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 26 April 2023 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Philip Macrae, Non-Executive, Committee Vice Chair (in the Chair)
Tim Allison, Director of Public Health
Cllr, Christopher Birt, Highland Council
Ann Clark, Board Non-Executive Director and Vice Chair of NHSH
Cllr, Muriel Cockburn, Board Non-Executive Director
Claire Copeland, Deputy Medical Director
Pam Cremin, Interim Chief Officer
Kate Dumigan, Staffside Representative
Joanne McCoy, Board Non-Executive Director
Kara McNaught, Area Clinical Forum Representative
Michael Simpson, Public/Patient Representative
Michelle Stevenson, Public/Patient Representative
Simon Steer, Director of Adult Social Care
Elaine Ward, Deputy Director of Finance
Neil Wright, Lead Doctor (GP)
Mhairi Wylie, Third Sector Representative

In Attendance:
Sarah Bowyer, Community Engagement Team, Healthcare Improvement Scotland
Rhiannon Boydell, Head of Strategy and Transformation
Stephen Chase, Committee Administrator
Fiona Duncan, Chief Social Worker, Highland Council
Arlene Johnstone, Head of Service, Health and Social Care
Fiona Malcolm, Head of Integration Adult Social Care, Highland Council (until 2pm)
Jo McBain, Deputy Director for Allied Health Professionals
Jill Mitchell, Interim Deputy Chief Officer
Kaye Oliver, Day Care Officer, Health and Social Care
Kate Patience-Quaite, Deputy Director of Nursing
Colin Stewart, Senior Contracts Officer
Nathan Ware, Governance and Assurance Co-ordinator

Apologies:
Gerry O’Brien, Catriona Sinclair, Cllr Ron Gunn

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1 WELCOME AND DECLARATIONS OF INTEREST

The meeting was introduced by the Vice Chair who noted that he would chair the meeting at the request of G O'Brien, who would return for the June meeting.

The meeting opened at 1pm, and the Chair 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.

1.2 DECLARATIONS OF INTEREST

None.

1.3 Assurance Report from Meeting held on 15 March 2023

The draft minute from the meeting of the Committee held on 15 March 2023 was approved by the Committee as an accurate record.

Regarding the rolling actions, it was noted that

- A meeting between the chairs of the HHSCC and Clinical and Care Governance Committee to establish governance routes and oversight for relevant items between the committees is due to take place in June.
- An interim update on the Integrated Children's Report will come to the September meeting.

The Committee
– **Approved** the Assurance Report, and – **Noted** the Action Plan.

1.4 Matters Arising From Last Meeting

Ross Memorial Hospital

- The Chief Officer confirmed that she had been in contact with M Stevenson with a response to her questions arising from the meeting in March. It was noted that a project manager should have been appointed and that Scottish Government had requested in December that no new capital building work commence for the time being. Work to address issues around fire compliance would be the main driver for work at the initial stage. It was agreed that an update would be provided in the Chief Officer's Report for June.

North Coast Redesign

The Chief Officer noted that at the last committee meeting M Simpson had raised some issues around the Caithness and North Coast hub redesign projects.

- M Simpson noted disappointment and frustration with the lack of progress with the North Coast Redesign despite the engagement work carried out over the past few years.
- The Chief Officer gave apologies that M Simpson had not been notified of the cross check event regarding the redesign and offered to meet with him outwith the meeting to address the issues and to provide details of community engagement activity. The Head of Primary Care and S Bowyer also offered to be involved in these discussions.
- It was noted that the crux of the issue was that the redesign project had not taken enough account of wider service issues beyond those concerning the building itself.
- It was asked if the Chief Officer could clarify at the next meeting what the scope of the North Coast Redesign was and that this might be discussed in the wider context of the district report for Sutherland.

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- The Chair gave apologies to M Simpson if any disrespect had been felt by him from the committee and wider process.

Dental Services
The Director of Dentistry will bring a position paper to the June meeting.

The Committee:
- **NOTED** the updates.
- **AGREED** that the CO in conjunction with the Head of Primary Care will meet outwith the Committee with M Simpson to discuss the North Coast Redesign.

2 FINANCE

2.1 Year to Date Financial Position 2022/2023

The Deputy Director of Finance gave apologies to the Committee that a report had not been available due to the process of reconciliation of the partnership end of year position for 2022-23. She provided a verbal update.

- The current position reported an overspend of just under £16 million compared to the initial plan estimate of £16.272 million which demonstrated a significantly improved position.
- The final quarter had seen a considerable number of additional allocations from Scottish Government and the through New Medicines Fund.
- There had been a reduction in top slices for some of the contributions NHSH had made to national projects as well.
- The Adult Social Care aspect of the HHSCP would see a break even position, as funding would be drawn down from the funding held over by Highland Council from the 2021-2022 financial year end.
- Details will be brought to the next meeting along with information on the financial plan for 2023-2024.

It was confirmed that a report would be available for the next meeting of the Board.

In discussion, the following areas were addressed,
- The Chief Officer noted that there would be a finance, efficiency and transformational change workshop the following week for executive staff and their deputies to discuss and set out plans in order to find focus and agreement on the board's appetite for transformational change including the difficult decisions around this.
- Positive work around the redesign of out of hours provision had been done in terms of workforce configuration and learning from this would be shared to encourage redesign work across the partnership such as work to reduce agency and locum spend and to do more around supporting Realistic Medicine.
- It was recognised that the transformational work would be difficult in terms of providing resources for services.
- The Chief Officer noted that a more robust plan would be possible after the meeting mentioned and would address the relationship between this work and the Annual Delivery Plan.
- The Head of Strategy and Transformation noted that Scottish Government had requested that the Annual Delivery Plan (ADP) for 2023-24 be submitted to them by June and that it would be seen by EDG in May. There was an aim to integrate savings plans with the ADP looking at performance, finance and workforce.
- It was commented that colleagues from Scottish Ambulance Service and General Practice should be included in these conversations in order to maximise transformational work and an integrated approach.

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After discussion, the Committee:	
– **Noted** the update and noted that a report would be provided for the purpose of assurance at the next meeting of the committee.	

3 PERFORMANCE AND SERVICE DELIVERY

3.1 Care Home Overview and Update

The Chief Officer provided an overview of the situation within the Care Home sector noting the turbulence within the independent sector, which had been felt acutely particularly over the last 12 months with the closure Castle Gardens Care Home.

- The past two years had seen the independent sector struggle to maintain provision. This had been particularly marked in Highland due to the smaller care homes found across the region which were more expensive to run and often in more rural locations.
- A number of mitigations had been put in place which had included good engagement with the independent sector in terms of being proactive in providing supporting and gathering intelligence.
- There had been four concluded care home closures since March 2022 and the partnership was currently in the process of closing Russell Gardens Care Home which represented a loss to the sector of 143 beds. When set against current delayed discharges across hospitals within Acute and Community services this showed a struggle with capacity.

Moderate assurance was offered to the Committee based on:

- A good understanding of the Highland market, issues and current challenges,
- A clear direction of travel for future delivery of quality care home provision in locations where they can be safely, sustainably and affordably resourced,
- The comprehensive responsiveness of the Partnership to individual viability issues as they emerge, the arising actions from which may by necessity not accord with the intended and desired direction of travel,
- Senior Partnership visibility of issues, risk and impact.
- Comprehensive closure oversight and management, with clear understanding of risks and mitigations.
- Ongoing and open channels of communication and support with providers and sector representation forums..

During discussion, the following areas were raised,

- It was noted that the National Care Home Contract determined the costs of care home provision in determining the rate of pay for staff. The majority of care homes under NHSH control are smaller and more remote and therefore have higher running costs due to issues around building age and are in locations which are more difficult to recruit to.
- It was confirmed that the responsibility to residents when care homes are closed is the first priority of NHS Highland as delegated by Highland Council who retain the responsibility to house care home residents.
- It was agreed that the Chief Officer report would take note of the current assessment around system impact and what data was being collected.#
- The Committee gave appreciative acknowledgement of the work of colleagues in the Care Home sector.

The Committee:	
– **NOTED** the report, and – **Agreed** to accept **moderate** assurance acknowledging the substantial challenges.	

3.2 Learning Disability Services Assurance Report

The paper followed previous reports relating to the provision of care and support to individuals with a Learning Disability. Previous papers highlighted developments in the delivery of services, particularly in relation to day opportunities and the August 2022 paper provided details of the structure of the service and the complex arrangements in relation to the Adult Social Care budget. The paper presented to the April 2023 committee focussed on the risks relating to work to achieve the recommendations of the Coming Home Report and the organisations work with independent sector support providers to commission support for individuals with complex needs who require 24/7 support.

The committee:
- Noted the risks associated with the provision of support to individuals
- with complex needs and the recruitment and retention difficulties
- being experienced by the support sector.
- Noted the consequences of the risks being experienced by support
- sector providers in our ability to achieve the recommendations of the
- Coming Home Report.
- Confirmed support for the actions to enable individuals with a learning disability and complex needs to lead full and active lives in their own homes in community settings.

The Head of Service gave a presentation summarising the findings of the report.
- It was noted that the housing required by individuals with complex needs was usually bespoke and designed in order to meet their needs, such as including high fencing and additional sound proofing, careful consideration of the location of houses and two exits from every room and delivered in cluster settings.
- The aim is to support the individuals to live well in their communities and the model was supported by Scottish Government and had been well researched as found to be the most effective and sustainable model of support delivery.
- It was noted that planning around such housing was a long process and that in that time an individual may come into the system who needs a place to live. In such cases isolated or non-cluster solutions may be provided along with a support worker to make regular checks. This model is far less sustainable due to the more isolated nature of the accommodation and can be very intensive from the perspective of support work.
- The above work is overseen by the Coming Home Implementation Report which includes specific recommendations for Highland to be involved with in a in a bid to enable the organisation to ensure that it can bring people back from out of area placements and also to maintain conditions for individuals to continue to live in their local area. NHS Highland has been fully involved in that report and has been part of the pilot project for the Dynamic Support Register and has been involved in the national work of which it is a part.
- A significant amount of work had been carried out to assist people to return to the Highland region in line with the Coming Home Report and in line with previous Scottish Government reports.
- A recent innovative development had seen NHSH work with Safest Houses to design and build brand new accommodation in Melfort in consultation with the service users and their supporters. This work was now complete with a key hand over in April 2023. However, there had been recruitment challenges to the support worker roles required for the buildings and their occupants and therefore it had not been possible to home anyone at the site.
- The recruitment issue was noted as much the same as that which had been experienced across the sector.
- Meetings were being held with Scottish Government to address the health inequalities of individuals with complex needs and the SG were in the process of setting up new learning networks across Scotland to ensure that each board area was able to meet the directive to provide required health checks.

- The challenge of having every person with a learning disability access a budget for their support provision was noted with regard to the impact of meeting these targets as well as the additional care support that NHS Highland provides for individuals.
- Limited assurance was offered to the Committee with regard to the significant concerns mentioned above to meet the needs of care and support for individuals with a learning disability or complex needs. However, it was felt that moderate assurance could be offered regarding the ability to carry out health checks.

During discussion,
- It was commented that the expected timescale for occupation of the newly built site at Melfort was unknown but that mitigating actions in partnership with the wider sector were underway with a view to using agency staff before staffing is fully recruited, however it was thought that there may be similar struggles around the recruitment of agency staffing.
- It was noted that there was no capital cost to NHS Highland for the new site which would be leased to a registered social landlord by Safest Houses. It was commented that the landlord would receive the money back via housing benefits but that costs would be borne by NHS Highland if the property is unoccupied after an initial three month period.
- The Head of Adult Social Care offered to give the Committee a briefing outside the meeting on the challenges in the sector and some of the proposed solutions. The Chair commented that this could be a good subject for a development session for the Committee.
- It was noted that the issue around the new build site and plans for two further sites be added to the Board Risk Register.

In summarising, the Chair noted that the Committee accepted limited assurance from the report and that a report would come back to the Committee which addressed some of the issues raised in discussion.

The Committee:
– **AGREED** to accept **limited** assurance from the report noting the areas of challenge.

The committee held a short break at 2.55pm and reconvened at 3.05pm.

3.3 IPQR Dashboard Report

The Head of Strategy and Transformation introduced the report and outlined some of the key areas, which proposed moderate assurance to the Committee noting the continued and sustained stressors facing both NHS and commissioned care services.

- Care At Home had seen relatively unchanging levels of unmet need related to availability and capacity in conjunction with a continued reduction in independent sector provision related to workforce issues.
- The picture for Care Homes was similar as noted above.
- Pressures on SDS had shown a relatively static position over the last six months following a rise over the summer.
- SDS had seen a continued rise in Option One direct payments, especially in remote and rural areas due in some degree to there being a lack of availability of other services
- The number of approvals for care breaks had fluctuated month by month and it was not possible currently to see a specific.
- Adult Protection had seen a continued rise in referrals.
- Psychological therapies had shown a significant reduction in long waits.
- Drug and Alcohol Recovery was performing just slightly under the national performance level.

In discussion, the following areas were noted,
- It was agreed that the Head of Strategy and Transformation would explore if data around waits for Care At Home could be feasibly extracted for the committee's reference.
- The Chief Officer commented that the Board had recently held a development session on IPQR and performance and that the discussion would feed into reporting and work with Joint Officer Group and Joint Monitoring Committee colleagues, and it was felt that Care At Home wait data would be beneficial for these groups.
- It was suggested that more detail be included in the IPQR narrative on improvements in patient waits for psychological therapies and that this be tied to the trajectory for improvement to be in line with Board-led work to make performance scrutiny more forward looking.
- It was confirmed that data on Raigmore fell outwith the IPQR for Health and Social Care Partnership in its reporting to Scottish Government which accounted for Raigmore's status in the report as 'non reporting'.
- It was asked why reporting is given in 'weeks' and in reply it was noted that this was to meet reporting standards but that this could be looked at in terms of assisting the committee's understanding of the data.
- The Chief Officer noted that triangulated data was necessary to get a handle on areas of omission in the statistics and that this could be the subject of a future development session.

The Committee:
- **AGREED** to accept **moderate** assurance from the report.
- **AGREED** that an update report come to a later meeting of the Committee.

3.4 Chief Officer's Report

The Chief Officer gave an overview of the report which included project updates from the urgent work group on plans for North Skye Healthcare and there had been improved collaboration between the parties concerned, and noted ongoing work on the Lochaber and Caithness redesign projects.

An update on Care Home Oversight was discussed above.

During discussion,
- It was noted that an invite had not been received by the committee's Lead Doctor Rep to the Caithness Redesign Cross Check event and that this would be remedied for future engagement work as soon as possible as an action for the Chief Officer to follow up.
- It was acknowledged that more community resource was necessary for the changing demographic but that this should not be at the expense of hospital services and for the things which they can do best.

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

3.5 Adult Social Care Fees and Charges

The Senior Contracts Officer introduced the paper to the committee and noted that the recommendations put forward were based on work undertaken with the Fee Briefing Group and subsequently endorsed by the Chief Officer and Director of Finance. Due process had been followed and the approach adopted followed the Scottish Government policy. The recommendation was to agree an uplift to be able to fund the Scottish Living Wage, which stood at £10 as minimum payment for staff delivering care. This was to cover all the registered services from care homes to care at home and housing support.

- It was noted that the National Care Home contract was not currently settled for the year and there were ongoing negotiations at the national level. The report requested an interim uplift following a recommendation from COSLA.

In discussion, it was noted that the two national offers had been rejected by Scottish Care.

- Negotiations at a regional level were being undertaken by Highland Council and the Chief Officer had made a request for an update from the Chief Social Worker at Highland Council on the position.
- The Head of Adult Social Care noted that there were likely to be further cost differentials beyond the negotiated position which may add further cost pressures. He also noted that current financial forecasts for NHS Highland are based on there being an agreed contract. If the contract is not agreed this would mean a change in the forecast would be necessary with a destabilised care home sector.
- If negotiations are not resolved by 30 June the most likely outcome would be for Highland Council (and thereby NHS Highland) to offer an extension to the current arrangements, however there would be no guarantee that the sector would accept this.
- Mitigation is underway with regular contact with sector representatives to maintain good lines of communication.
- The proposed level of assurance was discussed and it was concluded that the paper was robust in terms of due process and mitigating actions, accepting that the negotiations were not within NHS Highland's remit.

The Committee:

- Noted the requirements of the Scottish Government and COSLA regarding wages for care staff, and the status of current information received;
- Noted that the Fees Group had prepared recommendations, which were those as contained within the report, and which were endorsed by the Chief Officer and Director of Finance.
- Noted the National Care Home Contract interim increase for care homes but that settlement had not been achieved and that NHS Highland awaited further updates from COSLA, Scotland Excel and Scottish Government.
- In furtherance of the due process, the Committee considered and agreed the fee and contract recommendations outlined in Appendix 2 of the report.

The Committee agreed to take **substantial** assurance from the paper noting the caveats discussed above on the outcome of the National Care Home Contract negotiations.

The Committee:

- **NOTED** the report, and
- **Agreed** to accept **moderate** assurance from the report noting the caveats outlined above.

4 HEALTH IMPROVEMENT

District Reports

This item was postponed to the June meeting due to local system pressures.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Committee Work Plan

The Chair introduced the Work Plan for approval by the Committee and noted that the June meeting was likely to be a busy one.

- The Head of Strategic Commissioning noted that the request for items on Self-directed Support and rates for personal assistants was an item that may need to come to the June meeting. There was also a need to consider Cost Containment Plans for Adult Social Care.
- The Chief Officer noted the need to extend an invite to the Adult Protection Committee to provide its annual report, and that the Chief Social Worker's Annual report was likely to come to the Committee after it had been seen by Highland Council. There would also be an important paper on the Dental position.
- The Chief Officer requested that the Drug and Alcohol Recovery Services paper be postponed due to the significant work around MAT standards and in order to give the new service lead time to work on the report.
- The Chair confirmed that the above suggestions would be considered at the agenda planning session with the Chief Officer.

The Committee
- **noted** and **agreed** the Work Plan for 2023-24.

5.2 Risk: Level 1 Risks Report

The paper outlined the risk registers held by the Community Directorate across the operational areas of Community services, Primary Care services (including independent contractors in Optometry, Community Pharmacy, Dentistry), Out of hours Primary Care services, Mental Health and Learning Disabilities services; and Adult Care services. The summary of Community Directorate Risks was brought to the committee for assurance of action and mitigation taken.

The Committee was asked to consider the report and identify any matters that require further assurance or escalation to NHS Highland Board. A *moderate* level of assurance was recommended to the Committee.

- The Head of Primary Care noted that more of the data had now been transferred to digital from paper format which had made the data more visible.
- Monthly meetings had been taking place where divisional risks for operational units were discussed and scored, and data was updated around new risks and those escalated to senior management and on to the Health and Safety Committee, HHSCC or the Executive Directors Group.
- There were currently 47 risks recorded on Datix at level 2 and 3.
- The Dental position was recorded as a level 2 risk, and the Dental Director will provide a report to the June committee meeting.
- The Mental Health and Learning Disability situation was discussed above.
- Issues around Primary Care include sustainability of practices, recruitment in some of the Board-managed practices and the high use of locums.
- Remote and rural areas remain a significant area of concern for recruitment across all disciplines.
- Statutory Mandatory Training had seen an improving position due to sustained work on his area.
- There are some risks around premises and accommodation in terms of the maintenance backlog of ageing estate which required capital investment. There was a specific improvement plan around ligatures which was led by the Head of Mental Health, Learning Disabilities and Drug and Alcohol Recovery Services.

During discussion,
- It was noted that a community version of the OPEL monitoring system that was currently in use at Raigmore Hospital was under consideration and had received positive feedback to the Board. Discussions were underway to consider the merging of Community

Services and Mental Health Services as part of this work, and to have as full a picture as possible across Pharmacy, Optometry, Dentistry, General Practice. It is thought that the system will be rolled out for winter 2023 with development work over the summer.
- The current reporting system is the one that had been used for reporting around COVID across services.
- The Head of Primary Care noted that she was leading on a piece of work around out of hours provision and its sustainability in the organisation. This work would involve GPs in the redesign discussion.
- Work to address risk around remote and rural provision had involved collaboration with Scottish Ambulance Service colleagues.
- It was noted that information concerning a follow up to the pilot study which saw the Fire Service assisting with falls would be found and circulated to the Committee.
- The Chair noted the valuable work the Board was doing in terms of developing risk management.
- N Wright noted the importance of colleagues having the opportunity to illustrate some of the stresses experienced on service areas to assist with populating the risk register. The importance of intelligence received from the monthly risk meetings was acknowledged in this regard to making a dynamic, responsive system, and that the aim was to get to a position where it would be easier to identify struggling practices.

The Committee
- Accepted **moderate** assurance from the report.

6 AOCB

The Chair acknowledged the contribution of M Simpson as Public/Patient Representative on the Committee since 2017 and thanked him for his contribution and work on behalf of those he represented which has been vital to fuller representation of voices at the Committee.

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 28th June 2023** at **1pm** on a virtual basis.

The Meeting closed at 3.47 pm

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Item 1.3.1

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/Chair**	Chair to meet with Chair of CCG, and CO to determine route forward. Report back March committee meeting.
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).
15/01/2023	**Integrated Children's Report**	Interim 6-month update	**P Cremin/T Gervaise/I Kyle**	Added to Workplan: September committee

Agenda Item 3.1

Meeting: **Health and Social Care Committee**

Meeting date: **28 June 2023**

Title: **Care at Home Assurance Report - Proposed Care at Home Delivery Direction**

Responsible Executive/Non-Executive: **Pamela Cremin, Chief Officer**

Report Author: **Gillian Grant, Interim Head of Commissioning**

1 Purpose

This is presented to the Board for:

- Awareness
- Assurance

This report relates to an:

- Emerging issue

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

2 Report summary
2.1 Situation

This report sets out the current issues in relation to the provision and delivery of care at home services across the Partnership area and describes plans to co-create a care at home delivery vision and co-develop an accompanying and supporting commissioning approach.

The report is being provided to the Health and Social Care Committee for awareness of the proposed area of activity and for assurance as to the steps being taken to address current and forecast challenges.

2.2 Background

There are 21 independent sector care at home providers, who collectively deliver 8,900 hours of care at home provision per week, at an annual cost of £13.5m.

74% of provision is delivered in urban areas, 16% in rural and 10% in remote.

The size and scale of provider varies considerably, with NHSH commissioning between 30 hours and 1,800 hours per week across these 21 providers.

NHSH also operates a care at home service, delivering a total of 3,900 hours per week via 7 separate registered services. Enablement services deliver around 900 hours per week in addition to mainstream delivery. The total spend area around this activity is £15.7m pa.

Collectively therefore, there is a minimum of 13,700 hours per week of care at home provision, at a total cost of £29.3m pa. This figure does not include Options 1 and 2 where there is flexibility, choice and control although a large proportion of the support, around 80%, is to employ personal assistants.

There are also 322 older people receiving a service via an Option 1 or 2 care delivery model, at a cost of £5m pa. Option 1's in particular continue to increase due to the lack of alternative commissioning service delivery options.

The key objectives around commissioned care at home activity, are to achieve stable, resilient and assured provision and capacity release / growth.

Since August 2021, NHSH has been working closely with care at home partners through regular and structured dialogue in order to better understand the current issues and to work together to identify and implement sustainable solutions to address the key issues, summarised as:

- High attrition and unsuccessful recruitment, impacted by role pressures; (perception of) sector, role inequity; and fuel costs
- Staff wellbeing issues
- Specific geographic challenges in rural / remote delivery and the additional costs of providing care at home, as well as the more acute recruitment challenges in these localities.

Over the course of 2022-2023, there has however been a significant reduction of available commissioned services (by 1,430 hours pw), despite the measures put in place by NHSH to seek to stabilise provision, and ensure capacity release and growth – these being advance payments and continued UKHCA aligned tariff.

The current number of people delayed in both a community and hospital setting continues to increase, with 26 people delayed in hospital awaiting a care at home service and 307 in the community and overall, there is currently care at home unmet need of 2,600 hours per week.

It is highlighted that there is further and more detailed data on care at home delivery, as per the agreed datasets provided within the north Highland Integrated Performance and Quality report (IPQR) report elsewhere on the Committee's agenda.

The reduced capacity is due to the challenges noted above and have therefore impacted on the inability of providers to deliver to agreed baseline activity levels. In over 124 instances over the last 2 years, resulted in service "hand back" to NHSH due the service being operationally and financially unviable, requiring NHSH to mobilise to pick up services not intended or planned for in house delivery. Consequently, the current pattern of delivery is by circumstance, not by design.

Sourcing and retaining a sufficient workforce is challenging across all providers, due to the pressures of the role which is exacerbated by vacancy levels; the perception of the sector in crisis; pressured interactions with service users / families when delayed; more attractive, better paid and less stressful roles in other sectors (retail, hospitality, tourism); the role of carer not being valued by society as a whole; along with currently available terms and conditions.

Critical to achieving sustainability is both longer term planning and also a need to recognise the care at home workforce as equal partners in the wider health and social care system and to actively support the professional and financial recognition of this. This is a key aspiration being set out within the Partnership's Joint Strategic Plan.

2.3 Assessment

There has been a continued trend of reducing care at home delivered hours.

There has been an increased number of people delayed in hospital, waiting for the availability of care at home services.

There are significant staffing shortages across both in house and commissioned delivery. This position will continue to deteriorate without significant and intentional proactive actions.

Actions and interventions to date have not had the intended impact or desired outcome of increased capacity and stabilised provision.

We are on a trajectory of increasing demand and unmet need, with reducing service availability.

We therefore need to utilise the provision we have to best effect, and identify and deploy initiatives to stabilise and build a workforce to be able to meet both current and future need.

More impactful actions are now needed to realise and achieve stability and growth to address the current and future delivery gap.

The impact of care at home service provision on flow within the wider health and social care system is significant, and this needs to be recognised as part of the approach to, and solutions around, addressing care at home capacity.

It is therefore proposed that a specific programme area of work is established to co-create and co-develop a medium term (5 year) care at home delivery vision and supporting commissioning approach.

This will require dedicated input commensurate with both the level of whole system gain to be achieved and also the financial value of overall activity over the intended 5 year plan. The value of this activity over this 5 year period is in the region of £170m.

This programme would seek to deliver the following **five key objectives** for the future delivery of care at home services:

1. Maximise provision through processes, training and technology
2. Enable market and delivery stability
3. Create, sustain and grow capacity
4. Recognise, value and promote the paid carer workforce
5. Improve affordability

It is proposed that the product from the programme will be a created and developed **joint 5 year plan** to cover the following areas:

- Vision
- Current specific concern areas
- Learning from best / other practice
- Commissioning approach (to include ethical and collaborative commissioning, different contracting approaches and tests of change)
- Financial arrangements to support vision and commissioning approach
- Delivery and outcomes measurement
- Process and other changes needed

This programme would then require to be implemented, with ongoing resources to support this.

Independent sector providers and sector representatives would be critical partners in the co-design and co-development.

Identified wider key stakeholders would be invited to input and contribute to the process, the detail of which will require to be developed but existing feedback and networks will be utilised to maximise efficiency and avoid engagement fatigue:

- Service users
- Families of service users
- Unpaid carers
- Paid carers
- In house service provision
- Independent sector provision
- Representation (Scottish Care C@H Independent Sector Lead)
- ASCLT
- Senior Leadership Team
- The Highland Council

Strategic Landscape

There is a need to take cognisance of the Joint Strategic Plan, which remains in development and which will be consulted upon during 2023.

There will be proactive read across to this plan, however, the current care at home issues to be addressed need to progress at pace and may by necessity travel faster than this overarching Joint Strategic Plan.

It is not considered however that the direction of travel to support more people at home for longer and to consolidate and grow capacity, will be in conflict this the intention of this programme; rather that this programme area of activity will focus on articulating how this strategic imperative is to be delivered and to oversee its implementation.

Essential Imperatives

Whilst there is a necessity to reach a joint medium term plan, there is a pressing and current need to address the following 3 priority areas within 2023-2024, and at the earliest opportunity, which will require proposals to be presented and key decisions to be made around:

1. Delivered provision efficiency and affordability;

2. Independent sector workforce pay arrangements for 2023-2024; and

3. In year plan for workforce availability and flexibility for improved resilience and winter planning

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

Comment on the level of assurance
There is a thorough understanding of the issues impacting on the availability and delivery of care at home services and a high level of confidence in producing a 5 year plan.

3 Impact Analysis

3.1 Quality/ Patient Care

The intention of the development of a 5 year plan is to seek to create additional capacity so more people can be supported to remain in their own homes.

3.2 Workforce

A further intention of the 5 year plan is to grow the current care at home workforce, by attracting new staff into this sector and by implementing initiatives to improve staff retention within this sector.

3.3 Financial

There is a need for the 5 year plan to reflect affordability parameters.

3.4 Risk Assessment / Management

The purpose of the development of a 5 year plan is to address and mitigate current risks and challenges, and to change course from the current trajectory.

3.5 Data Protection

None.

3.6 Equality and Diversity, including health inequalities

None.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

The identified key stakeholders / partners will be involved in co-producing and co-designing the plan.

3.9 Route to the Meeting

There have been various prior reports / updates on this developing care at home direction as follows:

- Independent sector - care at home short life working group
- Joint Officer Group, 9 June 2023
- Senior Leadership Team, 14 June 2023

4 Recommendation

Decision:

- **Awareness** – For Members' information of the proposed area of activity.

- **Assurance** – As to the mitigating actions being taken to address current and forecast challenges.

4.1 List of appendices

The following appendices are included with this report:

- None.

Agenda Item 3.2

Meeting: Health and Social Care Committee

Meeting date: 28 June 2023

Title: Care Home Oversight Collaborative Assurance

Responsible Executive/Non-Executive: Pamela Cremin, Chief Officer

Report Author: Gillian Grant, Interim Head of Commissioning

1 Purpose

This is presented to the Board for:

- Awareness
- Assurance

This report relates to an:

- Emerging issue

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

The previous report provided to the Health and Social Care Committee on 26 April 2023, provided an overview of independent sector care home provision, focusing on the recent sector turbulence experienced over 2022-2023 and the mitigating actions in relation to the care home closures which had been or were being managed.

This further report now provides an overview of wider sector oversight during 2022-2023 and sets out the move towards collaborative care home support arrangements.

2.2 Background

A Care Home Oversight Group (CHOG) has been in place since May 2020, following a mandate from the then Health Secretary, that Partnerships' should establish such a group to enable enhanced professional clinical and care oversight for all care homes in their area.

The Health and Social Care Committee received an assurance report in April 2022 from this CHOG, which provided a reminder of the requirements relating to the Scottish Government mandated Care Home Oversight Group; provided assurance to the H&SCC as to the effective operation of this group during 2021-2022; described the current care home issues and those anticipated during 2022-2023; and provided assurance to the H&SCC with regard to the plans in place to address these issues.

Over 2022-2023, the CHOG has continued to meet fortnightly to oversee care home activity across the NHS Highland area, encompassing both Argyll and Bute and North Highland, receiving reports at each meeting covering the following areas:

- RAG status of all care homes across the area, both in house and independent sector;
- Detail provided of the situations around any denoted as red RAG status;
- Large scale investigations (if any)
- Suspension of admissions (if any)
- Sector viability update
- Bed vacancies
- NHSH mutual aid / community response team input
- TURAS compliance (completion of Scottish Government information requirements to enable national and partnership overview)
- Key headlines for the CHOG's consideration

A high level care home activity summary for 2022-2023 is provided at **Appendix 1.**

The significant challenges envisaged within the previous 2021-2022 report around anticipated sector turbulence, as reported to this committee in April 2022, have unfortunately been realised. This has required a significant level of consideration and responsiveness, as documented in detail in the referenced previous report to this committee in April 2023.

In moving to consider the organisational approach to care home oversight, it is highlighted that there has been a shift in approach by the Scottish Government.

This change of approach is a move away from clinical and care oversight, towards a holistic care and collaborative and improvement approach to supporting care home provision. This shift has been set out by the Scottish Government within their communications of 14 December 2022, 17 March 2023 and 24 April 2023 (attached as **Appendices 2, 3 and 4**).

In responding to the request contained within the communications, the Highland Health and Social Care Partnership provided a submission to the Scottish Government on 12 May 2023, which set out a proposed delivery plan around this area of activity and specifically set out a programme of work for utilisation of the £680k of funding available to support this area for the Highland Health and Social Care Partnership.

The key focus of the intended areas of activity is on embedding My Life, My Care, My Home, the Health Care Framework; and for tangible actions for improving outcomes for adults living in care homes. The submitted delivery plan sets out how the partnership will deliver the requirements of the Scottish Government in relation of the provision of support to care homes, for the specific purpose of:

- improving care and outcomes for people living in care homes;
- continuous improvement of quality and safety of resident care; and
- improving assurance arrangements which support these outcomes.

The delivery plan is a plan for a change of approach to support care homes across sectors to have structured NHSH organisational support when requested and to recognise that services are best delivered, and service outcomes for residents are optimised, where organisations work together as equal partners and with mutual respect.

A Collaborative Care Home Strategic Group is therefore being established to replace the previous CHOG which has been in place since May 2020, and will be responsible for delivery of this plan.

This new group will have a renewed focus on and towards holistic care delivery and support, assurance, the current context and the need to respond to current challenges, and will shift away from the previous attention on oversight and clinical care assurance.

2.3 Assessment

- CHOG has continued to provide oversight of clinical, care and wider arising care home issues over the course of 2022-2023;
- Many of the challenges anticipated to occur during 2022-2023, materialised and have required significant organisational support to the care home sector;
- There has been a Scottish Government shift from oversight to collaborative support, which require NHSH to respond to these changes accordingly;
- Funding to support this collaborative approach has been received from Scottish Government, and is being directed into a collaborative care home support delivery plan;
- The key objective of this funding is on improving the lives of those people living in care homes.
- Arrangements are being established to ensure both the delivery of this plan, and to reflect the shift towards holistic support; and
- Critical to the approach is that the independent sector is a partner within this collaboration.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

Comment on the level of assurance

Arrangements are being implemented to ensure that the submitted delivery plan is delivered as intended.

3 Impact Analysis

3.1 Quality/ Patient Care

The objective of the new focus and collaborative arrangements are specifically to improve the lives of those people living in care homes.

3.2 Workforce

There has been, and continues to be, extreme staffing pressures and challenges across the delivery of all care home services, which is a key precipitating factor in care home closures.

A focus of the collaborative support is to provide responsive, timely and multi-disciplinary input to care homes where needed, to support their staff on the ground. A further focus of this area of work is to identify and consider more strategic cross sector workforce solutions.

3.3 Financial

There are financial pressures arising from care home sustainability issues, as previously reported to this committee.

The allocated funding from Scottish Government is for the specific purpose of supporting actions to improve the lives of those living in care homes.

3.4 Risk Assessment / Management

There are a number of commissioned care home provision related risks, which are being managed within the Adult Social Care risk register.

In terms of the specific collaborative delivery plan as noted within this report, delivery of this plan will be overseen by the Strategic Group, who will also be sighted on associated risks.

3.5 Data Protection

None.

3.6 Equality and Diversity, including health inequalities

None.

3.7 Other impacts
None.

3.8 Communication, involvement, engagement and consultation
Representatives of the independent sector have been involved in the development of the collaborative support delivery plan.

3.9 Route to the Meeting
The following are noted as related background items to this report.

- Health and Social Care Committee, 27 April 2022 - Care Homes Oversight Group Annual Report 2021-2022; and

- Health and Social Care Committee, 26 April 2023 – Independent Sector Care Homes Overview

4 Recommendation

Decision:

- **Awareness** – For Members' information.

- **Assurance** – As to the arrangements being put in place to:

  - shift towards collaborative support and to improve the lives of those living in care homes; and

  - deliver the plan as submitted to the Scottish Government

4.1 List of appendices

The following appendices are included with this report:

Appendix 1 - Care Home Oversight – Key Activity Summary 2022-2023
Appendix 2 - Scottish Government Letter of 14 December 2022
Appendix 3 - Scottish Government Letter of 17 March 2023
Appendix 4 - Scottish Government Letter of 24 April 2023

Appendix 1

Care Home Oversight – Key Activity Summary 2022-2023

Assurance / Monitoring Activity Area	Actions	Outcome / Impact / Comment
Quality assurance and oversight	– Adult Social Care weekly dashboard and review of NES-designed Care Management System on TURAS, which allows care homes to escalate concerns, including requirements for additional staff through mutual aid.	– Organisational visibility of care home RAG status.
	– Regular (weekly) Clinical and Care Oversight Group safety huddle to identify, discuss and agree any required actions.	– Organisational oversight by key stakeholders – Timely flow of information to and between relevant stakeholders, assisting fast and effective decision making.
	– Operational and contractual meetings held with providers across all sectors in 2022-2023 are in excess of; – Q1 - 180; – Q2 – 239; – Q3 – 189; – Q4 - 197 – CRT continuing to provide significant amount of support to care homes – Reservist support to care homes	– Includes regular contract/operational meetings, Care Inspectorate feedbacks and escalation meetings with providers where there are identified issues, for assurance and oversight. – Dynamic and responsive Care Response Team (CRT), Reservist and Care Home Nursing Liaison input.
	– Attendance at Care Inspectorate feedbacks which have moved away from Covid-19 specific focus to routine framework inspections. Note that most inspections are now full inspections.	– Ongoing and as required. Raising operational awareness for any support required and concerns highlighted.
	– Quality Assurance Visits (round 2) as mandated by the Scottish Government – consolidating actions from all visits, reviewing outcome reports for each care home, and following up on actions as part of contract monitoring process.	– Completed.

Assurance / Monitoring Activity Area	Actions	Outcome / Impact / Comment
Large Scale Investigations	− LSIs initiated with 5 separate care homes.	− Escalation and liaison meetings with each provider during or after periods of LSIs to get a status update on the home, jointly look at improvements that are required, oversee issues and monitor progress, and discuss how NHS Highland can provide support or assistance.
Sector support	− Regular strategic and business meetings with care home providers to understand current issues and inform appropriate actions. Frequency tailored appropriate to level of activity. − Care home manager hotline, including 7 day cover where required. − Contingency planning support. − Care Home Liaison Team – provision of clinical and professional nursing leadership to support providers and the workforce.	− Open communications and clear points of contact. − Good sector intelligence and understanding of issues.
Provider Sustainability	− Supplier Relief applications for all providers as part of the response to COVID-19. − As at 29 March 2023, 1745 applications have been received. Claims paid to date amount to £9.9m (across all services).	− Providers supported with additional costs due to Covid-19 in line with Scottish Government requirement.
Care Home closures	− In 2022-2023 a total of 4 independent sector care homes have closed, 1 further home is confirmed for closure (now since closed in June 2023), (1 in house care home has also closed) and 1 independent home moved to in-house operation (on 1 April 2023).	− NHS Highland is working in partnership with providers to ensure a person centred, safe and smooth transition to alternative provision for the residents affected.

Appendix 2
Scottish Government Letter of 14 December 2022

2022-12-14-Local collaborative care hor

Appendix 3
Scottish Government Letter of 17 March 2023

2023-03-17-Funding for Collaborative Care

Appendix 4
Scottish Government Letter of 24 April 2023

Funding for Collaborative Care Hc

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Interim Director Social Care
Angie Wood
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14th December 2022

To: Chief Social Work Officers, IJB Chief Officers, Executive Nurse Directors, Directors of Public Health, Medical Directors
Cc: Local Authority Chief Executives and NHS Chief Executives

New Arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes - Advice Note

We are writing to confirm new arrangements for providing enhanced collaborative clinical and care support for social care in Scotland. This follows a review undertaken by a Short Life Working Group (SLWG) comprising a range of stakeholders from across the health and social care sector.

We know that the social care workforce is continually and tirelessly providing exceptional care and innovating in the face of many challenges. We would like to build on this strong platform by ensuring that the sector is supported when needed and there is a continuous cycle of cross sector collaborative support to strengthen what is already in place.

As you know, arrangements for providing additional whole system, multidisciplinary support for adult care homes have evolved during the pandemic since the original request in May 2020 from the then Cabinet Secretary for Health and Social Care. Arrangements were subsequently widened to include adult social care. There has been considerable learning and examples of excellent partnership working during this time, and a recognition of the outstanding contribution and skills of so many care home staff and the teams that support them. That learning has very much been a two-way process.

While there has been considerable value in the arrangements, it has been important to review them to ensure that they reflect the current context. Based on the findings of the review and taking account of the current pressures facing the sector, we have developed a number of recommendations. Overall we recommend continued enhanced support for adult and older people's care homes to support the sector as it emerges from the pandemic and as it deals with the current pressures. This note follows one from Caroline Lamb and Sally Louden on the 8th December on winter pressures and preparedness.

We note that such an approach outlined for care homes is also relevant for the wider social care sector, which many local systems have already adopted.

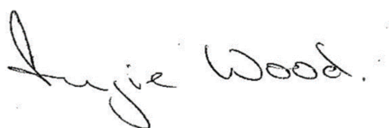
The recommendations are outlined in the advice note in Annex 1. They support a partnership approach, which recognises the experience of care home staff and the provision of support to care homes in the context of ensuring a homely environment in which people live and work. The note provides guiding principles and a framework which recommends that health and social care professionals continue to work together to identify ways to improve the health and wellbeing of people living in care homes, as described in My Health, My Care, My Home - healthcare framework for adults living in care homes published by SG in June 2022 and Health and Social Care Standards in Scotland.

We hope this will be helpful to you as you continue to work with and support care homes locally.

Yours sincerely

Iona Colvin
Chief Social Work Advisor

Professor Alex McMahon
Chief Nursing Officer



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Interim Director Social Care

Scottish Government
Riaghaltas na h-Alba
gov.scot

Annex 1

New Arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes - Advice Note

Overview

Enhanced clinical and care oversight arrangements for care homes were put in place early on in the pandemic to support care home staff to keep residents safe. This followed a request from the then Cabinet Secretary for Health and Sport for multi-disciplinary teams, comprising key clinical and care leads from NHS Boards and local authorities, to provide additional whole system support to protect residents and staff[1],[2]. There has been considerable learning and examples of excellent partnership working during this time. Using this learning, a Short Life Working Group (SLWG) comprising a range of stakeholders across the sector reviewed the arrangements.

Based on the findings of the review to date and, taking account of the current pressures facing the sector, this advice note sets out recommendations, informed by the SLWG, for new arrangements for providing continuing enhanced support to adult and older people's care homes in Scotland.

Many areas have already evolved their arrangements, in collaboration with care homes, to focus on improvement, sustainability and viability, taking into account the learning and experience of the pandemic and the strong, positive relationships built between local partners and care home staff, residents and families. The outstanding contribution and skills of so many care home staff and the teams that support them during the pandemic is recognised. Currently care homes, along with other parts of the health and social care system, are operating within an increasingly complex and pressurised environment. Their value and ongoing success is critical to the future sustainability of locally based health and social care provision.

The intention of this advice note is not to supersede existing arrangements, but to provide guiding principles and a framework for collaborative improvement to strengthen any locally developed approach whilst ensuring a level of consistency across the country.

Proposed new arrangements

There has been considerable value in the clinical and care oversight arrangements which have enabled whole system support to be provided to care homes during an

[1] Strengthened clinical oversight for care homes - gov.scot (www.gov.scot)
[2] Coronavirus (COVID-19): care home oversight - gov.scot (www.gov.scot)

unprecedented time of crisis. Local arrangements have generally worked best where conditions have been created for a partnership approach which has fostered mutual respect, trust and equal voice. Key to the approach has been a recognition of the experience of care home staff; assurance support in the context of ensuring a homely environment in which people live and work; and solution-focussed improvement support conversations with supportive follow-up.[3] Arrangements which link effectively with, rather than seeking to duplicate, wider regulation activity by the Care Inspectorate, have worked well.

On this basis it is recommended that:

- Assurance and support arrangements continue but there should be a continued focus on adult and older people's care homes. They should evolve to take account of the current situation to support care homes as they emerge from the pandemic and deal with the current pressures facing the sector. Where local systems have evolved to include the wider social care sector, these principles should also apply.
- Local oversight teams should be renamed as Collaborative Care Home Support Teams or local equivalent – removing 'oversight' from the name is recommended. This is to reflect the emphasis on building on existing good practice, collaborative improvement and assurance, wider considerations around the pressures of financial viability/ sustainability in the face of rising costs and to avoid confusion with the statutory duties of the Care Inspectorate.
- The local teams' TOR and membership should be reviewed in line with this shift, recognising that the need for flexibility to respond to current challenges (see below for more details around roles).
- Collaborative Care Home Support Teams should take a collaborative improvement approach, with health and social care professionals working together using approaches such as appreciative inquiry [4] to identify ways to improve health and wellbeing of people living in care homes as described in My Health, My Care, My Home - healthcare framework for adults living in care homes[5] published by SG in June 2022 and Health and Social Care Standards in Scotland[6]. There should be robust engagement with care homes including representatives for example through Scottish Care, CCPS.
- Collaborative Care Home Support Teams should not replicate inspection or regulation, which is the clear statutory responsibility of the Care Inspectorate. There should be a move away from an inspection model of assurance which has caused confusion in the sector and teams should not use Care Inspectorate terminology. For example, rather than making recommendations or areas for improvement identify what is working well and how to build on this in line with an appreciative inquiry approach. Decisions on assurance visits should be guided by local circumstances which may mean a nuanced approach.

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[3] Care home quality assurance during COVID-19 | Iriss
[4] Appreciative Inquiry practical resources SSSC https://lms.learn.sssc.uk.com/course/view.php?id=14
[5] My Health, My Care, My Home - healthcare framework for adults living in care homes - gov.scot (www.gov.scot)
[6] Health and Social Care Standards: my support, my life - gov.scot (www.gov.scot)

- Collaborative Care Home Support Teams will have an ongoing duty to respond to serious concerns by taking immediate steps to mitigate risks and reporting concerns to the regulator, who will consider what, if any, action may be appropriate at an individual or regional service level.
- The Care Inspectorate share with Executive Nurse Directors, Chief Social Work Officers and Health and Social Care Partnerships concerns about care services by providing both with copies of Letters of Serious Concern and Improvement Notices issued. These should be used to guide improvement with a multi-agency action plan put in place that includes the involvement of the Care Inspectorate.
- Where NHS Boards issue instructions or policies for their staff to provide mutual aid for local care homes then this work by NHS staff would fall within the scope of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). Nevertheless, where questions arise about individual cases, NHS Boards should consult the Central Legal Office about the Board's potential liabilities in those cases.

Supporting people to live well in a homely setting

Care homes, whether they provide residential or nursing care, are people's homes and are not clinical settings. However, it is nevertheless entirely appropriate that there should be assurance of clinical standards and quality of care sought by Executive Nurse Directors, in the context of Excellence in Care. This is a national approach which aims to ensure people have confidence they will receive a consistent standard and quality of care no matter where they live.

It is therefore recommended that:

- Arrangements should focus on clinical and care support with leadership from Executive Nurse Directors, Chief Social Work Officers, HSCP Chief Officers and Medical Directors in full partnership with providers and care home staff who are experts in providing care and support for people in a homely setting. Directors of Public Health should continue to play a role in outbreak support to care homes. The roles of other professionals to support the Group around understanding of pressures, developments and opportunities across the whole system will also be important. For example, Director of Planning and Commissioning and social care contracts team or equivalent to make best use of intelligence from contracts and commissioning teams.
- Executive Nurse Directors should ensure that care homes are being supported in the context of Excellence in Care to facilitate the best possible care for residents, including IPC support for embedding of the National Infection Prevention Control manual. Such support should be delivered in full and collaborative partnership and aligned with My Health, My Care, and My Home - healthcare framework for adults living in care homes, the Health and Social Care Standards in Scotland, Healthcare Improvement Scoltand IPC standards/national IPC requirements and the National Care Home Contract.
- Executive Nurse Directors and Chief Social Work Officers should continue to work in close partnership with the Care Inspectorate to act on findings from inspection and when intelligence is shared to guide the support to services. There should be a collaborative approach to the development of improvement

plans with care homes, HSCP operational/professional leads and the Care Inspectorate.

- Collaborative Care Home Support Teams should continue to monitor opportunities for people living in care homes to connect with their loved ones both in and out of the home in the context of the ongoing delivery of Anne's Law (named visitor policy, health and social care standards implementation and any forthcoming directions linked to provisions in the National Care Service (Scotland) Bill)

Support for responding to current challenges

Many of the challenges facing the care home sector that were apparent during the pandemic remain and have been exacerbated by recent cost of living crisis, staff shortages and wider pressures in the health and social care sector. Collective and ongoing support for care home staff and those living and working in care homes has never been more important at this time. It is therefore recommended that:

- Care Home Support Teams, under the leadership of the appropriate person should monitor the viability of care homes as far as is practicable, taking a whole system overview of capacity. The arrangements for this will vary locally depending on other support systems for example at Board level. Regardless of the arrangements, this should be supported by planning and commissioning teams in HSCPs.

- The following guidelines for Care Home Support Teams to assist in monitoring capacity and to support with the provision of assurance to Scottish Ministers will be useful. Collaborative Care Home Support Teams should have:

  - A pathway for escalating/report serious concerns about quality and safety in care homes to the Care Inspectorate
  - Ongoing review of local care home bed availability and viability, including workforce and financial risks, taking a whole system approach which appropriately balances risks and considers provider as well as individual service viability/sustainability.
  - Refreshed contingency planning for care home closures recognising that multiple care homes may fail due to viability
  - Sight of a strategic plan for commissioning care homes as developed by local Social Care Contracts and Commissioning teams
  - Where there are care home beds not being used there should be work with providers to understand reason for this and put supports in place, for example improvement support or support with staffing where appropriate, recognising that there are staffing challenges across the whole health and social care sector
  - Escalating concerns nationally through the recently redesigned "Director of Public Health" care home monitoring template which now focuses on viability and pressures.
  - Regular review of completion rates of the Safety Huddle Tool – this is particularly important for local planning.
  - Transitions of care between care homes and hospitals – consider drawing on best practice including hospital at home, to enable where appropriate admission prevention and planned interventions to keep residents safe in

their own home. In the same way, facilitation of timely discharge to hospital should be a key element of consideration.

- Started developing a local plan towards implementation of the Healthcare Framework for Care Homes, with MDT support to care home residents and a quality management approach based on the Health and Social Care Standards.
- Care Home Support Teams alongside providers may find it useful to undertake a self-assessment based on the healthcare framework to identify actions that can be taken forward by all partners to support people in care homes. We are already aware that many areas are or have undertaken a mapping exercise and prioritising which of the recommendations to focus on in the first instance. We will continue to support implementation in the New Year.

Conclusion

This advice note has been developed with input from SLWG members. It recognises that in many places assurance and support arrangements have already evolved to respond to the current context based on good practice and sound partnership working. These recommendations seek to provide guiding principles and a framework to support local approaches. With many significant challenges facing the care home sector at this time, such approaches will be essential to supporting those living and working in care homes.

Going forward collaborative work will commence to consider the development of a Collaborative Improvement Model to provide a framework to support local approaches aligned to existing work looking at improvement models and support in the social care sector. This will enable more detailed consideration and confirmation of the roles of clinical and professional leads including Executive Nurse Directors in context of a collaborative improvement approach.

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17 March 2023

To: Chief Social Work Officers, IJB Chief Officers, Executive Nurse Directors, Directors of Public Health, Medical Directors
Cc: Local Authority Chief Executives and NHS Chief Executives, NHS Board Directors of Finance

Funding for Collaborative Care Home Support arrangements 2023/24

We are writing to confirm the continued funding arrangements for providing collaborative clinical and care support for adult and older people's care homes. The Scottish Government is making £14 million available to maintain and build on the Collaborative Care Home Support (CCHS) arrangements (previously called Oversight arrangements).

The funding breakdown by NHS Board is outlined in Annex A. We hope this will be helpful to you as you continue to work with and support care homes locally.

The recommendation to continue the whole system multidisciplinary support arrangements was outlined in our letter and advice note of 14 December 2022 (Annex B). As you know this followed a review undertaken by a Short Life Working Group comprising a range of stakeholders from across the health and social care sector. In our December communication, we provided guiding principles and a framework to support health and social care professionals to continue to work together to identify ways to improve the health and wellbeing of people living in care homes.

The funding recognises the recovery phase that the social care sector is still in. It is to provide additionality, over and above core work and statutory roles, and is intended to create conditions for improving outcomes for people who live in care homes. We anticipate that it will maintain a network of support for care homes and those who live and work in them. The focus of this funding is improvement and

assurance, and complements the funding previously provided for multi-disciplinary teams.

As outlined in our advice note of 14 December 2022, staff roles funded by this allocation should focus on supporting the implementation of and embedding the recommendations made in the My Health, My Care, My Home - healthcare framework for adults living in care homes, and the Health and Social Care Standards.

The majority of funding and thus focus of attention should be directed towards continuous improvement affecting the quality and safety of resident care, and providing assurance. Where posts are continued or created to meet additionality required, it is expected that funded post holders will either be directly or indirectly involved in improving resident care. This should be demonstrated through role modelling, delivering and demonstrating high quality evidence-based care, provision of education, training and development for the care home workforce, monitoring the impact of the above, providing a voice for nursing, and through this assuring that care meets the health and wellbeing needs of residents or escalating timeously where there are concerns in order that appropriate action can be taken.

We know that many of you have already evolved your CCHS teams (or equivalent) in line with the principles and focus outlined in our December communication. Recognising the collaborative and coordinated multidisciplinary nature of the CCHS teams, the funding is being given to Health Boards with the intention that it will be appropriately distributed as deemed necessary to meet the aforementioned requirements between the Board and HSCP. This distribution should be agreed, overseen and monitored by the local CCHS team.

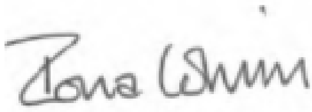
Outcomes and assessing progress

With the focus of improving the health and wellbeing outcomes of people living in care homes, CCHS teams should take an outcomes-focused approach to planning, implementing and evaluating support. Many of you will be utilising an existing or a locally developed set of outcomes to guide your work. The nine National Health and Wellbeing Outcomes which HSCPs use to support commissioning are a good starting point alongside the My Health, My Care, My Home - healthcare framework for adults living in care homes, which contains six core elements of care and support.

A condition of the funding will be a commitment to provide Scottish Ministers with information on the plans for your approach and the impact of the funding. To achieve this we ask a short overview is returned by 30th April on how local areas already are or envisage using the funding to improve outcomes (see Annex C).

We will consider how to understand and report on overall impact including sharing and dissemination of learning nationally and will be in touch in due course.

Yours sincerely



Professor Alex McMahon
Chief Nursing Officer

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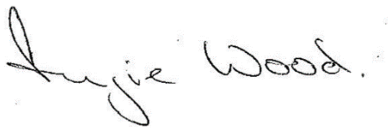

Angie Wood
Interim Director Social Care

Annex A

Table – Funding by Board

	NRAC Split*	NRAC Share
NHS Ayrshire and Arran	7.32%	£1,024,493
NHS Borders	2.15%	£300,400
NHS Dumfries and Galloway	2.97%	£415,362
NHS Fife	6.86%	£960,513
NHS Forth Valley	5.46%	£764,751
NHS Grampian	9.81%	£1,373,030
NHS Greater Glasgow & Clyde	22.18%	£3,105,168
NHS Highland	6.58%	£921,390
NHS Lanarkshire	12.28%	£1,719,370
NHS Lothian	14.97%	£2,095,862
NHS Orkney	0.49%	£69,017
NHS Shetland	0.48%	£66,659
NHS Tayside	7.80%	£1,091,860
NHS Western Isles	0.66%	£92,126
Total	100.00%	£14,000,000

*Based on 2022-23 NRAC split – to be adjusted when allocation is processed using 2023-24 split.

Annex B

Letter and advice note - 14 December 2022

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Chief Nursing Officer
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Interim Director Social Care
Angie Wood
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14th December 2022

To: Chief Social Work Officers, IJB Chief Officers, Executive Nurse Directors, Directors of Public Health, Medical Directors
Cc: Local Authority Chief Executives and NHS Chief Executives

New Arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes - Advice Note

We are writing to confirm new arrangements for providing enhanced collaborative clinical and care support for social care in Scotland. This follows a review undertaken by a Short Life Working Group (SLWG) comprising a range of stakeholders from across the health and social care sector.

We know that the social care workforce is continually and tirelessly providing exceptional care and innovating in the face of many challenges. We would like to build on this strong platform by ensuring that the sector is supported when needed and there is a continuous cycle of cross sector collaborative support to strengthen what is already in place.

As you know, arrangements for providing additional whole system, multidisciplinary support for adult care homes have evolved during the pandemic since the original request in May 2020 from the then Cabinet Secretary for Health and Social Care. Arrangements were subsequently widened to include adult social care. There has been considerable learning and examples of excellent partnership working during this time, and a recognition of the outstanding contribution and skills of so many care

home staff and the teams that support them. That learning has very much been a two-way process.

While there has been considerable value in the arrangements, it has been important to review them to ensure that they reflect the current context. Based on the findings of the review and taking account of the current pressures facing the sector, we have developed a number of recommendations. Overall we recommend continued enhanced support for adult and older people's care homes to support the sector as it emerges from the pandemic and as it deals with the current pressures. This note follows one from Caroline Lamb and Sally Louden on the 8th December on winter pressures and preparedness.

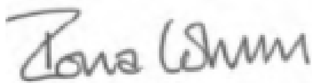
We note that such an approach outlined for care homes is also relevant for the wider social care sector, which many local systems have already adopted.

The recommendations are outlined in the advice note in Annex 1. They support a partnership approach, which recognises the experience of care home staff and the provision of support to care homes in the context of ensuring a homely environment in which people live and work. The note provides guiding principles and a framework which recommends that health and social care professionals continue to work together to identify ways to improve the health and wellbeing of people living in care homes, as described in My Health, My Care, My Home - healthcare framework for adults living in care homes published by SG in June 2022 and Health and Social Care Standards in Scotland.

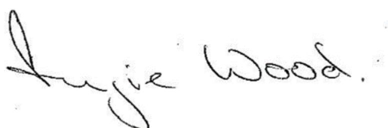
We hope this will be helpful to you as you continue to work with and support care homes locally.

Yours sincerely

Professor Alex McMahon
Chief Nursing Officer



Iona Colvin
Chief Social Work Advisor



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Interim Director Social Care

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Annex 1

New Arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes - Advice Note

Overview

Enhanced clinical and care oversight arrangements for care homes were put in place early on in the pandemic to support care home staff to keep residents safe. This followed a request from the then Cabinet Secretary for Health and Sport for multi-disciplinary teams, comprising key clinical and care leads from NHS Boards and local authorities, to provide additional whole system support to protect residents and staff[1],[2]. There has been considerable learning and examples of excellent partnership working during this time. Using this learning, a Short Life Working Group (SLWG) comprising a range of stakeholders across the sector reviewed the arrangements.

Based on the findings of the review to date and, taking account of the current pressures facing the sector, this advice note sets out recommendations, informed by the SLWG, for new arrangements for providing continuing enhanced support to adult and older people's care homes in Scotland.

Many areas have already evolved their arrangements, in collaboration with care homes, to focus on improvement, sustainability and viability, taking into account the learning and experience of the pandemic and the strong, positive relationships built between local partners and care home staff, residents and families. The outstanding contribution and skills of so many care home staff and the teams that support them during the pandemic is recognised. Currently care homes, along with other parts of the health and social care system, are operating within an increasingly complex and pressurised environment. Their value and ongoing success is critical to the future sustainability of locally based health and social care provision.

The intention of this advice note is not to supersede existing arrangements, but to provide guiding principles and a framework for collaborative improvement to strengthen any locally developed approach whilst ensuring a level of consistency across the country.

Proposed new arrangements

There has been considerable value in the clinical and care oversight arrangements which have enabled whole system support to be provided to care homes during an

[1] Strengthened clinical oversight for care homes - gov.scot (www.gov.scot)
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unprecedented time of crisis. Local arrangements have generally worked best where conditions have been created for a partnership approach which has fostered mutual respect, trust and equal voice. Key to the approach has been a recognition of the experience of care home staff; assurance support in the context of ensuring a homely environment in which people live and work; and solution-focussed improvement support conversations with supportive follow-up.[3] Arrangements which link effectively with, rather than seeking to duplicate, wider regulation activity by the Care Inspectorate, have worked well.

On this basis it is recommended that:

- Assurance and support arrangements continue but there should be a continued focus on adult and older people's care homes. They should evolve to take account of the current situation to support care homes as they emerge from the pandemic and deal with the current pressures facing the sector. Where local systems have evolved to include the wider social care sector, these principles should also apply.
- Local oversight teams should be renamed as Collaborative Care Home Support Teams or local equivalent – removing 'oversight' from the name is recommended. This is to reflect the emphasis on building on existing good practice, collaborative improvement and assurance, wider considerations around the pressures of financial viability/ sustainability in the face of rising costs and to avoid confusion with the statutory duties of the Care Inspectorate.
- The local teams' TOR and membership should be reviewed in line with this shift, recognising that the need for flexibility to respond to current challenges (see below for more details around roles).
- Collaborative Care Home Support Teams should take a collaborative improvement approach, with health and social care professionals working together using approaches such as appreciative inquiry [4] to identify ways to improve health and wellbeing of people living in care homes as described in My Health, My Care, My Home - healthcare framework for adults living in care homes[5] published by SG in June 2022 and Health and Social Care Standards in Scotland[6]. There should be robust engagement with care homes including representatives for example through Scottish Care, CCPS.
- Collaborative Care Home Support Teams should not replicate inspection or regulation, which is the clear statutory responsibility of the Care Inspectorate. There should be a move away from an inspection model of assurance which has caused confusion in the sector and teams should not use Care Inspectorate terminology. For example, rather than making recommendations or areas for improvement identify what is working well and how to build on this in line with an appreciative inquiry approach. Decisions on assurance visits should be guided by local circumstances which may mean a nuanced approach.

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[3] Care home quality assurance during COVID-19 | Iriss
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[6] Health and Social Care Standards: my support, my life - gov.scot (www.gov.scot)

- Collaborative Care Home Support Teams will have an ongoing duty to respond to serious concerns by taking immediate steps to mitigate risks and reporting concerns to the regulator, who will consider what, if any, action may be appropriate at an individual or regional service level.
- The Care Inspectorate share with Executive Nurse Directors, Chief Social Work Officers and Health and Social Care Partnerships concerns about care services by providing both with copies of Letters of Serious Concern and Improvement Notices issued. These should be used to guide improvement with a multi-agency action plan put in place that includes the involvement of the Care Inspectorate.
- Where NHS Boards issue instructions or policies for their staff to provide mutual aid for local care homes then this work by NHS staff would fall within the scope of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). Nevertheless, where questions arise about individual cases, NHS Boards should consult the Central Legal Office about the Board's potential liabilities in those cases.

Supporting people to live well in a homely setting

Care homes, whether they provide residential or nursing care, are people's homes and are not clinical settings. However, it is nevertheless entirely appropriate that there should be assurance of clinical standards and quality of care sought by Executive Nurse Directors, in the context of Excellence in Care. This is a national approach which aims to ensure people have confidence they will receive a consistent standard and quality of care no matter where they live.

It is therefore recommended that:

- Arrangements should focus on clinical and care support with leadership from Executive Nurse Directors, Chief Social Work Officers, HSCP Chief Officers and Medical Directors in full partnership with providers and care home staff who are experts in providing care and support for people in a homely setting. Directors of Public Health should continue to play a role in outbreak support to care homes. The roles of other professionals to support the Group around understanding of pressures, developments and opportunities across the whole system will also be important. For example, Director of Planning and Commissioning and social care contracts team or equivalent to make best use of intelligence from contracts and commissioning teams.
- Executive Nurse Directors should ensure that care homes are being supported in the context of Excellence in Care to facilitate the best possible care for residents, including IPC support for embedding of the National Infection Prevention Control manual. Such support should be delivered in full and collaborative partnership and aligned with My Health, My Care, and My Home - healthcare framework for adults living in care homes, the Health and Social Care Standards in Scotland, Healthcare Improvement Scoltand IPC standards/national IPC requirements and the National Care Home Contract.
- Executive Nurse Directors and Chief Social Work Officers should continue to work in close partnership with the Care Inspectorate to act on findings from inspection and when intelligence is shared to guide the support to services. There should be a collaborative approach to the development of improvement

plans with care homes, HSCP operational/professional leads and the Care Inspectorate.
- Collaborative Care Home Support Teams should continue to monitor opportunities for people living in care homes to connect with their loved ones both in and out of the home in the context of the ongoing delivery of Anne's Law (named visitor policy, health and social care standards implementation and any forthcoming directions linked to provisions in the National Care Service (Scotland) Bill)

Support for responding to current challenges
Many of the challenges facing the care home sector that were apparent during the pandemic remain and have been exacerbated by recent cost of living crisis, staff shortages and wider pressures in the health and social care sector. Collective and ongoing support for care home staff and those living and working in care homes has never been more important at this time. It is therefore recommended that:

- Care Home Support Teams, under the leadership of the appropriate person should monitor the viability of care homes as far as is practicable, taking a whole system overview of capacity. The arrangements for this will vary locally depending on other support systems for example at Board level. Regardless of the arrangements, this should be supported by planning and commissioning teams in HSCPs.

- The following guidelines for Care Home Support Teams to assist in monitoring capacity and to support with the provision of assurance to Scottish Ministers will be useful. Collaborative Care Home Support Teams should have:

  - A pathway for escalating/report serious concerns about quality and safety in care homes to the Care Inspectorate
  - Ongoing review of local care home bed availability and viability, including workforce and financial risks, taking a whole system approach which appropriately balances risks and considers provider as well as individual service viability/sustainability.
  - Refreshed contingency planning for care home closures recognising that multiple care homes may fail due to viability
  - Sight of a strategic plan for commissioning care homes as developed by local Social Care Contracts and Commissioning teams
  - Where there are care home beds not being used there should be work with providers to understand reason for this and put supports in place, for example improvement support or support with staffing where appropriate, recognising that there are staffing challenges across the whole health and social care sector
  - Escalating concerns nationally through the recently redesigned "Director of Public Health" care home monitoring template which now focuses on viability and pressures.
  - Regular review of completion rates of the Safety Huddle Tool – this is particularly important for local planning.
  - Transitions of care between care homes and hospitals – consider drawing on best practice including hospital at home, to enable where appropriate admission prevention and planned interventions to keep residents safe in

their own home. In the same way, facilitation of timely discharge to hospital should be a key element of consideration.
- Started developing a local plan towards implementation of the Healthcare Framework for Care Homes, with MDT support to care home residents and a quality management approach based on the Health and Social Care Standards.
- Care Home Support Teams alongside providers may find it useful to undertake a self-assessment based on the healthcare framework to identify actions that can be taken forward by all partners to support people in care homes. We are already aware that many areas are or have undertaken a mapping exercise and prioritising which of the recommendations to focus on in the first instance. We will continue to support implementation in the New Year.

Conclusion

This advice note has been developed with input from SLWG members. It recognises that in many places assurance and support arrangements have already evolved to respond to the current context based on good practice and sound partnership working. These recommendations seek to provide guiding principles and a framework to support local approaches. With many significant challenges facing the care home sector at this time, such approaches will be essential to supporting those living and working in care homes.

Going forward collaborative work will commence to consider the development of a Collaborative Improvement Model to provide a framework to support local approaches aligned to existing work looking at improvement models and support in the social care sector. This will enable more detailed consideration and confirmation of the roles of clinical and professional leads including Executive Nurse Directors in context of a collaborative improvement approach.

Annex C

CCHS teams reporting

Local CCHS teams should provide, by 30 April 2023, an overview of how the money will be spent in line with the objectives set out in 14 December 2022 letter and how improvement will be monitored and reported, using qualitative and quantitative measures.

We continue to receive a monthly return (previously Director of Public Health (DPH) return) from each Health Board that details immediate care home concerns and challenges including viability and we will review these along with the template below.

Template

Please send plans for your area to CareHomesCovidSupport@gov.scot, by 17:00 on 30 April 2023 with subject ‘Care Home Collaborative Support team plans’

1. What are the overall aims and anticipated outcomes of the work of the CCHS team, taking account of learning to date?
2. i) Outline how the CCSH team will support the objectives outlined in the 14 December 2022 letter?
2ii). How will the funding will be used to contribute to overall improvement and building capacity for improvement? (it might be helpful to use the pillars outlined in the healthcare framework to structure answer)
3. How are the CCHS team monitoring and evaluating improvement? If easier please send standalone reports have been carried out on specific projects to date.
4. What has worked well so far (what will you consider scaling up for example)?
5. What has worked less well so far? What have your learned that would be valuable to share with others (including challenges that you have had to overcome?)

6. Please detail anything else you would like to share with Scottish Ministers?

7. Please provide details of the expenditure of this funding, broken down into resource e.g. staff, whether full or part time, £value (see table below)

For example

Resource	Hours	Unit Cost	FTE	Total Cost
Advanced nurse practitioner	37	£40,000	1	£40,000
Staff Training		£5,000	N/A	£5000

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UPDATED VERSION - 24 APRIL 2023

17 March 2023

To: Chief Social Work Officers, IJB Chief Officers, Executive Nurse Directors, Directors of Public Health, Medical Directors
Cc: Local Authority Chief Executives and NHS Chief Executives, NHS Board Directors of Finance

Funding for Collaborative Care Home Support arrangements 2023/24

We are writing to confirm the continued funding arrangements for providing collaborative clinical and care support for adult and older people's care homes. The Scottish Government is making £14 million available to maintain and build on the Collaborative Care Home Support (CCHS) arrangements (previously called Oversight arrangements).

The funding breakdown by NHS Board is outlined in Annex A. We hope this will be helpful to you as you continue to work with and support care homes locally.

The recommendation to continue the whole system multidisciplinary support arrangements was outlined in our letter and advice note of 14 December 2022 (Annex B). As you know this followed a review undertaken by a Short Life Working Group comprising a range of stakeholders from across the health and social care sector. In our December communication, we provided guiding principles and a framework to support health and social care professionals to continue to work together to identify ways to improve the health and wellbeing of people living in care homes.

The funding recognises the recovery phase that the social care sector is still in. It is to provide additionality, over and above core work and statutory roles, and is intended to create conditions for improving outcomes for people who live in care homes. We anticipate that it will maintain a network of support for care homes and those who live and work in them. The focus of this funding is improvement and assurance, and complements the funding previously provided for multi-disciplinary teams.

As outlined in our advice note of 14 December 2022, staff roles funded by this allocation should focus on supporting the implementation of and embedding the recommendations made in the My Health, My Care, My Home - healthcare framework for adults living in care homes, and the Health and Social Care Standards.

The majority of funding and thus focus of attention should be directed towards continuous improvement affecting the quality and safety of resident care, and providing assurance. Where posts are continued or created to meet additionality required, it is expected that funded post holders will either be directly or indirectly involved in improving resident care. This should be demonstrated through role modelling, delivering and demonstrating high quality evidence-based care, provision of education, training and development for the care home workforce, monitoring the impact of the above, providing a voice for nursing, and through this assuring that care meets the health and wellbeing needs of residents or escalating timeously where there are concerns in order that appropriate action can be taken.

We know that many of you have already evolved your CCHS teams (or equivalent) in line with the principles and focus outlined in our December communication. Recognising the collaborative and coordinated multidisciplinary nature of the CCHS teams, the funding is being given to Health Boards with the intention that it will be appropriately distributed as deemed necessary to meet the aforementioned requirements between the Board and HSCP. This distribution should be agreed, overseen and monitored by the local CCHS team.

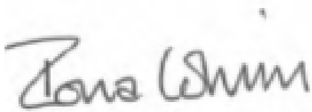
Outcomes and assessing progress

With the focus of improving the health and wellbeing outcomes of people living in care homes, CCHS teams should take an outcomes-focused approach to planning, implementing and evaluating support. Many of you will be utilising an existing or a locally developed set of outcomes to guide your work. The nine National Health and Wellbeing Outcomes which HSCPs use to support commissioning are a good starting point alongside the My Health, My Care, My Home - healthcare framework for adults living in care homes, which contains six core elements of care and support.

A condition of the funding will be a commitment to provide Scottish Ministers with information on the plans for your approach and the impact of the funding. To achieve this we ask a short overview is returned by 30th April on how local areas already are or envisage using the funding to improve outcomes (see Annex C).

We will consider how to understand and report on overall impact including sharing and dissemination of learning nationally and will be in touch in due course.

Yours sincerely



Professor Alex McMahon
Chief Nursing Officer

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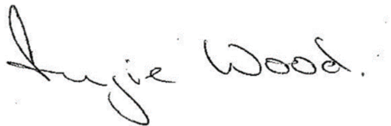

Angie Wood
Interim Director Social Care

Annex A

Table – Funding by Board

UPDATED TABLE 24 APRIL 2023

Funding will be the same as 2021-22 and 2022-23 and is based on the number of care home beds at a local level, with an uplift for the island Boards, rather than an NRAC share as previously indicated.

HEALTH BOARD	Allocation
Ayrshire and Arran	£ 1,023,040
Borders	£ 282,256
Dumfries and Galloway	£ 376,096
Fife	£ 1,053,216
Forth Valley	£ 795,984
Grampian	£ 1,372,272
Greater Glasgow and Clyde	£ 3,112,912
Highland	£ 864,800
Lanarkshire	£ 1,548,544
Lothian	£ 1,919,488
Orkney	£ 120,000
Shetland	£ 120,000
Tayside	£ 1,306,032
Western Isles	£ 120,000
TOTAL	**£ 14,014,640**

Annex B

Letter and advice note - 14 December 2022

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14th December 2022

To: Chief Social Work Officers, IJB Chief Officers, Executive Nurse Directors, Directors of Public Health, Medical Directors
Cc: Local Authority Chief Executives and NHS Chief Executives

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As you know, arrangements for providing additional whole system, multidisciplinary support for adult care homes have evolved during the pandemic since the original request in May 2020 from the then Cabinet Secretary for Health and Social Care. Arrangements were subsequently widened to include adult social care. There has been considerable learning and examples of excellent partnership working during this time, and a recognition of the outstanding contribution and skills of so many care

home staff and the teams that support them. That learning has very much been a two-way process.

While there has been considerable value in the arrangements, it has been important to review them to ensure that they reflect the current context. Based on the findings of the review and taking account of the current pressures facing the sector, we have developed a number of recommendations. Overall we recommend continued enhanced support for adult and older people's care homes to support the sector as it emerges from the pandemic and as it deals with the current pressures. This note follows one from Caroline Lamb and Sally Louden on the 8th December on winter pressures and preparedness.

We note that such an approach outlined for care homes is also relevant for the wider social care sector, which many local systems have already adopted.

The recommendations are outlined in the advice note in Annex 1. They support a partnership approach, which recognises the experience of care home staff and the provision of support to care homes in the context of ensuring a homely environment in which people live and work. The note provides guiding principles and a framework which recommends that health and social care professionals continue to work together to identify ways to improve the health and wellbeing of people living in care homes, as described in My Health, My Care, My Home - healthcare framework for adults living in care homes published by SG in June 2022 and Health and Social Care Standards in Scotland.

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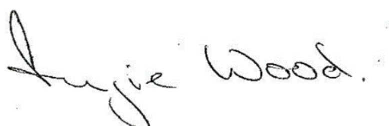

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Annex 1

New Arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes - Advice Note

Overview

Enhanced clinical and care oversight arrangements for care homes were put in place early on in the pandemic to support care home staff to keep residents safe. This followed a request from the then Cabinet Secretary for Health and Sport for multi-disciplinary teams, comprising key clinical and care leads from NHS Boards and local authorities, to provide additional whole system support to protect residents and staff[1],[2]. There has been considerable learning and examples of excellent partnership working during this time. Using this learning, a Short Life Working Group (SLWG) comprising a range of stakeholders across the sector reviewed the arrangements.

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- Assurance and support arrangements continue but there should be a continued focus on adult and older people's care homes. They should evolve to take account of the current situation to support care homes as they emerge from the pandemic and deal with the current pressures facing the sector. Where local systems have evolved to include the wider social care sector, these principles should also apply.
- Local oversight teams should be renamed as Collaborative Care Home Support Teams or local equivalent – removing 'oversight' from the name is recommended. This is to reflect the emphasis on building on existing good practice, collaborative improvement and assurance, wider considerations around the pressures of financial viability/ sustainability in the face of rising costs and to avoid confusion with the statutory duties of the Care Inspectorate.
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Care homes, whether they provide residential or nursing care, are people's homes and are not clinical settings. However, it is nevertheless entirely appropriate that there should be assurance of clinical standards and quality of care sought by Executive Nurse Directors, in the context of Excellence in Care. This is a national approach which aims to ensure people have confidence they will receive a consistent standard and quality of care no matter where they live.

It is therefore recommended that:

- Arrangements should focus on clinical and care support with leadership from Executive Nurse Directors, Chief Social Work Officers, HSCP Chief Officers and Medical Directors in full partnership with providers and care home staff who are experts in providing care and support for people in a homely setting. Directors of Public Health should continue to play a role in outbreak support to care homes. The roles of other professionals to support the Group around understanding of pressures, developments and opportunities across the whole system will also be important. For example, Director of Planning and Commissioning and social care contracts team or equivalent to make best use of intelligence from contracts and commissioning teams.
- Executive Nurse Directors should ensure that care homes are being supported in the context of Excellence in Care to facilitate the best possible care for residents, including IPC support for embedding of the National Infection Prevention Control manual. Such support should be delivered in full and collaborative partnership and aligned with My Health, My Care, and My Home - healthcare framework for adults living in care homes, the Health and Social Care Standards in Scotland, Healthcare Improvement Scoltand IPC standards/national IPC requirements and the National Care Home Contract.
- Executive Nurse Directors and Chief Social Work Officers should continue to work in close partnership with the Care Inspectorate to act on findings from inspection and when intelligence is shared to guide the support to services. There should be a collaborative approach to the development of improvement

plans with care homes, HSCP operational/professional leads and the Care Inspectorate.
- Collaborative Care Home Support Teams should continue to monitor opportunities for people living in care homes to connect with their loved ones both in and out of the home in the context of the ongoing delivery of Anne's Law (named visitor policy, health and social care standards implementation and any forthcoming directions linked to provisions in the National Care Service (Scotland) Bill)

Support for responding to current challenges
Many of the challenges facing the care home sector that were apparent during the pandemic remain and have been exacerbated by recent cost of living crisis, staff shortages and wider pressures in the health and social care sector. Collective and ongoing support for care home staff and those living and working in care homes has never been more important at this time. It is therefore recommended that:

- Care Home Support Teams, under the leadership of the appropriate person should monitor the viability of care homes as far as is practicable, taking a whole system overview of capacity. The arrangements for this will vary locally depending on other support systems for example at Board level. Regardless of the arrangements, this should be supported by planning and commissioning teams in HSCPs.

- The following guidelines for Care Home Support Teams to assist in monitoring capacity and to support with the provision of assurance to Scottish Ministers will be useful. Collaborative Care Home Support Teams should have:

  - A pathway for escalating/report serious concerns about quality and safety in care homes to the Care Inspectorate
  - Ongoing review of local care home bed availability and viability, including workforce and financial risks, taking a whole system approach which appropriately balances risks and considers provider as well as individual service viability/sustainability.
  - Refreshed contingency planning for care home closures recognising that multiple care homes may fail due to viability
  - Sight of a strategic plan for commissioning care homes as developed by local Social Care Contracts and Commissioning teams
  - Where there are care home beds not being used there should be work with providers to understand reason for this and put supports in place, for example improvement support or support with staffing where appropriate, recognising that there are staffing challenges across the whole health and social care sector
  - Escalating concerns nationally through the recently redesigned "Director of Public Health" care home monitoring template which now focuses on viability and pressures.
  - Regular review of completion rates of the Safety Huddle Tool – this is particularly important for local planning.
  - Transitions of care between care homes and hospitals – consider drawing on best practice including hospital at home, to enable where appropriate admission prevention and planned interventions to keep residents safe in

their own home. In the same way, facilitation of timely discharge to hospital should be a key element of consideration.
- Started developing a local plan towards implementation of the Healthcare Framework for Care Homes, with MDT support to care home residents and a quality management approach based on the Health and Social Care Standards.
- Care Home Support Teams alongside providers may find it useful to undertake a self-assessment based on the healthcare framework to identify actions that can be taken forward by all partners to support people in care homes. We are already aware that many areas are or have undertaken a mapping exercise and prioritising which of the recommendations to focus on in the first instance. We will continue to support implementation in the New Year.

Conclusion

This advice note has been developed with input from SLWG members. It recognises that in many places assurance and support arrangements have already evolved to respond to the current context based on good practice and sound partnership working. These recommendations seek to provide guiding principles and a framework to support local approaches. With many significant challenges facing the care home sector at this time, such approaches will be essential to supporting those living and working in care homes.

Going forward collaborative work will commence to consider the development of a Collaborative Improvement Model to provide a framework to support local approaches aligned to existing work looking at improvement models and support in the social care sector. This will enable more detailed consideration and confirmation of the roles of clinical and professional leads including Executive Nurse Directors in context of a collaborative improvement approach.

Annex C

CCHS teams reporting

Local CCHS teams should provide, by 30 April 2023, an overview of how the money will be spent in line with the objectives set out in 14 December 2022 letter and how improvement will be monitored and reported, using qualitative and quantitative measures.

We continue to receive a monthly return (previously Director of Public Health (DPH) return) from each Health Board that details immediate care home concerns and challenges including viability and we will review these along with the template below.

Template

Please send plans for your area to CareHomesCovidSupport@gov.scot, by 17:00 on 30 April 2023 with subject 'Care Home Collaborative Support team plans'

1. What are the overall aims and anticipated outcomes of the work of the CCHS team, taking account of learning to date?
2. i) Outline how the CCSH team will support the objectives outlined in the 14 December 2022 letter?
2ii). How will the funding will be used to contribute to overall improvement and building capacity for improvement? (it might be helpful to use the pillars outlined in the healthcare framework to structure answer)
3. How are the CCHS team monitoring and evaluating improvement? If easier please send standalone reports have been carried out on specific projects to date.
4. How has the funded team contributed to the improvements?
5. What has worked well so far (what will you consider scaling up for example)?
6. What has worked less well so far? What have your learned that would be valuable to share with others (including challenges that you have had to overcome?)

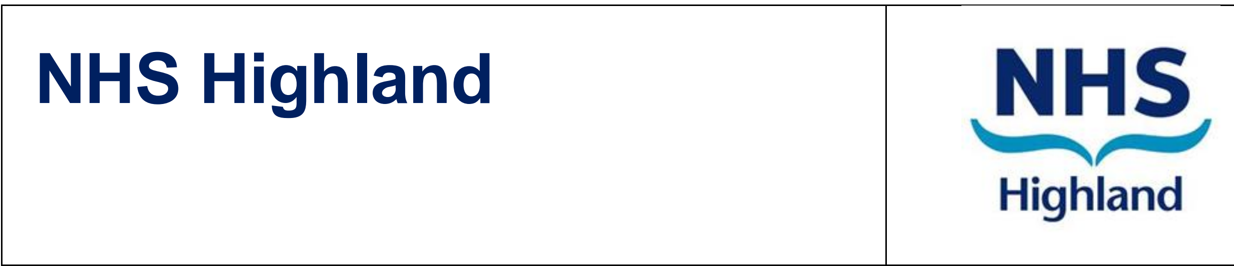
7. Please detail anything else you would like to share with Scottish Ministers?

8. Please provide details of the expenditure of this funding, broken down into resource e.g. staff, whether full or part time, £value (see table below)

For example

Resource	Hours	Unit Cost	FTE	Total Cost
Advanced nurse practitioner	37	£40,000	1	£40,000
Staff Training		£5,000	N/A	£5000

Agenda Item 3.3



Meeting:	**HHSCC meeting**
Meeting date:	**28th June 2023**
Title:	**Update on Dental Services**
Responsible Executive/Non-Executive:	**Dr Peters/Medical Director**
Report Author:	**John Lyon/Director of Dentistry and Clinical Dental Director (Public Dental Services)**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Emerging issue

This report will align to the following NHS Scotland 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		Progress well					

2 Report summary

2.1 Situation

Deterioration in access to Primary Care Dental Services
Increasing concerns about the sustainability of Primary Care Dental Services
Ongoing national reform of Primary Care Dental Services.

To note the current situation and actions being taken to mitigate, current reduced access to Primary Care Dental Services.

2.2 Background

There have been long-standing challenges in providing NHS Dental Services, many of which have been exacerbated by the Covid-19 pandemic.

There are a very limited number of Dental Practices accepting new patients for NHS dental registration. Some Dental Practices continue to face challenges providing routine dental care for registered patients. The main reason for current dental access issues, relate to limited recruitment to Dentist posts and poor retention of Dentists, willing to provide NHS dental care.

NHS (GDS) (Scotland) regulations 2010 apply to provision of General Dental Services. NHS Boards are not required to provide a full dental service to their population. However, NHS Boards are required to keep a list of Dentists providing NHS services in the Health Board area and publish this list. Health Boards do provide Urgent Dental Care, via the Health Board Public Dental Service, for unregistered patients.

2.3 Assessment

Currently, only one Dental Practice, in the HHSCP area is accepting new patients for dental registration.

3 Dental Practices have closed permanently recently (Kyle, Lochcarron and Ullapool). The Kyle Dental Practice agreed to transfer approximately 4000 registered patients to the Portree Dental Practice.

Recent Dental Practices that have informed NHSH that patients will be de-registered; 1500 in Ullapool, 600 patients in Dingwall, limited numbers of patient de-registered weekly at the Kingsmills Dental Practice (Inverness).

Some Dental Practices continue to re-profile their business model, on a planned basis, to reduce NHS commitment.

Approximately 50% of Dental Practices have reduced NHS registrations/activity compared to pre-Covid levels.

There are concerns that new patients cannot access routine NHS dental care and registered dental patients may have limited access to routine care.

Oral Health Inequalities may become more pronounced. Most Dental Practices offer patients access to private dental care options, therefore patients may opt to access private dental care.

For many years levels of Oral Health in Highland and across Scotland have improved significantly, measured by the National Dental Inspection Programme. It is likely that reduction in access to NHS Dental Services currently, will result in significant deterioration of oral health of the population.

There is ongoing Scottish Government Reform of Dental Services, although definitive detail on payment reform is awaited, following SG negotiation with the British Dental Association. There is risk of further delays in the reform process, or limited acceptance of reform by GDPs, accelerating de-stabilisation of NHS dental services. SG has confirmed their intention to implement payment reform from the beginning of November 2023. Payment reform is the first part of the planned reform of Primary Care Dental Services.

The Scottish Parliament Covid-19 Recovery Committee is currently carrying out a short enquiry into NHS Dental Services in Scotland. The Scottish Parliament Information Centre has provided an Update on NHS Dental Services in Scotland- see link at Appendix 1.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	x	None	

Comment on the level of assurance

To improve the level of assurance relies on many factors some out with the direct control of NHSH including recruitment and retention of NHS Dentists, including reducing barriers for non-UK trained dentists to register with the UK General Dental Council and successful implementation of the current reform process.

3 Impact Analysis

3.1 Quality/ Patient Care

As access to General Dental Services is limited. NHS Highland Public Dental Service (PDS) colleagues are increasing commitment to provide Emergency Dental Services (EDS) for unregistered patients, which is impacting delivery of routine dental care for priority patient groups and waiting times for patients referred for specialist dental services.

3.2 Workforce

Impact on PDS staff of providing access for increasing numbers of unregistered patients is negatively impacting on staff morale. Recruitment to PDS Dentist posts is poor, many Posts advertised have received no suitable applicants and have been re-advertised numerous times. The PDS are recruiting to Dental Therapist posts, where Dentist posts remain unfilled, to maintain dental services, albeit limited by the Dental Therapist Scope of Practice.

3.3 Financial

Vacancies within the PDS workforce will increase underspend on PDS budget, which may result in future decreased direct allocation of PDS funding from SG.

3.4 Risk Assessment/Management

A Scottish Dental Access Initiative Grant has been awarded to Fyrish Dental Practice, Alness. The Practice plans to register an additional 1500 NHS patients. NHSH is currently reviewing a further SDAI application for Inverness, to expand an existing Dental Practice.

NHSH Dental Helplines and PDS Emergency Dental Services resilience to cope with increased activity is under regular review by Dental Managers.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed yet, awaiting confirmation of upcoming payment reform process to inform this assessment.

3.7 Other impacts

N/A

3.8 Communication, involvement, engagement and consultation

Engagement with NHSH Area Dental Committee.

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.

NHS Dental Clinical Governance and Risk Management Group.

4 Recommendation

- **Awareness** – For Members' information only.

4.1 List of appendices

The following appendices are included with this report:

- Appendix No 1- https://spice-spotlight.scot/2023/06/06/nhs-dental-services-in-scotland-braced-for-change/

NHS Highland

Agenda item tbc

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**28 June 2023**
Title:	**Personal Assistant rates for Direct Payment, Option 1's**
Responsible Executive/Non-Executive:	**Simon Steer, Director of Adult Social Care/Pamela Cremin, Interim Chief Officer, Community Services**
Report Author:	**James Bain, Transaction/Income Manager**

1 Purpose

This is presented to the Highland Health and Social Work Committee for:

- Discussion
- Decision

This report relates to a:

- Policy/government directive
- Emerging issue

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

2 Report summary

To update the committee of the significant progress towards establishing a co-produced reference hourly rate for Options 1's in partnership with the SDS Peer Support Group by establishing a fair, transparent, and mutually understood personal assistant hourly rate for Option 1s.

2.1 Situation

2.1.1 NHS Highland is committed to developing a co-produced Self Directed Support (SDS) Strategy with input and support from SDS Scotland, In Control Scotland, The SDS Highland Peer Support Group, Community Contacts and NHS officers which has been regularly considered, debated and scrutinised at Highland Health and Social Care Committee (HHASC).

2.1.2 As an integral and enabling component of the new strategy, NHS Highland was approached by members of the SDS Highland Peer Support Group in March 2022 to start to explore the "true cost of care" with an additional requirement to see Option 1's as a positive alternative to other traditional delivery methods, ensuring people have flexibility, choice and control over their social care and support.

2.1.3 Costing Care and identifying budgets was identified as a key component and it is the aim of NHS Highland in partnership with others to 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 valued Personal Assistants is a realistic and sustainable option.

2.1.4 In Highland while developing this reference model with the Peer Support Group, NHS Highland has acknowledged at the outset that the current £15.52 per hour rate does not include the true overhead core cost components of delivering care and is therefore to those who are expected to manage Option 1's, not clearly understood and transparent.

2.1.5 The current Option 1 rate is therefore in the view of NHS Highland officers not defensible or sustainable and the current rate does require updating and modernising, subject to necessary funding, noting the current rates paid to external care providers are significantly higher than the current £15.52 per hour.

2.1.6 All Integrated Joint Boards and Local Authorities have a statutory duty to offer and provide all four options with the SDS Standards stating "the overall care budget needs to be realistic in terms of meeting assessed care need".

2.2 Background

2.2.1 For many years, the Option 1 rate was held at a lower hourly rate and it has just not kept pace with inflationary/staff cost overheads and this has been further exacerbated by the pandemic, where many service users were not able to access the appropriate level of care that they have been assessed for.

We do think this is directly linked to the hourly rate however it is not the only contributory factor, as the entire care sector is challenged by recruitment and retention stressors and there is also stiff competition from other recruiting sectors in our urban, rural and remote care settings.

2.2.2 It is important to note that despite the low hourly rate, the number has substantially increased for both younger and older adults in all areas, specifically in some of our more remote and rural areas. As at March 2022, 467 people were receiving an Option 1 compared to 613 people as at May 2023. This increase of 23% does however highlight

the unavailability of other care options and a real market shift as we are unable to commission "traditional" services and we see a reduction in delivered care-at-home and increased unmet need across Highland. 82% of Option 1's include an element of personal assistant input with 70% of the total number of people receiving an Option 1, having an accumulated balance.

2.2.3 NHS Highland is projected in 2023-24 to spend in excess of £11.4m on Option 1's with 613 people currently in receipt of an Option 1. This report also demonstrates the mix of those receiving Option 1s across our urban, rural and remote settings.

2.2.4 To date, NHS Highland has had eight individual meetings with the SDS Highland Peer Support Group since March 2022 and has now agreed on a mutual new reference rate proposal, subject to funding, which will clearly identify and include the core cost overheads and move closer to meeting the "true cost" of delivering care.

2.2.5 NHS Highland has also identified as part of a Promoting choice, control and flexibility in Social Work and Social Care Programme, five key areas where the need for significant system change and/or development requires systemic support.

One of these directly related areas aims to increase the level of independent support available across all the four options and is setting up a Project with funding available up to £0.200m, to procure independent sources of advice, information and support which are available to all those exploring the help open to them via self-directed support.

NHS Highland intends to develop the additional capacity to work in partnership with people to ensure they have a greater support to realise the Options available to them and to increase their role in decision-making about SDS.

2.3 Assessment

2.3.1 As stated above, while developing a reference rate model with the SDS Highland Peer Support Group, NHS Highland has acknowledged that the current £15.52 hourly rate does not include the required overhead core cost component's, therefore some initial modelling assumptions required to be tested at the outset by NHS Highland officers.

While acknowledging the complexity of calculating the true cost of care, it was important that any new reference model was fair, transparent, simple to understand and to implement and it could be portable in future years, aligning to future annual cost uplifts.

2.3.2 When considering a future, fair and transparent model, it was imperative that any starting point for the calculation of a reference hourly rate for Options 1's, should be based on the underpinning Scottish Government (SG) minimum pay requirement of £10.90 per hour from 1/4/23.

- *The current Care-at-home Highland Pricing Model (HPM) provides for a three tiered range of rates for urban, rural, and remote to take account of travel time and mileage across the geographical area.*
- *A transparent and understood methodology is understood by both commissioner and provider.*
- *2023-24 direct staff costs are based on a minimum £10.90 per hour.*

2.3.3 There was general support for a bespoke version of the above HPM model although some concerns were expressed from the group in earlier meetings around the preciseness of postcode definitions which were based on the Scottish Index for Multiple Deprivation. The primary considerations for the SDS Highland Peer Support Group were to agree on the following key principles before agreeing on a future reference model.

- *To consider/agree all relevant overhead percentage costs*
- *To consider/agree a composite average hourly rate* ***or*** *to progress with an urban, rural and remote rate for Option 1's.*
- *To consider if we require a bespoke "specialist" rate.*

A guiding principle was that any agreed model must be aligned to any further annual inflationary funded uplift that may be subject to available funding from SG.

2.3.4 After careful consideration of the September 2022 service user geographical split across North Highland, the SDS Highland Peer Support Group requested that Community Contacts and NHS Highland representatives provide some case studies/personal stories that could be presented to the group during February 2023, highlighting the reference rate model across Highland for final consideration and recommendation. See **Appendix Three** for further details.

2.3.5 There is not a nationally agreed Option 1 hourly rate although we do know that Social Work Scotland and others have been following with interest the work being undertaken by the group within NHS Highland.

2.3.6 After many good and equal conversations involving NHS Highland, Community Contacts and the SDS Highland Peer Support Group, we have co-produced and agreed for consideration and recommendation by NHS Highland, a three tier bespoke model of the Highland Pricing Model which is based on national methodology devised by the UK Home Care Association and is already in place within NHS Highland for providers delivering external care-at-home services.

2.3.7 For 2023/24, taking into account the minimum SG hourly rate has increased from £10.50 to £10.90 from **April 2023**, the new reference rates for Option 1s would be as follows:

- Current rate = £15.52 per hour
- Urban rate = £16.67 per hour
- Rural rate = £17.37 per hour
- Remote rate = £18.07 per hour

Before considering these new proposed reference rates, it is important to set these in context to what we currently pay external providers and our current in-house unit cost rate.

- Care at home urban = £22.45 per hour
- Care at home rural = £25.06 per hour
- Care at home remote = £27.69 per hour
- Support work rate = £20.41 per hour
- In-house current care at home unit cost = £54.59 per hour

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:

NHS Highland cannot control the individual circumstances around each Option1 care package and the assurance level given is specific to the proposed reference rate and due to significant consultation, input, and co-production with actual users of services involving the SDS Highland Peer Support Group and representative groups such as Community Contacts and SDS Scotland during 2022, the proposed level of assurance for committee consideration is therefore viewed as moderate.

This proposed fee rate model is also supported by detailed information led and a collaborative designed solution which demonstrates transparency of approach.

This new pressure and all other financial pressures will be carefully monitored and assured by the Joint Officer Group, which consists of representative Senior Officers of both NHS Highland and Highland Council.

3 Impact Analysis

3.1 Quality/ Patient Care

Significant recruitment and retention challenges are currently being experienced by many users of Option 1's accessing in their local communities the assistance necessary to meet their assessed care needs. This proposed increase in the Option 1 rate which acknowledges the geographical challenges of NHS Highland will help to sustain these much valued local services to support full flexibility, choice and control.

3.2 Workforce

In additional to significant sector wide recruitment and retention stressors, some users of Option 1's with care packages are on the verge of collapse which will result in additional resource pressures for NHS Highland and other care providers who are in some areas not able to provide services where we have seen a demonstrable growth in demand for Option 1's.

3.3 Financial

The financial commitment for NHS Highland is significant and this is estimated as a full year **additional** cost commitment **of £1.024m,** based on current information.

In recent years, significant accumulations have been recovered before, during and after the pandemic as partly due to the lower rate, many service users have not been able to access the care needs that they have been assessed for and it is expected that despite an increase in the rate, some Option 1 users will continue to experience difficulties to recruit personal assistants but any in year 2023-24 accumulations will be offset to ensure this additional cost commitment of £1.024m is part mitigated against.

During the short term, there is a cost pressure as we level up the current personal assistant rates but it is important to set this in context with the accumulation's and any sustainable further growth in Option 1's should be offset against a reduction in the

number of Option 3's. During 2022/23, £1.8m of accumulations were recovered, albeit some were impacted by the pandemic stressors. Current accumulated funds are monitored closely by business support and this is supported by robust standard operating procedures.

This significant cost investment is required to ensure the sustainability of our current Option 1 packages which are still the most cost effective and efficient delivery models which have grown primarily due to the absence of any other traditional delivery and more expensive care models as detailed above.

NHS Highland will continue to promote all SDS approaches and Option 1's as a sustainable delivery model in the absence of other service delivery models as this favoured option by many is deemed crucial to the sustainability of services, while continuing to promote choice, flexibility and control.

This investment is an underpinning core element of the overall SDS Programme and further investment to independent support organisations as highlighted at Section 2.2.5 requires to be put in place to support those who choose an Option 1 to ensure they are fully supported in this role.

3.4 Risk Assessment/Management

The risks are multi-faceted and complex but the primary risk is the future sustainability and growth of many Option 1 care packages if the current rate differential is not addressed.

3.5 Data Protection

None

3.6 Equality and Diversity, including health inequalities

None

3.7 Other impacts

The inability for recipients of Option 1's to continue to live in their own home with the flexibility, choice and control which they have a right too, can lead to increased stress and distress for families.

3.8 Communication, involvement, engagement and consultation

Extensive communication, involvement, engagement and consultation with the SDS Highland Peer Support Group, Community Contacts, NHS Highland and other stakeholders during the co-production of this proposal.

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.

- Eight meetings of the SDS Highland Peer Support Group starting April 2022
- Previous discussion at the Adult Social Care Leadership Team

- Meeting with Health and Wellbeing Minister on 18/8/2022
- Meeting with SDS Scotland on 23/11/2022
- Noting development of proposal at Highland Health and Social Care Committee in various reports during 2022 and 2023.
- Adult Social Care Leadership Team on 14/3/2023
- Joint Officers Group on 14/4/2023

4 Recommendation

The actions requested of the Highland Health and Social Care Committee is:

1) **To consider** the information, appendices and extensive engagement with SDS Highland Peer Support Group and other stakeholders in preparing this new co-produced Option 1 payment model.

2) **To consider and recommend** implementation of the new proposed reference hourly rate(s) from Monday 3rd July 2023, noting the additional cost commitment for this financial year of £0.750m which is based on the current service user profile.

4.1 List of appendices

The following appendices are included with this report:

- Appendix **One** – SDS slide deck for Health and Wellbeing Minister and other stakeholders.

2022-08-17 SDS Options 1s Final JB.p

- Appendix **Two** – Option 1 split as at September 2022 by urban, rural and remote.

SDS1 Sep-22 by urban-rural-remote a

- Appendix **Three** – Case studies for reference rate model.

Stories to illustrate the suggested model

- Appendix **Four** – Reference Option 1 hourly rate for 2023-23.

JB 2023-24 Reference Rates.pdf

- Appendix **Five** – Slide deck overview of proposal for Joint Officer Group.

Please see Word document 3.4.1 in Teams channel for links to appendices 1, 2 and 5

Stories to illustrate the suggested geographic reference model of Option 1's for North Highland.

The following stories have been developed to illustrate the potential reference model for new direct payment rates, which is based on the Scottish Government's Index of Multiple Deprivation currently used for determining external care at home hourly rates for urban, rural and remote.

Specific details of the proposed model are available as an Appendix to the document.

Example 1 - Donald and Mary, An older couple living in *Inverness (Urban)*

Donald cares for his 86 year old wife, Mary. They have been married for 62 years and have 2 children, 8 grandchildren and 2 great grandchildren, all living across the world. Their closest relative is their son, Graham who lives in Ullapool. When Mary was younger, she worked with children, opening and running her own playgroup which became her life's passion. Donald worked for the Council in Building Control. Mary's memory has recently become a cause for concern and gradually Donald has needed to do more and more to help her.

Mary now needs some assistance with personal care and Donald doesn't think that it is right for him to provide this care for his wife and has therefore approached NHS Highland to see if he can get some help. Following conversations with NHS Highland staff, it was agreed that Mary would benefit from some additional support and Donald agreed to an Option 1.

He has therefore been awarded a direct payment to enable him to employ personal assistants to help Mary to get up, showered and dressed every day. Donald has been awarded additional support to enable him to go out once a week for a couple of hours to meet his best pal, Duncan for a round of golf. Donald has developed an advert to

recruit personal assistants for an hour seven mornings a week, plus 3 hours to be worked in an afternoon once a week.

Donald and Mary's direct payment is worked out as:

10 hours personal care @ £16.14 per hour = £161.40 per week including an appropriate start-up cost for initiation of direct payment.

Example 2 – Julia, A young woman with a learning disability who is living with her parents in *Spean Bridge (Rural)*

Julia currently lives with her parents in Spean Bridge, ten miles from Fort William. Julia left college 2 years ago and since then, partly because of the pandemic, she has been getting bored and isolated at home. Julia would love to volunteer in a charity shop in Fort William and to do so, would need support as she doesn't know about buses and is worried that she might make a mistake while volunteering in the charity shop.

As a result, Julia has been awarded a direct payment to employ a personal assistant to help her realise her ambition and to help her progress with her independent living skills. She doesn't need additional funds for her travel as her bus pass enables a carer to travel with her for free. Community Contacts has helped Julia and her parents to develop recruitment advert for a personal assistant to work with her for 14 hours per week, which will give enough time to get to the shop twice a week, to volunteer, and then get home again. A bit of extra time has been allowed for within the direct payment as the buses aren't that regular between Fort William and Spean Bridge.

Julia's direct payment is worked out as:

14 hours personal care @ £17.29 per hour = £242.06 per week including an appropriate start-up cost for initiation of direct payment.

Example 3 - Angus and Rose, Living with motor neurone disease in *Lochinver (Remote)*

Angus was diagnosed with motor neurone disease (MND) a year ago. Since then his condition has deteriorated and now he needs help with washing, dressing, eating, drinking, using the toilet and taking his medication. He's lost the use of his legs too which means he uses a wheelchair and needs to be hoisted to get into it. Rose currently provides most of his care but she is exhausted with the around the clock care needs Angus now has. Angus and Rose know that the condition will result in a quick decline and that their time together is limited. They want to enjoy their last few months as best they can and have therefore approached NHS Highland for help. Following the assessment process, they have been offered a direct payment to enable support for Angus with all activities of daily life and to enable overnight respite at home once a week to give Rose a good night's sleep. Community Contacts has helped Angus and Rose to put a recruitment advert together for a team of personal assistants to offer 2 hours support every morning and a further 2 hours every evening. As Angus needs to use a hoist they need 2 personal assistants per visit during the day. A further personal assistant will be recruited for the nightshift. As a team is required, Rose wishes for one PA to take on a lead role to coordinate a rota.

Angus and Rose's direct payment is worked out as:

- *56 hours personal care @ £18.38 per hour = £771.96 per week*
- *7 sleepovers @ £119.85 per night = £838.98 per week*
- *Appropriate start-up cost for initiation of direct payment*

Example 4 - Betty, An older woman living alone, Daughter, Susan lives in Edinburgh

Betty lives in *Kingussie (Remote)* and is 92 years old and she has managed independently until she had a fall in December. She's been in hospital since then but is very keen to return home. She knows that she'll need help with the shopping, the housework, and with getting the main meal sorted. She thinks she can manage everything else, but the OT is worried about her safety in the shower and thinks she should have

someone nearby when she is getting up, washed and dressed in the mornings. The OT has put some additional equipment in Betty's house, which although she doesn't really want it, Betty has agreed to if this means that she will get home, eventually!

Betty's only daughter, Susan lives in Edinburgh. Whilst Susan is worried about her Mum going home, she knows that she must do her best to support her with her wish. Susan has also been told that there is not any available care at home that can help and that she'll have to consider having a direct payment and employ people to help her Mum. Whilst Susan isn't happy about this, she has agreed as it seems that this is the only way Betty will get home. Betty and Susan have been awarded a direct payment that will enable them to employ personal assistants each day to support each morning; to do some housework whilst Betty gets organised for the day; to do the shopping and to do some batch cooking for Betty's evening meal. They wish to employ personal assistants for an hour a day, plus an additional 4 hours to be used flexibly throughout the week.

Betty and Susan's direct payment is worked out at:

11 hours personal care @ £18.38 per hour = £202.18 per week including an appropriate start-up cost the for initiation of direct payment

Example 5 – Tracey, A younger woman with a physical disability, living in *Thurso (Urban)*

Tracey has cerebral palsy. She uses an electric wheelchair to get about. She works part-time doing some admin for a charity, mainly from home but with the occasional face-to-face meeting. Tracey has a long-term partner, Michelle and they live together with their cats. Tracey has always employed personal assistants using her direct payment and Independent Living fund (ILF). She has a budget that enables her to use support when she needs to go into the office or to do anything she needs help with out and about. Her PA also helps her to get up in the morning for about an hour a day. In total, Michelle pays for PA support for an average of 168 hours per 4 week period and her direct payment covers 98 hours with the remaining 78 being covered by ILF.

Tracey's direct payment is worked out at:

24.5 weekly hours personal care @ £16.14 per hour = £395.43 per week including an appropriate start-up cost for initiation of direct payment

Example 6 – Manveer, A younger man with autism living in his own tenancy in *Beauly* (Rural) with family nearby

Manveer is 25; he has two degrees, one in maths and another in ancient history. He can manage his bills and money without any problem, but struggles with meeting other people. He really wants to get married sometime and his family has said they will support him but he is anxious about meeting other people, let alone the thought of a relationship. He has been awarded a direct payment to help him try and make social connections and hopefully some friendships. He can employ a personal assistant for 5 hours a week.

Manveer's direct payment is worked out at:

5 hours personal care @ £17.29 per hour = £86.45 per week including an appropriate start-up cost for initiation of direct payment

Example 7 – Jennifer, 48 years old, lives in *Portree* (Remote) with OCD

Jennifer's life is a guddle. Her OCD means she has so many things to do around the house that she can't get to them all. She needs help to keep things organised; to make sure bills are paid and that the house is cleaned in the way Jennifer likes it to be. Her social worker has said she can employ someone for ten hours a week and Community Contacts is helping.

Jennifer's direct payment is worked out at:

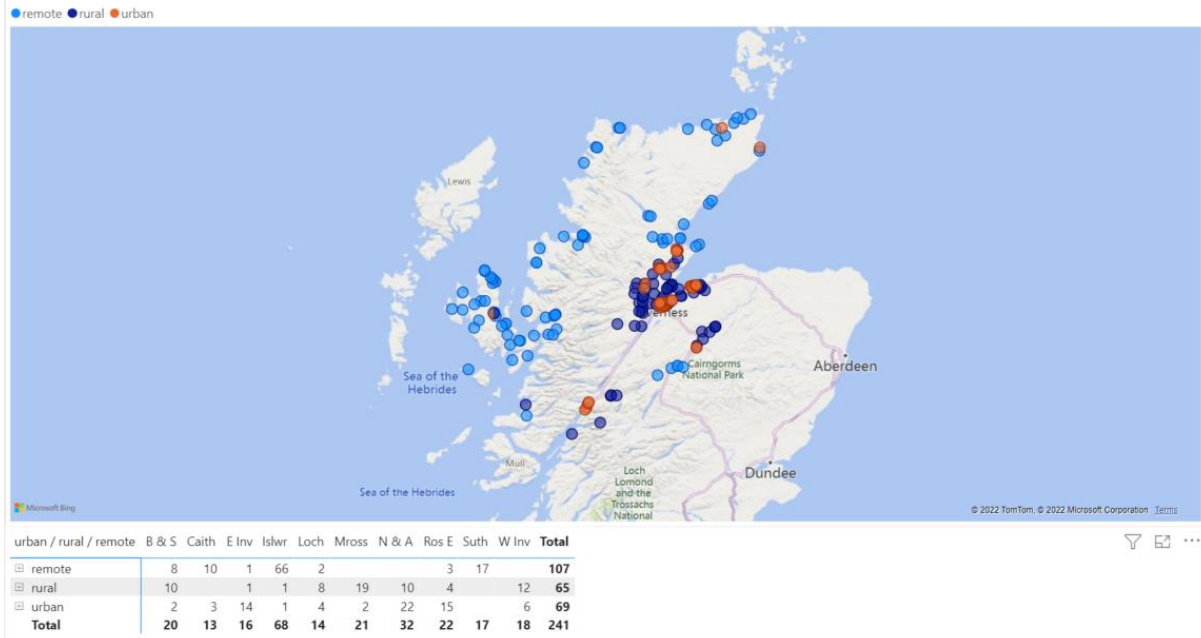
10 hours personal care @ £18.38 per hour = £183.80 per week including an appropriate start-up cost for initiation of direct payment

Appendix 1

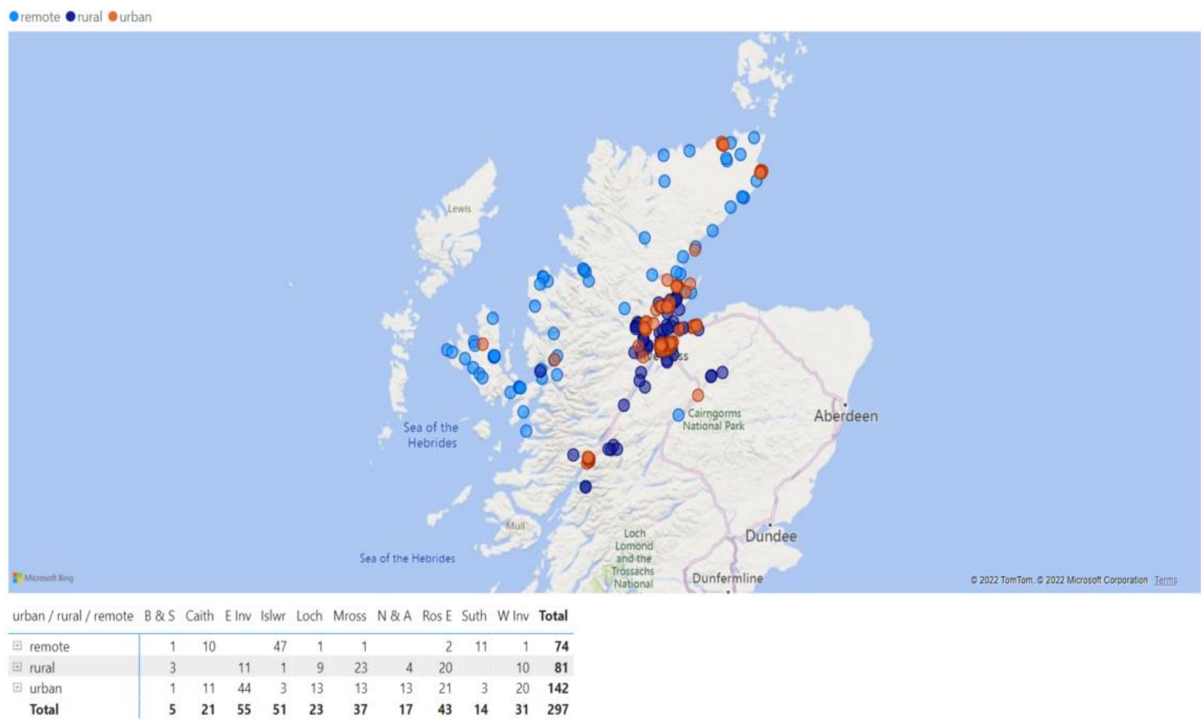
Post code examples:

Location	Example Post Code	Urban/Rural 8 Fold Designation Code	Urban/Rural 8 Fold Designation Name	NHS Highland Classification
Inverness	IV1 1LS	2	Other Urban Areas	Urban
Fort William	PH33 6PZ	2	Other Urban Areas	Urban
Wick	KW1 5LJ	5	Very Remote Small Towns	Urban
Thurso	KW14 8PX	5	Very Remote Small Towns	Urban
Nairn	IV12 4RY	3	Accessible Small Towns	Urban
Dingwall	IV15 9XF	4	Remote Small Towns	Urban
Beauly	IV4 7ED	6	Accessible Rural	Rural
Muir of Ord	IV6 7ST	7	Remote Rural	Rural
Aviemore	PH22 1RX	4	Remote Small Towns	Urban
Kingussie	PH21 1EH	8	Very remote rural	Remote
Tain	IV19 1JN	5	Very Remote Small Towns	Urban
Alness	IV17 0RH	4	Remote Small Towns	Urban
Invergordon	IV18 0NS	4	Remote Small Towns	Urban
Lochinver	IV27 4BA	8	Very remote rural	Remote
Golspie	KW10 6TR	8	Very remote rural	Remote
Ullapool	IV26 2XB	8	Very remote rural	Remote
Portree	IV51 9QR	8	Very remote rural	Remote
Cromdale	PH26 3LQ	7	Remote Rural	Rural
Grantown	PH26 3JG	7	Remote Rural	Rural

Appendix 2 – Option 1's split by Urban, Rural and Remote



urban / rural / remote	B & S	Caith	E Inv	Islwr	Loch	Mross	N & A	Ros E	Suth	W Inv	**Total**
remote	8	10	1	66	2			3	17		**107**
rural	10		1	1	8	19	10	4		12	**65**
urban	2	3	14	1	4	2	22	15		6	**69**
Total	**20**	**13**	**16**	**68**	**14**	**21**	**32**	**22**	**17**	**18**	**241**



urban / rural / remote	B & S	Caith	E Inv	Islwr	Loch	Mross	N & A	Ros E	Suth	W Inv	**Total**
remote	1	10		47	1	1		2	11	1	**74**
rural	3		11	1	9	23	4	20		10	**81**
urban	1	11	44	3	13	13	13	21	3	20	**142**
Total	**5**	**21**	**55**	**51**	**23**	**37**	**17**	**43**	**14**	**31**	**297**

Assumptions and breakdown of the price of an hour of homecare from 1 April 2023

	UKHCA	£10.90ph - UKHCA business costs		
		NHSH Urban	NHSH Rural	NHSH Remote
Basic hourly rate for contact time (SLW)		£10.90	£10.90	£10.90
GROSS PAY		£10.90	£10.90	£10.90
NI Contributions	4.92%	£0.54	£0.54	£0.54
Pension contributions	3.00%	£0.33	£0.33	£0.33
		£11.77	£11.77	£11.77
Holiday pay	11.25%	£1.32	£1.32	£1.32
Training	2.00%	£0.24	£0.24	£0.24
Sickness Pay	3.80%	£0.45	£0.45	£0.45
Notice pay / suspension pay	0.30%	£0.04	£0.04	£0.04
		£13.82	£13.82	£13.82
Distance travelled Mileage rate		£0.70	£1.40	£2.10
TOTAL CAREWORKER COSTS		£14.52	£15.22	£15.92
Business Costs:-				
Staff recruitment	0.36	£0.36	£0.36	£0.36
Training	0.48	£0.48	£0.48	£0.48
Statutory registration fees	0.09	£0.09	£0.09	£0.09
PPE & consumables	0.59	£0.59	£0.59	£0.59
Finance, legal & professional	0.30	£0.30	£0.30	£0.30
Other business overheads	0.33	£0.33	£0.33	£0.33
TOTAL BUSINESS COSTS	2.15	£2.15	£2.15	£2.15
TOTAL CAREWORKER COSTS & BUSINESS COSTS		£16.67	£17.37	£18.07
TOTAL COST		**£16.67**	**£17.37**	**£18.07**

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**28 June 2023**
Title:	**North Highland Health and Social Care Partnership - Integrated Performance and Quality Report**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer, HHSCP**
Report Author:	**Rhiannon Boydell, 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	X	End Well	X	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.

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.

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.

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 not included in this report.

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

3.5 Data Protection

This report does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document.

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

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, June 2023**

North Highland Health and Social Care Partnership Performance and Quality Report

28 June 2023

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

North Highland Health & Social Care Partnership

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

It is **recommended** that:

- Committee consider and review the agreed Performance Framework **identifying any areas requiring further information or inclusion** in future reports.
- Committee to note that although the continued focus is on Adult Social Care data, additional data on DHDs and Mental Health is included.

Development

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

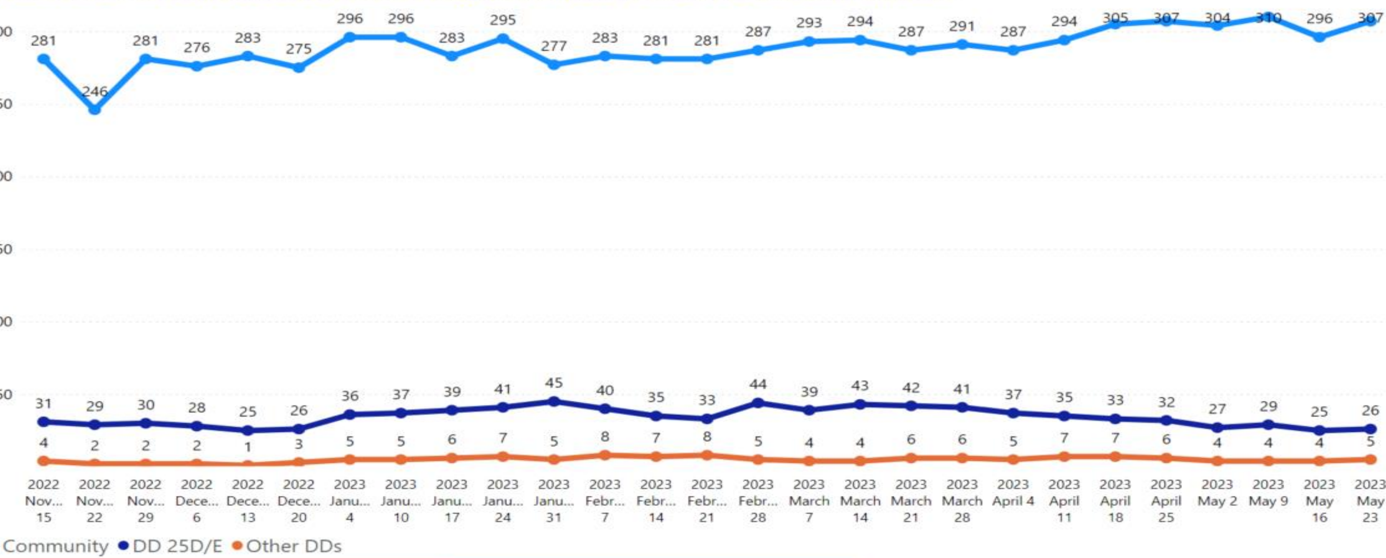
A Development sessions was held with committee in September 2022 where the format of the report and ASC indicators were discussed in detail with discussion on possible indicators to be included in future reports.

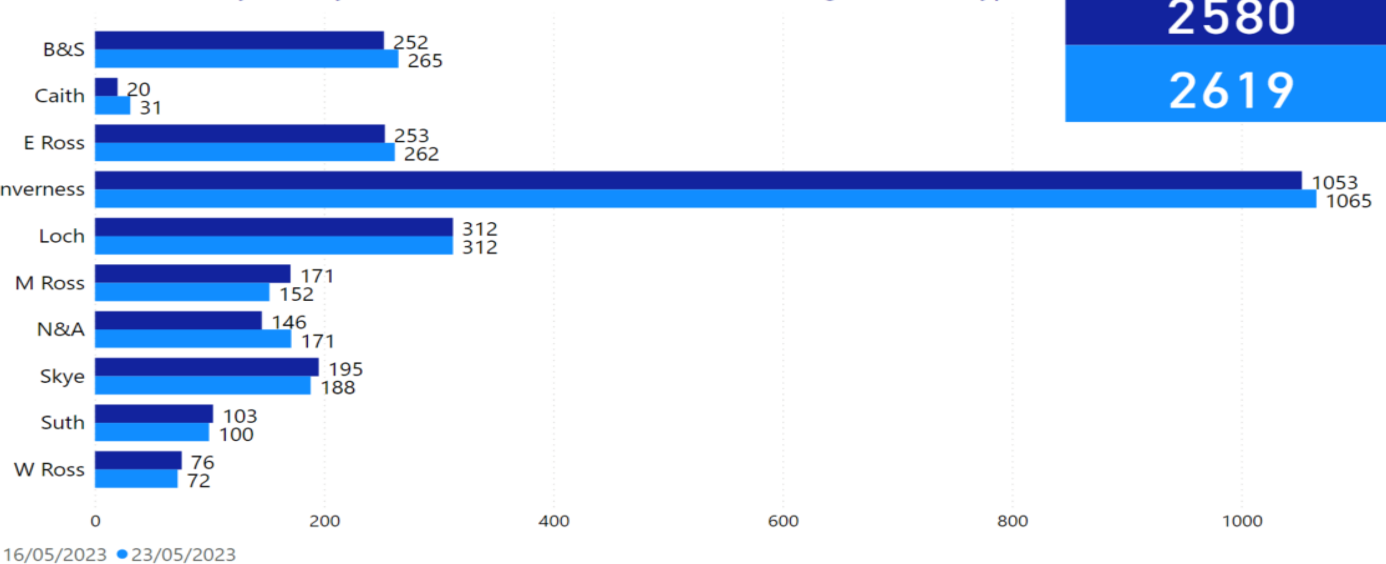
Content:

- Care-at-Home and Care Homes – slides, 4-7 & 8-9
- Delayed Discharge – slides 10-11
- Self Directed Support/Carer Short Breaks – slides 12-14
- Adult Protection included – slide 15
- Mental Health Psychological Therapies and Community Mental Health Services – slides 16-17
- North Highland Drug & Alcohol Recovery Services – slide 18
- Non MMI Non Reportable Specialties Waitlists – slides 19 & 20
- National Integration and relevant Ministerial indicators – to be reported as an annual inclusion

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)
Priority 2 - Embed a place approach to Home Based Care & Support and care homes so that proactive care is provided tailored to the needs of the individual
Priority 9A, 9B, 9C – Work together with H & SC partners by delivering care and support together that puts our population, families and carers experience at the heart

North Highland Care at Home – Unmet need





Currently provided weekly as part of the Public Health Scotland (PHS) weekly return.

This manual data return commenced late in 2021 and data is provided by internal care at home (CAH) colleagues.

Graph 1- All North Highland hospital DHD's are included which shows those assessed as requiring CAH in either a hospital, or at home.

- Community - 307 awaiting care at home service
- DHDs – 26 awaiting a care at home service
- DHDs – 5, awaiting a service for other coded DHDs (complexity)

This data is published by PHS and weekly returns from CAH officers are provided to allow for validation and analysis.

Graph 2 – Care at Home (District level) - the total number of weekly hours of unmet need for those above and includes hours required for people in receipt of a service with required additional hours.

Despite significant ongoing organisational and provider effort to improve flow, the overall unmet need for CAH continues to be around 2600 planned hours per week.

Update 06/06/2023

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

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

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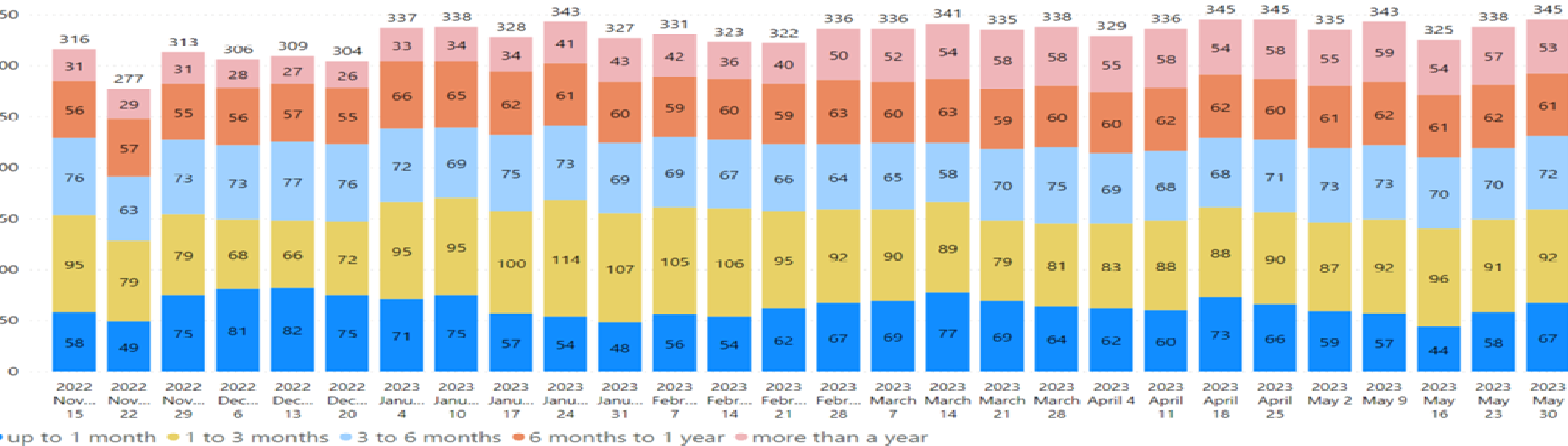
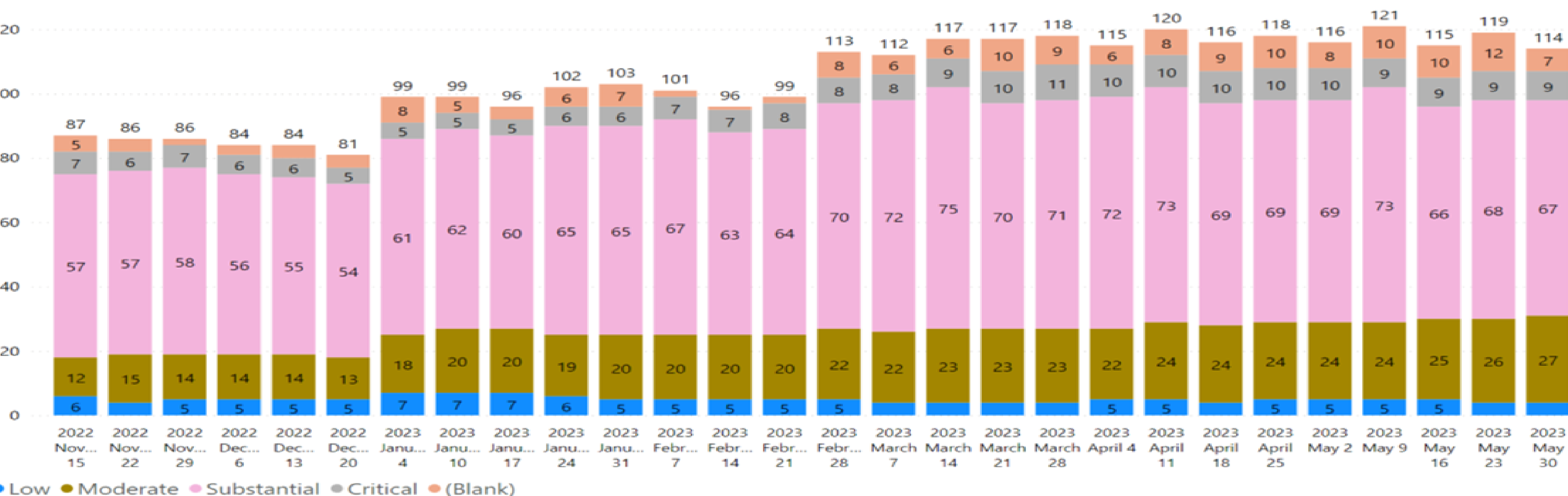
North Highland Care at Home – Unmet need





Graph 1- All North Highland unmet need for care at home, including waiting times

Up to 1 month – 67
1 to 3 months – 92
3 to 6 months – 72
6 to 12 months – 61
More than a year - 53

This data is published by PHS and weekly returns from CAH officers.

Graph 2 – Further breakdown of those waiting longer than 6 months by current waiting list criteria.

These charts are provided for the first time as per the request from the last committee

Update 06/06/2023

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

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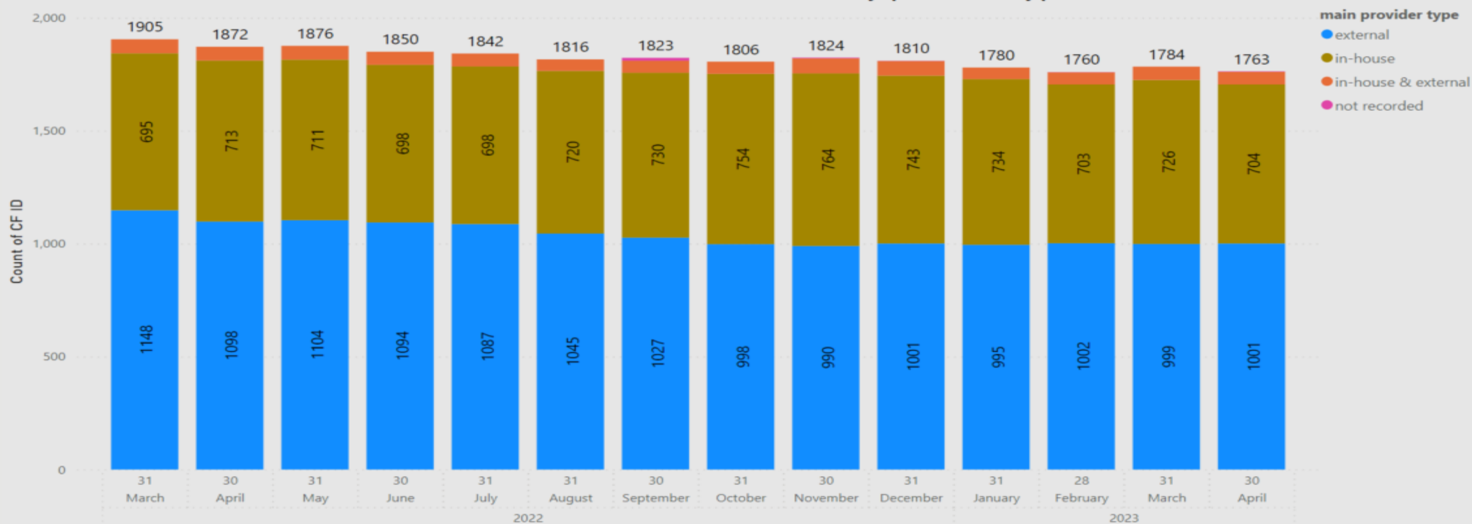
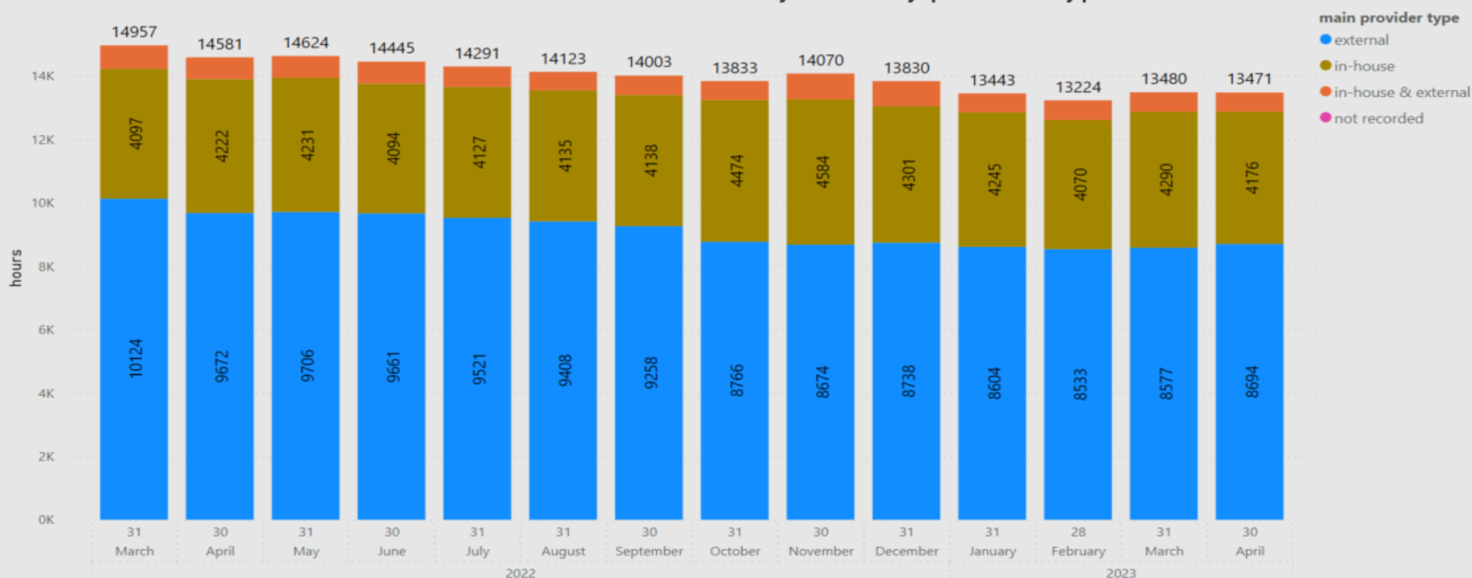
North Highland Care at Home





Care at Home

Overall numbers continue to fall after a period of significant and sustained reductions during 2021 and 2022.

We have not seen growth in external care at home and low levels of recruitment and the loss of experienced care staff continue to be the primary concern expressed by providers in our frequent and open discussions.

The impact of care at home service provision on flow within the wider health and social care system is significant, and this needs to be recognised as part of the approach to, and solutions around, addressing care at home capacity.

It is therefore proposed that a specific programmed area of work is established to co-create and co-develop a medium-term care at home delivery vision and supporting commissioning approach.

The programme would seek to deliver the following **five key objectives** below:

- Maximise provision through processes, training and technology
- Enable market and delivery stability
- Create, sustain and grow capacity
- Recognise, value and promote the paid carer workforce
- Improve affordability

NHS Highland and external care providers continue to operate in a pressured environment.

Update 06/06/2023

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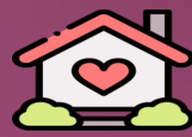
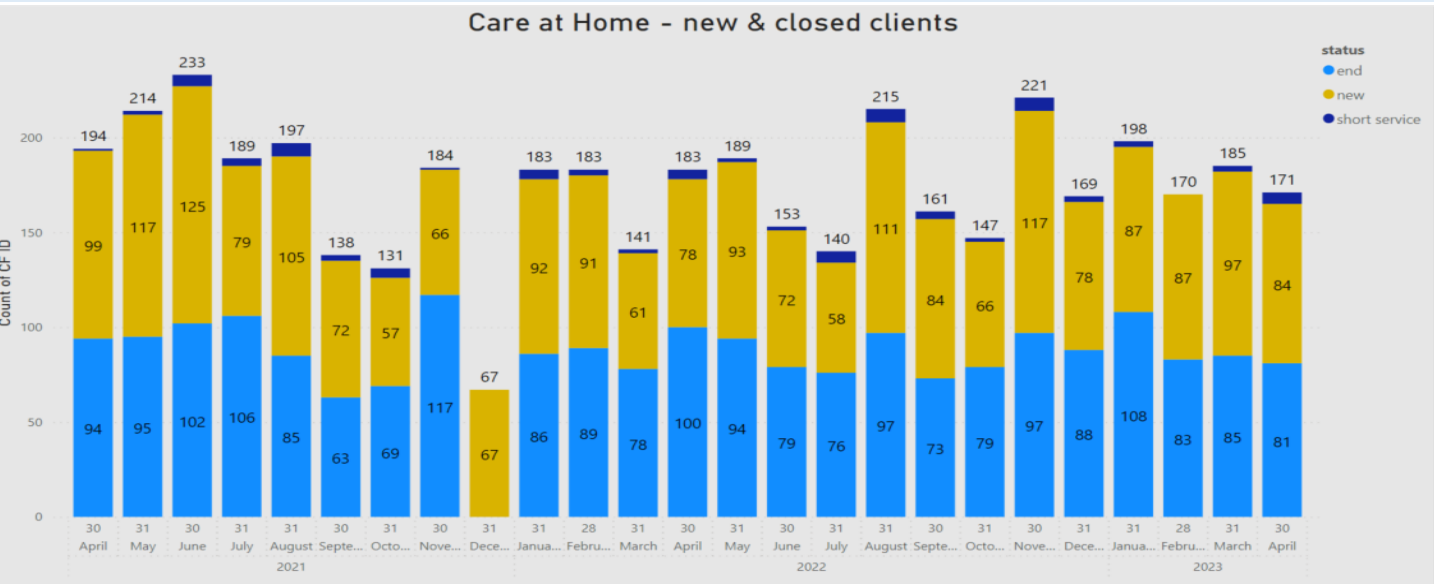
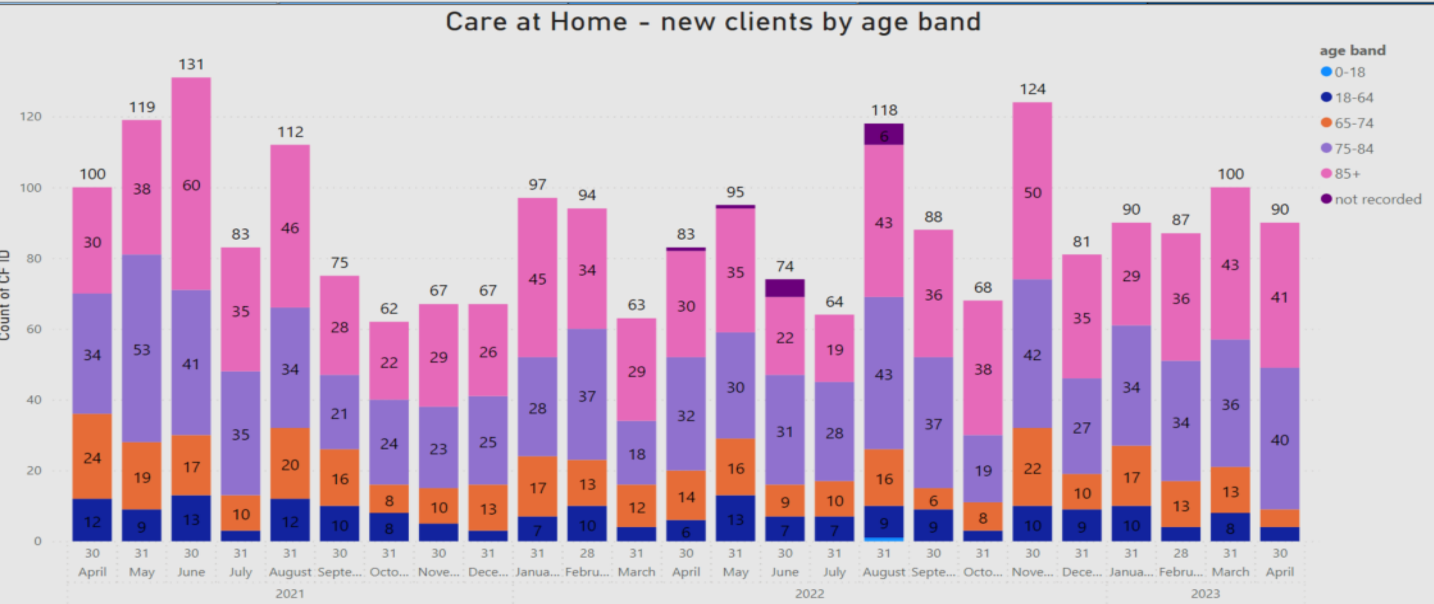


North Highland Care at Home





Care at Home – New & Closed Packages

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

Please note that available capacity to provide care-at-home to new service users is particularly challenging due to staffing related pressures in both in house and commissioned external services.

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

Update 06/06/2023

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

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

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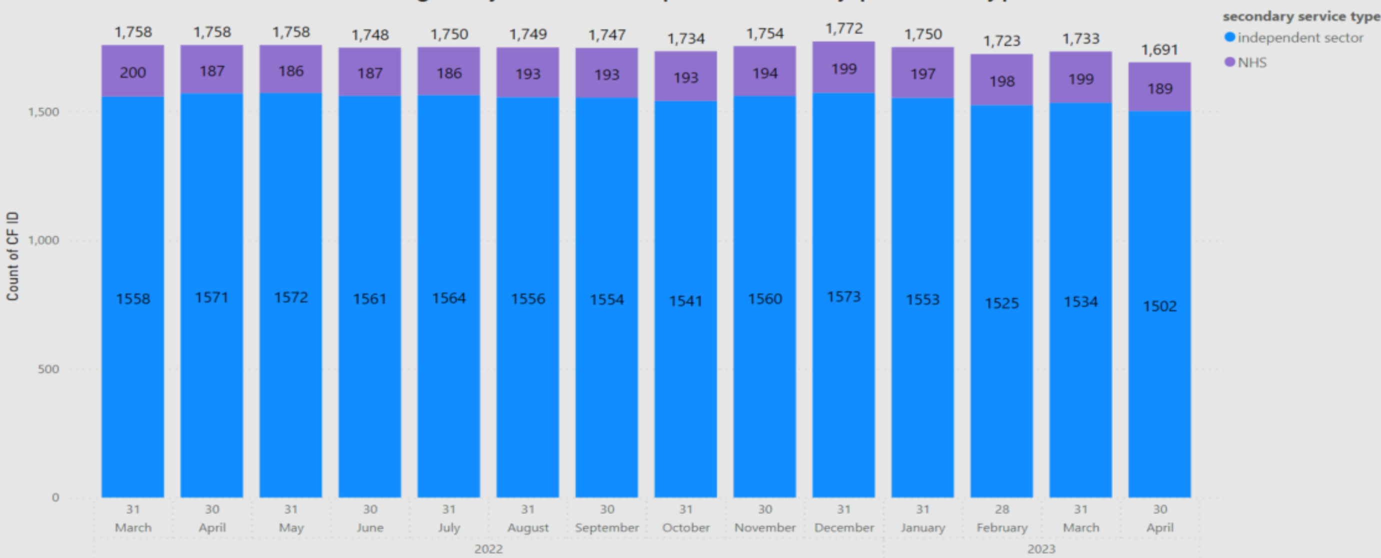
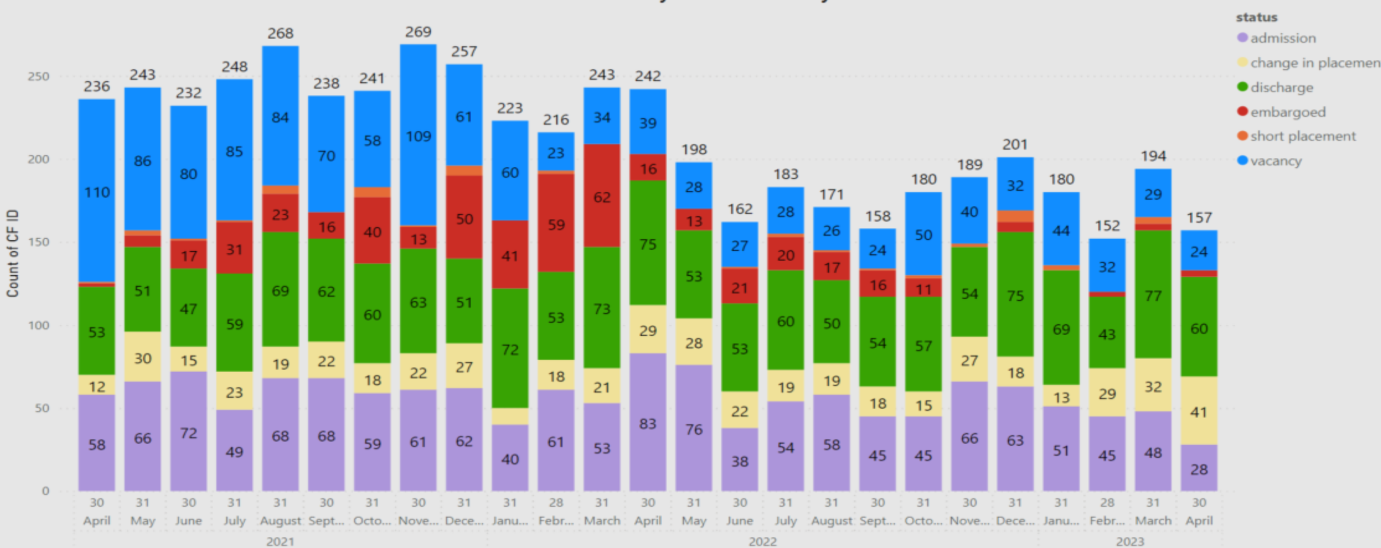
North Highland Care Homes





North Highland Care Homes

There has been significant independent sector care home fragility during 2022-23 and many are still under pressure. The single biggest challenge is the ability to recruit and retain staff in the remote and rural context that the services work within as many are competing with the NHS, tourism and other workforce sectors.

In-house care homes and some independent care home providers are experiencing significant staffing resource shortages.

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

The total number of independent sector occupied beds at April 2023 is 1502 which is the lowest for many years. This reduced bed availability is having an impact on the wider health and social care system, and in particular the ability to discharge patients timely from hospital settings.

Since March 2022, there have been 4 independent sector care home closures, with a further closure announced in March 2023, which is expected to conclude June 2023. Also, during this period, the partnership acquired a care home in administration to prevent the closure of this facility and a further loss of bed provision.

The HSCP are still working with the Highland Council to develop a strategy for care homes and an implementation plan to span the medium to longer term care environment.

Update 06/06/2023

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

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

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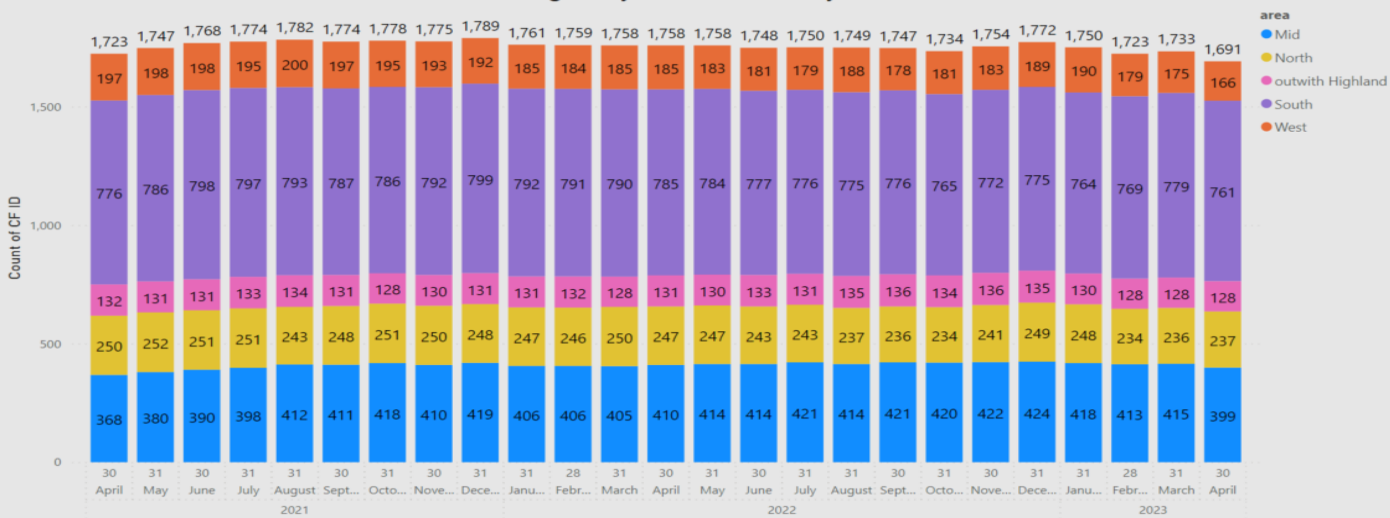
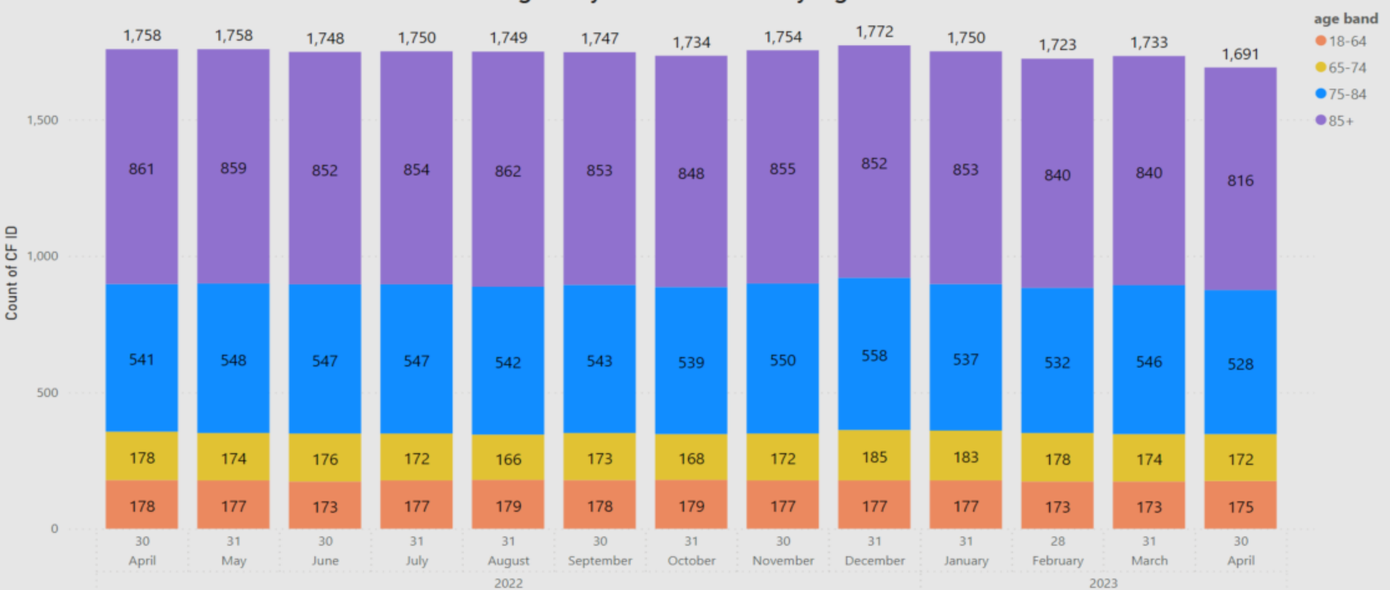
North Highland Care Homes





North Highland Care Homes

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

South: 761 occupied beds
Mid: 399 occupied beds
North: 237 occupied beds
West: 166 occupied beds
Out of Area: 128 occupied beds

In addition a further breakdown is provided by the current age of those service users for North Highland only, **showing 48%** are currently over the age of 85 in both residential and nursing care settings.

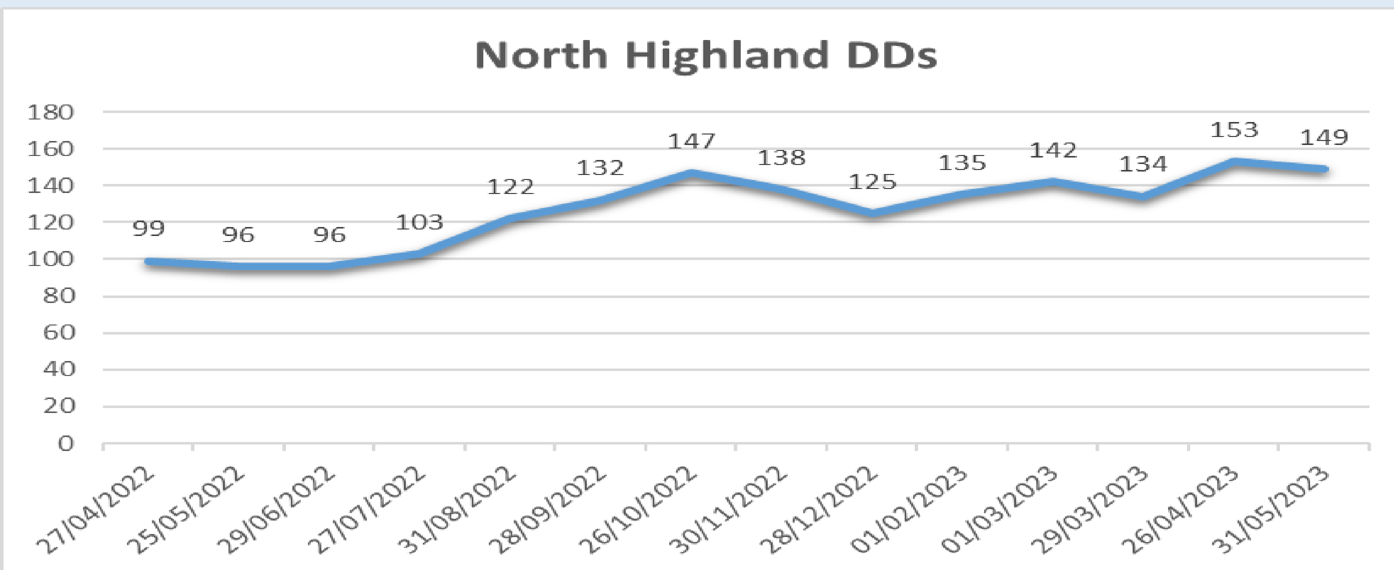
Update 06/06/2023

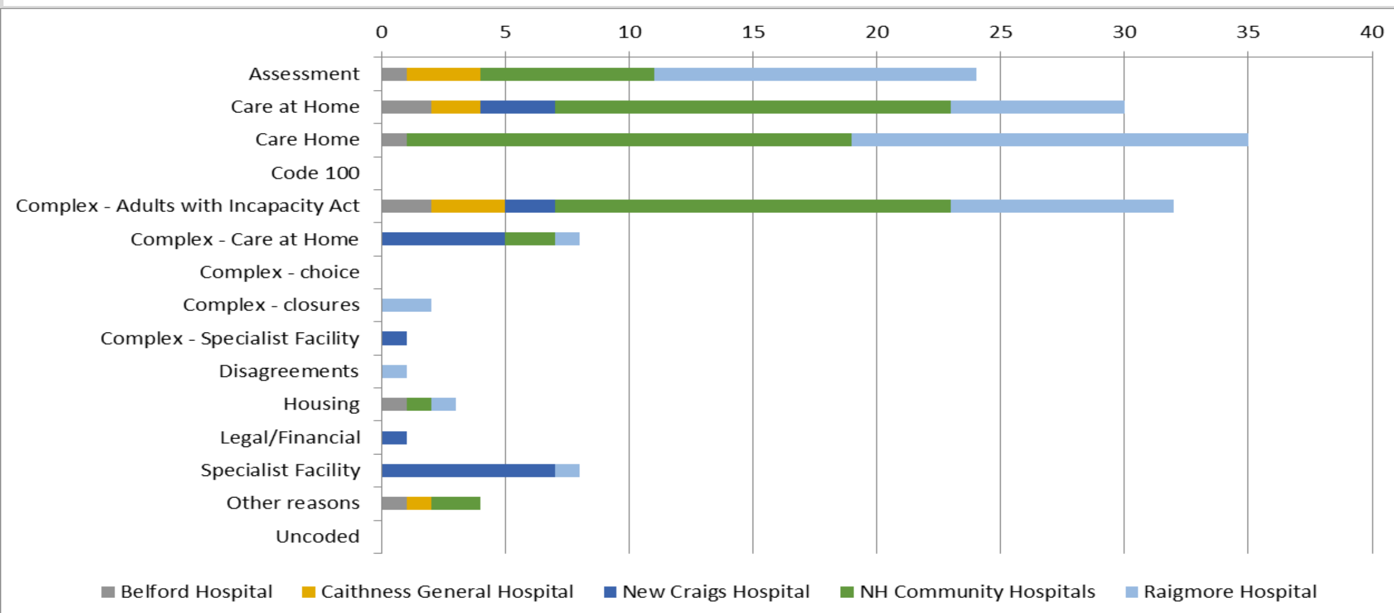
Strategic Objective 3 Outcome 11 – Respond Well

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

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

North Highland DDs





Performance Overview North Highland

Update: *149 delayed discharges @ 31/05/2023 with 22 of those code 9 (complex-AWI), 30 awaiting social care arrangements to return home (care at home/adaptations), 24 awaiting assessment and 35 awaiting care home placement.*

The graphs show the trend for total delayed discharges for North Highland and the reason for those awaiting discharge shown at a hospital level.

- Delayed discharges remain a concern. Hospital flow has undoubtedly been impacted by the latest independent sector care home closure (35 beds) and a total loss of 140 care home beds within the last year.
- The Discharge without Delay Delivery Group continues to focus on strengthening community pull activity, implementation of planned date of discharge across all hospital sites and daily oversight and planning for all people who are delayed, in addition to facilitating timely discharge of patients before they become delayed.
- Daily MDT Decision-Making Teams within each District also focus on preventative support for people in the community to avoid inappropriate hospital admissions.
- Additional areas of focus include a review of care at home provision to ensure most efficient and effective use of limited resources and the development of wrap-around models of care.
- Cross system working and adopting a whole system approach remains key to ensuring the success of this work.

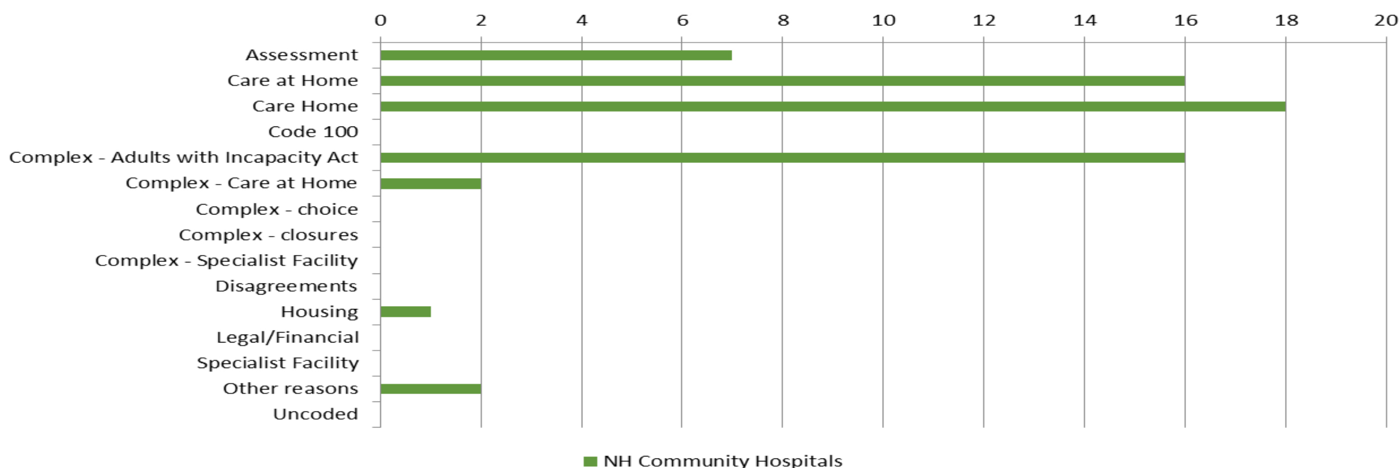
Update 08/06/2023

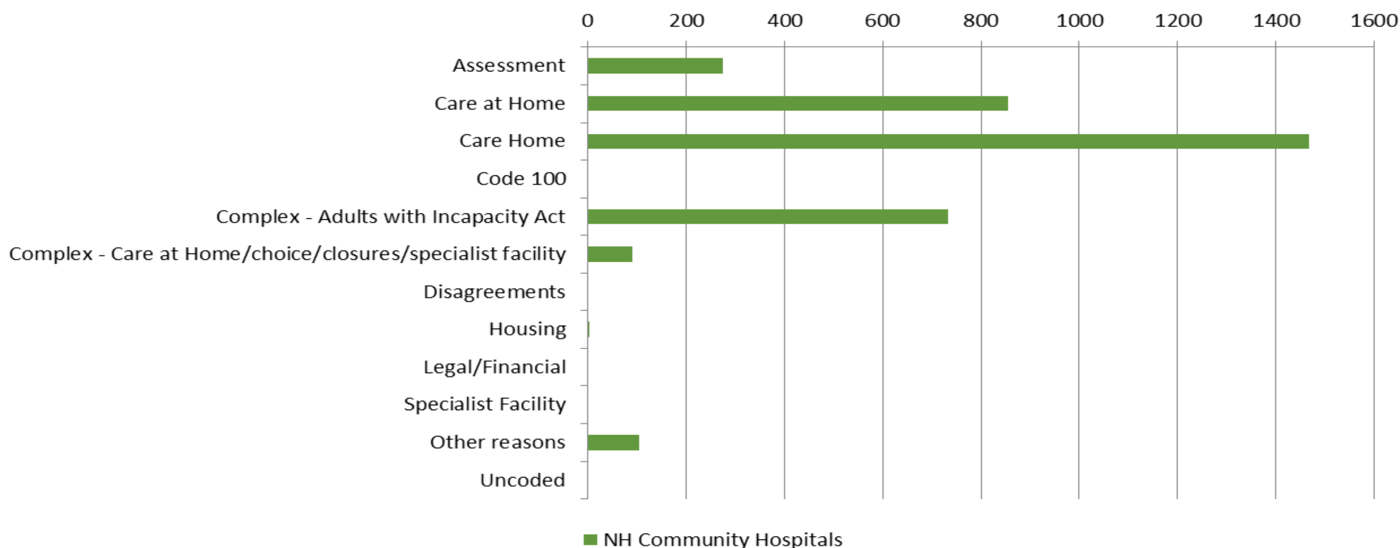
Strategic Objective 3 Outcome 11 – Respond Well & Care Well (Delayed Discharges)

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

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

North Highland Community Hospitals DDs





Performance Overview North Highland

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

Of the 149 delayed discharges at 31/05/2023, 62 are in North Highland Community Hospitals, an increase of 12 on the March reported position. 19 are in New Craigs hospital (-1 on March position) and the remaining 68 are delayed in acute hospitals.

All teams are focused on ensuring patients are discharged home as early as possible. Daily oversight and collective problem-solving is a key feature of DMT meetings in each of the Districts. These meeting also have oversight of those patients who are subject to AWI process to ensure focus and monitor progress.

Ongoing challenges with reduced care at home and care home capacity continue to impact throughout all of North Highland area.

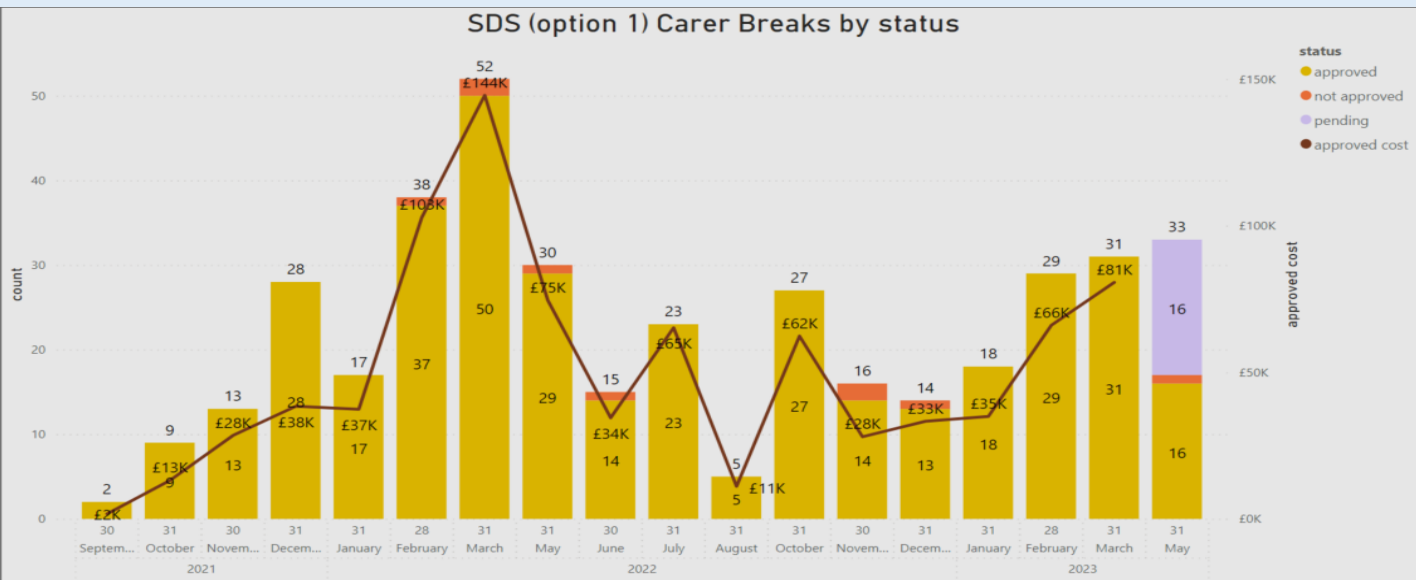
Update 08/06/2023

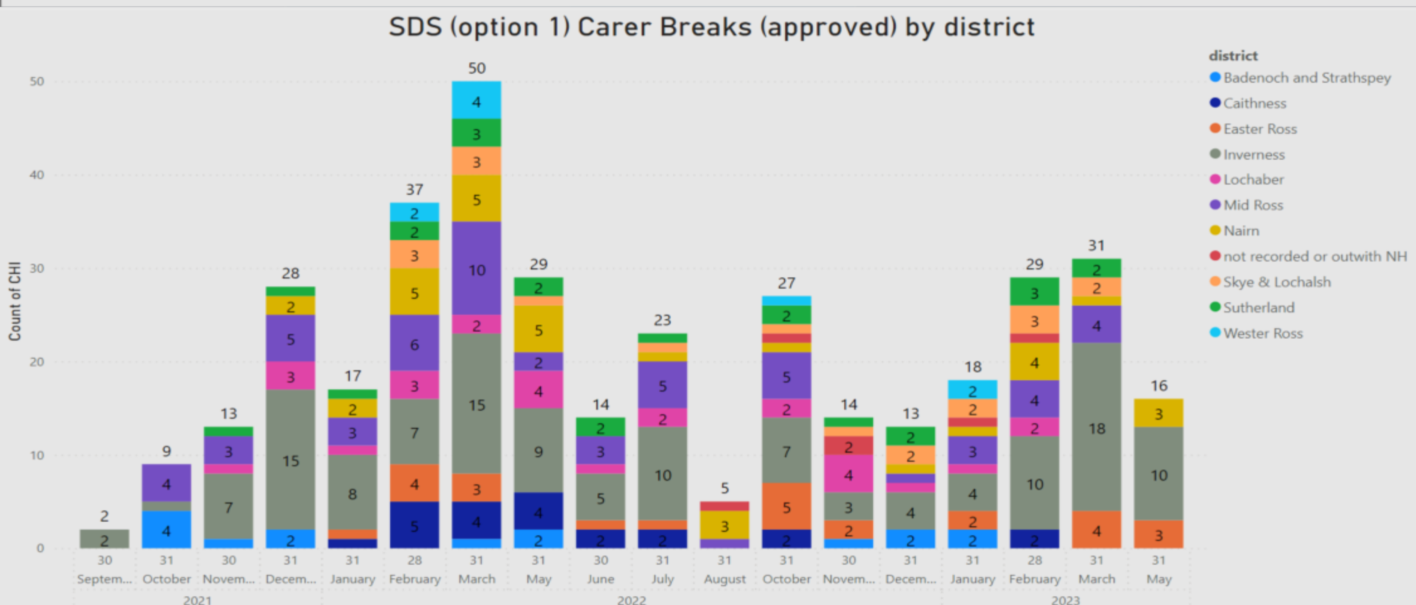
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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

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

Carer Breaks – Option 1 (DP)





SDS Option 1 (Carer Break scheme)

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

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

The scheme continues to be well received by carers and their families with the number of approved applications starting to increase again during recent months.

NHS Highland has partnered with a number of organisations to host a special event for unpaid carers on Thursday 15th of June.

NHS Highland Carer Support Services as well as many other support organisations such as Connecting Carers, Carr Gomm, and Befrienders Highland will be there to chat and offer support for carers.

The event comes as part of NHS Highland's celebration of Carers Week (5 – 11 June 2023), an annual campaign raising awareness of caring and highlighting the challenges unpaid carers face.

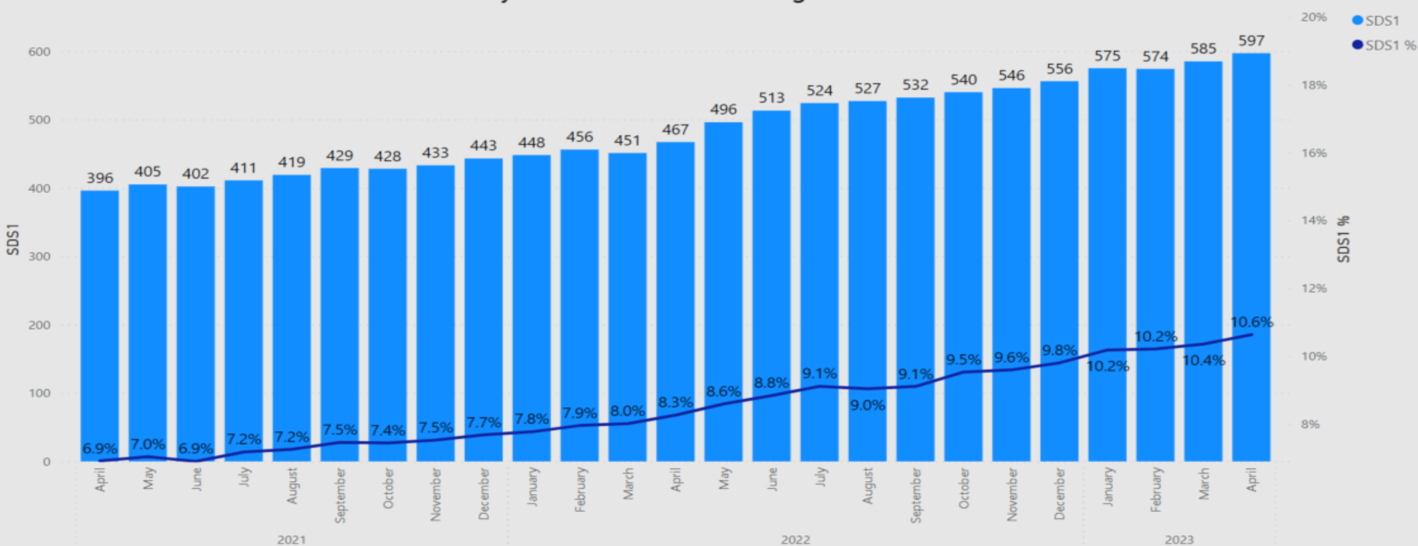
Update 06/06/2023

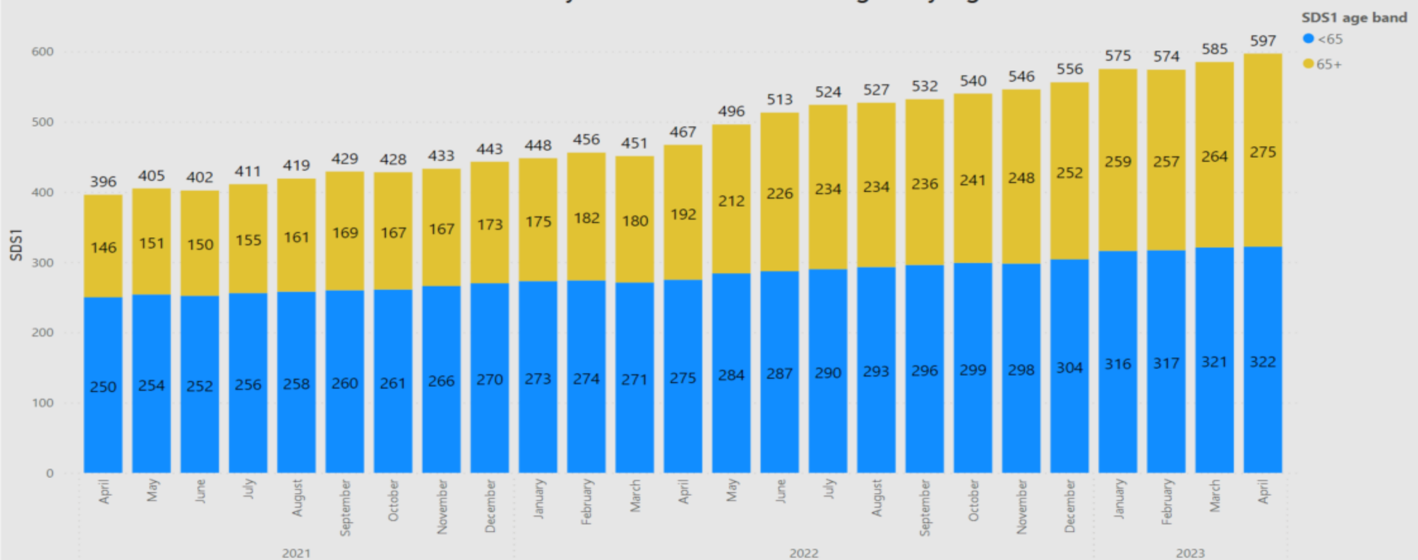
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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

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

Self Directed Support – Option1 (DP)





SDS Option 1 (Direct Payments)

Sustained growth in Option 1s for both younger and older adults in some of our more remote and rural areas. An overall increase of 201 since March 2022 with further growth expected this year.

The increase does highlight the unavailability of other care options and a real market shift as we are unable to commission other care services.

We are also aware of more and more Option 1 recipients who are struggling to retain and recruit personal assistants, which demonstrates the resource pressure affecting all aspects of care delivery.

Our current number of active service users receiving a direct payment as at Apr 23 is 597, with a projected cost of around £11.4m.

As an integral component of our Self Directed Support Strategy, work on identifying the core cost components of a personal assistant has concluded with the group agreeing on a co-produced new reference rate hourly proposal in March 2023 which has been considered within the appropriate governance and assurance structures of NHS Highland and will be presented to a future committee for consideration and final decision.

Option 1 service users who employ a personal assistant are currently paid based on an initial rate of £15.52 per hour from April 2023.

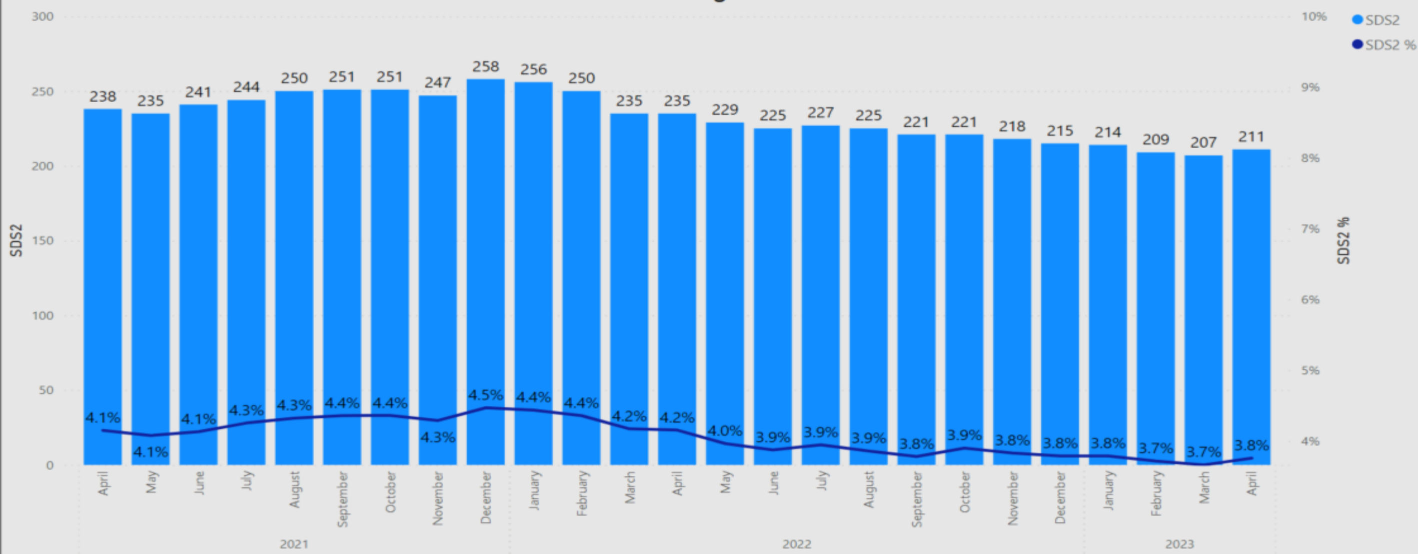
Update 06/06/2023

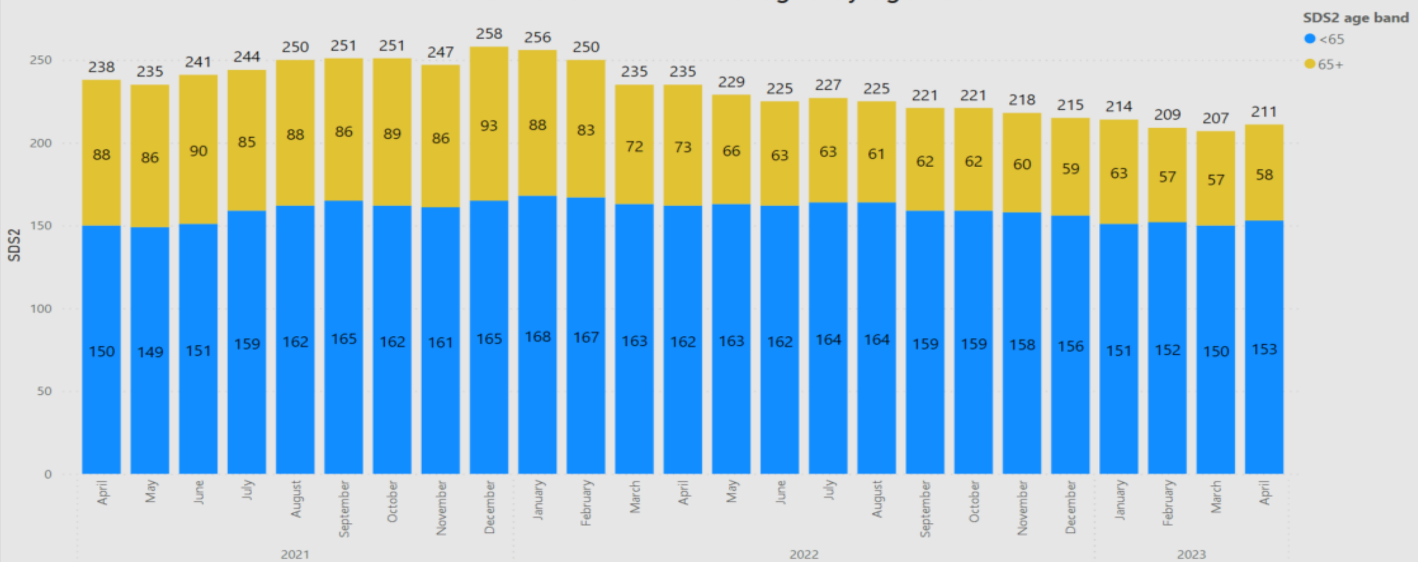
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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

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

Self Directed Support – Option2 (ISF)





SDS Option 2 (Individual Service Funds)

ISFs continued to reduce during 2022 after a peak of 258 in Dec 2021, although we have seen a stabilising of the position so far in 2023.

Overall number of ISFs split by age band, highlighting resource pressures which is a recurring theme across Health and Social Care.

Our current number of active service users receiving an ISF is 211 as at April 2023 with a projected annual cost of £5.1m.

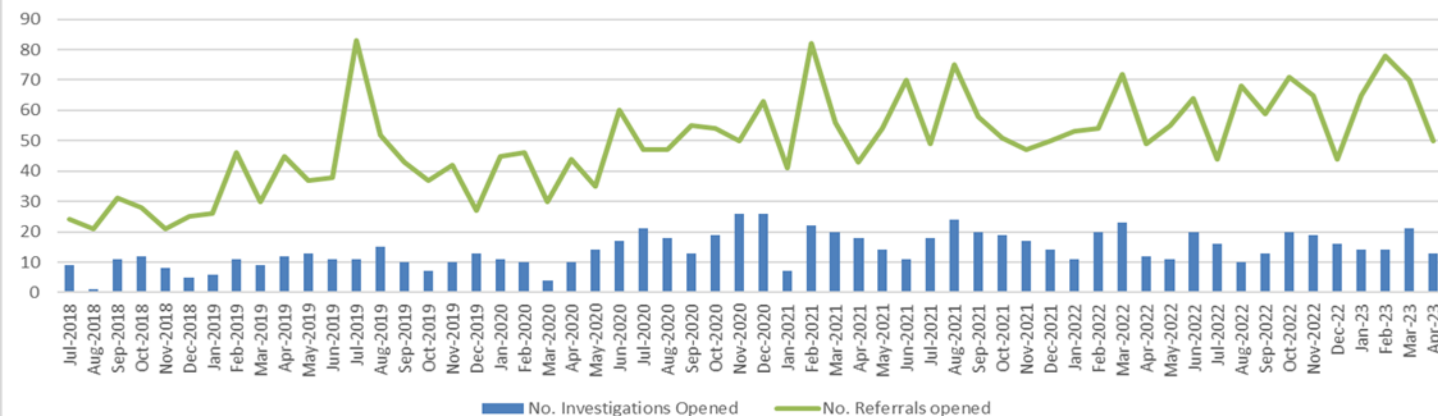
Plans are now in development to better understand and resolve any process barriers to growing the overall number of ISFs.

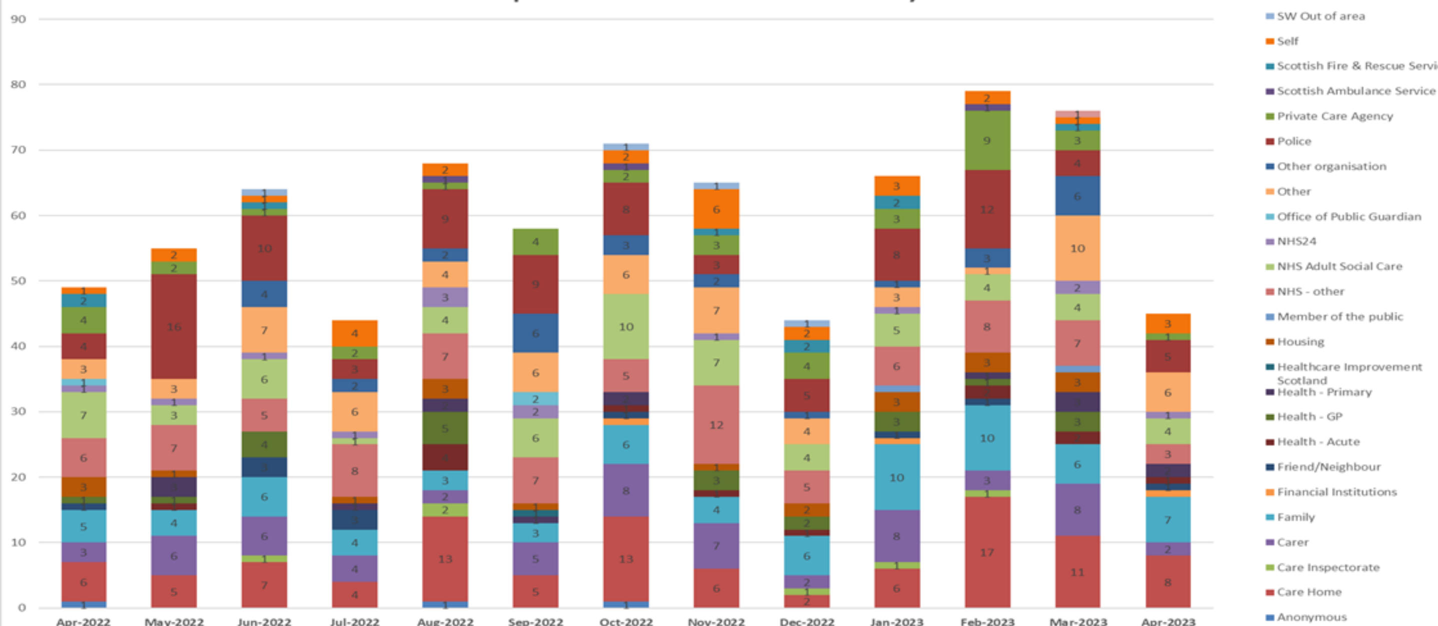
A restructure of the operation of Option 2's was agreed as a key work stream component within an overall programme for Promoting choice, flexibility and control.

Update 06/06/2023

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

Adult Protection





Adult Protection

Currently Adult Protection information is provided as part of an annual return to PHS.

A new National dataset is currently being introduced with guidelines received in January 2023. This will require an amendment to quarterly reporting and some amendment to data collected. These amendments are being progressed.

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

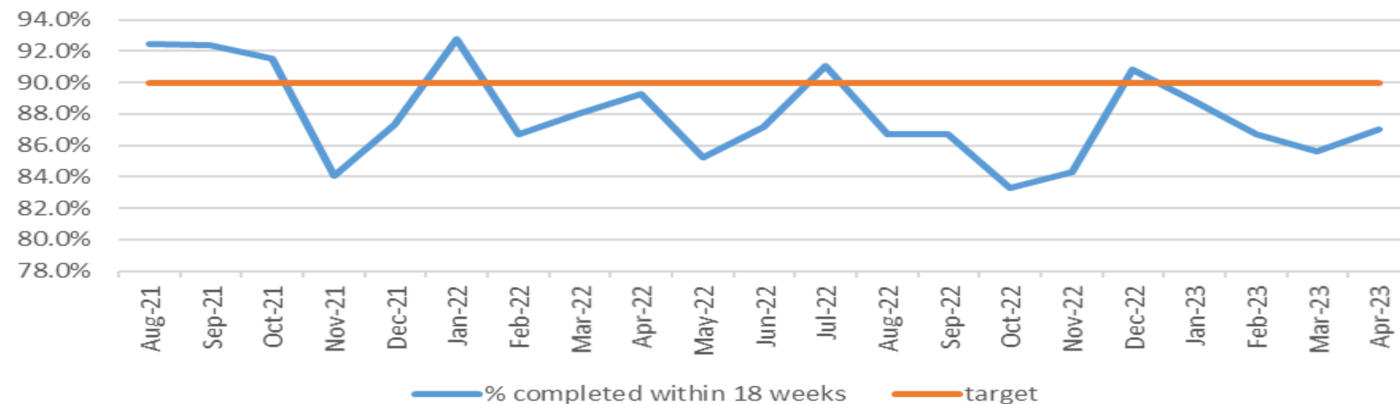
The number of referrals that progress to a full investigation following the initial inquiry is approximately 25%.

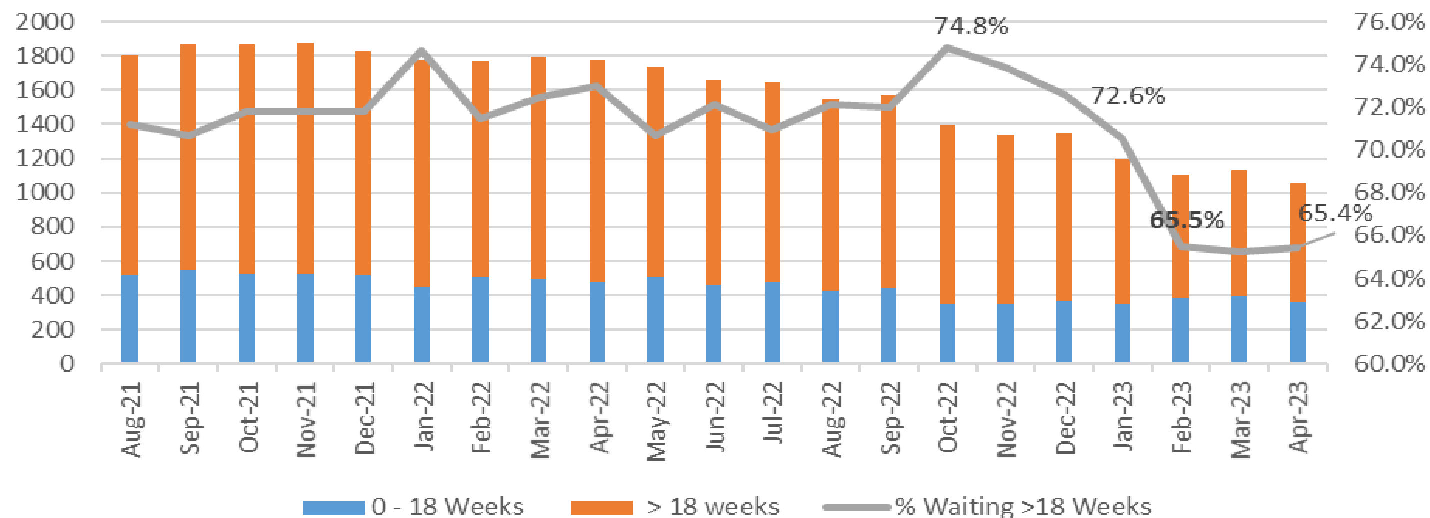
Update 06/06/2023

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

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

Psychological Therapies North Highland 87% April Performance





Psychological Therapies Performance Overview - North Highland

The national target:

90% of people commence psychological therapy based treatment within 18 weeks of referral. April 2023: Current performance 87%

As at April 2023:

- *1053 of our population waiting to access PT services in North Highland.*
- *689 patients are waiting >18 weeks (65.4% breached target) of which 393 have been waiting >1year.*
- *Of the 393 waiting >1 year, 38 of those are waiting for North Highland Neuropsychology services, this is a significant reduction, 121 awaiting group therapies and 210 awaiting AMH make up the majority of waits > 1 year,*

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

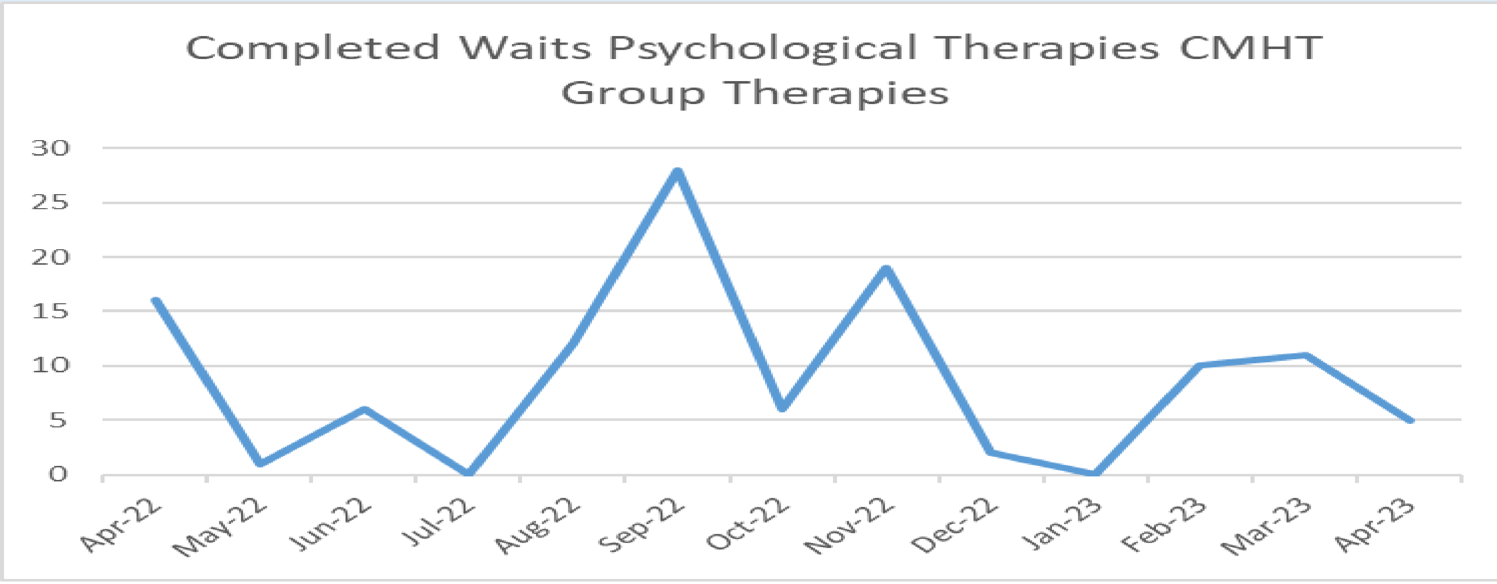
There will though always be a need for specialist services and the team are working to build a resilient model. The Director of Psychology is working closely with her team to reduce the current backlog and to build for the future. Recruitment and retention is difficult when national recruitment is taking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

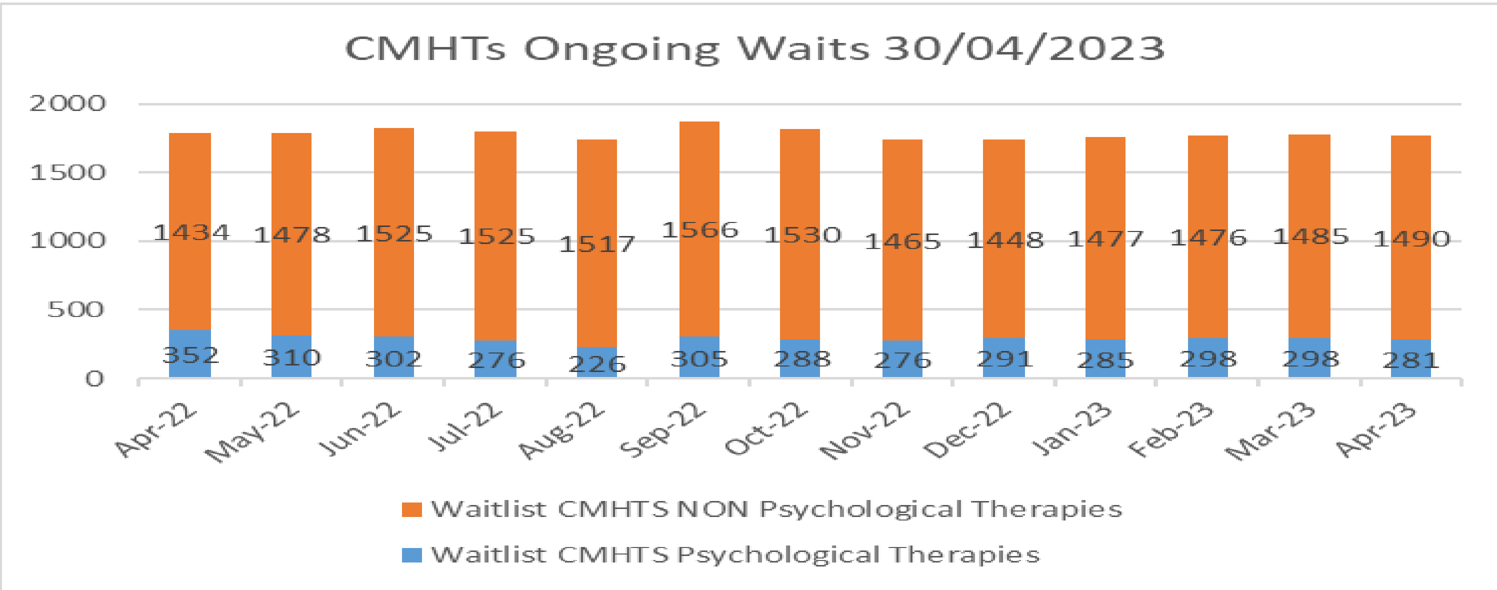
Updated 06/06/2023

Strategic Objective 3 Outcome 10 – Live Well

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

Community Mental Health Teams





Community Mental Health Teams

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

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

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

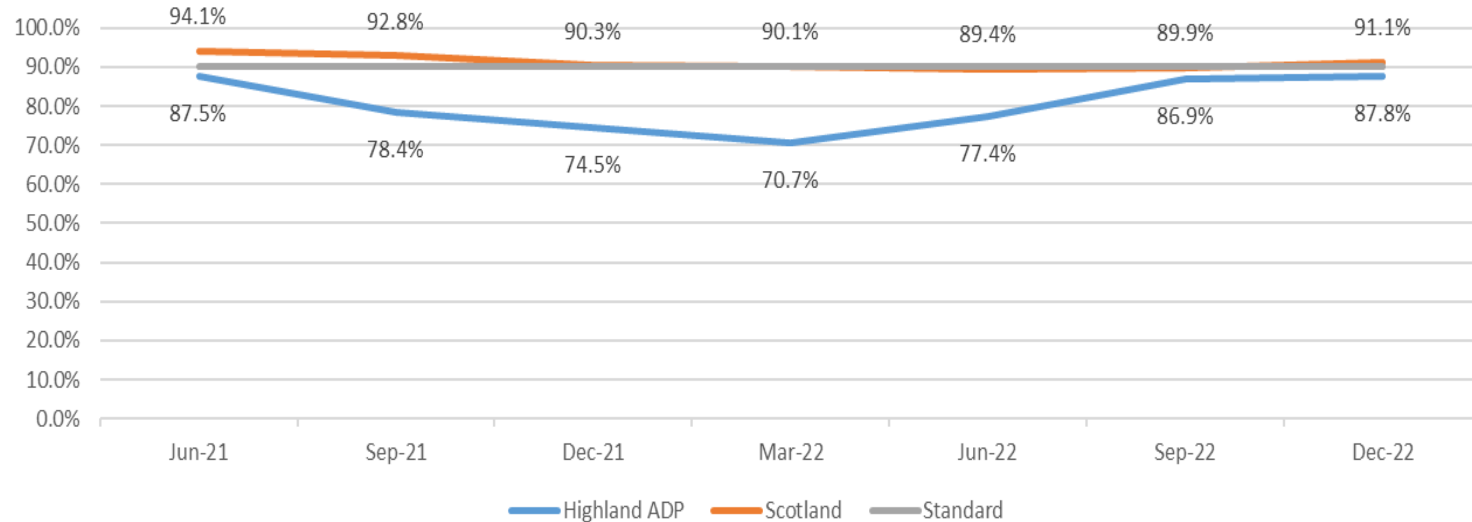
Graph 2 – shows the ongoing waits as recorded on PMS for the CMHTs, split between PT group therapies and other patients. Validation work is ongoing around this waitlist as has happened within PT.

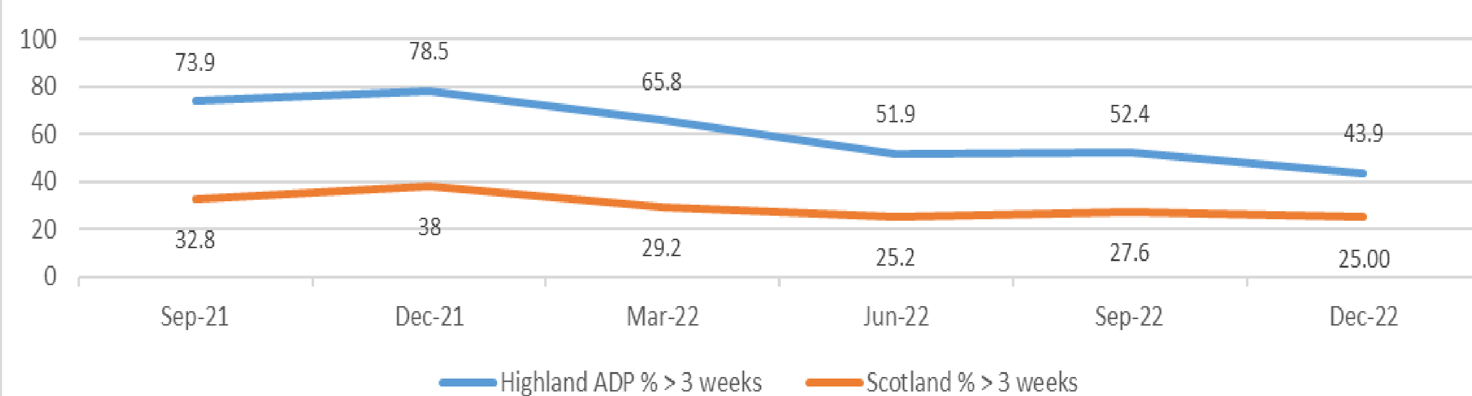
Updated 06/06/2023

Strategic Objective 1 Outcome 3 – Our Population

Priority 3b – No patient will wait longer than 3 weeks for commencement of treatment

Highland Drug & Alcohol Recovery Services





North Highland Drug & Alcohol Recovery Services Update

PHS Publication December 2022

North Highland Drug & Alcohol Recovery Service 87.8%, Scotland 91.1%

Main points Completed Waits from Publication

No. of referrals to community based services completed in quarter end 31/12/2023	Highland ADP	
Alcohol	*118*	
Drug	*72*	
Co-dependency	*6*	
Total completed	*196*	
<= 3 weeks	*172*	
% of referrals to community based services completed within target in quarter end	**Highland ADP**	**Scotland**
% completed <= 3 weeks - Alcohol	*87%*	*89.3%*
% completed <= 3 weeks - Drug	*89%*	*93.0%*
% completed <= 3 weeks - Co-dependency	*83.3%*	*93.8%*
% completed <= 3 weeks - All	**87.8%**	**91.1%**
TARGET	**90%**	**90%**
> 3 weeks	12.2%	8.9%

Main points Ongoing Waits from Publication

Ongoing referrals to community based services at quarter end 31/12/2022	Highland ADP	
Alcohol	32	
Drug	4	
Co-dependency	5	
Total ongoing	41	
<= 3 weeks	23	
> 3 weeks	18	
% breached ongoing waits as at quarter end 31/12/2022	**Highland ADP**	**Scotland**
% ongoing > 3 weeks - Alcohol	46.9%	25.9%
% ongoing > 3 weeks - Drug	25.0%	26.6%
% ongoing > 3 weeks - Co-dependency	40.0%	17.3%
% ongoing > 3 weeks - All	43.9%	25.0%

Priority areas include identifying areas for improvement using lean methodology and the method for improvement to release capacity in teams to further meet this standard. This work has started in some teams.

Updated: 11/04/2023

Current Overview of Non Reportable Specialties

Non Reportable Specialties – Ongoing Waits 29/03/2023

NHS Highand Non Reportable Specialties - Outpatient Ongoing Waits 31/05/2023 (Excludes Raigmore)

4000
3500
3000
2500
2000
1500
1000
500
0

0-4 wks, >4 wks, >12 wks, >26 wks, >52 wks, >78 wks, >104 wks, >130 wks, >156 wks, >182 wks, >208 wks, >234 wks, >260 wks, >286 wks, >312 wks, >338 wks, >598 wks

Total Waiting List – 13,355
Longest Wait > 598 weeks

This is new data to the service so requires further consideration of what it is showing. We need closer scrutiny in each of the areas in relation to data cleansing, waiting list management, waiting time targets and forward service planning.

All areas will have a level of waiting times and we need to understand what is reasonable and where the service is outside of this what are our options to reduce waiting times.

11/04/2023

Current Overview of Community Waitlists

NHS Highland Non Reportable Specialties - Outpatient Ongoing Waits 31/05/2023 (Excludes Raigmore)

MAIN SPECIALTY	0-4 wks	>4 wks	>12 wks	>26 wks	>52 wks	>78 wks	>104 wks	>130 wks	>156 wks	>182 wks	>208 wks	>234 wks	>260 wks	>286 wks	>312 wks	>338 wks	>598 wks	Total
Aviemore CMHS	17	18	11	20	14	2		4	9									95
Caithness CMHS	49	25	16	53	43	51	16	14	10	12	13	15	14	7	1	1		340
Child and Adolescent Psychiatry	25	27	24	19	2													97
Chiropody	685	484	146	51	1													1367
Clinical Psychology	16	12	17	34	39	40	7	3		1								169
Community Child Health				2														2
Community Dental	5	2	1	1	1				1									11
Community Paediatrics	18	39	51	56	3													167
Dietetics	256	306	246	90	18	17	12	6	1	1	1	1						955
East Ross CMHS	64	51	52	21	22	3												213
Electrocardiography	118	159	208	365	58	5	1		1									915
General Psychiatry	275	344	227	113	54	19	8	1	1	1							1	1044
GP Acute	91	92	42	20	4	1	2											252
Highland Community Mental Health Tean	27	33	49	72	49	23	13	3	2	2	2	1	1	1				278
Inverness CMHS	20			5														25
Investigations and Treatment Room			4	1	1			1				1						8
Learning Disability	10	29	28	88	55	34	18	20	15	20	16	18	7	1		2		361
Lochaber CMHS	27	32	21	40	35	47	10	28	17									257
Mental Health Nursing MHN	26	33	52	35	21	13	7	4	1									192
Mid Ross CMHS	23	17	17	48	5													110
Nairn CMHS	17	17	18	25	24	1	3	8	42									155
Obstetric	11	7	2															20
Obstetrics Antenatal	13	2	2	2														19
Occupational Therapy	30	40	3	5	3	5	3		1									90
Ophthalmology - Cataract		3																3
Optometry	89	112	140	136	13	1												491
Orthoptics	26	30	37	14	5													112
Orthotics	62	73	63	44	7													249
Physio Orthopaedic Service	57	32	7															96
Physiotherapy	1224	1265	756	360	65	33	13	6	14				1					3737
Psychiatry of Old Age	150	79	75	40	25	3												372
Psychological Services	103	147	154	160	109	98	52	15	2	2	1	1						844
Psychotherapy							2											2
Skye and West Ross CMHS	26	25	30	93	42	27	3	3	51									300
Social Work				1			1	1	1									4
Sonography		1	1			1												3
Total	**3560**	**3536**	**2500**	**2014**	**718**	**424**	**171**	**117**	**169**	**39**	**33**	**37**	**23**	**9**	**1**	**3**	**1**	**13355**

Total Waiting List – 13,355
Longest Wait > 598 weeks

This is new data to the service so requires further consideration of what it is showing. We need closer scrutiny in each of the areas in relation to data cleansing, waiting list management, waiting time targets and forward service planning.

All areas will have a level of waiting times and we need to understand what is reasonable and where the service is outside of this what are our options to reduce waiting times.

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**28 June 2023**
Title:	**Chief Officer Assurance Report**
Responsible Executive/Non-Executive:	**Pamela Cremin, Interim Chief Officer**
Report Author:	**Pamela Cremin, Interim Chief Officer**

1. Purpose

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

2. Project Updates – North Skye Healthcare; Lochaber redesign; and Caithness Redesign

North Skye healthcare (Portree out of hours/Sir Lewis Ritchie (SLR) report implementation update)

A meeting of the Sir Lewis Ritchie Implementation Steering Group took place on 20th June.

Scottish Futures Trust who are facilitating this work were also in attendance and there was good community representation.

Continued collaboration between clinicians across NHSH, NHS24, SAS and GPs, has co-produced a demand data informed model for urgent care in the North part of the Island.

There was an opportunity to table the Skye District Profile as part of the NHSH and The Highland Council Joint Strategy and this facilitated a discussion on wider service needs and service developments such as Hospital@Home, in reach care at home; and supported housing models. Initial engagement was encouraging and there will be wider participation and engagement on Skye as part of the Strategy engagement process.

Lochaber Redesign

As previously highlighted to the Committee, the principle supply chain partner, Balfour Beatty, and their design team were appointed in April to commence work on the design for the new hospital.

Work on the development of the acute service model for Lochaber has almost concluded, with a Clinical Output Specification developed for issue to the design team alongside a schedule of accommodation and technical briefing information. The service model was developed from the principles set out in the Initial Agreement through a series of workshops with staff, culminating in a crosscheck event held on the 18th of April at which each department presented their vision to colleagues. A public engagement event was held in Fort William's Nevis Centre on the 6th June where the community could view proposals and ask questions.

Requirements for support accommodation (e.g. locum, students) have also been agreed and we are now exploring options to deliver these with partners including the Highland Council and West Highland College.

Work on the community services solution is now starting to progress with Gavin Sell, Area Manager appointed as lead, and support being agreed with Buchan Associates.

Caithness and North Coast Redesign

Caladh Sonah Residential Care Home at Melness has been closed with residents safely moved to alternative local placements.

The development of the North Coast Hub model is progressing and we are widening engagement with Primary Care and third and independent sector.

A key risk is workforce planning and workforce sustainability for the future.

The area manager and team have been requested to provide the Community SLT in early July, with an update on the North Coast Redesign, the project risks and workforce plans accordingly.

Caithness General Hospital Redesign

The Caithness General Hospital model was developed through a series of workshops held from October 2022 to April 2023, facilitated by Buchan Associates and involving key members of staff. Four to five workshops were held for each of twelve departmental workstreams. The workshops first established a clear understanding of the existing services and challenges faced, then looked at factors that may influence the shape of services in future. They culminated in setting out a clear vision of the future service model to be delivered within the reconfigured hospital, termed the Clinical Output Specification (COS), which is supported by a Schedule of Accommodation (SoA) and Target Operating Model (TOM). Developing documents were shared with workshop participants after each session. The Clinical Output Specifications were presented by each workstream lead at a Crosscheck Event held in Wick on 11th May 2023. At that point the COS and SoA were in final draft, with the TOM for each department at various stages of development. The event allowed other workstream leads, senior service managers and representatives of this Programme Board to understand and

question the proposals. A number of actions are being progressed in response to the Cross Check event in relation to workforce planning, financial planning and digital technology plans.

HSCP Annual Performance Plan

The Annual Performance Plan is under development and will provide data and narrative to illustrate our delivery against the National Health and Wellbeing Outcomes for the year 2022, as required by the Public Bodies (Joint Working) Scotland Act, 2014.

Highland Partnership is responsible in ensuring that our local communities are clear on how health and social care integration is performing. The report highlights the key areas of achievement and challenges that we have faced over the year. During 2022 staff have worked hard to continue to provide excellent health and social care services for our Highland communities which consists of Primary, Community, Mental Health, Acute Care, Children and Adult Social Care.

This key report is important for the Committee as it will articulate triangulated narrative and data that will demonstrate key care outcomes and people's experience of care.

The Report will be presented to the next Health and Social Care Committee on 30th August and will be published thereafter in September 2023.

Ross Memorial Hospital

Changes to Ross Memorial Rheumatology Unit plans: An update has been requested for the Committee via the CO Report regarding the progress being made to undertake the fire upgrade work at Ross Memorial Hospital. Discussions are ongoing engaging the community and the Rheumatology clinicians and people who use the service and while ongoing engagement is taking place there is not an update for the committee.

Awards

Honour for services to rural nursing

Cathy Shaw, Lead Advanced Practitioner for the Remote and Rural Support Team (West) and the Hospital at Home Team Skye with NHS Highland, has been recognised and awarded an MBE for services to nursing in rural Scotland. Cathy, has worked with NHS Highland for six years. I am sure everyone will join me in congratulating Cathy on her award.

Honour for services to general practice

Dr Miles Mack, a GP with Dingwall Medical Group, has been recognised and awarded an OBE for services to general practice. Dr Mack has worked with the Dingwall practice for 30 years. Again I am sure everyone will join me in congratulating Dr Mack on his award.

HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE WORKPLAN TO 31 March 2024

Standing Items for every HHSCC meeting

- Apologies
- Declarations of interest
- Minutes of last meeting
- Finance
- Risk (Level 1 Risks)
- Performance and Delivery (IPQR: Dashboard and Chief Officer's Report)
- Health Improvement
- Committee Function and Administration
- Date of next meeting

01 MARCH 2023

Title	***Lead***	***Purpose***
District Reports (x2)	Rhiannon Boydell	Caithness & Sutherland
Children and Young People Performance Reporting	NHS: Tracey Gervaise, Highland Council: Ian Kyle	
Adult Social Care Fees and Charges Report	Gillian Grant	
Mental Health Services Assurance Report	Arlene Johnstone	Intended April
Third Sector Mental Health Funding	Mhairi Wylie	
Committee 2022/23 Annual Assurance Report	Chair and Chief Officer	
Committee Annual Workplan 2023/24	Chair	

26 APRIL 2023

Title	***Lead***	***Purpose***
District Reports (x2)	Jill Mitchell	Postponed
Annual Report of Care Home Oversight Board	Gillian Grant	Update received
Chief Social Worker's Annual Report	Simon Steer & Fiona Duncan	Needs to go through Council process first
Adult Protection Committee Annual Report	Simon Steer	Needs to go through Council process first
Learning Disability Services Assurance Report	Arlene Johnstone	
Mental Health Strategy	Arlene Johnstone	Deferred. Best time to be determined

24 MAY – Development Session: **a.) Public Health, b.) Integrated Joint Plan, c.) Assurance Matrix**		
	28 JUNE 2023	
Title	***Lead***	***Purpose***
District Reports (x2)	Jill Mitchell	
Care At Home Assurance Report	Gillian Grant	
Commissioning Strategy for Integrated Health and Social Care Services	Gillian Grant	Tbc
Public Bodies Annual Report	Chief Officer	
Dental Position Update	Director of Dentistry	
Highland Drug & Alcohol Recovery Services Delivery Plans	Arlene Johnstone	August
Annual Report of Care Home Oversight Collaborative	Gillian Grant	
Chief Social Worker Report		To follow Highland Council process
Adult Protection Committee Annual Report		To follow Highland Council process
5 JULY – Development Session: **a.) Financial Plans, Savings Targets and Delivery, Transformation plans and opportunities**		
	30 AUGUST 2023	
Title	***Lead***	***Purpose***
District Reports (x1)	Jill Mitchell	
Primary Care Improvement Plan Assurance Report	Jill Mitchell	
FHS Delivery Overview Report	All 4 workstreams to provide system-wide overview: Primary Care, Pharmacy, Dental, Ophthalmic	
Children and Young People Services (mid-year review)	Tracey Gervaise (NHS), Ian Kyle (Highland Council)	
Community Services Overview	Chief Officer	
Technology Enhanced Care Overview	Iain Ross	
Committee Terms of Reference	Ruth Daly	
Highland Drug & Alcohol Recovery Services Delivery Plans	Arlene Johnstone	
Mental Health Strategy	Arlene Johnstone	

20 SEPTEMBER – Development Session: a.) IPQR		
	01 NOVEMBER 2023	
Title	***Lead***	***Purpose***
District Reports (x2)	Jill Mitchell	
Engagement Framework Assurance Report	Ruth Fry	
Together We Care Implementation	Rhiannon Boydell	
Preparation for Winter	Chief Officer	
29 NOVEMBER – Development Session: a.) Sustainability Issues		
	(dtbc) JANUARY 2023	
Title	***Lead***	***Purpose***
District Reports (x2)	Jill Mitchell	
SDS Strategy Assurance Report		
Community Services Risk Register Assurance Report	Chief Officer	
Carers Strategy Update		
	(dtbc) MARCH 2023	
Title	***Lead***	***Purpose***
District Reports (x2)	Jill Mitchell	
Children and Young People Services Performance Report	Tracey Gervaise (NHS), Ian Kyle (Highland Council)	
Mental Health Services Assurance Report	Arlene Johnstone	
Adult Social Care Fees and Charges 24/25	Gillian Grant, Simon Steer	
Committee Annual Assurance Report 23/24	Chair and Chief Officer	
Committee Workplan 24/25	Chair	