forward, it is anticipated that the acute staffing issues experienced in 2021-22 will continue, and in addition to quality related impacts, these challenges will also present increasing viability and sector sustainability issues

Remobilising Day Services

Throughout 2121-22 day services paused, amended or flexed to respond to public health guidance and the needs of local communities. The most recent guidance now allows and increasing number of people to access buildings-based services and we are seeing further changes in response to this guidance. Day opportunities for adults with a learning disability have been transformed during the pandemic to ensure buildings based access for those with the most complex needs and an increasing focus on community based activity.
There have been some changes in the provision of older adult day care with some sector care homes choosing not to restart day care and some in-house areas opting for better use of local hubs. There is also a requirement to respond to the changing need and wishes of individuals who use these services and there is commitment to review and redesign day services to incorporate outreach and bespoke support when required.

"80% of adults receiving care or support rated it as good or excellent. That's comparable to previous years. The national average is 83%"

"75% of adults are supported at home agreed that they had a say in their help, care or support, which is a slight decrease from previous years. The national average is 75%"

Adults with Incapacity (AWI)

In response to the Mental Welfare Commission (MWC) Report, "*Authority to Discharge: Report into decision making for people in hospital who lack capacity*", NHS Highland submitted an 8 point action plan to address the 11 recommendations in the report.

A Senior Practitioner AWI Specialist was recruited in Sept 2021 to support and implement the action plan, to work collaboratively with health & social care staff to improve standards of practice, clarify processes, procedures and ensure compliance with the law across all disciplines.

Work is underway to address the training needs identified by staff across health and social care, with some immediate training needs being addressed and a rolling programme of training being planned to ensure compliance with statutory duties.

A focus of work has been to standardise and clarify social work processes for all relevant NHS Highland staff, to ensure accurate recording and accountable decision making in respect of adults who lack capacity, to ensure the legality of moves and patient's legal rights are upheld.

Looking ahead an AWI audit is planned, which will look at individuals who were discharged from hospital who lacked capacity between 1st Jan 2021 and Dec 2022. Due to the work already completed it is anticipated there will be evidence of improvement in practice during this period, and it will highlight areas for further development.

There has been an increase in new welfare guardianship orders & subsequent demand on social work teams, between 2019 (106) and 2022 (206), with the reduction in 2020 (107) due to the Covid Pandemic. The majority of social work teams saw a significant increase in Guardianship orders, with the Transitions team (supporting adults 18 – 25 years) seeing an increase of 112%. There were 51 orders granted in 2019, compared to 108 in 2022.

This has also increased demand on other professionals and services in Highland, such as medical practitioners, mental health officer's and legal services.

The total number of active Guardianships at March 2019 was 697 and at March 2022 was 888. This equates to a 22% increase in legal orders being supervised and managed by Social Work teams in Highland.

In terms of delayed hospital discharges linked to AWI issues, the following table shows the average number of AWI delays added per month & the number of AWI delays at the Public Health Scotland Census point

(which is the last Thursday in every month).

	2019-20	2020-21	2021-22
Average delays added per month	4.5	3.5	5.8
Number of delays at census point	9.3	8.6	16.5

Adults with Incapacity delays

Social Work Teams

The Social Work service has seen a predicted increase in demand over the period. The impact on social care services has created additional risks and pressures to individuals and their carers. Social work teams have seen a reduction in resources available to meet outcomes as well as an increase in statutory work relating to recruitment challenges.

The Adult Social Care Leadership Team are finalising the completion of a social work workforce review and workforce plan. This important piece of work will inform the future planning and development of the 15 adult social work teams across Highland, ensuring they are prepared and supported to meet future demand and practice improvement. Information to inform and advise the workforce planning has been gathered in partnership with social work team managers and colleagues in public health. The workforce review will focus on the following areas:

- The changing demographic across Highland
- Greater percentage and number of older adults (over 65yo) over time
- Increased population in urban areas; with rapid growth in some specific small populations
- Acknowledgement that the social work role is being reviewed
- Stronger, relationship based, and person-centred approaches are recommended
- Greater time and creativity are seen to be necessary for social work staff to effect community-based solutions – matching individuals' needs and aspirations to a flexible range of community resources
- There is a significant recruitment challenge across Highland and across all professions
- The social work profession needs to ensure its career pathways are clearly marked and attractive

We must ensure we maximise the potential of the Highland-based workforce

There are currently a range of social work vacancies across teams, at present there is only 1 adult social work team which is fully staffed. The current vacancies include recruitment to posts following additional funds from the Scottish Government to strengthen Social Work and multidisciplinary teams (this equated to the equivalent of 18.3 whole time social workers). Recruiting qualified and experienced social workers continues to be challenging. We have worked with team managers to explore creative solutions to these challenges, this has included the ongoing support to "grow our own" social workers through the trainee scheme. We have supported this by developing a full-time practice educator post, supporting 4 experienced social work practitioners to undertake the practice educator course, and work with team managers to consider when a trainee social worker may be a positive solution to recruitment challenges in their team.

In order to support and promote recruitment of social work into Highland we are working with colleagues in the NHS Highland communications team to develop a marketing plan which several existing Highland social work staff have volunteered to participate in, to promote the positive career opportunities and supportive environment working in Highland can offer.

Hospital Flow

Highland has seen a long period of sustained high numbers of delayed hospital discharges. NHS Highland is developing a discharge hub to ensure discharge without delay.

With the known pressures in the social care sector immediate improvement work commenced in April 2022. A core team was developed to consider support to local teams with coordinating discharge, preventing admission and with social work in reach; ensuring appropriate statutory support and a human rights approach is maintained during a stay in hospital. Intermediate care home beds are being utilised in one care home with a view to rolling this out around Highland. The CRT are utilising any capacity to support care at home teams to enable earlier discharge. While in its infancy this approach is proving successful with a focused approach on discharge with an additional 30 individuals being discharged with the support of this team in the first 5 weeks of operation.

Holistic Whole Family Support

The partnership has been developing plans to ensure that holistic whole family support is readily available across Highland to families that need it, with the National Principles of Holistic Whole Family Support ('the National Principles') embedded into the planning, commissioning and delivery of services provided to support children and families. They will be used to deliver high quality, preventive, holistic whole family support through their services for children and families.
This has been developed to ensure that:

- the services families experience feel integrated;
- families have access to the range of services they need to help them flourish and thrive; and
- they will have the support they need, when they need it, and for as long as they need it.

Pharmacotherapy

This service was introduced as part of transforming primary care to aid GP practices to support the implementation of serial prescriptions. This has helped to improve convenience and access for patients with long term prescriptions, whilst reducing footfall into practices.

As part of the Primary Care Pharmacy Service to GP practices we continue to work to increase rates of serial prescribing and to reduce rates of repeatable acute prescribing, both to reduce GP practice workload.

This year we were one of five Scottish Boards to successfully test serial prescribing for residents of care homes. We are looking to roll out serial prescribing to other care homes.

We are working towards prescribing processes, medicines reconciliation and serial prescribing being delivered primarily by pharmacy technicians and pharmacy support workers. We are supporting a focus on high-risk medicines and high-risk patients, using regular medication review and/or clinical patient management, providing pharmacists with a minimum proportion of their time spent providing direct patient care. This aims to help manage demand in practices and develop a sustainable service which will attract and retain pharmacists.

Pharmacy First

Pharmacy First was implemented in 2021-22. This is a national service that allows patients to use a community pharmacy as the first port of call for treatment. Recent analysis demonstrates increased use of this service, e.g. for Urinary Tract Infections, Shingles and skin infections, which has reduced demand on GP services. It has also helped to triage the number of GP referrals for more specialist treatment e.g. MAS. It is anticipated that the number of services and reach will increase.

Outcome 3

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

This indicator is about the quality of the services provided and client's ability to manage and be in direct control of the services that they require. Other indicators such as enablement and self-directed support are also relevant.

Overall since the decline in performance in these areas in 2019-20 there have been improvements shown in the 2021-22 national report. The percentage of people rating the care or support as good or excellent was above the national average and an improved trend. In 2020-21 and 2021-22 maintaining primary care services were a key element of our Covid-19 response.

The Highland Learning Disability Listening Group was established to ensure that the voices of people with a learning disability are heard by NHS Highland managers. The majority of group members are people with a learning disability from Inverness, Fort William and Thurso, other members are paid professionals. A Human Rights Approach, using the PANEL principles forms the foundation of the group. The group have been testing technology to ensure that participation is fully accessible.This service is due to be assessed.

First Contact Physiotherapy Service (FCP) NHS North Highland

As part of the Primary Care Improvement Plan, the FCP service provides fast access to expert physiotherapists for musculoskeletal (MSK) assessment/opinion in the general practice setting. From its creation in May 2019, this service benefited from all partners having a joint sense of purpose and a commitment to create a culture of collaboration. This commitment laid the foundations of the group, forming strong working relationships and governance based on honesty, trust and openness. Fuelled by regular communication this approach underpinned the planning and implementation stages of the service. The work stream was fully supported by AHP leadership, GPs, practice managers, e-health facilitators, primary care modernisation project manager, human resources, staff side representatives and FCP clinical leads.

By moving the MSK pathway upstream into the practice setting, the service transformed how patients access MSK Physiotherapy. Without the need to see the GP first, patients can now be assessed, diagnosed and treated, often without the need for onward referral. This helps promote earlier self management of acute conditions and adds to the prevention of and management of longer term MSK conditions. Current MSK Physiotherapists were able to progress into Advanced Practitioner roles, developing new skills and embracing the opportunities to learn from and share knowledge with new colleagues in the wider GP setting. Joining up patient care with shared records and timely case discussions also became a welcome reality, with the Physiotherapists feeling their contribution being more timely and of recognised value for patients' care.

Implementation of a service is never in isolation. Pragmatic solutions were sought to meet the challenges of delivering this service to practices across the unique geography of NHS North Highland. Individual practice and population needs as well as clinician availability meant a significant degree of flexibility was required. The concurrent service redesign within Physiotherapy added further complexity and introduced additional and particular challenges around staff movement and recruitment.

A recent patient survey using the validated CARE survey measure reflects a high positive patient experience of their consultations and in how easily they can now access MSK Physiotherapy. Full quantitative evaluation of the service has been interrupted by the response to the pandemic however some limited interim data is encouraging.Three years on the FCP service continues to deliver exceptional care, and we are still planning the evaluation so we can celebrate this!

We are also hoping to expand the service based on demand and increase release of GP time whilst providing further improved MSK services to patients in our North Highland communities.

Outcome 4

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

We continue to review all overnight support provision across Highland. The Inverness Waking Night Responder Service continues to be a highly effective model of night support and responds to approximately 40 people a night across Inverness.

The demand for the service continues to grow and we are reviewing the existing capacity to enable more support provision. The service also now provides a responder service to individuals in Sheltered Accommodation that do not have the required number of telecare responders.

This indicator is about the quality of life of the people who use those services. On average, we are now showing an improvement on previous performance or when compared with national position for most indicators, with focus continuing on reducing lengths of stay for our delayed discharge patients awaiting care in the private sector. This is a key challenge across the country, with limited care home availability, and is part of a national programme for improvement.

The percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life shows an improvement both over previous performance and compared with the national average.

In East Ross our falls prevention pilot, which started in 2020-21, is being undertaken using the Scottish Patient Safety Programme methodology. This involves all professionals asking the same initial falls screening questions, to identify those needing the full multi-factorial screening (MFS) tool to be used. The aim is to increase the number of social work and social care staff who are able to complete the MFS tool, thus speeding up identification and interventions for those most at risk.

The national falls rate indicators have shown an improvement in this perforfmance based on previous years and in comparison with the Scottish average.

The Government requested more multi-disciplinary care home assurance visits. This is to provide assurance that measures to mitigate risk of Covid transmission are in place and that physical, emotional and spiritual needs of residents are being met. This requires a blend of professional clinical and social work skills to identify any particular support needs the care home may have to enable a timely response by NHS Highland of any appropriate clinical support, advice or escalations.

A Project Team was set up involving social work, nursing, public health, infection, prevention and control, and allied health professional colleagues. Assurance visits commenced in February 2021. All 69 care homes in Highland received a quality assurance visit, and any support areas identified as part of the visit have been followed up during 2021-22.

The majority of co-morbidity of physical and mental illness in acute hospitals affecting older people is due to three disorders:

- Dementia
- Depression
- Delirium.

These conditions are a predictor of increased length of stay.

Mental Health

We developed our transformation and improvement plans during the year reflecting on the impact of transforming services post-pandemic to enhance prevention and early intervention in mental health while developing more responsive and effective services for people with mental health problems.

The mental health team commenced work on a comprehensive mental health strategy with a particular emphasis on engagement and inclusion as part of the development of the strategy and as a focus of the strategy moving forward. This work will be completed by the end of 2022-23.

Multi Outcomes Case study

Home is Best approach to integrated care

During 2020-21 in Inverness, we piloted an enhanced community service model of care. This was to trial the shift in the balance of care to deliver acute services in the community where appropriate.

In 2021-22, using learning from this pilot, we developed our Home is Best programme to provide care as close to home as appropriate. This redesign work is now embedded in NHS Highland's *Together we Care* Strategy, as part of the Care Well ambition.

The Programme is also looking at redesign of our Community Assets:

- Re-configure community hospitals as step-up
- facilities (not step-down)
- We have invested in staff (nurse and AHPs and medical) to enable a community response service to crises and to provide more effective and timely decision making if hospital or home required.
- Re-configure NHS Highland care homes as advanced care facilities.
- Permanently align Care Homes, Community Hospitals and Care at Home services to GP Practices.

Outcome 5

Health and social care services contribute to reducing health inequalities.

This indicator is about ensuring that communities in Highland are safe and healthy and that individual circumstances are taken into account. The premature mortality rate in Highland is lower than the National average and has improved since the last data was published.

Performance regarding the time taken to access drug or alcohol treatments services is similar to the performance in the previous year, with a gradually improving trend over time. We continued to implement further substantial strategic work on improving access to Psychological Therapies and CAMHS.

Health and Social care services contribute to reducing health inequalities. This indicator is about ensuring that communities in Highland are safe and healthy. This is a future intention, should funding be available. This will enable more local and agile diagnostic and treatment provision.

Working alongside the Alcohol and Drug Partnership is has been working this year to deliver on Scotland's national alcohol and drug strategy, Rights, Respect and Recovery, recognizing that families are assets and key partners.

Our strategy recognises that families have the right to support, in their own right, as well as the right to be involved in their loved one's treatment and support. In progressing this work, the partnership acknowledges that supporting adults is central to this work and that partners at national and local levels across children's and adults' services need to work together to ensure whole family support is provided.

Recognition that women can face a range of barriers that can hinder them entering and sustaining attendance with treatment and recovery programmes. wE are working to ensure that service responses are designed to support women overcome the trauma and loss that they often experience when involved in child protection and lose the care of their children. The programme aims to ensure strong, enduring, collaborative working arrangements between adult alcohol and drug services and children and families services.

Care Home Support and Engagement

NHS Highland continue to support care homes and care home providers in a number of ways:

Rapid responses

In 2020-21, 25 care staff were recruited by NHS Highland to complement existing, reassigned staff to form a care response team. It was formed to provide an effective response in situations where Care Services were impacted by Covid-19.

Through 2021-22, this Covid Response Team (CRT) has continued to support many services across Highland affected by outbreaks and there was a recognised need to further strengthen the team and to also confirm the permanent status of the core team members who have supported outbreak sites since the start of the pandemic. The additional Scottish Government monies made available during November 2021 enabled these plans to be executed and the employment status of these staff to be confirmed before Christmas.

The CRT team continues to be fully deployed to support services negatively impacted by Covid-19. Recent deployments have included care homes settings (independent sector and NHS), Care at home services (NHS) and hospital services.

The intention remains to develop the resource to continue to support care services in a more planned way by developing a roadmap to aid recovery and build resilience and this work will be developed with partners.

Recruitment continues at pace albeit staff numbers are fluid, and the team is expanding with more staff expected to join the team during April 2022. At the end of March 2022, 38 WTEs were recruited to the team with Team Managers, Team Leaders, Nurses, Admin Support, and predominantly 29.5 WTE Health & Social Care Workers/Assistants in post with permanent contracts.

Alongside this, work has commenced to restructure the team to allow for a more robust infrastructure to support current and anticipated growth.

Outcome 6

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Carers play a particularly important role in ensuring the health and wellbeing of clients, patients and communities. The purpose of this indicator is to determine if they are supported in that role and takes into consideration their own quality of life. Historically, this has always been a different area in which to capture and record performance information.

The Biennial Survey, which asked this specific question of carers, has been used in the past, but is no longer part of the survey.

We are meeting our duties to Carers within current practice and contractual arrangements, whilst reviewing processes to meet the intent, ethos and duties contained within the Carers Act, to deliver an open and flexible response to meeting Adult Carers' needs.

Self-Directed Support

The Highland Self Directed Support (SDS) Strategy is about forming relationships, building trust, sharing intelligence and co-producing the new ideas and solutions necessary to truly refresh our approach to implementing Self-directed support in Highland. It is being taken forward collaboratively with people with lived experience, unpaid carers, a number of representative groups including Partners in Policy-making, SDS Scotland, SWS Scotland, Community Connections (locally funded SIRD organisation), service providers, social work staff and managers (among others).

The work on the development of the strategy is being informed by the SDS Change Map, the SDS Standards and the Independent Review into Adult Social Care. Crucially however we are aiming to ensure it will also be shaped by a wide ranging and in-depth engagement and consultation process. Underpinning the work is recognition of the need to address cultural and service change. With the publication of both the SDS Standards and the Independent Review, we believe the timing is absolutely right to progress this important area of work within NHS (North) Highland.

The four options of Self Directed Support are available to any adult who has been assessed as requiring social care support. An outcomes-based assessment can be requested from any NHS Highland Integrated District Team.

A personal, outcomes-focused assessment will be completed jointly by the person in partnership with one or more professionals to determine support requirements, with the aim of adopting a strengths-

based approach to meeting identified outcomes and considering eligibility for assistance with care and support needs where required. Depending on the individual's circumstances, a financial assessment might also be undertaken. Assessments will normally be reviewed on an annual basis.

In adult services, substantial growth in Self-Directed Support, and in particular Options 1 and 2, has been seen over the last six years as demonstrated at Charts 2 and 3 below, albeit there has been a slight decrease in the number of Options 2s within the past year specifically due to one provider ceasing to provide services which were replaced by an Option 3 traditional service delivery model.

We recognise, in keeping with the national picture and the development of SDS Standards, that change is required at a transformational level to ensure more consistent practice in terms of adopting strengths-based and community-led approaches to practice and highlighting the importance of good conversations, i.e. the development of relationship based practice to inform assessments and support options. As a supportive measure to staff, lead professionals are able to discuss complex cases and the variety of possible support options.

We do not think there is a simple, technical fix to the complex set of implementation issues in respect of Self-directed support. Rather, we believe we need to bring people 'around the table' to explore how we can make the changes together.

Therefore, NHS Highland's SDS Strategy is about forming relationships, building trust, sharing intelligence and co-producing the new ideas and solutions necessary to truly refresh our approach to implementing Self-directed support in Highland.

Subsequent to a significant consultation effort a number of local co-production groups are now working to improve our delivery of SDS including by;

- Improving local information about how budgets can be used flexibly
- Exploring how SDS can be used to complement Community-Led approaches to act preventatively
- Agreeing a realistic budget that those managing an Option 1 can translate into good quality care, and
- Agreeing how we can best engage people in realistic and creative conversations about the choice and control that SDS can offer them

At year end (March 22) we had 467 Option 1s and 234 Option 2s in ASC in Highland. This means there has been an ongoing increase in the uptake of Direct Payments in Highland (although we are working with partners to explore a small drop-off in Option 2s). We anticipate the trend in Option 1s will continue over time – and we are keen to increase the availability of Independent Support to help those choosing this option.

The aim of the Scottish Patient Safety Programme is to reduce the number of events which could cause avoidable harm from care delivered in any setting. Work has been undertaken in the following areas in primary care:

- Safety culture
- High risk medicines
- Safer medicines
- Pressure area care
- Safety at the interface including results handling.

The work of the Child Protection Committee have strengthened their role in undertaking work in the following areas;

- Developing culture and practice in relation to trauma informed and responsive approaches to child protection.
- Review and update Highland Child Protection Guidance in line with updated National Guidance.
- Implementation of National Learning Review Guidance locally.
- Work with the Corporate Parenting Board in developing plans to deliver on 'The Promise'.
- Identify methods for consulting with parents and carers about their experiences of child protection processes.
- Community Engagement Strategy and Plan to be developed to raise awareness of child protection in local communities and encourage communities to report concerns.
- Develop a suite of recommended resources for use with young people in relation to exploitation.

Outcome 7

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

The purpose of this indicator is to ensure that there is support and services in place which ensure that clients are safe and protected from abuse and harm.

There is an increase in the percentage reporting as feeling safe, as is reflected elsewhere in the performance outcomes arising from the Biennial Outcomes survey both locally and nationally. This is an improvement on previous figures and at 86% is also higher than the national average of 80%.

Adult Protection

The work of the Highland Adult Protection Committee has progressed well in 2021-22. We have seen the consolidation of a number of working Sub-groups where partners are coming together to implement our continuous improvement framework. This work is being complemented by the initiation a number of SCR/ICRs.

At a practice level we have seen continuing high levels of demand:

- There were 675 Referrals received/recorded by Social Work Teams in 2021-22. This represents a 6% increase on the previous year's figures (636).
- These Referrals translated into 206 ASP Investigations. Therefore a third of Referrals resulted in Investigations (an Investigation involves the appointment of a Council Officer to assess the risks of harm to the identified individual).
- The completion of 206 Investigations represents a 2% decrease on the previous year's figures (211)

The "types of harm" which were the subject of an Investigation in 2021-22 are as below:

Principal type of harm which resulted in investigation	No. of investigations
financial harm	38
psychological harm	26
physical harm	39
sexual harm	8
neglect	54
self harm	6
other	35
total	**206**

The figure for Investigations for 2021-22 was 202. This is a slight decrease from the previous year – however it is clear that demand remains high in comparison to our pre Covid levels.

The aim of the Scottish Patient Safety Programme is to reduce the number of events which could cause avoidable harm from care delivered in any setting. Work has been undertaken in the following areas in primary care:

- Safety culture
- High risk medicines
- Safer medicines
- Pressure area care
- Safety at the interface including results handling.

The work of the Child Protection Committee have strengthened their role in undertaking work in the following areas:

- Developing culture and practice in relation to trauma informed and responsive approaches to child protection
- Review and update Highland Child Protection Guidance in line with updated National Guidance
- Implementation of National Learning Review Guidance locally
- Work with the Corporate Parenting Board in developing plans to deliver on 'The Promise'
- Identify methods for consulting with parents and carers about their experiences of child protection processes
- Community Engagement Strategy and Plan to be developed to raise awareness of child protection in local communities and encourage communities to report concerns

- Develop a suite of recommended resources for use with young people in relation to exploitation.

Child Protection Committee
The committee has this year been working to establish Local Child Protection Procedures. This marks a significant a shift moving from Multiagency Child Protection Guidance to Multiagency Child Protection Procedures. A series of information, training and awareness events have been held across Highland to inform all staff of the updated procedures and discuss any key changes to practice.

The committee has also been working to adopt the National Learning Review Guidance. This is an approach that replaces Significant Case Reviews and Initial Case Reviews. Information on the new Learning Review Guidance has been disseminated and discussed with frontline practitioners, managers and leaders.

The committee have drafted a Child Protection Committee Quality Assurance Strategy and established a new Quality Assurance Sub-Committee. They are also developing a suite of recommended resources for use with young people in relation to exploitation as well as developing and delivering training on exploitation awareness for residential staff, front line practitioners and community groups. In addition, they are delivering training in relation to trafficking and the National Referral Mechanism to ensure timely sharing of concerns. This work includes updating the local trafficking protocol to ensure practitioners and managers are clear how to share information in relation to trafficking concerns.

Within the committee's alcohol and drug sub group the focus is on developing services and support using a whole family early intervention and prevention approach to alcohol and drugs. Additional resource has been identified to improve partnership initiatives including a Perinatal Mental Health midwife, CAMHS Psychologist for Drugs and Alcohol and a health development officer to support early prevention and education.

Outcome 8

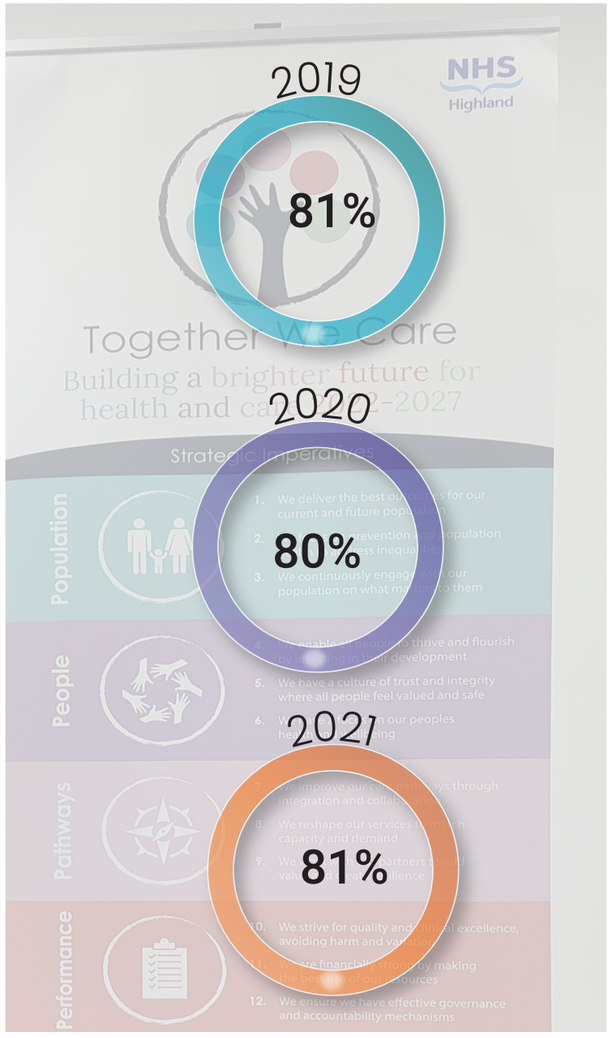
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Staff attending training find that the training is useful and increases confidence and abilities.
Although the ways of providing that training has changed and developed over the period shown, the measure as to whether it increases staff confidence has been maintained.

The system for review that staff have the required knowledge and skills framework has changed considerably and are no longer comparable. Sickness absence wosened slightly in 2021-22 from 4.8% to 5.38%

Workforce development and planning is being taken forward in collaboration with our Together We Care 5 year strategy and this is being translated into our 3 year Strategic Workforce Plan due in Autumn 2022.

Our People & Culture Programme Group was established for key decision making along with regular weekly wellbeing communications to ensure a healthy work-life balance for our staff. Our work on developing our workforce culture continued through 2021-22.
We continue to measure our success by the implementation of the iMatter programme which seeks to empower staff in fulfilling their potential as teams.



iMatter 2021-22

24 of iMatter question responses are in the highest quartile "strive & celebrate"

4 are in the "monitor to further improve" category

There are no responses in the "Monitor to improve" or "Focus to improve" categories

All responses show improvement since 2017

Children & Families

Within children and families vision is that 'All Highland's Children have the best possible start in life; enjoy being young; and are supported to develop as loved, confident, capable and resilient, to fully maximise their potential'

Our outcomes

Our outcomes consider the ways in which children and young people:

- Receive the help and support they need to optimise their well-being at every stage.
- Get the best start in life and enjoy positive, rewarding experiences growing up.
- Benefit from clear protocols, procedures and effective systems for recording observations and concerns which take account of best practice in information-sharing.

Our outcomes relate to the impact of services on the well-being of children and young people using the SHANARRI indicators. It focuses on their experiences and the extent to which their lives and life opportunities will be enhanced to ensure they are; Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included. This outcome has a specific focus on the following outcomes developed within our quality assurance and improvement framework.

- Children are protected from abuse, neglect or harm at home, at school and in the community.
- Children are well-equipped with the knowledge and skills they need to keep themselves safe.
- Young people and families live in increasingly safer communities where antisocial and harmful behaviour is reducing.
- Children and young people thrive as a result of nurturing relationships and stable environments.
- Children, young people and their families are supported well to develop the strengths and resilience needed to overcome any inequalities they experience.

Our Commitments

The partnership have outlined the following key commitments:

- Meet the requirements of the United Nations Convention on the Rights of the Child
- Deliver on 'The Promise'
- Deliver the the Care Leavers Covenant
- Develop a trauma informed approach
- Reaffirm the principles of 'Getting it Right'

Our partnership priorities for improvement are set around the following themes:

- Health and wellbeing including mental health
- Child poverty
- Children's rights and participation
- Child protection
- Corporate parenting
- Alcohol and drugs
- Governance and delivery arrangements
- Delivering the priorities

Delivery on the priorities and themes is undertaken by a delivery groups for each theme.

Each group is chaired by a lead officer from one of the partnerships and has membership across statutory services and third sector.

It is the responsibility of each group to develop the priorities and actions within their individual plans based on the agreed outcomes and needs assessment.

Plans are dynamic and monitored, evaluated and updated each time the group meets and formally reviewed annually.

Highland's Integrated children's Services Board provides oversight to the on-going work of the plan, scrutinise the deliverables and ensure the timescales are met. The board will provide regular updates to the CPP Board and will report formally to Scottish Government on an annual basis.

Child Poverty

This years focus has been on improving opportunities for training and apprenticeships for parents and young people, addressing food insecurity by increasing equity of access to good quality food, recognising the value of financial support for families during the school holidays, supporting the development of sustainable food tables and fridges in order to reduce the stigma associated with accessing food support and developing strategies to increase the uptake of free-school meals.

The partnership is also undertaking work to reduce the financial barriers of families by promoting the uptake of clothing grants, encouraging the uptake of concessionary leisure schemes for children with low income backgrounds, maximising the uptake of child related social security benefits and child specific benefits and the implementation of the health visitor financial inclusion pathway.

The partnership has imaintained a focus on staff wellbeing and professional skills development and responding to the needs of infants, children, young people and their parents/carers The partnership are also developing detailed plans to;

- develop perinatal mental health support
- maintain and further develop trauma informed and responsive approaches to universal and targeted food and healthy weight related initiatives for infants, children, young people and families
- agree and implement a trauma-informed infant mental health strategy to support very young children and their parents.
- undertake planning and redesign to develop a whole system approach to understanding and responding to the mental health needs of infants, children and young people and related access to support and services based on the Thrive model.
- understand and summarise the research in regard to the immediate and long-term impact of COVID-19 for the mental health needs of infants, children, young people and families.
- develop the skills, knowledge and confidence of Highland's staff through supported learning such as Promoting Positive Relationships, Mental Health Awareness and Change-Loss and Bereavement.
- Develop and promote online programmes for parents, teachers and community volunteers.
- Develop a 'whole school approach' to improving mental health.
- Provide effective counselling within an integrated approach to supporting children and young people.
- Ensure routes to request assistance from specialist services are in place and part of a staged approach that is understandable and supports accessibility of services.

Inspection of Services

Internal

Internal care services, such as Home Care, Day Care and Respite are regulated and inspected by the Care Inspectorate.

External

Commissioning Officers are responsible for managing the relationship between external providers and our service users.
Any concerns raised about the quality of care provided by an external provider are recorded and considered against other known information about the provider, such as previous concerns raised; and reports produced by the Care Inspectorate.

Where a concern has been raised, providers are responsible for developing and delivering an action plan identifying planned improvement activity which satisfies the Partnership (and Care Inspectorate if they are involved). This action plan will be monitored by Commissioning Officers to ensure it is being progressed and that improvements are being delivered within agreed timescales. This level of contract monitoring activity will continue until such times until we are satisfied that the provider has made the necessary improvements to ensure the care, safety and wellbeing of residents.

Where no improvement is evidenced, the Senior Management Team will take decisions in relation to any further action required to address on-going concerns, such as reductions in rates paid, increased monitoring activity such as on-site visits, and imposing conditions on the service until issues are resolved or contracts are terminated. Any action taken to address concerns raised about provider's service provision will attempt to do so in ways that put the best outcomes for service users first and which promote safety and wellbeing.

Reporting on Localities

Large Scale Investigation (LSI) Activity

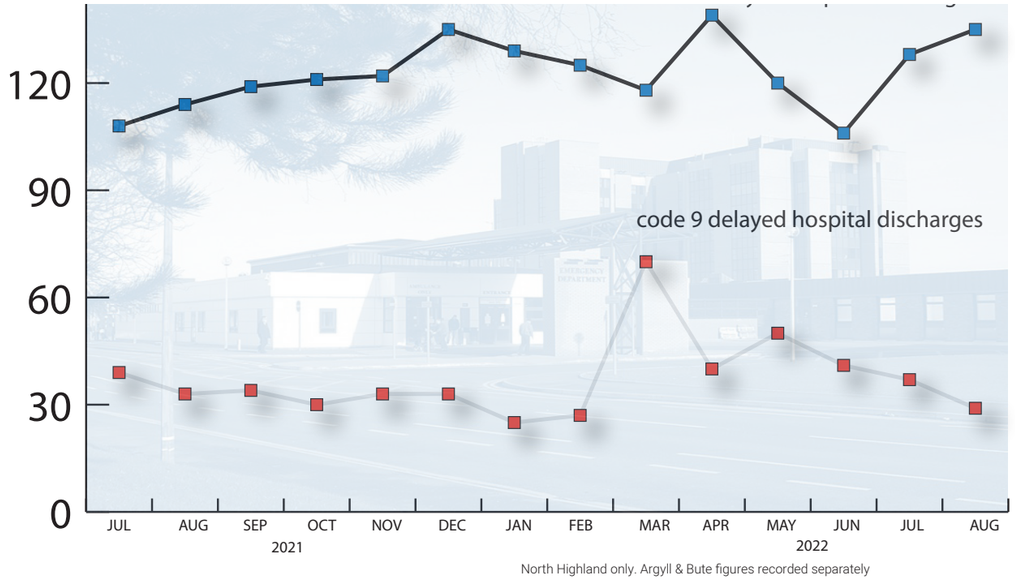
LSI activity has focused on where there are identified concerns within care/service settings

There have been 5 Large Scale Investigations initiated in year 2021/22 which is down from last year.

It should be noted that the Care Home sector face significant challenges in order to maintain high level/ quality of service delivery.

Care homes have reporting to NHSH when they have any issues relation to public health or staffing, and while there may be risks to residents, the ASP and LSI activity in care homes has reduced for this period. A contributing factor to this is the strengthened relationship between the sector and NHSH, and individual care home's assessment of their pressure points.

- RAG status (whether there are any care homes on "red" or "amber" status) and actions taken
- Public Health closure status
- Bed capacity
- TURAS compliance (completion of daily TURAS portal by all care homes)
- Care Inspectorate gradings
- New Scottish Government guidance/requirements and update on implementation
- Mutual aid deployment
- Risks
- Escalations
- Characteristics and dynamics of factors which may impact on the provider base.



North Highland only. Argyll & Bute figures recorded separately

Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services.

Home care costs and residential costs are published nationally. However, there are so many different factors contributing to these costs that national comparisons are largely meaningless. Similarly, the changes made to the payments system for the independent sector means the original indicator is no longer comparable.

Three of these four indicators depend on the compilation of national data, which has been delayed during and since the Covid pandemic.

The number of people waiting to be discharged from hospital when they are ready (Delayed Discharges) increased during 2021-22. Service improvements in this area continue to be a key National focus to improve patient flow through the whole health and social care system.

Finance Report to 31st March 2022

Financial Performance and Best Value

Financial modelling for service delivery 2021-22. Despite the operational and financial challenges of the Covid-19 pandemic and subsequently, there is still a requirement to deliver on savings and a similar programme managed approach will be taken to try and address the funding gap.

For 2022-23 and beyond, discussions continue, with our partners in The Highland Council to develop and agree a Three year cost containment and transformational plan within a joint governance and programme management structure. This is necessary to address the known budget quantum gap with continued support from Scottish Government as required with precise detail of plan, scale of savings and joint ownership to deliver on this ambitious transformational change programme.

Year One (2022-23)

Cost containment, transformation planning and resourcing of programme management team

Years Two and Three

Continued cost containment whist taking forward a comprehensive strategy of transformational change and system wide integration.

Summary

HHSCP financial position at month 12 which shows a year end overspend of £0.791m of which £2.355m relates to ASC and the balance being Health expenditure. Position includes SG funding in response to Covid-19

Final position to March 2022

For the 12 months to March HHSCP have overspent against budget by £0.791m, components of this overspend can be seen in Table 1 below.

2021-22 Plan		Month 12 March 2022 Summary Funding & Expenditure	YTD Position		
Annual Budget £000	Current Plan £000		Plan to Date £000	Actual to Date £000	Variance to Date £000
		HHSCP			
		NH Communities			
63,118	63,118	Inverness & Nairn	63,118	65,278	(2,160)
46,945	46,945	Ross Shire and Badenoch & Strathspey	46,945	46,378	568
40,654	40,654	Caithness & Sutherland	40,654	40,622	32
49,340	49,340	Lochaber, Skye & Lochalsh and Wester Ross	49,340	48,771	569
19,784	19,784	Management	19,784	22,074	(2,290)
4,312	4,312	Community Other	4,312	4,075	236
1,624	1,624	ASC Other	1,624	1,346	278
6,367	6,367	Hosted Services	6,367	6,143	224
232,144	**232,144**	**NH Community**	**232,144**	**234,688**	**(2,543)**
41,623	41,623	Mental Health Services	41,623		
139,737	139,737	Primary Care	139,737		
6,679	6,679	Adult Social Care Central	6,679		
420,183	**420,183**		**420,183**	**421,815**	**(1,631)**
		Support Services			
(15,650)	(15,650)	ASC Income	(15,650)	(16,491)	840
404,533	**404,533**	**Total HHSCP & Support Services**	**404,533**	**405,324**	**(791)**

Table 1

Within the NH Communities year end out-turn of £2.543m, an overspend of £4.480m relates to Adult Social Care expenditure – see appendix 1 for further detail on Social Care. Adult Social Care for 2021-22 saw an increase in activity due to packages being reinstated post covid and this was reflected in the year end position.

The balance within NH Communities mainly relates to underspends due to both vacancies and non pay. Recruitment issues continued from previous year with nursing and AHP experiencing the most vacancies.

Mental Health Services ended the year with a £0.008m underspend; whilst this position shows breakeven, a pressure of £1.200m relating to the FME service was the main outlier with underspends in nursing vacancies pulling the position back to breakeven.

Primary Care showed an underspend of £0.023m. Pressures in prescribing and locum usage (2c Practices) continued throughout the year with vacancies in the Dental service mitigating the pressure.

Within HHSCP Support Services, costs for Covid-19 were fully funded by the Scottish Government as well as slippage on the CIP target being covered.

Savings

NHS Highland identified a savings challenge of £32.900m to deliver a balanced position at the start of the year. Whilst there was some significant delivery of savings from the Division, additional support from the SG at the end of the year was required to deliver a breakeven position.

Conclusion

HHSCP financial position completed the year end with an overspend of £0.791m. This position reflects costs and funding associated with covid and funding to cover slippage against the CIP.

Governance Implications

Accurate and timely financial reporting is essential to maintain financial stability and facilitate the achievement of Financial Targets which underpin the delivery and development of patient care services. In turn, this supports the deliverance of the Governance Standards around Clinical, Staff and Patient and Public Involvement. The financial position is scrutinised in a wide variety of governance settings in NHS Highland.

Risk Assessment

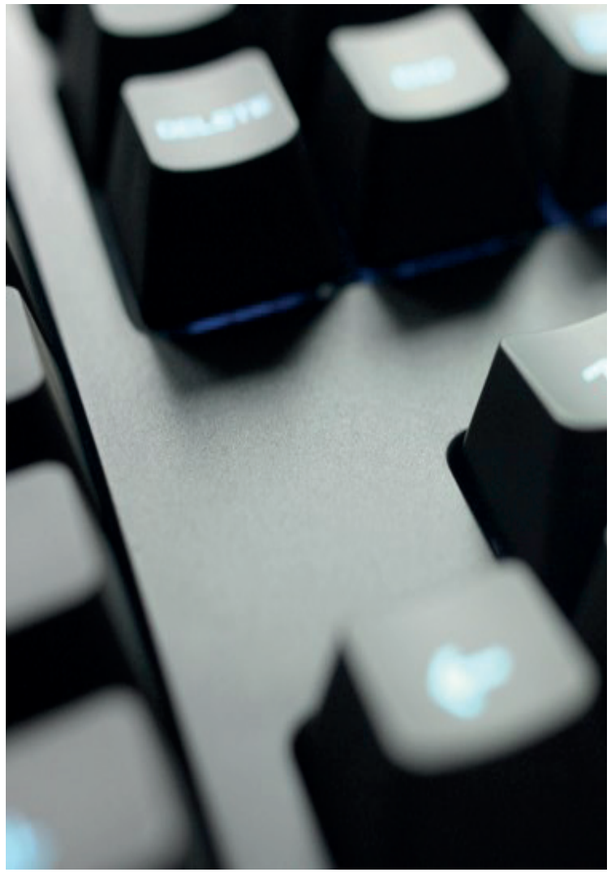
Risks to the financial position are monitored monthly. There is an over-arching entry in the Strategic Risk Register.

Planning for Fairness

A robust system of financial control is crucial to ensuring a planned approach to savings targets – this allows time for impact assessments of key proposals impacting on services.

Engagement and Communication

The majority of the Board's revenue budgets are devolved to operational units, which report into two governance committees that include staff-side, patient and public forum members in addition to local authority members, voluntary sector representatives and non-executive directors. These meetings are open to the public. The overall financial position is considered at the full Board meeting on a regular basis. All these meetings are also open to the public.



Appendices
Finance Table

Services category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Forecast Out-turn £000's	Forecast Variance £000's
Older People - Residential/Non Residential Care	14,717	14,717	12,702	2015	12,702	2015
Older People - Care Homes (In House)	32,042	32,042	32,004	39	32,004	39
Older People - Care Homes (ISC/ SDS)	1132	1132	913	219	913	219
Older People - Other Non-Residential Care (In House)	1252	1252	1094	158	1094	158
Older People - Other Non-Residential Care (ISC)						
Total Older People - Residential/ Non Residential Care	**49,143**	**49,143**	**46,713**	**2430**	**46,713**	**2430**
Older People - Care at Home						
Older People - Care at Home (In House)	14,607	14,607	13,832	775	13,832	775
Older People - Care at Home (ISC/SDS)	14,813	14,813	16,725	(1912)	16,725	(1912)
Total Older People - Care at Home	**29,420**	**29,420**	**30,557**	**(1137)**	**30,557**	**(1137)**
People with a Learning Disability						
People with a Learning Disability (In House)	4161	4161	3611	549	3611	549
People with a Learning Disability (ISC/SDS)	30,474	30,474	32,754	(2280)	32,754	1320
Total People with a Learning Disability	**34,634**	**34,634**	**36,365**	**(1731)**	**36,365**	**1869**
People with a Mental Illness						
People with a Mental Illness (In House)	463	463	363	100	363	100
People with a Mental Illness (ISC/SDS)	7271	7271	7388	(117)	7388	(117)
Total People with a Mental Illness	**7734**	**7734**	**7751**	**(17)**	**7751**	**(17)**
People with a Physical Disability						
People with a Physical Disability (In House)	1057	1057	745	312	745	312
People with a Physical Disability (ISC/SDS)	5837	5837	6946	(1109)	6946	(1109)
Total People with a Physical Disability	**6895**	**6895**	**7691**	**(797)**	**7691**	**(797)**
Other Community Care						
Community Care Teams	6882	6882	6184	698	6184	698
People Misusing Drugs and Alcohol (ISC)	31	31	21	10	21	10
Housing Support	5829	5829	5724	104	5724	104
Telecare	852	852	655	197	655	197
Carers Support	1000	1000	1000	(0)	1000	(0)
Total Other Community Care	**14,595**	**14,595**	**13,585**	**1010**	**13,585**	**1010**
Support Services						
Business Support	1632	1632	1473	159	1473	159
Management & Planning	(1398)	(1398)	873	(2271)	873	(5871)
Total Support Services	**235**	**235**	**2347**	**(2112)**	**2347**	**(5712)**
COVID	**8416**	**8416**	**8416**	**(0)**	**8416**	**(0)**

table continued overleaf

Services category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Forecast Out-turn £000's	Forecast Variance £000's
Total Adult Social Care Services	**151,071**	**151,071**	**153,426**	**(2355)**	**153,426**	**(2355)**
ASC Services now integrated within health codes	**4064**	**4064**	**4064**	**0**	**4064**	**0**
Total Integrated Adult Social Care Services	**155,136**	**155,136**	**157,490**	**(2355)**	**157,490**	**(2355)**

National Outcome Report

Key for all tables	
Benchmark is Scottish Average or local average where known Comparison benchmark is Scottish Average	
Performance is improving	G
Performance is stable	A
Performance is declining	R

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

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE	DATA CURRENCY
1.1	Percentage of adults able to look after their health very well or quite well	To maintain or increase	95% (2015/16)	93% 2019/20	G	A	92.4% NH 90.9% Scot Decreasing trend	Current (Biannual Report 2021/22)
1.2	Emergency admission rate (per 100,000 population)	To reduce	10,971 (2014/15)	10,779 2020/21	G	G	9,997 NH 11,636 Scot	Current 2021

Outcome 2
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE	DATA CURRENCY
2.1	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	To increase	83% (2015/16)	81% 2019/20	G	G	86.5% NH 78.8% Scot	Current (Biannual Report 2021/22)
2.2	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	To increase	77% (2015/16)	75% 2019/20	G	A	72.1% NH 70.6% Scot Dec. trend	Current (Biannual Report 2021/22)
2.3	Readmission to hospital within 28 days (per 1,000 discharges)	To reduce	92 (2014/15)	116 (2020/21)	R	R	113 NH 110 Scot	Current 2021

Outcome 3

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

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
3.1	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	To increase	73% 2015/16	74% 2019/20	G	A	71.9% NH 66.4% Scot Inc. trend	Current (Biannual Report 2021/22)
3.2	Percentage of adults receiving any care or support who rate it as excellent or good	To increase	83% 2015/16	80% 2019/20	G	G	83.0% NH 75.3% Scot Inc. trend	Current (Biannual Report 2021/22)
3.3	Percentage of people with positive experience of the care provided by their GP practice	To maintain	89% 2015/16	79% 2019/20	G	A	77.2% NH 66.5% Scot Dec. trend	Current (Biannual Report 2021/22)
3.4	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections and proportion graded 5 or above	To increase	76.8% 2015/16	83% 2019/20	G	G	80.3% NH 75.8% Scot	Current 2021/22

Outcome 4

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

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
4.1	Delayed hospital discharges for service users residing within areas covered by ISC C@H providers	ZERO	20 Total 13 IMF 7 N & W	N/A		A	20 Total 17 IMF 3 N & W	Current
4.3	Emergency bed day rate (per 100,000 population)	To reduce	116,910 2014/15	95,155 2020/21	G	A	106,529 NH 109,429 Scot Inc. trend	Current 2021
4.4	Falls rate per 1,000 population aged 65+	To reduce	17 2014/15	21 2020/21	G	G	14.5 NH 23.0 Scot	Current 2021
4.5	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	To increase	85% 2015/16	80% 2019/20	G	G	84.3% NH 78.1% Scot Inc. trend	Current 2021/22

Outcome 5

Health and social care services contribute to reducing health inequalities.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
5.1	Premature mortality rate (per 100,000 population)	To decrease	374 2014/15	527	G	A	413 NH 471 Scot Dec. trend	Current 2021
5.2	People who have dementia will receive an early diagnosis: maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources	To increase	N/A		G	G	2284	Last published 2019/20 ?

Outcome 6

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
6.1	Percentage of carers who feel supported to continue in their caring role	To increase	37% 2015/16	34% 2019/20	R	R	28.7% NH 29.7% Scot Dec. trend	2021/22

Outcome 7

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

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
7.1	Percentage of adults supported at home who agree they felt safe	To increase	84% 2015/16	83% 2019/20	G	G	86.0% NH 79.7% Scot Inc. trend	Current Biannual Report 2021/22

Outcome 8

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

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
No current measures								

Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
9.1	NHSH make payment of the C@H tariff rate within 28 days of receipt of a valid invoice	To increase	83.34%			G	89.56%	2018/19 measure no longer valid

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**2nd November 2022**
Title:	**Chief Officer Assurance Report**
Responsible Executive/Non-Executive:	**Louise Bussell, Chief Officer**
Report Author:	**Louise Bussell, Chief Officer**

1. Purpose

To provide assurance and updates on key areas of Health and Social Care in Highland.

2. Project Updates – Lochaber and Caithness

Lochaber

Work continues on service design, with departmental workshops taking place for the remainder of 2022 and final output expected in Feb 2023. Technical brief development is ongoing in parallel. PSCP appointment is programmed for March 2023 with design work commencing thereafter. Current construction completion estimate is late 2027, opening in 2028, dependent on funding timescales from Scottish Government. Community representatives are concerned about the timescales and we continue to work closely with them to support the project.

Caithness

Following Scottish Government approval of the Initial Agreement in February 2022, the redesign of adult health and social care services in Caithness is continuing at pace. It is following a similar trajectory to Lochaber, with service model workshops for acute colleagues (Caithness General) and community colleagues (Wick and Thurso Community Hubs) scheduled for the remainder of the year. These will produce a service operational brief for each of the three building projects in early 2023, allowing the appointment of the respective design teams by end March 2023. The redesign of services is not dependent on buildings, and a number of tests of change are underway.

North Coast services

In order to mitigate the risks to service provision and patient care a new, purpose-built community hub has been commissioned, which will be based in Tongue. The two existing care homes will be combined and re-located to a new facility within the community hub and will include step up beds, which will be used to prevent hospital admissions.

The health and social care integrated team for the North will also be based and managed from the community hub, which will enable all parts of the multi-disciplinary team to be based in one place to improve integrated working and a more innovative, flexible and integrated approach to service delivery.

It is recognised that a different, more flexible staffing model is required for the delivery of services, and it is therefore the team are working on a proposal would better integrate and promote cross working of staff working in a number of different services.

3. MAT Standard Improvement Plan

Mat implementation standards team (MIST) from Scottish Government visited our services at the end of August, as part of this day they carried out a QI workshop with DARS services, from this our action plan was completed, approved and submitted to the MIST Team at the end of September.

We are now asked to provide a monthly report to Scottish Government on our progress first report is due end of October. We are progressing the action plan on target at present.

These are the 10 MAT (Medical Assisted Treatment) standards our action plan is based on:

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.
4. All people are offered evidence-based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.
7. All people have the option of MAT shared with Primary Care.
8. All people have access to independent advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. 10.All people receive trauma informed care

The expected schedule for embedding the standards is MAT 1 - 5 by April 2023 and 5 - 10 by April 2024. We are currently on schedule.

NHS Highland have been awarded £420.000 funding for the next four years to support us to embed these standards.

One of our most challenging standards within the first 5 is MAT 1, due to NHS Highland having not only urban but some very remote and rural areas, our medical staff are based in Inverness and although they provide remote support and outreach to all our areas, this is around outpatient clinics, and can be once or twice a month, with support to staff available as needed in between.

The service in its current form is well supported by this model, however, same day prescribing on first presentation will often involve prescribing high dose controlled drugs and without one of our Doctors on site, this requires planning to ensure other staff are sufficiently trained and supported to do this.

With this £420.000 we intend to advertise for a GPWSI in Drug and Alcohol treatment or an associate doctor who will work more remotely to support MAT 1. We also wish to develop an Advanced Nurse Practitioner (ANP) model across DARS, in order that safe prescribing can be carried out (not only by doctors) in all areas, and all options of M.A.T are available. We are planning one ANP in every DARS team. In addition, four areas where capacity and demand are challenging where we are looking to support these teams by adding a further band 6 nurse in each area to increase capacity, these areas are, Osprey House, Inverness Community, Lochaber and Mid Ross.

These posts will also support the other MAT standards being implemented across our services.

It is important to note that most of the standards we have either met and are evidencing this or we will meet with the above developments.

4. Transitions Services

Young people in receipt of a service from children's services – which may be a universal service such as education – and who will then be entitled to a social care service from adult care services delivered by NHS Highland, fall within "Transition Services".

It is a key area for young people as they move on from a children's social work and/or education service to an adult care service and is thus a key interface in terms of the relationship between The Highland Council and NHS Highland.

It is a challenging area as the nature of the service is likely to change at the same time as the agency providing that service also changes and in recognition of that challenge this area has been identified as a specific programme of work in respect of younger adults with complex needs.

The work envisaged related principally to the remit of the transitions team and the financial arrangements in place and associated lack of guidance governing the interface between the transition of service from children's services -the Council – and Adult Services – NHSH.

In recognition of those concerns a project team comprising officers from both organisations was established with 2 principle aims being 1) preparation of guidance in terms of the interface between the 2 organisations; and 2) the remit of the transitions team established in the Inner Moray Firth Area in terms of its operation and how that interfaces with delivery of transitions in the rest of the Highland area.

<u>Preparation of Guidance</u>

For some time there had been concerns about how effectively transitions are managed and questions arose on a fairly regular basis about the timing of that transition and at what point a young person became the responsibility of Adult care services recognising that not all young people who receive a service from children's services will be eligible for an adult care service.

The legal framework surrounding transitions is therefore complex and in need of clear guidance to support operational service provision and decision making.

In recognition of that complex picture, previous managers agreed that regardless of the legal position, responsibility should transfer from Children's Services to Adult Services at 18. Whilst having the advantage of simplicity, it is widely agreed that this is not workable and has caused issues about management of cases and does not reflect the legal – or actual - position of Highland's young people. It was also recognised that whilst seeking to reflect that position more appropriately it would be helpful to update the guidance for the case management of transitioning cases.

In terms of that challenge, two documents have been prepared, these being guidance for staff managing transitions and a financial flowchart, which reflect an agreed position between both organisations and have been in place since April 2022. It is intended that they be reviewed after one year in terms of any issues which have arisen.
Remit of the Transitions Team

At present, transitions are managed in Highland by a Transitions Team for Inverness and the Inner Moray Firth and by the local teams out with those areas.

The Transitions Team is comprised of 2 separate teams of staff (1 Council and 1 NHSH) working together on a co located basis from an office in Inverness to provide a service to young people.

Whilst this colocation is considered positive, this is not something which operates out with the Inner Moray Firth area and as such there is ongoing work, in the form of an options appraisal, which is considering if a pan Highland approach is required and if so how that ought be delivered.

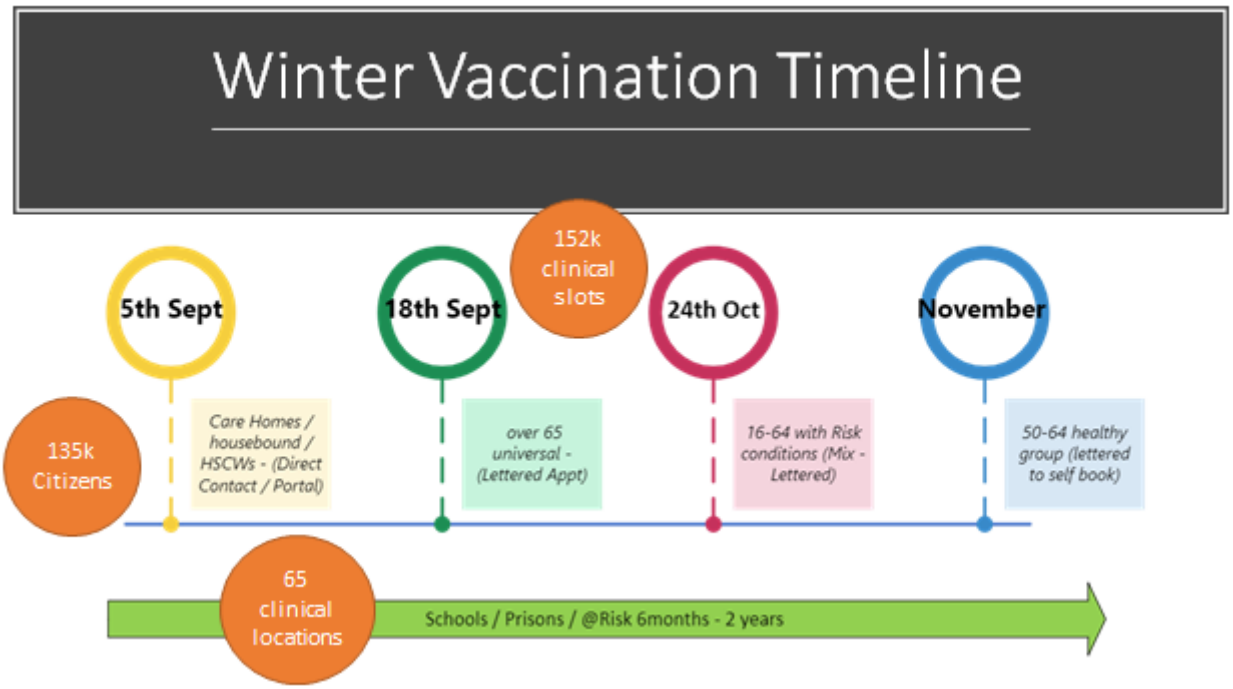
5. Annual Health Checks

We have met with colleagues in A&B and continue to be concerned about the implementation of this directive. We have requested a meeting with the SG to discuss and are awaiting to hear from them to arrange a date and time. The funding does not appear to have been released and there continue to be concerns voiced nationally about the ability of Primary Care to lead this work.

6. Vaccinations

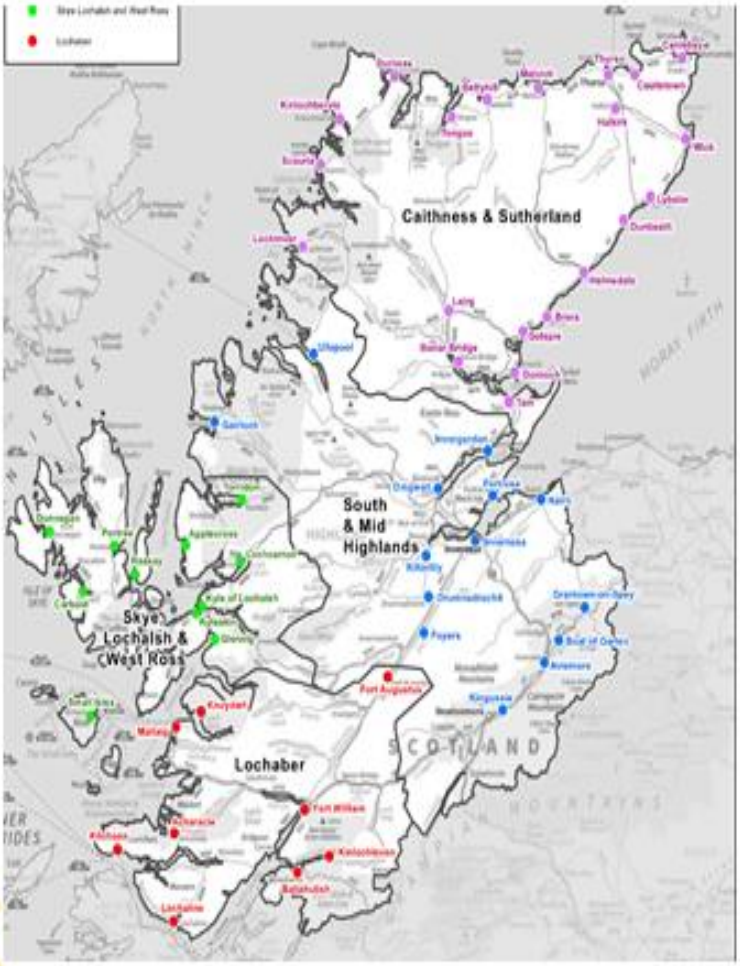
The Autum/Winter Covid and Flu Vaccination Campaign began on the 5th September and is running on an accellerated timeline with the expectation that 80% of the eligible population will be able to access appoinments in this time. The accellerated campaign ends on 5th December and letters for the final cohort (50-64 not identified as at risk) were sent on the 24th October.

The eligible population for covid vaccines is 149,722 and 160,000 for flu vaccinations.



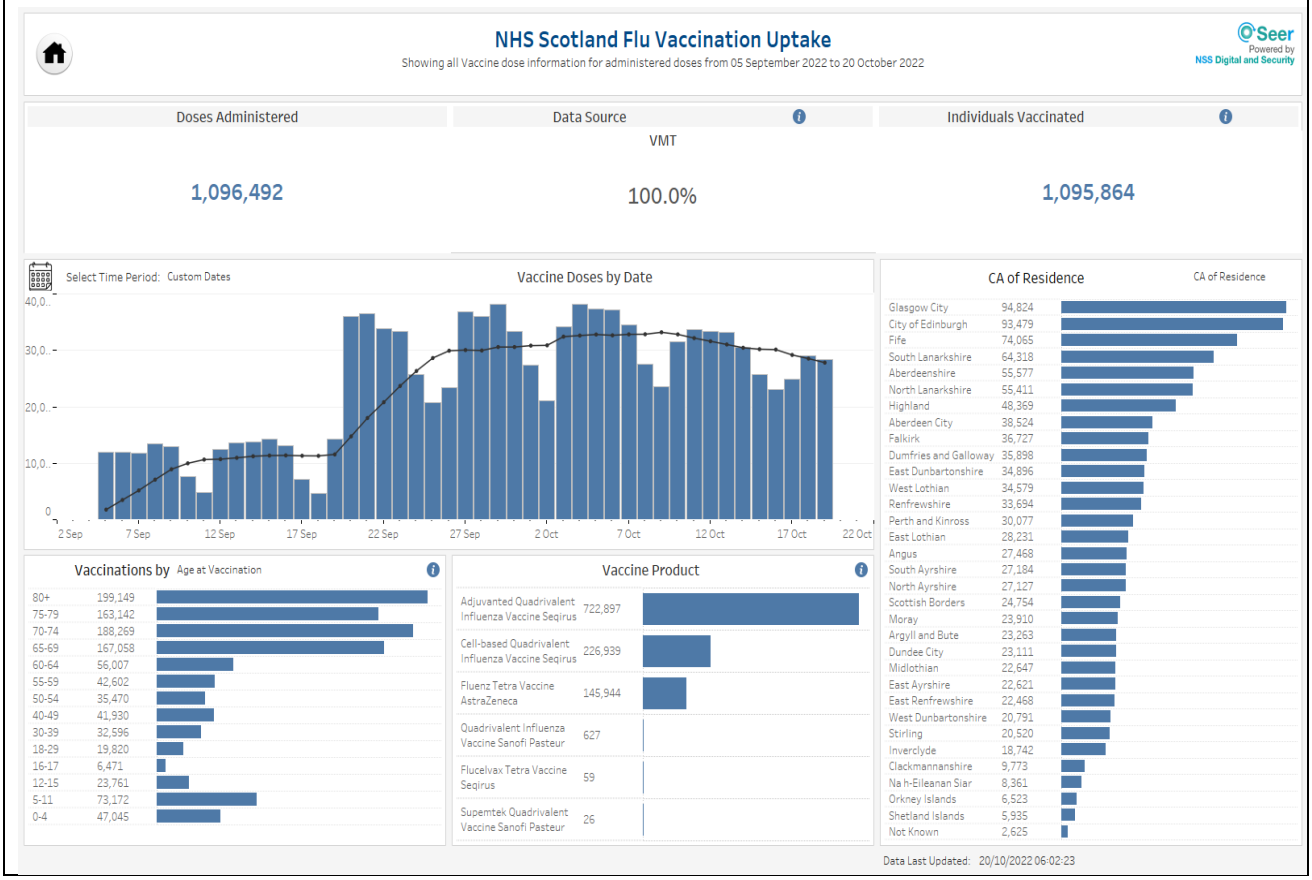
North Highland has been challenged in the number of locations it has been required to deliver clinics in and initial feedback that clinics were not close enough to home, especially for the over 65 age group led to remodelling of the model. This entailed cancelling some existing clinics to accommodate extra locations.

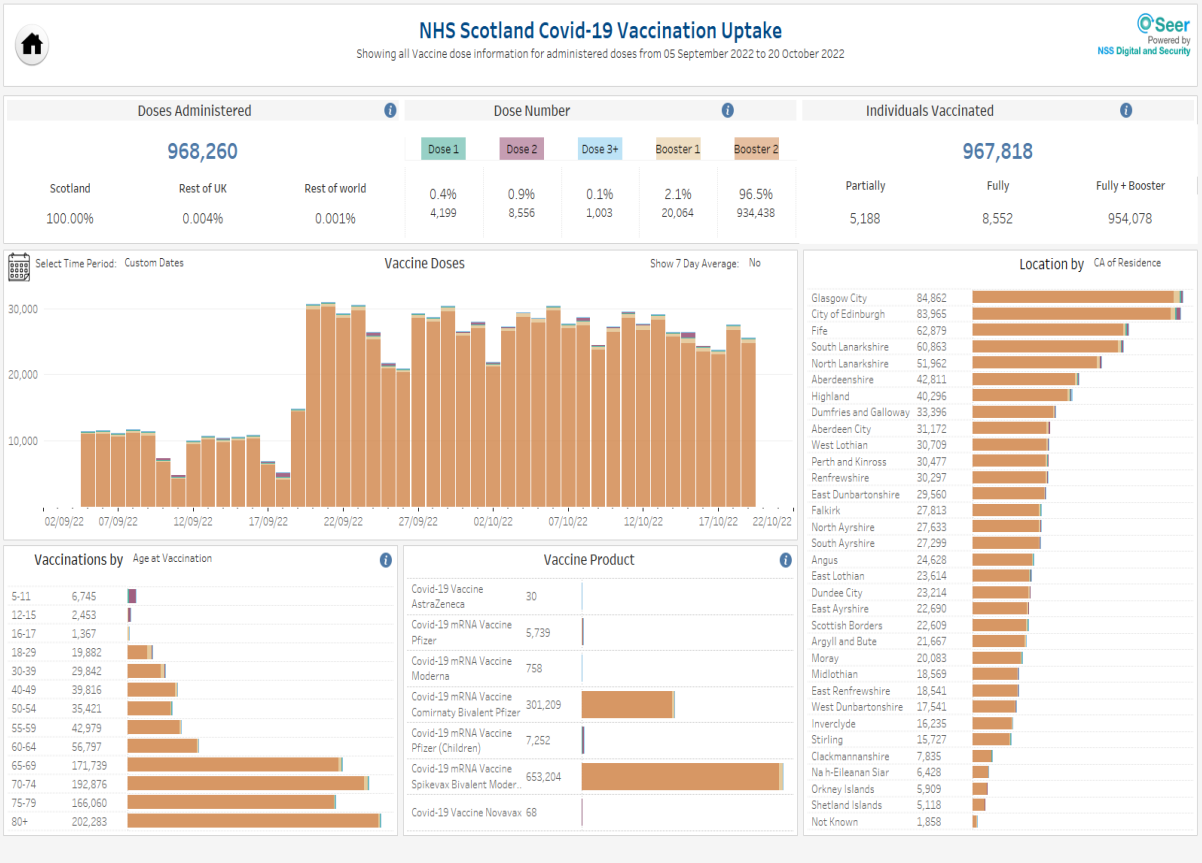
The following map identifies the remodelled community locations.



Current North Highland performance at 20th October 2022 is illustrated in the following 2 diagrams.

Flu vaccines delivered = 48, 369 (30% of eligible population)
Covid vaccines delivered = 40,296 (27% of eligible population)





North Highland faces challenges during the second half of the campaign including:

- Staffing issues – temporary registration has been extended for 2 years but we have seen a significant drop in bank shift pick up from the end of September.

- Clinic capacity. Acceleration requirement has meant the loss of 17,000 clinical slots. This is achievable in modelling however slot attrition through non-use or DNA's with more people rebooking for later in the campaign is placing pressure on availability.

- Ongoing issues to understand up to date capacity and demand figures. The speed of change and the complexity of information makes facts difficult to obtain in a timely manner. New processes being developed but the issues make capacity generation and scheduling extremely complex in the timeframes available.

7. GP Update

Caithness

There are 3 GP practices in Caithness that are managed by NHS Highland - Riverview (Wick), Riverbank (Thurso) and Lybster. In 2021 there was a merger of Riverbank practice in Thurso with Lybster practice which was operating as a single-handed GP practice. There is currently an organisational change process in place to now incorporate the Riverbank practice within this model. The three practices will operate as the 'Three Harbours Medical Practice' - a name change proposed by staff. The three practices will form a single primary healthcare team operating out of three locations.

The aim of this proposal is to provide resilience and sustainability across the three sites whilst improving staff professional development, training and peer support.

Invergordon & Alness

This practice transferred to NHS Highland on 1 February 2022 and remains a practice that is in active turnaround. Staff TUPE transferred to NHS Highland from that date and the process of harmonisation of terms of conditions will take place through an organisational change process. Similar to the Caithness primary care redesign, a staffing structure will be put in place supported by a comprehensive recruitment campaign. The practice is currently using a mix of both on-site and remote GP locums. Our forthcoming recruitment campaign will look at developing portfolio posts for a range of GPs. A patient participation group has been established which meets on a quarterly basis.