Highland Health and Social Care Committee
5 February 2020
Item 2.1

NHS HIGHLAND BOARD
FINANCE REPORT MONTH 9 DECEMBER 2019/20

FINANCE HHSC COMMITTEE
5TH FEBRUARY 2020

Director of Finance narrative – Dec 2019

- **Headlines:**

- The month nine position shows an adverse YTD position of £10.9m.
  >£8.6m YTD of planned deficit (£11.4m)
  >£3.5m cost pressures offset by;
  >(£1.1)m savings

- As summary YTD position highlights our major problem when looked at operationally is Raigmore with a £3.1m adverse YTD position. This is partly linked to both the premium cost interim and agency, increased prescribing issues along with clinical supplies, short stay ward and medical rota gaps. For detail see slide 9

- Premium pay costs are still a major pressure with locums spending £10.2m to month 9 and other staff groups £14.6m though both have reduced in month 9 - see slides 13 and 14 for more detail.

- Projected position remains at £11.4m.

- Month 9 position is showing £14m potential overspend at year end leaving a challenge of £2.5m to deliver the AoP target

Director of Finance narrative – Dec 2019

- The £14m projection is an improvement of £9.1m on the previous reported projections (see slide 8 for more info). £3.7m AoP planned non recurrent savings for central slippage was realised and actioned in month 9, this along with cost pressure mitigation has improved the projections

- Following month 8 a mitigation plan to reduce cost pressures NHS Highland wide was implemented, with targets of £4.9m and £1.9m identified (£6.8m). In month 9 £4.8m has been identified and brought into the projected position for current and future months forecast.

- Challenge of £2.5m to reach £11.4m target.

Funding 2019-20

Summary Funding & Expenditure 2019/20	Current Plan £m
SGHSCD -Baseline Funding	**644.8**
- Recurring Supplemental Allocations	**22.6**
- Non Recurring Supplemental Allocations	**0.5**
- FHS GMS Allocation	**67.7**
Sub total - SGHSCD Core RRL	**735.7**
- Non Core Funding	**46**
SGHSCD Funding at month 9	**781.8**
Anticipated funding	
- FHS Non Discretionary	**34.3**
- Recurring Pending allocations	**0.6**
- Non Recurring Pending allocations	**3.6**
- Non Core Pending allocations	**0.0**
TOTAL SGHSCD Funding	**820.3**
Add- Adult Social Care Quantum Funding	**100.6**
Less - THC Childrens services Transfer	**(10.8)**
Funding	**910.1**

- SG funding for 2019/20 assumes £820.3m
- This includes baseline funding uplifted by 2.56% for 2019/20
- Allocations received to date
- FHS allocation
- Anticipated funding for non Discretionary FHS, and other expected allocations
- Funding to and from The Highland Council for Adult and Children's services bring total expected funding to £910.1m

Summary YTD position by unit- December 2019

Expenditure to Month 9 - December 2019	Plan to Date £m	Actual to Date £m	Variance to Date £m	Components of Variance: Planned Deficit £m	Components of Variance: Unadjusted Pipeline £m	Components of Variance: Operational £m
South & Mid Division	168.8	168.7	0.1	0.0	(0.4)	0.5
Raigmore Division	144.4	148.4	(4.1)	0.0	(0.9)	(3.1)
North & West Division	114.7	115.9	(1.1)	0.0	(0.9)	(0.2)
Sub Total NH Operational Uni	427.9	433.1	(5.1)	0.0	(2.3)	(2.9)
Adult Social Care - Central	3.1	2.4	0.7	0.0	0.3	0.4
Facilities	17.7	18.5	(0.8)	0.0	(0.1)	(0.6)
e health	6.5	6.5	0.0	0.0	0.0	0.0
Tertiary	16.4	17.2	(0.8)	0.0	(0.3)	(0.5)
Central services	29.2	25.9	3.3	0.0	3.5	(0.2)
ASC Income	(9.9)	(10.2)	0.3	0.0	0.0	0.3
HSCP Corporate Support	0.8	0.8	0.0	0.0	0.0	0.0
H&SCP	491.9	494.2	(2.3)	0.0	1.1	(3.5)
Planned Defcit	(8.6)		(8.6)	(8.6)		0.0
Total Expenditure	483.3	494.2	(10.9)	(8.6)	1.1	(3.5)

- Month 9 overspend of £10.9m made up of;
- **£8.6m** of planned 'gap' (9 months of the AOP £11.4m)
- Saving delivery phasing of £1.1m
- Operational pressures of £3.5m

Broken down as follows;

Operational units

Raigmore £3.1m operational overspend (see slide 7 for more info)

North & West £0.2m overspend

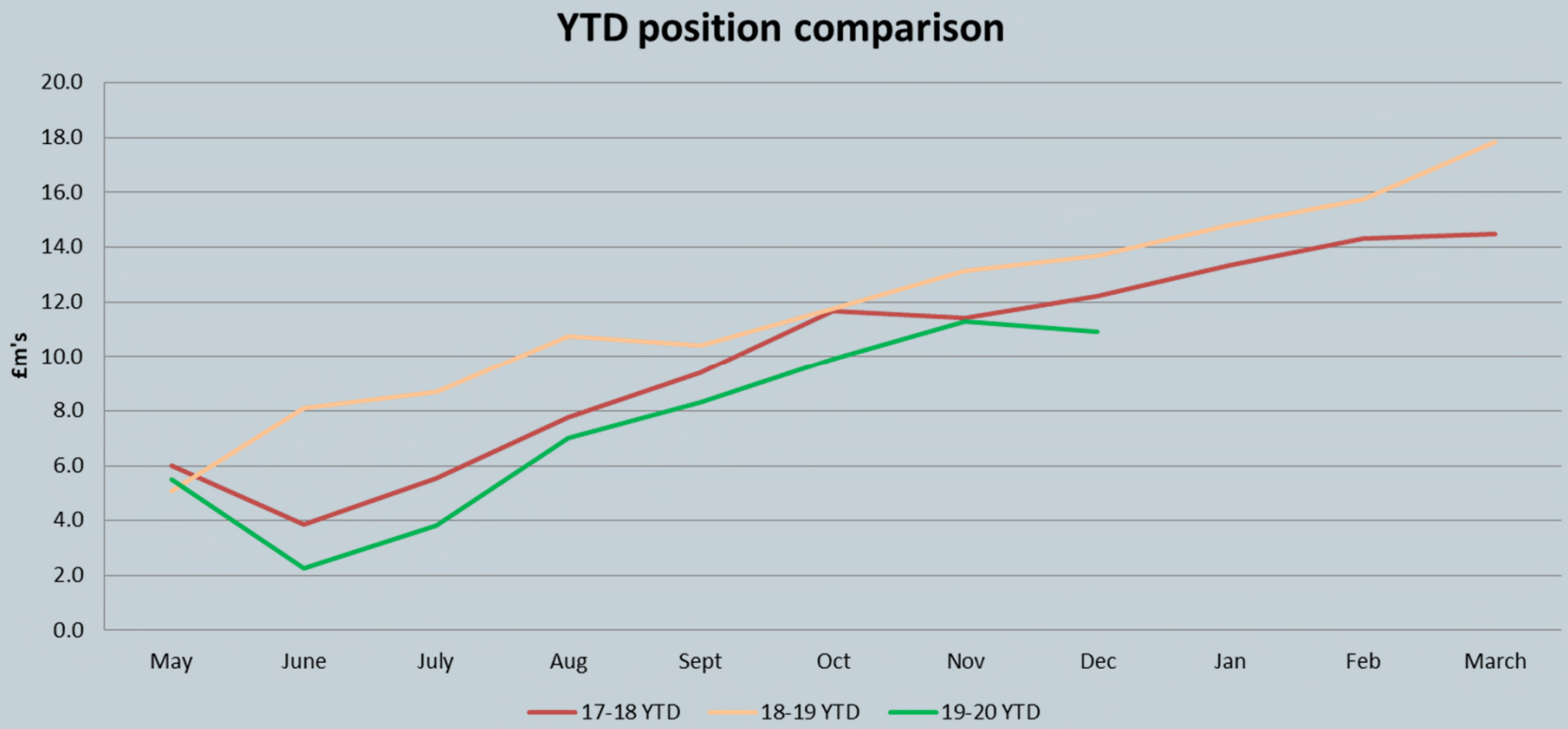
Support Services

Facilities £0.6m overspend (national waste contract)

Tertiary – out of area £0.5m overspend

Offset with underspends in South & Mid, ASC central and income.

Monthly Outturn Comparison



YTD position at month 9 is £10.9m overspend

NHS Highland

Forecast position as at month 9

Summary Funding & Expenditure Forecast	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m	Components of Variance: Planned Deficit £m	Components of Variance: Unadjusted Pipeline £m	Components of Variance: Op Var £m
South & Mid Division	225.2	226.7	(1.5)	0.0	(1.6)	0.0
Raigmore Division	191.4	196.6	(5.2)	0.0	(2.9)	(2.4)
North & West Division	153.5	156.0	(2.5)	0.0	(2.3)	(0.2)
Sub Total NH Operational Uni	570.0	579.3	(9.2)	0.0	(6.7)	(2.5)
Adult Social Care - Central	4.7	3.5	1.2	0.0	0.6	0.7
Facilities	23.3	24.8	(1.4)	0.0	(0.3)	(1.1)
e health	8.8	8.7	0.0	0.0	0.0	0.0
Tertiary	21.3	22.6	(1.3)	0.0	(0.6)	(0.7)
Central services	72.9	64.9	8.0	0.0	4.5	3.5
ASC Income	(13.2)	(13.3)	0.1	0.0	0.0	0.1
HSCP Corporate Support	1.9	1.8	0.0	0.0	0.0	0.0
TOTAL H&SCP	689.7	692.3	(2.6)	0.0	(2.5)	(0.0)
Planned Defcit	(11.4)		(11.4)	(11.4)		0.0
Total Expenditure	678.3	692.3	(14.0)	(11.4)	(2.5)	(0.0)

- Operational forecast at month 9 is £14m overspend.- negative movement in month of £2.2m
- Planned deficit as per AOP of £11.4m
- S&M have zero variance
- £2.5m of savings yet to be actioned
- Raigmore have a forecasted overspend of £2.4m (excluding workstream savings) due to drugs and locums and clinical supplies (see slide 7)
- N&W have an overspend after savings of £0.2m mainly due to locums
- Facilities have £1.1m pressure made up of the new national waste contract and energy costs

Forecast movement

NHS Highland wide mitigation plan

Forecast movements month 8 - 9	£m's
Non Recurrent AoP planned savings	3.7
Mitigation plan(incl £0.5m Raigmore	4.8
Raigmore savings	0.7
Central Inc ASC Centralcost reduction	0.3
Facilities	0.2
Total Movement	**9.7**

Planning slippage not required, Allocation slippage (to be reinstated in 20/21

Prof fees, year end flexibility, Raigmore and Corporate housekeeping eHealth programme slippage, other agreed programme slippage

HHSCP movement £9.1m – Corporate and A&B = £0.6m

Raigmore Cost pressures

Raigmore cost pressures	YTD £000's	Full year £000's
Medical pay pressures including locuma	1,072	1,042
Nursing pressures including worforce tool	1,120	1,069
Short stay ward - medical & nursing	275	367
Non Pay Theatres & endoscopy	528	593
Drugs - Ophthalmolgy	585	480
Cancer	634	690
Medical & Surgical	626	403
Radiology	355	492
Other	134	0
	5,329	5,136
Offsetting underspends	(2,212)	(2,760)
Operational pressures	**3,117**	**2,376**

Improvement from month 8 of £0.6m

Summary position by subjective spend

Subjective Spend	YTD Budget £m	YTD Actuals £m's	YTD Variance £m's	Annual Plan £m	Forecast Year End Out-Turn £m	Variance £m
PAY						
Medical & Dental	53.7	57.2	(3.4)	71.4	74.8	(3.4)
Medical & Dental Support	3.3	3.2	0.1	4.4	4.2	0.1
Nursing & Midwifery	86.6	87.5	(0.9)	116.2	117.0	(0.8)
Allied Health Professionals	15.4	14.6	0.8	20.4	19.7	0.8
Healthcare Sciences	8.9	8.6	0.3	11.8	11.5	0.3
Other Therapeutic	8.0	7.2	0.8	10.9	10.0	0.9
Support Services	17.5	17.4	0.1	23.2	23.3	(0.1)
Admin & Clerical	26.1	25.9	0.2	34.7	34.6	0.2
Senior Managers	1.0	0.9	0.1	1.3	1.2	0.1
Social Care	25.9	25.5	0.5	34.4	34.2	0.2
Commtments/Pay Savings	(0.2)	(0.4)	0.2	0.3	(0.2)	0.5
Pay - Total	**246.0**	**247.4**	**(1.4)**	**329.1**	**330.2**	**(1.2)**
Drugs	56.7	57.3	(0.6)	75.0	75.3	(0.4)
Property	24.5	25.0	(0.5)	32.5	33.5	(1.0)
Non Pay	19.8	20.6	(0.8)	27.3	26.5	0.8
Clinical non pay	26.2	28.0	(1.7)	34.8	36.7	(1.9)
Health care OOA	34.8	35.1	(0.3)	42.1	42.7	(0.6)
GG&C SLA	0.0	0.0	0.0	0.0	0.0	0.0
Social Care ISC	75.6	75.8	(0.2)	101.1	101.9	(0.8)
FHS	51.1	50.9	0.2	68.9	68.6	0.3
Commitments	(0.2)	0.0	(0.2)	38.9	35.8	3.0
Savings	(7.4)	0.0	(7.4)	(14.1)	(0.5)	(13.7)
Operational Income	(43.8)	(45.9)	2.1	(57.1)	(58.5)	1.4
Total	**483.3**	**494.2**	**(10.9)**	**678.3**	**692.3**	**(14.0)**

- Shown by subjective spend
- Medical pay has an overspend of £3.4m YTD overspend , other staff groups are bringing the total to £2.2m YTD overspend- £1.2m year end projection
- In non pay Clinical costs are the main driver with drugs and equipment being the main issues with a £1.9m projected overspend.
- Savings show £7.4m (9 months of £11.4)of savings outstanding YTD and £13.7m Forecast (£11.4m unplanned deficit and balance of delivery and workstreams)
- Over recovery of operational income of £2.1m

Savings Delivery

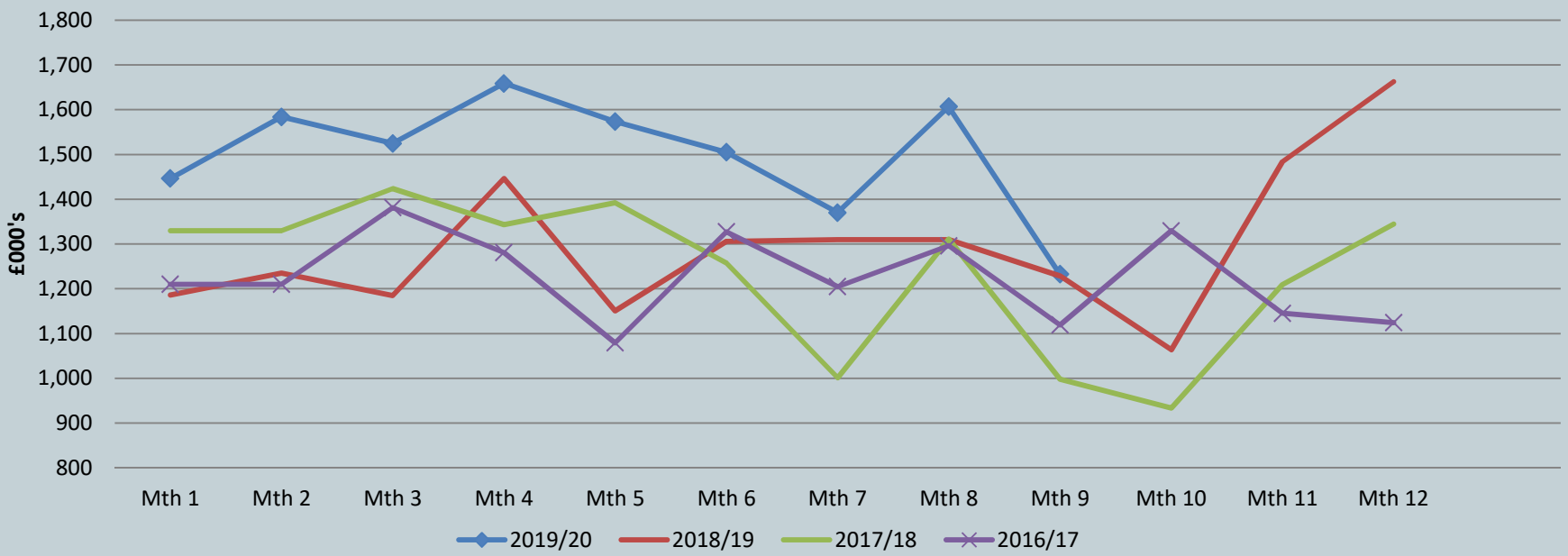
Savings mth 9	£m
NHS Highland Savings Target	**39.4**
Less Planned Deficit	**11.4**
	28.0
Less A&B	**6.0**
HHSCP Target to be achieved	**22.0**
Recurrent savings delivered & Forecast	**11.7**
Non Rec savings delivered and forecast	**7.8**
GAP to Target	**(2.5)**

Savings by unit

Workstreams	Delivered Recurrently To mth 9 £000's	Mths 10 - 12 £000's	Total £000's
South & Mid	445	280	725
North & West	213	87	300
Raigmore	1,170	451	1,621
Facilities	203	76	279
Tertiary	75	65	140
Central	1,995	332	2,327
ASC Central	488	312	800
	4,589	1,603	6,192
Houskeeping			
South & Mid	684	1,088	1,772
North & West	1,043	347	1,390
Raigmore	1,178	622	1,800
Facilities	139	46	185
Tertiary	56	19	75
ehealth	32	11	43
Central	75	157	232
	3,207	2,290	5,497
Rec Delivery	**7,796**	**3,893**	**11,689**

Non Rec Delivery	to mth 9	Mths 10-12	Total
South & Mid	1,500.0	190.2	1,690.3
North & West	247.8	47.5	295.3
Raigmore	713.7	316.5	1,030.2
Facilities	188.2	349.8	538.0
Central	2,997.6	1,225.0	4,222.6
	5,647	2,129	7,776

Locum spend



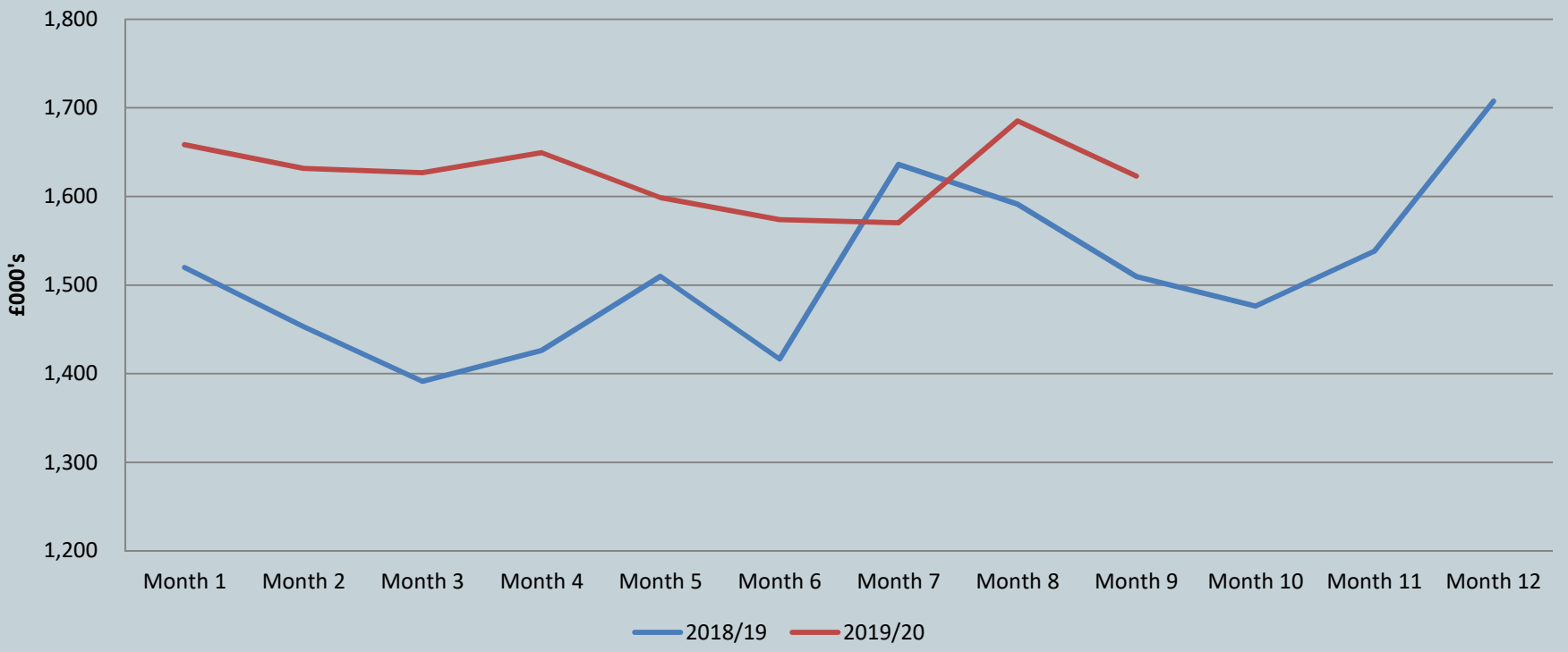
Spend of £10.2m to month 9 19-20 compared to £8.7m in 18-19 to month 9

2019-20 break down

Raigmore	£4.6m
S&M	£1.1m
N&W	£4.6m

Month 9 costs decreased by £450k

Supplementary staffing spend



2019/20 M9 costs of £1.62m - cumulative £14.62m
2018/19 M9 costs of £1.51 m -cumulative £13.45m

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 Thursday 7 November 2019 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:

Ann Clark, Board Non-Executive Director - In the Chair
Rhiannon Boydell, Mid Ross District Manager
Councillor Biz Campbell, Highland Council (from 1.10pm)
Dr Paul Davidson, Medical Lead
Frances Gordon, Head of Finance (South and Mid)
Deidre MacKay, Non-Executive Director
Philip MacRae, Board Non-Executive Director
Cllr Linda Munro, Highland Council
Adam Palmer, Employee Director
David Park, Chief Officer
Cllr Nicola Sinclair, Highland Council
Simon Steer, Interim Director of Adult Social Care (from 1.10pm)

In Attendance:

Gaye Boyd, Deputy Director of Human Resources
Manar Elkhazindar, Area Clinical Forum Representative
George McCaig, Performance Manager (from 2.00pm)
Brian Mitchell, Board Committee Administrator
Michael Perera, General Manager (Mental Health)(from 2.25pm)
Michael Simpson, Public/Patient Representative
Kenny Steele, CEO Highland Hospice (from 1.30pm)
Ian Thomson, Lead Social Work Officer (North and West)
Claire Wood, Associate AHP Director (Observing)

Apologies:

James Brander, Board Non-Executive Director
Dr Ann Galloway, Area Clinical Forum Representative
David Garden, Interim Director of Finance
Dr Ian Kennedy, Lead Doctor
Tracy Ligema, Head of Community Services

AGENDA ITEMS

- **Minute of Meeting of Finance & Performance Sub Committee on 26 September 2019**
- **Financial Position as at end September 2019**
- **Assurance Report from 4 September 2019**
- **Update on TTG/outpatient Performance**
- **Update on Summary Funding Agreement with Highland Hospice**
- **North Highland Workforce Report**
- **Minutes of Meetings of North Highland Local Partnership Forum held on 6 August and 10 October 2019**
- **Minute of Meeting of North Highland Health and Safety Sub Committee 11 September 2019**
- **North Highland Performance Reporting – Health and Wellbeing Balanced Scorecard**
- **Chief Officer's Reports**
- **NHS Highland Annual Operational Plan – Mental Health Update**
- **NHS Highland Winter Plan 2019/2020 Update**
- **Third Sector Funding Review**

DATE OF NEXT MEETING

The next meeting will be held on Thursday 6 February, 2020 in the Board Room, Assynt House, Inverness.

1 WELCOME AND DECLARATIONS OF INTEREST

At the commencement of the meeting a short Development Session was held to consider and discuss matters relating to the role and function of the Committee in providing appropriate assurance to the NHS Board. There was discussion as to the need for greater reporting on Workforce matters, Executive Director and other additional membership, and representation from the Executive Chief Officer for Health and Social Care in the Highland Council. . It was stated members should be empowered to raise relevant matters of concern during meetings, and with the Chair out with the regular meeting cycle. There was general agreement as to the need to review the existing Terms of Reference once the revised Partnership Agreement with Highland Council had been agreed. Issues relating to Workforce reporting would be considered in association with the Deputy Director of Human Resources as appropriate.

There were no formal Declarations of Interest made.

2 FINANCE

2.1 Minute of Meeting of Finance and Performance Sub Committee held on 26 September 2019

There had been circulated Minute of Meeting of the Finance and Performance Sub Committee held on 26 September 2019.

The Committee Noted the circulated Minute, taking relevant assurance from the same.	

2.2 Summary Financial Position as at end September 2019

F Gordon spoke to the circulated report advising as to the overall NHS Highland financial position, reporting a revenue budget overspend of £8.3m and a potential projected out-turn overspend of £25.2m, with £10.3m of required savings still to be delivered and potentially between £5m and £7m of operational pressures to be managed. She advised M Wilde and D Park were meeting with Divisions to discuss mitigation of current pressures. To date, progress had been made within South and Mid and similar activity would be undertaken within the North and West, and Raigmore divisions. D Park went on to advise as to the agreement reached in relation to the planned £11.4m year-end deficit and emphasised any additional operational deficit meant an associated increased savings target to achieve that year end position or additional mitigating measures to contain expenditure. He went on to reference the Adult Social Care budget and advised financial reporting was against the NHS Highland budget, not the level of funding received from Highland Council. Overall the relevant savings plan and cost pressures required to be successfully managed and additional savings remained to be identified. The two key messages at that time related to Operational efficiency and savings activity.

During discussion, relevant mitigating actions relating to cost pressures were welcomed and it was noted the NHS Board were sighted on this, with the potential for additional expenditure controls also being considered. On the point raised, in relation to the stated potential for 50% reduction of associated locum spend, it was advised more work was required in this area. Dr Davidson advised whilst this could be considered a ‘stretch’ target some real progress had been made in this area to date. It was confirmed recruitment to substantive Medical Staffing posts continued, with a number having recently been appointed. It was emphasised that no area could be considered exempt from review, with detailed consideration being given to every staff vacancy that arises. Relevant mitigation and escalation processes had been developed and were being applied. Cllr Campbell asked if the recommendations by Sir L Ritchie, in relation to redesign activity had resulted in

increased costs, and was advised this was the case. Discussion with Scottish Government had resulted in some extra funding having being promised but not yet received to reflect that additional cost burden.

Moving forward, it was confirmed consideration was being given to the financial position in 2020/2021, with recurring savings a continued focus for the NHS Board. Achieving increased efficiency and financial performance would remain a complex challenge. The Committee would continue to receive full updates on all relevant activity. Members agreed there was a need for a new Development session on Finance min order to better understand financial data and reporting.

ACTION: Agreed a Finance Development Session be arranged – **A Clark/D Park/D Garden**

After discussion, the Committee:	
• **Noted** the M6 year to date position of an £8.3m overspend on budgets, and a projected overspend of £25.2m.	
• **Noted** the forecast comprised £10.3m of unidentified savings.	
• **Noted** the proposed additional mitigating measures being considered by the Board.	

F Gordon left the meeting at 1.50pm.

3 PERFORMANCE AND SERVICE DELIVERY

3.1 Assurance Report from Meeting held on 4 September 2019

There had been circulated draft Assurance Report from the meeting of the Committee held on 4 September 2019.

The Committee Approved the circulated draft Assurance Report.	

3.2 Matters Arising

3.2.1 Update on TTG/Outpatient Performance

D Park advised activity remained a priority area of focus for the NHS Board, with all involved working to the detail of the Annual Operational Plan as submitted to Scottish Government. It was reported the associated September 2019 milestones had not been achieved, with an alternative plan having been agreed, again with Scottish Government with a view to bringing performance back to the original plan trajectory. Discussion was ongoing with all Specialties, supported by Government advice on relevant technical matters. It was stated, in order to bring performance in line with the original Plan trajectory by the end of the calendar year then further action would be required at a time of extreme pressure, especially within Raigmore. The three associated key risk areas were identified as being in relation to increased hospital demand and impact on hospital flow, changes to treatment profiles through planned service transformation, and vacancies within Medical staffing especially around single-handed services.

Noting the current position, the Chair took the opportunity to record her thanks to all staff involved in delivering services during an extremely challenging time and managing the associated demand levels being faced.

3.2.2 Update on Summary Agreement with Highland Hospice

D Park advised the Memorandum of Understanding referred to in discussion at the last meeting had related to Integrated Joint Boards rather than the Lead Agency model in

operation within North Highland. Further discussion with K Steele, CEO of Highland Hospice had resulted in the relevant funding stream having been agreed by both parties. K Steele confirmed the principles of the relevant CEL document that "Nothing is done to destabilise the current financial structure", were respected by the agreement referenced in discussion. Relevant legal requirements had also been met. He emphasised the importance of being able to work progressively together, in active mutual partnership, whilst recognising the relevant CEL legal framework.

3.2.3 Recruitment of Lay Representatives

The Chair advised that the initial recruitment exercise had attracted only one applicant. Further consideration was being given as to how to improve the level of interest in the role, with further recruitment activity to be undertaken in the New Year.

3.2.4 Self-Directed Support Update

The Chair advised an update had been scheduled for the April 2020 meeting.

3.2.5 Committee Action Plan

After discussion the Committee Administrator agreed to re-introduce the submission of a Rolling Action Plan for future meetings.

The Committee otherwise Noted the updates provided.

3.3 North Highland Workforce Report

G Boyd gave a presentation to members in relation to North Highland Workforce matters, advising a full North Highland written report was in development for submission to future meetings. She went on to present updates in relation to staff age profile and associated implications for future workforce planning; recruitment activity; hard to fill posts and associated national factors; planned work including on Modern Apprenticeships, youth employment, working longer, new and extended roles, and other associated initiatives. Further information was provided in relation to a reduction in staff turnover; use of Supplementary staffing; sickness absence and redeployment.

There followed discussion, during which there was recognition of the range of positive activity being undertaken in relation to risk areas such as Mental Health. On the points raised, G Boyd advised that in terms of turnover the figure quoted included those members of staff who had moved internally to other posts. The NHS Highland stability rate was comparable with similar NHS Boards in Scotland. To date, Brexit matters were having no material impact, with a recent questionnaire issued to EU nationals allowing for more personal contact with those staff members should that be required in future. C Wood emphasised the importance of 'grow your own' activity, with G Boyd agreeing that while there were positive examples of this in operation more would be required. The new NHS Highland Recruitment Strategy remained in development much of this was expected to be in place by the end of the current financial year. I Thomson advised the Trainee Social Work Scheme represented a successful example of the type of creative approach that can be undertaken in this area.

M Simpson referenced previous discussion around a UHI Carers Career path and was advised that a Carer's Academy approach was being actively considered. Any proposed changes around Carer activity would be undertaken in the context of associated service structure considerations. The Chair urged those present to not lose sight of the financial implications that may be associated with relevant activity. D Park went on to emphasise that a number of initiatives were either being considered or introduced at this time and advised a North and West Workshop Event, to consider relevant recruitment activity was being

developed in association with the implementation of appropriate mitigation activity. He stated there was a need to be flexible in how staff are both recruited and employed and emphasised that existing NHS Highland staff were often the best conduit to recruitment. The complex challenge being faced was recognised and no options were being rejected at this time. All agreed the need to work in partnership with other public agencies and communities wherever possible.

After discussion, the Committee Noted the presentation content.

3.4 Sub Committee and External Groups

3.4.1 Clinical Governance

There was no update provided to this meeting.

3.4.2 North Highland Local Partnership Forum

There had been circulated Minutes of Meetings held on 6 August and 10 October 2019.

3.4.3 North Highland Health and Safety Sub Committee

There had been circulated Minute of Meeting held on 11 September 2019.

The Committee Noted the circulated Minutes without comment.

3.5 North Highland Performance Reporting – Health and Wellbeing Balanced Scorecard

G McCaig introduced and spoke to the circulated report and Balanced Scorecard providing an update on progress against relevant performance indicators for services provided within Adult Social Care. It was further reported the Committee would, at future meetings, also receive a performance report in relation to the Annual Operational Plan which would include Operational feedback on the causes of variation and actions to address the same. Reports would be submitted to each meeting and would include performance data to the end of the previous calendar month. In addition, for each reporting cycle two or more performance areas would be examined in greater depth so as to give Committee members a deeper understanding of the issues within those areas. The AOP report would be expanded to include updates from Operational Services on the implementation of the AOP and enhanced detail regarding access waiting times. There were no plans to change the Health and Wellbeing Balanced Scorecard at that time.

There followed discussion, during which the Chair welcomed the proposed new reporting arrangements as a strengthening of the overall process for reporting and providing relevant assurance to the NHS Board. It was confirmed it would be for the Committee to identify those performance areas where receipt of greater detail and information was sought. The Chair sought further clarity in relation to both enablement and Guardianship and was advised there was a current focus on developing relevant Adult Support and Protection Plans. The matter of Guardianship was also being promoted more robustly, with the associated administrative burden involved being highlighted. Improvement was being evidenced in both these areas.

On the matter of re-ablement, it was advised there was mixed service provision at that time, with service redesign activity expected to improve existing efficiency levels. S Steer added the aim was to ensure a dynamic, responsive approach to re-ablement activity. I Thomson advised, in North and West, the model that had been adopted involved working with

Integrated Teams to maximise activity levels. This was one of a number of examples of strong joint working in that area.

After discussion, the Committee:

- **Noted** the content of the circulated report.
- **Noted** the new arrangements for the performance framework and reporting of performance information.
- **Noted** the Committee would receive, at future meetings, performance information relating to the implementation of the Annual Operational Plan.

The meeting adjourned at 2.45pm and reconvened at 2.55pm.

3.6 NHS Highland Annual Operational Plan – Mental Health Update

M Perera spoke to a circulated report providing updates on activity relating to significant changes introduced for Psychological Services across NHS Highland. Other updates were provided for General Psychiatry, Accident & Emergency, Custody Suites, GP Practices, Prison services and other settings. It was reported Dr P Davidson had been appointed Interim Medical Director for Mental Health. M Perera went on to highlight an improvement in Adult Psychiatry, advising that rotational assessment clinics had been established thereby enabling an appropriate treatment pathway to be defined and implemented. It was anticipated that a 0% waiting target would be achieved by December 2020. In addition, NHS Highland had become a test site for online CBT provision (TEC), the successful Tayside model relating to which was being introduced on a 24 hour a day basis. Near Me had also been successfully introduced for Psychology Services.

Other activity highlighted had included the introduction of Did Not Attend (DNA) appointment contracts with clients, which included a service cut-off date should clients not turn up for agreed appointments. The introduction of monthly scrutiny meetings in association with both CAMHS and Scottish Government colleagues had begun to have a positive impact. A 50% rise in General Psychology referrals over the previous five years had led to an RPIW Event being undertaken, leading to identification of a number of improvement initiatives to be introduced prior to consideration of the need for an additional Consultant Clinician. It was reported there had been a recent downturn in performance relating to Drug and Alcohol Services, although overall performance remained above 80%. Current inpatient levels at New Craigs were being impacted by staff shortages, with existing staff providing an excellent service at a challenging time which had resulted in reductions in both the length of stay and re-admission rates. It was highlighted that over 9,000 people in Highland were suffering from some form of Dementia and it was anticipated this would place increasing demand on inpatient services. Interviews were to be conducted for a Custody Services Clinical Lead. Most activity relating to ligature risk mitigation had been undertaken, with further guidance awaited with regard to windows and doors etc.

During discussion, and referencing a recent successful Mental Health Nurse Event, A Palmer sought an update on activity aimed at relevant redesign activity to mitigate the current concerns relating to recruitment and retention of RMNS staff. M Perera emphasised the need for appropriately trained Medical and Nursing staff and highlighted the crucial role played by the Third Sector in this activity area. There was need to maximise existing community resource. Work was ongoing, in association with UHI/NES, to ensure the training of multi-skilled nursing staff. There were 32 Registered Nurse vacancies within New Craigs at the time of the meeting. In addition, a number of existing staff members were working toward obtaining relevant qualifications and this formed one element of a range of interventions aimed at ensuring higher levels of staff retention. D Park took the opportunity to formally recognise the exceptional manner in which relevant staff groups were working

together to improve the outcomes for patients following previous Value Management/Service Redesign activity.

The Committee otherwise Noted the Mental Health Service update.

M Perera left the meeting at 3.25pm.

3.7 Chief Officer's Reports

D Park spoke to the circulated report which provided an overview of Operational activity across North Highland, highlighting areas of focus for improvement as well as areas of further opportunity. Updates were provided in relation to People (Recruitment and Selection and Sickness Absence), Quality and Safety (Improvement Activity), Waiting Times (Psychology), Care (Adult Social Care, Mental Health & Learning Disabilities and Drug & Alcohol Recovery, Out of Hours, Primary Care Services, Midwifery – Community Midwifery, Highland Sexual Health, Technology Enabled Care and Prison/Custody Services) and Service Redesign. Members were advised NHS Highland had intervened in relation to Elmgrove Nursing Home in Inverness, a third party facility, with all residents having been placed in alternative accommodation. Staff had provided exceptional support to residents and their families at an extremely stressful time, with families in turn valuing the input NHS Highland had provided.

During discussion, a request was in relation to the potential for introduction of the Raasay Care at Home model in Sutherland. In response, D Park gave an outline of what the Raasay model entailed in terms of ensuring relevant accommodation, staffing skill mix etc, and advised the model in question had been considered appropriate for this particular case. A Palmer advised the outcome of an application for introduction of a Recruitment Retention Premium was awaited. A question was raised as to the level of Delayed Discharges as at the date of the meeting and in response D park advised he would provide a full report to the next meeting outlining recent, positive change and recruitment activity. The Chair welcomed a future report on this area, noting this provided a clear example of the need for future reporting to be continuously reviewed to ensure relevant service and activity linkages were clear to members.

ACTION: Agreed full report on Delayed Discharge activity be submitted to the next meeting – **D Park**

The Committee otherwise Noted the detail of the Chief Officer's report.

3.8 NHS Highland Winter Plan 2019/2020

K Sutton spoke to the Committee and advised that a draft Winter Plan had been developed, with relevant additional funding allocated to a range of service areas following consultation with relevant colleagues and groups. With agreement that funding be allocated to Community Care activity, Chris Arnold (Flow Manager) was considering aspects relating to Social Care capacity in relation to Care at Home. The aim was to ensure more people were in the right place to receive the right care, and work was ongoing in this regard to ensure appropriate wraparound care provision. Discussion was ongoing with relevant Allied Health Professionals and Community Nursing colleagues. All involved to date had positively embraced the challenge presented.

K Sutton went on to advise that in terms of further developing the North Highland element of the Winter Plan, the GP Services element had yet to be defined but would be included within the final version. The initial indicative Plan had received a range of feedback, with this in the process of being considered in greater detail. Development of the Plan was therefore

ongoing at that time, with whole system working at the heart of all considerations. In terms of achieving the Government's 95% Emergency Department target level, it was emphasised that this was in the context of constantly increasing demand from patients with ever more complex conditions. There were a number of challenges to be met.

On the point raised in relation to the level of additional funding received, K Sutton advised NHS Highland could always find areas in which to apply further resource. She emphasised that any service transformation activity would take time to introduce and feed through in terms of efficiency, had to recognise patient needs as being at the heart of any change being considered and represented a key organisational aim.

L Munro referenced the Social Care Rapid Response Team and sought clarification as to the associated impact on other services and how relevant staff had been identified and engaged. K Sutton advised the first step had been to define the greatest area of need and this had been identified as being medical patients within the Inverness/Raigmore Hospital catchment area. A focus on Inverness had helped enable the creation of the Rapid Response Unit (RRU). In association with this, Chris Arnold had been working with relevant providers and they in turn had responded positively to the change. She went on to advise that the approach taken had differed from that before insofar as this had been based on a more predictive model, thereby enabling future capacity to respond to unexpected surges in demand. There was confidence the new model would be successful in driving associated service improvement. R Boydell added that in addition to the changes reported, a new Care at Home model would be required that involved staff being trained and qualified to a higher level than at that time. D Park confirmed service providers were in agreement with the approach being proposed and reiterated that, if successful, all this activity would release capacity within Raigmore Hospital. A test of change approach would be required

ACTION: Agreed a further update be brought to a future meeting – **D Park**

The Committee otherwise Noted the position in relation to development of the NHS Highland Winter Plan 2019/2020.	

K Sutton left the meeting at 3.50pm.

3.9 Third Sector Alignment, Sustainability and Collaborative Commissioning Plan 2018-2021

R Boydell spoke to the circulated report outlining progress on the review and development of the Third Sector Alignment, Sustainability and Collaborative Commissioning Plan. It was reported a contract had been awarded for Professional Advocacy services with effect from 1 October 2019. A further tender exercise was to be conducted for the provision of Independent Collective Advocacy, with the existing contract extended to 31 March 2020 to allow this to take place. A new funding application process had been established for those Third Sector providers seeking funding below £50k pa, and as at the relevant closing date some 66 applications had been received, representing four times the available resource. As such the Project Team had developed evaluation documentation and a three step evaluation process which had led to the agreement to fund a total of 26 providers, at a total spend level of £520,813.98 to 31 March 2021. A further 11 applications were to be considered as part of the process for funding above £50k pa. The Project Team had continued to liaise with the Public Relations and Engagement Team throughout the process. In terms of those providers seeking funding above £50k pa, notice had been given that existing contracts would be extended to 30 June 2020, to allow for a full strategic review. Agreement had been reached that all contracts in this category would be reviewed by end November 2019, with relevant Service or Locality Leads making relevant recommendations or decisions based on that review process. A Panel, formed by the Chair of the Project Board would have final

oversight of the intended outcome of the review, with final findings/recommendations the n reported to the Project Board.

D Park advised feedback received from the Sector, relating to the timing of awards, had led to agreement that where a funding stream was to be amended then improved communication would be at a much earlier stage in the process to provide sufficient Notice for providers to adequately plan their respective business models. It was acknowledged that the process for under £50k pa had been more complicated and challenging than anticipated, leading to some delays. D Park and R Boydell would shortly be attending a meeting with the sector. Those present stated they wished to record their thanks to J Paterson, and those further involved in supporting the positive and successful, revised process.

The Committee Noted the position.	

4 HEALTH IMPROVEMENT

There were no matters discussed in relation to this Item.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Future Meeting Schedule

The Committee **Noted** the following meeting schedule for 2020:

6 February
9 April
11 June
13 August
8 October
10 December

6 FOR INFORMATION

There were no matters discussed in relation to this Item.

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on 6 February 2020 in the Board Room, Assynt House, Inverness.

The Meeting closed at 4.00pm

FOLLOW UP FROM HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE ACTION PLANS – MARCH 2018 ONWARDS

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

	Item	Action / Progress	Lead	Outcome/Update
01/03/2018	**Sub Committee Terms of Reference**	Terms of Reference for Finance and Performance Sub to be finalized and approved at Committee (management action from internal audit report) Clinical Governance Sub Committee on hold	**A Clark/D Park**	February 2020
01/03/2018	**Health and Wellbeing Outcomes data - Sepsis**	Agreed that existing reporting arrangements be clarified. Is SEPSIS still a key objective for NHSH/national? Summary report on outcomes of improvement activity to date?		
01/03/2018	**Place of Care Strategy**	Report on progress to future committee	**S Steer**	July meeting?
08/03/19	**Integration Self-Assessment and Action Plan**	Draft self-assessment for submission to SG and action plan	**S Steer**	May
15/01/2019	**Care Academy Development**	Agreed progress report on development of a Care Academy be submitted to a future meeting.	**S Steer/I Thomson**	Future Meeting
08/03/2019	**Sutherland Drug and Alcohol Outreach Officers**	Agreed to clarity position.	**Public Health**	May 2019 Meeting
08/03/2019	**Mental Health Staffing**	Issue of Pay banding to be taken to Staff Governance Committee.	**D Park/M MacRae/ B Mitchell**	Staff Governance Committee
08/03/2019	**North Highland Staff Recruitment**	Agreed detailed report be submitted to a future meeting.	**D Park/G Boyd**	Future Meeting
04/07/2019	**Implementation of the Carers (Scotland) Act 2016**	Agreed detailed report, including financial aspects, be submitted to the next meeting and Carers' Representatives be invited to attend.	**S Steer**	February 2020
04/07/2019	**Commissioned Care at Home Service Fees**	Agreed report on discharge planning/care provision activity be brought to a future meeting.	**S Steer**	Future Meeting
04/07/2019	**North (Sutherland) Coast Redesign**	Agreed further update on progress be provided to the November 2019 meeting.	**M Johnstone/ C Nicolson**	November 2019
04/07/2019	**Primary Care Modernisation Implementation**	Agreed an update on Mental Health Service aspects be submitted to the November 2019 meeting.	**R Philip/ E Beswick**	**COMPLETE**
04/07/2019	**Primary Care Modernisation Implementation**	Agreed further detail be provided in relation to Pharmacotherapy spend.	**R Philip**	September 2019

04/09/2019	**Summary Financial Position**	Agreed consideration be given to receiving a wider Workforce report to the next meeting.	**G Boyd**	**COMPLETE**
04/09/2019	**Summary Financial Position**	Agreed any comments on revised report format be relayed to Committee Administrator.	**ALL**	**COMPLETE**
04/09/2019	**Clinical Governance**	Agreed detailed report relating to ASC Clinical and care Governance matters be submitted to a future meeting.	**S Steer**	Future Meeting
04/09/2019	**New Craigs Reconfiguration Activity**	Agreed consideration be given to future North Highland workforce reporting requirements.	**D Park/G Boyd**	**COMPLETE**
04/09/2019	**Children's Services Reporting**	Agreed to discuss relevant matters with newly appointed Executive Officer for Health and Social Care (Highland Council)	**A Clark/D Park**	
04/09/2019	**Health and Safety Update**	Agreed Sub Committee Terms of Reference be submitted to an early meeting.	**B Summers/ B Mitchell**	Future Meeting
04/09/2019	**NHS Highland Annual Performance Report 2018/19**	Agreed data relating to Outcome 8 be further scrutinised for accuracy.	**S Steer**	
04/09/2019	**Palliative Care Services – National Memorandum of Understanding between Integrated Joint Boards and Scottish Hospices**	Agreed D Park and K Steele further discuss the MoU prior to making a final recommendation to the Committee at the next meeting.	**D Park/K Steele**	**COMPLETE**
04/09/2019	**Chief Officers Report**	Agreed the Infection Control Manager be invited to address a future meeting in relation to Infection Prevention and Control activity.	**C Stokoe/B Mitchell**	Future Meeting
04/09/2019	**Chief Officers Report**	Agreed matters relating to patient personal management be discussed further with Clare Morrison.	**D Park/A Galloway**	
04/09/2019	**Chief Officers Report**	Agreed consideration be given to inviting C Morrison to address a future meeting on Near Me.	**A Clark/D Park**	Future Meeting
04/09/2019	**Chief Officers Report**	Agreed an update on SDS activity be brought to a future meeting.	**D MacKenzie**	Future Meeting
04/09/2019	**NHSH Annual Operational Plan**	Agreed to defer consideration of the AOP document to the next meeting.	**B Mitchell**	November 2019
07/11/2019	**Summary Financial Position**	Agreed to hold a new Development Session on Finance.	**A Clark/D Park/ D Garden**	Future Meeting
07/11/2019	**Committee Rolling Action Plan**	Agreed the Committee Administrator re-introduce submission of Rolling Action Plan for meetings.	**B Mitchell**	**COMPLETE**

07/11/2019	**Chief Officer's Reports**	Agreed full report on Delayed Discharge activity be submitted to the next meeting.	**D Park**	February 2020
07/11/2019	**NHSH Winter Plan 2019/2020**	Agreed a further update be brought to a future meeting.	**D Park/K Sutton**	Future Meeting

Flow Activity Update Report to Highland Health and Social Care Committee 5th February 2020

This report provides an update to the Highland Health and Social Care Committee on the Flow work stream and activity as presented to the Committee in September 2019.

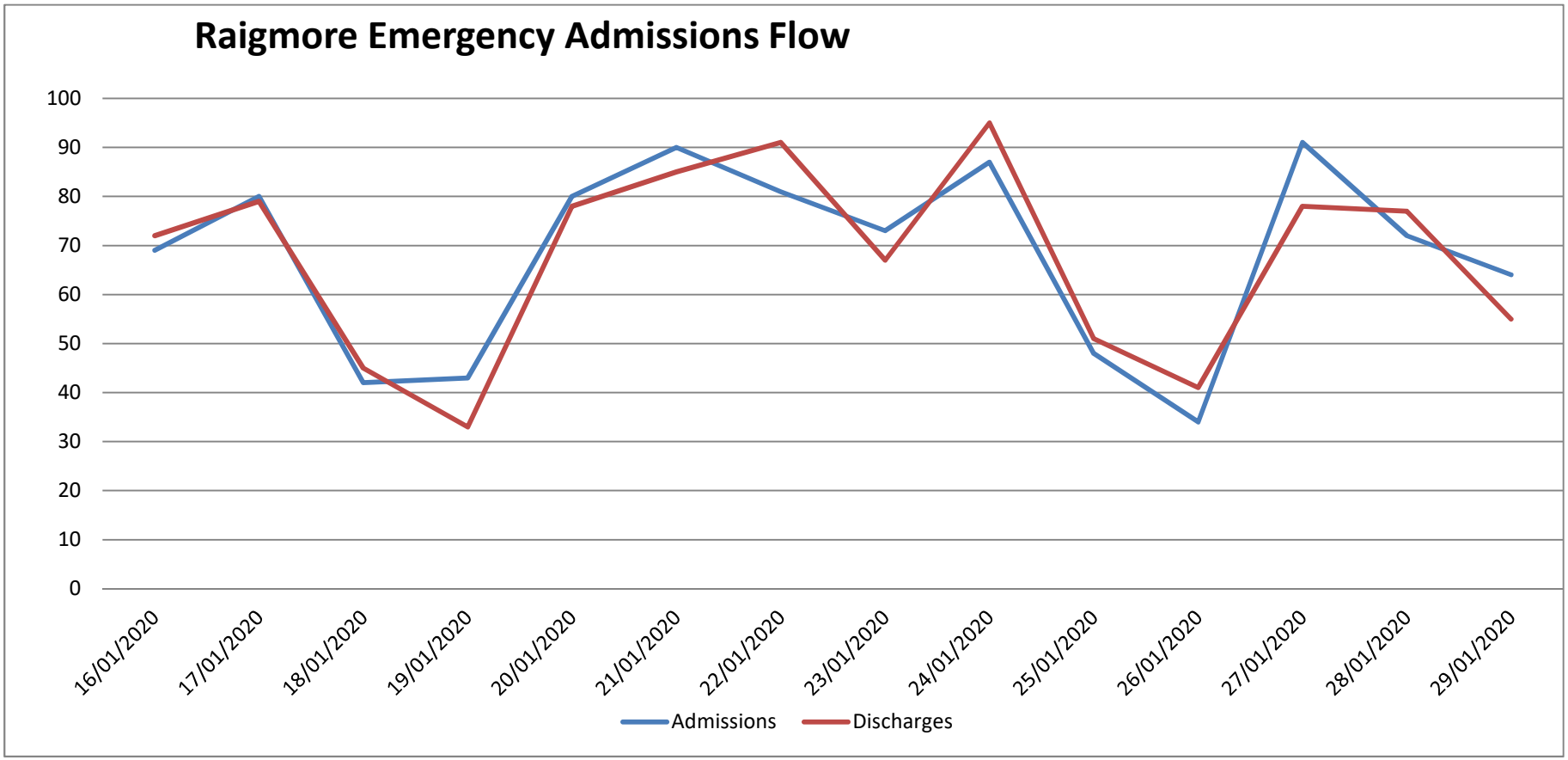
Background

A Flow Manager and team were established during 2019 with the purpose of providing a strategic overview of flow across the acute and community divisions., identify areas for improvement and provide focussed assistance to improve flow.

The Winter Plan for 2019/20 identified a requirement for increased community capacity and the Flow Manager has led on the implementation of the Enhanced Recovery Service to meet this requirement. This service began in mid-December 2019 and has consisted of enhanced care at home delivered by the independent sector.

Current Situation

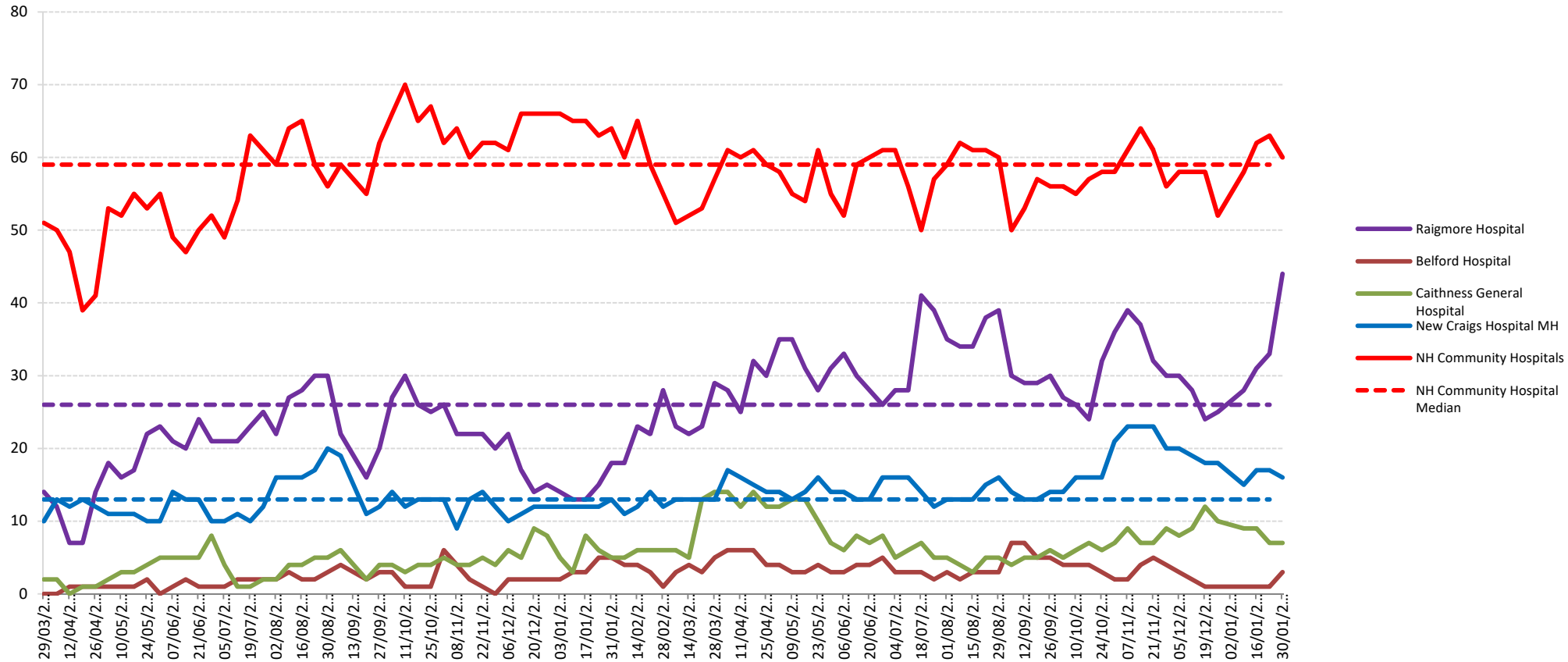
Flow over the last two weeks has been in line with previous flows, we see discharge and admission very closely related with drops in both rates at each weekend. Flows for admissions and discharges have been in line with the expected average.


Raigmore Emergency Admissions Flow
100
90
80
70
60
50
40
30
20
10
0
16/01/2020
17/01/2020
18/01/2020
19/01/2020
20/01/2020
21/01/2020
22/01/2020
23/01/2020
24/01/2020
25/01/2020
26/01/2020
27/01/2020
28/01/2020
29/01/2020
Admissions
Discharges

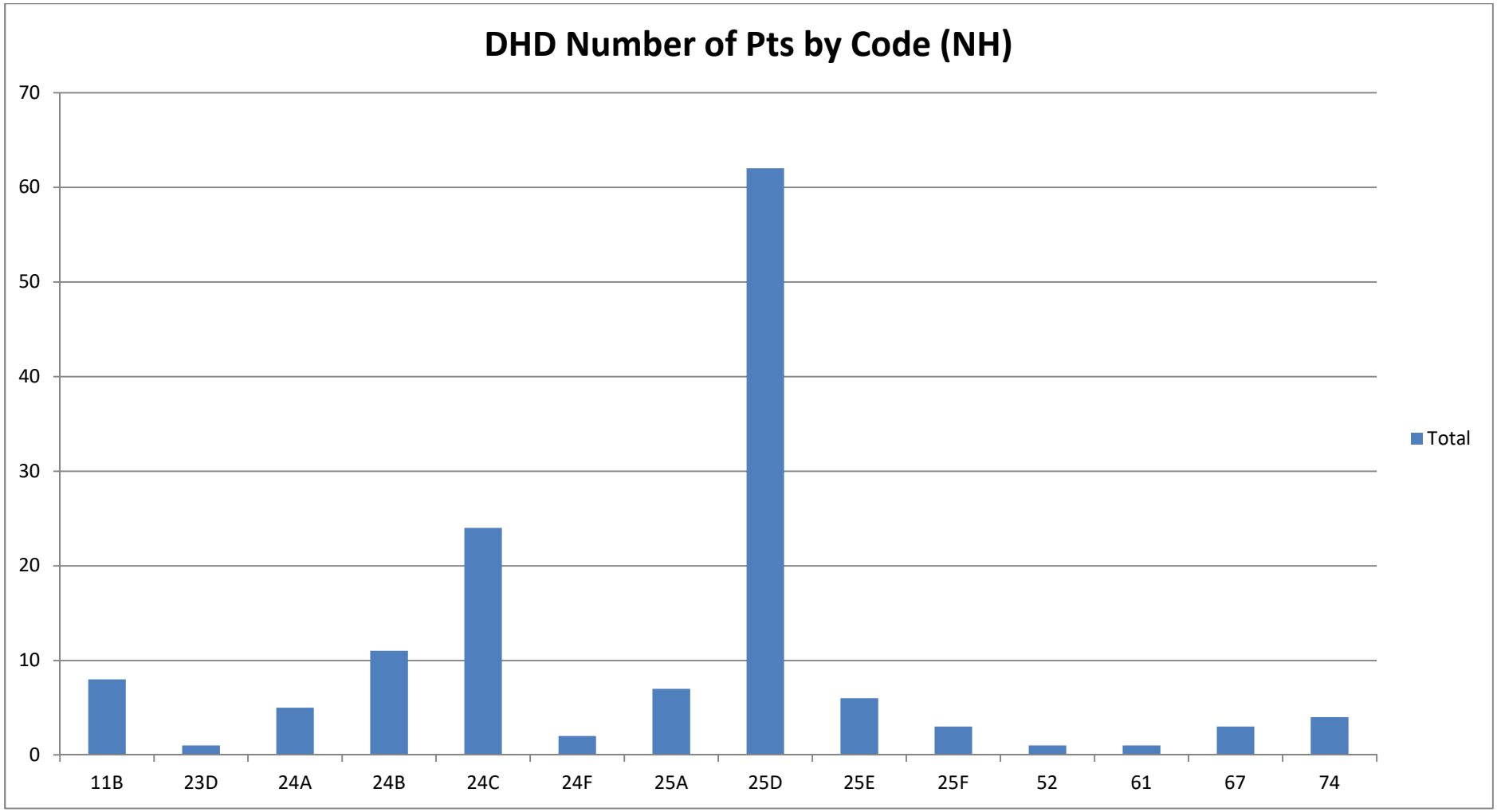
Number of Delays per Hospital Site/Group

Source: TrakCare PMS

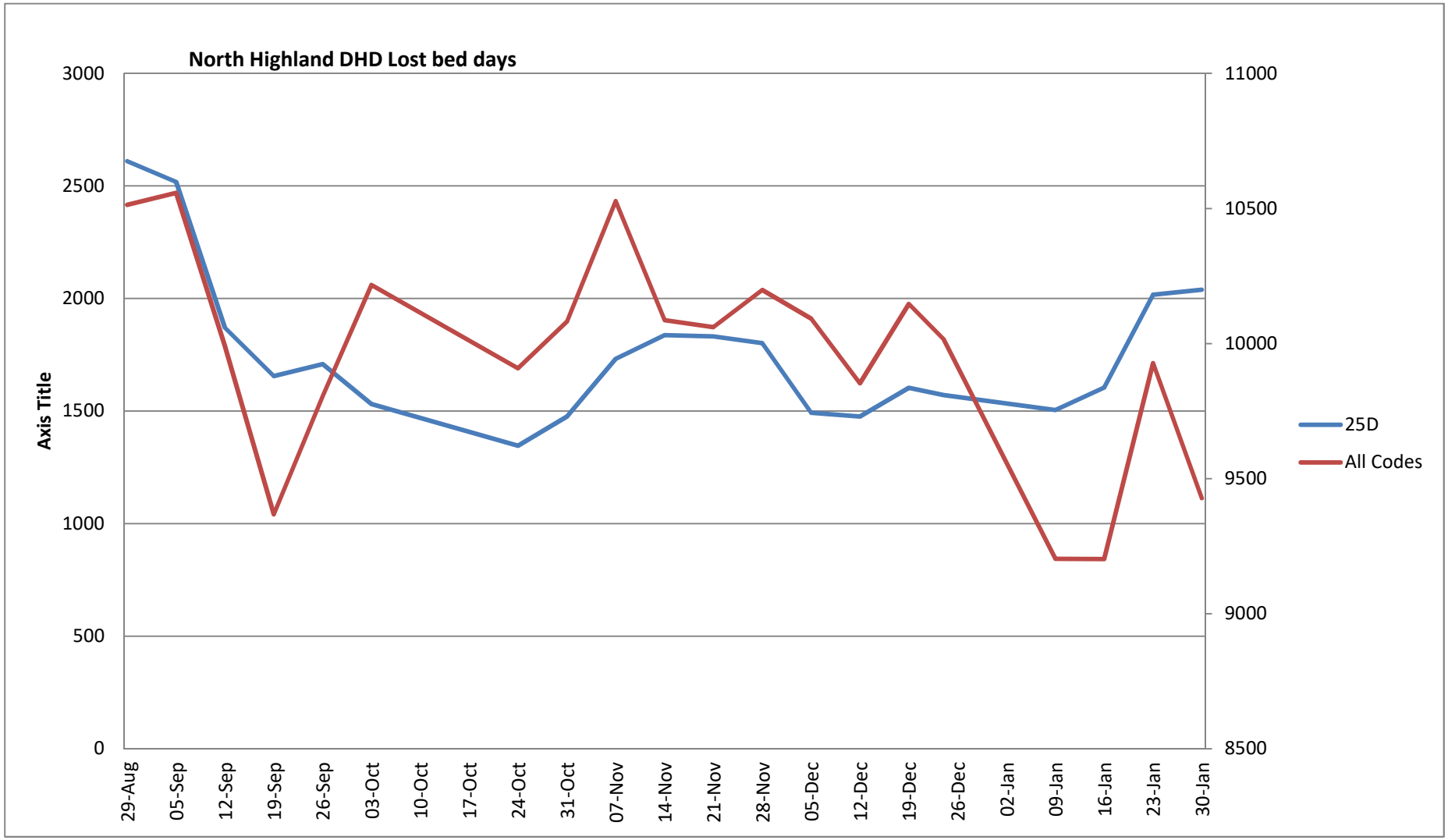
Census point: Weekly on Wednesday, as per chart axis



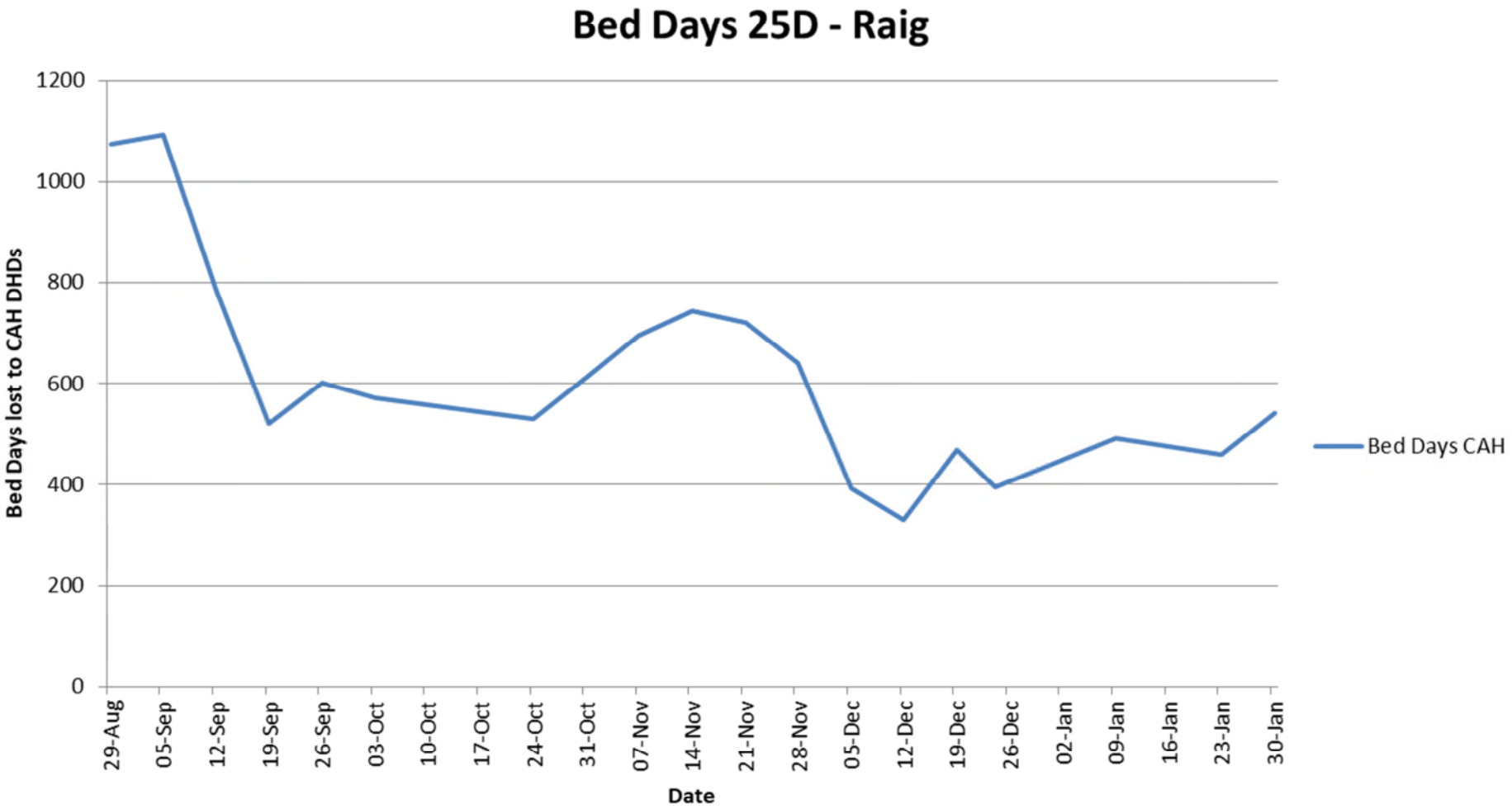
We can see that across (NH) 25D codes (Arrangements for living at Home) account for a significant majority of the delayed patients.



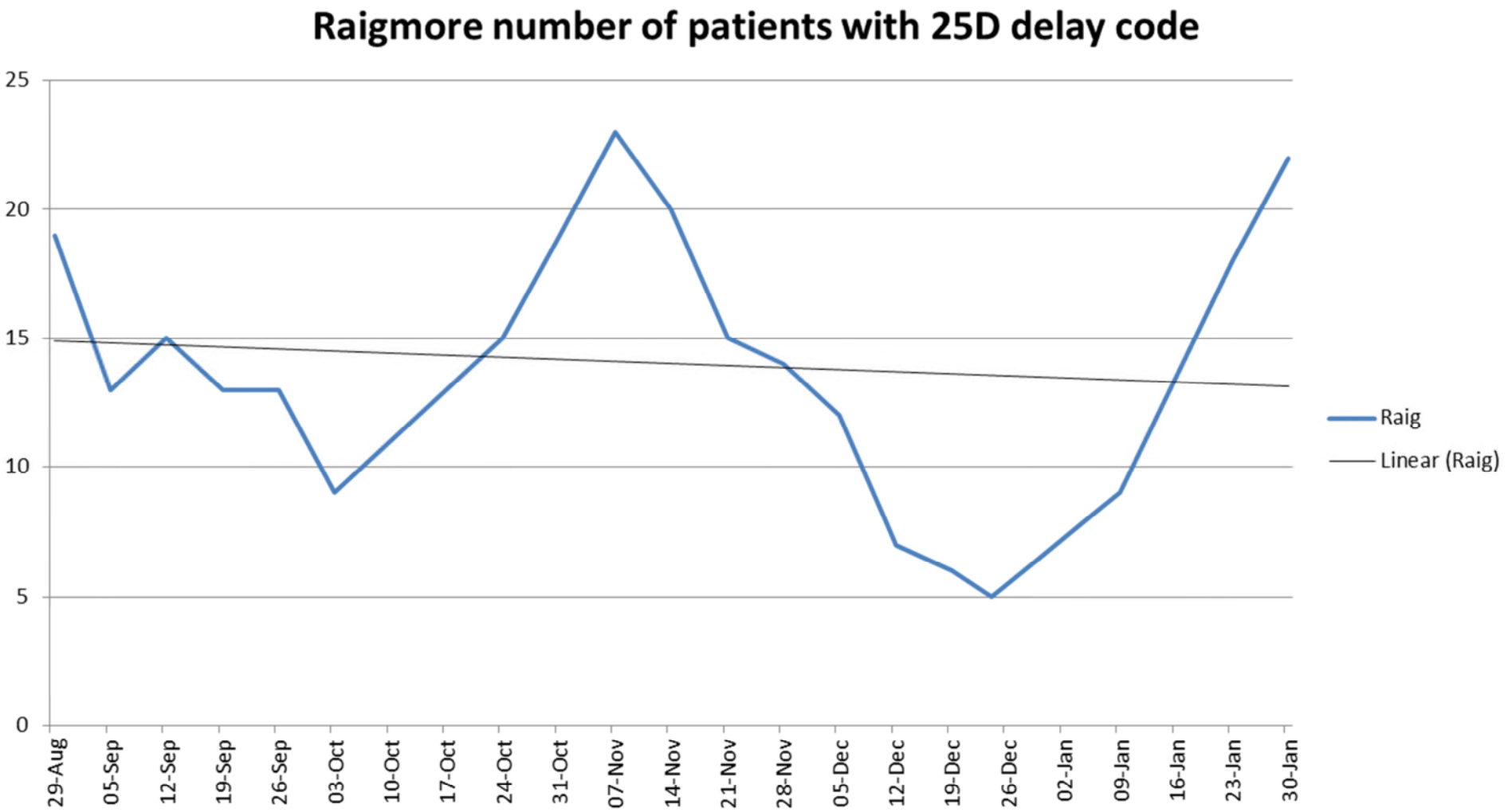
Lost bed days across North Highland are still showing improvement for all delay codes even against the increases seen with the 25D codes


North Highland DHD Lost bed days
Axis Title
3000
2500
2000
1500
1000
500
0
11000
10500
10000
9500
9000
8500
29-Aug
05-Sep
12-Sep
19-Sep
26-Sep
03-Oct
10-Oct
17-Oct
24-Oct
31-Oct
07-Nov
14-Nov
21-Nov
28-Nov
05-Dec
12-Dec
19-Dec
26-Dec
02-Jan
09-Jan
16-Jan
23-Jan
30-Jan
25D
All Codes

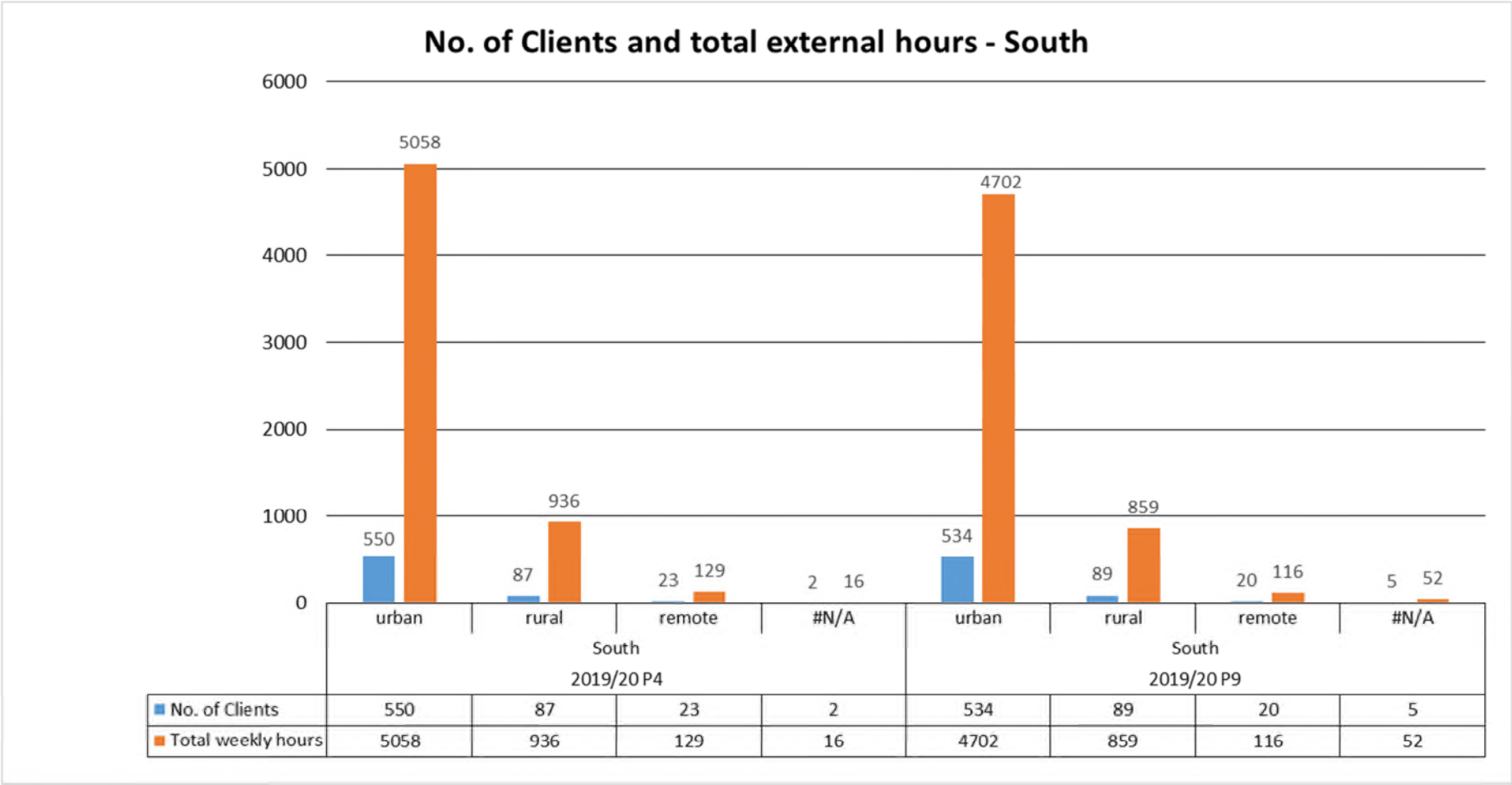
At Raigmore we have still seen and maintained significant improvement in Bed Days lost to 25D delays since August 2019



At Raigmore we are seeing increases again against the total number of individuals delayed with a 25D code and early indications of a pattern are emerging

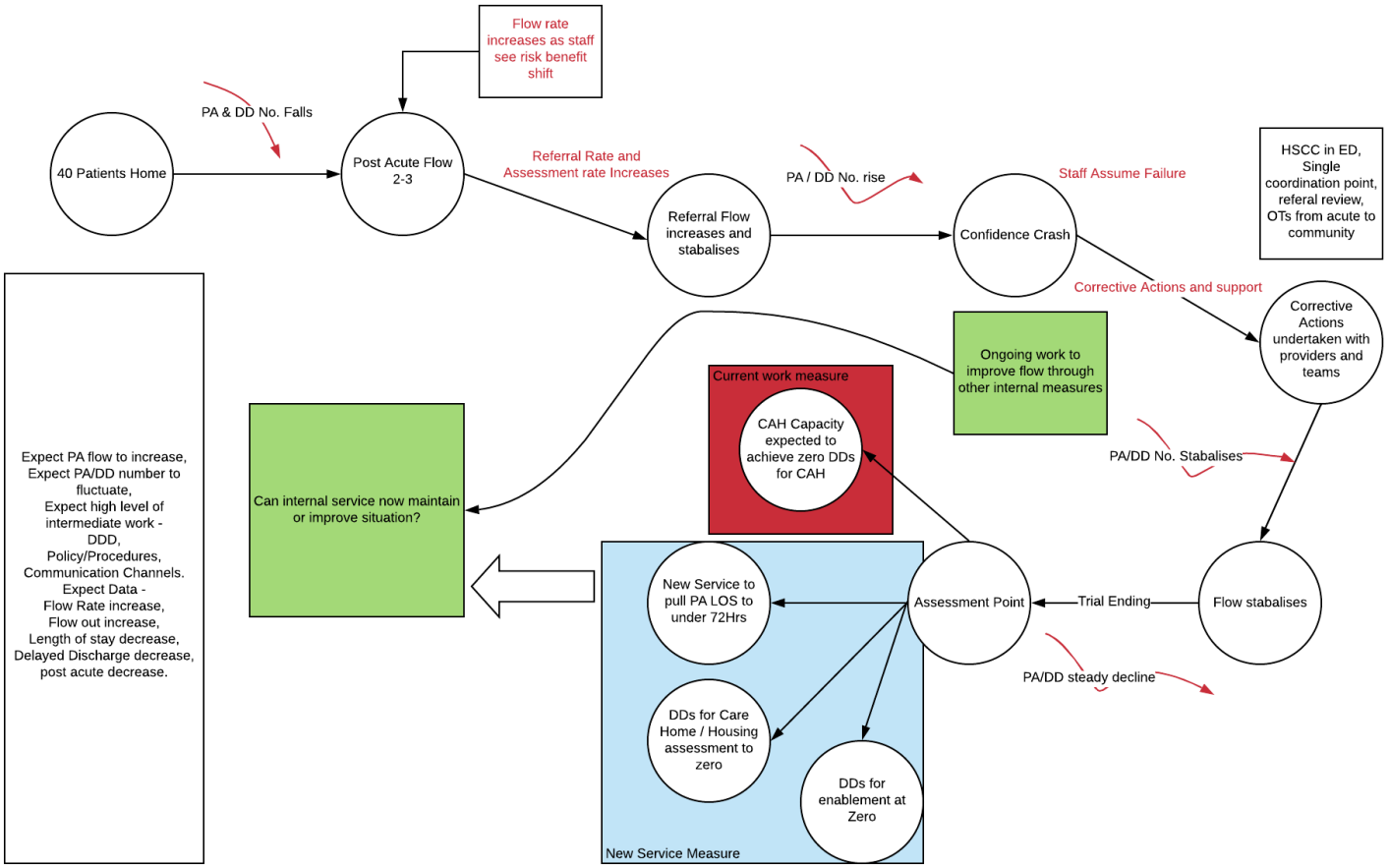


The emerging pattern is associated with a recent downturn in total care at home independent sector size locally - between periods 4 and 9 of 2019/20



	South 2019/20 P4				South 2019/20 P9			
No. of Clients	550	87	23	2	534	89	20	5
Total weekly hours	5058	936	129	16	4702	859	116	52

As part of the project plan for the Enhanced Recovery Service we documented and noted that we expected to see an improvement in DHD numbers followed by an increase in the potential there for a confidence crash.
We are 1 month into the new service model and suspect we are in this phase and so in line with the initial plan presented in September and shown below we are working to correct issues.



Actions

- Enhanced Recovery Service
  - Develop the ERS model to support further discharges across a wider geography.
- Discharge Hub
  - Development of a discharge hub/unit for a tasked focus approach
- Care Home coordination
  - Develop a single point of contact and coordination for all care home admissions
- Recruitment and retention
  - Work with the local independent sector to support improvement of recruitment and retention, this will be developed alongside the nation campaign for working in care
- Path Home Policy
  - Development and rollout of a new policy for the focus on supporting individuals home from supported environments.

IMPLEMENTATION OF THE CARERS (SCOTLAND) ACT 2016
Report by the Chair of the Carers Improvement Group and the Lead Social Work Officer (NHS Highland, North and West)

The Committee is asked to:

- **Note** the outline for progressing a 'Carers Programme'
- **Note** the steps proposed to bring together comprehensive Carers Strategy
- **Note** the outline of a development of a 'Carers Programme Budget'
- **Agree** the expenditure necessary to implement 3 carers services pilots
- **Agree** the high-level profile to direct a tender for high-quality and effective carers services in Highland
- **Note** the work being undertaken to comply with full range of duties contained in the act
- **Agree** the proposals to progress the recruitment a Carers Practice Development Officer

1. **Background**

1.1. The Carers (Scotland) Act 2016 introduced new rights for unpaid carers and duties for local councils and the health boards to provide support to carers. Key among these are:

- Section 6 – a new duty on local authorities to prepare an Adult Carer Support Plan (ACSP) for anyone they identify as a carer, or for any carer who requests one.
- Section 12 – a new duty on local authorities to prepare a Young Carer Statement (YCS) for anyone they identify as a young carer, or for any young carer who requests one.
- Section 21 – a duty on local authorities to set local eligibility criteria for carer support
- Section 24 – a duty on local authorities to provide support to carers that meet local eligibility criteria
- Section 25 – a duty on local authorities to consider options of breaks from caring when undertaking support planning.
- Sections 27 to 30 – a requirement that local authorities and health boards involve carers in carers' services, and to involve carers in hospital discharge planning.
- Sections 31 to 33 – a requirement that local authorities and health boards prepare publish and review a local carer strategy, including what that strategy must set out.
- Section 34 – a duty on local authorities to establish and maintain advice and information services for carers.
- Section 35 – a duty on local authorities to produce a short breaks services statement

2. **Bringing together a Carers Programme**

2.1. Work is now underway in Highland to develop a 'carers programme' aimed at systematically meeting our duties under the act. The appointment of a new Chair of the Carers Improvement Group complemented by the recruitment of a Carers Services Development Officer (CSDO) should provide significantly increased capacity to co-ordinate and realise a coherent approach to:

- Developing a comprehensive Carers Strategy which fully includes carers in its development;
- Outlining a 'carers programme budget' which will support the establishment of high-quality and effective carers services in Highland;
- Supporting local initiatives to increase access to practical help for carers in the short-term
- Specifying and tendering for the types of services that carers tell us they want, and which meet our duties to provide: advice and information; Adult Carer Support Plans (ACSPs); support for carers - including to access a range of short breaks;
- Bringing together a Short Breaks Statement which fully aligns to Highland's strategic direction for carers; and
- Meeting our duty to waive charges for services for carers;

3. **Preparing a Carers Strategy**

3.1. Under Sections 31-33 of the Act, NHS Highland and Highland Council have 'a duty to prepare, publish and review a local carer strategy'. This needs to be a fully consultative and collaborative piece of work, and will be led by the Carers Services Development Officer. It is envisaged that we will develop a set of short-life working groups to ensure all aspects of the strategy are covered, and that there is a clear carer and operational voice throughout the document. It is noted that this work is currently behind the initial implementation timescales - however to ensure that a new strategy (which will last for three years) is properly focused in identifying and meeting the needs of Highland carers, time to effectively complete this work with carer involvement is required. The proposed short life groups would cover:

- Carers and Employment
- Hospital Discharge Planning
- Breaks from Caring
- Promoting Health and Well-being; and
- Transitions pathways for young carers

3.2. It is proposed that the short life working groups will be made up of a mixture of carers, representatives from carers services and operational staff from NHS Highland (representing adult services) and Highland Council (representing young carers). They will meet regularly between February and April to develop a draft strategy followed by workshops across Highland between April and June to consult with carers at local level for 'lived experience' input into the draft strategy. Planned publication of the document is August 2020.

4. **Understanding resources available; setting out a carers programme budget**

4.1 Current Expenditure in respect of Carers, 2019-20 is as follows:

- Traditional "respite" services (a significant portion of which is understood to be 'services for carers') are currently commissioned as: Home based Respite and Residential Respite (in both in in-house and in independent sector Care

Homes). Taken together the expenditure for these services for adult carers will be circa £1.88m.

- Connecting Carers are also commissioned to provide services to carers. These services comprise: Carers Advocacy; services to young carers (commissioned separately via The Highland Council); Carers Link Workers (including the completion of ACSPs), and the provision of information and advice. Taken together the expenditure for these services will be £0.65m.
- In addition to the services above there is also current expenditure in respect of the new CSDO and in respect of Befriending services. Taken together this expenditure is expected to amount to less that £0.05m.

4.2 The implementation budget for 2020-21 for adult carers is as follows:

- Total Resource available for the implementation of an adult carers programme is £1.80m (this is made up, in part, from £0.85m passed over from THC for adult carers as part of an overall grant settlement, (this agreed amount is not uplifted annually), and £0.95m of identified, additional NHSH funding).
- Current commitments remain in relation to our existing services for carers (Connecting Carers etc.) until new services are tendered for.
- Commitments and in relation to the posts of Carers Services Development Officer and Carers Practice Development Officer (see section 7 below) are anticipated.
- Projected short term expenditures: Pilots are proposed (see section 5.2 below) which would be understood to use available budget.
- Projected long term expenditures: Tendered services for carers (from circa December 2020) will be able to use the available identified budget. An *indicative* breakdown is given below:

2020/21 Programme Budget **Carers Act - post tender**	
Information and Advice (inc 'SB Bureau')	150
Carers Link Workers (ACSPs) + Reactive Supports	1100
Carers Services Development posts	100
SDS Options (Planned Supports)	300
Other (Advocacy, Waiving charges etc)	150
Total	**1800**

N.B. Existing 'respite' expenditure is not included in the 2020-21 budget given above. Therefore steps need to be taken to rationalise the budget for all services to carers (as far as possible) within a Carers Programme Budget. The aim will be to ensure that all commissioned services are then shaped to meet, as fully as possible, the needs of carers.

5. Developing a new range of services for carers in Highland

5.1. A Project Team (which includes a carers representative from the CIG) have set out the proposed **service characteristics** for services for carers:

- Provide highly reactive practical supports to help carers at times of particular stress;
- Link carers to their local communities; and the sources of support they contain;

- Prevent carer breakdown and obviate the need for more formal services to the cared for person (including admission to residential care or hospital);
- Support carers when the person they care for is being discharged from hospital;
- Offer a range of planned 'short break' alternatives which are attractive and/or acceptable to both carers and the cared-for;
- Provide carers with the practical skills they need to manage their caring role; and
- Provide information and advice for carers which allow them to make informed choices about their role and supports decision-making in line with self-directed support principles.

Services commissioned for carers will also need to ensure they:

- meet our duty to provide an Adult Carer Support Plan and Young Carers Statements for those carers who wish one;
- provide information and advice to carers including at the time of hospital discharge;
- provide appropriate support after consideration of carers eligibility criteria; and
- involve carers in shaping how supports and services are delivered.

5.2. Responding to local initiatives

Developing services to comply with the duties of the Act and ensuring we adequately support carers in their caring roles is fundamental to improving the position of unpaid carers in Highland. To help us to begin to develop a new landscape of services for carers in Highland the CIG is supporting three pilot projects over a six month period. The list of 'service characteristics' (above) was used to assess the value each of the projects and the following outcomes are expected to be met by the individual projects

5.2.1. The rural project based in East/Central Sutherland looks to deliver immediate tangible help that carers may require at certain times and will be based on the needs expressed by carers living in remote, rural communities to prevent reaching crisis point. This will mean that carers will self-refer for short-term support ensuring support is delivered when it is required. There is no intention that this will replace needs for long term support and collaborative working between the third sector partner and NHS Highland should ensure creative short term approach is readily available to support carers in times of particular need. The pilot will last 26 weeks, cost a total of £36,498.

5.2.2. The aim of the urban pilot based at the Mackenzie Centre in Inverness will be to create and implement an innovative way of working collaboratively with carers that will build resilience within the community for both unpaid carers (of older people) and the person they care for. The pilot will be fronted by a Development Worker who will develop and deliver training programmes offering support to carers over a four week period with a total of four sessions being built into the project. The training will be delivered adopting a partnership approach by identified experts in their areas and may include practical tips on supporting someone living with dementia, fluid and nutrition, managing distress, advice on welfare benefits and developing back up plans. The person being cared for will be offered support at the Mackenzie Centre over and above allocated days to enable carers to attend and feel supported to attend training. The Development Worker will evaluate each four week season and any learning will be developed into a Blueprint for sharing across other services. The cost of the project is calculated at £52,500 (tbc).

5.2.3. Purpose of the Hospital Carer Link worker Pilot Project will be to use the opportunity to identify a key ward (Trauma, Fracture or those awaiting discharged) within Raigmore to help address the following:

- To assist unpaid Carers to understand and be a vital link in the hospital discharge planning of the cared for person
- To aid NHS Highland to fulfil section 28 of the Carers (Scotland) Act 2016 – the duty to involve carers in hospital discharge planning
- To be a link to the continued support of unpaid carers in the community
- To increase awareness in hospital staff of the Carers (Scotland) Act 2016 and the duties to involve carers
- Promoting the role and the services available to the carer during the hospital stay and once back in community
- Advocating with and on behalf of the carer during the discharge planning process
- Ensuring medical staff are aware of the process regarding making a referral in a timely and effective manner
- Ensuring the carer receives the individual support they require
- To support with necessary referrals to services to ensure that the health and well-being of the carer is maintained enabling the caring role to continue – a preventative approach
- To identify key areas of support required and common issues experienced by unpaid carers during a hospital admission/duration

This post/pilot is currently funded through Connecting Carers, and therefore incurs no additional cost, but is an opportunity to ensure we are meeting the statutory duty arising under Section 28 of the act by working in a much more collaborative way.

5.3. Setting the shape for services

The CIG have also considered the 'service characteristics', above, in relation to developing a high-level "shape" of services to commission into the future. The Group considered that the following breakdown should guide our work in the progression of a tender:

5.3.1. Information and Advice Service

- Highland-wide
- High-level advice and information in respect of meeting needs of carers
- Specific advice in relation to accessing services for carers
- Advice in relation to SDS, specifically Option 1
- Advice in relation to accessing personalised and planned Short Breaks (particularly through the use of SDS monies); and
- A programme of practical education and training for carers

5.3.2. Local Carers Link workers

- District based
- Provide emotional, social and practical support to identified carers
- Provide Adult Carer Support Plan as requested
- Identify eligible need in respect of SDS
- Co-ordinate the provision of short-term (reactive) practical help for carers
- Identify the need for the provision of planned (proactive) short breaks
- Utilise local budget, or identified provision, to implement carer support
- Be accountable for the use of support resource;
- Be involved in the authorisation process for the use of Self Directed Support (across all options including Option 3 – traditional respite services).

5.3.3. Available resource for Self Directed Carer Support

- Available resource (realisable through SDS Options 1 and 3) to be accessed by carers who have been assessed as eligible for a planned Short Break

5.4. Tendering for services

The tender process is governed by a Project Board (PB) and progressed by a Project Team, with membership for each from Operations, Contracts Team, Finance, Public Health and non-executive board members (PB only).

The tender process is a formal process with clear instructions and timescales to be followed by suppliers and involves the following steps:

- All tender documentation drafted, TUPE issues resolved and budget agreed; and all approved by the Project Board prior to publishing/inviting bids
- Contract Notice published on the Public Contracts Scotland website:www.publiccontractsscotland.gov.uk
- Suppliers submitting a bid by a set deadline (late bids are not accepted)
- Evaluation of the bid(s) by the Project Team
- Approval/sign off by the Project Board to progress suppliers to the bidder interview stage of the process
- Undertaking of bidder interviews
- Evaluation of the bidder interviews by the Project Team
- Approval/sign off by the Project Board to award the contract to the winning supplier

The Carers Improvement Group's remit within the tender process is as follows:

- To ensure that during the tender process, the carers voice is heard in the securing and shaping of the carers services required to meet the new rights for unpaid carers in Highland, consistent with the Act;
- Provide the Tender Team with direction/recommendations on the services for carers to be commissioned, ensuring services for carers are designed by carers; and
- To have additional oversight and monitor the activities of the Tender Team, to help inform the CIG's wider progress reporting to the Health and Social Care Committee.

The Project Team is aiming to undertake the tender process during March 2020 – June 2020. It is stressed these dates are subject to peoples availability; and all tender documentation being drafted and approved prior to publishing

6. Meeting our other duties under the Act

6.1. Short Breaks Statement

Section 35 of the Carers Act places a duty on local authorities to produce a Short Breaks Statement. Work has been ongoing between the CSDO, the Highland Council and the CIG to progress a draft. The latest draft is at Appendix I for information.

6.2. Waiving Charges for services for carers

To understand where and when it will be necessary to waive charges to carers it is important that there is a clear understanding of the differences between support for carers and cared-for persons. By defining services to carers we will be clearer what services are specific to carers and, therefore, where charges can be waived. There has been work (presented at the CIG) to provide professionals with guidance which outlines how we understand services to carers and, by extension, where we would expect to waive charges.

Business support staff are currently working with the CSDO to develop a process that will help us (Adult Social Care) effect the duty to waive charges for services to carers.

The current process defaults to many services (excluding Home Based Respite) being chargeable unless specifically indicated otherwise by a social worker or other.

In line with the new carers legislation we are working to ensure that we have a comprehensive system in place to ensure where the services provided are specifically to support the carer charges can be waived. In addition (see sections 5.3.2. and 5.3.3. above) we hope to ensure, going forward, that many identified services for carers are assessed and authorised by Local Carers Link Workers: and that the provision of these services will be supported by an authorisation process which will ensure that no charges are applied in the first instance.

7. **Supporting practice across Highland**

7.1. **Carers Practice Support Officer**:

Providing support to carers is a duty which applies - in the first instance - when a carer has identified, outstanding eligible needs which are not, nor cannot, be met by services or assistance provided to the cared-for person. Statutory services, in determining what self-directed support to provide to a carer under section 24 (4) of the Act, must consider, in particular whether, the support should take the form of, or include, a break from caring. Further, where it is identified that self-directed support is required to meet a carers eligible needs statutory services have a duty to waive charges to Carers.

Hitherto (before the provisions of the new act) support to carers has routinely been included in care arrangements made for the cared-for person (most often by a social worker); and ways of utilising/refining the support available to the cared-for person to enable a carer to take a break from their caring role has characterised practice for many years.

Understanding carers' needs and supporting these are seen as critical to managing demand in the Social Care Sector. Providing person-centred and flexible responses to the carer which dovetail with the supports already provided to any cared-for person will require for the professionals involved a solid grounding in the respective legislation requirements and local policy priorities (for carers and the cared-for).

Given how embedded current practice is, and given the substantial shift in practice which will be required as a consequence of our setting out a new shape of services for carers (above) it is recommended that the detail of a job and person specification is fully developed through the Carers Improvement Group.

Ann Pascoe
Ian Thomson
28/01/2020

HIGHLAND PARTNERSHIP:

DRAFT SHORT BREAKS STATEMENT

Jennifer Campbell

1/23/2020

Contents

1 Introduction

In Highland, we are committed to ensuring that Carers, Young Carers and Cared-for people have access to quality Short Breaks. We have begun work to consolidate the availability and range of Short Break options to ensure that breaks are flexible and meet people's outcomes. Following targeted research (HCCF Respite report 2016) and the ongoing feedback from our Social Workers, other District professionals and Carers Link Workers we are developing a better understanding of the range of options that people need. Our future focus will be to help the people who need them access Short Breaks in a straightforward and convenient way – with the result that Carers, and those they care for, get the type of Breaks and the kind of care which has the biggest impact on maintaining the Carers' willingness and ability to continue in their valued roles.

NHS Highland, The Highland Council, Connecting Carers and the Highland Carers Improvement Group have developed this Statement. It has been informed by the views of local Carers, people with care and support needs, practitioners and representatives from a range of agencies. Taken together we believe this has enabled us to have a greater understanding about what people want from a Short Break

Sign off of document to be added

2 Background

The Carers (Scotland) Act 20126 and Unpaid Carers

Under Section 36 of The Act; Local Authorities have a duty to prepare and publish a Short Breaks Statement. Such statements should provide information about the short breaks services available for carers and cared-for persons. This information needs to be accessible to, and proportionate to the needs of, the persons to whom it is provided.

The aim of the statement is to help carers and cared-for people understand:

- What Short Breaks are
- Who can access them
- What short break opportunities are available to carers and
- How carers can access short breaks

By developing a statement we want carers in North Highland to consider whether a planned Short Break would make a difference to their life and to give a better understanding of what a Short Break might look like – and how it could make that difference.

However, people have also told us that there can be barriers for them in accessing and taking a break, including knowing what is available to them, how to access it and what the cost will be. We therefore want this Statement to give people concise information, and we recognise that developing good communications are necessary to make sure that people continue to have access to the support and information that they need.

The statement has been developed in partnership with unpaid carers and discussed through the Carers Improvement Group and will continually be reviewed and developed in line with feedback from carers and the ongoing development of carer's services.

The statement will outline what Carers can expect to be available locally and how such services can be accessed. It will also support professionals and organisations delivering carer services to support carers to access bespoke short breaks.

3 Purpose of the Statement

This Statement aims to provide information to ensure that there is an understanding of the information and advice necessary to plan and arrange a Short Break that works for the carer

4 What is a Short Break?

A Short Break is anything which allows an individual of any age to have some time and space away from their day to day routines and their responsibilities and ideally should be tailored to meet the specific needs and wishes of the individual carer.

For Carers a Short Break can often be crucial in supporting the willingness and ability to continue to Care. In Highland we are committed to ensuring that Carers who need one have access to meaningful, personalised Short Breaks. The Break should make a difference to the carer's life, and this is sometimes described as a positive personal outcome. We have been making a collective effort to understand what is important to people and what it is that truly makes people feel that they have had a Short Break. This approach is beginning to make us think differently beyond what people may have experienced with traditional Short Breaks.

It is inevitable that Short Breaks for Carers must include consideration of how the care needs of a Cared-for person or persons (child or adult) that the Carer supports will be met. Some Carers may have a caring role that is reciprocal and may need to plan Short Breaks for themselves and their mutual Carer.

Health and Social Care services have for many years provided services and supports that have given valuable relief to Carers by providing short term care to the person they care for. Often this care is provided in a group living setting or at a day care service, sometimes as a specialised unit or as part of a Care Home. Some of these services are known as 'Respite Care' and it is recognised that this is a valuable way of providing essential support for Carers. A reliable care service can relieve the Carer of caring responsibilities for short periods to give them some time to themselves from the day to day stresses of caring.

Many people benefit from this type of traditional respite/short break arrangement and it is anticipated that this type of support will continue to meet the needs of some Carers and Cared-for persons. In a number of circumstances this will be the only help that some Carers are looking for.

Current traditional respite resources

Respite Resource/organisation	What they offer	Accessibility
Pulteney House, Bayview House, Seaforth House *Dail Mhor House, Telford Centre, Anacharsaid, Lochbroom House, Strathburn House* *Home Farm,* *Highview Care Home* *Grant House, Wade Centre*	Residential Care Nursing Care Nursing Care Residential Care	Accessibility for dedicated respite beds is via the cared-for persons assessment and arranged via their allocated worker and arranged via a centralised booking point

Carr Gomm & Crossroads Respite Care Skye	Home Based Respite	Accessibility for home based respite is via the cared-for persons assessment and arranged via their allocated worker

Even when Care Services are delivered in the most personalised way some Carers find that the traditional type of Care Service does not always suit them or the person they care for. Some Carers may find that they need something different or something in addition to the provision of alternative Care and Support Services.

Because each Carer and the person they support is unique Carers and Cared-for people have worked with services and supports to develop increasingly personalised, flexible and responsive ways to meet their outcomes and design a break that works for them. When Carers talk about what a Short Break means to them they will often talk about 'quality time' or 'time away' as well as the aspiration to have a new experience or re-establish a hobby or interest which had become too difficult to continue due to the caring role. In general, people felt that a break is what the individual feels will make a difference and that it should benefit both the Carer and the person they are caring for. People saw it as a time to look after themselves and look at their own individual needs. It also enabled them to have peace of mind.

Help is available to all Highland Carers to consider what type of Short Break might meet their outcomes from Connecting Carers. Connecting Carers will also be able to ascertain whether carers may be eligible to self-directed support to meet their need for a Short Break. Connecting Carers also offer various short break funding opportunities and staff will offer support to access the available funds which include:

'Time 2 Be'

'Wee Treat Grant'

Respite (Short Breaks) Fund

Caroline Thomson Legacy Fund

They can contacted on **01463 723575**

https://connectingcarers.org.uk/

5 Who can have a Short Break?

Anyone can, but Carers and the people they support sometimes need a bit more help to have a Short Break and to make the arrangements for this. This Statement is for Carers, Young Carers and Cared-for people. The definitions below should help people identify if this applies to them or someone that they know.

Carers

- The Carers (Scotland) Act 2016 describes a Carer as an individual who provides, or intends to provide, care for another individual (the "cared-for person"). This is not the same as someone who provides care professionally, or through a voluntary organisation.
- A Carer is anyone who cares, unpaid, for a friend or family member who is affected by illness, disability, frailty, mental health challenge or alcohol or drug use. Many Carers support people through giving practical help, people tend to associate caring with physical tasks but giving emotional support can also be a big part of caring. Whether you give practical or emotional support or both you are a Carer. The circumstances of each Carer are unique. Carers can be any age and Carers are part of every community and culture. Carers may be parents, spouses, grandparents, daughters, brothers, same sex partners, friends or neighbours. Some Carers may be disabled or have care needs themselves. Sometimes two people with care needs are Carers for each other. Some Carers can provide care and support for more than one person.
- A Young Carer is a child or young person under the age of 18, or someone who has reached the age of 18 years and is still a pupil at a school. They may have practical caring responsibilities or be emotionally affected by a family member's care needs. Young Carers can sometimes put the needs of the person for whom they care before their own. This means that they can sometimes miss out on things that other young people get to do. This can mean that Young Carers experience stress, anxiety, and worry. Because of this, they may sometimes need help or support from other people. For all practitioners working with families where there are Young Carers it is important to recognise the important differences between Young Carers and Adult Carers and the importance of Young Carers being seen as children first and foremost. This will help to consider what further supports are required to enable them to access the same opportunities as their peers and achieve their full potential. When a Young Carers needs have been identified then a Young Carers Statement can be developed in partnership with the Young Carers Worker. There are opportunities for young carers in caring roles to get together, have fun and have their voices heard. There are numerous services across Highland than can offer support to Young Carers

https://connectingcarers.org.uk/carers-services/connecting-young-carers.aspx

https://www.skyeyoungcarers.co.uk/

http://www.spanglefish.com/caithnessklics/

6 What can a Short Break look like?

In Highland, people have told us that a Short Break could be anything and we have received a wide variety of responses from people to demonstrate this. As a Carer you can make choices about how you might have a Short Break. You might choose to have a Short Break by yourself or with family and friends or with the person you support.

For more examples of the types of Short Breaks visit

https://www.sharedcarescotland.org.uk/learning-exchange/short-break-short-stories/

7 Emergency Breaks

It's always best to take the opportunity to plan Short Breaks however there are times when people need access to emergency support including alternative care for the Cared-for person. Emergency arrangements are not the same as Short Breaks but can sometimes achieve some Short Break outcomes.

Where possible an Emergency Plan should be discussed by the Carer and the Cared-for person and plans prepared in advance of any crisis. Carers might take the opportunity to raise this when the person they are supporting is undergoing an assessment and care planning. Another time that this could be discussed this is when a carer is offered or undertaking an Adult Carers Support Plan or Young Carers Statement. Cared-for people who do not have an assessment can still make an emergency plan; if they do not have or want external support they can record their own plan. Further advice and a possible template is available at:

https://www.enable.org.uk/get-support-information/families-carers/future-planning/emergencyplanning/

8 Why take a Short Break?

For Carers, a Short Break from caring can offer support in many ways including reducing stress in a caring role and enabling a carer to continue to care in good health as well as increasing confidence and giving a better life balance. There are several reasons that people who have care and support needs (Cared-for people) may want to consider a Short Break. These include giving their Carer a Short Break as well as reducing isolation, relief from the stresses, anxiety of day to day life, and recharging their batteries.

Some Cared-for persons may not want a Short Break and when this is the case they may choose to seek (alternative) care arrangements that allow their Carer to have a Short Break with minimal disruption to their daily routines.

Whether a Carer or Cared-for person short breaks should make a real difference to a carer's life and make carers feel they have had a break from their caring responsibilities.

Carers might find out information and inspiration by speaking to other Carers, or to workers or by visiting Carers websites.

There is consistent information that accessing a Short Break reduced stress and maintained or improved health. For Carers, it gave them time to be themselves. This often allowed Carers to reconnect with the sometimes buried relationship with the person they supported and others, they could be a partner, a friend, a mum or a son again as well as having a caring relationship. People felt that a Short Break was vital to protect relationships and continuing a balanced caring role. Other benefits include supporting recovery and "re-charging batteries".

9 How can you get a Short Break?

Any break should make a difference to the Carer: it should help them better able and more willing to continue in their caring role into the future. It might, therefore, be helpful to discuss this with someone in a similar situation for whom having a Short Break has had a positive impact and/or to hear about what other Carers have done. There may also be help to pay for your break: where Carers are thought to have a high level of need of support to help them continue in their caring role they may be eligible for statutory assistance

10 Help to arrange a Short Break

There are lots of people that you can speak to in the first instance to find out about what Short Breaks might be available to a Carer. This could be a worker in an organisation that you already know including a Teacher, Social Worker, Nurse or a Support Worker etc. Where you are a Carer and where you think you need some support to help you continue in your role a referral can be made to Connecting Carers. Connecting Carers can help a Carer complete and Adult Carer Support Plan – this will detail how caring role is impacting on their lives – and may detail the help they require to continue in that role. Among this help may be the provision of a Short Break

"We cannot underestimate the value of respite. I feel confident in saying it is respite that plays a huge part in maintaining the home situation for as long as possible in the majority of cases."

11 Short Breaks for a Cared for Person living in Highland

Some of the people who are supported by Carers may also get help with their own Short Break. Adults who need care and support can request an Outcome Focussed Assessment from the Highland Health and Social Care Partnership. Social Work (Scotland) Act 1968 places a duty on Local Authorities to assess a person's community care needs and decide whether to arrange any services: therefore, Short Breaks here will be to meet the Cared-for person's needs as distinct to those of the Carer (although any break may serve as a Short Break for the Carer at the same time). Any assistance will be based on an assessment of the person's care needs, eligibility criteria and should take account of their preferences. The services provided to meet the persons outcomes will be set out in their care and support plan based on this assessment which is expected to include a record of the Carer's views.

12 Short Breaks for a child with a Additional Support Needs living in Highland

Scottish Local Authorities have a general duty under the Children (Scotland) Act 1995, to safeguard and promote the interests of children in need. The law recognises disabled children as being in need. This gives a right to have your child's and family's needs assessed by Children and Families Service. The support offered to the child and their family may include Short Breaks.

13 Paying for a Short Break?

There are a number of ways that a Short Break can be resourced and funded. Sometimes there is no cost, and sometimes people will pay for their own break. Others may have the support of friends and family - but sometimes a Carer will need extra help. People have told us that being able to pay for their break can be their most difficult challenge.

When a Cared-for person has completed an assessment with the Health and Social Care Partnership they might be eligible to get assistance with the cost of the Short Break. Provision of supports and services is determined under Highland Eligibility criteria which can be found here:

https://careinfoscotland.scot/topics/how-to-get-care-services/national-eligibility-criteria/

As a Carer there are many ways that you can be supported to fund your break and Connecting Carers will discuss this with you in the completion of an Adult Carer Support Plan or Young Carers Statement. This process will identify more information about your caring role and how you can better meet your outcomes.

Your outcomes may be met through services already available in your community; however where this is not possible or appropriate Self-directed Support (SDS) funding may be offered to provide you with a Short Break. When services and supports are identified as primarily meeting the Carers needs charges will be waived under:

http://www.legislation.gov.uk/ssi/2018/31/contents/made

If it is agreed that you are eligible to have a funded Adult Carer Support Plan or Young Carers Statement you can choose from four options which allow you to decide how much control and responsibility you want to take over your funding. These options are:

- *A Direct Payment (a cash payment) where you choose how the budget is used and you manage the money.*
- *You direct how the budget is used, but the money is managed by someone else (sometimes called an Individual Service Fund).*
- *You ask the council to choose and arrange services for you.*
- *You can choose a mix of these options for different types of support.*
-

14 Feedback and Review

We welcome all feedback on this Short Breaks Services Statement to continue to provide accessible information to people.

The Highland Health and Social Care Partnership are responsible for this Statement. You can contact: https://www.whatdotheyknow.com/body/the_highland_partnership with specific feedback or comments about the Statement. Please let us know your suggestions for ensuring this Statement is communicated to everyone that needs it.

The Short Breaks Statement will be reviewed annually by the Carers Improvement Group of the Highland Health and Social Care Partnership.

15 Useful Contacts

Adult Carers

Connecting Carers provide an information and advice service for Carers of all ages on behalf of Highland Health and Social Care Partnership. If you are a Carer who lives in Highland or a Carer who supports a Highland resident you can get in touch for advice about the supports available to you at

As well as giving information about the role of the Adult Carer Support Plan and Short Breaks the staff at Connecting Carers can advise you about their support services and other supports that may help you.

https://connectingcarers.org.uk

Cared-for persons

If you are looking for more care and support for the adult or child you look after to allow you to have a Short Break you can get in touch with any of the Health and Social Care, Social Work and Education professionals who are currently working with them.
Alternatively, if you are caring for an adult and you think a discussion about their care needs is required you may wish to get in touch with your local Integrated Health and Social Care District Team:

Single Point of Contact

Caithness - 01955 606915

Sutherland - 01408 664018

East Ross - 01349 853131

Mid Ross - 01349 860460

Lochaber - 01397 709873

Inverness West - 01463 888333

Inverness East - 01463 888333

Nairn - 01667 422702

Badenoch & Strathspey - 01479 812618

Skye, Lochalsh & Wester Ross – 01471 820174

Health & Social Care Co-ordinator for Skye & Lochalsh

Health & Social Care Co-ordinator for Wester Ross

Young Carers

If you are a Carer under 16 y or you are caring for someone under 16, and are unable to contact the relevant Social Care, Social Work and Education professionals you can

contact Children and Families Service if you or the child/ young person need to discuss more care and support:

https://www.highland.gov.uk/info/886/schools_-_additional_support_needs/827/young_carers

Finally, if you or the Cared-for person have an urgent matter and the above services are closed you can contact the Out of Hours Service:

Socialwork.outofhoursteam@highland.gov.uk

Telephone: 08457 697284

Jennifer Campbell

Carers Services Development Officer

22nmd January 2020

CLINICAL GOVERNANCE COMMITTEE	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Textphone users can contact us via Typetalk: Tel 0800 959598 www.nhshighland.scot.nhs.uk/
DRAFT MINUTE	**3 December 2019 – 9am**

Present Ms Ann Clark, Non-Executive Director (in the Chair)
Ms Elspeth Caithness, Staff-side representative
Ms Deirdre Mackay, Non-Executive Director
Mr Adam Palmer, Board Non-Executive
Dr Boyd Peters, Medical Director
Dr Hugo Van Woerden, Director of Public Health

In attendance Ms Fiona Campbell, Clinical Governance Manager, A&B – VC
Dr Jim Docherty, Clinical Lead for eHealth
Ms Gillian Gunn, Project Lead - Custody Suite Healthcare & Forensic Medical Examiner Service
Dr Rebecca Helliwell, Associate Medical Director, A&B - VC
Ms Rachel Hill, Clinical Governance Manager
Ms Fiona MacBain, Committee Administrator, Highland Council
Dr Ken MacDonald, Associate Medical Director, Raigmore
Dr Stewart MacPherson, Associate Medical Director, South & Mid
Ms Jocelyn Michael, Quality and Patient Safety Administrator
Ms Mirian Morrison, Clinical Governance Development Manager
Dr Ian Rudd, Director of Pharmacy
Ms Susan Russel, Principal Officer (Nursing), Highland Council
Ms Sara Sears, Lead Nurse, North and West
Ms Lisa Steele, Diabetic Retinopathy Service Manager
Mr Simon Steer, Interim Director of Adult Social Care
Ms Claire Wood, Associate Director, AHPs

1 Apologies

Committee Members:
Dr Gaener Rodger, Non Executive and Chair
Ms Margaret Moss, Chair of Area Clinical Forum
Ms Heidi May, Nurse Director
Ms Fiona MacLean, Public Representative
Mr Graham Peach, Public Representative

Regular Attendees:
Andrew Nealis
Kate Patience-Quate

1.1 Declarations of Conflict of Interest

There were none.

2 Minute of meeting on 10 September 2019 and Action Plans

The Committee **approved** the minute.

Action updates were provided as follows:

- **Point of Care testing equipment / Medical Device Management Group / Obsolete or out of date equipment** – a meeting about this had been cancelled but would be reorganised.
- **Information Assurance Group** – a report was on the agenda (Items 7 and 18)
- **Relationship between CGC and the Highland Health and Social Care Committee, and with Adult Social Care** – on hold pending outcome of Integration Review in April 2020.
- **Terms of Reference** – revisions had been approved by the Board
- **Colposcopy Performance** – Gaener Rodger to discuss with Boyd Peters.
- **Succession planning for the RD&I Director** – the current post holder was due to leave in 2020 but might stay on for a short time if the vacancy was not filled on the first round of advertising. The role was considered vital in relation to clinical trials and innovation, and as it currently reported to the Chief Executive rather than the Medical Director, Boyd Peters would discuss with the Chief Executive and the RD&I Director.
- **Medical Education issues** – Gaener Rodger had been in touch with Emma Watson and would follow up on concerns raised in the ME annual report at the CGC meeting in September 2019.
- **Chair for S&M Mental Health SAERs** – Adam Palmer reported that this had been addressed.
- **Highland Children's Unit Staffing** – involvement of Elspeth Caithness, staff-side rep, to be clarified outwith the meeting (email sent 4 Dec 2019).
- **Point of Care Testing Committee** – the new Chair was Dr Rosemary Clark.

The Committee **noted** and **agreed** the actions as appropriate.

2.1 Matters Arising

a. Antenatal Scanning Internal Audit Report – Update on Outstanding Actions - Mary Burnside

Three actions were highlighted which had not been possible to complete in the initial timescale:

- A prioritisation process had been undertaken for the significant number of out of date policies and guidelines, with many archived. All top priority issues had been assigned to reviewers, with some awaiting completion due to capacity issues. Mitigation being undertaken for the extended deadline, from January 2020 for six months, was explained.

  Following discussion about the importance of all guidelines and policies being stored centrally on TAM (Treatments and Medicines) website, where anyone who required them could easily access them, it was **agreed** this would be further discussed outwith the meeting.

- As a result of capacity issues for antenatal clinics due to a consultant shortage, evaluation of two additional antenatal clinics showed that while they had helped, they had not had the expected impact. The clinic model was being reviewed again with a view to being reconfigured in line with Best Start Continuity of Carer teams and Consultant attachment to geographical areas / community caseloads.

- Work was ongoing to identify premises outwith Raigmore hospital site for a Community Midwives base and Antenatal Hub. Outside Inverness, midwives mostly operated within GP practices.

- GROW and CTG training had been added to the Statutory and Mandatory Training Prospectus for midwifery, with both added onto the Learn Pro System to support a system for monitoring compliance for midwives and obstetricians

The Committee **noted** the update and that progress on actions would also be reported to the Audit Committee.

b. Actions from Gosport Report update – Chair

A Controlled Drugs Inspection Officer was now in place for North and West Operational Unit, although only for 16 hours per week, when 24 hours per week would have been preferable to facilitate a more proactive role. It was clarified that Gosport had been a complex situation in which poor practice had become embedded. A key issue which would be addressed by the Inspection Officer was good governance of drugs and investigation of any concerns, and while additional hours would be helpful, the cost had to be balanced against potential risks of a similar situation arising. Attention was drawn to the gap in mortality reviewing in community hospitals and it was confirmed that this process was starting in South & Mid, and would be rolled out to other Operational Units.

The Committee **noted** the update and it would be verified outwith the meeting if this now closed off the relevant action.

3 Change of Committee Date - February 2020

The Committee **noted** the meeting scheduled for Tuesday 4 February 2020 had been rescheduled to Wednesday 12 February 2020.

4 Case Study: Maternity Transfers - Mary Burnside, Head of Midwifery

In 2018, of 1956 births Raigmore Hospital, nine had been born before arrival at the hospital. Details of two case studies were provided, along with learning outcomes, which included Antenatal Education and Planning with women, Clinical Decision Making, SAS Transport Options Transportation of Baby by Ambulance, Multi-disciplinary Team Working, Training, Equipment and Protocols.

Improvements included an additional information leaflet for women on Community Midwife Units (CMUs), transfer distances and times, ambulances being equipped with small baby harness, local Protocols & Guidance (Transfer Pause), multi- disciplinary training for RGH & Community Hospital teams, GPs and SAS, a team learning event for SAS, Midwives and ScotSTAR, and increased Family Friendly patient accommodation Raigmore. Ongoing work and future risks were also summarised.

During discussion, the following issues were considered:

- It was clarified there was no increase in transfer numbers from the new CMU in Caithness than there had been under the consultant-led service. Women could attend the CMU for assessment and be transferred if labour was established.
- In response to concerns that staff in community hospitals, who only infrequently had to deal with emergency births, might not have up to date training and skills, measures put in place to mitigate this were summarised. These included regular updates for community hospital staff on emergency obstetrics and neonatal resuscitation, and being part of the same training regime as staff in Rural General Hospitals.
- Attention was drawn to the variation in transfer rates, with only 1% in Skye and 20% for Argyll & Bute and Caithness. Issues that could be relevant included the size of the caseload, the health demographics and economics of an area, the distances from the hospital, the willingness of patients to use private transport instead of an ambulance, and the length of time there had been an established CMU in the area. Given the range of possible reasons it was not

thought the transfer statistics alone were an appropriate measure of quality of service and a more in-depth analysis would be required, with particular relevance on the pathway type of the mothers. The Head of Midwifery would discuss this variance outwith the meeting and report back on whether further investigation was required, with one option being to invite the Scottish Ambulance Service to attend the meeting.

- Clarification was provided that the gap of 300 between annual bookings in 2018 (2300) and births (2000), was because the figures included all bookings for the year, with some of the births take place the following year, and were not counted, nor were those who were booked the previous year.
- Deirdre Mackay asked about the timescale for the National Perinatal Network - Maternity (Best Start) clinical decision making tool for use at time of transfer, to support remote practice.

The Committee **noted** the presentation and **agreed**:

- The Head of Midwifery discuss out with the meeting the variance in transfer rates from different operational units and report back on whether this required further investigation;
- The Head of Midwifery provide Deirdre Mackay with information on the delivery of the decision making tool as detailed, and if known.

5 Executive and Professional Reports by Exception

The Committee **noted** the issues identified and received assurance that appropriate action was being taken/planned:

a. Forensic Medical Examiner Services Update – Gillian Gunn

The update provided a high level view of the project and including activity in A&B as requested. It was confirmed that Police premises would be available until February 2020. In relation to tests of change, one concerned IT issues for the use of Near Me in Police premises and was being resolved, and another was the use of the rural support team in Skye which was helping to provide custody healthcare support and would require Near Me.

b. ChemoCare – Ian Rudd

The Director of Pharmacy explained that ChemoCare was the IT system used to prescribe, administer, support the dispensing of, and schedule patient attendance for, anticancer therapy in NHS Highland and the other four cancer centres in Scotland, as well as the majority of cancer centres in England and Wales. It was now running on unsupported software and this risk was due to be placed on the corporate risk register the following week. eHealth was aware of the issue.

There would be information governance and research governance issues arising from this and the Director of Pharmacy would ensure the correct people were informed.

c. Avastin update – Ian Rudd

The CGC had previously supported the use of off-label medicine Avastin for the treatment of Wet Age-related Macular Degeneration. A Court of Appeal case brought by pharmaceutical companies in England against this practice had recently been heard and a judgement was awaited. If the appeal went in favour of the pharmaceutical companies, the NHS Highland position on the use of Avastin might have to be reconsidered.

6 Operational Unit Reports by Exception and Emerging Issues with Minutes of Meetings of Patient Quality & Safety Committees / A&B Clinical and Care Governance Group

The Committee **noted** the issues identified and received assurance that appropriate action was being taken/planned.

6.1 Argyll & Bute IJB and minutes of Clinical & Care Governance Group of 5 September 2019

Following a summary of the report, the following issues were discussed:

- Attention was drawn to the reported staff shortages and recruitment difficulties and although it was felt there was a lack of detail, it was acknowledged this was a general and well noted problem in many areas. Due processes were being followed in relation to recruitment and it was decided that unless there were areas of outstanding clinical risk, a more detailed report was not required.
- The improving complaint performance was welcomed.
- In relation to the Care Opinion project in A&B, it was hoped this might be extended to other operational areas and it was confirmed that the Director of Corporate Communications was currently investigating how this might be rolled out.

6.2 North and West, and minutes of QPS group of 13 November 2019

- The Strathy ward in Migdale Hospital was due to reopen on 6 January 2020. Framework agency mental health nurses were covering in the interim pending recruitment of registered mental health nurses.
- Attention was drawn to concerns raised in North & West around the movement of Quality Leads to the centrally based Programme Management Office (PMO), and this would be addressed at Item 11 on the agenda.
- Exit interviews were conducted with departing doctors but the process was not as robust as it could be.
- Reference was made to work being undertaken by NHS 24 in East Lothian related to triaging and fragility and would be discussed further outwith the meeting, noting that representatives from East Lothian had been invited to visit Highland and share learning.

6.3 South and Mid, and minutes of QPS group of 31 October 2019

- Attention was drawn to the ongoing review of mental health governance, SAER decision making, quality and patient safety issues and external scrutiny for this area, which was considered much valued work.
- The work to reduce medication errors was welcomed.
- Clarification was sought on a comment in the QPS minutes of 31 Oct 2019 that management no longer had oversight of complaints and it was explained that after a trial of a new process, it had been decided to bring oversight of complaints back to the operational units to ensure feedback was provided in a timely manner.

6.4 Raigmore, and minutes of QPS group of 20 August, 17 September and 15 October 2019

Following a summary of three key issues in the report, discussion took place as follows:

- Electronic order communications for test requesting was the solution for the reported problems in the paper-based radiology reporting. This had been an ongoing eHealth project, many years in the making, which apparently had been put on hold for the remainder of the financial year to assist with financial recovery and concern was expressed that this was a significant clinical risk and was affecting the level of clinical care, noting no assurance had been provided the project would be restarted in 2020-21. The Chair noted this was not the position which had been reported to the recent Board meeting and it was agreed this risk be escalated to the Board.
- Attention was drawn to the lack of formal process to track errors made specifically by junior doctors on Datix. Discussions were ongoing on links between Medical Education and Quality

and Patient Safety. A Medical Education exception report had been proposed for the QPS Group but this had not happened, and the current proposal was for the Associate Director of Medical Education to attend the QPS sub-group, which looked at data in more detail from SAERs which would identify if there had been significant junior doctor involvement. Reference was made to the numbers of other non-medical under- and post-graduate students whose performance might also require to be more strongly linked to the governance function of the Board. This issue was noted and the matter would be discussed further with the Board Secretary outwith the meeting.

- Capacity issues and increasing demand for Systemic Anti-Cancer Treatment (SACT) were being addressed and had a Clinical Lead for Highland.

6.5 Highland Council and minutes of 15 November 2019

In future the Principal Officer (Nursing), Highland Council, would attend the new Child Health Group and report issues through their exception report.

6.6 Child Health Clinical Governance Group and draft agenda for 9 December 2019

It was clarified that infants were now included in the group's remit.

7 SBAR of Proposed Restructure of the Information Assurance Group Donald Peterkin, Data Protection Officer, on behalf of Deborah Jones, Senior Information Risk Owner, NHS Highland

Clarification was provided on the proposed main membership of the group, with the intention of having a core group and seeking 'champions' from operational areas, this possibly on a rotational basis. Historic challenges with attendance and quorum were summarised. The importance of Highland Council representation was emphasised and would be discussed outwith the meeting. Once the structure had been agreed, the detailed Terms of Reference would be developed.

In response to a suggestion of an ongoing risk that the IAG would not be sufficiently connected to some areas of the organisation, it was clarified that the intention was for a robust system of escalation for areas that were not engaging and that the structure would be reviewed after a 6-12 month trial period. Reference was also made to the wider report on the IAG structure to the Board on 26 November 2019, and that the clinical governance element was only one part of the wider range of information governance risks. The report reflected the corporate risk matrix and action plan.

The Committee:

- **Noted** the contents of the update.
- **Approved** the proposed restructure of the Information Assurance Group.
- **Agreed** consideration be given to Highland Council representation on the Group outwith the meeting.

8 Diabetic Retinopathy Screening

a. Diabetic Retinopathy Screening: Update on National Incident
Sally Amor, Public Health Specialist, on behalf of Professor Hugo Van Woerden, Director of Public Health

Details of two separate incidents had been circulated, one a national issue, the other a local ophthalmology outpatient concern.

The national incident had been a system failure which had not managed patient pathways, following a software changeover in 2017. Locally, a group of eye clinic patients had been lost to follow up having not transferred to the new system and were now being reviewed and followed up.

A process has been undertaken to identify and communicate with all individuals concerned, and to offer an apology and an appointment by the end of December 2019. It was considered the risk of severe adverse consequences was low.

The Scottish Government and NSS were concerned because there were some patients who, against advice, had chosen to delay their referral until February or March 2020, though all had been offered appointments before the end of December 2019.

During discussion, the following issues were considered:

- Patients had autonomy to make decisions against medical advice, but it was important the risks to them were properly communicated.
- Lothian and Highland had been the regions most affected by the national incident, with a factor for NHS Highland having been the lack of a Board coordinator to check issues.
- Although assurance was provided that the DRS incidents were being resolved, they had unveiled a wider concern with the complex appointment system at Raigmore and a future report or update was suggested on this and on the need for a coordinator for DRS screening.

The Committee:

- **Noted** a screening incident where a failure in recall of the Scottish Diabetic Retinopathy (Vector) IT system had impacted on individuals in the Highland and Argyll and Bute Health and Social Care Partnerships
- **Noted** the clinical advice from a Consultant Ophthalmologist, that the number of patients with diabetes with referable retinopathy requiring treatment, was low. This meant the numbers at risk of delayed treatment due to delayed screening was also low, but not zero.
- **Noted** that the individuals affected had been notified of the incident and offered follow up appointments.
- **Noted** the follow up of individuals would continue into 2020 until all those partaking in follow up had been seen and reviewed.
- **Agreed** an update be provided on resolution of issues in relation to the Raigmore appointment system and the need for a Co-ordinator for DRS screening.

b. SBAR Ophthalmology Failsafe
Dr Jenny Wares, Consultant in Public Health Medicine, on behalf of Professor Hugo Van Woerden, Director of Public Health

The Committee **noted** the SBAR, with discussion having taken place as part of Item 8a.

9 Adverse Event Management: NHS boards self-evaluation report
Mirian Morrison

A key message from the national self-evaluation was the inconsistencies across all Boards in categorisation and investigation of category one adverse events. Healthcare Improvement Scotland (HIS) has been asked to investigate this as a matter of urgency and to give clear guidance to Boards. National reporting of category one events to HIS should start from January 2020.

There was awareness that NHS Highland had variance in practice and work was being undertaken in the Clinical Governance support team to tackle this, including the development of an SBAR template to improve consistency. A key area in need of improvement was the correct involvement of patients and their families in the process. A monthly report to HIS was now required.

The Committee **noted** the Adverse Events Management: NHS Board self-evaluation Report and the plans for developing a national reporting system.

10 Quality Dashboard

The dashboard was ready to be published on the intranet but there was an issue with the cost of clickview licences. It had been hoped to provide access to around 100, or more, users but this now seemed unaffordable, so information was being sought on key people requiring access.

It was intended the dashboard would mainly be used at Quality and Patient Safety level to interrogate data and report issues through their exception reports.

The Committee **noted**:

a. Progress with development of the quality dashboard.
b. The measures being monitored via the dashboard.

11 & 12 Impact of PMO on Staffing Levels and Update on Scottish Patient Safety Programme (SPSP)
Dr Boyd Peters, Medical Director, and Mark Wilde, Strategic Advisor, Health Finance

Responsibility for SPSP had transferred over a year earlier to the Director of Transformation and Quality Improvement, a post which had not been filled when the post-holder retired, and the current proposal was for SPSP to be returned to the responsibility of the Medical Director. An additional challenge for the SPSP was the team lead being on a year-long career break which had recently been extended for a further year. In light of this, a review of SPSP was required. In the meantime, SPSP meetings were continuing, although with some vacancies and gaps which required to be addressed by the review.

A presentation was provided on the following:

- A list was shown of Quality Improvement (QI) staff transferred to the PMO. QI Training and capability was important in managing resource to optimise patient care. The PMO had a financial focus but all workstreams received a quality and safety impact assessment.
- The need to make best use of other staff with QI training, of which there were many throughout the organisation.
- Impact assessment of various areas of work, including mental health and theatre productivity.
- What was going well, and what the main challenges were.

During discussion, the following issues were considered:

- The PMO provided a structure for QI to bring about system-wide changes. It was a productive use of resource, although it was important to ensure the best possible use was made of the investment in quality training. The Medical Director referred to the importance of focusing on organisation-wide robust systems rather than on individual staff.
- Quality trained staff were often fully occupied with their day job activities and there was a risk of their talents not being fully utilised without a coordinated focus.
- Information was sought on the future vision for the SPSP, with national discussions ongoing and differing opinions on the future direction for the programme. The timescale for national review was unknown, and local focus was recommended in the interim.
- Concern was expressed at the loss of QI staff in operational units to the PMO which resulted in a decrease in improvement work for the benefit of patients. There was a lack of capacity amongst remaining staff to continue improvement projects, and concern was expressed at the focus on finance rather than quality of service. It was known that QI staff were meeting to try to address concerns and improve overall focus and it was clarified that QI staff in operational units and in the PMO were working to the same overall goal. It was anticipated that after the initial period of change, activity would settle, and clarity would improve.

- There was no current Director taking on the role of Senior Responsible Officer for overall QI and this required consideration alongside ongoing discussion about the SPSP and priorities for QI work.
- The importance of SPSP and QI work, including the Highland Quality Approach, was emphasised and should be maintained and escalated if necessary, although it was suggested the work was still happening but was less visible and this needed to be understood more clearly. Similarly, professional leads required more information about work happening in their areas.

The Committee **noted** the presentation but **did not receive assurance** in relation to leadership and capacity for QI work and the organisation's ability to make proper use of the quality training that had been provided. It was **agreed** this lack of assurance be escalated to the Board and a further update be provided in April 2020 to include proposals for the future of SPSP.

13 Scottish Patient Safety Programme – Adult
Dr Stewart Lambie, Consultant Nephrologist

No report had been submitted and this matter would be included in the update agreed under item 11 & 12.

14 Scottish Patient Safety Programme – Medicines
Jackie Agnew, Professional Secretary, Medicines Safety Sub Group of ADTC

The Board **noted** the update.

15 2018 In Patient Survey
Barbara Maczka, Clinical Governance Facilitator

- No action plan had been received from A&B, and this would be followed up.
- The survey had been undertaken in 2017 and in future it was hoped more 'real time' data could be obtained and actioned. Workload capacity was an issue and Care Opinion was suggested as a possible means of obtaining the necessary feedback across the whole of NHS Highland
- It was difficult to compare NHS Highland to some other Boards due to the significant differences in clinical settings and other factors. It would be helpful to know what successful Boards were doing well, and it was welcomed that Highland had performed well.
- Confirmation would be sought that the Survey results had been widely communicated.

The Committee **noted** the update.

REPORTING GROUP ANNUAL REPORTS

16 Feedback on new Annual Reporting Procedure

The Committee **noted** the pilot policy that had been trialled in 2019 of presenting annual reports without requiring attendance at the committee, with issues / questions being reported back and / or a representative being invited to the following meeting to address concerns.

Feedback included that the annual report template was useful and that time was saved when senior staff were not required to attend the meeting to present their reports. However, it was also pointed out that on one occasion a serious issue had been raised as a result of attendance at the meeting.

The Committee **agreed** to continue with the new procedure.

17 Pregnancy and Newborn Screening
Sally Amor

The Committee **noted** the report had been deferred to February 2020. This was due to work force pressures in the blood science lab and lack of capacity to undertake the lab analysis for the report.

18 Information Assurance Group
Andy Nealis, Information Assurance & IT Security Manager

This had been discussed at Item 7.

19 Care Experience Group
Esther Dickinson, Quality Improvement Project Lead, Nursing Midwifery and Allied Health Professions on behalf of Heidi May Board Director of Nursing

There were no additional comments.

20 Transfusion Committee

The Committee **noted** this report had been deferred to June 2020 as the Committee had a new Chair who would start in February 2020.

In relation to an outstanding action about 'Emergency Blood stocks at Mackinnon Memorial', this would be considered at a forthcoming N&W Wednesday meeting.

21 Any Other Competent Business

There was none.

22 Reporting to the Board

The Committee agreed the Chair report the following to the Board:

- Issues relating to the Highland Quality Approach, Quality Improvement and leadership (Items 11&12)
- The paused investment in eHealth for the Order Comms project (Item 6.4)

23 Close of meeting: 12.40pm

24 Information Items

a. Control of Infection Committee minutes 12 Sept 2019
b. Information Assurance Group minutes 24 Aug 2019
c. HSMR Reports Aug and Nov 2019
d. Confirmed Dates of Clinical Governance Committee 2020:
12 Feb (was 4 Feb), 14 Apr, 9 Jun, 25 Aug, 6 Oct, 1 Dec.

Electronic invites had been issued for all meetings and papers would be attached to the calendar entry, with an email alert.

	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk
DRAFT MINUTE of MEETING of the NORTH HIGHLAND LOCAL PARTNERSHIP FORUM Board Room, Assynt House, Inverness	**5 December 2019 – 2.30 pm**

Present Adam Palmer, Employee Director (In the Chair)
Elspeth Caithness, Staffside Representative
Graham Jepps, Day Centre Officer (UNITE)
Michelle Johnstone, North Area Manager (Videoconference)
Margaret MacRae, Lead Nurse Representative

In Attendance Brigitte Johnstone, People and Change Manager
Brian Mitchell, Board Committee Administrator
Caroline Morrison, Education, Learning and Development Manager
Katherine Sutton, Head of Acute Services (from 3.15pm)

1 WELCOME AND APOLOGIES

Apologies had been received from Gaye Boyd, Tracy Ligema, Etta Mackay and David Park.

2 MINUTE OF MEETING HELD ON 10 OCTOBER 2019

The Minute of Meeting held on 10 October 2019 was **Approved**, subject to the following amendments:

Page 1, Sederunt – Amend C Morrison title to "Education, Learning and Development Manager".
Page 1, Item 1 – After Apologies, add "As the meeting was inquorate members noted that any decisions taken would require to be ratified at the next meeting".
Page 3, Item 5.2, 1st Line – Amend to read "…North and West was somewhat…"

3 MATTERS ARISING

3.1 Attendance at Meetings

A Palmer raised the matter of engagement and attendance at meetings, and advised he would raise the matter with D Park in his capacity as Co-Chair.

3.2 Staffside Concerns at New Craigs

M MacRae referenced the discussion at the last meeting and sought greater assurance in relation to the points that had been raised, with particular reference to risk management and mitigation activity. It was stated the issues had been known for a considerable time. B Johnstone advised local restructuring activity was underway, with national solutions also being sought.

The Forum Noted the position.

4 UPDATES FROM LOCAL NETWORKS

Members received the following updates:

4.1 North and West

M Johnstone advised the latest meeting had been held the previous week, with discussion being held in relation to Culture Fit for the Future activity (courageous conversations training, and other training requirements). Updates had been received in relation to service redesign activity for both the North Coast and the Skye, Lochalsh and South West Ross areas. It had been noted that progress was being made in relation to SSSC registration ahead of the 13 December 2019 deadline. It had also been noted that Human Resources training had been made available for managers to uptake. Members had been advised there would be an update to the next local meeting with regard to Migdale Hospital. It was advised discussion with relevant staff would be followed up on 13 December 2019, noting staff also operated within the community setting as and when Strathy Ward was closed to patients. M Johnstone went on to state there had been issues with regard to Staffside representation at these meetings, this point being echoed by E Caithness. M MacRae expressed concern that approved Minutes from previous meetings had not been submitted to this Forum.

During discussion, M MacRae sought an update in relation to the review of Older Adult Mental Health Services at Migdale Hospital and was advised activity was ongoing, in the context of awaiting clarification as to the relevant overall strategy position. M Johnstone stated numerous factors had combined to leave the current position and agreed consideration was required as to how best to move forward. The view was expressed that the contributory factors referenced had all been predictable in nature and as such mitigating action should have been considered at an earlier point.

4.2 South and Mid

On the point raised by M MacRae, A Palmer advised further Staffside representation had yet to be identified at this time.

4.3 Raigmore

B Johnstone advised a meeting had taken place on 22 November 2019, with future meetings to be led by Etta MacKay, and established in association with the Employee Director. It was hoped to be able to define relevant membership, agenda profile and meeting format in early course and have this confirmed at the first subsequent meeting expected to take place in January 2020. E Caithness took the opportunity to stress that these meetings need not be overly formal in nature.

After discussion in relation to Local Networks, A Palmer emphasised the need for all local administrative arrangements to be set, and disseminated to respective members in early course. All relevant meeting Notes should also be submitted to this Forum.

The Forum otherwise Noted the current position with regard to Local Partnership Networks.

5 NEW CRAIGS SECURITY

Further to discussion earlier in the meeting, members were advised, in the absence of a formal update, and in light of a recent serious incident that a site audit was to be conducted, the Terms of Reference of which would be set in association with the Health and Safety Team. Meetings were also to be held with representatives of Police Scotland to discuss the implications arising from the particular incident concerned. The majority of staff involved had accepted the offer of relevant psychological support.

M MacRae stated this was not a minor, nor an isolated incident, with overall security concerns having been raised by staff previously. She went on to advise that a number of staff members were now in favour of introducing a locked door entry system at the New Craigs site. Whilst not supporting this approach, M MacRae reiterated the view that long term, excessive pressures had seriously impacted on relevant staff members and this was adding to overall concern in relation to both patient and staff welfare/wellbeing. E Caithness emphasised the importance of staff feeling safe and supported at this time, adding the view another serious event of this nature could give rise to a crisis situation among staff. A Palmer confirmed that Serious Adverse Event Reviews (SAERs) were taking place that would give rise to a number of potential recommendations, with Trades Union representatives also meeting with management with a view to establishing a constructive way forward in this area. He agreed the need for early consideration of all the points raised.

Members noted that related clinical issues were being raised and discussed at the Hospital Sub Committee, Area Medical Committee and Area Clinical Forum. On this matter, it was stated the impact of the care requirements being placed on nursing staff, by relevant clinicians, can in some cases add to the feeling of insecurity as well as undermining the role of these staff members as a direct consequence. The impact of clinical decisions relating to patient management, on staff members, had to be further considered by clinicians and management in association with relevant nursing staff. K Sutton expressed concern in relation to these points, given the desire of NHS Highland to move to a more clinically led working model. The importance of respectful working relationships and effective team-working was emphasised. A Palmer advised he had previously raised similar issues with management, with meetings scheduled to take place between Trades Unions and New Craigs management in early course.

The Forum:

- **Noted** the issues and concerns raised in discussion.
- **Agreed** to await the outcome of discussion between management and Trades Unions.

6 RAIGMORE FLOW ISSUES

K Sutton spoke to members and advised that despite the earlier than usual introduction and implementation of the NHS Highland Winter Plan 2019/2020, anticipated capacity issues were already being impactful at this time. The Winter Plan itself had been developed not on the basis of what had been before but looked to maximise the use of current existing capacity. She advised the GP community had been requested to provide their input to the Plan, in addition to the views of clinicians and nursing representatives. She advised a key aspect emerging from this consultation was a desire for the provision of increased Care at Home services and as such C Arnold, Flow Manager had been tasked with increasing this within the Inverness area. The contracting process for this activity had again been instigated

much earlier than in previous years. Advising members that over half of inpatient boarders at any one time would be in the post-acute phase of their individual care, there had been agreement that the introduction of a Discharge to Assess function would release significant bed capacity as a result. This had therefore been introduced from 1 December 2019, with the relevant anticipated impact expected to be feed through in early course. Other relevant activity at that time included assessment of how best to utilise increased Care Home capacity due to come on stream in the New Year, with a bid for additional funding to secure this having been submitted. Whole system flow meetings, incorporating all of North Highland, had also been introduced on a weekly basis and these were also expected to result in improved capacity utilisation and associated performance. K Sutton took the opportunity to formally recognise the sterling efforts of all staff at this busy and challenging time.

There followed discussion, and on the point raised by A palmer, K Sutton confirmed that future Daily Capacity Status Reports were expected to include data for Belford and Caithness General Hospitals. With regard to the anticipated additional Care Home capacity it was advised this would likely be primarily for patients who would otherwise be located within the RNI. The Care Home provider involved had yet to fully define their respective business model and as such further discussion would still be required.

M MacRae sought an update in relation to the previous discussion around the potential for the appointment of peripatetic nursing staff, not attached to a specific ward area. K Sutton stated she was unaware of this proposal and would seek an update for members, advising that a number of new graduate nurses had recently been employed. These employees had been advised they would be appointed on the basis of not having a specific work area, such as a particular ward, reflecting the need for a flexible workforce at this time. As and when staffing numbers increased, the need for such flexibility would become less pressing.

A Palmer referenced recent activity in relation to the release of Theatre capacity across NHS Highland, and was advised that to date over 100 patients who would otherwise have been seen at Raigmore had received treatment in either the Belford or Caithness General Hospitals. This activity was having a positive impact however there was more to be done in this area. K Sutton added it was important to educate patients as to the need for such an approach and highlighted a move to introduce a whole Highland Waiting List approach could also bring further positive benefits.

G Jepps queried the breakdown of Care at Home provision and was advised the majority of this was delivered by the private sector, with a mixed picture present across the Highland area. M MacRae highlighted activity by NHS Highland to seek to improve the Terms and Conditions of sector workers since Health and Social Care integration as a positive move. She advised that overnight services were provided by a mix of private sector providers and highlighted that Winter services would be based on the same delivery model.

After discussion, the Forum otherwise Noted the position.

7 HIGHLAND PARTNERSHIP AGREEMENT

A Palmer advised partner organisations were required to have a revised Agreement in place by end March 2020. In the context of recent press coverage, there was continued liaison with Highland Council around such aspects as appropriate savings proposals, underwriting of any residual funding gap and future activity etc. The existing financial position was considered unsustainable. An update report, outlining progress on negotiations to date, was expected to be presented to the next meeting of the NHS Board.

M MacRae stated the unique Lead Agency model in operation in North Highland meant that HR issues relating to the Partnership Agreement required to much higher up on the current

agenda for discussion. The view was expressed that Highland Council had been late to recognise and embrace the concept of effective Staffside engagement. It was stated this highlighted the need to not only focus on financial resource but also equally consider aspects relating to Clinical and Staff Governance issues. Recognising the points made, A Palmer stated the lack of a current agreement on funding arrangements meant this had to be the initial priority discussion area. He went on to say it was possible that at some point the two partner organisations may be required to consider reverting to an Integrated joint Board model, such as that operated in Argyll and Bute, thereby introducing shared responsibility although there had been no formal discussion on this to date.

The Forum otherwise Noted the position.

8 FINANCIAL RECOVERY UPDATE

There was no discussion in relation to this Item.

9 CULTURE FIT FOR THE FUTURE

C Morrison spoke to a circulated paper providing progress updates in relation to the four Organisation and Workforce Development Work Streams of the overall culture Programme. She went on to advise a meeting had also been held with members of the Culture Programme Board on 2 December 2019, at which aspects relating to overall wider engagement and communications processes had been raised. The closing date for applications in relation to the position of External Advisor/Facilitator(?) (8 hours per week) had been set for 13 December 2019, with Terms of Reference for the Programme Board, which this individual would Chair, being actively consulted upon. It was confirmed relevant Work Streams involved consideration of matters relating to wider Staff Health, Wellbeing and Safety as well as taking forward an appropriate Healing Process and aspects relating to the proposed Review to be conducted in the Argyll and Bute area. It was reported P Maber, Business Support Manager would be engaged around overall planning aspects. A Palmer went on to add the NHS Board had recently received a presentation from the Director of Human Resources with regard to developing a future Healing Process, with Staffside having been invited to contribute to deliberations.

E Caithness expressed concern the Programme Board remained remote from the wider workforce and whilst various Work Streams had emerged there were no clearly defined avenues for staff to link to this activity. She emphasised the need to help staff understand the range of wider activity underway, as well as the steps currently being taken and ensure this was shared as widely as possible across the organisation. These points were accepted, with C Morrison advising the relevant Programme Plan and refreshed associated Action Plan would provide greater detail in that area. E Caithness stated this level of detail was not being provided to the wider establishment and urged that the opportunity to become involved and contribute to activity not be restricted to a small cohort of individuals, moreover this should be widened to ensure both increased awareness and improved Programme capacity. She also requested consideration be given to sharing relevant updates with Management Teams with a view to ensuring improved information sharing. C Morrison stated that overall, there was acceptance of the need to better communicate with all staff, ensure better Staffside involvement and raise awareness of the activity being undertaken as well as the results being achieved.

M MacRae took the opportunity to advise the Royal College of Nursing was in the process of considering whether to conduct a survey of nursing staff within the Argyll and Bute area, parallel to and mirroring the survey proposed for the wider establishment in that area.

Consideration was also being given to extending the scope of the RCN survey across all of NHS Highland.

After discussion, the Forum Noted progress on the Culture Fit for the Future Programme.

10 CURRENT ISSUES FROM STAFFSIDE

G Jepps referenced a recent Care Commission Inspection which had highlighted recruitment process consistency issues, particularly the employment reference requirements of NHS Highland compared to those of the rest of the NHS in Scotland where two written references were required. He questioned the disparity highlighted and was advised that NHS Highland did indeed seek two written references although verbal references were also sought on the day of interview. It was noted this subject had contributed to the relevant Care Commission Report findings and conclusion having been downgraded as a result. Having referenced the relevant PIN Policy document, M MacRae advised this stated a single written reference was required where an individual had been continuously engaged for a period of three years with their current employer.

The Forum Noted the position.

11 HEALTH AND SAFETY

E Caithness, as Co-Chair of the parent Health and Safety Committee, expressed disappointment that the newly established North Highland Health and Safety Sub Committee had met only once to date. She requested that members engage with that Sub Committee where appropriate.

E Caithness went on to outline the need for effective connection and cross-fertilisation between Local Partnership Networks and the wider Health and Safety Committee/Sub Committee governance and assurance framework. Matters such as the current Staff Health and Wellbeing agenda had clear links to both areas of interest.

The Forum otherwise Noted the position.

12 AOB

There were no matters raised in relation to this Item.

13 DATE OF NEXT MEETING

It was agreed that the next scheduled meeting of the Forum will be held on 25 February 2020 at 2.30pm in the Board Room, Assynt House, Inverness.

The meeting closed at 4.35pm

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NHS Highland

Note of Meeting of the North Highland Health and Safety Sub Committee, Anteroom, Assynt House	**11 September 2019 1.30pm – 3.30pm**

Present:	David Park, Chief Officer (Chair) Bob Summer, Head of Occupational Health and Safety Brian Nixon, Health and Safety Officer Alison Moore, Health and Safety Manager Amanda Glen, Health and Safety Manager Sarah Crawshaw, Moving and Handling Manager Maria Dickson, District Manager, S&M Sally Bassett, Medical Staffing Officer, Unison Representative Eric Green, Head of Estates Tracy Ligema, Head of Community Services N&W
In Attendance	Arlene Johnstone, Head of Service, Learning Disabiity/Autism Catriona Berry, Violence & Aggression Prevention Advisor Fiona Miller, Health and Safety Manager (Estates & N&W)
Apologies::	Linda Rawlinson, Occupational Health Representative Rosie Brunton, Health and Safety Manager Karen-Ann Wilson, Health and Safety Manager Katherine Sutton, Head of Acute Services, Raigmore Michael Perera, General Manager, Mental Health Ann Clark, Non-Executive Director

1. Welcome & Apologies:

David Park welcomed members to the meeting. Apologies were noted from Linda Rawlinson, Rosie Brunton, Karen Ann Wilson, Katherine Sutton, Michael Perera and Ann Clark

2. Purpose and Reason for the Group

David Park provided members with an explanation to the purpose of the sub-committee and the rationale behind this. It was recognised the meeting was to discuss health and safety issues involving both patients and staff providing assurance to the Health and Safety Committee, which would feed into the HH&SCC.

3. Draft Terms of Reference:

The Committee discussed the role and remit of the meeting. DP commented summary reports should be provided rather than full reports. It was recognised the meeting should not cause duplication rather its purpose was to provide assurance to the HH&SCC. It was suggested the Health and Safety Representatives meet with management prior to the meeting to allow for seamless feedback and reporting. It was agreed Estates would be represented within the Sub Committee.

DP emphasised to all members present attendance at the meeting was mandatory therefore should a member be unable to attend a representative should be sought. It was also noted there should be a management and a health and safety representative for all areas present.

Questions were raised around the Mental Health team as they had previously been reported under the remit of S&M. It was agreed that Mental Health will report into the Committee independently.

4. Divisional Health and Safety Management Plans – Performance Update

Mental Health

BS advised an audit of risk assessments were due to be carried out, with a validation exercise to be carried out in 2020, however further work is required to be carried out around this. It was considered local managers were best placed to complete health and safety assessments however they required an understanding of the process. DP advised Health and Safety Advisors to liaise and support local managers around health and safety assessments as a higher level of confidence was required.

Discussion took place around the ligature reduction programme and it was advised sensor doors had not been installed over the whole site only being introduced in high risk areas. The Committee were further advised locked windows were causing issues due to the air exchange not being sufficient. This requires further consideration.

The Committee thereafter discussed violence and aggression training. BS advised an SBAR had been put through SLT highlighting issues around the training. Mental Health Nurses are being recruited to help with workforce issues which was hoped would alleviate problems for staff attending their mandatory training. Assurance was received around the action plan to ensure the roll out of Violence and Aggression training.

DP advised a summary of serious or reportable events should be reported and discussed within the sub-committee.

S&M

BS advised on the areas causing concern in S&M which included medical gas training, fire safety and violence and aggression. The Committee were advised the focus was around STATMAN training. Issues were apparent with face to face training which was being addressed. It was recognised management support was required around this.

MD raised a concern of aggressive patients being placed in community hospitals and questioned how this should be approached. It was considered each case should be looked at on an individual level however work was currently ongoing around patient discharges which may help alleviate some of the problem.

DP recognised there was no representation from fire safety in the meeting however EG advised 3 permanent fire advisors and 1 bank member of staff have been recruited by NHSH and would be available if required. The Committee were advised work was currently ongoing around the fire strategy. Discussion took place around fire risk assessments and the Committee considered whether local managers had access to fire risk assessments however it was anticipated they did not. It was advised such information should be fed back to the meeting. Further discussion took place around who was responsible for fire risk assessments to which EG advised this was the building owner's responsibility however it was considered no one had been identified to take responsibility for Assynt House or Larch House. It was agreed a Responsible Professional Officer was required for these sites.

BS spoke of discussion being required around these issues. The Committee were advised Estates take a principal role around fire safety however this did not cover the Health and Safety role. Following discussion it was agreed an expectation was placed on staff to do a role they were not trained to do therefore consideration of a way forward was required. An update should be brought back to the next meeting for further discussion.

North:
BS advised issues requiring improvement in the north included risk assessments, lone working, skin health and moving and handling. He spoke of his encouragement to completed action plans and to the quality assurance process.

BS considered an understanding was required around various areas and what improvements have been achieved every 2 months along with staff challenges including staff moving into new roles. It was agreed a lack of continuity affects change.

West:
BS spoke to the Health and Safety concerns in the West advising skin health required improvement. The Committee were advised of training, policy and procedure changing. It was advised an audit would be prepared to check on the implementation of the updated policy.

Estates:
BS advised a section monthly scorecard to highlight issues similar to operational units would be made available to future meetings. This will take consideration of hand/arm vibration as well as ligature risks within New Craig's. EG advised estates have a Health and Safety Representative within their department.

Discussion took place around the control of contractors as it was considered this was a wider issue than being the sole responsibility of estates. It was agreed to discuss this further at the next meeting.

5. Revised 2020 Health and Safety Management Plan:
BS advised ongoing work was taking place to review the Health and Safety Plan advising a simpler plan was being created. It was advised one action per theme would be part of the plan. It was hoped the revised plan would go live in April 2020 however feedback from units is awaited. It was considered achievable actions would be part of the new plan.

6. Audit Feedback & Updates – by Exception
BS spoke to the ongoing work around audit advising of S&M undergoing an environmental audit which would include scrutinising buildings, security, staff attack alarm and disabled toilets. The Committee were advised of issues around the alarm system and lack of response.

An asbestos audit is currently ongoing.

7. Advise Event & Near Miss/RIDDOR Reporting/Safety Action Notices - by Exception
BS advised a safety action notice had been received around collapsible anti-ligature curtain rails. It was advised a response had been received from A&B however nothing had yet been received from New Craig's.

The Committee were advised of 3 adverse events having taken place in New Craig's which were HSE reportable.

DP advised a bi-monthly Datix report should be provided to allow further discussion around these events.

8. HSE Enforcement Intervention Updates/Reports:

BS advised the Committee of various ongoing issues within NHS Boards involving HSE Enforcement. Discussion took place around Violence and Aggression Training and the assumption these classes would be filled. It was agreed local managers had a responsibility to ensure staff who required face to face training ensured this was kept up to date. It was agreed procedures should be put in place so it becomes more difficult to withdraw from face to face training.

9. Change Management/Service Redesign/Construction/Refurb Projects with potential Health and Safety Impacts:

EG advised of the various projects taking place within NHSH advising no issues were evident at the time.

DP advised he would be looking for Operational Managers and Health and Safety Managers to provide an overall update on all areas across NHSH.

10. For Information:

Health and Safety Committee Minutes

BS advised the Health and Safety Committee had not met since April however was planning to meet in October. He advised the Committee the main item of the next meeting would be the Health and Wellbeing Strategy.

11. AOB

Face Fit Testing:

BS advised face fit testing was required to be provided to nurses and medics before the end of the year. He advised the Committee it was hoped to create a register of fit face testers with training to be provided on the 1st October 2019.

The Committee were advised a letter was due to be sent to nurse managers looking for nominations for the training.

12. Date of Next Meeting:

21 November 2019
2.00pm – 4.00pm
VTBC

(Due to no management representation at the meeting on the 11.09.19 a supplementary meeting was held on the 12.09.19)

Present: David Park, Chief Officer
Bob Summers, Head of Occupational Health and Safety
Anna Cudmore, Staffside Representative
Fiona Gordon, Health and Safety Advisor
Katherine Sutton, Head of Acute Services, Raigmore

4. Raigmore

A supplementary meeting was organised for the 12 September 2019 to discuss Raigmore Health and Safety issues. BS advised on the Raigmore medical dashboard commenting on the key aspects of the report however it was highlighted the main key area was risk assessment. BS and FG emphasised the dashboard

reporting but highlighted this was required to be quality checked by way of audits to provide assurance.

DP spoke of the different areas within Raigmore being separated and it was considered whether a combined Raigmore report would be a more useful way to provide assurance. Discussion took place around the lack of progress within Surgical and it was highlighted risk assessments were problematic. It was recognised areas of concern required to be supported.

Following discussion it was agreed a standardised way forward for Raigmore was required. Following improvement within Medical it was agreed to look at surgery.

Face fit testing requires to be completed. BS advised KS that a letter is being sent out with plan to collate names of people who will be trained to be fit face testers in October. BS and KG advised the plan was to have a bank of testers on the Raigmore site.

Action	**Responsible Person**	**Required**
MP to provide meeting with costed proposal for the proposed work on door sensors.	Michael Perera	November 2019
Operational Areas to check they have access to fire risk assessments.	All	November 2019
Responsible Professional Officer required for AH and LH.	Bob Summers/David Park/Eric Green	November 2019
Consideration of way forward to provide fire safety training to local managers.	Bob Summers	November 2019
Responsibility and control of contractors to be discussed further at next meeting.	All	November 2019
Bi-monthly Datix report to be provided to next meeting.	Bob Summer	November 2019

Performance reporting for NHS North Highland

Report by George McCaig, on behalf of Deborah Jones, Director of Strategic Commissioning, Planning and Performance

This report recommends that the Board review the Health & Wellbeing balanced scorecard identifying any areas requiring further information or future exemption reports and details changes to the performance framework and reporting to future Committees

1.0 Background

1.1 At the last Health & Social Care Committee on 7 November 2019 it was agreed that this Committee will, in future, receive performance reports for both the Annual Operating Plan (AOP) and the Integration Scorecard (i.e. the Health & Wellbeing scorecard attached to this report) for NHS North Highland. It previously only received the Integration scorecard.

1.2 This report details the performance outcomes for the Integration scorecard that have been presented to this Committee in the past. Work is underway to convert the Annual Operational Plan Performance Indicators into NHS North Highland specific indicators and these will be included in future performance reports.

1.3 The Committee previously requested elective waiting time performance data for NHS North Highland and this has been included in this report.

2. Monitoring and Reporting

2.1 The Health & Wellbeing scorecard is at Annex A and the majority of the indicators are updated to Quarter 3. Changes since last reported are summarised below.

2.2 Indicator 1.3. Enablement: % of people receiving enablement interventions that do not require ongoing care interventions after initial 6 weeks. South & Mid are showing a slight improvement though still considerably below target at 18%. North & West is also showing a decline to 34% (previous Qtr 50%).

2.4 Indicator 1.5b. New Sensory Impairments indicators for self-management. Maintaining previous levels of performance at 84.4%.

2.5 Indicator 2.6. Receiving personal care at home. This has improved over baseline from 51% to 55%, but is still under the Scottish average (61%).

2.6 Indicator 2.12. SDS options. Uptake of option 1 is increasing. Option 2 has declined slightly.

2.7 Indicator 2.15. Telecare. Uptake of basic telecare is increasing. Enhanced telecare is static. The percentage of referrals received per quarter with reason

given 'to enable to remain at/return home' & 'to enable independence' has declined to 22% (previously 38%). The total number of adults provided with activity monitors has is static at 39.5%.

2.8 Indicator 5.4. Psychological Therapies – 18 weeks referral. The percentage of clients who have received treatment within the 18 weeks deadline has declined throughout the year to 77.5% at the end of Qtr 3.

2.9 Indicator 5.5. The time taken to access drug or alcohol treatment services. Performance continues to be below the 90% target and is 86.7% at Sept 2019.

2.10 Indicator 8.3. Sensory awareness training. Target of 100 people annually has been surpassed at the end of Q3 (119).

3. Elective Waiting Times for NHS North Highland

3.1 NHS North Highland are looking to deliver the position detailed in table 3.1 against quarter 4 targets.

	End of Mar 2019	
	OP	TTG
AOP Plan	1,065	1,298
Forecast best case	1,402	1,715
Current Variance	-337	-417

Table 3.1 NHS North Highland Forecast Position at Year-end

3.2 The detail for individual specialties for Outpatients is given in Table 3.2 and for Treatment Time Guarantee (TTG) is given in Table 3.3.

3.3 Updated waiting times figures are produced weekly by the Planning & Performance Team. An update on the current position will be given verbally at the Committee.

3.4 At the time of writing the key issues preventing further improvement are:

Outpatient Summary

- Gynaecology – Waiting list initiative – number of clinics originally planned is now less than expected
- Orthopaedics – Reduction in proposed Hand Therapy appointments and unable to recruit to Spinal Advanced Practitioner resulting in a worsening position
- Paediatric Medicine – Reduction of capacity available in Q4 will reduce capacity by 104
- Urology – Consultant vacancy leading to a reduction in capacity

TTG Summary of movements

- ENT – staffing vacancies
- General Surgery – volume of patients as issues around access to theatres
- Orthopaedics – volume of patients

NORTH HIGHLAND - OUTPATIENTS

	24/01/2020					27/03/2020				
		MODEL		VARIANCE			MODEL		VARIANCE	
SPECIALTY	AOP	BEST CASE	WORST CASE	BEST CASE	WORST CASE	AOP	BEST CASE	WORST CASE	BEST CASE	WORST CASE
Cardiology	73	38	38	35	35	80	3	26	77	54
Clinical Genetics	54	1	1	53	53	54	1	1	53	53
Dermatology	24	49	49	-25	-25	50	60	60	-10	-10
ENT	76	104	104	-28	-28	82	89	89	-7	-7
Gastroenterology	0	139	139	-139	-139	0	0	106	0	-106
General Medicine	23	17	17	6	6	21	31	31	-10	-10
General Surgery	114	87	105	27	9	100	92	151	8	-51
Gynaecology	15	74	74	-59	-59	15	110	149	-95	-134
Haematology	15	0	0	15	15	15	2	2	13	13
Neurology	5	9	9	-4	-4	5	12	12	-7	-7
Neurosurgery	5	3	3	2	2	5	0	0	5	5
OMFS	40	0	0	40	40	30	0	0	30	30
Ophthalmology	13	134	134	-121	-121	-4	93	93	-97	-97
Orthodontics	2	4	4	-2	-2	5	0	0	5	5
Orthopaedics	254	697	697	-443	-443	260	498	498	-238	-238
Paediatric medicine	30	56	56	-26	-26	30	154	154	-124	-124
Pain Management	3	17	17	-14	-14	0	21	21	-21	-21
Plastic Surgery	5	18	18	-13	-13	5	9	9	-4	-4
Rehabilitation Medicine	5	6	6	-1	-1	5	33	33	-28	-28
Respiratory Medicine	159	67	73	92	86	185	31	90	154	95
Restorative Dentistry	0	26	26	-26	-26	0	27	27	-27	-27
Rheumatology	102	5	5	97	97	117	17	17	100	100
Surgical Paediatrics	5	5	5	0	0	5	6	6	-1	-1
Urology	0	96	96	-96	-96	0	113	113	-113	-113
TOTAL	**1023**	**1652**	**1676**	**-630**	**-654**	**1065**	**1402**	**1688**	**-337**	**-623**

Table 3.2 Current and Forecast year-end position for Outpatients

NORTH HIGHLAND - TTG

	24/01/2020					27/03/2020				
		MODEL		VARIANCE			MODEL		VARIANCE	
SPECIALTY	AOP	BEST CASE	WORST CASE	BEST CASE	WORST CASE	AOP	BEST CASE	WORST CASE	BEST CASE	WORST CASE
Breast Surgery	10	2	2	8	8	10	0	0	10	10
Cardiology	0	1	1	-1	-1	0	1	1	-1	-1
Community Dental	80	40	40	40	40	80	37	37	43	43
Dermatology	0	0	0	0	0	0	0	0	0	0
ENT	121	310	311	-189	-190	75	300	308	-225	-233
Gastroenterology	0	0	0	0	0	0	0	0	0	0
General Medicine	0	1	1	-1	-1	0	1	1	-1	-1
General Surgery	180	325	341	-145	-161	150	222	381	-72	-231
Gynaecology	113	97	98	16	15	120	73	95	47	25
Haematology	0	0	0	0	0	0	0	0	0	0
Neurology	0	1	1	-1	-1	0	3	3	-3	-3
Neurosurgery	0	0	0	0	0	0	0	0	0	0
OMFS	83	42	42	41	41	76	16	16	60	60
Ophthalmology	152	237	241	-85	-89	135	41	201	94	-66
Orthodontics	0	0	0	0	0	0	0	0	0	0
Orthopaedics	559	862	862	-303	-303	510	884	884	-374	-374
Paediatric medicine	0	1	1	-1	-1	0	1	1	-1	-1
Pain Management	50	68	68	-18	-18	50	63	63	-13	-13
Plastic Surgery	17	34	34	-17	-17	17	13	20	4	-3
Rehabilitation Medicine	0	4	4	-4	-4	0	6	6	-6	-6
Respiratory Medicine	0	0	0	0	0	0	0	0	0	0
Restorative Dentistry	0	0	0	0	0	0	0	0	0	0
Rheumatology	0	1	1	-1	-1	0	2	2	-2	-2
Surgical paediatrics	15	28	28	-13	-13	15	22	22	-7	-7
Urology	76	142	143	-66	-67	60	30	67	30	-7
TOTAL	**1457**	**2196**	**2219**	**-740**	**-763**	**1298**	**1715**	**2108**	**-417**	**-810**

Table 3.3 Current and Forecast year-end position for TTG

3.5 Committee Members should note, however, that the position is under continual review and a verbal update will be given at Committee.

.

5. Recommendations

5.1 It is recommended that:

- the Committee review the Health & Wellbeing balanced scorecard identifying any areas requiring further information or future exemption reports

- Committee note the project outturn (including verbal update) on Outpatients and TTG waiting times for NHS North Highland.

George McCaig
Business Support
28 January 2020

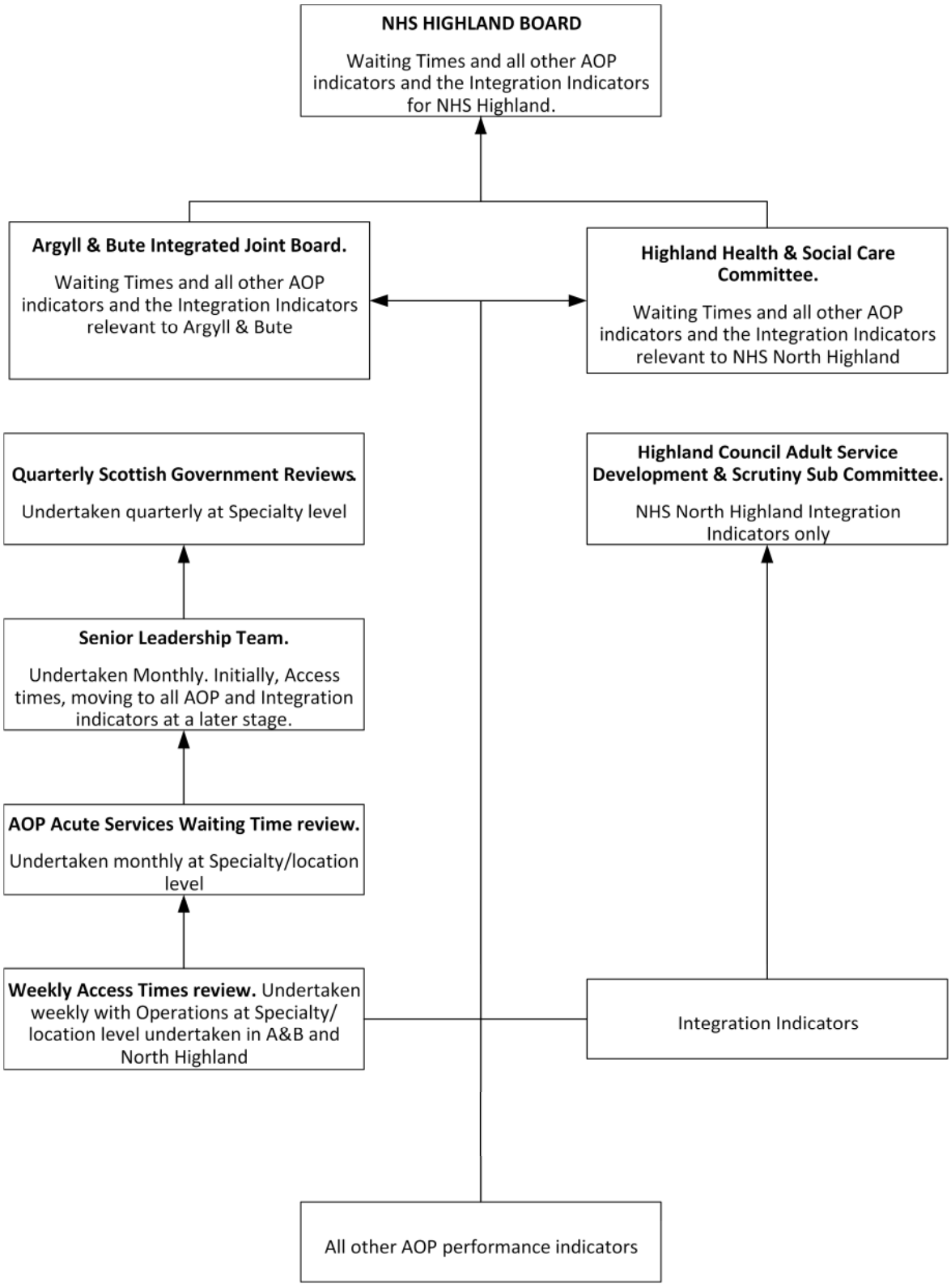

Chart 3.1 Performance Information Flow

NHS Highland Health & Wellbeing Scorecard ASC

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

Key	Performance improving	Performance declining		Performance is stable			
	Indicators	**Target**	**Baseline**	**Benchmark (Scottish average or local average where known)**	**Comparison to Benchmark position current Scottish average)**	**current performance**	**comment**
1.1	Percentage of adults able to look after their health very well or quite well	To maintain or increase	95% (2015/16)	95% 2015/16 93% 2017/18	↑	↓	Biennial National Health and Care Experience Survey (NI-1) 2017/18 Survey - Highland declined slightly 94%, Scotland 93%
1.2	Emergency admission rate (per 100,000 population)	To reduce	10971 (2014/15)	12,026 2014/15 12,295 2015/16 12,229 2016/17 12,207 2017/18 12,195 2018/19	↑	➲	Annual National Indicator produced by ISD (NI - 12) 2015/16 Highland 11,086, 2016/17 - 10,570, 2017/18, - 10,655, 2018/19 10,820 (Revisions made by ISD main difference is increase to Scotland figure) Highland showing slight increase on 17/18 but still well below Scottish average and a 1.54% shift
1.3	South & Mid Enablement: % of people receiving enablement interventions that do not require ongoing care interventions after initial 6 weeks	40%	39%			↓	Baseline 2016/2017 - based on annual cumulative completed enablement service clients/clients with 'no further care required' Q1 2017/18 (32%) , Q2 (29%), Q3 (42%), Q4 (22%), annual 2017/18 was 31% (114 of 369 people) Q1 2018/19 (20%), Q2 (21%), Q3 (28%), Q4 (24%) annual 2018/19 is 24% (87/369 people with NFA) Q1 2019/20 (20%),(23 of 116), Q2 (16%) 13 of 80, Q3 18% (10 of 55) cumulative is 18% a decrease overall
	North & West Enablement: % of people receiving enablement interventions that do not require ongoing care interventions after initial 6 weeks	40%	29%			↓	Baseline 2017/2018 - based on annual cumulative completed enablement service clients/clients with 'no further care required' (24 of 73 clients) 2018/19 Q1 (46%), Q2 (30%), Q3 (65%), Q4 (33%) annual 2018/19 is 46% (39/84 people with NFA) 2019/20 Q1 (30%) 3 of 10 cases), Q2 (50%) 6 of 12 cases, Q3 (14%) 1 of 7 NFA, cumulatively 34% quarter showing significant decline although numbers generally small
1.4	The number of health screenings provided for people with learning disabilities: all people with learning disabilities and epilepsy are offered an annual nurse led review of their condition	To maintain or increase	97.00%			↑	Local Annual Indicator Baseline 2015/16, 2016/17 191/197, 97% seen in year, 2017/18 226/236 patients seen 95.8% 2018/19 98.57% (207 of 210)

update

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current performance	comment
1.5a	Sensory Impairment (Sight)- Self Management (Client Outcomes), The Percentage of completed rehabilitation courses who have achieved independence or achieved independence above expectation	90%	71.6%			↓	Sight Action -Local Annual Indicator baseline data 2015/16 2016/17, 74.7%, 2017/18: 78.6%, Agreement to implement a consistent methodology across services with Quarterly information, a target of 90% has been introduced, July-March 19 - 86% (146/170 people), 2019-20, Q1 - 72%, Q2 - 84.4%, overall the 6 monthly position has declined
1.5b	Sensory Impairment (Hearing)- Self Management (Client Outcomes), The Percentage of completed rehabilitation courses who have achieved independence or achieved independence above expectation	90%	47.0%			→	Deaf Services Baseline data for 2016/17 only, new methodology across services introduced Q2 18/19, 81%, 2018/19 Jul-Mar overall 83% achieved, 2019/20 Q1 - 87%, Q2 - 87%, static on previous Q1, overall 6 month position improvement on previous year

update

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

Key	↑Performance improving	↓Performance declining	→Performance is stable			
	Indicators	**Target**	**Baseline**	**Benchmark (Scottish average or local average where known)**	**Comparison to Benchmark position current Scottish average)**	**current performance**	**comment**
2.1	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	To increase	83% (2015/16)	83% 2015/16, 81% 2017/18	→	↑	Biennial National Health and Care Experience Survey, Baseline 2015/16 -NI-2 (local survey TBD) 2017/18 Highland 86%, Scotland 81%
2.2	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	To increase	77% (2015/16)	79% 2015/16 76% 2017/18	↓	↑	Biennial National Health and Care Experience Survey, Baseline 2015/16 NI-3 (local survey TBD) 2017/18 Highland improved to 79%, Scotland 76%
2.3	Readmission to hospital within 28 days (per 1,000 discharges)	To reduce	92 (2014/15)	97 -2014/15 103 -2017/18 103 - 2018/19	↓	↓	Annual National Indicator produced by ISD -NI-14 2015/16 Highland 89, Scotland now 98 2016/17 Highland 92, Scotland 101 - 2017/18 Highland 107 2018/19 Highland 112 per 1,000 discharges, (revised at Sept 19)

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current performance	comment
2.4	Proportion of last 6 months of life spent at home or in a community setting	To increase	89% (2014/15)	86% 2014/15 88% 2017/18 88% 2018/19	↑	→	Annual ISD NI-15 2015/16 Highland 89% no change,Scottish average increased to 87% 2016/17 Highland 89% no change, Scotland 87% 2017/18 Highland 90%, 2018/19 is 90% static (revised Sept 19 by ISD)
2.5	Percentage of adults with long term care needs receiving care at home (LTCs are health conditions that last a year or longer, impacts on a person's life, and may require ongoing care and support)	To increase	54% (2014/15)	61% 2014/15 61% 2015/16 62% 2016/17 61% 2017/18 62% 2018/19	↓	↑	Annual ISD NI-18, measure amended to long term care removing intensive needs 2015/16 Highland 51%, 2016/17 Highland 54%, 2017/18 Highland 50%, 2018/19 Highland 55%
2.6	% of people aged 65 or over with long term care needs receiving personal care at home	To increase	51.03%	60.0%	↓	↑	Annual SOLACE Indicator (SW3a), 2014/15 Baseline =no. clients receiving care at home 65+/clients receiving care at home 65+ plus long stay care home residents 65+ plus HBCCC/continuing care clients 65+ 2015/16 Highland 52.55%, Scotland 60.7%, 2016/17 Highland 49.92%, Scot 60.12%, 2017/18 Highland 53.24%, Scot 61.75%, 2018/19 Highland 55.55%, Scot 61.02% (no validation possible as data not provided by IS)

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current performance	comment
2.7	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)	Better joint working and use of resources	1455 (2014/15)	1044 - 2014/15 841 - 2016/17 762 - 2017/18 793 - 2018/19	↓	↑	Annual ISD NI-19 (Discharge is to an appropriate setting best suited to enablement) 2015/16 Highland 1,585 Scottish average reduced to 915 2016/17 Highland 1580, 2017/18 Highland 1,300, 2018/19 Highland 1,248,(slight reduction on 17/18 continuing reducing trend) Sept 19 slight change from ISD on 18/19 data
2.8	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (cost of emergency bed days for adults)	To reduce	24% (2014/15)	24% - 2014/15 25% - 2017/18 24% - 2018/19	→	→	Annual ISD NI-20, 2015/16 - Highland 23% 2016/17 - Highland 23%, Scotland 24%, 2017/18 - Highland 21% , 2018/19 - 21% revised data Sept 19 ISD
2.9	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	TBC	TBC	TBC			Annual National Indicator under development (ISD) NI-21

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where	Comparison to Benchmark position current Scottish	current performance	comment
2.10	Percentage of people who are discharged from hospital within 72 hours of being ready	TBC	TBC	TBC			Annual National Indicator under development (ISD) NI-22
2.11	Expenditure on end of life care	TBC	TBC	TBC			Annual National Indicator under development (ISD) NI-23
2.12	Uptake of SDS option 1 - Mid	To increase	72				Option 1 -no. of clients- 2017, 91 @ Qtr 1, 92 @ Qtr 2, 88 @ Qtr 3, 84 @ Q4, March 18 2018, 79 @ Q1 (June 18), 78 @ Q2, 80 @ Q3, 82 @ Q4, 2019, 85 @ Q1 (Jun 19), 89 @ Q2, 92 @ Q3,
	Uptake of SDS option 1 - South		143				Option 1 no. of clients - 2017, 137@ Qtr 1, 134 @ Qtr 2, 131 @ Qtr 3, 131 @ Q4, 2018, 131 @ Q1 (June 18), 127 @ Q2, 125 @ Q3, 126 @ Q4, 2019, 121 @ Q1 (Jun 19), 127 @ Q2, 131 @ Q3,
	Uptake of SDS option 1 - North		35				Option 1 no. of clients - 2017, 48 people @ Qtr1, 50 @ Qtr 2, 49 @ Qtr 3, 49 @ Q4, 2018, 52 @ Q1 (June 18), 53 @ Q2,50 @ Q3, 47@ Q4, 2019, 52 @ Q1 (Jun 19), 49 @ Q2, 51 @ Q3,
	Uptake of SDS option 1 - West		82				Option 1 no. of clients -2017, 98 people @ Qtr 1, 101 @ Qtr 2, 98 @ Qtr 3, 103 @ Q4, 2018, 99 @ Q1 (June 18), 99 @ Q2,98@ Q3, 100@ Q4, 2019, 101 @ Q1 (Jun 19), 104 @ Q2, 107 @ Q3,
	NHS Highland Option 1 Total Clients		332				Option 1 no. of clients -20177, 374 people @ Qtr 1, 377 @ Qtr 2, 366 @ Qtr 3, 367 @ Q4,March 2018 2018/19 - 361 clients @ Q1, (June 18), 357 clients @ Q2, 353 @ Q3, 355 @ Q4, March 2019 2019/20 - 359 @ Q1 (Jun 19), 369 @ Q2, 381 @ Q3, increasing number since the start of the year
	Uptake of SDS option 2 - Mid		26				Option 2 no.of clients - 2017, 76 people @ Qtr 1, 83 @ Qtr 2, 87 @ Qtr 3, 81 @ Q4,March 2018 2018/19 -83 @ Q1, 80 @ Q2, 77@ Q3, 74 @ Q4, March 2019 2019/20 - 73 @ Q1, 73 @ Q2, 59 @ Q3,
	Uptake of SDS option 2 - South		55				Option 2 no. of clients - 2017, 85 people @ Qtr 1, 94 @ Qtr 2, 97 @ Qtr 3, 95 @Q4, March 2018 2018/19 - 93 @ Q1, 96 @ Q2, 100@ Q3, 105 @ Q4, March 2019 2019/20 - 112 @ Q1, 114 @ Q2, 108 @ Q3,

update

	Uptake of SDS option 2 - North		5				Option 2 no. of clients - 2017, 13 people @ Qtr 1, 12 @ Qtr 2, 12 @ Qtr 3, 12 @ Q4,March 2018 2018/19 - 11 @ Q1, 12 @ Q2, 13@ Q3, 14 @ Q4, March 2019 2018/19 - 13 @ Q1, 13 @ Q2, 14 @ Q3,
	Uptake of SDS option 2 - West		19	N/A			Option 2 no. of clients - 2017, 39 people @ Qtr 1, 53 @ Qtr 2, 56 @ Qtr 3, 59 @ Q4,March 2018 2018/19 - 62 @ Q1, 66 @ Q2, 66 @ Q3, 68 @ Q4, March 2019 2019/20 - 66 @ Q1, 63 @ Q2, 69 @ Q3,
	NHS Highland Option 2 Total Clients		105				Option 2 no. of clients -2017, 213 @ Qtr 1 (102% increase on baseline), 242 people at Qtr 2, 252 people @ Qtr 3, 247 @ Q4 March 2018 2018/19 -249 clients @ Q1, 254 clients @ Q2, 256 @ Q3, 261 @ Q4, March 2019 2019/20 - 264 @ Q1, 263 @ Q2, 250 @ Q3,
	Uptake of SDS option 3 - Total	TBC	4541	TBC			Options 3 - the number of people receiving a traditional service, this is a unique count of people who may be in receipt of multiple services (this figure excludes some services where data is not available) baseline @ Feb 16 -update March 2017 - 5116 people- March 2018 - 5114 people, March 2019 - 5038
	Uptake of SDS option 4	TBC	120	TBC			Option 4 - people who are receiving a mix of options 1,2 & 3, baseline Jan 16 ,March 2017 - 189 people, March 2018 now 183 people, March 2019 192 people
2.13a	Age of admission to long-term residential and nursing care (All Adults)	To increase	76	78			Annual Care Home Census based on mean age of admission LTC residents baseline March 2016 (table 9), March 2017 (latest update Sep 18)both Highland and Scotland remain static although Highland 10 year change 2007-2017 shows increase of 3 years (2007 - 73 mean age)
2.13b	Age of admission to long-term residential and nursing care (Older People)	To increase	81	81			Annual Care Home Census based on mean age of admission LTC residents baseline March 2016 (table 9), March 2017 is 82 years old. 10 year change 2007 (78)-2017 (82) is an increase of 4 years, Scotland no change
2.14a	Length of stay in long-term residential and nursing care (All Adults)	To reduce	2.5 years	2.3 years			Annual Care Home Census based on mean average complete length of stay of residents baseline March 2016 (table 10), March 2017 slight increase to 2.6 years, Scottish average increased to 2.4 years no significant change. no published update since 11/9/18 10 year change 2007-2017 is 0.2 years

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current performance	comment	
2.14b	Length of stay in long-term residential and nursing care (Older People)	To reduce	2.7 years	2.3 years			Annual Care Home Census based on mean average complete length of stay of residents baseline March 2016 (table 10), March 2017 shows reduction to 2.2 years, change over 10 years 2007-2017 is -0.2 years	
2.15a	Total number of adults receiving basic or enhanced Technology Enabled care	To increase	Basic - 1,929 Enhanced - 419	N/A			Baseline is March 2016 March 2017 position Basic - 1.993 and Enhanced - 485 March 2018 Basic - 2,113 and Enhanced 527 March 2019 Basic 2134 and Enhanced 588, 2019/20 Q1 2196 basic, 599 enhanced, Q2 -Basic 2268, Enhanced 599, Q3 2019 basic telecare 2308 increasing, Enhanced 594, static	update
2.15b	Percentage of referrals received per quarter with reason given 'to enable to remain at/return home' & 'to enable independence'	To increase	46/137 33.6%	This is a national dataset but there are no published results at this time			Baseline is Quarter April-June 2016,46 of 137 referrals Jan-Mar 2017 - 61/165 referrals, 37%, Q2, 2017 - 78/198 referrals 39%, Q3, 17 - 82/206 39.8%, Q4, March 18 - 85/251 referrals 33.9%, 2018/19 -Q1- (56/241) 23.5%,Q2 32.7% (74/226), Q3 26.7% (55/206) Q4-23.6% (56/237) 2019/20 Q1, 35.2% (94 of 267), Q2 38.1% (101 of 265), Q3, 22.41% (52 of 232) reduced	update
2.15c	Percentage of new installations in quarter with activity monitors i.e falls monitors	TBD	30.5%	This is a national dataset but there are no published results at this time			Baseline April-June 2016, 159/521 new installations Jan-Mar Q4,2017 192/615, 31.2% 2017/18,Q2, - 217/699, 31%, Q3 - 270/697, 38.7%, Q4 17/18 - 325/829 39.2%, 2018/19, Q1 330/847 is 39%, Q2 - 39.9% (291/730),Q3 41.35% (287/694), Q4 40.8% (324/794) increase in total installations in quarter 2019/20 Q1, 38% (328 of 863), Q2, 39.4% (357 of 906), Q3, 39.5% (295 of 746)	update

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.							
Key	⇧Performance improving	⇩Performance declining		⇨Performance is stable			
	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current performance	comment
3.1	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	To increase	73% (2015/16)	75% 2015/16 74% 2017/18	⇩	⇧	Biennial National Health and Care Experience Survey NI-4 2015/16 baseline - 2017/18 Highland 76%, improvement on previous results
3.2	Percentage of adults receiving any care or support who rate it as excellent or good	To increase	83% (2015/16)	81% 2015/16 80% 2017/18	⇧	⇨	Biennial National Health and Care Experience Survey NI-5 (also SOLACE SW4A) 2015/16 baseline - Q28 2017/18 Highland 83%, no change
3.3	Percentage of people with positive experience of the care provided by their GP practice	To maintain	89% (2015/16)	85% 2015/16 83% 2017/18	⇧	⇩	Biennial National Health and Care Experience Survey NI-6 (local survey TBD) Baseline 2015/16 survey 2017/18 Highland 87%, showing reduction on previous results
3.4	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections and proportion graded 5 or above	To increase	76.8% (2014/15)	81.2% 2014/15 85.4% 2017/18 82% 2018/19	⇧	⇨	Annual National Indicator produced by ISD is grade 4 and above NI-17 2015/16 Highland 77.8% , Scotland increased to 82.9% 2016/17 both Highland and Scotland showing as 83.8% 2017/18 Highland 86.3%, 2018/19 Highland 86%
a	Care Homes with grade 4 or better - Independent Sector	100%	78.6%			⇧	A new framework for inspections for older people's care home gradings based on 5 key questions implemented. Combined evaluation Care Support & Wellbeing now being used. March 2017 (81.8%) March 18 (84.9%) March 19 (75%) new grading system 2019/20 Q1 (76.9%)2 improved to grade 4, 1 declined to grade 3, Q2 (79.2%), 1 improved to grade 4
b	Care Homes with Grade 4 or better - In House	100%	82.4%			⇩	March 2017 (76.5%) March 18 (93.3%) March 19 (86.7%)new grading system combined evaluation process 2019/20, Q1 no change, Q2 80%, 1 G4 declined to a G3
c	Care Homes with grade 5 or better - Independent Sector	To maintain or increase	35.7%			⇧	March 2017 (34.5%) March 18 (45.3%) March 19 (51.9%)new grading system combined evaluation process 2019/20, Q1 (48.1) 2 G5s declined to G4 (25/52), Q2 (49.1%) 1 increase to G5 (26/53)

update

update

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current performance	comment
d	Care Homes with grade 5 or better - In House	To maintain or increase	29.4%			↑	March 2017 (35.3%) March 18 (66.7%) March 19 (53.3%)new grading system combined evaluation process 2019/20, Q1 no change, Q2 (60%),MacKintosh Centre now G5
e	Care at Home with grade 4 or better - Independent Sector	To increase	87.5%		↑	→	Baseline 31 March 2016, 14 of 16 services grade 4 or better -March 2017 -14 of 18 grade 4 or better, 77.8%, March 2018 -20 of 21 services, 95.2%, June 18 - 100%, Sept 18 - (19 of 20) 95%, Dec 18 (20 of 21) 95.2%, March 19 (19 of 20) 95% 2019/20 June - 18 of 19 (94.7%),Sept 19 (15 of 16) 93.8% care at home contracts signed @ 01/07/2019
f	Care at Home with grade 4 or better - In House	To increase	100.0%		→	→	Baseline Dec 17 all services now graded, March 18 no change, March 19 no change 3 of 3 grade 4 - 100% 2019/20,June 2 of 3 (66.7%) C@H West reduced to grade 3, Sept 19 no change
g	Care at Home with grade 5 or better - Independent Sector	To increase	37.5%		↑	→	Baseline 31 March 2016, (6 of 16) services grade 5-6, March 2017 -(7 of 18) grade 5-6 (38.9%), March 2018 - (9 of 21) -42.9%, June 18, -(9 of 20) - 45%, Sept 18, (10 of 20) - 50%, Dec 18 (9 of 21) 42.9%, March 2019 (9 of 20) 45% 2019/20, June- 8 of 19 (42.1%) , Sept- 8 of 16 (50%) services with contract @ 01/07/2019
h	Care at Home with grade 5 or better - In House	To increase	0.0%		↑	→	Baseline 31 Dec 2017 all services have gradings none have a grading of 5 or above, March 2018 no change, March 2019 North Highland service improved to grade 5 now 33.3%, 2019/20, June - no change, Sept no change
3.5a	People with a Sensory Impairment(s) - Sight - who have undergone an assessment, confirm an understanding of their condition	90%	96%			↑	New Indicator - Baseline taken as 1st Quarter (Q2 18/19), Sight Action, July to March 19 - 95% overall (156/64 people) 2019-20, Q1 - 89%, Q2 - 91% improvement on previous quarter overall 6 monthly position above target
3.5b	People with a Sensory Impairment(s) - Hearing -who have undergone an assessment, confirm an understanding of their condition	90%	65%			↓	New Indicator - Baseline taken as 1st Quarter (Q2 18/19), Deaf Services July - Mar 19 -79% overall improvement shown in each quarter (171/216 people) 2019/20 Q1 -90%, Q2 -84% note reduction in Q2, (overall 6 month position is an improvement on previous year)

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	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current performance	comment
3.6a	People with a Sensory Impairment(s) - Sight -who have undergone an assessment, confirm information on their condition is available and accessible in a format of their choice	90%	96%			↑	New Indicator, Baseline taken as 1st Quarter (Q2 18/19), Sight Action July-March 19 - 85% (139/164 people) reduction showing quarterly 2019-20, Q1 - 85%, Q2 - 90.6% improvement from Q1 and this quarter above target overall 6 month position showing improvement on previous year to date
3.6b	People with a Sensory Impairment(s) - Hearing -who have undergone an assessment, confirm information on their condition is available and accessible in a format of their choice	90%	57%			↓	New Indicator, Baseline taken as 1st Quarter (Q2 18/19), Deaf Services Jul-Mar 19 - 47% (102/216 people) overall reduction showing quarterly 2019/20 Q1, 43% , Q2 39% (19/49) declining position on quarter and 6 month position on previous year
Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.							
Key	**↑Performance improving**	**↓Performance declining**		**➲Performance is stable**			
	Indicators	**Target**	**Baseline**	**Benchmark (Scottish average or local average where known)**	**Comparison to Benchmark position current Scottish average)**	**current position**	**comment**
4.1	Delayed hospital discharges for service users residing within areas covered by ISC C@H providers	ZERO	20 Total 13 IMF 7 N & W	N/A		↑	~~Baseline March 2016 census data for month end~~ DDs 10/1/18 Local indicator - monthly - 25D Awaiting completion of social care arrangements - In order to live in their own home – awaiting social support (non-availability of services), Census M/E numbers @ Mar 17 (14), June 17 (23), Sept 17 (25), Dec 17 (21), March 18 (32), June 18 (30), Sept 18 (35), Dec 18 (24), March 19 (34) Q1, June 19 - 42 with 25D codes, Q2 Sept 19 - 28 code 25D (N &W -5, IMF 23), Q3 26 Dec - 23 code
4.3	Emergency bed day rate (per 100,000 population)	To reduce	117,866 (2014/15)	128,596 (14/15) 126,651 (16/17) 122,720 (17/18) 116,485 (18/19)	↑	↑	Annual National Indicator produced by ISD NI-13 2015/16 Highland 121,323, Scotland 128,398 2016/17 Highland 120,208, 2017/18 Highland 107,393, 2018/19 Highland 103,444 Revisions by ISD on year end data but still significant reducing trend for both Highland and Scotland
4.4	Falls rate per 1,000 population aged 65+	To reduce	17 (2014/15)	21 - 2014/15 22 - 2017/18 22 - 2018/19	↑	➲	Annual ISD NI-16 2015/16 Highland reduced to 15-Scotland no change 2016/17 Highland 16 - Scotland 21 2017/18 Highland 15 - 2018/19 - 15 no change

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current position	comment
4.5	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	To increase	85% (2015/16)	83% 2015/16 80% 2017/18	↑	↑	Annual ISD NI-7 - (also see SOLACE SW4B) 2017/18 Highland 86%,slight improvement
Outcome 5: Health and social care services contribute to reducing health inequalities.							
Key	**↑Performance improving**	**↓Performance declining**		**➲Performance is stable**			
	Indicators	**Target**	**Baseline**	**Benchmark (Scottish average or local average where known)**	**Comparison to Benchmark position current Scottish average)**	**current position**	**comment**
5.1	Premature mortality rate (per 100,000 population)	To decrease	374 (2014/15)	423 2014/15 441 2015/16 425 2017/18	↑	↓	Annual National Indicator produced by ISD NI-11 - Integration Outcomes, 2016/17 Highland 377, Scotland 440 - per 100,000 2017/18 Highland 373 per 100,000, Scotland 425 per 100,000, 2018/19 Highland 402 per 100,000 Scotland 432 per 100,000. Both showing an increase
5.2	People who have dementia will receive an early diagnosis: maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources	To increase	2146	N/A		↑	Local Indicator - monthly - 2168 @ March 2017, March 18 is 2156 people, Mar 19 (Q4) 2229 2019/20, Q1 -2259, Q2 - 2273. The QOF website is no longer available. A new GP dashboard has replaced this however it has not been fully updated and currently only shows data to March 19.
5.3	The number of people with learning disabilities who are in further education	To increase	9.32%	7.60%	↑	↑	National SCLD dataset from e-Say return, baseline 2015 report published 10/8/16 2017 report shows Highland with an increase to 11.9% while the Scottish Average has reduced to 6.2% Recent draft publication for 2018 shows 10.4%, Scottish average 4.4%
5.4	Deliver faster access to mental health services and 18 weeks referral to treatment for Psychological Therapies	90%	80%	79.3% @ Dec 2018	↑	↓	Local Indicator - monthly - baseline March 2016 June 2017 -86%, Sept 17 -84% Dec 17 - 87%, Mar 2018 82% (under target) Scotland average 78.2% on 31/03/2018 June 18 - 71% , Sept 18 - 79%, Dec 18 - 75%, Mar 19 - 92% fluctuations month to month above target at year end June 19 - 81%, Sept 19 79%, Dec 19 77.5% (183 of 236 patients seen in Dec within 0-18 weeks)

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current position	comment
5.5	The time taken to access drug or alcohol treatment services	90% or higher	77%	93.9% @ Dec 2018	↓	↓	Amended to ISD published data for NHS Highland from June 18 % seen within 3 weeks - quarterly - Dec 2016 83.6% - March 2017 - 78.8%, June 17 - 84.9%, Sept 2017 -84.4%, Dec 2017 -89.7%, March 18 -86.3%, June 18 -88.3%, Sept 18 - 86.1%, Dec 18 - 84.8%, March 19 -90.9%, June 19 - 90.1%, Sept 19 - 86.7% (per ISD published data)Q2 shows slight reduction and below target

update

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

Key	↑Performance improving	↓Performance declining	➲Performance is stable			

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current position	comment
6.1	Percentage of carers who feel supported to continue in their caring role	To increase	37% (2015/16)	40% 2015/16 37% 2017/18	↓	↑	Annual ISD NI-8- Integration Outcome Q45e 2014/15 Health and Care Experience Survey (amended Dec 18) 2017/18 Highland 38%, slight improvement

Outcome 7: People using health and social care services are safe from harm.

Key	↑Performance improving	↓Performance declining	➲Performance is stable			

	Indicators	Target	Baseline	Benchmark	Comparison to Benchmark position current Scottish average)	current position	comment
7.1	Percentage of adults supported at home who agree they felt safe	To increase	84% (2015/16)	83% 2015/16 83% 2017/18	↑	➲	Biennial National Health and Care Experience Survey NI-9 (local survey TBD) Q36h 2014/15 Health and Care Experience Survey (amended Dec 18) 2017/18 Highland 84%, no change
7.2	Adult Protection Plans are reviewed in accordance with Adult Support and Protection (ASP) Procedures	90%	57%	N/A		➲	Local indicator, baseline is amended to 2017/18 as target timescale 3 months, 38 initial cc's 23 with 1st reviews required, 13 completed within target timescale 2018/19 -54% within target (15/28 initial case conference reviews)

	Indicators	Target	Baseline	Benchmark	Comparison to Benchmark position current Scottish average)	current position	comment
7.3	Reviewing and monitoring of Guardianships. Number of Guardianships reviewed - annual required timescale.	TBC	50.0%				Local Annual indicator - baseline 2015/16 - % is based on records on CareFirst for reviews completed March 2016/17 - 49.9% - 242 of 485 completed March 2017/18 - 37.9% - 224 of 592 Guardianships 2018/19 - 48.25% did have a review during the year however 14% completed within timescale
	Reviewing and monitoring of Guardianships. Number of New Guardianships reviewed within required timescale of 3 months.	TBC	57%	N/A			Local Annual indicator - baseline 2015/16 March 2016/17 - 31.25% March 2017/18 - 23.85% 2018/19 - 20.13% completed within timescale (31 of 154 new Guardianships) a total of 40.26% were reviewed in the year
Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.							
Key	**Performance improving**	**Performance declining**		**Performance is stable**			
	Indicators	**Target**	**Baseline**	**Benchmark (Scottish average or local average where known)**	**Comparison to Benchmark position current Scottish average)**	**current position**	**comment**
8.1	Percentage of staff who say they would recommend their workplace as a good place to work	To increase	Under development				Annual National Indicator produced by ISD under development
8.2	Workforce is Adult Support and Protection effectively trained	TBC	100%	N/A			Local Annual indicator, baseline 2015/16 (1158 of 1158 people trained reported higher confidence) 2016/17 - 1,411 trained, 1,205 completed evaluation of which 99% felt more confident 2017/18 - 993 trained, 929 evaluations of which 909 (98%) felt more confident 2018/19 - 1,077 trained, 1,027 evaluations of which 1,023 (99%)felt more confident. Training is also available on LearnPro & Brightwave, a further 1,345people completed the on-line training.
8.3	People and professionals across Highland can access and benefit from Sensory awareness training "I have increased skills and tools that enable me to communicate in a way that I want"	100 People annually					Learning Services (SHHELS) Q2 2018/19 -108 in total: Q3 -total 99: Q4 - total 60, 2018/19: 60 face to face, 97 Sight Loss e-module, 110 Deaf Awareness e-module a total of 267 2019-20, Q1 - 78,Q2 - 59 people, Q3, 119 people, this exceeds the annual target, the e-learning modules have now been approved to be incorporated s part of mandatory training for

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current position	comment
8.4	Employee engagement index (from iMatters)	TBC					2017 & 2018 - the response rate was less than 60% therefore no EEI is available, published Feb 2019 no update for 2019 is yet available
8.5	Uptake of Knowledge and skills Framework	TBC	27.3%			➲	Based on 'Reviews completed and signed off excluding A & B' Baseline March 2016 (2423 of 8876 posts), March 2017 25.3% (2432 of 9601 posts), Jan 18 is 26% (2537/9759) e-KSF unavailable Feb/Mar 18, Figure are KSF and will not change until Turas Reporting in place
8.6	Sickness absence levels	TBC	4.88%	5.2% @ Mar 17 5.39% @ Mar 18	⇧	➲	NHSH Operational Units Annual Average Sickness Trends report baseline March 16 (% NHSH Local) Dec 16 update NHSH Local 4.92%, March 2017 - 4.86%, June 17 - 4.87%, Sept 17 - 4.83%, Dec 17 - 4.84%, Mar 18 -4.96% June 18 is 4.93%, September -4.97%, Dec 18 - 5%,Mar 19- 4.93%, Jun 19 -5.01%, Sept 19 -5.01%, Dec not yet available

update

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

Key	⇧Performance improving	⇩Performance declining	➲Performance is stable			

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current position	comment
9.1	NHSH make payment of the C@H tariff rate within 28 days of receipt of a valid invoice	To increase	83.34%				"A revised care-at-home" contract has been implemented which is effective from the 2nd July 2019 and as a result of this change, a new streamlined bulk invoice process has been implemented which has drastically reduced the number of invoices being received which should also improve the percentage paid within 28 days once fully understood and implemented by providers. No update is currently available on new process" March 17 - 89.25%, Q1 2017/18 - 93.23% (2340 of
9.2	Home Care costs per hour for people aged 65 or over	No target	£31.18	£20.24	N/A	N/A	Annual SOLACE Indicator, 2015/16 Highland £32.66, Scotland £21.19 2016/17 Highland £36.09, Scotland £22.64 2017/18 £29.79, Scotland £23.76 2018/19 £29.46, Scotland £24.67 (adjustment pending this year amendment to include SDS in home care)

update

	Indicators	Target	Baseline	Benchmark (Scottish average or local average where known)	Comparison to Benchmark position current Scottish average)	current position	comment	
9.3	Self Directed Support (option 1) spend on people aged 18 or over as a % of total social work spend on adults	No target	4.16%	6.90%			Annual SOLACE Indicator, 2015/16 Highland 5.26%, Scotland 6.66% 2016/17 Highland 6.29%, Scotland 6.36% 2017/18 Highland 6.10%, Scotland 6.72% (pending adjustment) 2018/19 Highland 6.46%, Scotland 9.07% (pending adjustment)	update
9.4	Net Residential costs per resident per week for Older Persons (over 65)	No target	£410.77	£371.43	N/A	N/A	Annual SOLACE Indicator, 2015/16 Highland £426.74, Scotland £364.71 2016/17 Highland £448.22, Scotland £372.36 2017/18 Highland £481.89, Scotland £372.42 2018/19 Highland £514.06, Scotland £381.01 (adjustment pending)	update

Highland Health and Social Care Committee
5 February 2020
Item 3.7

Report Title:	**Highland Health and Social Care Annual Performance Report 2018-19**
Report By:	**Chief Executive**

1. Purpose/Executive Summary

1.1 This report introduces the Highland Health and Social Care Annual Performance Report 2018/19

2. Recommendations

2.1 Members are asked to scrutinise and comment on the Annual Performance Report.

3. Implications

3.1 Resource
There are no immediate resource issues in relation to this report. Intensive partnership work involving senior staff from both the Council and NHS Highland is now underway to provide a deep analysis of the financial position and outlook. This work will be taken to the Joint Monitoring Committee (JMC) as soon as it is completed. An expected date is early January.

3.2 Legal – None

3.3 Community (Equality, Poverty and Rural) – None

3.4 Climate Change / Carbon Clever – None

3.5 Risk – None

3.6 Gaelic – None

4. Highland Health and Social Care Annual Performance Report

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

4.2 This arrangement was superseded by the Public Bodies (Joint Working) Scotland Act, 2014. This requires an Annual Performance Report, which provides an opportunity to reflect on 2018/19 and to celebrate the achievements delivered.

4.3 The Annual Performance Report is based upon information previously provided to the JMC in June 2019 and is provided at **Appendix 1**. This summaries performance information in relation to both children's services and adult social care. As noted earlier in section 3.1 of this report extensive financial assessment is ongoing and will be brought forward in early January.

4.4 The report has been presented to the Care, Learning and Housing Committee, and is made available to all members.

Designation:	Chief Executive
Date:	27 November 2019
Author:	Ian Kyle, Children's Planning Manager
Background Papers:	

Highland Health & Social Care

Annual Performance Report 2018-19

Drafting Note

The Partners agreed that they would adopt the same format as the Argyll and Bute document to maintain consistency of approach across the NHS Highland Partnerships. The Argyll and Bute was not available at the time of drafting, therefore this report has been produced in a simple text format pending further editing of presentation style.

Introduction by Chief Officer and Head of Children's Services

David Park, Chief Officer Highland Health and Social Care Partnership:

The annual report provides a time of reflection over the delivery of care that is provided for the people of our communities. This year we have seen unprecedented challenges around growing demand for services, workforce pressures and finances. We remain committed to improving on our services yet we have some very complex, bold and testing decisions to make around what services will look like in the future.

These pressures however have not prevented us from delivering high quality services and I am very pleased to see that we continue to make progress across many areas as well as largely positive comparisons against National performance.
The challenge for coming year is to focus on delivering better support to Carers, developing and extending home based care options and working with the innovative communities of the Highlands to develop more local, community based provision and support.

I wish to recognise the tremendous contribution made by all the people dedicated to providing care, which include NHS staff, Independent and Voluntary organisation staff, as well as other volunteers and carers. Thank you. This report really reflects our collective delivery of care to people in Highland.

Karen Ralston, Interim Head of Children's Services. Highland Council.

This annual report confirms our commitment to give every child and young person in Highland the best possible start in life; enjoy being young; and are supported to develop as confident, capable and resilient, to fully maximise their potential ensuring our children to be safe, healthy, achieving, nurtured, active, respected & responsible and included.

Our integrated children's services plan includes measures to provide children with the best possible start in life and the necessary support to enable them to achieve their potential. The latest iteration of this plan (For Highland's Children 5) is currently under development and reaffirms our commitment to ensuring effective collaborative leadership leads to better outcomes for our children, young people and their families in the communities.

This report provides an overview of performance within the Highland partnership, during 2018/19. During this period, services in Highland have continued to be resilient and effective in addressing the main challenges and opportunities.'

Executive Summary

The Public Bodies (Joint Working) (Scotland) Act 2014 obliges partnerships to produce and publish an Annual Performance Report setting out an assessment of performance in planning and carrying out the integration functions for which Integration Joint Boards in Scotland are responsible.

The Annual Performance Report 2018/19 therefore encompasses the following:

- Assessing Performance in relation to the National Health and
- Wellbeing Outcomes
- Financial Performance And Best value
- Reporting on Localities and the work of Locality Planning groups and community stakeholders
- Inspection of services, to include details of any inspections carried out in 2017/18 relating to the functions delegated to the partnership, by scrutiny bodies.
- Ministerial Strategic group Integrated Joint Board scorecard – Performance measures assessment.
- The 9 National Health and Wellbeing Outcomes describe what people can expect from the HSCP. Performance against each outcome is analysed in the performance assessment sections, with illustrative practice examples demonstrating how local services are working to achieve the outcomes.

Overall, the report identifies the progress achieved and the work that is ongoing within our Localities. It also demonstrates some of the challenges the Health and Social Care Partnership (HSCP) is facing and highlights the significant changes that will take place to shape services fit for the future.

Strategic Context

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

In taking forward our plans, the Health and Social Care Partnership works to the vision that it stated when we began our integration journey:

"We will improve quality and reduce the cost of service through the creation of new, simpler organisational arrangements that are designed to maximise outcomes." The Highland Council & NHS Highland 16 December 2010

Put more simply our aim is: "Making it better for people in the Highlands".
Progress is measured through tracking work and improvement plans and key measures. This report sets out a number of important measures of progress. It also describes some of the main areas we have been working on and the difference this has made.

The Annual Performance Report is a chance to reflect on 2017/18 and to celebrate the achievements delivered by employees and partners. It is also a chance to think about those things that have not gone so well, and to appreciate the challenges that face us in terms of our performance now and in the coming year.

In terms of governance and reporting arrangements the Integration Scheme details that the Lead Agency is responsible for the operational management and performance of integrated services, including shared services. As such, the NHS report to the Council in relation to adult care; and the Council reports to the NHS Board on children and families.

The Highland Partnership between NHS Highland and the Highland Council has agreed to a set of good governance principles, namely:

- Each Lead Agency has a governance structure that reflects single governance, single budget and single management
- Each Lead Agency adopts a Strategic Commissioning approach to working with partners across the Public, Independent and third sectors to develop the Strategic Plan
- The Partnership is agreed on the functions of scrutiny and governance and where these responsibilities are discharged.
- The Partnership has a Strategic Plan which is shared and equally owned
- The commissioning agency monitors the impact on outcomes.

Assurance is provided via reports to Council and Board Committees on a regular basis. This report therefore represents a summary of the detailed reporting that takes place throughout the year.

Performance Against National Outcomes

The National Health and Wellbeing Outcomes (NHWBO) provide a strategic framework for the planning and delivery of health and social care services. These suite of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO), and 23 sub-indicators which form the basis of the reporting requirement for the Health and Social Care Partnership.

The following sections provide a detailed breakdown of the HSCPs performance against each NHWBO target for 2018/19, where possible, we have indicated how we have performed against national comparisons, as well as a comparison to its position in 2016/17 and 2017/18

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

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

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

Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected

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

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

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

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

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

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services

In addition Highland has the following outcomes specifically for Children:

Outcome C1. Our children have the best start in life.

Outcome C2. Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

Outcome C3. We have improved the life chances for children, young people and families at risk.

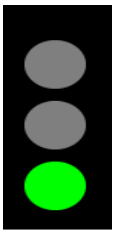
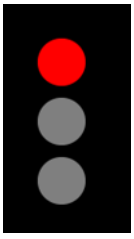
Outcome 1:

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

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

There is one general indicator which is derived from the Biennial National Health and Care experience survey (last undertaken during 2017/18) supplemented by information gathered locally regarding how many emergency admissions we admit to hospital, our success rate in enabling clients to live normal lives in the community following a spell in hospital and our success rate in offering annual health screening to clients with learning disabilities and supporting clients with a sensory impairment. These indicators are generally showing an improvement over this period except for enable in South & Mid area where successful enablement outcomes have been decreasing year on year.

This information is detailed in Table 1

Outcome 1	 **X 4**		 **X 1**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Percentage of adults able to look after their health very well or quite well	To improve on Scottish average	Scotland – 95% Highland – 95% (2015/16 baseline)	Not applicable	Scotland - 93% Highland – 94%	Not applicable	Better than Scottish average – Biennial data.
Emergency admission rate (per 100,000 population)	To improve on 2016/17 baseline (10,559 admissions)	Scotland – 12,281 Highland – 11,081	Scotland – 12,215 Highland – 10,559	Scotland – 12,192 Highland – 10,666	Scotland – 11,492 Highland – 10,666	Better than Scottish average admissions) and showing year-on-year improvement
Enablement: % of people receiving enablement interventions that do not require ongoing care interventions after initial 6 weeks	To improve on 2016/17 baseline of 40%	Not applicable	South & Mid only 38.8%	S & M – 31% N & W – 33%	S & M – 24% N & W – 46%	2017/18 S & M -114 of 369 people N & W – 24 of 72 2018/19 S & M – 86 of 365 people N & W – 39 of 84

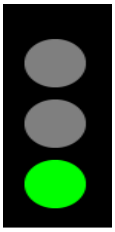
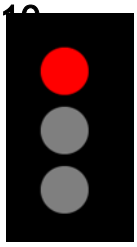
Outcome 1	 X 4		 X 1			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
The number of health screenings provided for people with learning disabilities: all people with learning disabilities and epilepsy are offered an annual nurse led review of their condition	To maintain or improve on 2016/17 baseline of 97%	Not applicable	97%	95.8%	98.6%	Performance was improved in 2018/19
Sensory Impairment (Sight)- Self Management (Client Outcomes), The Percentage of completed rehabilitation courses who have achieved independence or achieved independence above expectation	Amended to 90% target	New 2018/19 indicator			July 18 – March 19 data - Sight services– 86% Deaf services – 83%	New methodology introduced in 2018 by Sensory Impairment organisations to allow for consistency and new indicators agreed.

Table 1 – Outcome 1

To support these outcomes, improvement work has been undertaken around the **Single Point of Access** for each community team to ensure that there is ease of access for referrers and service users in times of crisis. This links in with the Social work duty system and the "step up" beds in residential homes, which can be used to prevent emergency hospital admission where there is no acute medical need. In Inverness, a virtual ward model is being developed to support an integrated approach to admission prevention for those identified as being most at risk of repeated hospital admission.

Enablement services are developing across North Highland. In the South & Mid Division we are looking working to synchronize data collection and format which will provide clear sustained detail regarding the service. There are ongoing developments in the work with local associated professionals to ensure a seamless coordination of services and expectations. One significant area of change will be a structural change to 6 registered services, managed more locally, this will provide greater integration between local district

teams and local enablement services, which we believe will enable more reactive and cohesive responses with improved outcomes. The North & West Division services continue to transition to an enablement model, the current service provides a mix of internal and external care at home as well as the enablement services. A specific local focus is the partnership with local external providers for care at home, this is to ensure sufficient capacity is available for transfer from enablement for an ongoing service where required, lack of capacity reduces the flow of patients and ay delay enablement starts with subsequent consequences for outcomes achieved.

All service users in Caithness receiving support from the Enablement team are provided with an end of service questionnaire to ascertain how they felt about the service they received and if they have any ideas or suggestions to improve the service.

This exercise is at a very early point with seven questionnaires completed questionnaires, the results of which are below:

	Totals									
	Strongly Agree		**Agree**		**Disagree**		**Strongly Disagree**		**Not Applicable/ Don't Know**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Were you happy with the goals set for you at the beginning of your service?	5	71%	2	29%						
Were you involved in the goal setting process?	4	57%	3	43%						
Did you feel that the service provided was appropriate to your needs and circumstances?	6	86%	1	4%						
Did you feel confident and safe with the staff assisting you to achieve your goals?	7	100%								
Do you feel that the service you received allowed you to regain your independence and confidence at home?	7	100%								

	Number	**Percentage**
No further assistance required	5	71%
Transferred to mainstream Care at Home Service	2	29%

	Excellent		**Good**		**Average**		**Poor**		**Very Poor**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**

Overall, how would you rate the quality of the service you received?	6	86%	1	4%	112					

The results so far have been very positive with all service users grading the service they received as either excellent or good and all rating their satisfaction with staff and service outcome in terms of retention of independence at home, as excellent.

Although the relatively low number of responses received does not lend itself to reliably identifying any trends, the lowest grades (good) were in the questions relating to the goal setting process and service user involvement in this process.

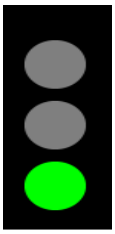
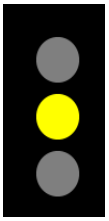
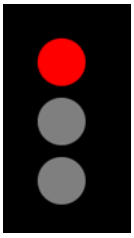
Perhaps the best sign of success is that 71% of respondents were able to live independently following their enablement service, without being referred to the mainstream Care at Home service.

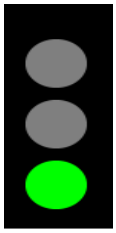
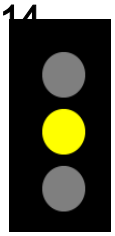
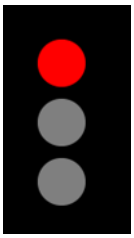
Outcome 2: 113

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

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

Overall, the picture is an improving one with clients spending longer in the community and less time in institutional settings such as care homes or hospitals. There is increasing uptake of Self Directed Support, particularly of option 2 where clients or their agents are taking direct control of their care needs.
Year-on-year performance is increasing in most of the indicators, although some are still below the Scottish national average.

Outcome 2	 **X 9**		 **x 1**		 **x 1**	
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Percentage of adults supported at home who agreed that they are supported to live as independently as possible	To improve on Scottish average	Scotland – 83% Highland – 83% (baseline)	Not applicable	Scotland - 81% Highland – 86%	Not applicable	Improvement . Outcome above the Scottish average - Biennial data.
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	To improve on Scottish average	Scotland – 79% Highland – 77% (baseline)	Not applicable	Scotland - 76% Highland – 79%	Not applicable	Performance improving. Outcome above the Scottish average - Biennial data.
Readmission to hospital within 28 days (per 1,000 population)	To maintain or improve on 2016/17 baseline of 92 readmissions	Scotland – 98 Highland – 89	Scotland – 101 Highland – 92	Scotland – 103 Highland – 107	Scotland – 98 Highland – 108	Performance has declined with an increase in the number of readmissions in 2018/19

Outcome 2	 **X 9**		 **x 1**		 **x 1**	
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Proportion of last 6 months of life spent at home or in a community setting	To maintain or improve on 2016/17 baseline of 89%	Scotland – 87% Highland – 89%	Scotland – 87% Highland – 89%	Scotland – 88% Highland – 90%	Scotland – 89% Highland – 91%	Performance has improved over baseline.
Percentage of people aged 65 or over with long term care needs receiving personal care at home	To maintain or improve on baseline	Scotland – 60.7% Highland – 52.5%	Scotland – 60.1% Highland – 49.9%	Scotland – 61.7% Highland – 53.2%		This is a SOLACE indicator which was amended, no update for 18/19 as yet
Number of days people spend in hospital when they are ready to be discharged, per 1,000 pop ulation (75+)	To maintain or improve on 2016/17 baseline of 1,585 days	Scotland – 915 Highland – 1,585	Scotland – 841 Highland – 1,580	Scotland – 762 Highland – 1,300	Scotland – 805 Highland – 1,284	Performance improved considerably in 2017/18 with slight reduction in 18/19 although still well over the Scottish average
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	To maintain or improve on 2016/17 baseline of 24%	Scotland – 24% Highland – 23%	Scotland – 24% Highland – 23%	Scotland – 25% Highland – 21%	Scotland – 22% Highland – 20%	Performance has improved in 2018/19
Uptake of Self Directed Support options 1 and 2	To maintain or improve on 2016/17 baseline of 437 clients	Not applicable	437 @ Year End Option 1 - 332 Option 2 – 105	614 @ Year End Option 1 - 367 Option 2 – 247	616 @ Year End Option 1 - 355 Option 2 – 261	Uptake of Self Directed Support Options 2 continues to increase Option 1 has reduced slightly 2018/19

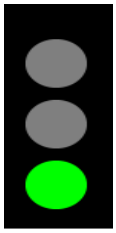
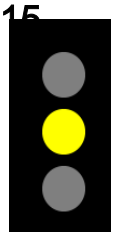
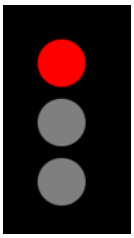
Outcome 2	 X 9		 x 1		 x 1	
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Total number of adults receiving basic or enhanced Technology Enabled care	To improve on baseline –	Basic - 1,929 Enhanced - 419	Basic - 1,993 Enhanced - 485	Basic – 2,113 Enhanced - 527	Basic – 2,134 Enhanced - 599	Performance has improved year-on-year
Percentage of referrals received per quarter with reason given 'to enable to remain at/return home' & 'to enable independence'	To improve on baseline	Not applicable	Annual total 36.9%	Annual total 36.3%	Annual total 26.4%	The number of referrals continues to increase, the reason to improve safety/reduce risk of harm is predominant reason being recorded
Percentage of new installations in quarter with activity monitors i.e. falls monitors	To improve on baseline	Not applicable	Annual total 31%	Annual total 35.2%	Annual total 40.2%	New performance indicator for 2017/18. Performance improving.

Table 2 – Outcome 2

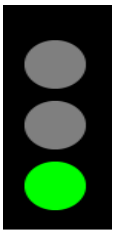
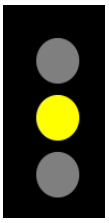
A key indicator in this group is the number of delayed discharges which is well above the Scottish average. Delayed discharge continues to be a challenge, with lack of care at home services and care home placements accounting for around 90% of the delays for the over 65 age group. Considerable improvement has been made in increasing the amount of care at home provided by the independent sector, but additional care at home capacity is still required.

There are also significant issues around the lack of care home capacity. It does further strengthen the need to identify and provide support for clients at an earlier stage well before any hospitalisation incident. Should a client be admitted to hospital it also highlights the importance of effective discharge into the community as soon as possible to prevent increasing dependency leading to a requirement for placement in a care home.

Outcome 3:

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

This indicator is about the quality of the services provided and client's ability to manage and be in direct control of the services that they require. Apart from the indicators in table 3 below, other indicators such as enablement (Table 1) and self-directed support (Table 2) are also relevant. Clients and patients in Highland are consistently scoring Health and Care services above the national average.
The proportion of care services graded 4 and above in Care Inspections is above the national average.

Outcome 3	 **X 3**		 **X 1**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	To improve on Scottish average	Scotland – 75% Highland – 73% (2015/16 baseline)	Not applicable	Scotland - 74% Highland – 76%	Not applicable	Performance improving. Outcome above the Scottish average - Biennial data.
Percentage of adults receiving any care or support who rate it as excellent or good	To improve on Scottish average	Scotland – 81% Highland – 83% (2015/16 baseline)	Not applicable	Scotland - 80% Highland – 83%	Not applicable	Performance stable and above Scottish average - Biennial data.
Percentage of people with positive experience of the care provided by their GP practice	To improve on Scottish average	Scotland – 85% Highland – 89% (2015/16 baseline)	Not applicable	Scotland - 83% Highland – 87%	Not applicable	Performance declined slightly in 2017/18, but still above the Scottish average - Biennial data.

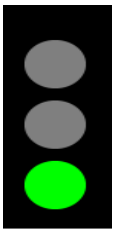
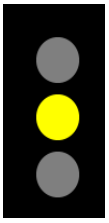
Outcome 3	 X 3		 X 1			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	To improve on Scottish average	Scotland – 82.9% Highland – 77.8%	Scotland - 83.8% Highland – 83.8%	Scotland - 85.4% Highland – 86.3%	Scotland - 82% Highland – 86%	Performance static and above Scottish average.

Table 3 – Outcome 3

Care at Home has continued to be a commissioning priority. Work was undertaken with the sector representatives to develop an alternative to the Care at Home Tariff which had been the model of commissioning for a number of years. Currently a new commissioning model is being implemented to address the ensure that quality, speed of delivery and geographical accessibility are improved.

In terms of Learning Disability:

All overnight support provision is in the process of being reviewed. An outcome of the first phase of this review is the development of the Inverness Waking Night Responder Service. This service provides a planned and responsive service to people with a learning disability currently living in their own home. The service is successfully supporting people to stay in their own home with access to shared night time support. One man was able to go out with his friends to an event in Eden Court and arrange for the Waking Night Responder Service to be present in his home when he arrived back to ensure that he took his medication correctly and his house was properly secured after they assisted him to bed.

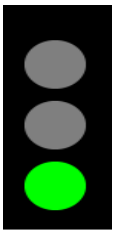
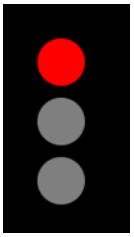
The Highland Learning Disability Listening Group has been established to ensure that the voices of people with a learning disability are heard by NHS Highland managers and planners. The majority of group members are people with a Learning Disability from Inverness, Fort William and Thurso, other members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

Outcome 4:

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

The previous indicator is used to determine the quality of the services being provided. This indicator is about the quality of life of the people who use those services. Apart from the delayed, this also paints a positive picture with fewer falls and a lower emergency day rate than the National average.

Scoring at 86%, a high number of patients and clients agree that the services provided do improve their quality of life. Of particular interest in future years will be the new indicator on social and geographical connectivity given the mix of urban and rural communities found in Highland.

Outcome 4	 **X 3**		 **X 1**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Delayed hospital discharges for service users (code 25D) residing within areas covered by ISC C@H providers	20	20	14	32	34	Following improvements in 2016/2017, performance has declined
Emergency bed day rate (per 100,000 population)	119,517 bed days	Scotland - 128,250 Highland – 121,771	Scotland - 126,945 Highland – 120,390	Scotland - 123,160 Highland – 107,197	Scotland - 107,921 Highland – 98,017	Performance has improved year-on-year
Falls rate per 1,000 population aged 65+	17 patients admitted due to falls	Scotland - 21 Highland – 15	Scotland - 21 Highland – 16	Scotland - 23 Highland – 15	Scotland - 22 Highland – 15	Performance has remained stable year-on-year

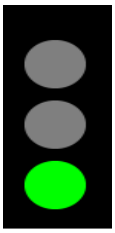
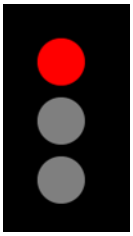
Outcome 4	 **X 3**		 **X 1**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	To improve on Scottish average	Scotland – 83% Highland – 85%	Not applicable	Scotland – 80% Highland – 86%	Not applicable	Slight improvement. . Outcome above the Scottish average - Biennial data.

Table 4 – Outcome 4

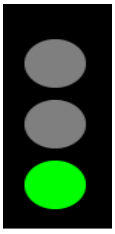
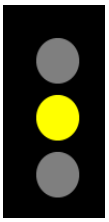
In South and Mid (East Ross) a pilot is being undertaken around falls prevention using Scottish Patient Safety Programme methodology. This involves all professionals asking the same initial falls screening questions, to identify those needing the full multi-factorial screening (MFS) tool to be used.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

Outcome 5:

Health and social care services contribute to reducing health inequalities.

This indicator is about ensuring that communities in Highland are safe and healthy and that individual circumstances are taken into account. Table 5 shows that the premature mortality rate in Highland is lower than the National average.

The time taken to access drug or alcohol treatments services is improving year-on-year from 77% in 2016/17 to 84.4% in 2017/18, but has yet to reach the 90% target set by Scottish Government.

Outcome 5	 **X 3**		 **X 1**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	To improve on Scottish average	Scotland – 75% Highland – 73% (2015/16 baseline)	Not applicable	Scotland - 74% Highland – 76%	Not applicable	Performance improving. Outcome above the Scottish average - Biennial data.
Percentage of adults receiving any care or support who rate it as excellent or good	To improve on Scottish average	Scotland – 81% Highland – 83% (2015/16 baseline)	Not applicable	Scotland - 80% Highland – 83%	Not applicable	Performance stable and above Scottish average - Biennial data.
Percentage of people with positive experience of the care provided by their GP practice	To improve on Scottish average	Scotland – 85% Highland – 89% (2015/16 baseline)	Not applicable	Scotland - 83% Highland – 87%	Not applicable	Performance declined slightly in 2017/18, but still above the Scottish average - Biennial data.

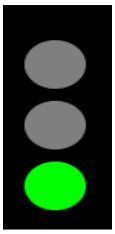
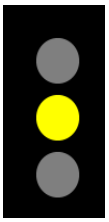
Outcome 5	 **X 3**		 **X 1**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections and proportion graded 5 or above	To improve on Scottish average	Scotland – 82.9% Highland – 77.8%	Scotland - 83.8% Highland – 83.8%	Scotland - 85.4% Highland – 86.3%	Scotland - 82% Highland – 86%	Performance static and above Scottish average.

Table 5 – Outcome 5

In Inverness the team are looking at funding to provide people areas to receive a High Life Highland family membership to encourage them through the door of the leisure centre.

Outcome 6:

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

Carers play a particularly important role in ensuring the health and wellbeing of clients, patients and communities. The purpose of this indicator is to determine if they are supported in that role and takes into consideration their own quality of life. Performance has improved, albeit only slightly, between 2016/17 and 2017/18, though performance Nationally had fallen.

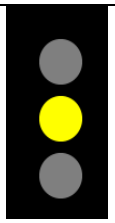
Outcome 6	 **X 1**					
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Percentage of carers who feel supported to continue in their caring role	To improve on Scottish average	Scotland – 40% Highland – 37%	Not applicable	Scotland – 37% Highland – 38%	Not applicable	Performance is slightly improved and better than the Scottish average - Biennial data.

Table 6 – Outcome 6

Carers
The Carers (Scotland) Act 2016 introduces new rights for unpaid Carers and new duties for local councils and the NHS to provide support to Carers. This part of the report recognizes that we have significant progress to make, and uses the Annual Performance Report as a vehicle for setting the agenda for the future.

Work is now well underway to ensure that NHS Highland is in a position to meet these new statutory duties as they relate to Carers. This work has, hitherto, focused on the completion of an Implementation Plan with an outline of associated costs; and the completion of salient action contained therein.

The partnership recognises the huge contribution made by unpaid Carers in Highland; and it is keen to ensure that we are in a position to support these Carers to ensure they feel willing and able to continue in their valuable and valued caring roles.

Carers Improvement Group: Monitoring and Progressing the Implementation plan
The latest iteration of the Carers Implementation Plan was considered at the Carers Improvement Group (CIG). This group – representing Carers, Carers Representative Organisations, Statutory Services and third sector partners – should be well placed to oversee and monitor progress against the Plan. The CIG has agreed to provide Reports to this Committee to ensure progress is shared, issues are raised and its 'direction of travel' agreed.

Preparing Adult Carer Support Plans (ACSPs)
With the use of a Highland ACSP and the National Eligibility Framework for Carers agreed for Adult Carers; Connecting Carers are now undertaking the completion of these plans with Carers when a referral has been made. Carers Link Workers are in situ across most of the Highland Districts to effect this.

At this point the use of the ACSP is new and level of demand (of referrals) is low – but it is already reported to be rising sharply. The CIG is exploring the feasibility of a enlisting a wider variety of third sector organisations to complete the ACSP. This will have costs in terms of time and training.

Providing for Eligible Need
Where Adult Carers are assessed to be in Critical or Substantial need they may be entitled to Self-Directed Support. At this point work is underway with NHS District Teams, Adult Social Workers and Connecting Carers Link Workers to relay the steps necessary to access statutory provision.

It is recognised that this is fundamentally a new process and therefore work is in train to strengthen working relationships between Connecting Carers Link Workers and District Professionals. Joint-working will need to be evidenced for Resource Allocators to have assurance that any resources identified for Carer Support are as targeted as possible, and that any resource made available is fully complementary to the resource provided to the Cared-for person.

Short Breaks Statement
The CIG has received and considered the first draft of a Highland Short Breaks Statement. This was well received by the Group and steps are underway to consult with Carers on its content. The Group is aiming to provide an “easy-read” version of the Statement to promote engagement with a wider group of audiences.

Setting our Duties in context – Practice Support and Training Plan
It is recognised that the impact of the Implementation of the Carers Act will to change many well established practices across Social Care and Social Work. Hitherto Social Workers, for example, have undertaken assessments of ‘adults in need’ which have often fully incorporated an element of respite for the Carer. As we move ahead we recognise that this model will need to change.

At root we recognise that “Short Breaks” and other support aimed specifically at supporting Carers ability and willingness to care need to be understood as complementary to – but separate from – the support provided the cared-for person.

Understanding Carers’ needs and supporting these are seen as critical to managing demand in the Social Care Sector. Providing person-centred and flexible responses to the Carer which dovetail with the supports already provided to the Cared-for person will require for the professionals involved to have a solid grounding in the respective legislation requirements and local policy priorities (for Carers and the Cared-for).

To this end the Group welcomed proposal that a “Carers Practice Support Officer” role, or similar, is created to support practice in the multi-agency environment. Resource would come from Carers Act Implementation monies. A key component of that post will be to bring together a comprehensive Training Plan for all of those working with Carers.

Waiving Charges: impact and process
The Scottish Government statutory Guidance is directing local authorities to ensure that charges are waived for services that are provided primarily to support a Carer's willingness and ability to care. That Guidance, supported by Examples given by Cosla's Waiving Charges Group, also seeks to add clarity as to how authorities might interpret which services these are.

Currently a local, Highland Policy is being drafted by NHS Highland which is seeking to operationalise the available Guidance in respect of charges to Adult Carers. However it is recognised that that local Policy also needs a clear "Business Process" to ensure that our duty is reflected in our generation of invoices etc. Given we have, as described at 3.2 (above), often fully incorporated support to Adult Carers in the packages to Adults in Need this work is not uncomplicated. Work to promptly describe a robust process for separating out which existing charges should be waived is underway.

Developing a Strategic Approach
Currently practice in Highland can be seen to be seeking to meet our duties to Carers within current practice and contractual arrangements. In large part this means routing the requests to meet the Eligible needs of Adult Carers (indentified in ACSPs) through existing District Care Planning processes. Notwithstanding the fundamental need to ensure that the supports to Carers and to the Cared-for are fully complementary, this approach is likely to be considered both bureaucratic and Service-led.

As the CIG looks ahead to meeting the intent, ethos and duties contained within the Carers Act it has spent some time considering the key components required in Services for Carers; and has reflect upon what characteristics they will require to have to deliver an open and flexible response to meeting Adult Carers' needs.

Meeting Core responsibilities: Information and Advice
A public-facing, engaging and accessible presence that clearly attracts those who are identifying themselves as a Carer was considered to be necessary to provide 'upstream' advice, information and peer support to enable Carers to develop their own resilience in their caring role.

Placing ACSPs at the centre
The salient right for Adult Carers in the new Act is the right for them to complete an Adult Carers Support Plan. Once completed these plans will, where relevant, identify the outstanding, eligible needs of the Carer. To support the Carer's willingness and ability to care it is considered that this will, most often, take the form of the need for a short break from caring.

It is recognised that the completion of these ACSPs will be a highly skilled and nuanced task: it will also require significant joint-working to ensure that the needs of the Carer and Cared-for person are meet in a fully complementary way.

The CIG considered ensuring we have the ongoing, trained capacity to support the completion of ACSPs to be a key plank in the shape of Carers Services into the future.

Developing a Short Breaks Bureau
Given that a significant majority of Carer need will require to be met by some form of "Short Break" the CIG has considered that it makes sense to develop speciality in this area. The

development of a Short Breaks Bureau was agreed as a good way to meet this demand. The aim will be that such a bureau will develop best practice in finding/developing innovative, person-centred responses to need as well as providing access, where necessary, to currently commissioned provision.

It is thought that a Short Breaks Bureau could not only provide a "front door" to this existing provision (albeit it may support its evolution over time) but that it may also be able to access/allocate additional resource contained within the Carers Act Implementation monies associated with meeting outstanding eligible need.

Carers Advocacy

Advocacy can help deliver a range of positive outcomes for individuals; safeguarding their voice and situation etc. In order to be completely on someone's side in achieving these outcomes, and to avoid areas of potential conflict it is important that advocacy services are independent of other service providers. Independent advocates, whether paid or volunteers, can ensure that their loyalties lie with the person who needs advocacy rather than those who may have conflicting loyalties.

The demand for Carers advocacy appears to be rising and evidence of this was seen during the third quarter of 2017 when Highland Carers Advocacy were supporting Carers across the Highlands in over sixty live cases covering a wide range of issues. It is expected that we will see a further increase in demand for advocacy with the introduction of Adult Carer Support Plans.

The Carers Improvement Group wants be central to the planning and commissioning of the carers' advocacy service ensuring it is designed by Carers, for Carers.

Charting Carers Services going forward

Taken together, a new shape of Services is suggested. Although this will require further approval and, in course, to be commissioned and contracted, an outline of reshaped services to Adult Carers is shared below (Chart 2) for discussion:

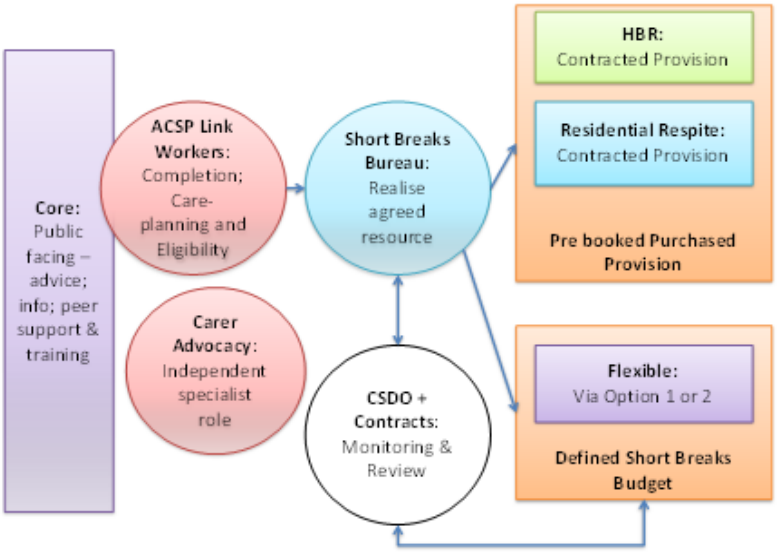


Chart 2

Outcome 7:

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

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

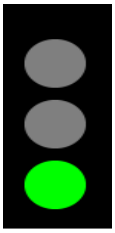
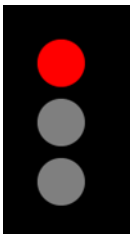
Outcome 7	 **X 1**		 **X 3**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Percentage of adults supported at home who agree they felt safe	To improve on Scottish average	Scotland – 83% Highland – 84%	Not applicable	Scotland - 83% Highland – 84%	Not applicable	Performance is stable, but still exceeds the Scottish average - Biennial data.
Adult Protection Plans are reviewed in accordance with Adult Support and Protection Procedures	Target is 90%	Not applicable	Not applicable	57%	54%	Revised in line with 3 month timescale.
Reviewing and monitoring of Guardianships. Number of Guardianships reviewed - annual required timescale.	To improve on baseline of 50% reviewed within timescale.	50%	49.9%	37.9%	48.25%	Performance again below baseline against a background of an increasing number of Guardianships.
Reviewing and monitoring of Guardianships. Number of New Guardianships reviewed within required timescale of 3 months.	To improve on baseline of 57% reviewed within timescale	57%	31.25%	23.85%	20.13%	Performance is declining against a background of an increasing number of Guardianships.

Table 7 – Outcome 7

Although the national survey results suggest that clients in the Highlands do feel safer in comparison to the national average, local targets in respect of guardianship are not being met. There is also on-going work underway to define and more accurately record performance with regard to adult protection plans.

This report also reflects on the outcomes of last year's Adult Support and Protection thematic inspection. This provided the Partnership with a strong foundation for improvement that has seen an increase in focus on ASP performance.

Outcome 8: 128

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

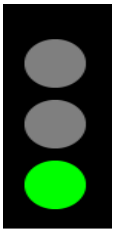
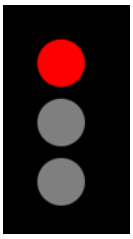
Outcome 8	 **X 1**		 **X 2**			
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
Workforce is Adult Support and Protection effectively trained	Target is 100% of staff trained	100%	99%	98%	99%	Performance is stable with vast majority of staff trained confirming training has been effective.
Uptake of Knowledge and skills Framework – reviews completed and signed off	Year-on-year improvement	Not applicable	27.3%	25.3%	Not applicable	e-KSF unavailable Feb/Mar 18, Turas replacement system data not yet available
Sickness absence levels	To improve on local baseline of 4.88%	4.88%	4.92%	4.96%	4.93%	Performance has not improved on baseline.

Table 8 – Outcome 8

Staff attending training find that the training is useful and increases confidence and abilities. Sickness absence continues to increases and the national target of 4% has not been met. However, it is lower than the Scottish average for 2017/18 which was 5.39%.

<u>Adult Support and Protection</u>

In 2017, NHS Highland was one of six partnerships who were subject to a joint inspection of adult support and protection. This inspection looked at 3 quality indicators which were as follows:-

- Outcomes – are adults at risk of harm safe, protected and supported
- Key processes – referrals of adult support and protection concerns, initial and subsequent investigations, case conferences, adult protection plans and the use of protection orders
- Leadership and governance – this was leadership and governance as exercised by senior leaders and managers, the adult protection committee, the chief officers group and the chief social work officer. There was an expectation that leadership should be inextricably linked to sound operational management

In terms of the protection of vulnerable adults, the joint inspection team had a key precept for this area of work and their scrutiny of it, which was - need to do, not nice to do.

With reference to the above quality indicators, NHS Highland was assessed as being adequate in all 3 areas.

Following the production of this report, there have been many changes to staff in key roles, in relation to adult support and protection. At the same time, a detailed post inspection action plan was drawn up, to tackle the issues identified by the joint inspection team.
There has been a review of a range of policies and procedures including approval of new Significant Case Review Guidance.

Outcome 9:

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

Outcome 9	**With some many differing factors contributing to the calculation over these costs within each IJB/Lead agency, a "traffic light" summary is not appropriate for these indicators.**					
Indicators	**Baseline**	**2015/16 Outcome**	**2016/17 Outcome**	**2017/18 Outcome**	**2018/19 Outcome**	**Comments**
NHSH make payment of the C@H tariff rate within 28 days of receipt of a valid invoice	Year-on-year improvement	83.3%	89.25%	92.13%	89.56%	Performance declined slightly
Home Care costs per hour for people aged 65 or over	National Average	Scotland – £22.07 Highland – £32.66	Scotland – £23.07 Highland £33.18	Scotland – £23.76 Highland – £34.08	Not Yet Available	Commissioning methodology has changed in 2018/19 and is therefore not directly comparable
Self Directed Support (option 1) spend on people aged 18 or over as a % of total social work spend on adults	National average	Scotland – 6.66% Highland – 5.26%	Scotland – 6.49% Highland – 6.29%	Scotland – 6.74% Highland – 6.09%	Not Yet Available	Slightly below national average
Net Residential costs per Capita per week for Older Persons (over 65)	National average	Scotland – £364.71 Highland – £426.74	Scotland – £372.36 Highland – £448.22	Scotland – £386.25 Highland – £481.89	Not Yet Available	Above national average

Table 9 – Outcome 9

Although SDS1 uptake continues to grow in Highland, it still lags behind the national average.

Home care costs and residential costs are published nationally. However, there are so many different factors contributing to these costs that national comparisons are largely meaningless.

Joint Monitoring Committee – Integrated Governance and Decision-Making

Due to significant organizational changes in the Council and the NHS, the Joint Monitoring Committee did not meet in the year as planned. Whilst meetings took

place of relevant scrutiny and assurance bodies, (NHS Health and Social Care Committee, Council Scrutiny and Care and Learning Committees) this did not satisfactorily reflect the Partners aspirations for integrated, cross sector involvement. Plans are in development to resolve this

Financial Performance
The Partnership's Adult Care provision represents a large and complex use of revenue, capital and human resources.

Financial Performance (Adult Services)
This section aims to present the financial outturn for Integrated Children's Services and the Highland Health and Social Care Partnership (HHSCP) for 2018/19 together with the key budget issues for 2019/20 and future financial outlook.

Highland Council and NHS Highland entered into a lead agency arrangement for Children's Services and Adult Social Care Services in financial year 2012/13.

Under the current integration arrangement within Highland, to deliver integrated Health and Social Care Services through a Lead Agency model, Highland Council commission NHS Highland to deliver Adult Services, similarly NHS Highland commission Highland Council to deliver Children's Services.

The commissions for both adult social care and children's services are for services that are integrated into wider service provision for the two lead agencies. It is increasingly difficult to distinguish between services that are funded via the commission and those funded by the lead agent.

As a general principle, the focus should be on outcomes measures (or - where these are not available – on proxy measures) rather than on 'inputs'.

However, it is recognised that where there are issues regarding outcomes then there may be a need to scrutinise inputs.

Financial Position 2018/19 - NHS Highland

Overall Position – Forecast Month 12 March 2019

Table 1 overall position

HHSCP March 2019	132 Forecast Variance		
Unit/Area	Month 11 £000's	Month 12 £000's	Movement £000's
South & Mid Division	(16)	29	45
Raigmore Division	(2,253)	(2,220)	33
North & West Division	(648)	(596)	52
Sub Total NH Operational Units	(2,918)	(2,787)	130
Adult Social Care - Central	927	950	24
Facilities	(132)	(132)	1
e health	94	101	8
Tertiary	(17)	(132)	(115)
Central services	3,956	5,510	1,553
ASC Income	911	368	(543)
HSCP Corporate Support	68	92	24
TOTAL H&SCP	2,889	3,971	1,081
AOP Unidentified Savings	(19,000)	(19,000)	0
Surplus (Deficit)	(16,111)	(15,029)	1,081

The table above shows the year end position and movement from month 11.

Month 12 (April – March 2019) Further Details

Position against Budget

For the 12 months to March 2019 HHSCP have overspent against budget by £15m, excluding the £19m unidentified savings target this is an improvement in month of £1.1m. The main cause of the £15m overspend is unachieved savings, drugs predominately in Raigmore (oncology), Adult Social Care costs and continued use of locums.

In the HHSCP, the three operational divisions have an overspend of £2.8m, a small improvement on the month 11 positon, the main cause of the overspends being; unachieved savings (£2.4m), drugs predominately in Raigmore oncology (£2.2m), Adult Social Care expenditure (£1.7m) and continued use of locums, offset by in year benefits and underspends. In Support Services an adverse movement in ASC income is due to new accounting rules requiring a bad debt provision being created. A small adverse movement in Tertiary and further benefit in Central with additional slippage in allocations, late income receipts from SLA's, road traffic accident income and a benefit (notified in month 12) of the national CNORIS contribution. Table below shows the current month 12 position. It should be noted that this is a draft position and is subject to the annual accounts and audit year end process. Overall the Health & Social Care Partnership overspent by £15m compared to initial estimates of £19m. NHS Highland requested brokerage from Scottish government and the HHSCP share of this is shown in the table below, effectively giving the HHSCP a breakeven position for 2019/20.

Table 2 - Operational forecast 133

Operational Unit	Plan £m's	Year end Out-turn £m's	Variance £m's
South & Mid Division	216.6	216.6	0.0
Raigmore Division	182.8	185.0	(2.2)
North & West Division	147.4	148.0	(0.6)
Sub Total NH Operational Units	546.9	549.6	(2.8)
Adult Social Care - Central	6.9	6.0	1.0
Facilities	23.2	23.4	(0.1)
e health	9.0	8.9	0.1
Tertiary	20.8	20.9	(0.1)
Central services	32.9	27.0	5.9
HSCP Corporate Support	1.1	1.0	0.1
TOTAL H&SCP	**640.8**	**636.8**	**4.0**
AOP Unidentified Savings	(19.0)		(19.0)
Total HHSCP Month 12	**621.8**	**636.8**	**(15.0)**
SG brokerage to cover	15.0		15.0
Draft Outturn	**636.8**	**636.8**	**(0.0)**

In addition to the analysis by unit shown above, it is also helpful to consider the position by type of spend, as this indicates key themes that cut across the organisation which may be relevant when seeking efficiencies. Table 2a presents information by type of expenditure.

Pay is showing an underspend of £3.3m overall and includes locums and supplementary staffing. Non pay is showing an overspend at year end of £9.2m with Social Care (ISD), drugs and clinical non pay being the significant pressures.

Unachieved savings, offsets in operational income, combined with the issues above brings the HHSCP year end position to £15m overspend – offset with SG brokerage.

Table 2a – Subjective

Subjective Spend	YTD Position Plan £ m's	 Actual Em's	 Variance fm's
Pay **Medical & Dental** **Medical & Dental Support** Nursing **& Midwifery** **Allied Health Professionals** **Healthcare Sciences** **Other Therapeutic** **Support Services** **Admin & Clerical** **Senior Managers** **Social Care** **Pay Holding/vacancy factor**	 **68.0 4.2 109.5 18.9** **11.0 8.6 21.5 31.4 1.3** **36.7 (0.0)**	 **713 4.1 106.2 18.1** **10.7 8.5 21.2 31.0** **1.2 34.7 0.6**	 **3) 0.1 3.2 0.8 0.3 0.1 0.3 0.4** **0.1 2.0** (0.7)
Total Pay	**310.9**	**307.6**	**3.3**
Drugs **Clinical Non Pay** **Non Pay** **Property costs** **FHS** **Social Care** **SLA's & Out of Area**	**73.2** **34.2** **39.2** **31.6** **65.3** **94.0** **42.1**	**76.5** **35.2** **38.8** **32.4** **65.1** **98.2** **42.6**	(3.3) (1.0) **0.4** **(0.8)** **0.2** **(4.3)** **(0.5)**
Non Pay	**379.7**	**388.8**	(9.2)
Commitments **Savings** **Operational Income**	**7.4** **(4.6)** (52.7)	**0.6** **0.0** (60.3)	**6.8** **(4.5)** 7.6
Total	**640.7**	**636.8**	**4.0**
AOP Unidentified savings	**(19.0)**		(19.0)
HSSCP Out-turn	621.7	636.8	115.01
SG Brokerage	**15.0**		**15.0**
Total	636.7	535 5	: 0.0

Appendix 1 below shows the Social Care costs in more detail and appendix 1a shows social year costs year on year.

NHS Highland

APPENDIX 1

Adult Social Care Financial Statement at Month 12 2018-19

Services Category	Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn £m	Forecast Variance £m
Older People ReedentiaLNon Resdential Care						
Older People - Care Homes (In House)	10,265	10.265	10.545	(280)	10.545	(280)
Older People- Care Homes - (ISCADS)	27.031	27.031	30.127	(3.096)	30.127	(3,096)
Older People - Other non-residential Care (in House)	981	981	1.013	(33)	1.013	(33)
Older People-Other non-residential Care (15C)	1.473	1.473	1.463	10	1.463	10
Total Older People Residential/Non Residential Care	39,750	39.750	43.149	(3.399)	43,149	(3,399)
Older People Care at Home						
Older Pecs* • Care at Herne (in House)	14,291	14,291	13,113	1,177	13.113	1.177
Older People • Care at home (1SOSDS)	13,210	13,210	13,754	(544)	13.754	1544)
Total Older People - Care at Home	27,501	27,501	26,867	634	26,867	634
People with a Learning Disability						
People with a Learning Disability On House)	3,911	3,911	3,547	364	3.547	364
People with a Learning Disability (IscSDS)	25.796	25,796	26018	(222)	26,018	(222)
Total People with a Learning Disability	29.707	29,707	29,565	142	29,565	142
People with a Mental Illness						
People with a Mental Ilness (In House)	542	542	439	103	439	103
People with a Mental Ilness (ISOSDS)	6.001	6031	6470	(470)	6.470	(470)
Total People with a Mental Illness	6.543	6.543	6,909	(366)	6M9	(366)
People with a Physical Disability						
People with a Physical Disability (In House)	639	639	520	119	520	119
People with a Physical Disability (ISC/SDS)	e,e20	6420	6627	(206)	6.827	(206)
Total People with a Phyical Disability	7,259	7,259	7,347	(88)	7,347	(88)
Other Community Care						
Community Care Teems	6.442	6.442	5.979	463	5.979	463
People Misusing Drugs and Akohol (ISC)	69	es	34	35	34	35
licusing Support	5.764	5.764	5.681	83	5,681	83
Telecom	989	989	788	201	788	201
Total Other Community Care	13,264	13,264	12,481	782	12,481	782
Support Services						
Business Support	1.937	1,937	1.458	479	1.458	479
Management and Planning	1.481	1.481	1,353	129	1.353	129
Total Support Services	3.418	3.418	2.811	607	2,811	607
Total Adult Social Care Services	127,442	127,442	129,130	11,688)	129,1301	(1,688)

Forecast Overspend at Month 12 is • f1,688m -a

Three Care categories account for 77%of total spend on ASC

Older People accounts for the largest proportion of the Forecast overspen

Savings

HHSCP total savings target for 2018-19 is £42.5m, with £19m unidentified from the start of the year, leaving £23.5m of identified savings expecting to achieve, made up of £8.7m of containment savings and £14.8m of operational savings.
The current position of savings can be seen in the table below with £23.5m achieved in year. It must be noted though that of that amount only £10.4m (44%) has been achieved recurrently adding to the recurrent deficit going into 2019-20

Table 3 – Savings

Containment plans	Target £000's	Recurrent Savings Achieved £000's	N/Rec Savings Achieved £000's	Total Achievemen £000's	In Year Balance £000's
Adult Social Care	4,668	2,980	0	2,980	1,688
Hospital Drugs	2,695	541	0	541	2,154
Prescribing	1,308	527	0	527	781
Total	8,671	4,048	0	4,048	4,623

Summary	Annual Target £000's	Recurrent Savings Achieved £000's	N/Rec Savings Achieved £000's	Total Achieved £000's	In Year Balance £000's
Operational Savings	14,788	6,311	8,511	14,822	(34)
Unidentified savings	19,000			0	19,000
Containment	8,671	4,048	0	4,048	4,623
	42,459	10,359	8,511	23,493	23,589

Conclusion

Highland Health and Social Care partnership has improved the year end forecast to £15m which is below the £19m reported to the Board and Government in the Annual Operational Plan (AOP). The lack of sufficient recurrent savings to close the AOP gap is the main cause of the overall overspend, with £19m of the unidentified and £4m of containment savings not achieved in year. Cost pressures in Drugs, Adult Social Care (detail in App 1), Out of Area and benefits in pay underspends and allocation slippage has resulted in a 2018/19 outturn of £15m overspend.

Net spend on services for the year totalled £559.254m. This sum exceeded the budget available by £2.354m. This position reflects a substantial improvement from that forecasted at the end of quarter 3 when an overspend of £5.550m was forecast.

Net income received from Council tax was £0.074m in excess of budget.

Overall a year end deficit of £2.280m requires to be funded from the Council's reserves. This, combined with the planned use of earmarked reserves, has seen a reduction in the Council's general fund reserves of £4.762m over the course of the year.

As at 31 March 2019 the Council's general fund reserves stand at £20.300m. Of these £12.375m are earmarked (i.e. held for specific purposes), with the balance of £7.925m not earmarked.

The non-earmarked reserve, which acts as a general contingency against unforeseen events or to meet unbudgeted costs, has reduced by £0.637m over the course of the last year. At this level the reserves represents 1.4% of the 2018-19 net revenue budget, below the minimum level suggested by Audit Scotland for this reserve of 2% of annual revenue budget. A reserve of such a low level exposes the Council to the risk of not having enough funding to invest in transformational change or address any cost pressures that might arise in the future.

The following near final revenue monitoring statement shows overall the Council is reporting a net overspend of £2.354m against service budgets. The combination of the net service overspend of £2.354m, less the overall net excess on Council Tax income of £0.074m equates to the sum of £2.280m that needs to be funded from reserves at year end. The position is described 'near final' pending the completion of the year-end accounts and audit process.

Revenue Expenditure Monitoring Report - General Fund Summary

1 April to 31 March 2019

	Actual	Annual	Year End
	Near Final	Budget	Variance
	£000	£000	£000
Table A: By Service			
Care and Learning	349,646	346,814	2,832
Chief Executive's Office	4,805	5,101	(296)
Corporate Resources	28,695	29,754	(1,059)
Community Services	63,082	63,509	(427)
Development and Infrastructure	48,371	49,133	(762)
Welfare Services	4,979	5,291	(312)
Service Total	**499,578**	**499,602**	**(24)**

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Valuation Joint Board		2,484	2,550	(66)
HiTrans Requisition		91	91	0
Non Domestic Rates reliefs		657	671	(14)
Loan Charges		57,120	57,113	7
Interest on Revenue Balances		(676)	(330)	(346)
Unallocated Budget		0	(98)	98
Unallocated Corporate Savings		0	(2,699)	2,699
Total General Fund Budget		**559,254**	**556,900**	**2,354**
Table B: By Subjective				
Staff Costs		329,849	336,606	(6,757)
Other Costs		449,242	430,912	18,330
Gross Expenditure		**779,091**	**767,518**	**11,573**
Grants		(68,897)	(63,598)	(5,299)
Other Income		(150,940)	(147,020)	(3,920)
Total Income		**(219,837)**	**(210,618)**	**(9,219)**
Total Revenue Expenditure		**559,254**	**556,900**	**2,354**
Table C: Appropriations to Reserves				
Contribution to earmarked balances		5,544	5,544	0
Contribution to Other reserves		3,197	2,817	380
Total Contributions to Balances		**8,741**	**8,361**	**380**
Table D: Financed By				
Aggregate External Finance as notified		434,757	434,757	0
Additional resources		2,650	2,650	0
Council Tax		120,063	119,609	454
Use of earmarked balances		7,883	7,883	0
Use of non earmarked balances		2,423	143	2,280
Use of Other reserves		219	219	0
Total General Fund Budget		**567,995**	**565,261**	**2,734**

Management Actions to Deliver a Balanced Budget

The worsening position since quarter 2 was monitored by the Council's Executive Leadership team and a suite of management actions introduced. These actions can be assumed to have contributed positively to the reduction in the overspend forecast at Q3 to that which prevailed at year end. These actions will continue into financial year 2019/20 in light of the financial challenges that lie ahead.

The key controls in place are around recruitment where jobs are only put to advert if deemed essential. This has been backed up by a restriction on recruiting agency staff. This measure has seen a significant reduction in the number of posts being advertised.

Further, a freeze on non-essential spend covering a wide range of expenditure types has also been implemented. Directors have instructed the effective implementation of this approach within their service areas. The effects of this action have already been seen in a number of areas, not least in the amount of travel undertaken across the organisation.

A review of all the Council's reserves and balances has taken place. This review had a particular focus on earmarked balances, i.e. those held for a particular purpose, to ensure they were still being held appropriately. Balances totaling £1.786m were found to be surplus to requirements and have been transferred to non-earmarked balances during 2018-19.

Care and Learning Integrated Health Monitoring Statement 2018/19

The table below sets out the near final revenue budget position on Integrated Child Health Services - i.e. all areas of the Council's Care and Learning service budget that support Child Health activity. The total budget for these areas for 2018/19 is £26.5m which is supported by funding of £9.7m from NHS Highland. At year end these service areas show a combined underspend of £1.7m.

2018/19 Integrated Health Monitoring Statement			
Activity	**Budget**	**Actual to**	**Variance**
Allied Health Professionals	3,272,428	2,905,745	-366,683
Service Support and Management	675,826	656,400	19,426
Child Protection	476,378	434,863	51,802
Health and Health Improvement	530,707	478,905	-48,734
Family Teams	17,249,478	16,376,679	173,499
The Orchard	1,255,505	1,206,771	-34,020
Youth Action Services	1,539,435	1,365,936	
Primary Mental Health Workers	566,070	474,468	
Payments to Voluntary Organisations	915,027	881,007	
Total	**26,480,854**	**24,780,774**	**-1,700,080**
Commissioned Children's Services income from NHSH	**-9,655,608**	**-9,655,608**	**0**

Commissioned Children's Services Financial Statement 2018/19

The Children and Young people's Resource and Commissioning Group, comprising officers from NHSH and HC, meet regularly throughout the year. A financial statement is produced by HC twice a year showing the position as at 30 September and 31 March. As highlighted at 5.1 above, it is increasingly difficult to separate out the NHSH element matching the NHSH financial contribution. However, it does highlight where there are any major variances, which form the basis for discussion within the Group.

For the purposes of this report, a financial statement for the year ended 31 March 2019 has been prepared by HC and is shown at 7.4.3 below. To inform the Committee, NHSH specifically funded expenditure is highlighted along with the corresponding variances. In summary, the report shows the near final outturn position, for the NHSH element, is £10.336m compared to the NHSH quantum paid to HC of £9.656m. This is a shortfall of circa £0.7m in 2018/19. For demonstrative purposes this shows that, from a financial perspective, that NHSH is getting value for money and if the budget was balanced then NHSH funded expenditure would exceed the quantum by circa £1.5m. This excludes the ancillary costs associated with supervision, travel and property costs.

Commissioned Children's Services 18/19				
Staff		**Annual Budget**	**Actual YTD**	**Variance**
FTE		**£**	**£**	**£**
Nursing Management	1.00	89,141	107,510	18,369
Family Teams	107.85	4,875,711	4,632,470	-243,241
YAT nurses	2.00	103,669	72,206	-31,463
LAC nurses	2.00	106,128	110,317	4,189
Continence Products - contract		48,479	41,034	-7,445
Cradle to Grave	2.00	88,721	60,026	-28,695
LAC Respite - The Orchard	10.20	1,255,505	1,206,771	-48,734
Health Improvement - Early Years	1.00	81,761	52,455	-29,306
Health Improvement - Schools - immunisation	3.81	118,113	122,200	4,087
Health Improvement	1.00	51,553	30,528	-21,025
Child Protection Advisors	6.70	397,246	365,801	-31,445
Allied Health Professionals	74.28	3,272,428	2,905,745	-366,683
Primary Mental Health workers	12.70	566,070	474,468	-91,602
Primary Mental Health workers - early years		23,419	23,419	0
Early Years Collaborative		1,977	0	-1,977
Infant Feeding Support workers		60,000	60,000	0
Youth Action Teams - Youth Justice Practitione	11.00	370,089	370,089	0
Family Nurse Partnership	6.00	-68	-122	-54
Sub Total	**241.54**	**11,509,942**	**10,634,917**	**-875,025**
Business Support		405,714	405,714	0
ICT		96,385	96,385	0
Payments to Voluntary Organisations		317,415	319,271	1,856
Payments to Youth Voluntary Organisations		286,904	286,904	0
Property (including The Pines)		86,230	103,023	16,793
Training		13,732	42,850	29,118
Sub Total		**1,206,380**	**1,254,147**	**47,767**
Total	**241.54**	**12,716,322**	**11,889,064**	**-827,258**
Funded by:				
SG/NHSH funded		9,655,608	10,335,511	-776,493
Scottish Government FNP		430,594		
Highland Council		2,564,490		
		12,650,692		

The largest element of the underspend is in staffing costs, particularly under the Allied Health Professionals and the Family Teams. This is due to a combination of problems recruiting to establishment, geographical challenges and regular staff turnover. In relation to staff turnover the time period from a vacancy arising to a new appointee taking up post can vary, but will usually mean that there is some accrual of savings relating to the vacancy.

Family Teams were impacted by the Voluntary Redundancy scheme introduced by Highland Council in 2016, with the loss of a number of management and practitioner posts. Posts with external funding, including funding by NHS Highland, were exempted from this process.

Financial Pressures

There are various financial pressures the HC have had to absorb and deal within the overall Care and Learning budget. They can be summarised as follows:

- Pay inflation as a result of the settlement agreed with COSLA of 3.5% for 2018/19 and 3% for the next two financial years. The uplift received from NHSH in 2018/19 was 1.5%
- Ongoing training programme of Health Visitors will have to be funded by HC from 2019/20 onwards. This will be ongoing for a number of years due to a number of retirements in the next few years and to maintain the agreed establishment
- The development of a Joint Transitions Team serving ages 14 to 25 developed a model with a single management and governance structure. However pressures currently met by HC resulting in increased costs of supporting young adults over the age of 18 years in HC residential homes and foster care. Dealing with adult caseload work is also creating pressure as the time devoted should be directed to 18 year olds and under

- Related to the above are unmet costs for Self Directed Support for over 18 year olds

- Costs associated with hosting of NHSH staff are increasing year on year particularly in respect of supervision, travel and property costs

By far the biggest financial pressure HC has to deal with is the regrading of the Health Visitor posts from Band 6 to Band 7. The full additional cost to the top of Band 7 is circa £0.750m by 2022/23. This is exceptional and over and above the normal inflationary uplift, and on this basis, the Council expects NHSH to pass on additional funding to HC to meet the full cost of this regrading in order to avert a significantly detrimental impact on services.

NHS pension scheme employers contribution rate will increase by 6% from 14.9% to 20.9% with effect from 2019/20. The increase is circa £0.4m, however NHSH will have to increase the quantum to take account of this as it is fully funded by Scottish Government. The Council expects NHSH to pass on additional funding to HC to meet the full cost of this change in order to avert a significantly detrimental impact on services.

Financial Savings

The Care and Learning Service is looking to invest in additional services to support more children and young people to be supported to remain in Highland, close to families and communities of origin and better manage cost pressures of out of direct care.

NHSH currently funds elements of a specialist mental health service for Care Experienced children and young people though it is not sufficient to respond to Care and Learning aim of more children and young people staying within Highland services. Specialist mental health input and expertise will underpin the anticipated success of the development as distress from disrupted attachment and multiple adversity/trauma often drives placement provision and sustainability and the ability to engage with learning.

A service model has been developed and costed with the current proposal that this be managed as a contracted service with the offer of funding to NHSH, rising from circa £0.146m in year 1 to £0.328m by year 3.

Payment of the additional services will be by invoice and will be in line with the service specification currently under discussion between HC and NHSH.

Other Potential Financial Issues

Health Visiting Service Improvements. In 2018/19 an NHSH allocation of £0.5m passported through to HC to cover the funding of additional 13.25 Health Visitor posts. A further financial pressure may arise when the additional funding to health boards for the extra Health Visitor posts loses its 'ring-fenced' status and becomes part of the wider financial package received by NHSH. There is a risk that the full cost of the health visiting services may not be funded by NHSH when the ring-fencing is removed from the funding for additional posts. To mitigate the risk, HC recommends the previously ring-fenced funds are added to the quantum on a recurring basis.

Family Nurse Partnership 2018/19 budget allocation per Scottish Government letter dated August 2018 stated £480,594. Included in NHSH quantum is £430,594, a shortfall of £50,000. It is planned that the Family Nurse Partnership funding moves to be part of the general allocation to Health Boards and loses its ring-fenced status. There is a risk that the full cost of the scheme may not be funded by NHSH when the ring-fencing is removed from the funding for additional posts. To mitigate the risk, HC recommends the previously ring-fenced funds are added to the quantum on a recurring basis.

The Immunisation Team have extensions to their fixed term contracts ending June 2019 where they will become substantive posts, when the provision will return to NHSH. Consequently the funding to be returned to NHSH is the original immunisation budget of £49,000 per annum.

Financial Outlook 2019/20 and beyond

The outlook for public sector finances for the foreseeable future continues to look particularly challenging. In all sectors core funding is either decreasing or increasing at a lower rate than the cost base. Two factors likely to bring significant cost pressures in the coming years include demographic change and consequential increasing demand for services and an end to public sector pay restraint.

By law the Council is required to set a balanced budget prior to the start of every financial year and agree its Council Tax rates for the coming year. At its meeting on 14 February 2019 Highland Council approved the budget for

2019/20, and as part of the budget setting process, also approved the Council's change programme, 'A Sustainable Highland', to deliver £37.456m of savings over the next three years.

'A Sustainable Highland' reflects a change programme, informed by extensive staff and public engagement, focussed around four key themes of:

1. Making the Council More Efficient;
2. Commercialism and Income Generation;
3. Redesign and Improvement; and
4. A Flexible and Well Managed Workforce.

For the three year period the Council faces an estimated budget gap of £60.297m due to anticipated cost increases, predominately around salary costs, and inflation. The savings to be delivered through 'A Sustainable Highland', in tandem with changes to Council Tax, will address the forecast budget gap; increase the Council's reserves to a more sustainable level over the next three year period; and provide funding to effect the significant changes required to deliver the change programme.

It is becoming increasingly apparent across both organisations that in the current climate it will not be possible to sustain current levels of service provision within the level of resources available.

Under the Lead Agency Model NHS Highland is commissioned to deliver Adult Social Care Services on behalf of Highland Council. The terms of the Partnership Agreement between the Council and NHS Highland states that the organisations will review the Quantum of funding provided for these services in accordance with the local government grant settlement.

This year, the terms of the local government financial settlement, state that the Council may reduce the funding by up to 2.2% (based on 2018/19 funding levels) but then must increase it by the Council's share of the additional funds made available by Government.

Of the amounts where distributions across local authorities have been confirmed the Council will pass on £4.721m to NHS Highland (of a national £108m) for Health and Social Care. The Council will also pass on £0.459m of funding (of a national £10.5m) for the Carer's Act Extension and £1.221m of funding (of a national £29.5m) for Free Personal Care for Under 65s.

The Council is having an ongoing dialogue with NHS Highland to inform and implement any savings to be made in order to balance the budget for adult social care. Despite the option to reduce the current level of funding the Council is not minded to make any reductions to the total funding passed to NHS Highland, but will look to ensure that £2.07m (the equivalent of a 2.2% reduction) of the overall funding is redirected for spending on the Council's priority areas. The full details of how this arrangement will work will require to be established with NHS Highland.

Both partners face a continuing challenge in respect of the provision of Adult Social Care due to continuing budget pressures from an increasing number and complexity of care demands, increases in demand for services due to demographic change, and

cost pressures associated with pay awards and other inflationary pressures. Even with this additional funding NHS Highland will require to identify and implement savings measures in order to deliver a balanced budget in 2019/20. 14.5

Resources – the paper acknowledges that there will be an ongoing period of financial challenge with a continuing squeeze on public expenditure. The development of financial strategies for both Adult and Children's Services will require to reflect the financial positions of both NHS Highland and Highland Council.

Inspection Findings

Social Care and Social Work Improvement Scotland

Care Homes

There are 68 care homes registered in North Highland which are used by NHS Highland. Of these, 54 are independent sector care homes which NHS Highland contracts with and 14 provided by NHS Highland. In March 2019, 49 (76.6%) of all care homes were graded 4 or better. Of these 33 (51.6%) were graded 5 or better.

The focus on improvement across the care home sector continues and there are a number of improvement activities underway.

Care at Home

There are 19 care at home services registered in North Highland which NHS Highland currently uses. 16 of these are independent care at home services which NHS Highland contracts with and 3 are delivered by NHS Highland. In June 2019, 18 (95%) of all care at home services were graded 4 or better. Of these 8 (42%) were graded 5 or better.

NHS Highland introduced new contract arrangements for independent sector providers on 1 July 2019. These are expected to see an improvement in flow, quality, cost containment and an improved reach into remote and rural areas. .

Overall, the picture is one of improving the quality of Care in the Highlands.

Strategic Plan Review

The Highland Strategic Commissioning Plan for Older People **2014-2019**, was Highland's first strategic commissioning plan and was co-produced during 2013-2014 with all sectors and representatives of carers and service users through the Adult Services Commissioning Group (ASCG) (which fulfils the function of the Strategic Planning Group).

The development of the strategic commissioning plan was recognised to be an evolving process, where the journey of establishing solid relationships with and between commissioning partners, was a critical achievement.

The first plan focused on meeting the needs of older people in Highland and was the first step on an important journey to better understand and meet these needs, with a view to focusing on other adult population groups in future years. The priorities of the plan centred on actions around the capacity, flexibility and quality of care at home and care home provision for older people.

The plan was presented to the NHS Board on 1 April 2014 and has since been refreshed annually to include broad commissioning intentions and most recently, other client groups.

The **2015-2016** annual refresh provided a sustained focus on the existing care at home and care home activity, under the following objectives:

- *Sufficient capacity to meet need*
- *Highland wide coverage*
- *Consistent high quality*
- *A range of models (e.g. sitter service, re-enabling)*
- *Flexible and responsive services*

*The **care at home** priorities were to:*

- *Grow capacity and capability of quality **care at home** provision to meet unmet need.*
- *Change the way that we work with all providers through:*
- *Collaborating on recruitment;*
- *Developing a single tariff for all care at home providers;*
- *Commitment to purchase rates enabling payment of living wage;*
- *Collaborating on geographical zoning for providers so that caseloads/runs are sustainable;*
- *Revising the balance of in-house/independent provision to ensure that this reflects commissioning and SDS principles.*

*The **care home** priorities were:*

- *More quality provision and flexible use of **care home** resources.*
- *Change the way that we work with providers through:*
- *Achieving quality goal is for 95% all provision, both in-house and independent sector, to be grade 4 or above by 2019.*
- *Commissioning short term, re-enabling care, as an alternative to hospital;*
- *Exploring new models of care such as housing with support*

Collaboration on workforce issues to ensure a sustainable pool of sufficiently trained and qualified staff;

- *Collaboration with communities on alternative models to meet local needs.*

During the course of 2015-2016 and in order to support the Improvement Groups to identify future commissioning intentions for their areas, a commissioning skills event delivered by the Joint Improvement Team of the Scottish Government, was held to help the Improvement Groups to be better equipped to progress their commissioning role.

The **2016-2017** refresh contained the existing care at home and care home activity already in motion to further progress, develop and embed this activity and for the first time, included commissioning intentions relating to broader population groups. This followed on from a workshop session of the Improvement Groups to focus on translating the high level delivery aims of “live well, keep well, die well” into 2016-2017 commissioning intentions.

The annual refresh was considered by the Health and Social Care Committee on 3 March 2016 and signed off by the NHS Board on 5 April 2016.

Key achievements over the course of 2016-2017 are noted as follows:

- Improved quality grades
- Increased sector pop up activity
- Creation of a sector level playing field
- Roll out of care at home zoning
- Sector self-management
- Continued payment of living wage for care at home (in place since April 2015)
- Continued fair tariff for care at home
- Commissioned joint review of co-produced tariff conditions
- Sector recognition of a different (and better) commissioning approach
- Development of patient reported outcome model
- NHSH, Albyn and Carbon Dynamic collaboration on “Fit Homes”
- Improved sector dialogue and collaboration
- Development of overnight care service (rolled out in 2017-2018)

In terms of Future Direction, a refreshed Strategic Commissioning Plan for 2018-2021 is under development for sign off and implementation from April 2018.

The Partners of NHS Highland and the Highland Council have agreed that whilst a high level vision for the care of adults has been described in the Strategic Commissioning Plan, a further more focused piece of work is required which succinctly describes the next level of detail of how the Partnership plans to meets the triple challenge of demography, sustainability and cost; whilst delivering both better quality and increased choice.

WHAT ARE WE TRYING TO ACHIEVE?

In developing this vision, the Partners have asked the question of **"What does good look like?"** in the future. Taking into account the long established views that the people of the Highlands have expressed, the answer appears to be that people want to be given realistic choices that enable them remain at home, or as close to home as possible.

To this end, the Partners envisage a future state which in which:

- People remain at home for as long as possible through a range of statutory and community services which support both care and wellbeing Key to this is the promotion of realistic expectations, choice and control using the philosophy and mechanisms of self directed support.
- Interim care options are available as locally as possible to support individuals and carers in case of illness or injury with localised respite and palliative care options which make more dynamic use of local resources such as Care Homes
- Where people cannot remain in their own homes due to either the appropriateness of the accommodation, or the provision of care being unfeasible, housing clusters and care village developments will be progressed to make care accessible and sustainable.
- Advanced complex care packages and facilities, such as specialist challenging behaviour care, are likely to be in centres of population across highland where we can ensure quality, safety and sufficiency of available staff resources.

If the vision of the future is as above, then the next question is **"What is stopping us?"**, and the reality is that there are three key issues:

- There are not new resources available to make the change
- The fabric of external care provision to underpin the change, has not been fully developed (with particular challenges experienced in North and West)
- We have not yet engaged communities in the discussion about what is in the art of the possible.

This leads to the question of **"What needs to change?".** This is the substance of this report.

The Partners recognise that, to sustain quality, cost effective services that can meet demand is a challenge in itself, but to do this the added complexity of historical investment patterns has to be addressed. Simply put, this paper starts to explain how we plan to shift investment from current ways of providing care, to invest in new, better ways of providing care.

CONTEXT

The Partners have agreed that historic investment patterns in some service areas are limiting the Partnership, and ultimately the community, of the opportunity to explore new models of care which can offer both better quality and greater efficiencies. In an effort to explore and implement better models of care, the Partners have focused on the following areas:

1. Care at Home
2. Care Packages
3. Care Homes – Older People
4. Day Care Centres - Older People
5. Day Care Centres - Learning Disabilities
6. Housing Support
7. Community Care Teams
8. Continuous Improvement and Efficiency

It is important to note that Care at Home and Care Home proposals are the most developed proposals, therefore these have been provided as detailed exemplars of the approach. Work is underway on proposals for items 2, 4, 5, 6, 7 & 8 and, whilst the current state of development is reflected in this paper, it must be recognised that the current position is that some of these areas represent work in progress.

OVERALL AIM

It is important to note that no single component of the eight focus areas above can be viewed in isolation, any more than it is possible to focus solely in any one of the interlinked pressures of increasing need; sustainable recruitment and cost.

The overall aim is to keep people in their homes or communities for as long as possible, if that is their preference, through:

- working with families and communities to support solutions
- use of technology such as telecare, health and home monitoring systems and health assistance equipment
- supporting people to use Self Directed Support to receive personalised care by managing the budget themselves or using a broker or service provider
- supporting communities to develop activities as a result of income from Self Directed Support
- working with communities to develop local care at home provision
- developing our prevention services including support for anticipatory care, identifying local networks of support and facilitating carer support
- supporting communities to take an asset based community development approach that will build on current strengths and empower them to look after their community members
- working with GPs and other services to co-ordinate care and minimise unexpected problems or admissions (anticipatory care)
- improving palliative care and end of life experiences to support people to remain in their own home or community
- working with partners and communities to develop a range of suitable accommodation options

Where people still require nursing care in a residential setting, we will ensure that there is a network of high quality care homes in NHS Highland. In the future, this may require people to travel further, but we hope to minimise the time spent in residential care by developing a broader range of accommodation options that allow people overall to stay in their own community for as long as possible.

There are potentially five parts of the adult social care system which need to work together to ensure that people are able to flow through the care system without getting stuck due to restraints of availability:

- Keeping people at home for as long as possible.
- Interim care (in case of illness or injury, reablement)
- Clusters of 2-8 units of amenity housing based in local communities
- Care village models (higher volume nursing care)
- Advanced complex care packages and facilities

Providing complex care at or near home is not necessarily at low cost. Specialised services both at home and in a care home setting that provide both health and social care support are increasingly needed. Considerable development work will be required to ensure that quality, sustainability and capacity are geographically consistent. There also needs to be a greater understanding of the reasons why people are using care home provision and what the cost and sustainability of alternatives to this would be, including overnight care.

Implementation of this vision will require a redistribution of funds from existing residential care home places to services that support people staying at home and in their communities for as long as possible. Transitioning from where we are now to where we want to be will require careful consideration of a range of factors including the impact on flow through all parts of the adult health and social care system.

Outcome C1

Outcome 1: Our children have the best start in life.

This outcome has a specific focus on the following outcomes developed within our quality assurance and improvement framework.

1. Children and young people experience healthy growth and development.
2. Children and young people are supported to achieve their potential in all areas of development.
3. Children and young people thrive as a result of nurturing relationships and stable environments.

The indicators show improvement in the majority of measures during the last year. Significant improvement activity has taken place over the last three years to ensure robust and detailed data concerning children achieving their developmental milestones is available. This data is collated from detailed developmental overviews undertaken on every child in the highlands.

Family Nurse Partnership

The Highland Family Nurse Partnership (FNP) programme began in 2014 as a three year pilot to see if the model could be successfully provided in Highland. The service provides specialist support to young first-time parents. The pilot was limited to an area approximately within a 40 mile radius of Inverness, covering both the Mid and the South areas of Highland Council. This area covers 67% of the under-25 year old population in Highland. The initial team consisted of one supervisor, 4 Family Nurses and a Data Manager.

The Scottish Government remain committed to ensuring that all eligible women in Scotland have access to the programme so after the successful pilot it was agreed to undertake a stepped expansion of the programme in Highland. It should be noted that the programme is fully funded by the Scottish Government.

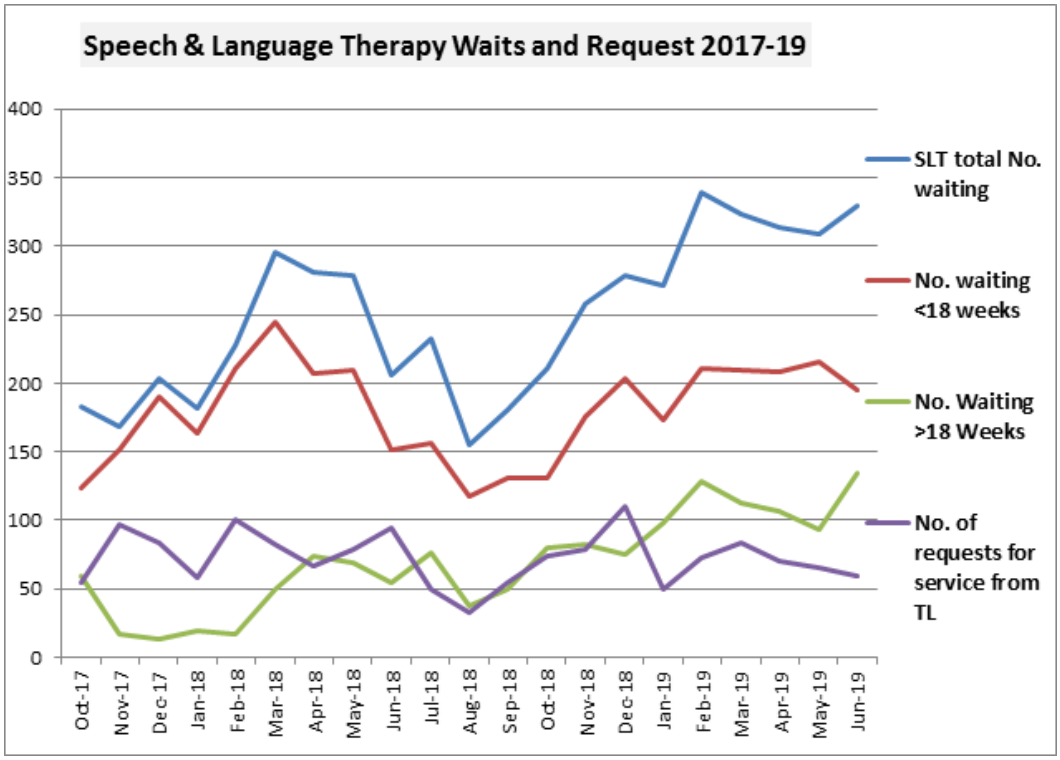
The first stage was to move from fixed cohort recruitment to a continuous recruitment process. In January 2016 recruitment to this rolling programme within the existing area began. In 2017, in order to enable caseloads to remain at or below the requirement of 25 per nurse, two additional Family Nurses have been recruited. This rolling programme is continuing and the current team staffing level is able to maintain the levels of recruitment and include a level of targeting to ensure that the most vulnerable clients agree to become part of the programme.

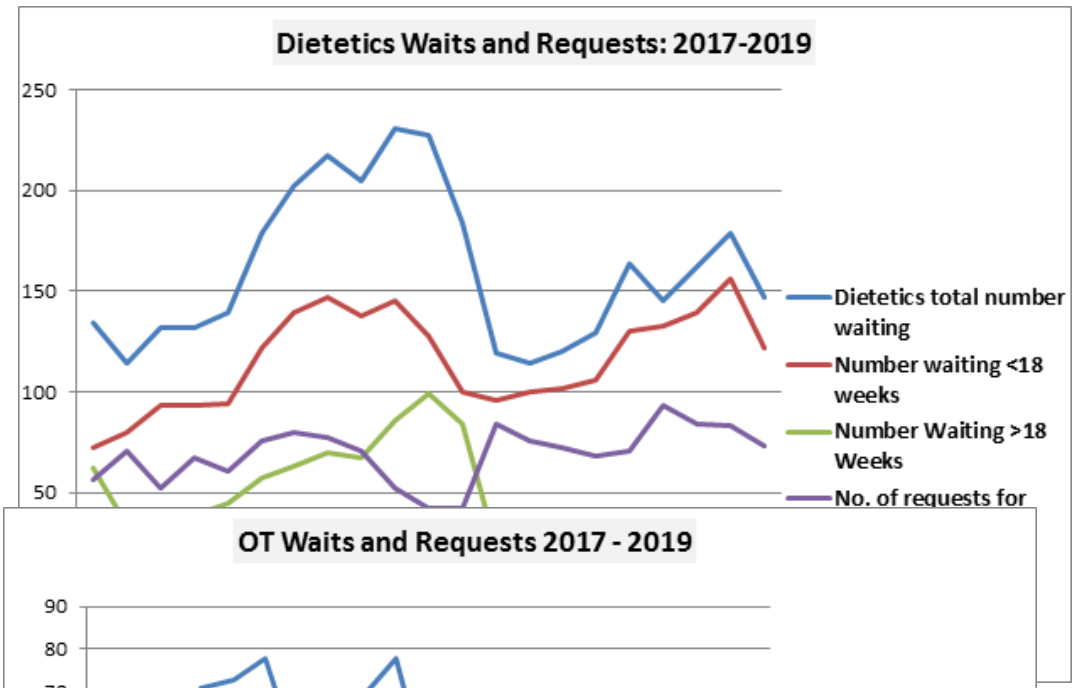
The second stage is expanding into other parts of Highland. Aggregating the number of births to first time mothers under the age of 20 years over the past 6 years suggests that the area which would benefit most from geographical programme expansion is the Caithness.

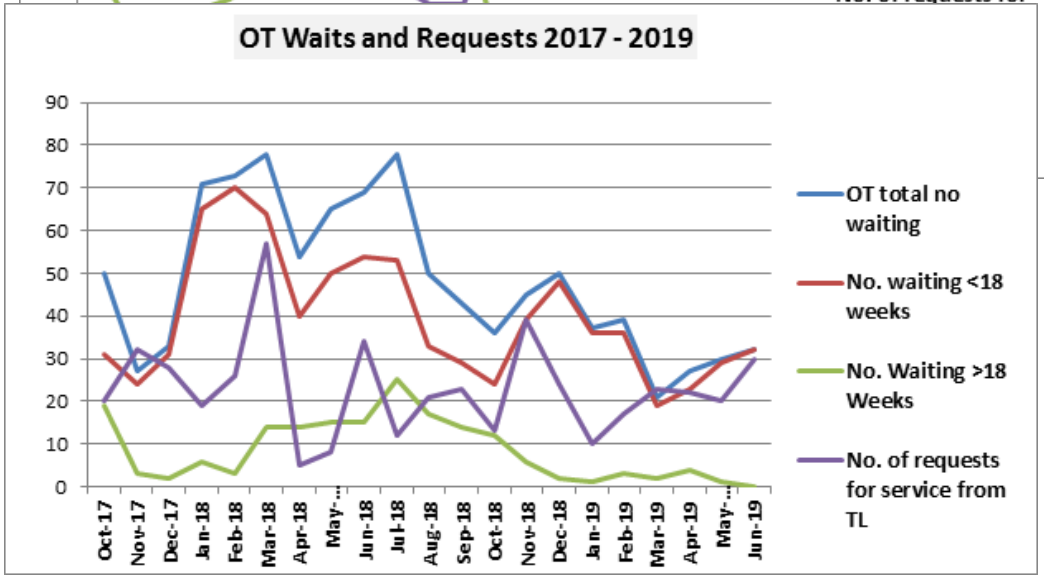
Allied Health Professionals

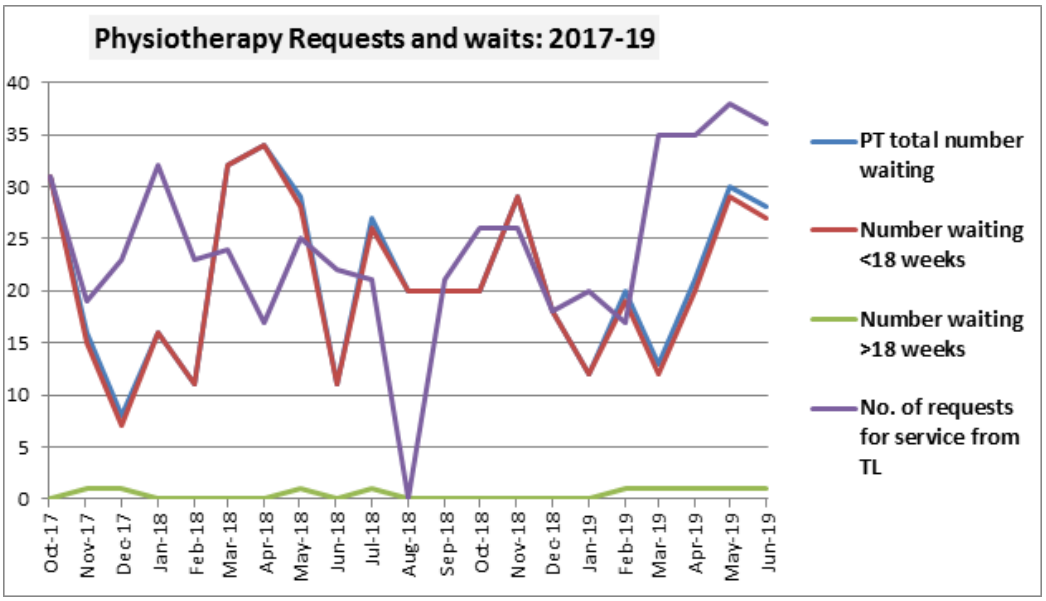
Waiting times within Allied Health Professionals service continue to present a mixed picture. Physiotherapy and Occupational are presently within target, but Dietetics and Speech and Language Therapy are not. The Jan 2019 figures are as follows (with Oct 2018 figures bracketed):-

Profession	Total number waiting		Number waiting <18 wks		% <18 wks	
Dietetics	129	(119)	106	(96)	82%	(81%)
Occupational Therapy	37	(36)	36	(24)	97%	(67%)
Physiotherapy	12	(20)	20	(20)	100%	(100%)
Speech and Language Therapy	271	(211)	173	(131)	64%	(62%)
Total	449	(386)	327	(271)	73%	(70%)








Physiotherapy Requests and waits: 2017-19
40
35
30
25
20
15
10
5
0
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
PT total number waiting
Number waiting <18 weeks
Number waiting >18 weeks
No. of requests for service from TL

Our Children have the best start in Life

Indicator 1	Target	Baseline	Status	Imp Group	Current
Percentage of children reaching their developmental milestones at their 27 – 30 month health review will increase	85%	75%	➔	Early Years	71.6%

Analysis
This data is collected quarterly from NHSH. The latest data is from June 2019. The baseline was established in 2013 and quarterly variations have been within the 55 – 70% range during that time.

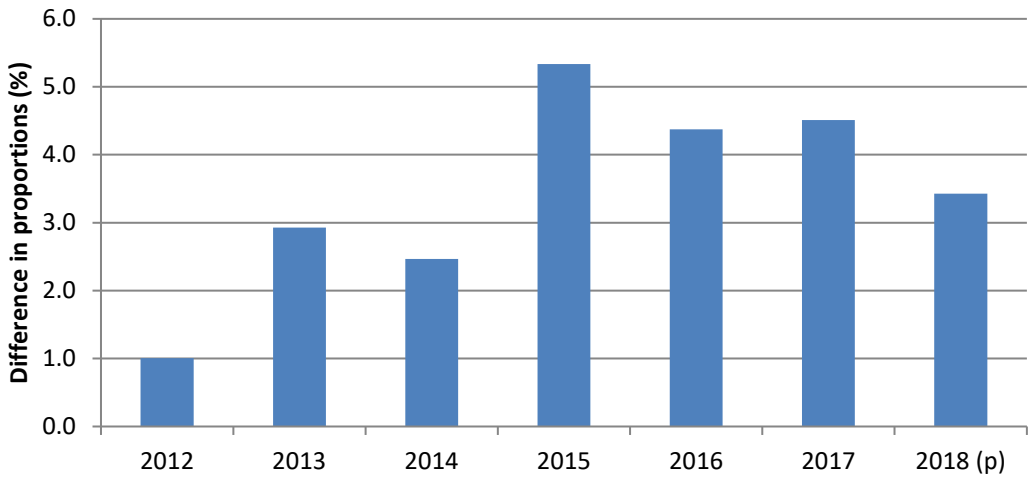
Indicator 2	Target	Baseline	Status	Imp Group	Current
Percentage of children will achieve their key developmental milestones by time they enter school will increase	85%	85%	↑	Additional support Needs	86%

Analysis
This data has been collected annually since 2015. The data shows little variance over that time.

Indicator 3	Target	Baseline	Status	Imp Group	Current
There will be a reduction in the percentage gap between the most and least deprived parts of Highland for low birth weight babies	Improve from baseline	1%	↓	Early Years	3.4%

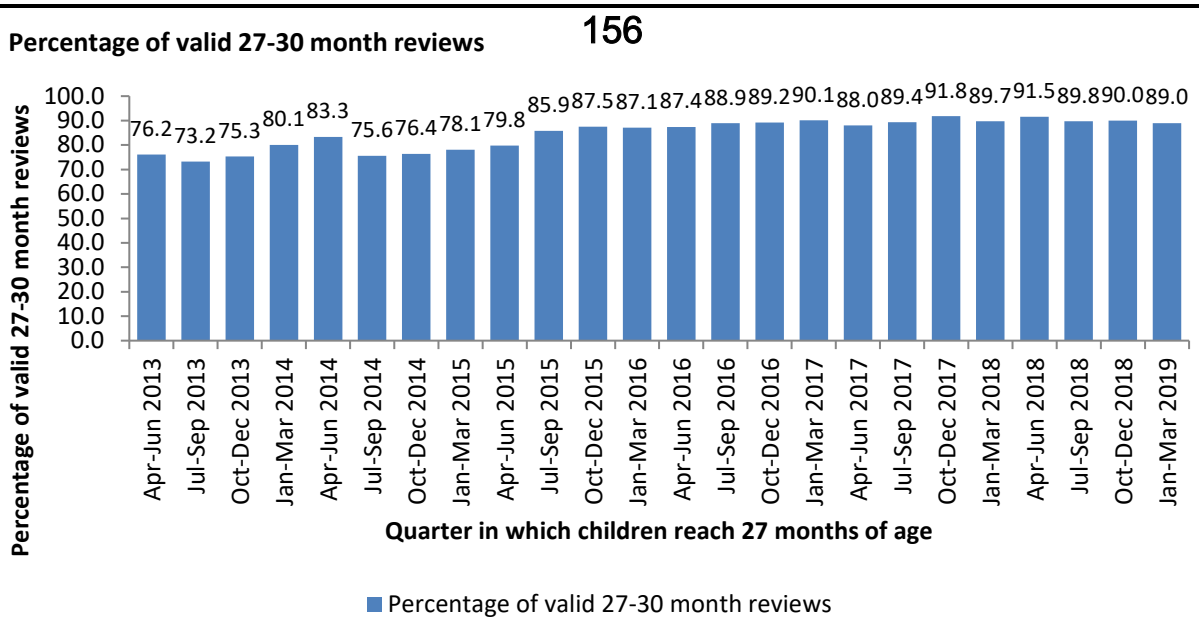
Analysis
This data is collected annually from NHSH. The latest data is from 2018.The baseline was established in 2012. The data is shown in the table.

Difference in proportions (%) between most and least deprived qunitiles



Indicator 4	Target	Baseline	Status	Imp Group	Current
Improve the uptake of 27-30 month surveillance contact	95%	52%	↑	Early Years	89.0%

Analysis
This data is collected quarterly from NHSH. The latest data is from March 2019. The baseline was established in 2011 and not withstanding quarterly variations the percentage of reviews has risen incrementally over that time.



Indicator 5	Target	Baseline	Status	Imp Group	Current
Improve the uptake of 13 -15 month surveillance contact	95%	98.4%	↑	Early Years	99.3%

Analysis

This data is collected quarterly from NHSH. The latest data is from June 2019. The baseline was established in 2016.

Child health surveillance contact at 13-15 months

Birth cohort			Period for review			
Quarter	Year	Number of children in birth cohort	Quarter	Year	Number of valid 13-15 month reviews	Percentage of valid 13-15 month reviews
May-Jun	2016	308	Jul-Sep	2017	303	98.4
Jul-Sep	2016	472	Oct-Dec	2017	461	97.7
Oct-Dec	2016	503	Jan-Mar	2018	491	97.6
Jan-Mar	2017	487	Apr-Jun	2018	482	99.0
Apr-Jun	2017	479	Jul-Sep	2018	477	99.6
Jul-Sep	2017	567	Oct-Dec	2018	561	98.9
Oct-Dec	2017	439	Jan-Mar	2019	431	98.2
Jan-Mar	2018	448	Apr-Jun	2019	445	99.3

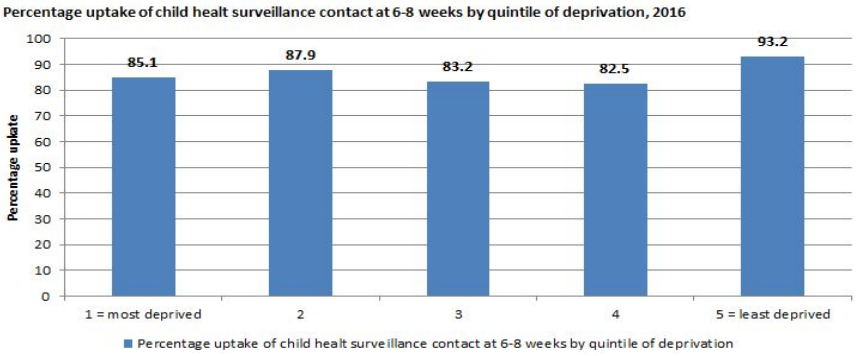
Indicator 6	Target	Baseline	Status	Imp Group	Current

95% uptake of 6-8 week Child Health Surveillance contact	95%	87.1%	↑	Early years	87.8%

Analysis
This data is collected quarterly from NHSH. The latest data is from September 2017. The baseline was established in 2012 and only small quarterly variations have been observed over time showing no real pattern of improvement.

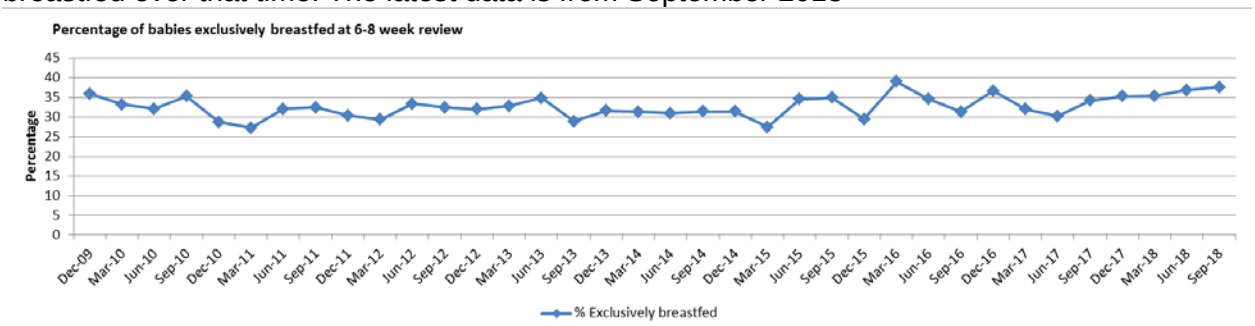
Indicator 7	Target	Baseline	Status	Imp Group	Current
6-8 week Child Health Surveillance contact showing no difference in uptake between the general population and those in areas of deprivation	No variance	-8.4%	No new data	Early years	0.2%

Analysis
The baseline was established in 2013. The 2016 data is showing the percentage uptake of child health surveillance contact by quintile of deprivation is shown in the table below.



Indicator 8	Target	Baseline	Status	Imp Group	Current
Achieve 36% of new born babies exclusively breastfed at 6-8 week review	36%	30.3%	↑	Maternal infant nutrition	37.7%

Analysis
The baseline was established in 2009. The table below shows the percentage of babies exclusively breastfed over that time. The latest data is from September 2018



Indicator 9	Target	Baseline	Status	Imp Group	Current
Maintain 95% uptake rate of MMR1 (% of 5 year olds)	95%	94.6%	↑	Early Years	96.2%

Analysis
This data is collected quarterly from NHSH. The latest data is from March 2019. The baseline was established in 2012.

Indicator 10	Target	Baseline	Status	Imp Group	Current
Sustain the completion rate of P1 Child health assessment to 95%	95%	93.1%	No new data	Early Years	82.4%

Analysis
This data is collected quarterly from NHSH. The latest data is from March 2018. The baseline was established in 2012.

Indicator 11	Target	Baseline	Status	Imp Group	Current
90% CAMHS referrals are seen within 18 weeks	90%	80%		Mental Health	100%

Analysis
This data is reported quarterly for the Primary mental health service. The baseline was established in 2013 and the latest data shows that all the children and young people referred to the service were seen within the 18 week target. The target is a national NHS HEAT target. The current data is from June 2019.

Indicator 12	Target	Baseline	Status	Imp Group	Current
Waiting times for AHP services to be within 18 weeks from referral to treatment	95%	85%		Additional support Needs	75%

Analysis
The baseline was established in 2014. The latest quarterly data is from June 2019.

Outcome 2: Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

This outcome has a specific focus on the following outcomes developed within our quality assurance and improvement framework.

1. Children and young people are equipped with the skills, confidence and self-esteem to progress successfully in their learning and development.
2. Children and young people are supported to achieve their potential in all areas of development.
3. Families are valued as important contributors and work as equal partners to ensure positive outcomes for their children and young people.

Highland Council's Care and Learning Service has developed an ambitious programme of Educational transformation throughout the reporting period. This programme has four key strands.

1. Raising attainment

2. Reducing Exclusions

3. Additional Support Needs

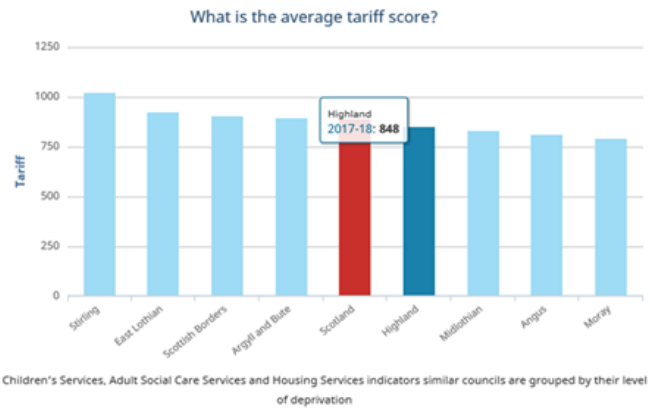
4. Early Learning and Childcare expansion programme

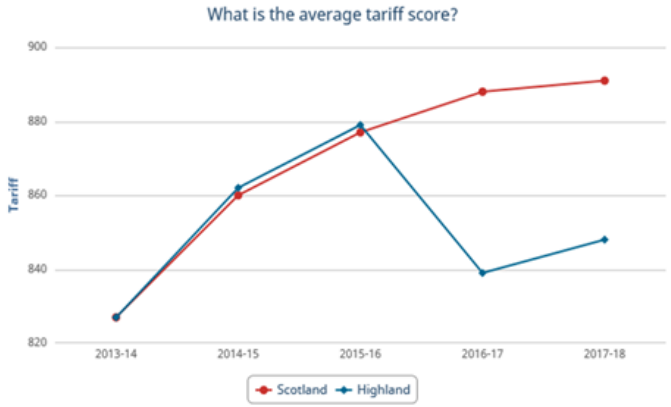
Performance information and high level priorities are shown in the illustration below.

Education Transformation

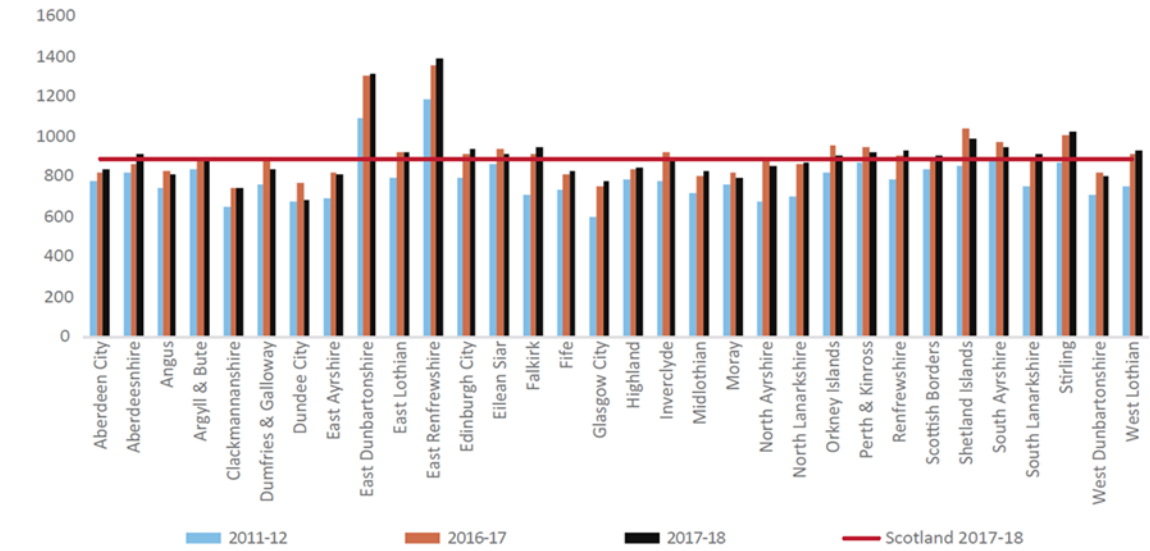
Improvement Priority 1: Raising attainment

Tariff points translate your qualifications and grades into a numerical value. Many qualifications (but not all) have a Tariff value, which will vary dependent on the qualification size, and the grade you achieved.



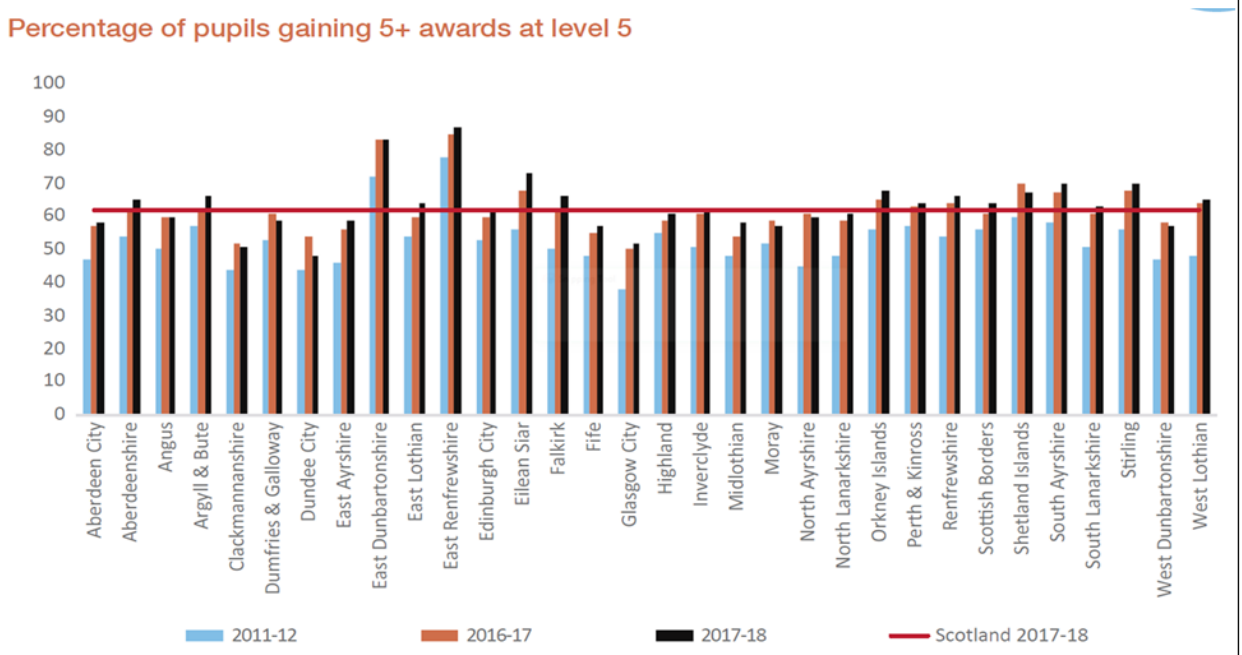


Source: LGBF Data (http://www.improvementservice.org.uk/benchmarking/explore-the-data.html)



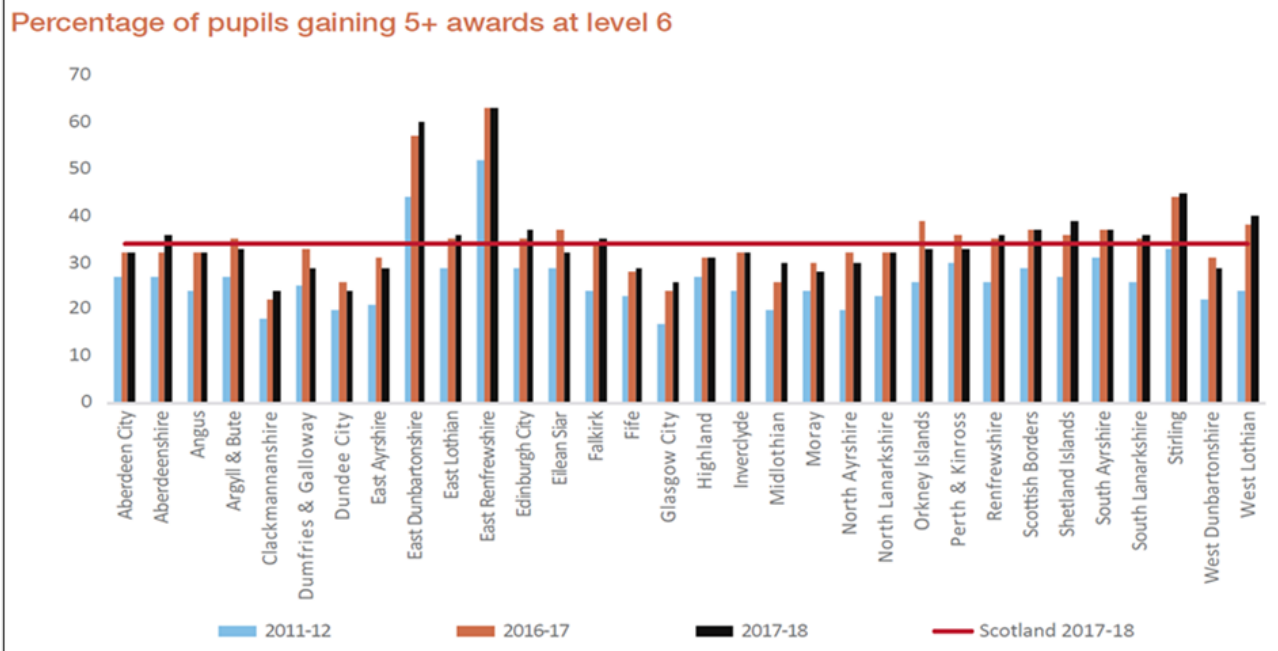
Source: LGBF Data (http://www.improvementservice.org.uk/benchmarking/index.html)

Data collected from the SQA Exam results. Chart below displays the percentage of the total assessed pupils that achieved five or more



qualifications at Nat 5 or above. Data allows for authority comparison and national comparison.

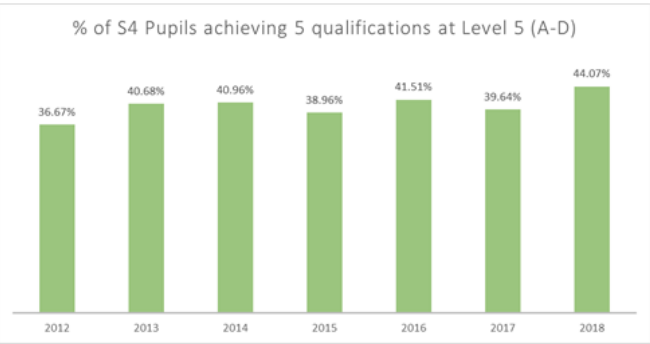
Source: LGBF Data (http://www.improvementservice.org.uk/benchmarking/index.html)

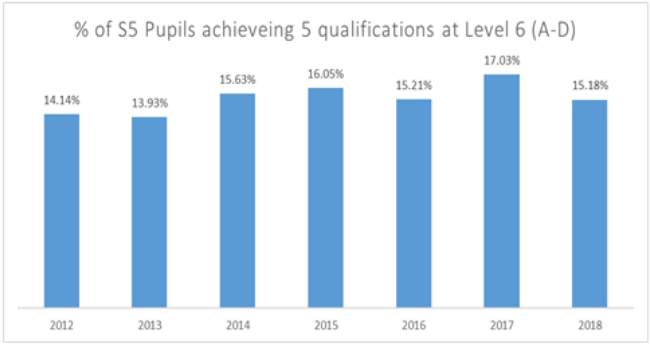


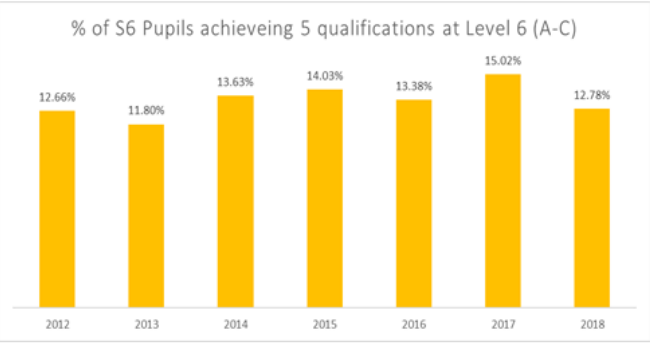
Data collected from the SQA Exam results. Chart below displays the percentage of the total assessed pupils that achieved five or more qualifications at Higher (Level 6) or above. Data allows for authority comparison and national comparison.

Source: LGBF Data (http://www.improvementservice.org.uk/benchmarking/index.html

Charts display the SQA Exam results from 2012 through to 2018







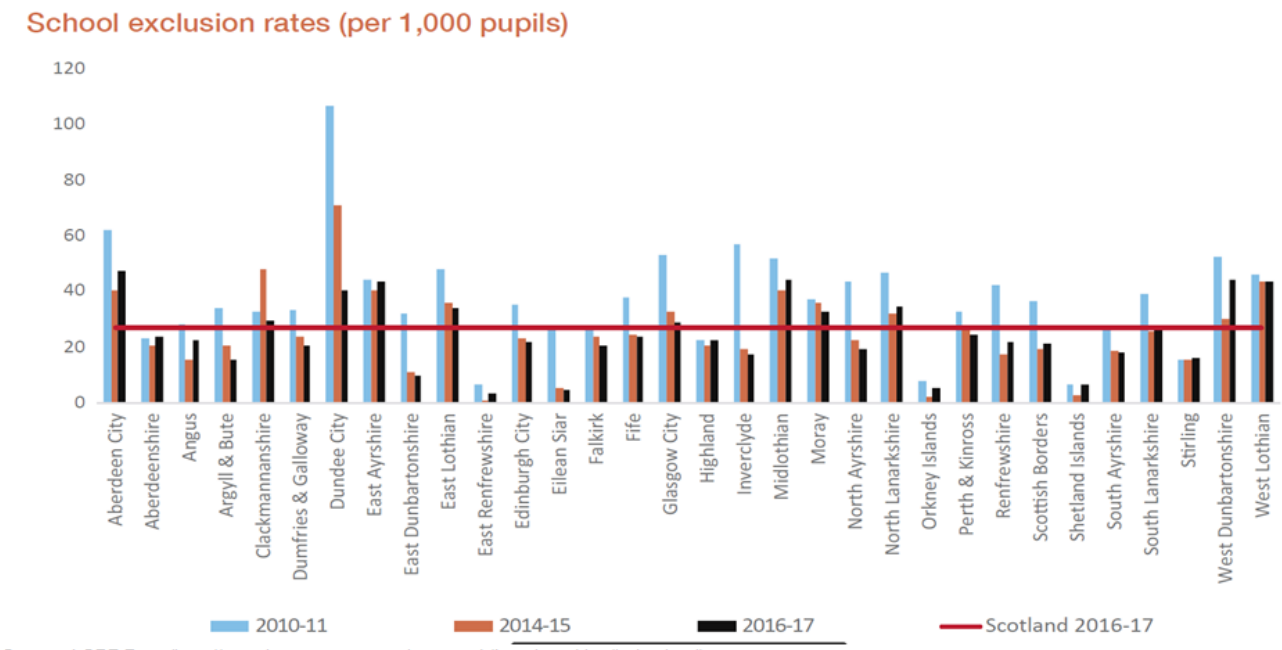
for the Highlands.

Level 5 = National 5 Level 6 = Higher

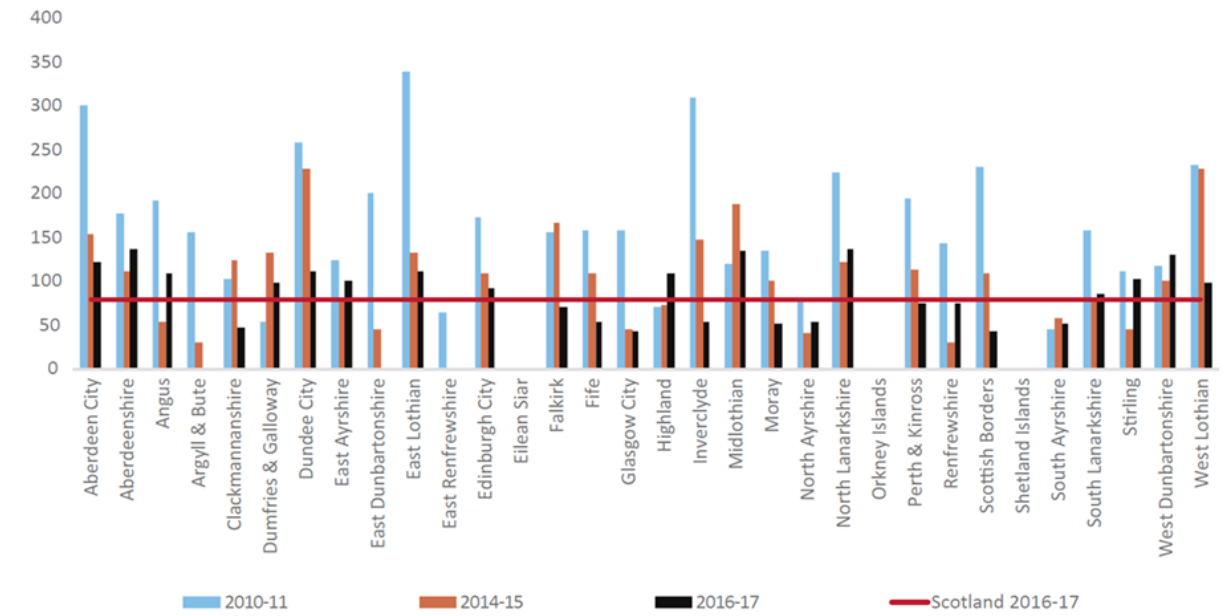
Actions	Timescale	Performance management
Deliver better outcomes for Children and Young	By June	Refreshed schools improvement plan

people through a programme of educational transformation delivered through a refreshed schools improvement plan.	2020	articulates clear improvement data for each of the transformational themes.
Refreshed the service quality assurance framework with a focus on raising attainment.	By June 2020	Framework indicators matched to performance management.
Ensure there is improved awareness of opportunities for improving achievement through gathering and sharing best practice information.	By June 2020	Impact measures to be determined.
Improved outcomes measured against Local government benchmarked framework indicators for attainment.	By June 2022	Attainment data for Highland improves in comparison to National and LGBF improvement family average.
Establish a baseline for wellbeing by making the lifestyle survey mandatory across Highland schools.	By June 2020	Baseline data from mandatory Lifestyle survey established as part of FHC5 performance management framework.
Improved outcomes measured against Local government benchmarked framework indicators for positive destinations –	By June 2020	Attainment data for Highland improves to above the LGBF improvement family average.

Improvement Priority 2: Reducing Exclusions

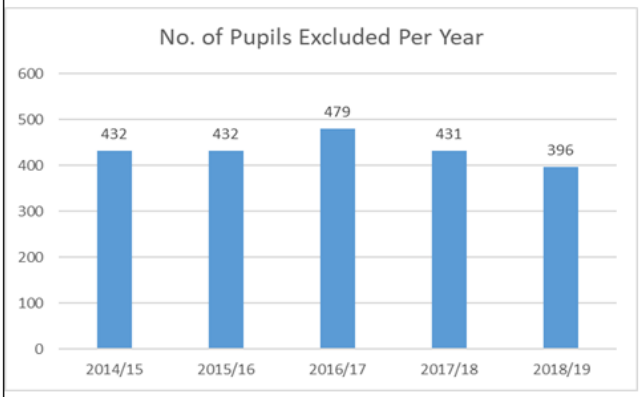


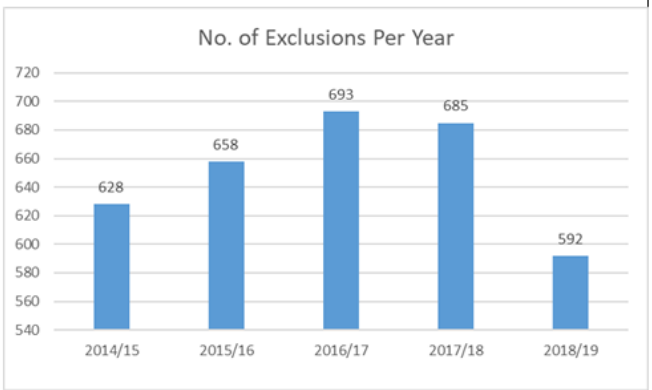
Source: LGBF Data (http://www.improvementservice.org.uk/benchmarking/index.html)



Source: LGBF Data (http://www.improvementservice.org.uk/benchmarking/index.html)

Highland Council Data displaying both the total number of pupils excluded per year and the total number of exclusions per year.

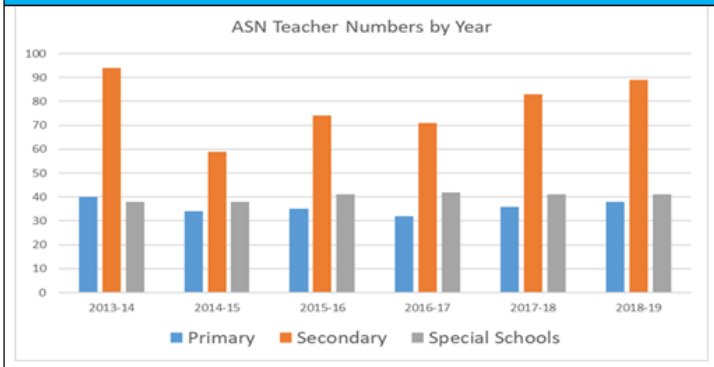


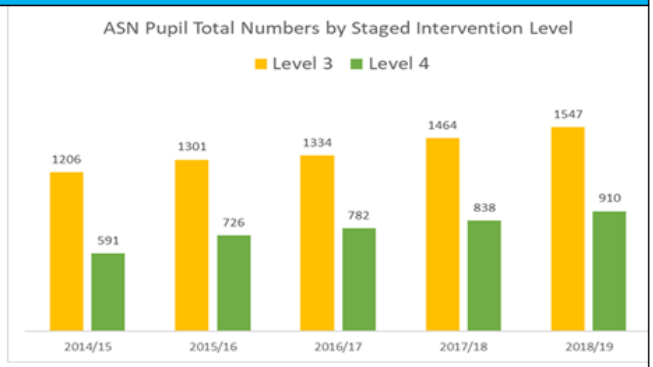


Source: SEEMIS

Actions	Timescale	Performance management
Provision of enhanced opportunity to participate in wider achievement including awards that have SQA recognition	By June 2020	Comparative data provision available at family team level
Develop and ensure that the improvement framework is embedded across Highland schools	By June 2020	Framework indicators matched to performance management.
Deliver inservice training for class teachers on promoting positive relationships, nurture and curricular differentiation.	By June 2020	Accurate data showing increase in number of teaching staff attending training. Improvement measures for to consider impact identified.

Improvement Priority 3: Additional Support Needs





Actions	Timescale	Performance management
1. Improve outcomes for children with additional support need through a programme which enhances the skills of all staff.	By June 2020	Impact measures to be determined.
2. Work across services to refresh the 'Highland Practice Model'	By June 2020	Timescales met for revised model
3. Review and establish a refreshed allocation model.	By June 2020	Allocation model identified as in place and effective.

Improvement Priority 4: Early Learning and Childcare 1140 Hours expansion programme

Needs assessment 165

The Scottish government has determined that by 2020, all three and four year olds and eligible two year olds will have access to 1140 hours of funded Early Learning and Childcare.

Actions	Timescale	Performance management
Establish an early learning and childcare workforce to deliver 1140 hours to all eligible children.	By December 2020	Evidence collated that workforce are at the correct establishment.
Ensure that all children can be offered a place to receive their entitlement of 1140 hours.	By December 2020	Evidence collated that here is local availability of provision where required.
Match the levels of provision available locally to local need sustainably	By December 2020	Any unmatched provision identified through performance management processes

Outcome 3: ***We have improved the life chances for children, young people and families at risk.***

This outcome has a specific focus on the following outcomes developed within our quality assurance and improvement framework.

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

Much of the data collected over the last five years shows significant improvement in the wellbeing of the most vulnerable children in Highland. Independent scrutiny of 'The Highland Practice Model' demonstrates improving trends through earlier intervention.

An increasing number of parents and families can describe the ways in which the model supports them and their children and young people. Continuous improvement through engagement is a consistent feature of ongoing improvement planning.

A number of key themes for strategic improvement within this outcome are articulated below.

Improvement Priority: Improve services for Children and Young people at the Edge of Care		
Performance information Current performance 40 children came into residential care in 2017/18. Target 20% reduction in the number of children placed in residential care by August 2020		
Actions	**Timescale**	**Performance management**
Reduce the number of residential placements	August 2020	Reduce placements by 20% in this period. This amounts to a real term reduction of 8 posts
Provide intensive family & community outreach work to support young people on edge of care	December 2019	Establish data set that determines the number of families accessing this service who have not accessed this service previously
Provide a short-term respite service for families in crisis	May 2020	Detailed data analysis of the number of children and young people in receipt of this service determining how many of these children would have had their needs met outwith Highland.

Improvement Priority : Return children and Young people who are looked out of area to Highland

Performance information 167

Current position: 32 young people OOA at July 2019 as compared with 41 at July 2018.

Since expansion of Placement Services Programme at June 2019, 24 children have returned to Highland avoiding costs of over £5m as compared with them remaining out of area for a full year.

Actions	Timescale	Performance management
Return a further seven children to Highland	December 2019	Available data shows this increase
Undertake monthly area meetings with family teams to determine return plans for individual children	Reviewed formally in December 2020	Meeting notes reviewed formally determining impact of increased provision.
Design and deliver education packages for returning youngsters	Reviewed formally in December 2020	Data shows that each returning youngster is able to access their entitlement to full time education.
Guarantee appropriate residential provision is available to accommodate children returning	Reviewed formally in December 2020	Increase by two the number of Highland Residential Units Data shows that each returning youngster is accommodated appropriately.

Improvement Priority : Identify and respond to recommendations from QA needs assessment for child protection

Needs assessment

There is an identified need for partners in NHS Highland, Police Scotland and Third Sector agencies and the Council to work with the Child Protection Committee to ensure that child protection processes in Highland are effective in keeping children safe and ensuring their wellbeing needs are met.

Actions	Timescale	Performance management
Review and update Child Protection guidance ensuring it reflects local processes and national priorities and is available to all staff electronically	December 2020	Consider child protection data available to Highland Council, NHS Highland and Police Scotland on a regular basis to establish and compare trends
Enable staff and managers to contribute to the development of child protection guidance, procedures and practice issues through consultation events and local roadshows	May 2020	Data gathered showing improving participation in events.
Seek the views of children, young people and parents/carers involved in child protection cases using Viewpoint and/or other appropriate methods	May 2020	Data gathered shows an increase in the number of children using 'viewpoint'
Ensure audit processes are robust and in place to review and monitor child protection cases	December 2020	Data shows an increase in audit processes undertaken within Health and Social Care service.
Review the effectiveness of child protection tools including the Graded Care profile within Care and Learning and NHS Highland	December 2019	Data shows consistent use of graded care profile.

Agree, implement and review recognised model for conducting significant case reviews, collating feedback from practitioners and disseminating key messages using the 7 minute briefing model	December 2019	Number of staff attending 7 minute briefings is recorded and shows increase.

Improvement Priority : Provide enhanced fostering and adoption provision

Needs assessment

We know that children and young people have better outcomes in family based placements including kinship.

We can demonstrate better value for money regarding the spend in children's services with increased fostering and adoption provision. Fostering costs less that residential placements and with increased fostering placements available we would be better able to meet the demands within our own services.

We currently have 43 children placed with independent foster carers at a cost of £191000 per month. This would cost significantly less if they were placed within our own fostering services. 17 of these children are waiting for adoption and should move on in the coming year when they have been matched with prospective adaptors.

Four young people have moved to a foster placement from an out of authority residential placement. This demonstrates a saving of £200,000 in the financial year 2018 /19.

Pressure has increased in recent years as more Children and Young People have required to be placed in residential care. This has put a pressure on residential places and an increased number of Children and Young People have been placed outwith Highland.

66% of children within our fostering service are under 10 years of age.

Highland Council is the lowest paying local authority nationally for both fees and allowances. Foster carers have only had two pay increases in the last ten years and we pay fees per property not per child. Kinship carers receive the same rate of allowances for foster carers but are not in receipt of fees.

Actions	Timescale	Performance management
Undertake a review of fostering & adoption (and kinship) payments including detailed financial impact assessment demonstrating Council affordability for any proposed changes	December 2019	An financial impact assessment and business case for increased fees for foster carers will be developed
Reduce delay and drift in Permanency Planning processes through the promotion of the learning from the PACE programme across Highland.	May 2020	PACE data from current Pilot will be replicated for other areas to demonstrate impact and improved performance
Reduce the number of CYP in foster care who experience multiple placement moves through audit of CYP in foster care who experience three or more unplanned placement moves in a 3 month period.	May 2020	Monitoring and Scrutiny systems developed to show impact
Increase the resilience and confidence of adopters and permanent foster carers in their parenting abilities.	May 2020	Design audit template to measure impact

We have improved the life chances for children, young people and families at risk.					
Indicator 1	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
Number of households with children in temporary accommodation will reduce.	95	100		Child Protection	96
Analysis The data is collected quarterly. The baseline was established in 2014 and shows a small reduction over time. The target was met for the first time in 2016.					
Indicator 2	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
The percentage of children on the child protection register who have been registered previously will reduce.	Improve from baseline	5.31%		Child protection	4.27%
Analysis The data is collected quarterly but due to short term variation, as shown in the graph below, is only statistically significant when analysed annually. The baseline was established in 2014 and this data shows continuous improvement over the last four years					
Indicator 3	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
The number of children reporting that they feel safe in their community increases	Improve from baseline	84.7%		Public Health and wellbeing	88.7%
Analysis This is data taken from the 2017 lifestyle survey. The survey is undertaken every two years across Highland schools. The 2011 lifestyle established a baseline for the data. The data shows continuous improvement over this period.					
Indicator 4	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
The number of children and Young people reported to SCRA on anti social behaviour grounds reduces	20% reduction	90		Youth Justice	86
Analysis This data is reported monthly. The baseline was established in 2012 and the latest data shows a reduction from the baseline and between the current reporting period and the same time last year.					
Indicator 5	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**

The number of offence based referrals to SCRA reduces	Improve from baseline	528		Youth Justice	356
Analysis This data is reported monthly. The baseline was established in 2012 and the latest data shows a reduction from the baseline and between the current reporting period and the same time last year					
Indicator 6	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
The delay in the time taken between a child being accommodated and permanency decision will decrease	9 months	12		Looked after Children	18.5
Analysis This data is collected quarterly and the baseline was established in 2016. The variance this that the reporting timeframe shows the average length of time and can vary considerably from case to case. During certain periods we have continued to seek permanency for harder to place children with, significant additional support needs, older children or sibling groups. For these children the overall time target has not been achieved due to the complexity of ensuring effective transitions.					
Indicator 7	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
The number of LAC accommodated outwith Highland will decrease (spot purchase placements)	30	44		Looked after Children	32
Analysis This data is reported monthly. The baseline was established in 2016.					
Indicator 8	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
The number of children needing to live away from the family home but supported in kinship care increases	20%	19.3%		Looked after Children	18.5%
Analysis This data is reported monthly. The baseline was established in 2016.					
Indicator 9	**Target**	**Baseline**	**Status**	**Imp Group**	**Current**
The number of children where permanence is achieved via a Residence order increases	82	72		Looked after Children	93
Analysis This data is reported monthly. The baseline was established in 2016.					

Highland Health & Social Care Committee Report

Community Divisions including Hosted Services

5 February 2020

1. INTRODUCTION

This report will provide an overview of activity in North Highland and will highlight areas of focus as well as areas of further opportunity.

2. PEOPLE

2.1 Recruitment and Selection

North & West Division:

Lochaber
There has been successful recruitment to the Registered Manager posts in both Telford Centre and Invernevis House. There has also been a very good response to the Band 5 Community Mental Health Nurse post and Band 6 Social Worker post. Some of the pressure placed on the West community nurse team has been eased by the appointment of some very experienced community nurses to the integrated nurse bank.

The Diabetic Nurse specialist service is still under established, however, the Lochaber post will be submitted to vacancy monitoring for review this month.

Skye
Recruitment continues to be a challenge within the District. The new Renal service planned for Skye only recruited one of the 3 qualified staff required, so has gone back out to advert. We staff have significant vacancies in Care at Home and ongoing challenges with long term sickness in the hospitals. We are looking to recruit into some fixed term posts to ease the pressure on hospital staffing and enable the reopening of Glamaig Ward in Portree.

We have ongoing Community Mental Health vacancies which have not been filled. We are looking to re model the service in the hope this will prove more successful, by introducing an OT to the team.

Caithness
In recent weeks there has been pressure on staffing at the Dunbar and Bayview in recent weeks. This is a result of a mixture of both staff sickness and vacancies. ATRs have been completed and the vacant posts will be advertised through the appropriate channels. There are also vacancies in the community nursing team on the west.

The post of Advanced Practitioner for Social Work is currently out to advert (closing date 27/01/2020). Interim arrangements have been put in place to ensure appropriate support for Adults with Incapacity/Adult Support & Protection.

Both post holders for east and west integrated team leads are in fixed term/seconded posts. It is the intention to advertise these and make more permanent arrangements.

Sutherland
There is a slightly improved position within recruitment for this report.

Strathy Ward, Migdale Hospital is now open supported by two agency nurses at present however applications are being processed for RMN posts and RGN posts as a result of the use of Stirling Cross

recruitment agency.

Band 6 cover at the hospital. We have been unable to recruit for the SCN role at Migdale therefore the model has been reviewed at the hospital and the vacancy monitoring process is commencing.

Fragility continues in terms of recruitment to care at home posts in North West Sutherland however some posts have been appointed to in Lochinver.

District Nursing in North Sutherland has seen an improved position with the Band 5 Community Staff Nurse post appointed to however the recruitment process continues for the Band 6 Caseload holder position with the post being advertised for the third time.

CPN services in Sutherland remain fragile as we continue through the recruitment for an Older Adult Mental Health Nurse and the post in West Sutherland remains vacant. (Agency cover is in place at present in West Sutherland.

South & Mid Division:

As previously reported, work is ongoing in nursing teams and with professional leadership to create sustainable nursing teams across the division. Nursing professional leadership is currently working with operational managers to understand the number, location and type of vacancies in nursing teams with the aim of then creating a sustainable recruitment and retention plan.

All Social Work team lead posts in South and Mid have now been recruited to.

2.2 Staff Experience

2.2.1 Learning and Development

The completion of statutory and mandatory training in South and Mid division remains a priority and is a standing item on management team agendas. The division is achieving above 80% compliance for the core learn pro modules and exceptions are targeted for improvement. Currently district managers are working with administrative staff on improving completion of the moving and handling learn pro module relevant to them which is the current exception at 57.4% for the division.

2.3 Sickness Absence

By month	September 2019 %	October 2019 %	November 2019 %	Cumulative Total %
North & West Division	5.15%	5.39%	5.73%	5.11%
South & Mid Division	4.97%	5.40%	5.99%	5.53%

3. QUALITY & SAFETY

3.1 Improvement Activity

North & West Division:

Tissue Viability and falls work being continued at the present time. Systems will continue to be reviewed and improved.

South & Mid Division:

Quality Improvement work is continuing in South and Mid this year. In 2019/20 Intermediate HQA training was delivered to 18 people in Inverness Community Team with the intention of developing a network of people skilled to take forward Quality Improvement work within their teams. As part of this there has been a focus on establishing daily management with these teams. Most now have a visual management board which they report out at on a regular basis.

Invergordon and Affric Wards started Value Management. New Craigs is participating in the National Collaborative for Value Management with immediate plans to roll out to 3 further teams.

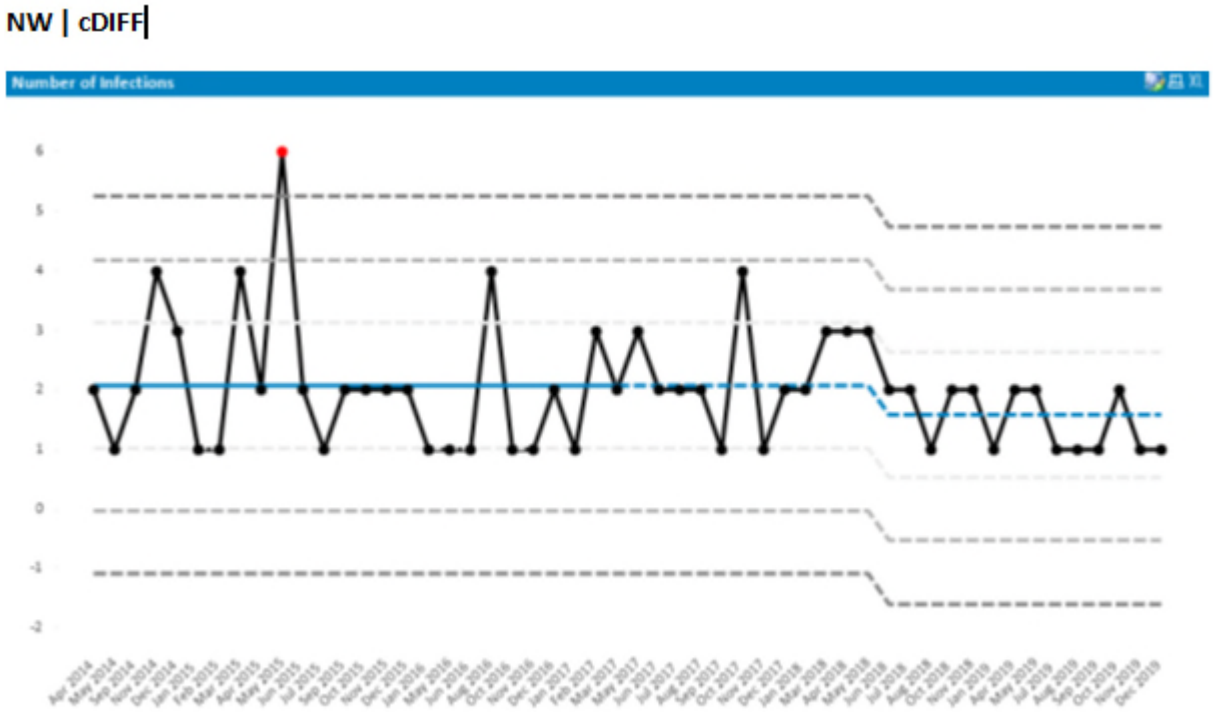
3.2 Infection Prevention & Control

North & West Division:

Clostridium Difficile Cases (C Diff).

- North & West Division currently have 11 CDIFF cases reported. These have been all investigated and reviewed at the CDiff / SAB meeting and there has been no identified links with any of the cases. We are currently below the recommended HEAT target.

North & West Operational Unit C *diff* toxin positive

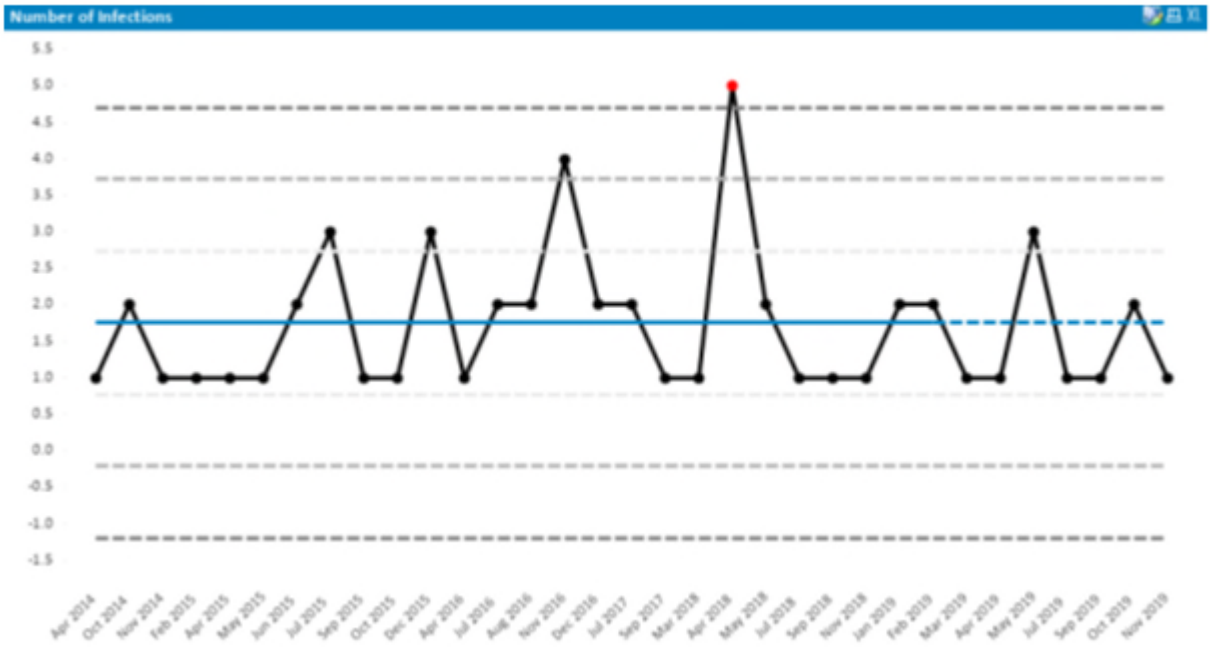


S*taphylococcus aureus* bacteraemia (SAB) Incidence:

Since the start of April 2019, there have been 10 cases of SAB incidents. A root cause analysis has been undertaken for each case to determine where improvements can be made and learning identified. There have been no identified links to cases.

North and West *Staph aureus bacteraemia*

NW | SABS



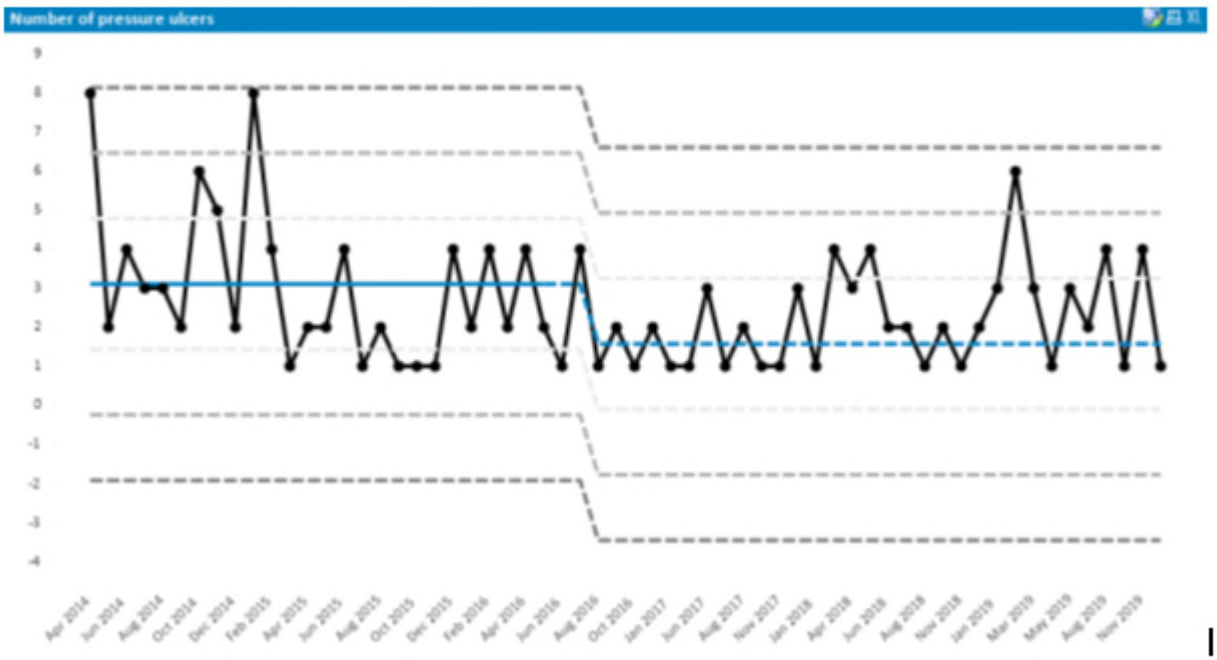
Tissue Viability

Hospitals:

Table 1: Incidence of pressure ulcers arising in hospital excluding Grade 1 to end Nov 2019.

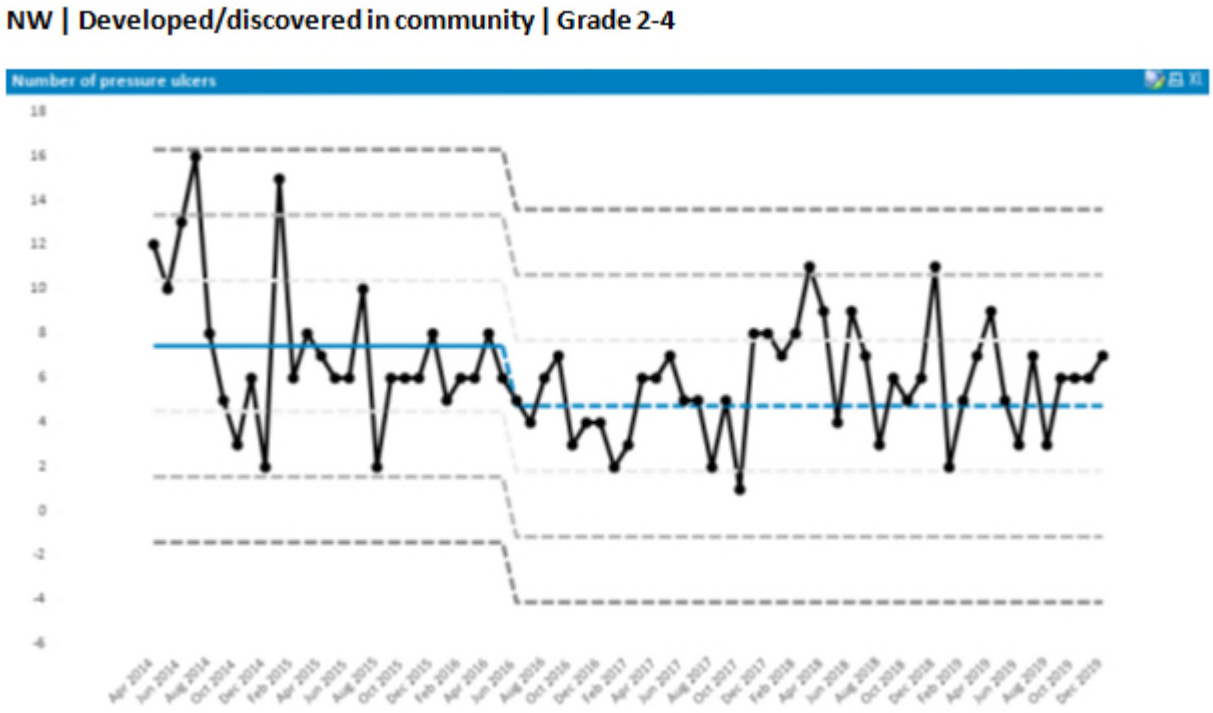
Pressure Ulcers – Number of Hospital Acquired Pressure Ulcers

NW | Developed in hospital | Grade 2-4

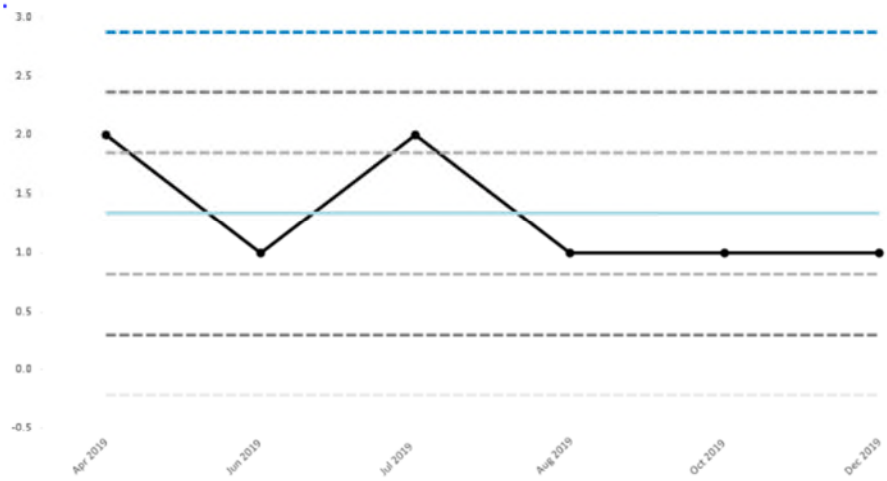


Community:

Table 1, below, Incident of pressure ulcers arising in community excluding Grade 1 to end December 2019.



South & Mid Division:



This graph is only until December 2019 therefore the 2 new cases are not identified.

No SAB's

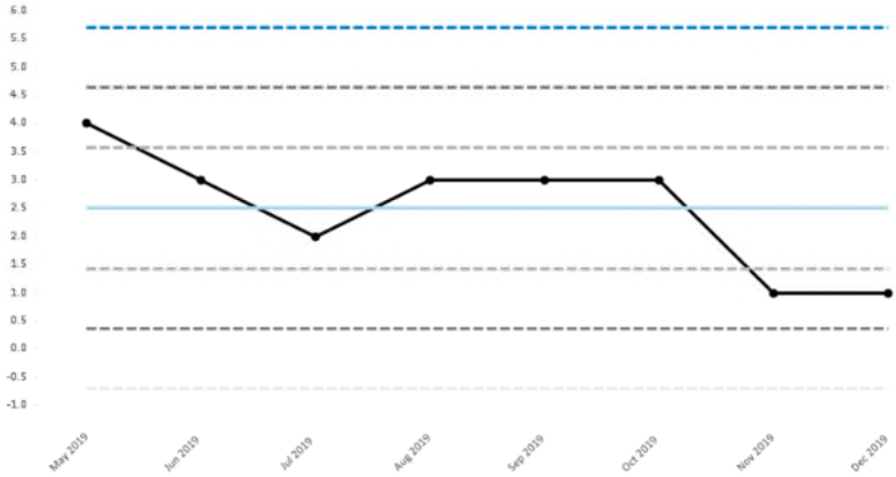
Outbreaks

- 2 confirmed outbreaks + 1 probable
- St Vincent's - probable GI outbreak, staff only affected
- Ian Charles- Confirmed norovirus out break- 6 patients and 7 staff affected
- Invergordon - 5 patients confirmed flu, 1 member of staff affected-(this is probably under reported as several staff off with cold like symptoms prior to outbreak

Emerging Threats

PHE Infection Control guidelines for Wuhan respiratory virus infection:

Tissue Viability



This graph shows our grade 3 and 4 pressure ulcers up to December 2019. We are below our control line for the second month.

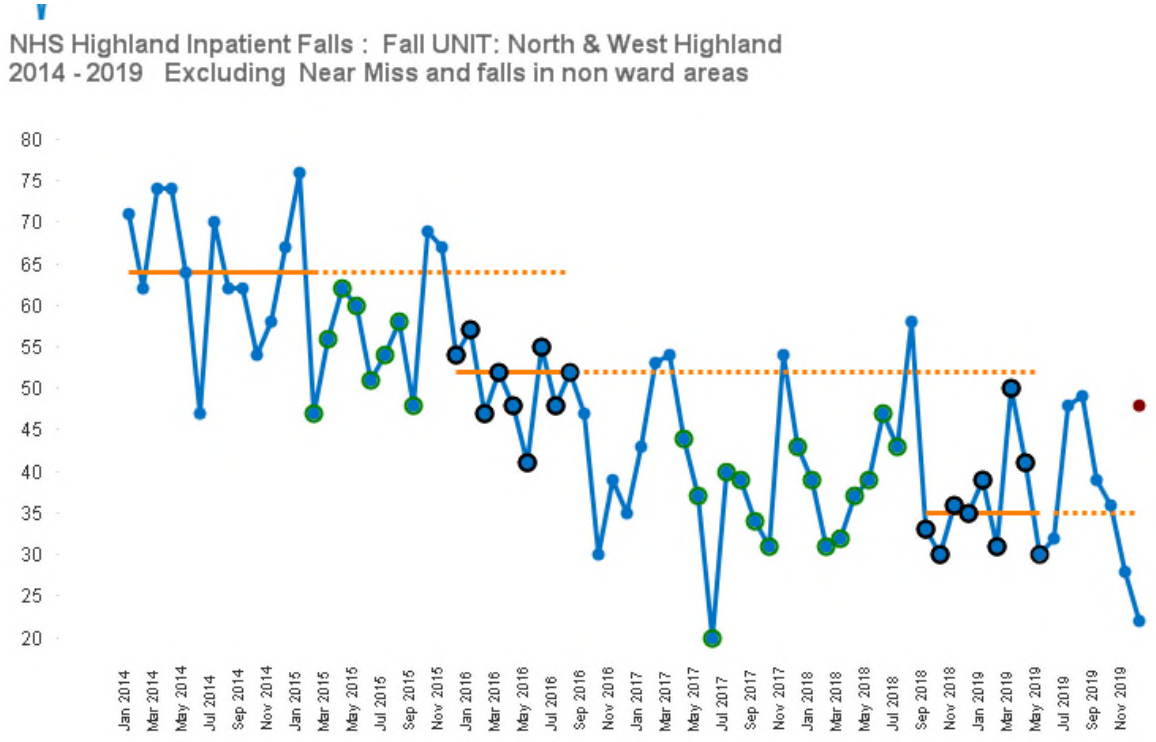
3.3 Patient Safety

3.3.1 Scottish Patient Safety Programme

North & West Division:

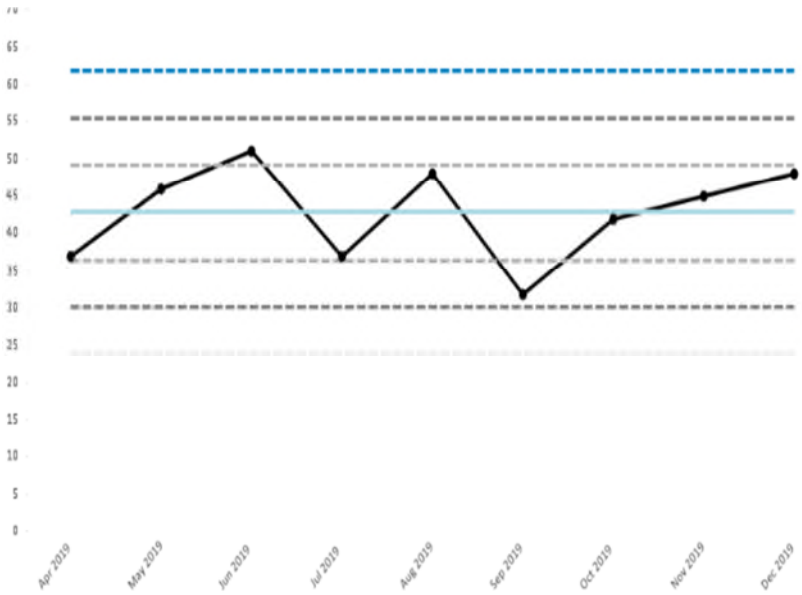
Falls

Data below showing a sustained reduction in falls. Work continues to improve the reduction in falls.



South & Mid Division:

Falls



Falls | contributory factors (%)	
Unaware of own limitations/limited mobility	62%
Confusional state	37%
Result of medical condition	30%
Inappropriate footwear	12%
Poor task control	11%
Result of medication	3%
Inadequate lighting	3%
Contaminated floor/walkway	3%
Poor housekeeping	0%
Defective floor	0%
Total contributory factors	90%

This graph shows the falls up to December 2019. There has been a slight increase in patients – 5 more than the previous month. However the table demonstrates that the majority of these were caused by patients being unaware of their own limitations (62%). There were no falls with harm.

There is ongoing work with the community teams in Invergordon. The main objectives are improvement of communication across teams, clarity around the falls pathway and providing evidence of falls management and improved outcomes for patients.

4. CARE

Service and Delivery

4.1 Adult Social Care

4.1.1 Delayed Hospital Discharge

Delayed Discharge figures as at 27 January 2020:

Hospital	Care at Home	Placement (inc EMI/Dementia)	Complex	Other	TOTAL
DUNBAR HOSPITAL, THURSO	0	1	2	0	3
CAITHNESS GENERAL HOSPITAL	1	5	1	1	8
TOWN & COUNTY HOSPITAL WICK	0	1	2	0	3
LAWSON MEMORIAL HOSPITAL,	0	2	0	0	2
RNI COMMUNITY HOSPITAL	3	1	3	1	8
RAIGMORE HOSPITAL	18	7	2	8	35
TOWN & COUNTY HOSPITAL NAIRN	6	2	1	2	11
IAN CHARLES COMMUNITY HOSPITAL	2	1	0	0	3
BELFORD HOSPITAL	0	0	1	0	1
ROSS MEMORIAL HOSPITAL	2	2	0	0	4
COUNTY COMMUNITY HOSPITAL	5	2	6	5	18
NEW CRAIGS HOSPITAL	1	4	12	0	17
MDALE: MIGDALE HOSPITAL	1	1	2	1	5
Total	**39**	**29**	**32**	**18**	**118**

4.1.2 Care at Home (including commissioning)

The Pathway Home pilot service commenced a phased start on 2 December 2019, with full operations commencing from 13 January 2020. The SOS Overnight service in Inverness works in conjunction with this service and has been extended in line with the end date for the Pathway Home service, allowing both services to be evaluated consecutively for future commissioning plans.

Whilst current ongoing assessment has shown a 14 day reduction in the average length of stay for post-acute patients in Raigmore Hospital and a decrease in delayed discharges from 44 to 24, we are now seeing the impact of wider sector capacity decline affecting the flow out of the enhanced recovery service.

Commissioned care at home services continue in line with the new contract, with pick up taking place across North Highland where providers are able to offer capacity. However, capacity is currently recorded as zero with essentially now a one out, one in system.

Analysis of data has shown a reduction in the total number of provided hours, alongside an increase in queued demand. The initial conclusion is that this appears to be as a result of recruitment challenges in respect of recruiting and retaining suitable staff.

Further analysis is therefore being undertaken with regard to the current issues affecting both the enhanced services and commissioned care at home in order to review and seek proactive solutions to these circumstances. This approach will involve dialogue with providers to inform a short, medium and long term strategy to address these issues.

Within East Ross, one provider is withdrawing, with services being transferred to other providers

operating in the area. In Mid Ross, a provider delivering SDS Option 2 care at home services is seeking to withdraw from a number of services. Replacement care is proving challenging and work is ongoing with providers to seek alternative provision.

All independent sector care at home services are planned for monitoring in February and March 2020.

4.1.3 Care Homes

There are specific areas of work ongoing under the structure of the Programme Management Office, to consider redesign and bed utilisation areas.

As part of the internal redesign to review models of care in NHS Highland's in house care homes, new Project Team and Project Board arrangements have been established to provide enhanced support to this key area of work.

With regard to care home sector dialogue, a joint work plan requires to be discussed and agreed with the sector. A workshop with Scottish Care took place on 16 December 2019 in this regard. This was a session facilitated by Donald McAskill, Chief Executive of Scottish Care, and was for the purpose of discussing Development Officer input and a work plan for 2020-2021. This was a positive meeting and actions have been agreed to strengthen linkages between the care home sector and NHS Highland, and specifically to focus on sector engagement, improvement, innovation and quality areas.

There is one suspension of admissions in place as at 22 January 2020.

A new care home in Inverness (Castlehill) opened on 27 January 2020. As at the time of writing, due diligence requires to be completed before the issuing of a contract for the use of this facility. Any placements made by NHS Highland will be through a single point of contact, with an appropriate phasing pace.

4.1.4 Self Directed Support

North and West Division:

As of 31 January 2020 the number of people accessing a Direct Payment across North and West Division are distributed as follows:

The current 4 weekly payments at district level are as follows:

Area	District	Number Active	Total 4 Weekly Payments
North	Caithness	26	39,065
North	Sutherland	22	25,550
West	Lochaber	34	67,847
West	Skye & Lochalsh	54	52,382
West	Wester Ross	19	11,911
Total		**155**	**196,754**

The following one-off payments have been made during 2019/20:

Area	District	Number	One Off Total
North	Caithness	3	9,096
North	Sutherland	4	4,801
West	Lochaber	6	1,800
West	Skye & Lochalsh	10	17,014
West	Wester Ross	2	600
Total		**25**	**33,311**

There are currently 155 active direct payments with a total 4-weekly payment of £196,754.
South and Mid Division:

As of 31 January 2020 the number of people accessing a Direct Payment across South and Mid Division are distributed as follows:

The current 4 weekly payments at district level are as follows:

Area	District	Number Active	Total 4 Weekly Payments
Mid	Badenoch and Strathspey	12	14,672
Mid	Easter Ross	39	57,208
Mid	Mid Ross	49	62,835
South	East Inverness	62	100,651
South	Nairn and Ardersier	24	24,452
South	West Inverness	32	43.290
Total		**218**	**303,108**

The following one-off payments have been made during 2019/20:

Area	District	Number	One Off Total
Mid	Easter Ross	6	5,184
Mid	Mid Ross	11	3,950
South	East Inverness	13	28,220
South	Nairn & Ardersier	3	3,251
South	West Inverness	5	4,258
Total		**38**	**44,864**

There are currently 218 active direct payments with a total 4-weekly payment of £303,108.

4.2 Integrated Health & Social Care Community Services

4.2.1 Single Point of Access

Ongoing work reviewing the huddles and DCP processes within the teams. Integrated team work plan developed to take forward system improvements and create capacity.

4.3 Mental Health & Learning Disabilities and Drug & Alcohol Recovery

4.3.1 New Craigs hospital

The General Manager retires on 3 April 2020. Discussion continues as to future management arrangements including appointment of a replacement.

Interviews for the Clinical Director (Mental Health and LD) will take place 31 January 2020,

The scrutiny meeting with Scottish Government took place on 21 January 2020.

4.3.2 Community Mental Health Services

North & West Division:

Band 6 MH OT vacancy and one band 3 HCA vacancy. Addictions 1 WTE band 3 post (0.5 WTE Skye and 0.5 WTE West Ross) vacancies. Workforce establishment reviews completed. Waiting lists in place for OA in Skye.

South & Mid Division: The Senior managers of mental health services have been meeting jointly to standardise Clinical Governance arrangements and Quality and Patient Safety issues. N&W managers also participate in the Mental Health SMT monthly meeting.

4.3.3 Migdale Hospital, Bonar Bridge

Adult community services: The current Community Psychiatric Nurse vacancy in West Sutherland has been re-designed to include substance misuse and generic mental health, and as in other areas, is proving challenging in recruiting, and is being advertised for 4th time. Currently agency staff covering this lone post, pending recruitment.

4.3.4 Learning Disabilities and Autism

North & West Division:

An event was held in Inverness during December 2019 to celebrate 100 years of Learning Disability Nursing. There was a significant contribution to this Highland wide effort by Learning Disability Nurses from the North and West Division. Several people that use the service enjoyed the afternoon, having made the effort to travel from as far afield as Golspie and Fort William.

There is a vacancy for a 0.5 w.t.e Band 6 Learning Disability Nurse in Wester Ross. It is currently being re-advertised after a couple of “near misses” in attempts to fill it during 2019.

Sustaining the Commitment was published on 31 December 2019. This report is part of the UK’s ongoing modernisation agenda for Learning Disability Nursing and includes specific direction from the Scottish Government which will inform a local delivery plan.

South & Mid Division:

Work to review and redesign Highland Learning Disability Day Care Services continues. A Project Manager has been seconded to ensure all commissioned and in-house services will be reviewed within the next six months. The refresh to the Keys to Life, Unlocking Futures for People with Learning Disabilities Implementation framework and priorities 2019-2021 has been published and we are working to ensure that the priorities are weaved into the work in Highland.

The Highland Learning Disability Listening Group (a group of people with a Learning Disability) meet regularly and in November 2019 held an event which launched the aspiration of One Page Profiles for

every person with a Learning Disability. Work is ongoing with community health professionals and third sector support providers to ensure the realisation of this request from supported people.

Redesign of Overnight Support continues across Highland and is following a “slow and steady” approach to ensure that people will be safe overnight and both individuals and their families are confident that the new models of support meet the needs of their loved ones.

We are progressing work to ensure better communication across health, social care and third sector support providers by arranging learning events, joint business meetings and discussing potential new models for commissioning in partnership.

The Adult Autism Assessment Service (AAAS) continues to have high waiting lists and times, however we have expanded the team, have reviewed the referral process and are arranging to meet with other clinicians in an attempt to increase assessment at first point of contact.

4.4 Support for People with Dementia and their Families

North & West Division:

A pop- up Dementia Cafe is being supported by Marks and Spencers. This will also provide a venue to promote and engage with the public on the further development and review of the Lochaber Community Partnership Adult Plan which highlighted improving facilities for supporting the care of the care of the older adult with dementia as one of its key priorities.

South & Mid Division:

Recruitment to the role of Directorate service Manager for Older Adult Mental health Services was successful. Interviews for the Clinical Director role will take place in February. The review of Dementia services continues led by Public Health.

4.5 Drug and Alcohol Recovery

- Oct – Dec 2019 wait times are to be submitted 24 January 2020, data to be published March 2020
- Ongoing staffing concerns in some teams have impacted in sustaining 90% target but improvements should be noted from Jan – March 2020
- Service Development session planned for 25th February to review and develop an action plan to implement changes across north Highland services to ensure robust management of vacancies / absences.
- Support Workers recruited via HADP resource, commence mid February 2020, this will increase capacity and improve prison through care support and step up/step down services.

4.6 Primary Care Services

Recruitment & retention

There are no GP recruitment and retention issues within the South & Mid Division.

Within the North & West Division, there are several GP practice sustainability concerns.

We continue with the use of Locum GP cover in Scourie/Kinlochbervie and Durness. The vacancy has been advertised several times, and to date we have received minimal interest.

There are current GP Vacancies in Riverbank, Thurso, and Riverview in Wick, along with Advanced Nurse Practitioner vacancies.

The GP's in Tongue Medical Practice have advised that they will both resign at end March 2020, and work is ongoing to recruit to the provision of General Medical Services for this area.

Acharacle Medical Practice has a GP vacancy, which has been advertised on three occasions, again with minimal interest. We are about to go to advert in the British Medical Journal, in an attempt to attract applicants to this practice. At present the practice is reliant on Locum GP cover, and they have been successful in securing the services from GP's from the Rediscover the Joy locum scheme.

Mallaig & Arisaig Medical Practice - the GP in this practice has decided to resign at end of March 2020, to take up a position within the Alness & Invergordon Medical Practice. We are currently advertising for the provision of GMS services in this area, with an advert being placed in the British Medical Journal, and highlighted widely on social media. In the interim NHS Highland will require to take over the running of this GMS service from 1st April, 2020, and GP cover will require to be covered by Locum GP's.

Ullapool Health Centre, and Cannisbay & Castletown Medical Practice also have current GP vacancies.

Appointments have been made to the Primary Care Team: Head of Primary Care, 4 Primary Care Managers and a Project Officer.

GP Quality Clusters

The six quality clusters continue to make progress in their quality-driven areas. We are looking to how we can showcase projects and share the learning across all quality clusters.

Primary Care Improvement Plan (PCIP)

Pharmacotherapy (Year 1 funding)
Skill mix of staff employed:
17 x Band 7 Pharmacists (13.22WTE)
4 x Band 5 Pharmacy Technicians (4WTE)
3 x Band 8a pharmacy team lead posts currently out to advert

It is planned to add Pharmacy Support Workers to this service with these posts introduced in Spring 2020.

59 out of 65 practices are receiving a pharmacotherapy service, with full implementation planned for Spring 2020.

This workstream is continuing to focus on supporting increasing skill mix; sharing best practice; to reduce variation in practice; identify gaps in service and to continue to recruit.

Additional Professional Roles
MSK First Contact Physiotherapist (Year 1 funding)

The workstream has achieved 71% of anticipated recruitment to FCP roles (10.83WTE) and this is anticipated to reach 100% in the first few months of 2020, reaching the agreed model of 1WTE:13,000 population. Solutions to IT issues have been identified and funding has been agreed where this is preventing service delivery. There are also concerns about destabilising existing physiotherapy services during the process of redesign of existing services to accommodate the FCP model. However, this is being addressed through careful planning to avoid any withdrawal or disruption to exiting provision.

Additional Professional Roles

Mental Health Workers (Year 1 funding)

The scoping of this service will take place during 2020, which will include a workforce recruitment plan. There are currently workforce shortages in mental health and it is important that a system approach is adopted to staff recruitment, which does not destabilise existing mental health services. A workshop to engage with a range of stakeholders to scoped and inform a model of care for support in General Practice for mental health services is planned for 28 February 2020.

Community Link Workers (Year 2 funding)

This workstream has agreed to target allocation of resource to those most in need and so contribute to reducing health inequalities using the Scottish Index of Multiple Deprivation to identify levels of deprivation of areas served by GP practices. Therefore, 29 out of 65 practices have been identified to receive this service, which will be commissioned from the community and voluntary sector through a procurement process due to be completed by June 2020.

Community Treatment and Care Services (Year 2 funding), Urgent Care (Year 3 funding) and Vaccination Transformation Funding (Year 3 funding)

We are looking to deliver CTAC, VTP and Urgent Care on a collaborative basis whereby resource can be pooled and economies of scale can be achieved. We are looking to consult with local practices, quality clusters and GP sub-committee on best configuration of local models.

4.7 Midwifery - Community Midwifery Units

Midwifery staffing remains an issue in Skye and Lochalsh. However the team are still providing a local birth service out of hours. Adverts for staff are ongoing and the team are covering all gaps.

Midwifery staffing in Caithness is challenging, ATR submitted for band 5/6 midwife. The Community Midwifery Unit continues with out of hours on call provision for unscheduled care and home births.

The community engagement exercise in October 2019 for the focus group meetings were conducted by Higher ground health care. Although around 600 invites were sent women who had used the midwifery service since the change to Community Midwifery Unit service, participation was lean. A draft report is now circulating for group discussion then presentation to the board.

Midwifery staffing in Sutherland remains tight, but have had success in recruiting 1wte band 6 midwife. Due to difficulty in recruiting midwives, the team lead and lead midwife have considered skill mix for future sustainability. A band 3 job description has been prepared for vacancy monitoring. Workload continues to be reviewed and risk assessed on a daily basis by the team lead with the team currently covering gaps.

Badgernet (electronic maternity patient record) is now in use for all women being newly booked within NHSH. Staff continue to familiarise themselves with the new system. It is anticipated that all caseloads in NHSH will be on Badgernet towards the last quarter of 2020.

As an early adopter board, teams continue to work towards implementing the best start framework. All women have an identified named/primary and buddy midwife. CMU midwives continue to manage their own caseload aiming to provide the majority of care to women on that caseload. Work continues to align consultants with teams across Highland and aim to provide the target of 50% for direct care of their caseload. Women continue to have the choice of their place of birth. Implementing skill mix within teams is ongoing. HCSWs and MCAs are becoming more involved providing services within the community e.g parentcraft, breastfeeding support, aquanatal and assisting midwives at clinics undertaking observations and providing antenatal education or post natal support.

4.8 Chronic Pain Service

This service continues to provide an NHS Highland wide service (excluding Argyll and Bute). We continue to receive approximately 950 to 1000 new referrals with the same resources/funding in place for a service design of approximately 300 to 400 new referrals per year.

We are currently have waiting times of approximately 20 weeks for new referrals and new injection procedures and therefore we are not meeting government waiting time targets for TTG. There are 117 new patients waiting for an injection procedure and we continue to ensure that all theatre lists are fully utilised with a 97% to 98% theatre occupancy.

There are significant waiting times for some of our repeat appointment:

- MDT clinics: 11 month wait (99 patients waiting to be seen)
- Dr Review clinics: 12 month wait (93 patients waiting to be seen)
- Repeat injection procedures: 12 month wait (236 patients)
- All other clinics have a 4 to 6 month waiting times

The band 2 medical note preparation hours are no longer been covered and this has now been taken over by Central Records (Raigmore). This has meant that our service has been fully converted to electronic medical notes for majority of our clinics (apart from 2 clinics per week that are carried out in Caithness which use Caithness medical records). This change has removed the H&S risk of lifting paper medical notes, reduced the risk of infection of handling multiple user paper medical notes and transport to various clinic locations within NHS Highland. The clinicians have highlighted it does take longer to go through electronic notes to locate relevant documentation, therefore increasing consultation of approximately 3 to 5 minutes per patient.

A chronic pain proposal paper has been drafted and submitted for the Annual Operation 3 Year Plan. This proposal is for funding to address the current capacity/demands issues and to support a new Chronic Pain Management Service model design and delivery.

4.9 Highland Sexual Health

The service manager/nursing lead recruitment process is complete, with Kimberley MacInnes now appointed to this role. Kimberley was previously the SCN for Highland Sexual Health; recruitment to her post will shortly be underway. Therefore the challenge of staffing clinics remains unchanged due to medical staff vacancy, sickness of locum medical staff and maternity leave of a Nurse Practitioner. Active recruitment to the nurse bank is underway but employing staff in such a specialist service is difficult.

The impact of PrEP (pre-exposure prophylaxis) introduction continues to have an impact on waiting times locally and nationally.

Online appointment booking via the Sexual Health NaSH system is now live and working well within Highland. Online booking of certain types of appointments went live end November 2019 and the number of people booking appointments this way is increasing week on week. The aim is to increase the number of types of appointments available to book in this way. To date around 90 people have booked appointments through the online system- we have seen a small reduction in telephone calls to the department since online booking went live.

4.10 Technology Enabled Care

Florence Scale-Up Blood Pressure monitoring and management

Delay to starting work in earnest on the Scale-Up BP programme has continued. The National Team have now completed their work on the Information Governance pack and this is being reviewed locally. We cannot commence work until Information Governance has been signed off by NHS Highland which is delayed. Thereafter, we will be moving into live testing of the integrated reporting solution, which provides for reports of patients' BP readings being loaded automatically into Docman, so they can be dealt with as part of GPs' normal workflow.

Meanwhile, we are still in the process of recruiting our Clinical Lead, now planned to be a practice nurse, whose role will be to work with the TEC team to encourage GP practices to take advantage of the opportunities offered by Florence. Unfortunately, there has been some unavoidable delay in the recruitment process.

Although we won't be starting our full programme of engagement activities with GP practices until everything is in place, we have nevertheless recruited three new GP practices to use of Florence over recent months, and we are in the process of upgrading those who already use Florence to use of the new national protocols for BP monitoring and management.

TEC Pathfinder – Transformation of Respiratory Services

The initial stages of the project have been somewhat delayed due to the need to recruit staff and to obtain ethical approval for research to be undertaken. However, as of the end of December, everything is now in place for work to move forward at pace.

The project is using the Scottish Approach to Service Design, which puts service-users at the centre of the design process. Initially, this will involve exploring the end-to-end life experiences and journeys of people with respiratory conditions, in order to identify issues in the current provision of services. Later in the project these same people will be involved in the redesign of services.

The majority of this work will be undertaken by UHI researchers, who will be running workshops in five locations across the Highlands - Inverness, Alness, Lochinver, Fort William and Golspie.

4.11 Dental

National Detailed Inspection Programme (NDIP)

The findings of the National Detailed Inspection Programme (NDIP) of P7 children in school year 2018/19 have been released by the Information Services Division (ISD).

NDIP is carried out annually under the auspices of the Scottish Dental Epidemiology Co-ordinating Committee on behalf of NHS Boards.

Main points:

- *More than three quarters (80%) of P7 children in Scotland had no obvious decay experience in their permanent teeth in 2019 (For Highland the figure is 82.5%). This is a large improvement since ISD started recording this information in 2005 (53%).*
- *The average number of P7 children's teeth affected by obvious decay experience in 2019 is 0.42 (for Highland the figure is 0.35). This is less than a third of the average number of teeth affected in 2005 (1.29).*
- *There has been a small improvement in the inequality metrics but clear dental health inequalities remain. Only 69.5% of P7 children have no obvious decay experience in the most deprived areas compared with 88.1% in the least deprived areas.*

Dental:
National Oral Health Improvement Plan (2018)

Domiciliary dental care services – care homes
NHS Highland continues to monitor the introduction of contracting with accredited independent contractor General Dental Practitioners (GDPs) which is being progressed in some Health Boards as part of the NOHIP. Progress has been delayed nationally whilst legal advice is sought on contractual issues. Ongoing

Oral Health Risk Assessment and the Preventative Care Pathway for Adults
Details of the new model of care have not yet been published and it is acknowledged that the new pathway will be a significant change to the GDP contract. Ongoing

4.12 Prison & Custody Services

Prison
- Population remains consistently above capacity. This is a SPS establishment wide issue.
- Vacancy in mental health staffing out to advert
- Clinical Manager retires end March – transition plan in place to support service while replacement recruited
- Mental Welfare Commission visit due – awaiting dates

Police Custody/FME
- New Team Lead started 13 February 2019
- 2 full-time practitioners for custody start 27 January 2020 and one in February 2020. This should ensure 24 hour cover of all shifts.
- Paramedic support model to be reviewed – additional support was offered from SAS over the festive period, potential to consider how this may support the service in the future.
- Custody Link Workers recruited by HTSI are now in post and will work with the team to support those in our care to link in to community services where indicated.
- Lead FME recruited, anticipated start date of 10th March
- Progress towards the development of the Dalneigh suite replacement underway.
- Out of hours on call Forensic Nurse Service commenced 11th November – 11 staff recruited to support Forensic Medical Examiners in cases of sexual assault.

5 SERVICE REDESIGN

Lochaber

Work is being undertaken to finalise the clinical model. Final comments from stakeholders are awaited.

An audit of ward 1 has been completed and there is a meeting scheduled to discuss the audit to inform the rehab model.

Additionally the Project Team are looking at the strategy and will be holding an options appraisal to appraise a list of possible solutions for delivering services in Lochaber. This options appraisal needs to be documented for the Initial Agreement.

Possible service/ strategic solutions for delivering services in Lochaber to be appraised are:
1. Do minimum – service change within existing arrangements (based on current arrangements)
2. Redesign health and care services across Lochaber and enhance acute facilities
3. Retain existing service arrangements but still enhance acute facilities
4. Col-locate hospital and health centre services
5. Re-locate acute services and enhance primary care within Lochaber

The whole estate in Lochaber needs reviewed and the following needs concluded:

1. Base level data – current issues and building utilisation data to understand occupancy of Lochaber estate
2. Outpatient activity in the Belford and whether this could be provided in Fort William Health Centre
3. There needs to be workshop about what is feasible in Lochaber
4. Ascertain other facilities available in the 3rd sector

Skye

Construction began on the site of the new hospital in Broadford on 19th August 2019 by primary contractors Balfour Beatty with the expected completion date as 19th April 2021. Additional parking has been provided for staff and visitors to the hospital on the opposite side of the High Road for the duration of the build phase.

A Lead Stakeholder Workshop and also a wider stakeholder update was held in Broadford on 28th November 2019. This gave all participants an oversight of the final design and an opportunity to ask any questions about the new community hospital.

Also in November, Macmillan Cancer Support with their design team and NHSH Project Manager met with current and past chemotherapy patients to gain input on the design of the Infusion Suite which is being funded by the efforts of fundraisers in the area in previous years. They also held a session with the Macmillan nurses and staff in the hospital to discuss the design and get feedback about whether the design would work with the service. Renal service will also be held in this area and has now been confirmed as a service going into the new hospital.

The Estates team have now appointed an M&E (mechanical & electrical) contractor for Broadford Health Centre to convert the top floor into office space for the Integrated Team. We will now move to confirm the design and apply for planning.

A migration task force has been set up to take forward the transition of departments into the new hospital.

Balfour Beatty have been meeting with the community in Skye, Lochalsh and South West Ross in January 2020 as part of their community benefits programme. They carried out 5 Developing Young Workforce workshops as part of Portree High School's STEM day for about 75 S3 pupils. They also met with local councils about how they can support local initiatives moving forward. The community reps will be issuing Balfour Beatty with a list of areas where they can help.

The SLR work streams are continuing to progress. As part of the work stream 2 (Community Beds) a series of information sessions and option appraisal workshops are scheduled for Feb – April 2020 and will be independently facilitated by Norman Sutherland. These sessions will be an equal mix of hospital clinicians, managers and members of the community. It is hoped that following the conclusion of these events a clear way forward for the future of community beds in North Skye will be in place.

North Coast

As has been indicated in previous reports NHS Highland has continued to work with both Highland Council and Wildland to progress both design and funding options. As agreed Highland Council has produced a costed design for the original site while Wildland working to the same schedule of accommodation as the Highland Council are looking at options for the new site option.

A draft memorandum of understanding (MOU) between Wildland, NHS Highland and Highland Council has been prepared. NHS Highland and Highland Council (estates teams) made some initial comments but are happy with it as it stands so have passed it on to their respective legal departments

to review and formally agree.

Fraser Mackenzie (project manager for estates) instructed a firm of Chartered Surveyors to provide and opinion of market rent for the “doable” Highland Council design. A figure has been returned and he is liaising with Wildland re this figure in terms of rentable value / potential lease arrangements.

In case there are any issues with the MOU or the rentable value NHS Highland and Highland Council are keeping up the dialogue about options for the original site.

Modernising Health & Social Care Services in Caithness

As has been previously noted the Board of NHS highland received ministerial approval for the redesign plan in Caithness from the Cabinet Secretary for Health and Sport in the Spring of 2019. The next state in the process is submission of the Initial Agreement (IA) which the project team expects to submit by end March 2020.

As part of that IA process two design “National Design Assessment Process” (NDAP) and “Achieving Excellence in Design Evaluation Toolkit” (AEDET) events were held in early January. The first focused on Caithness General Hospital while the second focused on community buildings e.g. Dunbar, Bayview, and the Community Health Centre on Davidson’s Lane in Thurso, Town & County, Pulteney House, the Old Medical Centre and the primary care facility at Martha Terrace in Wick. The sessions were facilitated by NHS Scotland and Architecture and Design Scotland. Half-day follow up events are planned for the end of January.

The team locally continue to work with the Scottish Futures Trust (SFT) on the development of the local care model for Caithness; focus is on the following work streams: Multidisciplinary Team (for proactive case management), Single Point of Access (SPOA), Supporting Services (access to specialist opinion), Estates, Workforce and Community Engagement. Each of these work streams has a lead and project manager allocated.

Maternity Services Focus Groups

While maternity services were not part of the public consultation in the autumn 2018 it did come up at meetings particularly early on in the consultation. There did seem to be a greater understanding and acceptance around why the old model was not safe but there remained a strong feeling that more could be done to improve travel, transfers and accommodation for instance. It was agreed to hold some focus groups, externally facilitated to explore any concerns in more detail with service users. Higher Ground Healthcare Planning Ltd. was commissioned to undertake a series of focus groups with women who have used the services since the model changed in January 2017. They also spoke to midwives involved in the delivery of the service. The focus groups were held in Wick and Thurso in October 2019. A draft report with recommendations has been prepared. It will be presented initial to the Senior Management Team of NHS Highland prior to the Board and Highland Health & Social Care Partnership.

Raigmore & Rural General Hospitals

2. PEOPLE

2.1 Recruitment and Selection

Raigmore clinical services continue to be challenged with regards to recruitment in a variety of areas.

Plans are underway relating to a board wide project that will explore all options to help increase the size of the workforce across a variety of areas that are currently significantly challenged.

2.2 Staff Experience

2.2.1 Learning and Development

Raigmore Senior Leadership Team is engaging with the NHS Highland Board Culture Programme Organisation and Workforce Development Plan which is developing a comprehensive programme of leadership and management development in response to the Sturrock report concerns regarding the lack of investment in development opportunities for those in or aspiring to management and leadership roles.

2.3 Sickness Absence

By month	September 2019 %	October 2019 %	November 2019 %	Cumulative Total %
Raigmore	5.10%	5.05%	5.16%	4.56%

2.4 Service Redesign

A change programme is being progressed to support the establishment of an Acute Services Division. This is considering how to establish a management structure with a strengthened clinical leadership approach to support delivering Acute services across the North Highland area. The aim being to deliver Acute Services as locally as possible for patients and being clear of how to maintain the highest quality of service and accessibility for all service users and their families.

3. QUALITY & SAFETY

3.1 Improvement Activity

- Value Management continues in several areas within Raigmore where progress is being seen (endoscopy, OPD, Paediatrics).
- 5S work is progressing in vascular theatres at Raigmore.

3.2 Waiting Times

3.2.1 Out-patients

As at week ending 27 December 2019, there were 1,832 outpatients waiting over 12 weeks for a first appointment in NHS Highland which is a reduction of 878 breaching patients as at end of September 2019. The Scottish Government Access Support funding was agreed in July and plans are in place around the interventions required to achieve forecast.

The biggest risk is around Orthopaedics with 695 patients breaching 12 weeks. Additional funding has been received to use the independent sector to reduce this number by the end of March.

Work on implementing TTG rules is now complete and our Patient Management System has been reconfigured and gone live from the beginning of January 2020 with full implementation of TTG rules. This will allow our booking department to book patients in the correct order.

3.2.2 Treatment Time Guarantee

As at week ending 27 December 2019, there were 2,155 TTG patients waiting over 12 weeks for treatment with NHS Highland. This is an increase of 140 as reported at the end of September 2019. However, we have now been asked by the Government to change the way we count TTG patients and include patients who are shown on our waiting list as a "shell entry". This change has added approximately 380 breaching patients into those reportable.

Further funding has been received in January 2020 from the Scottish Government to undertake further activity to reduce waiting times by the end of March 2020. In particular, Ophthalmology have received funding to reduce the number of patients waiting for cataract surgery.

3.2.3 Key Diagnostic Tests

As at week ending 27 December 2019, there are currently 883 Scope patients and 280 Radiology patients waiting over six weeks in NHS Highland.

Plans are in place to have a further three weeks of the mobile MRI van on the Raigmore site to help reduce the number of patients waiting for a scan.

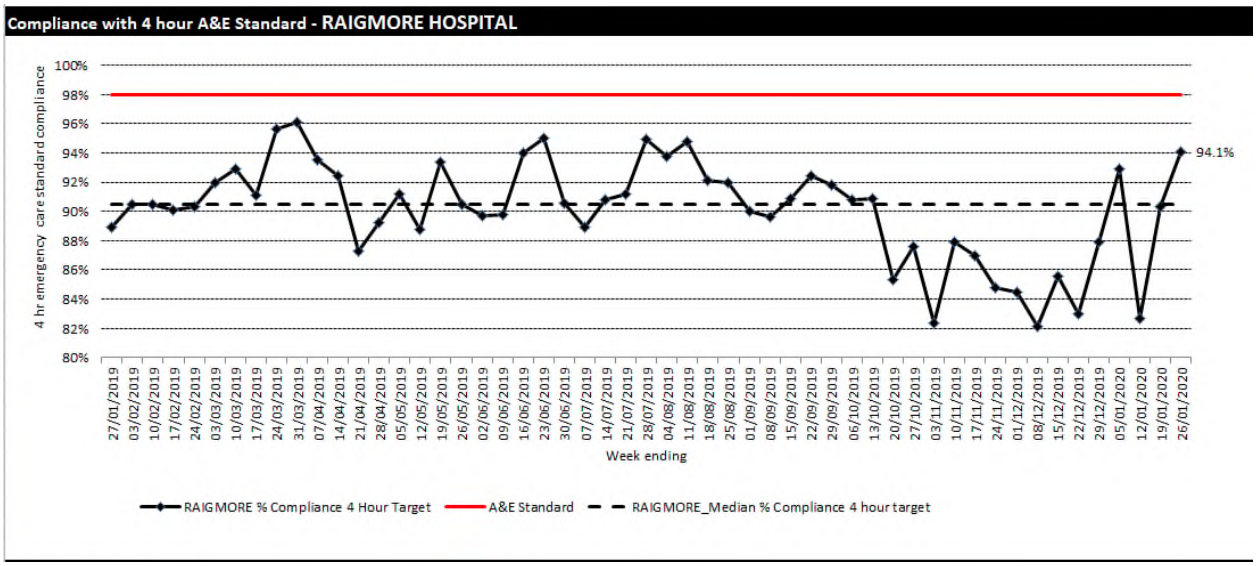
3.2.4 ED 4hr Compliance

Raigmore: The overall ED 4hr target as at 31 December was 85%.
There were 3136 attendances to the department in December (including planned returns 3222).

- There were 466 patients who breached over 4 hours.
- 319 patients > 4 hours
- 135 patients between 6-12 hours.
- There were 12 patients who breached > 12 hours.

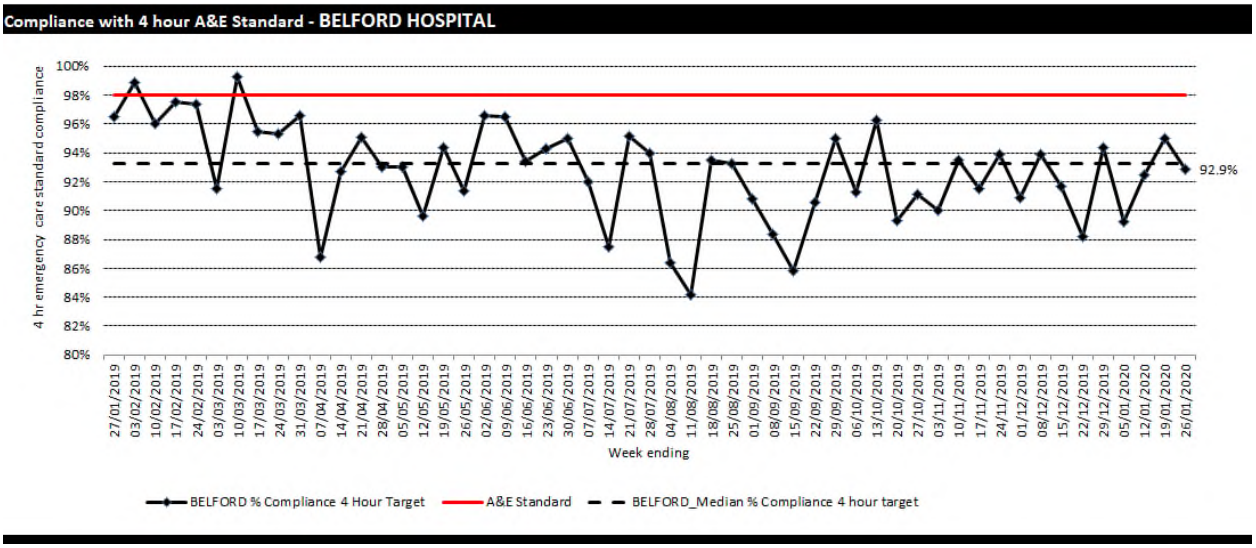
There were 0 receiving days for any specialities in December. Flow issues within the ED and wards continue to impact on the 4 hour performance target. The breaches and causes continue to be monitored and reviewed by both clinical and management staff. Escalation policies continue to be re-enforced, discussed and monitored.

Raigmore compliance with 4 hour A&E Standard as at 26 January 2020:

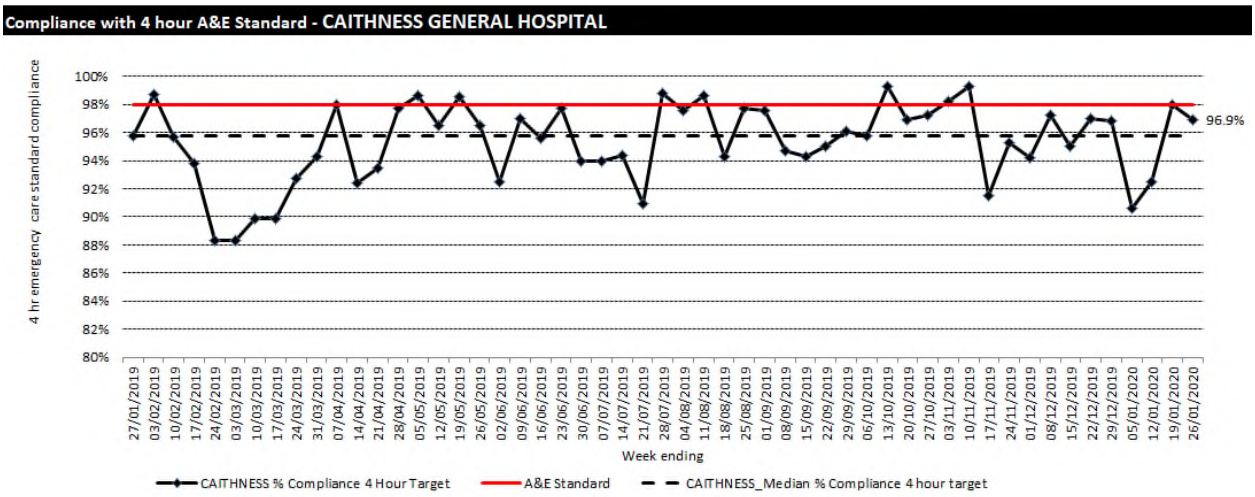


North & West Division:

Belford compliance with 4 hour A&E Standard as at 26 January 2020:



Caithness General compliance with 4 hour A&E Standard as at 26 January 2020:



3.2.5 Cancer Access & Treatment Times

The Board wide performance for the month of December 2019 was 80.1 per cent for the 62 Day Standard and 96.2 per cent for the 31 Day Standard. Continued capacity challenges within Urology and the scope utilising tumour times are the main reasons for failure to achieve the 62 Day Standard to the required standard of 95 per cent.

Weekly Performance Escalation meetings with the SGHD continue with the Board prioritising its efforts on reducing the large numbers who have Beached the 62 Day Standard but have not been diagnosed and/or treated. This week (w/c 27 January) it amounts to a total of 25 patients, of which 20 are Colorectal (scopes) or Urology.

3.3 Infection Prevention & Control

- Enhanced surveillance continues for SABs and CDI. All actions from RCAS carried out are monitored through RHICC.
- Unannounced senior leadership walk rounds continue every 2 weeks supported by estates, patient council. Health and safety, Domestic services and IPC team. All actions are monitored through smart sheet.
- One norovirus outbreak in November which closed the stroke unit for 10 days. No other ward closures due to either flu or Norovirus.
- Review of SSI in Obstetrics theatre is going well and this is whole team approach.

4. CARE

Service and Delivery

4.1 Hospital Inpatients

4.1.1 Older People in Acute Hospitals (OPAH)

- SCN led Case reviews continue in all of the inpatient areas and the learning from the reviews are being shared at the SCN QI forum
- Assurance reviews at senior nurse level are also in place the outcome of which is followed up with the SCN and team at the time
- Themes to date from the reviews which require improvement are lack of initial assessment

within timescales, poor completion of documentation and some poor patient journeys as a result of patients being decanted out of speciality.

- Themes to date from the reviews which are positive are some very good examples of discussions around treatment escalation decisions with patient and families, patients feeling involved in their care and some good examples of where documentation has been completed well.

4.2 Mental Health & Learning Disabilities and Drug & Alcohol Recovery

4.2.1 Support for People with Dementia and their Families

There is some good work going on with Dementia champions who are taking forward small scale pieces of work locally to improve the care of people with Dementia during an acute admission

4.3 Modernisation of Hospitals and Community Services

The Critical Care Upgrade programme continues to run to timescale with completion anticipated by the end of April 2020. At this point all the newly refurbished theatres will be in operation.

Work continues to complete the Raigmore fire upgrade work.

New ways of delivering and modernising services continues through the Out-Patients and Theatre Cross Cutting work.

Monitoring the Delivery of Adult Social Care Contracted Services

Report by Gillian Grant, Commissioning, Contracts and Compliance Manager, on behalf of Deborah Jones, Director of Strategic Commissioning, Planning and Performance.

The Committee is asked to:

Note the planned approach for contract monitoring in 2019-20, the outcomes of the 2019-20 second and third quarter reviews, and progress made in resolving issues highlighted in previous reviews.

1. Background

1.1. On 10 January 2013, the Health and Social Care Committee agreed a contract monitoring framework to provide information on adult social care contracts.

1.2. This report details the outcomes of the monitoring process for Quarters 2 (July to September 2019) and 3 (October to December 2019).

2. Reviews Undertaken

2.1. **Financial Year 2019-20 (1 April 2019 to 31 March 2020)**
Plans are in place to monitor over 125 contracts for NHS Highland during the period 1 April 2019 to 31 March 2020 through a formal contract monitoring visit or a desk-top exercise, depending on the level of agreed risk. A new contract monitoring approach for 2019-20 was agreed with Operational Management, which takes into account a reduction in staffing resources, as well as the Third Sector Review, which is currently being undertaken. This approach includes more focus on high risk relationship management; less focus on low risk/value contract monitoring; more in-depth contract monitoring visits; and more outcome-based contract monitoring. This approach also includes a more robust reporting requirement by providers.

2.2. **Quarters 2 and 3 (July to December 2019)**
A total of 37 dedicated contract monitoring visits were undertaken in Quarters 2 and 3, monitoring a total of 49 contracts for NHS Highland during this period. For information, a further contract monitoring visit was undertaken for The Highland Council, under agreed shared service arrangements.

2.3. A summary of those contracts monitored in Quarters 2 and 3 for NHS Highland is provided at **Annex 1**. It should be noted that some providers have multiple contracts and it is normal to monitor these in one visit and produce one report.

2.4. In addition to the dedicated contract monitoring visits, monitoring is also undertaken through operational meetings with providers, as well as desk-top monitoring (primarily for low value and/or low risk contracts). It should be noted that the number of operational meetings with providers has significantly increased in recent months. In Quarters 2 and 3 (July to December 2019), there were approximately 70 operational contract meetings; some of these were planned regular meetings with providers, others were arranged as a result of concerns or emerging issues and escalated risk.

2.5. Following the Scottish Government's new Living Wage requirements from 1 May 2019, monitoring of the payment of the Living Wage (£9.00 per hour) for care staff remains a priority.

3. Progress in Resolving Issues

3.1. Contract monitoring regularly highlights issues and concerns, which involve further follow up action and review. In Quarters 2 (July to September 2019) and 3 (October to December 2019), 40 main issues/concerns were identified, which are currently being acted upon. These include management/staffing issues; service delivery concerns; a number of potential or actual ASPs/LSIs; concerns with financial viability; a change of provider/owner; and transfer of packages to another provider.

3.2. There has also been progress and ongoing follow-up with a number of providers regarding service delivery concerns, as identified in previous quarters. This has led to, for instance, discussion under the LSI Protocol, where appropriate, and the on-going review of provider Service Improvement Plans. The Contracts Team is implementing a new system for escalating and de-escalating risks to service delivery.

3.3. In addition to the above, NHSH has initiated arrangements for closer liaison with the Care Inspectorate, Scottish Fire and Rescue Service and other statutory agencies, to strengthen trend reporting regarding care issues and are looking to put in place joint training to improve oversight and feedback arising from individual reviews.

4. Conclusion

4.1. Routine contract monitoring continues to identify and resolve issues in relation to adult social care contracted services and the intention remains to focus effort on priority areas.

Gillian Grant
Commissioning, Contracts and Compliance Manager
24 January 2020

Annex 1

Contract Monitoring Visits Undertaken in Quarters 2 & 3 (July to December 2019)

Area	Service Type	Issues Identified / Concerns / Comments
Pan Highland	Day Care Service	Annual report on service delivery outstanding; this has been followed-up with the provider and was subsequently submitted. It was noted that the service was accepting self-referrals without review by NHSH of service need; it was agreed that all future self-referrals would be vetted by local health and social care teams to ensure appropriateness.
North and West Division	Care Home Service	No issues highlighted.
	Care Home Service / Day Care Service (2 contracts, 1 provider)	No issues highlighted.
	Care Home Service / Day Care Service / Residential Respite Service (3 contracts, 1 provider)	Concerns regarding staffing deployment, recruitment and long term financial viability were identified; in addition service delivery concerns identified during the Contract Monitoring Visit led to an initial multi-agency planning meeting; regular monitoring of a service improvement plan is currently being undertaken.
	Care at Home Service / Housing Support Service / Day Care Service (3 contracts, 1 provider)	No issues highlighted.
	Support Service / Third Sector Service (2 contracts, 1 provider)	Provider was not paying Living Wage to relief staff; this has since been rectified, with payment of Living Wage backdated appropriately.
	Day Care Services x 2	No issues highlighted in one of the services; the provider has flagged concerns about the impact of the new charging process, which imposes a significant administrative burden on the organisation with associated cost implications. No issues highlighted in the other service; Contract Monitoring Visit flagged the need to review the contract, with potential need to add spot provision to contract.
	Third Sector Services x 2	Financial viability concerns noted in one of the services; the current funding does not cover the level of the commissioned service and the organisation is using its own reserves to subsidise the delivery of service. In addition, the uncertainty of the outcome of the Third Sector Review has impacted on the Organisation seeking other external funding. NHS Highland senior managers have subsequently met with the Board of this organisation to discuss. Financial stability noted as ongoing concern in the other service; clearer statutory guidance required with respect to charging for aids.
South and Mid Division	Care Home Services x 15	No issues highlighted in 10 of the services. No issues highlighted in one of the services, however, given level of funding, it was noted that greater scrutiny through regular operational meetings was beneficial.

		Contract Monitoring Visit in one of the services identified numerous serious concerns that led to a Large Scale Investigation and subsequent closure of the care home. In one of the services, no GDPR or Duty of Candour training evidenced; this will be followed up by the end of the financial year. In one of the services, there were some areas of non-compliance regarding a specialist unit, which is being reviewed with operational managers. Also, supervision and appraisals not being carried out as planned due to change in management; this has been identified by the new manager and is being addressed. In one of the services, staff supervision has slipped due to multiple changes in management, but being addressed by provider. The provider noted significant challenges with the recruitment of nursing staff, which is being picked up in operational meetings.
	Care Home Service / Day Care Service (2 contracts, 1 provider)	No issues highlighted.
	Support Service / Housing Support Service (2 contracts, 1 provider) x 2	No issues highlighted.
	Support Service / Housing Support Service / Third Sector Service (3 contracts, 1 provider)	No issues highlighted.
	Housing Support Services x 3	No issues highlighted in one of the services. In one of the services, underprovision of service noted; this is being followed up through contract review and operational discussions. No issues highlighted in one of the services, however, it was noted that there were a significant number of ISF packages being delivered, which added to the sustainability of the service.
	Housing Support Service / Day Care Service (2 contracts, 1 provider)	No issues highlighted.
	Day Care Services x 2	No issues highlighted.
	Third Sector Service	Financial viability concerns noted.
	Non-Standard Service	Policies and procedures require review; this will be reviewed at the next Contract Monitoring Visit.

SCOTTISH PARLIAMENT ADULT SOCIAL CARE INQUIRY – CALL FOR VIEWS

Report by Simon Steer, Interim Director of Adult Social Care

The Committee is asked to:

- **note** the Scottish Parliament Health and Sport Committee's current call for views on a social care inquiry, in which it is seeking to explore the future delivery of social care in Scotland and what is required to meet future needs; and
- **note** that a joint response is being prepared by the Joint Monitoring Committee, will be considered by the Strategic Planning Group and thereafter submitted on behalf of the Highland Health and Social Care Partnership.

1.0 Background

1.1 Following closures of residential care facilities and general funding issues with independent, voluntary and council run facilities, the Health and Sport Committee has agreed to undertake an inquiry into social care for adults over 18 years, in order to explore the future delivery of social care in Scotland and what is required to meet future needs.

1.2 The Scottish Government held an event, *Scotland 2030: A Sustainable Future for Social Care for Older People*, on 16 November 2018, in collaboration with Scotland's Futures Forum, to consider the future of social care for older people in Scotland. The event considered the general proposition of how social care would look (and be financed) in 2030.

1.3 The Scottish Government Adult Social Care Reform Programme is currently working to reform social care in Scotland. This inquiry will not focus on replicating that work, it will instead explore the future delivery of social care in Scotland and what is required to meet future needs. The Scottish Government has been working with Convention of Scottish Local Authorities (COSLA), people with lived experience, unpaid carers and other stakeholders to develop a national programme to support reform of adult social care.

1.4 The national programme, launched in June 2019, is intended to:

- Support integration authorities, the wider sector, and communities in planning and taking forward changes.
- Advise Scottish Ministers if national changes or interventions are required.
- Raise awareness of the role of social care support in Scotland and its social and economic value.

1.5 More information is available on the Scottish Government website - Reforming adult social care support.

1.6 The key questions in the call for views are as follows:

Experiences of social care in Scotland

The Parliamentary Committee is seeking views from people with lived experience of receiving adult social care or being a carer for someone receiving care and would like to hear:

1. Your story and experience of social care in Scotland.

2. What you would change about your experience of social care?

The future delivery of social care in Scotland

The Parliamentary Committee also wishes to receive responses to the following questions:

1. How should the public be involved in planning their own and their community's social care services?

2. How should Integration Joint Boards commission and procure social care to ensure it is person-centred?

3. Looking ahead, what are the essential elements in an ideal model of social care (e.g. workforce, technology, housing etc.)?

4. What needs to happen to ensure the equitable provision of social care across the country?

1.7 The call for views is open until Thursday 20 February 2020.

2.0 Highland Response

2.1 The Joint Monitoring Committee were advised of this parliamentary inquiry at its meeting on 22 January 2020 and has agreed to hold a workshop during mid February 2020, to consider and develop a response.

2.2 It is intended that this response will then be provided to the Strategic Planning Group at its meeting on 19 February 2020, before submission on 20 February 2020.

2.3 The purpose of this report is therefore to advise the Health and Social Care Committee of this call for views and to advise of plans for a joint response, a copy of which will thereafter be provided to this committee for information.

3.0 Contribution to Board Objectives

3.1 It is intended that the Highland response to be provided will assist to influence national policy and address adult social care issues in the Highland area.

4.0 Governance Implications

No issues / impact.

- **Staff Governance**
- **Patient and Public Involvement**
- **Clinical Governance**

- **Financial Impact**

5.0 Risk Assessment

No issues / impact.

6.0 Planning for Fairness

No issues / impact.

7.0 Engagement and Communication

Engagement in the development of the Highland response will take place through the Joint Monitoring Committee and Strategic Planning Group.

Simon Steer
Interim Director of Adult Social Care
23 January 2020