NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**11 January 2023**
Title:	**HHSCC Finance Report – Month 8 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 8 2022/2023 (November).

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 NHS Highland financial position at Month 8, the Highland Health & Social Care Partnership financial position at Month 8, 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 8.

.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 8

2.1 For the eight months to the end of November 2022 NHS Highland has overspent against the year to date budget by £23.692m and is forecasting an overspend of £40.511m at financial year end.

2.2 The year to date position includes slippage against the CIP of £11.030m with slippage of £16.714m 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 November 2022 (Month 8)

Current Plan £m	Summary Funding & Expenditure	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
1,087.576	**Total Funding**	687.724	687.724	-	1,087.576	-
	Expenditure					
406.409	HHSCP	271.904	277.807	(5.903)	417.972	(11.563)
246.988	Acute Services	167.401	184.912	(17.511)	274.743	(27.754)
200.140	Support Services	93.692	93.723	(0.031)	200.934	(0.794)
853.537	**Sub Total**	**532.996**	**556.441**	**(23.445)**	**893.649**	**(40.111)**
234.038	Argyll & Bute	154.728	154.975	(0.248)	234.438	(0.400)
1,087.576	**Total Expenditure**	**687.724**	**711.416**	**(23.692)**	**1,128.087**	**(40.511)**

2.4 Whilst a Recovery Plan has been developed to reduce the forecast overspend at Month 3 the forecast presented above only reflects those actions which have delivered to date. These will flow through to the position when there is certainty around deliverability.

3 HHSCP – Period 8

3.1 The HHSCP is reporting an overspend of £5.903m at the end of Period 8 with a year end overspend of £11.563m forecast.

3.2 The forecast position includes slippage of £6.288m 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 November 2022 (Month 8)

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
223.215	NH Communities	148.795	153.669	(4.874)	232.312	(9.096)
44.955	Mental Health Services	30.336	31.022	(0.685)	46.874	(1.919)
142.087	Primary Care	94.568	94.228	0.341	141.789	0.298
(3.848)	ASC Other includes ASC Income	(1.796)	(1.112)	(0.684)	(3.002)	(0.846)
406.409	**Total HHSCP**	**271.904**	**277.807**	**(5.903)**	**417.972**	**(11.563)**

Table 3– HHSCP Financial Position as at 30 November 2022 (Month 8)–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					
247.423	Health	164.926	169.801	(4.875)	255.297	(7.875)
158.986	Social Care	106.978	108.005	(1.028)	162.675	(3.689)
406.409	Total HHSCP	271.904	277.807	(5.903)	417.972	(11.563)

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

Table 4– North Highland Communities as at 30 November 2022 (Month 8)

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
68.130	Inverness & Nairn	45.468	45.673	(0.205)	69.257	(1.128)
47.872	Ross-shire & B&S	31.981	32.472	(0.491)	48.813	(0.941)
43.103	Caithness & Sutherland	28.863	28.842	0.021	43.338	(0.235)
49.355	Lochaber, SL & WR	32.911	32.372	0.539	50.089	(0.735)
5.167	Management	3.152	7.693	(4.541)	10.818	(5.651)
4.593	Community Other AHP	3.080	2.901	0.179	4.414	0.179
4.997	Hosted Services Includes Midwifery	3.340	3.715	(0.375)	5.582	(0.586)
223.215	Total NH Communities	148.795	153.669	(4.874)	232.312	(9.096)
70.973	Health	47.088	50.784	(3.696)	76.222	(5.248)
152.242	ASC	101.707	102.885	(1.178)	156.090	(3.848)

3.5 A year to date overspend of £4.874m is reported within NH Communities with this forecast to increase to £9.096m by financial year end.

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

- £2.919m 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 November 2022 (Month 8)

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					
21.181	Adult Mental Health	14.144	15.029	(0.885)	23.102	(1.921)
12.656	CMHT	8.492	8.083	0.409	12.084	0.570
5.961	LD	3.979	4.227	(0.248)	6.518	(0.557)
5.158	D&A	3.722	3.683	0.039	5.169	(0.011)
44.955	Total Mental Health Services	30.336	31.022	(0.685)	46.874	(1.919)
34.363	Health	23.269	24.790	(1.521)	37.321	(2.959)
10.593	ASC	7.067	6.232	0.835	9.553	1.040

3.8 Mental Health Services are reporting a year to date overspend of £0.685m with this forecast to increase to £1.919m by financial year end.

3.9 The overspend within the Health element of Mental Health Services is being driven by unachieved savings (£1.136m), agency costs (£0.899m) within the learning disability and dementia units and ongoing locums within Psychiatry and £0.450m in respect of services previously provided out of area. Ongoing vacancies continue to mitigate 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 £0.341m with this forecast to move to reduce to an underspend of £0.298m by financial year end. Recruitment challenges within the Dental service continue to mask locum costs associated with provision in 2C practices.

3.12 ASC Central is forecasting an overspend of £0.846m with ongoing vacancies mitigating the forecast slippage on the Cost Improvement Programme of £2.100m.

4 Savings Programme

4.1 The HHSCP has a savings target of £9.293m (including ASC) for 2022/2023. £3.005m of savings are currently forecast to be achieved with slippage against the Cost Improvement Programme forecast at £6.288m.

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). Mental Health allocations will be made in Q4 based on spend forecast up to 31 March 2023. Finance Business Partners are currently progressing a number of returns for Scottish Government alongside operational leads.

6 Recovery Plan

6.1 The NHS Highland forecast overspend of £40.511m is based on a number of assumptions in relation to both expenditure levels and funding and is considered to be the likely position should the remaining actions identified within the Recovery Plan submitted to SG at the end of September not materialise.

6.2 SG requested that a Recovery Plan was submitted detailing actions which would bring the forecast financial position in line with the financial plan submitted in March 2022. For NHS Highland this means delivery of a position that is no more than £16.272m overspent.

6.3 The plan submitted detailed £19.997m of potential mitigating actions which if delivered would would have brought the forecast position down to an overspend of £13.603m.

6.4 At the end of month 8 benefits arising from technical adjustments, a VAT reclamation exercise and NI rate movement have been built into the forecast position. However, since submission of the plan there has been further slippage on the CIP and cost pressures have accelerated in some areas.

6.5 £14.846m of mitigating actions are still being pursued. Should these all materialise the forecast position at month 8 would reduce to £25.665m. This is £9.393m adrift from the position SG are expecting the Board to deliver – work continues to identify further efficiencies which could be delivered before financial year end.

7 2023/2024 Budget Update

7.1 The Deputy First Minister announced the Scottish Government's Budget for 2023/2024 in Parliament on 15 December 2022. This budget is still subject to amendments through the Scottish Parliament's Budget Bill process – it also recognises further work in relation to Covid-19 and pay funding arrangements.

7.2 The main points included are summarised below:

- Compared to 2022/2023 budgets Boards will receive a total increase of 5.9% for 2023/2024.
- This includes recurring funding for the 2022/2023 pay award and a baseline uplift of 2%.
- £69.1m was allocated to Boards in 2022/2023 to support the increased NI levy. Whilst NI rates have reduced back down this funding will remain with Boards. It is not ringfenced and Boards can utilise this resource locally.

7.3 The Baseline position for NHSH is detailed in the table below:

	£m
Baseline allocation	725.6
Recurring allocations (2022/2023)	(0.5)
2022/2023 Pay Uplift	27.8
Total 2022/2023 Allocation	752.9
Uplift	15.3
2023/2024 Total Allocation	**768.2**
Uplift % age	*5.9%*

7.4 The 2022/2023 Pay Uplift is an estimate at this time. SG have been asked for background on this estimate as is it significantly lower than the NHSH estimate of funding required to fully fund the 2022/2023 uplifts.

8 Recommendation

- Highland Health & Social Care Committee members are invited to discuss the month 8 and forecast financial position as presented in the paper.

Appendix 1

Services Category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's	Forecast Variance £000's
Older People - Residential/Non Residential Care						
Older People - Care Homes (In House)	14,777	9,498	9,153	345	14,884	(107)
Older People - Care Homes - (ISC/SDS)	32,452	21,741	22,437	(696)	33,650	(1,197)
Older People - Other non-residential Care (in House)	1,150	784	723	61	1,088	63
Older People - Other non-residential Care (ISC)	1,590	1,061	1,034	27	1,307	284
Total Older People - Residential/Non Residential Care	**49,970**	**33,084**	**33,348**	**(264)**	**50,928**	**(959)**
Older People - Care at Home						
Older People - Care at Home (in House)	14,969	9,967	9,702	264	14,785	184
Older People - Care at home (ISC/SDS)	16,577	11,251	12,331	(1,080)	17,873	(1,296)
Total Older People - Care at Home	**31,546**	**21,217**	**22,033**	**(816)**	**32,658**	**(1,112)**
People with a Learning Disability						
People with a Learning Disability (In House)	4,413	2,928	2,178	750	3,593	820
People with a Learning Disability (ISC/SDS)	34,431	23,214	23,286	(72)	35,117	(686)
Total People with a Learning Disability	**38,844**	**26,142**	**25,463**	**679**	**38,711**	**133**
People with a Mental Illness						
People with a Mental Illness (In House)	520	346	195	151	308	211
People with a Mental Illness (ISC/SDS)	7,890	5,276	5,186	91	7,674	216
Total People with a Mental Illness	**8,410**	**5,623**	**5,381**	**242**	**7,983**	**427**
People with a Physical Disability						
People with a Physical Disability (In House)	911	612	422	190	730	181
People with a Physical Disability (ISC/SDS)	6,878	4,658	4,517	141	7,688	(810)
Total People with a Physical Disability	**7,789**	**5,270**	**4,939**	**332**	**8,418**	**(629)**
Other Community Care						
Community Care Teams	7,625	5,118	4,372	746	6,864	761
People Misusing Drugs and Alcohol (ISC)	16	11	7	4	10	6
Housing Support	6,091	4,038	3,840	198	5,992	99
Telecare	889	625	478	147	749	140
Carers Support	512	820	820	-	512	-
Total Other Community Care	**15,133**	**10,613**	**9,518**	**1,095**	**14,127**	**1,005**
Support Services						
Business Support	1,730	1,151	1,033	119	1,541	190
Management and Planning	5,563	3,878	5,692	(1,814)	8,308	(2,745)
Total Support Services	**7,293**	**5,029**	**6,724**	**(1,696)**	**9,848**	**(2,556)**
COVID	**-**	**-**	**599**	**(599)**	**-**	**-**
Total Adult Social Care Services	**158,986**	**106,977**	**108,005**	**(1,028)**	**162,675**	**(3,689)**

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 2 November 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
Cllr, Ron Gunn, Highland Council
Philip Macrae, Board Non-Executive Director
Joanne McCoy, Board Non-Executive Director
Michael Simpson, Public/Patient Representative
Catriona Sinclair, Chair of Area Clinical Forum
Wendy Smith, Carer Representative
Michelle Stevenson, Public/Patient Representative
Simon Steer, Director of Adult Social Care
Neil Wright, Lead Doctor (GP)

In Attendance:
Natalie Booth, Board Services Assistant
Stephen Chase, Committee Administrator
Lorraine Cowie, Head of Strategy
Pam Cremin, Deputy Chief Officer
Fiona Duncan, Chief Social Work Officer, Highland Council
Ruth Fry, Head of Communications and Engagement
Frances Gordon, Finance Manager
Arlene Johnstone, Head of Service, Health and Social Care
Marie McIlwraith, Project Manager, Communications and Engagement
Boyd Robertson, Chair of NHS Highland Board
Nathan Ware, Governance and Assurance Coordinator

Apologies:
Gerry O'Brien, Elaine Ward, Mhairi Wylie, Fiona Malcolm.

Ian Thomson had stepped down from Area Clinical Forum and a new representative will be appointed in due course.

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 and no declarations of interest were made.

- The Chair drew the committee's attention to the decision of Prof. Boyd Robertson to step down as Chair of NHS Highland in March 2023, and encouraged members to circulate the advertisement for the post which is available on the Public Appointments Scotland website (https://www.gov.scot/collections/public-appointments/) and the new NHS Highland website (https://www.nhshighland.scot.nhs.uk/careers/board-and-committee-appointments/).
- The Board has been reviewing the Non-Executive membership of the Board Governance Committees and a paper will go to the next meeting of the Board with proposed changes. These changes will only directly affect Non-Executive members.
- The Chair requested that item 5.2 be considered at this point in the meeting.

5.2 Appointment of Vice Chair to the Committee

The Chair noted that following a process open to NHSH Non Executive Director members, P Macrae had expressed interest in the position of offered his nomination as Vice Chair of the committee and she sought approval for his appointment.
The committee were happy to approve P Macrae as Committee Vice Chair.

- **The Committee APPROVED** the appointment of P Macrae as Vice Chair of the committee.

2 FINANCE

2.1 Year to Date Financial Position 2022/2023 [PP.1-9]

F Gordon gave an overview of the month 6 position from the paper on behalf of E Ward.

- A one-year plan had been submitted to Scottish Government in March, with a further revision submitted in July. This identified an initial budget gap, of £42m of which £26m referred to Cost Improvement Programme and £3m to Adult Social Care, leaving a balance of £16m unfunded.
- The Quarter 1 statement showed that the position had worsened and therefore a recovery plan was put in place with mitigating actions to be monitored by the EDG and FRB Committee.
- During Period 6, NHS Highland had overspent by £19m to date with a predicted overspend of £39m for the year end.
- A worsening position was shown from month 5 due to a more pessimistic forecast on savings and a to lower than anticipated allocation from Scottish Government for Scheduled Care.
- The majority of actions for the recovery plan are from Central Services with some cross-cutting actions mainly in locum and agency.

During discussion,

- Assurance was given that there is a recovery plan to address rising costs which has been submitted to the Board and Scottish Government.
- The Chief Officer added that there are increasing pressures to expand services to address winter demands and at the same time to contain costs and this is a difficult balance to achieve. Planning methods are currently under review with the new Director of Finance, especially in terms of addressing hot spots such as locum agency spend. These challenges do not have quick fixes, and work is underway to assess essential services and those areas of provision which do not have an established budget.

- There are areas within Community Services which have only had short-term money and therefore there is a need to assess if some of these services should continue or be delivered in a different way.
- The Chief Officer provided an overview of the structures for monitoring the financial position and progress against the recovery plan, these include: a senior leadership team who meet every week when the core areas report on the current state of their improvement plans and financial position; the Finance Recovery Board sits once a week to review escalated reports (the processes for this latter group are under review in order to better link with the Strategy Team's work on performance); the EDG (Executive Directors Group) have oversight of escalated matters and are tasked with making the difficult decisions about the direction of travel and how to manage governance processes.
- Cllr Cockburn expressed caution at stopping those areas of work in receipt of short-term funding, especially where these projects have been beneficial to the population, and emphasised the importance of looking for solutions from staff at ground level.
- L Bussell commented that no significant decisions have as yet been made regarding reducing non-funded services and that serious consideration was being given to these services where beneficial impact has been noted. Both L Bussell and A Johnstone commented how staff had been involved in a number of aspects of savings solutions.
- The Chair asked the Chief Officer to summarise the main reasons for the difficulty experienced over the past year in achieving savings and to suggest how ASC might manoeuvre itself into a better position for the forthcoming year.
- L Bussell noted the impact of COVID funding and other pockets of support from Scottish Government which had encouraged a mindset of building and developing service provision which is now faced with a retraction of support when the multiple pressures these services have sought to address have not gone away.
- J McCoy asked about the national piece of work to address the reliance on locums and agency staff.
- L Bussell responded that there had not been an update on the national work. In the meantime other avenues for containing locum spend continued to be explored. This is a challenge when vacancies are a national issue which means that if NHS Highland tightens controls locums are easily able to find work elsewhere.
- Cllr Gunn asked about the significant spend by NHS Highland for taxis delivering medication to patients and if there was a more economical way. M Stevenson noted that there had been ongoing problems of logistics with the company used to deliver medication via courier to people in the Highlands, and that Royal Mail next day delivery had been more reliable.
- L Bussell answered that transport is under active consideration in terms of medication and more generally. The geography of the area and population sparsity means that sometimes taxis are the most efficient and effective mode of delivery.
- It was asked what the unachieved savings referred to in point 3.6 were. This was clarified as the month to date position.
- N Wright asked what the process is for making difficult decisions, and commented on the responsibility to provide palliative care and the importance of the chronic pain service to the population of Highland, which requires better funding to address both the immediate need and in reducing admissions to Acute Services.
- L Bussell answered that Enhanced Community Services had been supported with money from Scottish Government, however this was non-recurrent and there is now a service gap. The Palliative Care Helpline, had been funded out of COVID monies, and work is underway to consider how this can be supported in its current form or how it might be redesigned to work as part of normal services.
- The decision-making approval process involves representatives from all the professional leads and interacts with a variety of key partners and organizations with a quality impact assessment approach.

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 31 August 2022 [PP.10-22]

The draft Assurance Report from the meeting of the Committee held on 31 August 2022 was approved by the committee pending a correction to show that P Macrae had been in attendance.

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

3.2 Matters Arising From Last Meeting

M Simpson commented that he had expected information on the energy costs for NHS Highland arising from discussion at the August meeting as part of the Finance Update for the present meeting. It was agreed that E Ward will provide information at the next meeting.

The Committee:
- **AGREED** that E Ward update the committee on the matter of energy costs for NHSH.
- **NOTED** the update.

3.3 Winter Planning [PP.23-30]

L Bussell introduced the presentation and noted that this work had been carried out in conjunction with work on Unscheduled Care, that planning had been shared with Scottish Government, and that a Task and Finish Group has been running weekly.

- L Cowie gave an overview of the key points of the slide show which had been circulated ahead of the meeting and noted that the planning had been aligned with the overall strategic objectives for NHS Highland through Together We Care Key Performance Indicators.

During discussion the following points were addressed,
- F Duncan noted that Scottish Government had asked for all unsafe discharges from hospital to be monitored during the winter planning through a variety of different reporting places including the Clinical and Care Governance Group which monitors any ‘unsafe discharges’ from hospital into the community.
- It was clarified that ‘unsafe discharges’ refer to situations which arise on occasion e.g. where a patient has been discharged from hospital into the community without the proper medication, without enough resource or feedback in terms of care required to enable them to remain safely at home. Communication breakdowns and staff shortages in care at home services are examples of contributory factors.
- S Steer added work is underway to determine how often this happens and noted that these situations ought to be recorded via Datix, and that this work is a part of the larger Winter Planning programme.
- L Bussell confirmed that a report would be provided soon to the committee on the revised arrangements for clinical and care governance as far as the Community Directorate is concerned.
- W Smith asked if there was any provision for people who are particularly vulnerable or with complex health problems to take priority.
- L Bussell confirmed that a key area of planning was to ensure that there are good Community contingency plans in place for any vulnerable people who are known to the service in order to address breaks in service due to things such as inclement weather. This information is communicated via an individual’s link worker.
- T Allison emphasized the need to communicate the importance of preventative elements such as the vaccination programmes.

- L Bussell commented that the communications plan will have a focus on making the public aware of preventative measures. NHS Highland is working with its partners in the Third Sector to ensure provision is joined up and resilience maximised.
- M Simpson asked if there was provision to check that discharged patients were being returned to a warm home. He also noted the difficulty of accessing 'warm hubs' in remote and rural areas and asked what role the community planning partnerships play in this regard.
- L Cowie commented that Kate Cochrane, as part of her resilience remit, is leading on coordination work with partnerships.
- The Chair commented that locality reports from each of the nine districts are due to be trialled and these will include a focus on any activity going on under the auspices of the Community or in conjunction with the Community Planning Partnership.
- P Macrae noted that there is a lot of work going on across the nine community partnerships within the Highland area which is feeding in to the Winter Planning.
- In the Mid Ross area there is a concentration on topics such as poverty and mental health, and noted with T Allison that the role of the partnerships is to assist coordination of deliver more so than delivery of service itself.
- M Cockburn commented that there had been feedback to the Council that the idea of 'warm hubs' is welcomed but that there is a fear of leaving the house in the community post-COVID and into the harsher weather which may put people off using the hubs.
- S Steer commented that Kate Cochrane's work is looking for solutions to the issue of whether or not warm hubs are appropriate in remote and rural areas, and that the feedback to the Council will inform decision making.
- L Bussell noted that assurance around the progress of the Winter Planning would be seen via the IPQR dashboard reporting, and that it would be useful for a report to come to the committee in late winter/early spring to help show what the planning has achieved and what have been the challenges.

The Committee:

- **NOTED** the Winter Ready Planning work and that an assurance report would come to the Committee in 2023 evaluating challenges and achievements.

The committee held a short break at this juncture.

3.4 Engagement Framework [PP.31-62]

R Fry introduced the report and noted that this is the second year of a three-year communications and engagement strategy and there was still a requirement for a strategic level blueprint to help shape and guide engagement activity across all services with guidance for procedures and a template for training. The framework was presented with a view to receiving feedback as to what the committee would like to see included and what assurance reporting would be welcomed.

In discussion the following questions were raised,

- W Smith commented that it would be beneficial to have carer or patient representation on the oversight group to give input to the governance process.
- The Chair noted the density of the activity implied by the proposed governance atrrangements and asked if the short life working group had considered any alternative approaches to oversight, such as embedding responsibility within the existing performance framework.
- R Fry clarified that the short life working group had noted a significant concern that there be representation from patients, from carers, and from others who use NHS Highland's services, and it didn't feel like there was an exact fit for that in any existing mechanism within the board.
- M McIlwraith added that the advisory group would be closer to the ground and enable more of a two-way conversation, and that the oversight group would be looking at the

larger engagement picture and provide structured recommendations where that was needed.

- The quorum status of the oversight groups was under consideration due to the desire to have wide representation while also addressing the difficulty for attendance at every meeting. The oversight group currently has carer representation.
- J McCoy asked if the meetings would be digitally accessible, if support was available during the meetings to those who would require it, and if funds were available to assist with travel if this was not the case.
- M McIlwraith answered that work is underway with partners to ensure meetings are accessible and that information will be available in different formats. Costings for this are also under consideration.
- M Simpson commented that due to the detail and all-encompassing nature of the report that it should be assessed after 12 months in order to get a good picture of progress.
- R Fry noted that there was a list in the appendix of all the groups who had been consulted, who while they may not have attended the meetings had had sight of the draft framework.
- W Smith commented on the difficulty of engaging with carers especially in terms of demand on their time.
- M McIlwraith noted that there had been a number of pilot projects with Mental Health and Learning Disability work which had been crucial to the tools in the framework. Work is under way with Ian Thomson's group around how the organisation engages with carers as part of the Mental Health and Learning Disability framework.
- The Chair suggested that in addition to an annual assurance report to the Committee, that all substantive reports on service redesign and locality services should include information on implementation of the engagement framework to better embed the work as part of business as usual.
- The Chair noted that it is the Board who will approve the Engagement Framework, that the committee's role in this instance is advisory and suggested that R Fry and M McIlwraith's team consider the feedback and return with an update especially with regard to quorum membership and equity and inclusion of views.

The Committee:

- **AGREED** to accept moderate assurance from the report.
- **Agreed** that an update return to the committee

3.5 Dashboard Reporting [PP.63-78]

L Bussell introduced the report, noting the good discussion that had been had on the topic at the committee's development session in September, and invited questions from the committee.

During discussion, the following points were addressed,

- The Chair asked if Board level data on vaccinations and Drug and Alcohol were possible for the partnership area. L Cowie confirmed this was possible.
- L Bussell noted that the Board is paying more for activity in order to sustain Care Homes, especially smaller homes which cost more to run. Some care homes are dependent on agency staff from outside the partnership area.
- J McCrory commented on p.72 of the papers with reference to the graphs describing delayed discharge blockages on assessments,.
- L Bussell answered that this data was being examined in detail as there had been some changes to coding of different situations, for example when someone is assessed but waiting funding, which could be distorting the picture regarding assessments.
- The Chair asked in relation to psychological therapies if there are agreed trajectories for improvements and whether we are sufficiently joining up investment in the Third Sector with investment in Primary Care and Community Mental Health Teams. L Bussell agreed

that early intervention in the community and Primary Care is critical, confirmed the Director of Psychology is heavily involved in improving pathways.
- The Chair noted a previous offer from M Wylie to report on the funding from SG being administered by her organisation and suggested this be requested alongside the next report to Committee on mental health services.

The Committee:
- **AGREED** to accept moderate assurance from the report.
- **AGREED** that M Wylie be invited to contribute a report on outcomes from the funding for community mental health projects at a future meeting.

3.6 Annual Report (Public Bodies) [PP.79-97]

L Bussell noted the positive information and progress seen in the report with especial reference to benchmarking. Concerns had been expressed from some groups such as Carers who feel that they have had a long past two years and need better support.

The Chair noted that the evidence from carers confirmed the importance of the work being undertaken on the SDS and Carers Strategies. There was much to celebrate regarding work to sustain services despite the impact of COVID.

The Committee:
- **NOTED** the report.

3.7 Chief Officer's Report [PP.98-105]

L Bussell gave an overview of the report and noted that a couple of areas in the report had less detail due to their inclusion in the IPQR reporting and invited the committee to provide feedback on the level of detail.

In discussion,
- M Simpson asked for clarification that the North Coast Redesign will not be subsumed into the Caithness Redesign, and commented that there is a need for better communication with the community on matters such as ensuring GP provision for the area and determining how the redesign will work if it is not building dependent as stated in the report (p.78)
- L Bussell confirmed that there is no plan to subsume the redesign projects and that the pieces of work are reported on by separate teams. There is work to be done in terms of wording and communication of the work with the communities as the proposals for reshaping services progress. Part of the aim in bringing certain areas of work such as Out of Hours under one section is to assess the different models used in the districts and provide a more consistent level of service.
- M Simpson asked when engagement in line with the framework discussed earlier in the meeting would beging with regards to the North Coast Hub and whether there would be scope to use the reprovisioned buildings for other needs such as accommodation for health and professional care workers.
- L Bussell noted that dates for consultation and discussion are being set out, and that any public building will go through the standard process for asset transfer when they become available.
- W Smith commented that it was good to see a breakdown in the finance paper of the different needs for people living with different kinds of disabilities but that there appeared to be information missing regarding what is left on carer spend or plans for future spend for carers.
- It was agreed that this information would be clarified for the next meeting.
- J McCoy asked if the uptake for vaccinations had been as expected.

- T Allison commented on the complicated picture which showed varying levels of uptake by area and age group. The vaccinations programme had been accelerated under instruction from Scottish Government with the aim of completing the programme for the 50- to 65-year-old age group by early December and this is slightly behind and expected to complete later in December.
- L Bussell clarified reference in the report (p.104) to the loss of 17,000 clinical slots due to the acceleration of the programme. In addition to the reprofiling of clinics required by the acceleration of the target end date a high Did Not Attend (DNA) rate early in the programme with associated rebookings by DNAs to later clinics has also been problematic.
- Comments were made by a number of members on the need to provide positive messaging to ensure better vaccination take up. There were also anecdotal accounts of the pressures at oversubscribed local clinics which had delayed availability of vaccinations in some areas, and the inappropriate building settings for some clinics which necessitated negotiating steep stairs.
- T Allison noted that wastage of vaccinations from did not attend (DNA) appointments is generally minimal.
- L Bussell accepted there had been challenges in finding suitable venues but efforts continued to find alternatives where necessary.

The Committee:
- **NOTED** the report.

4 HEALTH IMPROVEMENT

- Cllr Birt commented that there had been no items for discussion under this heading since he had started attending the Committee.
- T Allison noted that this omission reflected committee dynamics, in that pressing matters of health improvement oversight were often considered via other committees such as the Clinical Governance Committee, but that there was certainly scope for items to be considered at the HHSCC.
- The Chair noted that there was to be a meeting with the Director of Public Health to which Cllr Birt would be invited to review future areas for discussion by the committee on a Public Health theme.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Committee Annual Work Plan

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 noted** that the Work Plan would be reviewed and presented at the January meeting.

5.2 Appointment of Vice Chair to the Committee

(*See above, after item 1*.)

- **The Committee APPROVED** the appointment of P Macrae as Vice Chair to the Committee.

6 AOCB

- M Simpson commented that this was the last meeting of the committee before the Christmas break and wished the Chair and the Committee well for the holidays, which the committee returned in kind.

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

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 11th January 2023** at **1pm** on a virtual basis.

The Meeting closed at 3.55 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

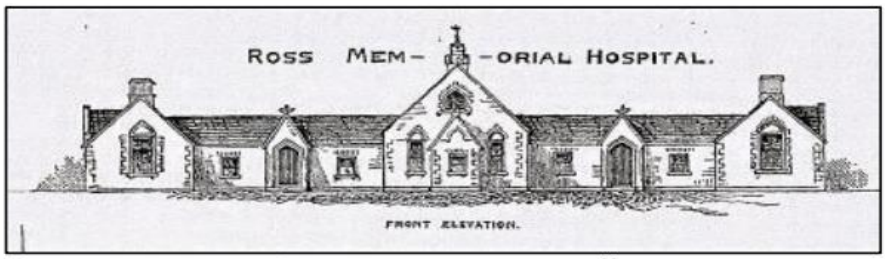
Items to be Followed Up Outwith Meetings

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

District Profile



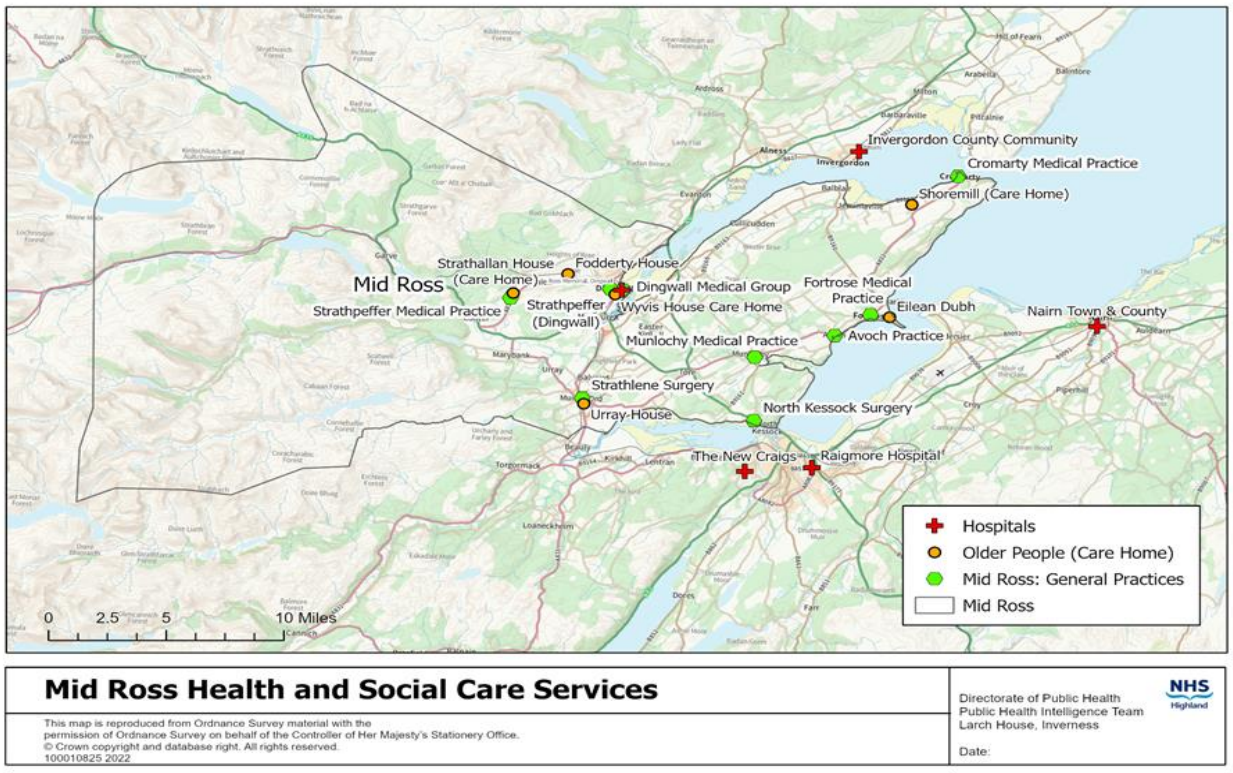
Original Front Elevation[88]

District: Mid Ross District

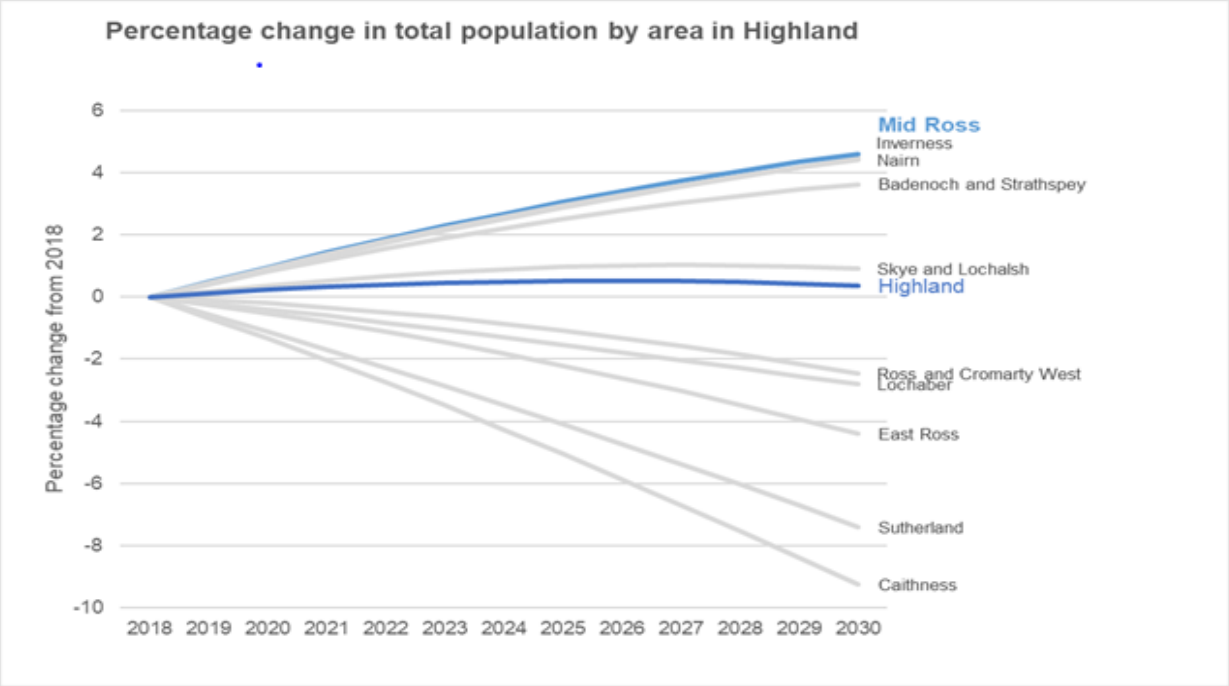
Manager: Kenny Rodgers

Locality Demographics

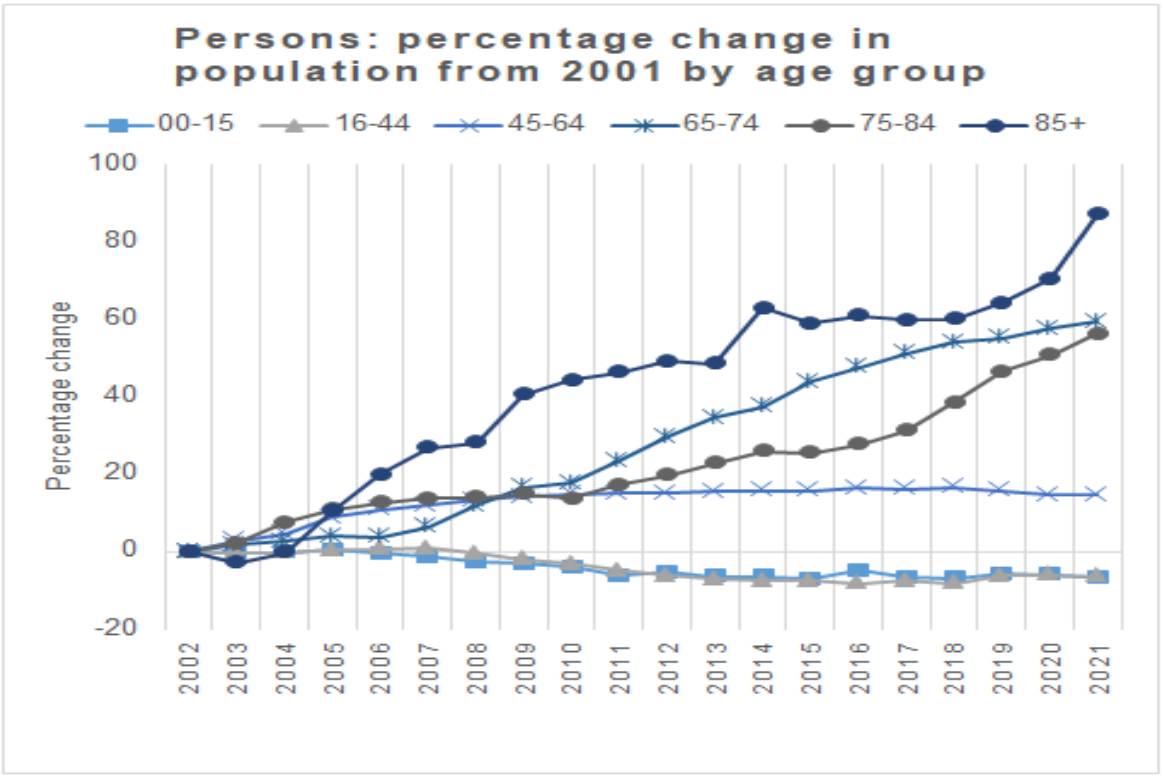
Mid Ross District serves the geographical area of Dingwall, Seaforth and the Black Isle.



The population is just under 25,000 people with the main population centred in the county town of Dingwall. Other key population centres are Strathpeffer, Muir of Ord, Munlochy, Fortrose, Cromarty and Culbokie. There are significant rural populations around Strathconon, Garve, Leanaig and the Black Isle.



The population is the highest projected change in population growth in Highland in the main due to inward migration from increases in housing in Muir of Ord, Dingwall, Munlochy, Fortrose and Avoch.



The population is increasingly elderly with an increasing demographic in the over 85 age group since 2018.

The over 65 population has increased from 17% of the population in 1998 to 25% in 2021 and is forecast to be 31% in 2030.

The increase in the over 65 population and in particular the over 85 population increases the demand for older people care services as more people are living longer with increased frailty, dementia and co-morbidities.

Services provided and current workforce

Mid Ross district provides health and social care services from the base at Ross Memorial Hospital in Dingwall.

These services encompass the community hospital, District Nursing, Enablement, Community Rehabilitation Physiotherapy, Occupational Therapy and Social Work. The district also oversees the services provided by the independent sector care homes (x6) and care at home services (x6). Services to the district are accessed via a single point of access.

Community Teams provide care across a wide geographical area and provide vital services to support people in their own homes. The increased number of older people with co-morbidities is a particular challenge as are the increasing complexity of care needs that can be provided in the home. Insulin administration is a particular problem for District Nurses where the numbers of patients has increased significantly leading to challenges in delivering safe care at the right time. An increase in demand for supporting end of life care at home has had a significant impact on our district nurses and enablement care at home provision.

Occupational Therapy and Physiotherapy provide key services such as inpatient, community, neurological rheumatology, pulmonary and cardiac rehabilitation and also significantly support the Enablement / Assess at Home service in preventing hospital admission and early supported discharge home.

Mainstream Care at Home is provided by the independent sector and is a key service to ensure that people can remain at home with the support they require following a period of assessment and rehabilitation. There services are vital in ensuring care is delivered to people in the right way, at the right time. Unfortunately, due to recruitment and retention challenges, the capacity of this service is continually reducing whilst demands for care are increasing due to people living longer with more complex conditions and the desire of people to continue living in their own home The largest provider in Mid Ross has in the last 9 months handed back 300 hours per week of care on the Black Isle which has presented significant challenges in sustaining care for existing clients and has negatively impacted on support available for those who do not have the care they require.. Mid Ross District works closely with the 6 providers and local communities to encourage and grow a pool of care staff that are local to the area and ensure that these providers have long term sustainability. Independent sector providers strive to grow their staff capacity to meet the unmet need in the community, but in reality maintaining existing services is a challenge in itself.

The Enablement Service is our in house care at home service that supports assessment and care over a short term period. The focus of this team is ensuring that robust assessment of needs takes place and that care is delivered with rehabilitation focused approach to maximise independence of those living at home and ensuring that ongoing care delivered by the independent sector is tailored to patient need. The Assess at Home service has been developed from within the enablement service and primarily focuses on a

functionally based assessment which a rehabilitation first approach to support people to be discharged home from hospital with the right care at the right time or to prevent the need for admission to hospital.

The recently redesigned Highland Rheumatology Unit (HRU) provides a Highland-wide service for Rheumatology patients and includes 5 inpatient beds, consultant and specialist nurse outpatient clinics, specialist inpatient and outpatient Occupational Therapy and Physiotherapy services and an infusion service. All Rheumatology care now takes place in Dingwall reducing pressure on Raigmore and improving holistic access to services in one location for patients. The unit works closely with the Puffin Pool on the hospital site and patients access the pool as part of their care during an inpatient stay or as an outpatient.

The general ward has 9 beds and forms part of the Mid Ross community care model. Patients belonging to Mid Ross are 'pulled' from Raigmore to the ward for rehabilitation, end of life care or complex discharge planning. The community teams work with inpatients and families to support early discharge home with the right care in place supporting an independence approach.

The outpatient department accommodates a wide range of services including dental, musculoskeletal outpatient physiotherapy, ENT, Orthopaedics, Audiology, Care of Elderly, Cardiology, Scotcap, X-Ray and Bone Density scanning. There is significant demand for outpatient accommodation at Ross Memorial and there are not enough rooms to meet demand. Additional spaces have been opened up to provide additional outpatient rooms however these rooms are not bespoke and are in poor condition. Ross Memorial is popular with visiting services that provide regional services as it is a central location with easy access away from the Raigmore site.

The biggest challenge in Mid Ross District is the age and condition of Ross Memorial Hospital. The hospital is the oldest in the NHS Highland estate and celebrates 150 years of service to the community in 2023.

There are significant issues in respect of backlog maintenance, fire compliance, infection control and accessibility for disabled people. The floors on the ward slope through years of subsidence on old foundations on a tidal plane.

A development plan is required to ensure that fire compliance is met in the parts of the hospital building that can be operational going forward.

HAI (Hospital Acquired Infection) audits have highlighted an increasing number of essential works over the last few years such as compliant wash hand basins and internal maintenance / decoration that require to be addressed for compliance with infection control standards.

A series of high profile visits over the last year have recognised that Ross Memorial provides a high standard of innovative care with well-established and trained staff but the overall picture is an outdated facility of poor condition that does not meet modern hospital standards. These visits have been well received by staff who have been recognised for their hard work and dedication to quality improvement and innovation in order to ensure a high standard of innovative care is provided to the people of Mid Ross.

There continues to be a strong demand for clinical accommodation at Ross Memorial however there are not enough clinical rooms to meet demand, there is ongoing work to develop a plan for the future of the Ross Memorial Hospital.

The hospital is highly valued by local communities, and local authority members and community councils who are engaged in the development plans for the future of Ross Memorial with senior leaders in NHS Highland.

Finance & Performance

The total budget for the District is £16.5m and in 2020-21, underspent by £78k.

£13.4m of the budget relates to Adult Social Care services with £6m spent on Care Home services and £1m spent on Care at Home services.

£2.8m of the budget relates to community health services with £1m spent on District Nursing, £1.5m on hospital services and £800k on AHP services.

Care at Home capacity is now a significant challenge to support people in their own homes and facilitate timely hospital discharge.

The challenge of an increasing elderly population, living longer with increased co-morbidities and frailty set against a reducing number of home carers to deliver care is a 'wicked' problem that is a national and societal issue as well as a local challenge. The district currently has 264 hours per week of unmet need with the main pressure areas being Dingwall, Conon and Muir of Ord.

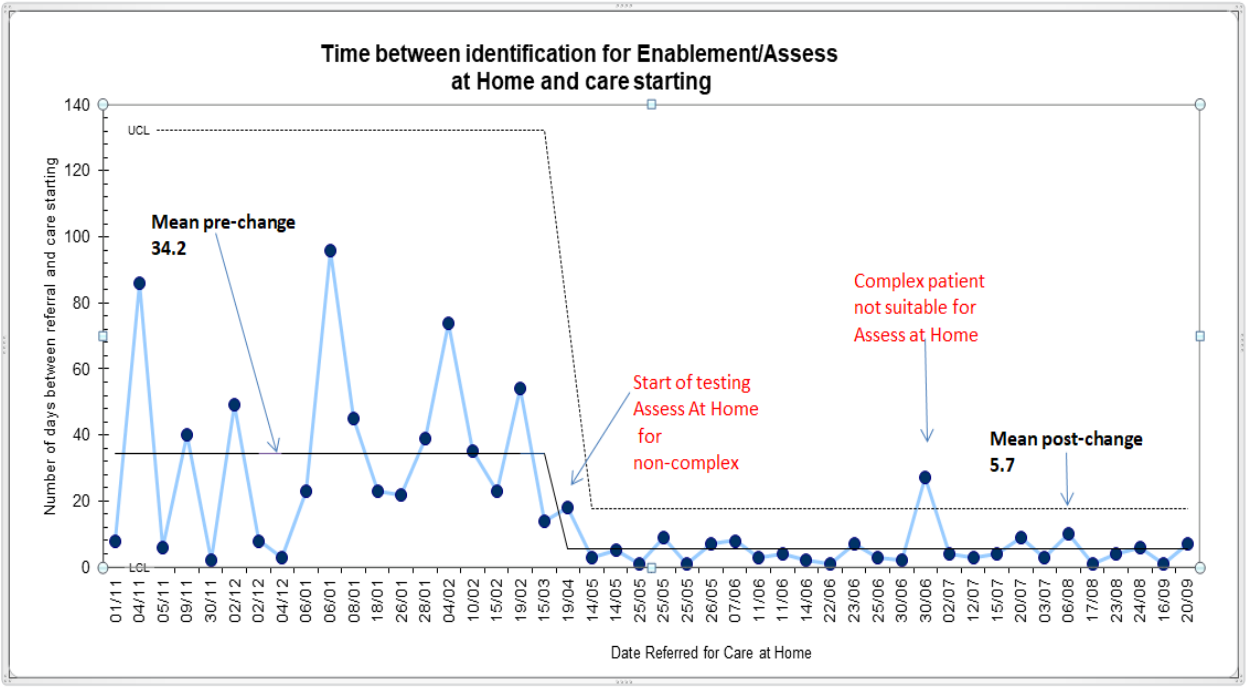
We are fortunate in Mid Ross to commission care at home services from 6 providers, all covering different geographical areas. We have a good working relationship with these providers and we work together to manage the existing care capacity to ensure that capacity is maximised and travel time minimised.

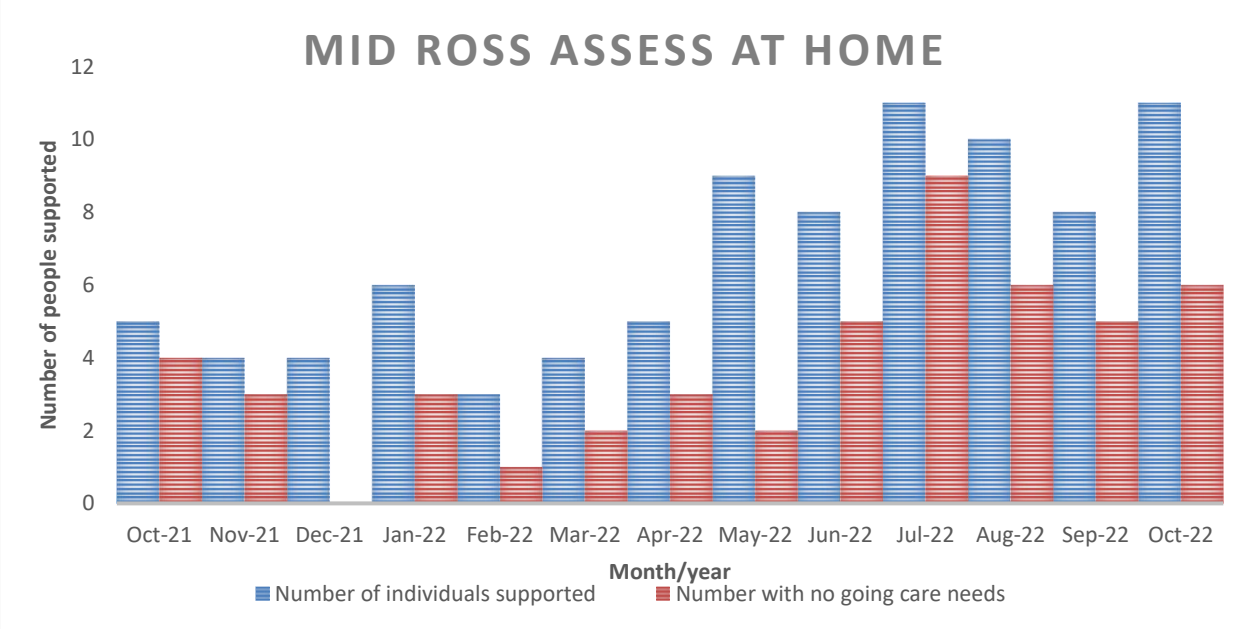
We have been working with our local communities and care providers to identify ways of increasing care provision using local people encouraged by their communities to enter the care profession. This approach is working well with Eilean Dubh Homecare on the north Black Isle and Top Care on the south Black Isle.

Opportunities and Developments

Mid Ross District has developed an Assess at Home service using the Rehabilitation framework which seeks to support early discharge from acute care with a functionally based assessment and delivery of rehabilitation focused care. This avoids the wait for care capacity following assessment which prevents the historical delay between assessment and care being available. The model seeks to promote a home based assessment of need as opposed to a hospital based assessment with a focus on regaining / promoting independence. This means that we can provide the right care in the right place at the right time for our patients. 54% of the individuals supported by assess at home were discharged with no ongoing care needs which has had a huge impact on our ability to manage the shrinking independent sector care at home capacity.

The Assess at Home service has been developed using non-recurring funds from within the District budget. Whilst recurring funding was allocated by NHS Highland for this service and staff recruited on permanent contracts, the future of this service is in doubt due to financial constraints on NHS Highland's budget.



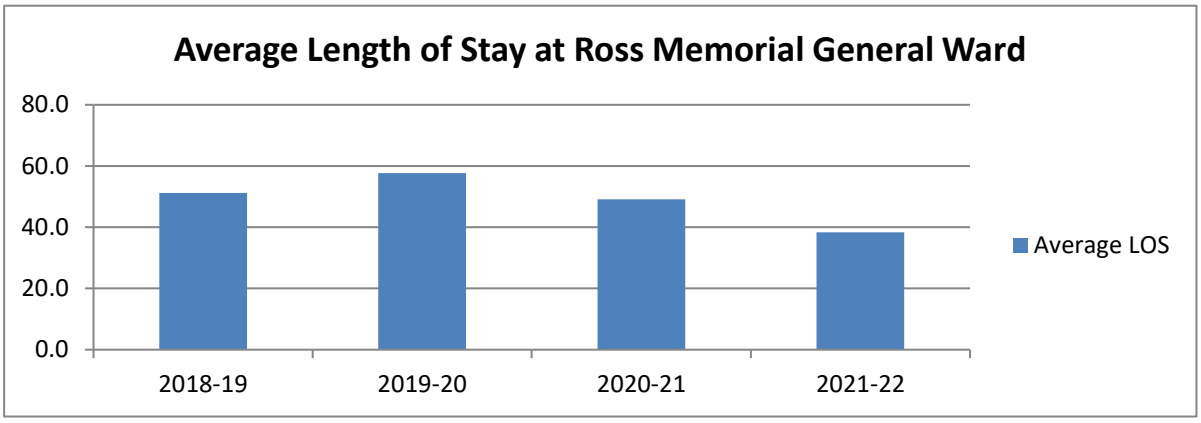


Mid Ross District has been developing a Discharge without Delay model that identifies and 'pulls' patients from the acute hospital into community services and seeks to plan care early in the acute phase of an individual's admission to minimise delay of assessment and discharge. Through use of community services, care homes, care at home, assess at home and community hospital, the District Team is able to forward plan early assessment and identification of care capacity to reduce length of stay in hospital and provide the appropriate care improving outcomes for patients.

The use of the inpatient general ward beds at the Ross Memorial has been a key driver in improving patient flow and supports the integrated team to rehabilitate patients prior to returning home with an appropriate discharge plan. It also allows comprehensive multi-disciplinary team working to ensure complex discharges are well planned. Activity shows that generally, Mid Ross has 9 patients in Ross Memorial and 5 patients

in County Community Hospital Invergordon at any given time indicating that the bed capacity best fit is around 14 beds.

Through the use of the community pull model, early assessment and discharge planning, the average length of stay in the general ward has reduced from 57 days to 38 days and the number of discharges has increased from 66 to 80 per annum. This means that more patients receive care in the ward and their stay is shorter. It has also meant that Mid Ross patients are cared for closer to home which is really important for people.



Community Engagement

The District Manager has recently embarked on a series of engagement sessions with the 15 community councils in Mid Ross District, local GP Practices, Local Authority Members and local interest groups.

These sessions have focused on the public view on 'what works well' and 'what works not so well' in the District and these sessions have been lively and productive with lots of contribution from local communities.

Whilst this work has not yet been concluded, (10/15 community councils visited), common themes have emerged as follows:

What Works Well

- Wide range of outpatient services at Ross Memorial
- Preference to receive care locally in Dingwall rather than Raigmore or Invergordon due to accessibility
- Value the services at Ross Memorial especially the care on the ward
- Strong support for District Nursing service in the community
- Good access to Physiotherapy services in Ross Memorial and community
- Strong sense of Ross Memorial being part of the community

Ongoing Challenges

- Local demands for the reopening of the Minor Injury Unit
- Strong concern about the condition of the Ross Memorial Hospital and fear of possible reduction in services.
- Access to GP services

- Availability of home care to meet current and future care needs – demographic and recruitment issues.
- Would like more access to outpatient services locally at Ross Memorial

Generally, there is significant support within the community for the services delivered by Mid Ross District. We openly share the challenges with communities and elected members and they have been constructive and mature in their dialogue with us.

Communities are well positioned for future discussions on the future of health and social care in the District, in particular the future of Ross Memorial.

This relationship should form the platform for discussing the way forward for the Ross Memorial Hospital and organisationally NHS Highland are asked to support the development of a strategy of care in the District including replacement buildings on the Ross Memorial Campus.

Afterward

Finally, A quote from The History of Ross-shire Hospitals:

In 1938, there was a survey of all Scottish hospitals and this coincided with visits to the Ross Memorial by personnel from the Department of Health. Their joint visit of the hospital was not encouraging for its future. It was considered by 'no means an up to date hospital and could never be so'. There were said to be drainage problems due to its low altitude so that the drains apparently backed up at high tide. The main building was overcrowded and its 'but and ben arrangement and bitty organisation made it difficult to operate.

Plus ça change – 84 years later, Ross Memorial still provides a high standard of care to patients despite the challenges with the hospital estate.

Source: History of Ross-shire Hospitals
JC Leslie and SJ Leslie

Completed by: Kenny Rodgers, District Manager Date: 24 November 2022

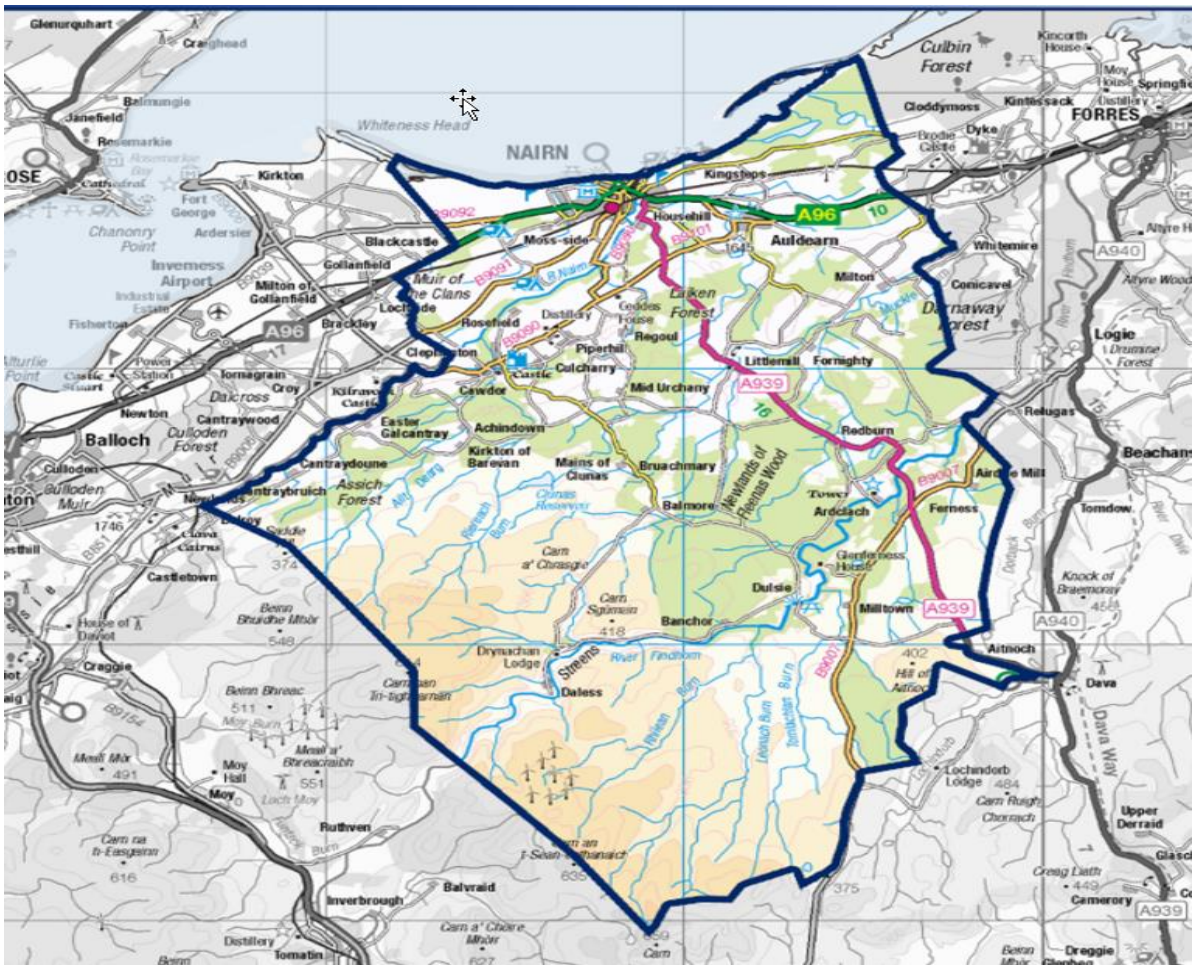
District Profile

District: Nairn

Manager: Ros Philip

Locality Demographics

As of 2021 the National Records of Scotland show that Nairn and Nairnshire had a population of 13,670 people as detailed below. However the boundary used to formulate the reports for Nairn & Nairnshire (as per below map) reflects the Council boundary which does not include our entire health and social care boundary which reaches out to the new Tornagrain area and Arderseir. Each of the demograph graphs within this document therefore are not a full representation of the population we deliver services to.



Current estimated population by age group,2021

Age Band	Nairn and Nairnshire	Highland	Scotland
All ages	13,670	238,060	5,479,900
Under 1 year old	88	1,842	46,782
1-4 years	418	8,321	208,655
5-15 years	1,511	27,967	656,085
16-39 years	3,223	61,405	1,671,841
40-64 years	4,879	83,301	1,822,676
65-74 years	1,958	30,598	595,578
75+ years	1,593	24,626	478,283
85+ years	452	6,691	131,309
0-15 years	2,017	38,130	911,522
16-64 years	8,102	144,706	3,494,517
65+ years	3,551	55,224	1,073,861

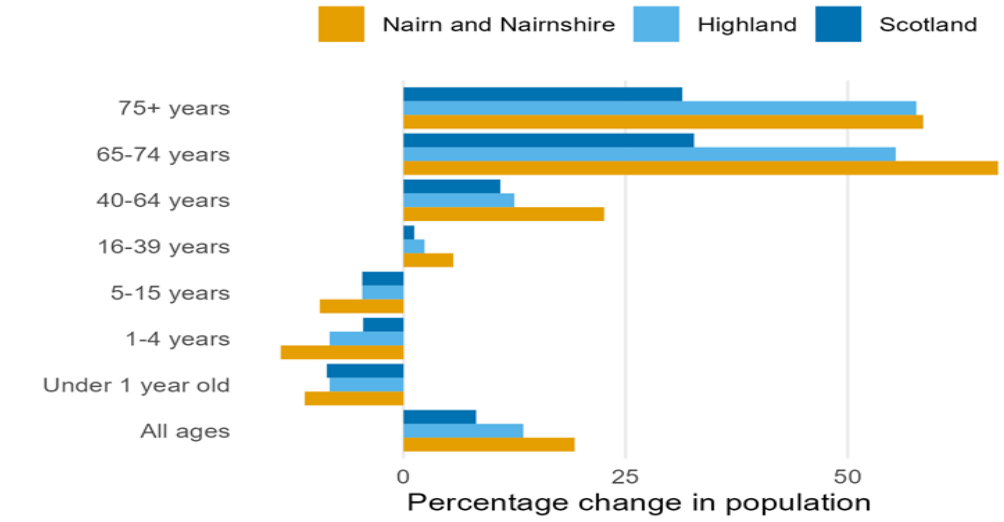
Source: National Records of Scotland, Small Area Population Estimates 2021

The patient demography of those registered with Nairn Healthcare Group as at 1 October 2022 are detailed below. Due to the boundaries between general practice and the NHS, and NHS and the Council being different, in addition to the provision of care for all of the Nairn registered patients, our local services also encompasses provision for patients who are registered with Inverness practices, and for whom we don't have the demographic data. The over 65 population as at October 2022 registered with Nairn Healthcare Group alone is 26% of their overall list size.

Age Group	0-4	May-14	15-24	25-44	45-64	65-74	75-84	85+	TOTAL
Male	291	812	761	1664	2284	1055	621	190	7678
Female	269	758	657	1622	2412	1121	770	298	7907
TOTAL	560	1570	1418	3286	4696	2176	1391	488	15585

The National Records of Scotland data as at 2021 shows of the Nairn & Nairnshire population of 13,670, 14.8% were children aged 0-15 years, 59.3% were people aged 16-64 years and 26.0% were people aged 65 years and over. There is a greater percentage decrease in the population aged 0-15 years compared to Highland or Scotland.

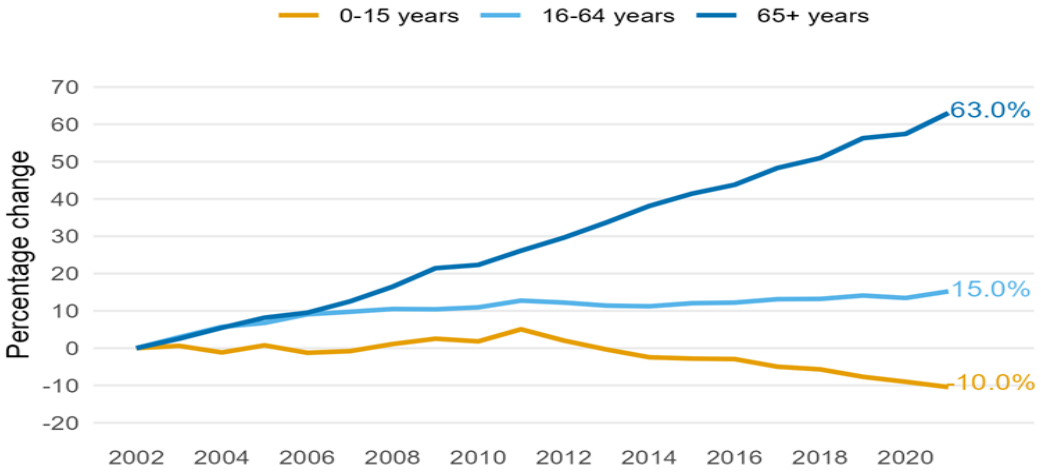
Percentage change in population by age group, 2002 to 2021



Source: National Records of Scotland, Small Area Population Estimates 2021

The National Records of Scotland shows population has increased by 19% in the period 2002 to 2021 with a difference between age groups with regard to population change. There was a 63% increase in the 65+ age group, which occurred year on year since 2002. We have seen a greater percentage decrease in the population aged 0-15 years compared to Highland or Scotland.

Percentage change in population by broad age group, 2002 to 2021

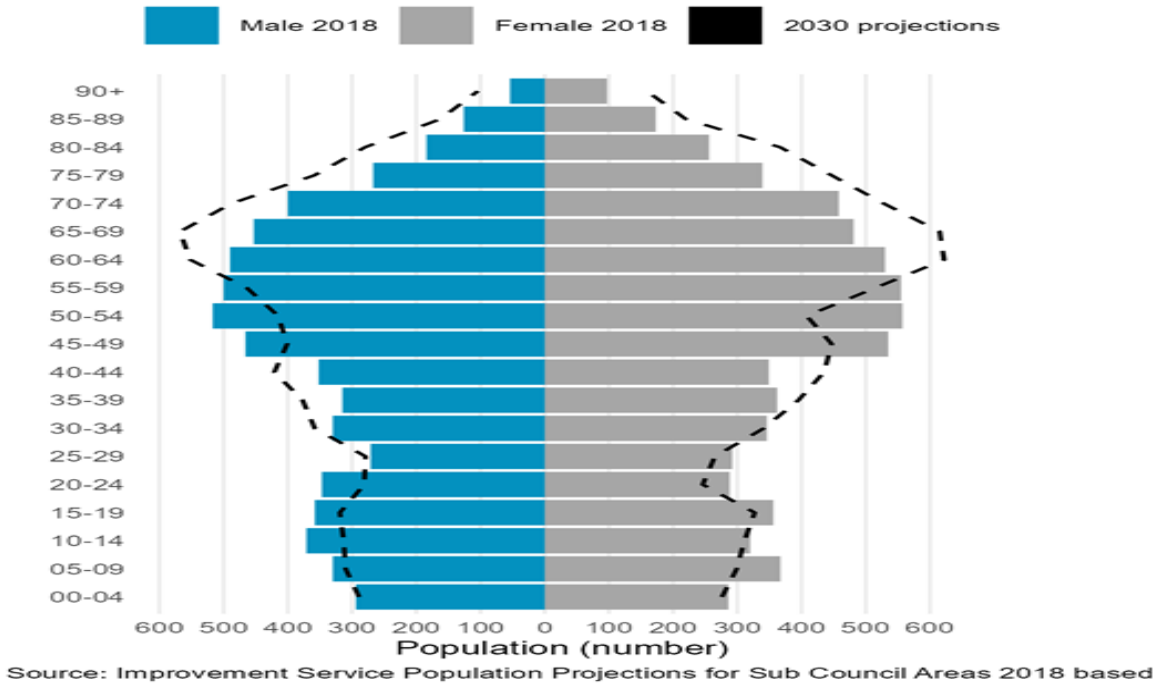


Source: National Records of Scotland, Small Area Population Estimates 2021

It is estimate that the overall population will increase between 2018 and 2030 and that the population will continue to age. The number and proportion of people in the 65-74,

75-84 and 85+ age groups are projected to increase, whereas the population aged 0-15 years and 45-64 years are projected to decrease.

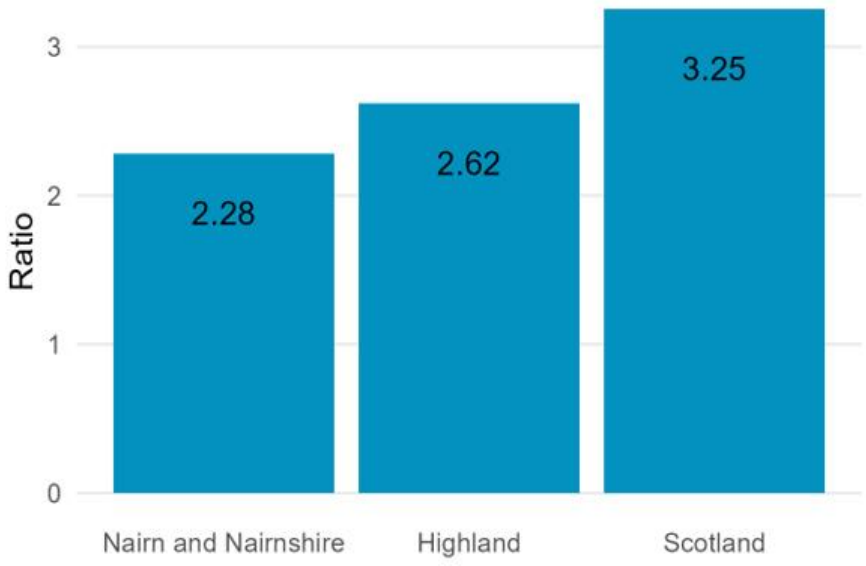
Estimated population in 2018 and projected population in 2030



Source: Improvement Service Population Projections for Sub Council Areas 2018 based

The ratio of people of working age (16-64 years) to older people (age 65 years and over) is lower compared to Scotland overall.

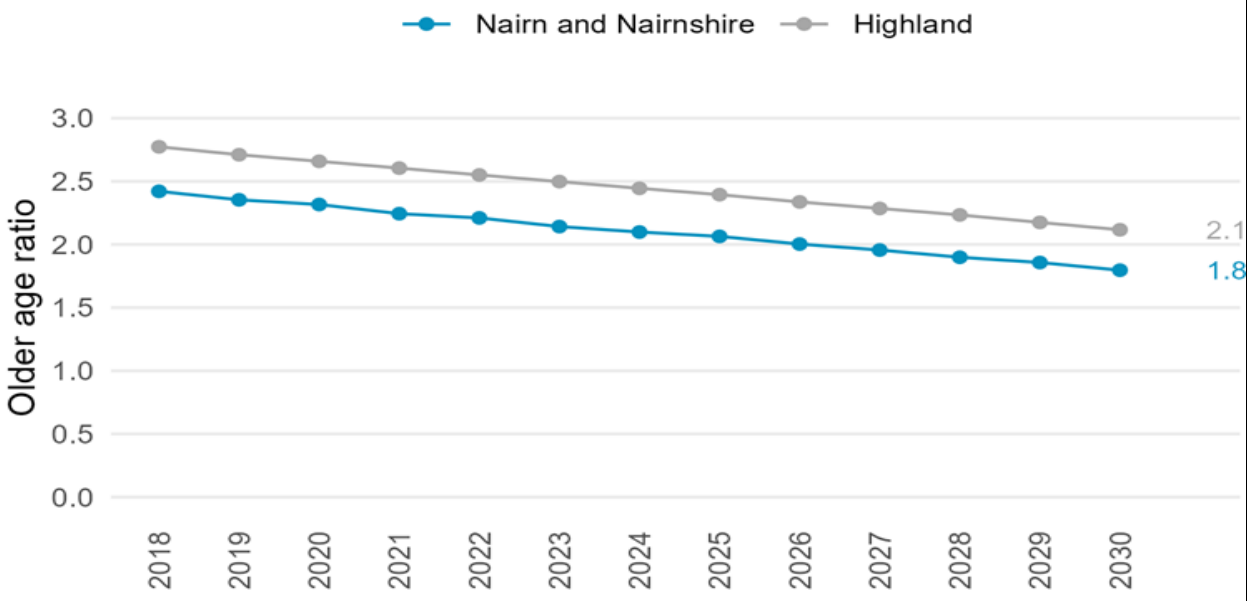
People of working age (16-64 years) for every person 65 years and older in 2022



Source: National Records of Scotland, Small Area Population Estimates 2021

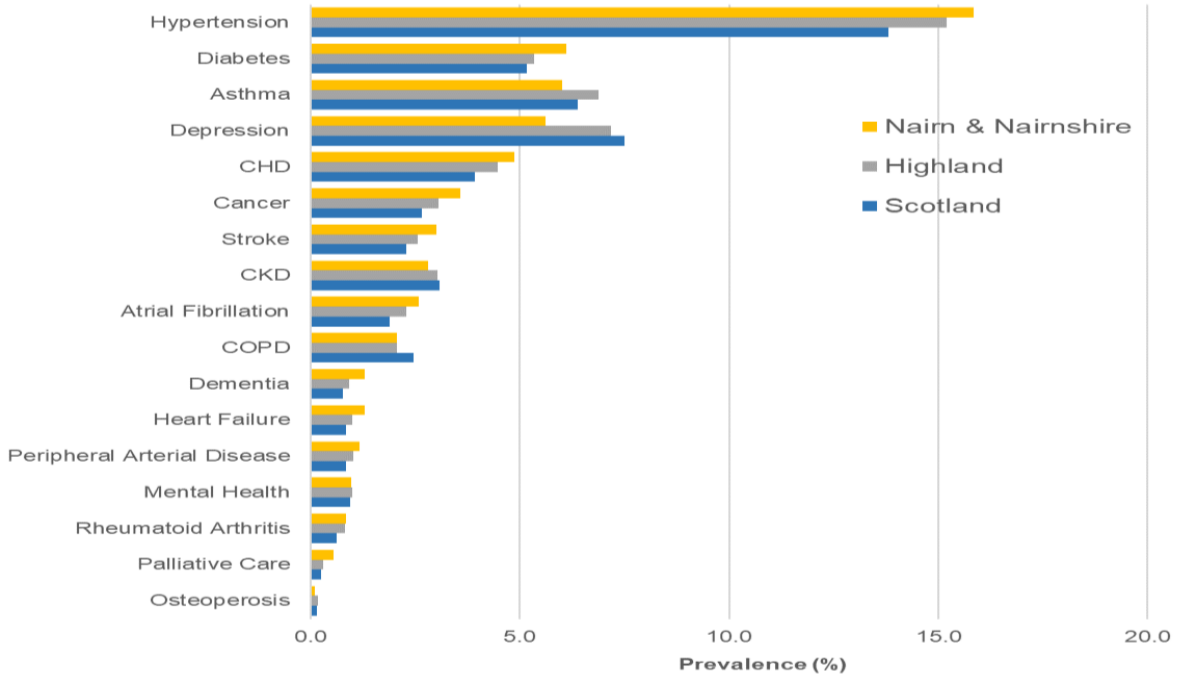
The impact of long-term demographic changes will mean that the ratio of people of working age to people aged 65 years and older will further decrease. **This pattern has implications for staffing and recruitment.**

Projected ratio of people of working age (16-64 years) for every person 65 years and older



Source: Improvement Service Population Projections for Sub Council Areas 2018 based

Number of people with health conditions: prevalence of chronic diseases (%)



Aggregation of General Practice disease **registries to Community Partnership areas for 17 chronic conditions**

The graphic is based on data published from QoF (Quality and Outcomes Framework) disease registers. Data was extracted by ISD (now Public Health Scotland(PHS)) from QoF and is available here:The data is based on Read codes entered by practice staff in the GP practice system.
Rates per 100 population are based on the populations included in the data and so can be considered as broadly accurate.

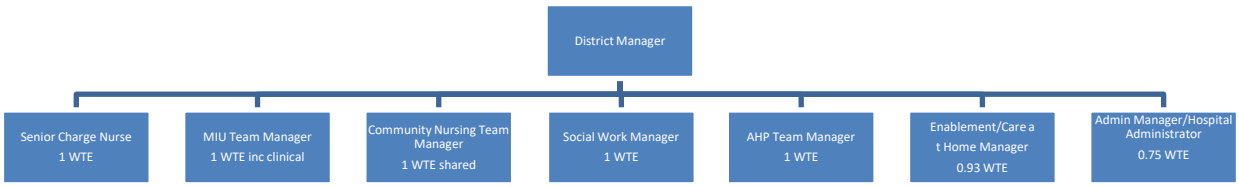
Services provided and current workforce

Nairn Town & County Hospital houses various services/agencies with the staff and services within the district manager area of responsibility being:

Community Nursing
16 bed Inpatient Ward
Physiotherapy
Social Work
Enablement/Care at Home
Minor Injury Unit/PCEC
Occupational Therapy
Support Services

Children's services (including child social work), podiatry, X-ray, CMHT, SAS, pharmacy, dental, midwifery and the general practice, whilst also based in the hospital are managed outwith the district management structure.

The District manager directly line manages the Integrated and Hospital Team with a Team Lead in place for each service (1 for AHP). All services are situated within the same building allowing effective multi-disciplinary working which proves effective.



The teams within the District are small with any absences/vacancies causing significant impact. Of particular challenge are within the below teams as a result of vacancy/LTS/maternity along with any short term sickness combined with the level of complexity of work within the community.

	Mon-Fri	Sat/Sun	Team Establishment		Issues
			Qualified WTE	Unqualified WTE	
Ward	24 hour	24 hour	14.21	10.71	1.53 WTE qualified maternity leaves only partial cover picked up.
Minor Injury Unit	24 hour	24 hour	6.07		Unsuccessful in WFP 0.71WTE. Career break imminent with no applicants.

Community Nursing	08.30-16.30	08.30-16.30 Reduced Staffing	8.72	0.96	Increasing complexity and caseload with up to 60 visits per day being undertaken by the nurses. Team also provide ITR clinic demand exceeds resourced capacity. Admin post vacancy unable to appoint to date impacting on Team as no capacity in district to provide admin outwith the admin heavy resource required to support ITR clinics. Post out to advert again.
Enablement Team	08.00-21.00	08.00-21.00 Reduced Staffing(no manager/scheduler)	15.4	0.8 WTE (2 posts)	1.68 WTE vacancies out to recruitment. Continuing to support ISP packages. Plans in place for contingencies.
Social Work	09.00-17.00	Unavailable	5	4.87	1 WTE qualified maternity leave and 1 WTE unqualified on long term leave. No HSCCs from 6/12/2022
Occupational Therapy	08.30-16.30	Unavailable	2.58	2.53	1.44 WTE qualified out to recruitment. (1 qualified reducing from January 2023 + utilising Band 5 hours as unable to fill B 5 post).
Physiotherapy	08.30-16.30	Unavailable	2.15	1.6	0.7 WTE qualified unable to recruit. Only 1 qualfied staff member available for rehabilitation service currently (who is the AHP Team Manager).
Admin/Portering	08.30-17.00	Reduced staffing		5.08 (6 are part time)	Supporting ITR clinics takes up significant resource.

Services Provided

Ward

The Ward is a 16 bed inpatient ward overseen by a Senior Charge Nurse. The ward play a key role in ensuring community flow with the beds full the majority of the time (graph highlighted further below). The service provides rehabilitation and end of life care. Two community access beds are allocated and admissions to these beds are utilised both for community admissions but also to transfer end of life care patients from Raigmore or directly from Raigmore A&E where appropriate. Medical cover is provided by the local general practice and Dr Andrew Jamieson Consultant Physician attends all MDT meetings. Qualified nursing staffing regularly runs below WFP requirements and B5 shifts filled where possible with a B2. It is a regular occurrence for the ward to be short of a B5 as a result of uncovered elements of maternity leave and short term sickness/COVID.

MIU

Nairn MIU is nurse led with a GP on call for support if required. In hours Mon-Fri the on call GP is available from the Practice via the emergence mobile. Out of hours the GP

is available on the emergency mobile from home although they are in attendance at weekends and several GPs stay in the hospital overnight when on shift. The MIU staff support the ward night shift 7 nights a week. This involves being present on the ward once all MIU work is complete (returning to MIU to see patients as required), covering breaks, assisting with patient care and being included in staffing numbers to ensure fire safety overnight.

This is a complex job requiring specialist skills and knowledge. The majority of the nurse shifts are worked alone. The nature of the job requires staff to make complex decisions in sometimes challenging and urgent situations. In order to carry out the job safely and avoid risk they require appropriate skills, training and support in terms of regular clinical supervision and personal development planning.

Workload can include falls/collapse, drug overdose, fractures/dislocations, burns, wound care, head injury, MSK injury, chest pain, infection/sepsis, breathing difficulties, assaults, mental health, Stroke, RTC, pregnancy complications. Consultation time can vary and can take up to 2 hours. With current pressures on SAS delays of 4+ hours are common with a lone working nurse juggling a busy MIU department and monitoring for a deteriorating patient awaiting onward transfer.

Community Nursing

The Community Nursing team provides preventative, reactive and maintenance clinical care to patients in the community. The elderly age profile and care homes in the area are above average. The team leads on End of life Care and are well above the national average supporting patients to die at home. There has been a real shift from secondary care to the community to provide high end complex clinical care. This impacts on team resource to provide care and also training to upskill on new procedures. Ongoing work force planning evidences the increased complexity and dependency of client group requiring the knowledge and skills of band 6 nurses. Services require to be reactive with minimal opportunity for any waiting lists. The aim is to avoid hospital admissions and expedite timely discharges.

We provide a community nurse lead clinic for complex care not provided by practice nurse services. Patients are seen close to home, avoiding the need to attend secondary care.

Investigation and **T**reatment **R**oom service (**ITR)** is covered by the community nursing team. It runs at over 125% of the resource allocated. Clinician AL, absence etc is not resourced leaving extra pressure on community team and there is no resource for the associated administration required for the ITR service.

We have been unable to recruit to the community nursing admin post which impacts on the team who are trying to cover this role. The post is out to advert again.

Physiotherapy

The Nairn physiotherapy service covers all aspects of clinical service delivery. This includes inpatient rehabilitation to the 16 bed unit, medical out patients, MSK, Pelvic dysfunction, Cardiac rehabilitation and Pulmonary rehabilitation, Falls and Frailty

intervention and Community rehabilitation. Service is currently provided by the AHP Lead, 2 part time qualified staff and 3 part time non registered staff.
Resource was taken from mainstream physiotherapy to fund the development of FCP service. Whilst this was a good opportunity for staff and service development, it led to a shortfall in funding for mainstream physiotherapy services. Patient flow into MSK services has reduced from GP referrers but all other referring sources have continued to grow. The Band 6 rehab staff member resigned at the end of August 2022. As this is a part-time post it has been difficult to recruit which has resulted in services having to stop including falls, cardiac and pulmonary rehabilitation and community rehabilitation will be severely reduced causing significant delays that will impact on admission prevention and discharge support. The WFP undertaken had recommended an additional 1.5 WTE B6 and 1 WTE Band 4, however this was not resourced.

Occupational Therapy
There are high levels of volume of referrals being received and with the ever increasing complexity in a high elderly population the team are having difficulty with an increasing waiting list for services. The team are aware of the OT staff levels within other similar areas appearing to be higher than this district which impacts on staff morale and raises concerns regarding staff's willingness to remain in post in this area. Currently there are qualified staff vacancies in the team and from 1 January 2023 unless we recruit we will have only 1.14 WTE qualified staff.

Enablement/Care at Home Team
The Team currently have 2 vacancies and the team continue to support ISP packages which have been handed back which brings challenges however solutions are detailed further below in the document. As in other districts we are seeing increasing elderly population with increase frailty and co-morbities which increases the need and level of care.

Social Work
The Social Work Team currently have 2 long term leaves and 2 vacancies which is impacting on the service. Due to the high number of elderly clients and complex learning disability/disability clusters they generally have a high number of Guardianship orders that require to be reviewed. At one stage they had 54 clients who were subject to a Guardianship Order and required a review or are subject to a member of the team (qualified Social Worker) being their legal guardian. It is anticipated this number will increase as the population continues to grow in the local area. High numbers of ASP inquiries are common. Nairn has 7 care homes housing 196 beds which is a high number within a small district.

The Team are cognisant of the SDS options available to support people and utilise Option 1 wherever possible, however within the Nairn area there are ongoing recruitment and retention difficulties in all sectors of adult social care including self directed support option 1, and housing support.

Independent sector care homes within Nairn housing 196 beds

No of Care Homes	Client Group	No of Beds

4	Older People	88
1	Older People/Learning Disability	42
1	Learning Disability/Physical Disability/Severe and Complex	43
1	Mental Illness	23

General Practice/s
Nairn has 1 general practice which provides care for all of the population in Nairn, along with patients registered who reside in Arderseir and Croy. The local GPs work closely alongside the hospital services linking in with the integrated team, inpatient ward, Minor Injury Unit/PCEC and all other services within the building.

Integrated Working/Complexity within the District
The teams provide integrated services to a population of approximately 16,000, the majority of whom, but not all, are registered with the Nairn general practice. An ever increasing complexity of care is required, and whilst we as far as possible aim to ensure the Home First principles are embedded, and implement the recommendations in the NHSH Enhancing Community Health and Care Model, this is challenging within our current resource and taking in to account our geography.

The Teams work closely together to ensure provision of services for the population are available utilising an integrated approach. Patients within hospitals are monitored daily with person centred wrap around care, with acute referrals from Raigmore directed to the ward senior charge nurse, and the integrated team linking in across all sectors.

Teams are linking to ensure our vulnerable people list is updated on an ongoing basis and that ACPs and personal contingency plans are in place for everyone included on the list.

We work very closely with our local GP colleagues linking in around palliative and end of life care along with routine core services. Dying at home remains the first choice for the majority of patients who are coming to the end of life. Nairn has a high proportion of elderly population, and the community caseload is complex with workload continuing to increase. Data shows the end of life care provided at home ratios are higher in Nairn in comparison to other areas (based on 2018/19 GP Cluster data).

We are fortunate in Nairn as the hospital provides the opportunity for co-location of staff groups in the building. This means that health, social work and care at home teams are sharing offices with the wider integrated team, which promotes and enhances integrated working, and allows strong relationships with the general practice, hospital, mental health and Children's Services colleagues.

The hospital also provides outpatient clinics as detailed below:

CMHT	Diabetic Retinopathy	Podiatry
Physiotherapy	X-ray	Alzheimers
Psychiatry	CAB	Cardiac/Heart Failure

Childrens Services	Paediatrics	SLT
Dietetics/Weight Management	Epilepsy	Learning Disability
Midwifery	Psychology	Parkinsons Disease
Viral Hepatitis		

With the rollout of the Primary Care Modernisation as detailed in the GP contract we are seeing pressure on availability of both clinic and administration space as we have the additional need for pharmacotherapy, First Contact Practitioner, Primary Care Mental Health Services and Community Link Worker being embedded.

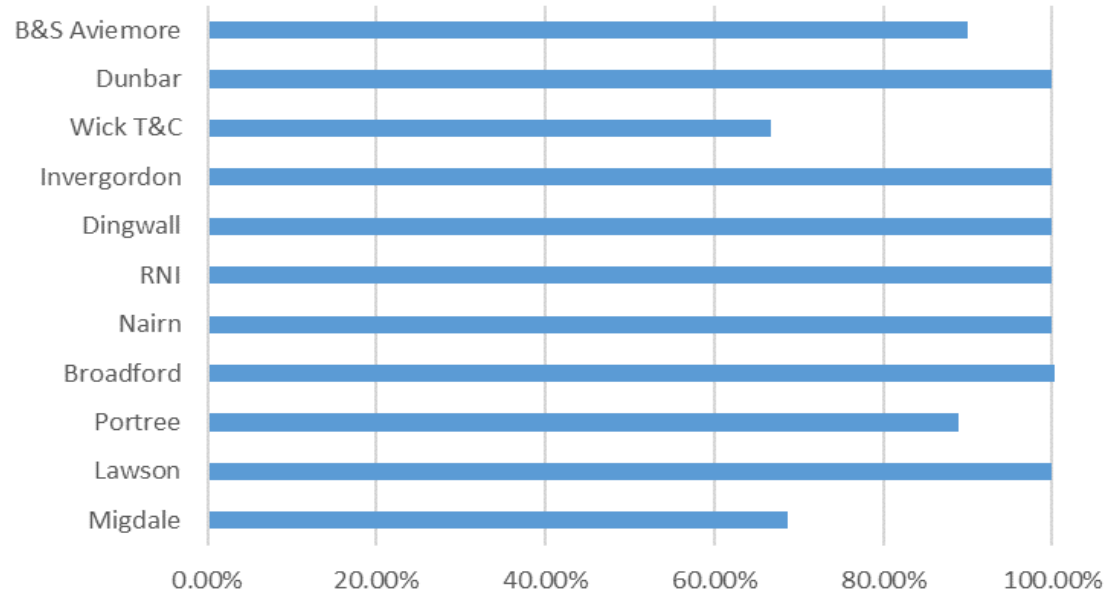
Finance & Performance

Finance

The budget for 22/23 for the District is £13.178m of which £0.045m relates to hospital and community services, and the balance of £0.865m being ASC. At the time of writing the projected year end is being forecasted at a £0.447m overspend. This overspend can be broken down into Health £0.119m and ASC £0.327m. The Health year end variance mainly relates to inflationary pressures of £0.082m due to rental costs and increased prices and the balance being mostly staffing pressures due to maternity and sickness. ASC overspend of £0.327m is due to ISC mainly in younger adult and LD packages where costs have increased post pandemic.

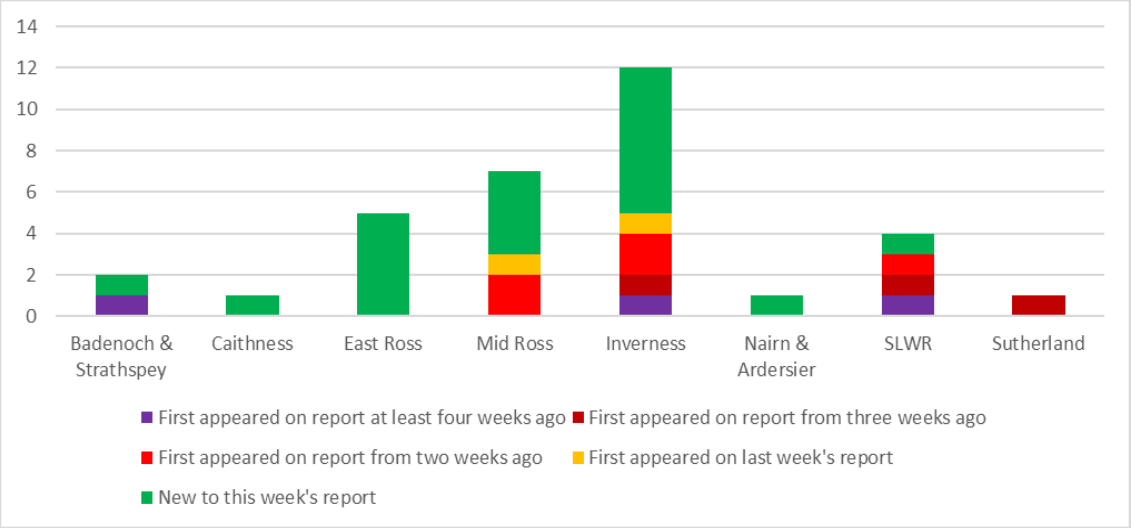
We understand the Board is undertaking a baseline review of resources per district and it will be interesting to establish our position with regard to the share of budget vs activity.

Nairn Hospital Bed Occupancy (systems pressure report 21/11/2022)



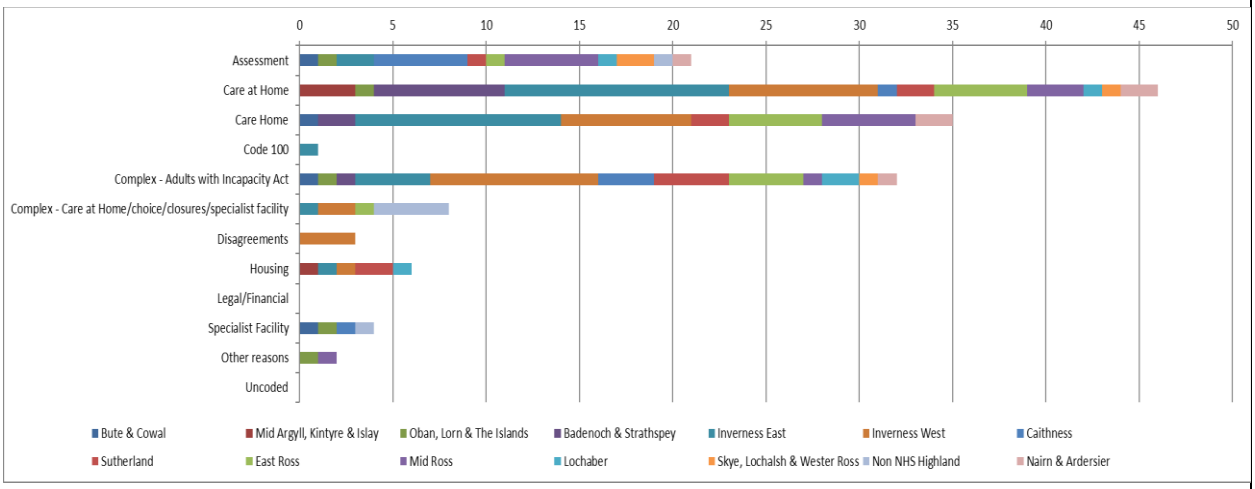
The hospital runs at capacity 100% of the time.

Wait period for a Community Hospital Place (systems pressure report 21/11/2022)



While the hospital is running at 100% capacity the above graph demonstrates the efficiencies within the Nairn hospital system that allow for short waiting periods for transfers. We have a daily system in place which brings oversight to people in hospital, and pull them through to either the hospital or out to the community where appropriate. We currently use an EDD for patients however meetings are arranged to discuss embedding PDD within the district.

Delayed Discharges by District (systems pressure report 21/11/2022)



A system is in place to review our DDs on an ongoing basis. Pressures exist with the long wait for guardianship processes and many areas utilising any care home beds that become available. The above table highlights the 4 main areas of delay pressure which are care home, care at home, AWI and assessment by social work.

DATA ANALYSIS – DQ Errors by Category and Hospital Location (September 2022)
Nairn is among the teams who that ensure appropriate DD codes are utilised, thus reducing errors in reporting and data collection.

Unmet Need Hours by Locality (systems pressure report 21/11/2022)

Despite the withdrawal of Providers from Nairn described further below in this report, Nairn has managed to maintain a level of control of the unmet need and plans are in place to improve the unmet need, and allow for contingencies should further providers reduce or withdraw their services.

Patient Feedback
We have many examples of patient feedback the most recent example is detailed below.

"For NHS purposes my full name is xxxx and my CHI number is xxxx. As you can see it has been a challenging year for me medically this year with a herniated disc, suspected MS, mental health challenges, diagnosis of Neurological Lyme and IV treatment.

As we draw to year end all the tests for MS are negative the diagnosis for Lyme's was confirmed and my IV treatment has now finished. During the whole of this time, I have received outstanding service from the NHS, particularly Nairn Healthcare and the various GPs I have seen, Raigmore and the AEC team and consultants plus the OPAC team and finally the District Nurses at Nairn who were great undertaking my daily IV transfusions. Finally, the receptionists at the GP practice and indeed xxxx at MIU".

Opportunities and Developments

Again opportunity to raise what you are currently developing and the good work that is ongoing on within the districts improving C@H discharge to assess etc clinical bridge..

Recognising the financial constraints what can you do differently or let go?

Clinical Bridge
The Clinical Bridge which is being piloted in Nairn is a software package aimed at supporting integrated teams to better manage their "at risk" patients. There have been connectivity issues and we are hopeful these can be fully resolved. This will allow us to move forward to develop our "virtual ward" accessible by the teams allowing easy access to information for at risk patients. The system works through Bridge interfaces/viewing screens which include patient details, ACP in place, AWI/Guardianship and all team actions/outstanding actions. These interfaces are situated in the GP Duty Room, ward, integrated team office and the physiotherapy gym where AHPs have their daily huddle.

Currently within this "virtual ward" we have included patients who are inpatients at Nairn but are not DDs, patients who are recently discharged from hospital as well as patients who are on end of life care, or who have Just in Case medications in their home. The plan is to develop this further in liaison with the general practice and the integrated team to include other vulnerable patients. The Bridge allows each team to add in their actions to allow the other teams to identify what is in place and what is outstanding. Maximising the potential is dependent on improving the Bridge connectivity, as well as our ability to staff vacant HSCC posts who will be responsible for inputting information.

Care at Home Redesign

Independent Sector provision of Care at Home has been challenging for several years. New providers came into the area in 2020 however unfortunately, over the last two year we have seen the withdrawal of three providers. Recruitment and retention are cited as the reason for withdrawal. We have one new provider to the area who came in 2021, and we have also as a result of rural location being developing our in house service.

As part of the enhancement of our service the focus is on our unmet need and to reactive patient flow. This will significantly expand our in house care at home service, and further recruitment is currently in hand. Our aim is to enhance both in house enablement and care at home services. The enablement part of the service will also be expanded to ensure that service users potential for independence is fully maximised, and this will be a supportive branch of the overall team. We foresee a key link being supporting patient discharges home from hospital for assessment, with appropriate ongoing rehabilitation from the wider team.

FIT Homes

Nairn is set to benefit from a new generation of advanced assisted living homes. We expect that the FIT homes will meet the needs of people at all stages of life including those with health conditions that affect their mobility and who may need care and support at home. The FIT homes are being built on land just north of the Hermitage, St Olaf Manor, Cawdor Road to provide accommodation for tenants with various medical needs that allows them to be supported while maintaining their independence. There are 6 x 1 bedroom and 4 x 2 bedroom flats with completion due in September 2023.

We expect priority will be given to individuals:

- who are likely to benefit from the key FIT Home features (additional space, fully accessible, easily adaptable, digital support opportunities, cluster setting)
- whose existing home no longer meets their needs
- who currently receive care and support services at home, or are likely to in the near future, including those who may be considering residential care or who cannot return home from hospital
- whose physical mobility is reduced as the result of a long-term health condition or ageing
- who already live in Nairn

The NHS, Highland Council and the Albyn Housing Society are the 3 partners who will be involved in considering allocations of the Homes. Meetings are ongoing on these considerations and it is likely there will be agreement to maintain a balance of needs within the FIT Homes cluster to keep a self- supporting environment alongside care and support provision.

Community Engagement

How are you linking into the CPP and the Community Councils also generally members of the public and our partners including third sector – the meetings that you have with the independent sector etc

Community Planning Partnership (CPP)
The Nairn CPP is a strong active group which is chaired by our police colleagues which meets on a quarterly basis. Sub groups are in place who meet on a more regular basis and are responsible for taking forward actions.

We had undertaken community engagement sessions in May 2019 in Nairn and Arderseir supported by the community engagement officers which were allocated to the Community Planning Partnership related to NHS performance in Nairn. Feedback received related to the GP practice, transport, discharges from Raigmore and schools. Any issues were passed on to the appropriate department/organsation and a response fed back to the Community Planning Partnership.

Independent Sector
The General Practice has routine meetings with the Independent Care Home managers to which the District and Social Work Manager are invited. Whilst these meetings stopped as a result of the pandemic, they have now been restarted. This provides a platform to discuss any issues and concerns and is welcomed. The Social Work team have developed strong links with the providers, which has proved beneficial.

Regular meetings take place with our Care at Home Independent Sector providers. Four weekly review meetings are in place which includes Contracts, along with weekly allocation meetings with our local team. We have strong links with our providers, and whilst there has been delay in some pick up of packages with one particular provider, we anticipate some improvement.

Highland Council
Monthly locality meetings take place to which a local Councillor is invited and attends along with representatives from children's services. The Ward Manager sits on the local Care for People Group.

Community Councils
The 7 Community Councils that exist in Nairn are invited to and frequently attend and engage at the Nairn Community Planning Partnership. A meeting is arranged with the Council Ward Manager as to how we can further engage with the community councils to look at community resilience. To date it has been challenging to bring these groups together, or to bring them in to both the Care for People group, and the previous Adult Plan Sub Group.

The Adult Plan had completed all the actions allocated with the direction from NCPP to focus on the Community Led Support (CLS) HUB.

CLS
The first community 'Here for Nairn' pop up hub took place on the morning of Thursday 30 June 2022 in the Library in Nairn, and these have taken place monthly until November. The 'Here for Nairn' is a series of community pop-up hubs which highlight all the ways in which the community can help its population. Colleagues from NHS Highland, other organisations and 3rd Sector representatives attend to help the local

community in Nairn understand what community led support is available to them from the various community groups that exist locally.

We aim to enable people to explore the wide range of options and services available to them in their community. These are drop-in events which will allow people to come along at a time and chat to those in attendance. This allows us to highlight all the different ranges of support available, not only from organisations such as the NHS or Council, but also voluntary groups who can also provide support and advice.

The events have been advertised via NHS Highland social media accounts, the general practice and by the local community groups and organisations involved. The community pop up hubs are part of the Community Led Support project, which was part of a Scottish Government initiative for which Nairn has been designated as a pilot site.

The agencies/groups who have expressed their interest in attending includes:

Highland Third Sector Interface	Move On Project	CAB
Home Start	High Life Highland	Housing
Mikey's Line	Sense in Mind	Listen Well Scotland
Highland Senior Citizens Network	Alzheimers Scotland	Connecting Carers
Welfare Team	Home Energy Scotland	SFRS
Wellbeing Project 23:3 Project	KOMP (tech enabled care)	Health Walks in Nairn
Social Security Scotland		

The footfall to the HUB has been disappointing and we have only supported 16 people to date with no footfall at all on 2 occasions. We currently have free use of an area in the High Life Highland library in the High Street which limits the number of organisations we can invite on each HUB session. The format will be reviewed and we are trying to source funding from the Council Discretionary Fund in liaison with the Ward Manager, to allow us to resource using a larger venue and arrange a large event which may bring greater success.

Completed by: Date:

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**January 2023**
Title:	**SDS Strategy Development**
Responsible Executive/Non-Executive:	
Report Author:	**Ian Thomson, Head of Service, ASC**

1 Purpose

This report is presented to the Committee for:

- Discussion

This report relates to:

- Government policy;
- Legal requirements; and the
- Implementation of a Health and Social Care Partnership Strategy

This aligns to the following NHSScotland quality ambition(s):

- Effective
- Person Centred

This report relates to the following Corporate Objective(s)

Clinical and Care Excellence • Innovating our care		**Partners in Care** • Working in partnership • Listening and responding • Communicating well	
A Great Place to Work • Being inclusive • Learning from experience • Improving wellbeing		**Safe and Sustainable** • In control • Well run	

2 Report Summary

2.1 Situation

Self-directed support (SDS) describes the Scottish Government's approach to the delivery Adult Social Care support in Scotland. It includes the idea that service-users and carers should exercise choice and control over the supports they receive. However there is recognition that the implementation of SDS is not as far advanced across Scotland as it

was envisaged (see IRASC and Care Inspectorate Reports), nor there been the shift in practice to reflect the ethos which its underpinning legislation aimed for i.e. stronger, conversational and relationship-based practice which supports the tailoring of care around individuals' particular circumstances.

The Committee is asked to contribute to our "good conversation" on how SDS should work in Highland; and discuss how the work we describe at Section 3 can best shape our approach to the delivery of Adult Social Care in Highland going forward.

2.2 Background

A Reference Group was brought together in April 2021 to help set out a preliminary "Vision" for Self-directed Support in Highland. That group focused on the need to build flexibility, choice and control into the way we deliver Self-directed support in Highland.

We sought, and received, the support of people who manage an Option 1, in-Control Scotland, Community Contacts (our local Support in the Right Direction (SIRD) provider), SDS Scotland, about Dementia and the SDS Project Team from Social Work Scotland: with their help we wanted to ensure we were informed of the 'best practice' components which should inform both our vision and our engagement and consultation processes.

The group's Approach was to embark on a Consultation exercise to gather views of service users, carers and those who work in services on what they saw as was important in respect of SDS, and what we needed to do to realise it in Highland

We heard a wide variety of views, with over 200 responses, and there was a significant amount of work undertaken to pull this information together into a number of coherent themes and messages. This work has been brought together in the *Self-Directed Support in Highland – Consultation Report*.

Self-directed support in Highland - Consultation Report (office.com)

At a very simple level, the process identified 10 high level action points which firmly set the direction of travel for the implementation phase of the Strategy's development

What we need to do, ultimately, is:

Listening: Hearing

1. Ensure people benefit from a 'good conversation' with a trusted professional: work to enable people to access the support they need, wherever that may come from.
2. Ensure there are independent sources of advice, information and support available to all those exploring the help open to them.
3. Work in partnership with people who need support and partners to ensure they have a greater role in decision-making about SDS, at all levels.

Equitable. Sustainable

4. Provide (a framework of) clear and simple information about how to identify and secure the resource necessary to deliver the supports that people need.

5. Ensure that resources and supports are used effectively and efficiently to meet people's needs and outcomes: and are complementary to other sources of support.
6. Maximise people's choice, control and flexibility over the resources available to them.
7. Provide comprehensive information about the full range of choices (support options) available to those needing support.

Community

8. Enable people to access natural and community supports wherever possible.
9. Invest in our community infrastructure so that strong networks can develop across our local partnerships which are complementary and effective in providing informal solutions to community members who need help.

Workforce

10. Ensure there is a sufficient workforce which has the confidence, competence and capacity to work to these local principles, and the National Standards for Self-directed support

2.3 Assessment

Understanding “what we need to do” gave the Implementation of the Strategy clear direction.

Self-directed support in Highland - Making the Change Together (office.com)

However those charged with Implementation believe *how* we make the necessary changes is just as important as the content of the changes themselves. Our SDS group are clear that we need to build relationship across the system to ensure that people who may need support, their carers and those involved in providing care and support are fully involved in shaping and effecting the changes required. We want to develop networks, share perspectives and build working alliances to ensure the changes we make are made together. We don't think there is a simple, technical fix to the complex set of implementation issues in respect of Self-directed support.

Rather our aim is to set up a series of local groups and co-production groups where we can have "good conversations" about how we make the changes required. These conversations should be informed by the perspectives of those in need of social care support and their carers, alongside professionals from the different sectors. The hope is that the groups will provide suggestions for new ways of working which everyone can agree with.

Information and Intelligence

We have brought partners from the statutory and voluntary sectors together with people who need support and carers in Fort William to explore how the provision of information about what Self-directed support is, and what support is available locally, can be improved.

People have told us that it would be great to have easily accessible and good quality information about the SDS legislation and how the Options work etc.. However, understanding how to develop the links locally and how to stimulate greater levels of available hands-on care is not simply about the provision of information: it's about making contacts, understanding who is doing what, and developing working alliances locally; it's about understanding opportunities and building intelligence across the system.

Our aim is, then, to develop one or two simple routes to good quality information that will benefit people working in, and affected by, the social care system. Having one simple on-line learning module on TURAS was thought by all involved to be a good way forward: as was having much more info available to all on Aliss. However providing focused opportunities for people operating across the social care system to come together to understand their own issues and take action upon them is also being progressed.

Community Led Approaches

We are engaged with work already underway in Caithness, Nairn and Lochaber to try to make sure that Community Led Support approaches being established there dovetail with an ethos of Self-directed Support. We want to help support a community of practice whereby all those providing proactive community supports - of whatever type - see themselves as part of an integrated system, and understand how the SDS Options can be used flexibly to provide the right help at the right time.

Currently the SDS role has been a complementary one: we have been involved throughout the span of the Community Led Support Project development, providing advice, information and training as requested.

Costing care and Identifying budgets

We are working with those managing an Option 1 (Direct Payment) and with those with budget responsibilities in Adult Social Care to see if we can describe a fair, equitable and sustainable framework for the calculation of Individual Budgets. We think this should support the exercise of choice by ensuring that the recruitment and retention of Personal Assistants is a realistic and sustainable option.

Work with a local "Peer support group" is well advanced; and a model which recognises the real cost of employing a PA in our rural and remote geographies is being worked on.

Better Conversations

We are working with social workers, integrated teams and professional leadership - across Adult and Children's services - to create the conditions for open, honest and trusting relationships (and conversations) to grow between people who need support and professionals. In line with the Framework of Standards for SDS we would like to extend 'worker autonomy', and we would like to promote relationship-based practice.

Given this, work is underway to greatly simplify and clarify our costing and approval processes to increase worker autonomy and reduce frustration, confusion, and extra work. Ultimately we are working to seek approval for a clear, simple and sustainable process to match resources to need - removing all unnecessary bureaucracy in respect of social workers appropriately offering access to all four Options. The SDS Standards are clear: social workers have to have the authority and be enabled to exercise professional discretion to plan, support and set personal budgets within agreed delegated parameters

We would also like to use the experiences of service users to exemplify the key components of choice and control as part of robust foundational training for workers in the principles and practice of SDS. Empathy and a good understanding of the perspectives of people needing support are key to forming strong and equal working alliances. During our consultation we have had a number of offers from people who have support to provide input: our aim will be to include this in developing a single SDS Turas module.

Independent Support

We have identified funding to increase the Independent Support available to people exploring and managing SDS in Highland. Our Implementation Group is working with our contractual colleagues to describe a route to realise this Support. Discussions to date support the idea that this specification should be as flexible as possible, and support people along their journey to getting the help they need. The group agreed it should include the development of a much better quality web-site than anything currently available; and that Independent Support should include drop-ins (road-shows), peer support, support for personal assistants, and maybe an element of mediation.

The group are keen to complement the Independent Support already in place in Highland and hope we can build on the links and relationships already made.

Option 1: Short Breaks for unpaid carers

We are continuing to use powers within the Carers Act to provide an Option 1 Short Breaks scheme for carers. It seeks to make resources available to carers via a simple application process supported by a social worker or a carers link worker etc. The scheme is largely free from resource allocation decision-making processes, and seeks to rely on professionals and carers coming together to identify the kind of break that would be right for them. We think this is a good opportunity to demonstrate the benefits of worker autonomy.

Work is underway with national colleagues - via the award of "Promoting Variety" funding - to provide our local workers with "outcomes-focused good conversations" training.

Option 2

We are working with our partners, in-Control Scotland, to better understand the operation of our Independent Service Funds. We know there are issues in offering greater choice and control in this area: and we have brought different component parts of our system - including recipients, contracts, providers, managers and workers - together to see how these can be addressed. As a result of three workshops we have identified the main themes for improvement.

These themes relate to creating an equal working alliance between workers and supported people, and increasing the autonomy of workers to realise flexible and creative three-way care planning with providers and supported people. It is recognised that this work is now closely aligned to our work to create "Better Conversations" (above) and, in that, we are working to seek approval for a clear, simple and sustainable process to match resources to need and outcomes. Introducing maximum contractual flexibility to enlist appropriate provision will be a key component of this.

Developing capacity: "place-based commissioning"

We are working with representatives of the local community in West Lochaber to explore how SDS might be used to offer a range of opportunities to reshape Social Care in the area. We are hoping that this work might develop into a collaborative, "placed-based" commissioning exercise - pulling the different parts of the system together behind a common purpose.

We want to explore how a full range of opportunities can be stimulated and made available for people in local communities. Interestingly IRISS is taking notice of this work – they are interpreting it as an early example of an “ethical commissioning” approach.

Personal Assistant Support

We are currently offering opportunities to support the Personal Assistant (PA) workforce in Highland. SDS Scotland is working collaboratively with us to offer events for PAs and PA Employers in Highland to learn about the new PA and PA Employer Handbooks. We hope this will be a good opportunity to have more people "join our conversation" about how to develop SDS

We have also sought - alongside our WEA colleagues, the targeted engagement of existing Personal Assistants in Skye and Lochalsh: we wanted to explore how we might develop networking and peer-support for this group. Unfortunately this engagement has not been a great success: we need new ideas about how to better engage this part of the social care workforce.

Shared Ethos

We are working to develop a series of real-life stories - using a range of media and to be made available across a number of electronic platforms - including a bespoke TURAS module as mentioned above - to clearly convey the values of choice, control and flexibility that underpins the ethos of Self-directed support.

We hope this information will be easily accessible to all - but also that it will play an important part of a robust foundational training for workers in the principles and practice of SDS. Currently we are seeking to gain the support of national partners to explore whether a Turas module could be created for a Scotland-wide audience.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

The level of assurance is in respect of how well our services conform to the updated Statutory Guidance of the Social Care (Self-directed Support) (Scotland) Act 2013. It is understood that the work described (at 2.3) above will, when more fully developed, address many of the risks associated with non-compliance. However there is a significant amount of effort still required to address the change of culture necessary to fully embrace

the Act's ethos of choice, flexibility and control. Individualisation, deregulation and creativity around care-planning will be central to this.

3. Other impacts

Workforce

The Strategy seeks to support the workforce to work in line with the National Standards for Self-directed support. It also seeks to support the workforce to have the skills, knowledge and values to realise the ethos of Self-directed support

Financial

The Strategy will not affect the financial resource available to Adult Social Care. However the Strategy is explicit in seeking to ensure that all resources are used effectively and efficiently to meet people's needs and outcomes: and are complementary to other sources of support.

Equality and Diversity, including health inequalities

A draft EQIA is in situ and records the assessment that the Strategy is likely to have a positive impact on Equalities and Disadvantaged groups. This is predicted on the reasoning that an explicitly value-led, person-centred and strengths based process should promote equality and challenge discrimination for those individuals we work with. However work has been initiated with Public Health to check that reasoning, and to ensure any further steps required are identified and taken.

4 Recommendations

The Committee is asked to:

- Recognise the work being undertaken to promote Self-directed support approaches
- Contribute its ideas as to how Self-directed support might work in Highland to shape a progressive and enabling approach to the delivery of Adult Social Care.

Agenda Item 3.5

NHS Highland

Meeting:	**Health and Social Care Committee**
Meeting date:	**11 January 2023**
Title:	**Community Risk Registers**
Responsible Executive/Non-Executive:	**Louise Bussell, Chief Officer, Community**
Report Author:	**Pamela Cremin, Deputy Chief Officer**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well					

2 Report summary

2.1 Situation

A summary of Community Directorate Risks is brought to the committee for assurance of action and mitigation being taken.

2.2 Background

The Community Directorate hold risk registers across the following operational areas:

- Community services
- primary care services (including independent health contractors - Optometry, Community Pharmacy, Dentistry)
- out of hours primary care services
- mental health and learning disabilities services; and
- adult care services.

A Community Risk Register Monitoring Meeting is held monthly to monitor all risks and ensure mitigation action is recorded and that risks are reviewed and updated.

A summary of Community Directorate Risks is brought to the committee for assurance of action and mitigation being taken.

Exception reporting is part of the governance of the meeting with escalation as necessary to Community Senior Leadership Team Meeting, Clinical & Care Governance Committee, Health and Safety Committee and this Committee.

Health and Social Care Committee is asked to consider the report and identify any matters that require further assurance or escalation to NHS Highland Board.

2.3 Assessment

There are 54 risks recorded on DATIX system for Community Directorate.

Out of hours assurance group holds its own risk register and has reviewed their risks and reduced them significantly. The remaining risks have been added to an issues log and will be reviewed under the out of hours redesign programme.

Key risks for the community directorate are in relation to:

Workforce availability - and the impact this has on the sustainability of services especially in remote and rural areas. There are a series of mitigation plans in place to address this risk, albeit this is a national workforce availability aspect that is impacting across many sectors.

Statutory and Mandatory Training compliance is an ongoing risk in that not all staff achieve compliance. There are robust plans in place to address this including targeted intervention to support teams and individuals who are facing challenges to complete online training. A short life working group is being set up to have more focus on positive outcomes in this area.

Financial risks are associated with reduced budget allocations from the centre and increasing demand across all services. A number of action plans and mitigation are in place and being regularly reviewed across a number of fora.

Sustainability of smaller care homes – an emerging risk due to staffing and other pressures such as compliance with accommodation and environmental standards. Regular assessment of care home sustainability is overseen via the care home oversight group and escalation of emerging issues to Joint Officer Group.

Winter Pressures – this year's Winter Ready Action Plan (WRAP) has been formulated within the context of a continuing increase in demand for unscheduled care. It reflects collaborative action between the North Highland Health and Social Care Partnership (HSCP) and the Acute Sector, building on the lessons learnt from last winter.

Premises and accommodation risks – there are a number of risks that affect people's access to services. This is mainly due to a backlog of maintenance required and/or buildings outgrowing their service. These issues are escalated and action taken to improve via the community accommodation group which is led jointly by community and estates and facilities staff working together to achieve joint accommodation solutions. The asset management group has a key role and is an escalation route for all accommodation risks.

Ligature risks at New Craigs Hospital - a steering group has been set up and via a validated assessment tool, 8,000 ligature points have been identified in New Craigs Hospital. A plan and a programme of work to remove ligature points are being undertaken and overseen by the mental health programme board and the ligature audit group.

Lack of low or medium secure beds in Scotland – there is a current issue at New Craigs which is currently being mitigated by the use of supplementary staff. A trigger plan has been agreed with Police Scotland to support the management of people who require medium security but are placed in mental health acute units. This issue has been escalated to Scottish Government via regular set meetings and communication structures that are in place.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

Moderate assurance is provided in line with the actions being taken to record, review and escalate risks to care and service delivery.

3 Impact Analysis

3.1 Quality/ Patient Care

Describe any positive and negative impact on quality of care (and services).

3.2 Workforce

High use of locum and supplementary staffing to address staff shortages introduce some risks of inconsistent care, poor experience of care and reduced job satisfaction. Some risks may impact on the delivery of the culture programme and positive staff experience.

3.3 Financial

Funding required to mitigate against some risks for example, investment in IT solutions. Some difficult decisions need to be taken about some service delivery that needs to be temporarily suspended due to cost (unfunded posts and associated cost pressures).

3.4 Risk Assessment/Management

As outlined above at 2.3.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

An impact assessment is not required to report on risk registers.

3.7 Other impacts

Describe other relevant impacts.

3.8.1 Communication, involvement, engagement and consultation

Community risk monitoring group meetings held monthly. Most recent meetings held on 14 November and 12 December 2022.

3.9 Route to the Meeting

4 Recommendation

Health and Social Care Committee is asked to consider the report and identify any matters that require further assurance or escalation to NHS Highland Board.

4.1 List of appendices

The following appendices are included with this report: None

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**11 JANUARY 2023**
Title:	**Highland Health and Social Care Partnership - Integrated Performance and Quality Report**
Responsible Executive/Non-Executive:	**Louise Bussell, Chief Officer, HHSCP**
Report Author:	**Lorraine Cowie, Head of Strategy & Transformation**

1 Purpose

This is presented to the Committee for:

Assurance

This report relates to a:

Annual Delivery Plan

This aligns to the following NHS Scotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

The North Highland Integrated Performance & Quality Report (IPQR) is a set of performance indicators used to monitor progress and evidence the effectiveness of the services that North Highland provides aligned to the Annual Delivery Plan.

A subset of these indicators will then be incorporated in the Board IPQR.

2.1 Situation

In order to standardise the production and interpretation, a common format is presented to committee which provides narrative on the specific outcome areas and aims to provide assurance.

There is still a need to establish targets for improvement measures and these will be developed for incorporation with the Annual Delivery Plan for NHS Highland.

It is intended for this developing report to be more inclusive of the wider Health and Social Care Partnership requirements and to further develop indicators with the Community Services Directorate, Adult Social Care Leadership Team and members that align to the current strategy and delivery objectives.

With this in mind additional indicators have been added to this report and include drug and alcohol waiting times and non MMI specialty waiting lists to give a broader overview of other community services.

It is intended to include moving forward wider primary care intelligence along with additional quality/performance metrics relating to community hospital. The national integration and relevant ministerial indicators will be reported annually.

2.2 Background

The IPQR for North Highland has been discussed at the September 22 development session where the format of the report and the Adult Social Care indicators were agreed**.**

2.3 Assessment

As per **Appendix 1**.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

3 Impact Analysis

3.1 Quality / Patient Care

IPQR provides a summary of agree performance indicators across the Health and Social Care system primarily across Adult Social Care and some specific Community based service areas.

3.2 Workforce

IPQR gives a summary of our related performance indicators affecting staff employed by NHS Highland and our external care providers.

3.3 Financial

The financial summary is now separate.

3.4 Risk Assessment/Management

The information contained in this IPQR is managed operationally and overseen through the appropriate Programme Boards and appropriate Governance Committees. The Deputy Chief Officer provides a report on risk to the HHSC Committee.

3.5 Data Protection

The Plan does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

No relevant impacts.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document. We aim to share this more widely internally and externally to develop understanding of the system.

3.9 Route to the Meeting

This report has been previously considered by the following stakeholders as part of its continued development:

- Health and Social Care Committee Development Session, Sep 2022
- Adult Social Care Leadership Team
- Management feedback and narrative from respective operational leads

4 Recommendation

This report is provided to the Health and Social Care Committee and committee are asked to:

- Consider and review the agreed performance framework identifying any areas requiring further information or inclusion in future reports.
- To accept moderate assurance and to note the continued and sustained stressors facing both NHS and commissioned care services.

4.1 List of appendices

The following appendices are included with this report:

- **IPQR Performance Report, January 2023**

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**11th January 2023**
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, North Coast and Caithness

Lochaber

Service Workshops in Lochaber are ongoing with a final cross-check workshop planned for early February 2023. This will mark the culmination of what has been a very intensive process for the staff involved and will allow us to finalise the Clinical Output Specification. This key document will describe the services to be provided in the new Belford Hospital and describe the accommodation required, forming a key part of the brief for the new building.

The appointment process for the Principle Supply Chain Partner, who will both design and build the new facility, is underway and expected to complete in March 2023, with design work commencing thereafter.

Caithness

The focus of the redesign remains on the development of the service model in sufficient detail to inform workforce and accommodation requirements. This is being progressed through a series of intensive service stakeholder workshops for acute (Caithness General) and community (Wick and Thurso Community Hubs), which will run until early March 2023. These will produce a service operational brief for each of the three building projects, for issue to the respective design teams when they are appointed at the end March 2023.

A technical appraisal of shortlisted sites for the Wick Community Hub & Care Village has been undertaken, and a recommendation on the most suitable option will be made to the Programme Board in January 2023.

A successful test of change for an overnight care service in East Caithness is now complete.

This was shown to facilitate discharge, reduce admissions, and provide greater choice in location of end of life care. Any continuation or extension of this service is dependent on funding. Construction work to create two step up beds at Pulteney House care home is set

to complete in January 2023, which will enable another test of change of the new service model.

North Coast services

North Coast Care Hub

The Project Team are focusing efforts to close out RIBA Stage 2; it will allow the Design Team to progress with RIBA stage 3 work. The Planning Application forming stage 3 will be submitted this week, the intention of it being formally registered by The Highland Council before the Christmas break. Stage 3 will develop and refine technical aspects of the design; the Project Team will be front and centre through the process, our input is required to develop and review proposals at key stages alongside the Design Team.

The local team are working on the business case, financial model and workforce plan. Efforts are focused on moving this through the formal governance routes (Project Team and thereafter Programme Board) for approval. The next programme board is 13th January.

3. Care Home Pressures

- There have been significant pressures on independent sector care home provision across Highland over recent years (Covid-19 and ongoing staffing challenges) and during 2022, the sector has experienced unprecedented increased cost pressures around utility, food and staff / agency costs, and subsequent financial instability.

- There have been 3 care home closures in Highland since January 2022 (Cromarty, Grantown and Portree), with a loss of 85 registered beds.

- There are sustainability issues concerning a number other care homes, in relation to which ongoing discussions are taking place and further sector instability in early 2023.

- The pressing areas in Highland relate to staffing availability, availability of accommodation for staff and the direct and indirect agency costs associated with being unable to recruit and retain staff.

- In addition, there are increased costs across all aspects of service delivery (eg utilities, food, supplies etc), which is compounded in the more remote and rural areas of Highland and in key tourism locations where there is lack of available and affordable housing.

- The size and scale of care home provision and care home provider in Highland poses specific sustainability challenges to the Partnership and has been in dialogue with the Scottish Government in relation to these issues.

- The Scottish Government have initiated wider oversight arrangements to better understand the scale of sustainability issues across Scotland and it is noted that other parts of the country are now starting to experience provider instability issues.

- NHSH have been considering the necessary strategic and operational actions necessary to manage this area of activity.

- A Joint Monitoring Committee development session was held in November 2022 to discuss the current sector fragility and to develop a direction for the future of care home provision in Highland.

- Progress was made in the forward direction of travel to deliver sustainably staffed and affordable models of provision into the future. This information is being included within the Partnership's strategic plan, which will be available for consultation in draft form in early 2023.

- Whilst progress on forward direction is being made, there are inevitably time sensitive situations arising which require immediate operational actions, which may not necessarily be aligned to the preferred direction of travel due to the individual circumstances.

- Where such situations do occur, these are to be managed through a decision making framework, with assurance reporting thereafter to this Committee.

- In the event of a care home closure decision or necessitated action by a commercial provider, NHSH has a comprehensive standard operating procedure for such a situation, which is understood will be made more widely available by the Scottish Government as a best practice tool.

4. Alness & Invergordon GP Practice

We continue our commitment to the turnaround and development of this practice which is a long-term process to rebuild and regain patient confidence in services provided.

Following TUPE transfer of staff, we have set a staffing budget for the practice and will be embarking upon an organisational change process in January. This will harmonise staff onto NHS terms and conditions and to match staff into roles within the structure. All vacant posts will be advertised in early 2023 including a campaign to recruit into key clinical leadership roles.

We continue to operate with locum GPs many of whom have been able to provide regular cover which has assisted with continuity of care. We us a mix of locums working remotely and also on-site.

We have seen a reduction in the number of complaints over the last few months and continue to monitor the type of complaints coming in. We established a Patient Participation Group for the practice in Summer 2022 and continue to support and develop a group of interested patients into this role. The PPG are keen to support with the recruitment campaign in early 2023.

A recent staff meeting, the staff expressed the desire to change the name and rebrand the practice.

We will be commencing several quality improvement projects in January/February 2023 with an initial focus on diabetes and asthma.

5. Winter pressures oversight and urgent care

<u>Winter Ready Action Plan</u>

This year's Winter Ready Action Plan (WRAP) has been formulated within the context of a continuing increase in demand for Emergency Care. It reflects collaborative action between the North Highland Health and Social Care Partnership (HSCPs) and the Acute Sector, building on the lessons learnt from last winter.

The Board's performance against the 4 hour Emergency access standard has been challenging over the summer period although we continue to perform well against other Boards in Scotland.

However, there are continuing high levels of demand and we need to be able to respond to:

- A continuing challenge with the numbers of delayed discharges within our system due to acute care demand, capacity within care homes and care at home
- Sustaining our trajectories for planned care to meet the National SG Targets
- The continuing financial challenge.

The aim of this work is to translate a strategic blueprint into service delivery that includes the development of the OPEL (Operational Pressures Escalation Levels) framework to help assist us with decision making.

This Winter Ready Action Plan represents a series of actions to develop and improve our services, whilst providing reassurance and mitigation plans to respond to the seasonal challenges.

Urgent Care

Continuous service improvement and change, led by the Urgent & Unscheduled Care Programme Board are underpinned by WRAP over the winter period; and we have been supported by additional financial award from the Scottish Government to add extra capacity.

We are currently adding additional workforce to community hospitals to make the most use of available beds; we are scoping a hospital at home model in partnership with Acute Directorate and locality planning groups; we are providing the public with signposting information via a targeted media campaign; and we are redesigning our services in line with the high impact changes set out by Scottish Government.

Redesign of Urgent Care is a key workstream and we are refocussing our overall approach to out of hours service coordination and delivery. This encompasses better scheduling of unscheduled care into next day scheduled services.

All of this work is also being aligned with the NHS Highland's strategy "Together We Care", of which Care and Respond Well are the key work streams that this relates to.

6. Fees discussion update

The Committee will recall that fee and contract recommendations for 2022/2023 were discussed at the meeting on 27 March 2022 and each of the fee and contract recommendations at appendices 2 and 3 in the report was agreed.

The report also requested an addition to the Adult Social Care Fees - Commissioning, Briefing and Instruction Group (Fees Group) mandate, this being to: apply fee rate increases requested in respect of bespoke, non-standard or other similar arrangements, where such increases have been fully considered by the Fees Group, are aligned to Scottish

Government direction and contained within the Scottish Government stated percentage uplift.

The Committee endorsed this on the basis that this mandate applies to issues arising between meetings of the HHSCC.

The Fees Group, which has responsibility for the oversight of fees for adult social care services in North Highland, has continued to meet with an interim role and remit which has enabled the group to make recommendations to the Chief Officer, Highland Community and the Director of Finance. The Chief Officer, Highland Community and Director of Finance then determine whether to approve, defer for further information or reject the recommendations.

Moving forward, work is on-going with the new Director of Finance to consider future governance arrangements to provide an appropriate solution which allows decisions related to fees to be made timeously. An update on this work will be available shortly.

7. MAT Standard Improvement Plan

Current Progress of MAT Standards 1-10 including challenges, improvement areas and good practice

MAT1: **All people accessing services have the option to start MAT from the same day of presentation**
The Central Treatment Service in NHS Highland (Osprey House, Inverness) is offering MAT 1 as per standard with data being collected. Pathways linking Inverness Community team to Osprey House are in final draft. In other areas there has been challenge offering same day MAT with a lack of non-medical prescribers, lack of accommodation, and general challenge in rural locations. There is a need to recruit to a full-time permanent community pharmacist post. Rural teams have adapted MAT 1 to offer MAT within 7 days with a view to reducing this timeframe as staff complete non-medical prescribing course. Job descriptions have been completed for ANP roles with rural teams hoping to go to advert soon. Analysis for need for ANP role still to be completed for Inverness teams as they have medical representation resident. The MIST resource will support Advanced Nurse Practitioner (ANP) training and then uplift from Band 6 to Band 7 on completion of studies. Improvement work has started with Mid and East Ross Team with the creation of their quality improvement board with aims to reduce their waiting list and waiting times. Associated PDSA's include starting drop-in and appointment clinics week beginning 12th December 22.

MAT 2: All people are supported to make an informed choice on what medication to use for MAT and the appropriate dose
Central Treatment Service in NHS Highland (Osprey House, Inverness) is delivering MAT 2. Community protocol final draft is completed and we hope this will be ratified at the next policy, procedures and guidelines meeting for use in all areas.

MAT 3: All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT
The Integrated (DARS, CJSW) non-fatal overdose immediate response team established in Inverness have commenced reaching out to NFOD (social worker joins in Jan 23). Rapid response pathway for NFOD discussions have started in all areas. A pathway meeting has taken place with Caithness and partners including Inverness team. It is likely

that Inverness will be the central point of contact who will liaise with rural teams who will then provide the outreach. Mid and East Ross quality improvement board provides a weekly count of NFOD and those outreached which will identify any local trends. It is hoped to commission a Third Sector Highland wide drug and alcohol (non-medical) support service that provides alternative as well as complimentary support to people/families affected by drug use. A draft service specification has been circulated to the Project Team for discussion/development. Justice teams will be included in tests of change to meet this standard.

MAT 4: All people are offered evidence-based harm reduction at the point of MAT delivery
Training programme developed with dates disseminated by Harm Reduction Service (HADASS) to locality teams. SOP in final draft approval. It has been identified not all team members are confident at delivering all evidence-based harm reduction therefore as part of quality improvement some teams are introducing as a test of change 'module of the month' to not only increase the capacity to deliver harm reduction but also improve the uptake.

MAT 5: All people will receive support to remain in treatment for as long as requested
A SOP is to be developed for no unplanned discharges and safe exit from treatment across all locality teams. We are currently exploring examples of good practice in other areas via MATS-IN Teams channel. Team capacity to meet this standard was highlighted as a challenge so a 2 week capacity exercise has been completed within some teams. This has identified areas for improvement using lean methodology and the method for improvement to release capacity for direct care within the team to allow people to remain in treatment.

MAT 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
Our service has a 'core skills' standard training expectation Matrix which is mandatory for all new staff. As an area of improvement some teams are hoping to improve the percentage of their staff trained in low intensity psychosocial interventions and the percentage of staff then delivering. Uptake of supervision is low and is also being monitored with a view to improve.

MAT 7: All people have the option of MAT shared with Primary Care
Although there is awareness of MAT across GP practices there is little engagement from our primary care partners. This standard has many challenges. We are reviewing materials to be distributed and will attempt to engage our GP colleagues. Primary care pharmacy will be represented in our oversight group. A meeting is arranged with primary care to review the NHSH Local Enhanced Service (LES) contract for Drug Use Treatment to include MAT Standards. Recruiting to the GP/Associated Specialist post will help deliver a shared care model**.**

MAT 8: All people have access to independent advocacy and support for housing, welfare and income needs
There is evidence for all, that independent advocacy is offered at assessment however the uptake is low. Some teams are completing analysis around why uptake is low as a quality improvement exercise. There is a joint funding proposal from Highland Advocacy and Partners in Advocacy being considered by HADP of which a decision will be made in

December 2022. A commissioning project team is established and draft service specification includes links to advocacy support**.** We are also developing a lived experience panel to improve access to family and carer support.

MAT 9: All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery
Meeting set for Monday 12th December 22 with leads to discuss clear priority referral pathways, governance structures and joint protocols between the Drug and Alcohol Recovery Service and Mental Health Service for those with co-occurring drug use and mental health difficulties.

MAT 10: All people receive trauma informed care
It will be raised at the MAT oversight group the requirement to have secure executive level management and estates support to increase trauma sensitive accommodation/the clinical space required in most areas to improve access to treatment. A CBT therapist has been recruited to HMP Inverness and will commence post early in 2023. CBT therapist vacancy will be advertised in December 2022 for DARS.

MAT Implementation in HMP Inverness
There is good appetite for MAT in HMP Inverness and Highland are the first site to include justice settings and community in data collection. Preliminary work to provide MAT has just started. A shadowing visit happened in November to commence the initial self-mapping assessment and the MIST team are arranging QI workshops to scope out improved pathways with the assertive outreach team inclusive of justice partners.

NEXT STEPS
For all MAT Standards a strategic oversight team group has been established, including Argyll and Bute colleagues to oversee the MAT standards development and implementation.

8. Vaccination Update

By Public Health Scotland calculations –
68.1% of eligible individuals have received a covid -19 booster (70.3% in Scotland)
60.1 of eligible individuals have received a flu vaccine (62%) in Scotland

Local data indicates - 84% of eligible people where appointed and offered a vaccination opportunity (with 15.9% DNA rate)

We outperform the national average in the following cohorts:
Older adult care homes (flu and covid)
Frontline health and social care workers (flu and covid)

We remain within a few percentage points of the national average for all other cohorts (details attached)

Vaccination clinics remain available until the 19th December with some continuing in the run up to Christmas and then they will all recommence after the new year.

Several clinics have had to be cancelled with late notice due to the adverse weather conditions.

9. Public Health

Following discussions about the importance of ensuring the committee has a focus on population health and health improvement, a meeting was held on 16 December to explore the how to approach this. At the meeting it was highlighted that understanding population health needs is an important and integral part of the process of service development and improving outcomes. It was agreed that Tim Allison, Director of Public health would consider what the best route would be for public health reporting into the various committees and what would sit best within the HHSCC. In addition, report writers would be asked to consider public health information within their submissions.

HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE WORKPLAN TO 31 March 2023

Standing Items for every HHSCC meeting

- Apologies
- Declarations of interest
- Minutes of last meeting
- Finance
- Performance and Delivery (IPQR: Dashboard and Chief Officer's Report)
- Health Improvement
- Committee Function and Administration
- Date of next meeting

MARCH	
• Learning Disability Services Assurance Report	Postponed to August
• Children and Young People Performance Reporting	
• Adult Social Care Fees and Charges Report	Completed
• Chief Officer's Report	Completed
• Committee Annual Workplan Assurance Report	Completed
• Committee Annual Workplan 2022/2023	Completed
• Committee Terms of Reference	Completed
APRIL	
• Report into Care At Home and Wider Community Services	Chief Officer's Report
• Annual Report of Care Home Oversight Board	Postponed to June

• Chief Social Worker's Report	Postponed
• Adults with Incapacity (Mental Welfare) Report	Chief Officer's Report
• Adult Protection Committee Annual Report	Chief Officer's Report
JUNE	
• NHS Highland Strategy: Together We Care	Completed
• Carers Strategy	Completed
• Care At Home Assurance Report	Completed
• Fees Group	Completed
• Commissioning Strategy for Integrated Health and Social Care Services	POSTPONED
• Community Planning/Engagement Strategy	POSTPONED
• Public Bodies Annual Report	POSTPONED
• IPQR	POSTPONED
DEVELOPMENT SESSION (29 July) ***Staff Experience Item from Sexual Health Team***	
AUGUST	
• Primary Care Improvement Plan Assurance Report	Complete
• Mental Health Services Strategy	Postponed to January/March 2023
• Drug and Alcohol Services	Addressed in Chief Officer's Report
• Learning Disability Services Assurance Report	Complete
• IPQR Dashboard Report	Discussed at Development Session (September)
• Committee Terms of Reference	Complete

Development Session (29 September) **Climate Change and Health & Social Care** **IPQR Dashboard reporting**	
NOVEMBER	
• Community Health Services	Postponed
• Preparation for Winter	
• Public Bodies Annual Report	
• Engagement Framework	
JANUARY 2023	
• Adult Social Care Fees Arrangements	Provisional
• Community Services Locality Report	
• SDS Strategy Assurance Report	
• Community Services Risk Registers	
•	
[Development Session: TBA: Commissioning Integrated Services]	
MARCH 2023	
• Highland Council Commissioned Services Assurance Report	
• Mental Health Services Strategy	
• Adult Social Care Fees and Charges	
• Public Health item	