HIGHLAND HEALTH & SOCIAL CARE GOVERNANCE COMMITTEE
Report by Committee Chair

The Board is asked to:

- **Note** that the Highland Health & Social Care Governance Committee met on Wednesday 28 June 2023 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Philip Macrae, Non-Executive, Committee Vice Chair (in the Chair)
Tim Allison, Director of Public Health (until 3pm)
Ann Clark, Board Non-Executive Director and Vice Chair of NHSH
Cllr, Muriel Cockburn, Board Non-Executive Director
Claire Copeland, Deputy Medical Director
Pam Cremin, Interim Chief Officer
Kate Dumigan, Staffside Representative
Cllr, David Fraser, Highland Council (until 3pm)
Cllr, Ron Gunn, Highland Council
Joanne McCoy, Board Non-Executive Director
Kara McNaught, Area Clinical Forum Representative
Gerry O'Brien
Kaye Oliver, Staffside Representative
Michelle Stevenson, Public/Patient Representative
Simon Steer, Director of Adult Social Care
Neil Wright, Lead Doctor (GP)

In Attendance:
James Bain, Transaction & Income Manager, Adult Social Care
Sarah Bower, Healthcare Improvement Scotland
Rhiannon Boydell, Head of Strategy and Transformation
Louise Bussell, Nurse Director
Sarah Compton Bishop, NHS Highland Board Chair
Stephen Chase, Committee Administrator
Fiona Duncan, Chief Social Worker, Highland Council
Gillian Grant, Head of Commissioning
Arlene Johnstone, Head of Service, Health and Social Care
Donellen Mackenzie, Depute Director Adult Social Care
Nathan Ware, Governance and Assurance Co-ordinator

Apologies:
Simon Steer, Catriona Sinclair, Cllr Chris Birt, Cllr David Fraser, Mhairi Wylie, Fiona Malcolm.

1 WELCOME AND DECLARATIONS OF INTEREST

The meeting began at the later time of 2pm and was introduced by the P Macrae who noted that he would chair the meeting at the request of G O'Brien, who would return in full to committee duties following the present meeting.

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The meeting opened at 2pm, and the Chair welcomed the attendees and advised them that the meeting was being recorded and would be publicly available to view for 12 months on the NHSH website.

The meeting was quorate.

1.2 DECLARATIONS OF INTEREST

There were none.

1.3 Assurance Report from Meeting held on 26 April 2023

The draft minute from the meeting of the Committee held on 26 April 2023 was approved by the Committee as an accurate record pending the following amendment:

- K Oliver noted a correction regarding her recorded job role.
- Item 3.5: clarify the agreed level of assurance.

The Committee

- **Approved** the Assurance Report pending the amendments noted, and
- **Noted** the Action Plan.

1.4 Matters Arising From Last Meeting

- M Stevenson read a letter from former member Michael Simpson to the Committee:
  The letter noted that a promised meeting to discuss the North Coast Redesign with the Chief Officer and colleagues had not taken place and expressed disappointment with the lack of engagement with him on this issue. He also noted that he had not received a promised official letter acknowledging these services.
  The Chair expressed regret that the meetings had not taken place and that this had been due to work pressures. It was clarified on the latter point that a letter from the regular Chair had been posted but had not been received.

- G O'Brien noted that he had met with the Chairs of the Clinical Governance Committee and the Audit Committee in relation to care, governance and that he and the Chief Officer would discuss this further to bring a proposal having determined the appropriate governance route, to the Board. A further update would come to the next meeting.

The Committee:

- **NOTED** the updates.

2 FINANCE

2.1 Year to Date Financial Position 2022/2023

The Chair gave apologies to the Committee that a report had not been available due to illness, noting that this was especially unfortunate as no update had been provided to the previous meeting.

- A Clark suggested that, though there may be extenuating circumstances, this was a significant matter which should be mentioned in the Committee's update to the Board at its next meeting.

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3 PERFORMANCE AND SERVICE DELIVERY

3.1 Care At Home Assurance Report

This report set out the current issues in relation to the provision and delivery of care at home services across the Partnership area and described plans to co-create a care at home delivery vision and co-develop an accompanying and supporting commissioning approach. The report was provided to the Committee for awareness of the proposed areas of activity and with a proposed level of moderate assurance as to the steps being taken to address current and forecast challenges.

During discussion, the Committee considered the following areas,

- In terms of collaborative commissioning, this work had been driven in response to the Feeley Report to work more with Third Sector partners and assist with their sustainability through coproduction. This would enable contracts to be extended as opposed to repeatedly returning to market and would ensure better workforce experience through continuity.
- G Grant commented that there was a short life working group looking at collaborative commissioning which was considering the issues from the ground up, ways to encourage and promote collaboration, and the practical issues faced by workers on the road between clients.
- The need to support flexibility for staff was discussed and it was noted that the Reservists programme had been a good means to address the needs of staff who wish to work in alternative ways due to care and other responsibilities. It was also noted that some of the reservists have gone on to take permanent contracts due to the experience of having been afforded the opportunity of this experience of work. The response to the programme has been positive but there are infrastructure issues to address to support the larger than expected uptake.
- It was commented that the engagement work around the first objective outlined in the report around improving outcomes was integrated with the strategic plan. The engagement work had addressed areas of confusion around the Joint Strategy and the Together We Care programme and areas of engagement fatigue.
- It was suggested that the assurance level offered by the report maybe did not address the scale of the challenge faced from a workforce perspective and that previous measures mentioned in the paper had not had the intended impact. It was felt that the failures outlined were largely due to the larger than expected impact of external providers pulling out of care home provision due to sustainability issues.

The Chair noted the change from an initial assurance level of substantial to moderate. This was to acknowledge the challenges ahead but to note the robust procedures and work streams in place to mitigate against the challenges.

It was requested that an update on the immediate actions arising from the report be brought to the Committee in six months' time either as a standalone item or via the Chief Officer's report.

The Committee:

- **NOTED** the report, and
- **Agreed** to accept **moderate** assurance and that an update on the immediate actions would come to the Committee in six months.

3.2 Annual Report of Care Home Oversight Collaborative

The previous report provided to the Committee on 26 April 2023, gave an overview of independent sector care home provision, focusing on the recent sector turbulence experienced over 2022-23 and the mitigating actions in relation to the care home

closures which had been or were being managed. This further report provided an overview of wider sector oversight during 2022-2023 and sets out the move towards collaborative care home support arrangements and proposed a level of substantial assurance to the Committee.

- G Grant spoke to the paper and noted that the collaborative continued to oversee activity meeting fortnightly over 2022/23. It had addressed issues around black and red status care homes and provided oversight of large-scale investigations, any suspension of admissions, and bed vacancies.
- The second part of the report related to the shift in approach from Scottish Government and they requested partnerships to move away from oversight towards a collaborative support approach and with the intention of improving lives of people in care homes.
- Scottish Government had allocated the Highland Partnership £681,000 on the basis of putting in a submission detailing how that resource would be directed and targeted toward the collaborative working.
- Appendix 5 of the paper included information that submitted as part of the bid (appendix one of this appendix 5 outlined the NHS Highland element) and set out specific proposals for the use of the allocation.
- The collaborative Care Home support team will be invested in to broaden capacity and scope. This will include among other things, speech and language therapy as a drawdown resource when needed.
- The second element regards collaborative workforce solutions for work with the independent sector.
- The third element concerned bed availability and supporting beds to become available.

During discussion,

- It was clarified that Scottish Government were still to come back to the Collaborative with its responses to the plan.
- The shift from the Care Homes Strategic Group and the new Collaborative arrangement was noted as having been welcomed by partners and that partners had been keen not to have activity imposed and appreciated a more ‘draw down’ responsive resource approach.
- It was noted that NHS Highland is well placed to effect the new collaborative approach and that it had good engagement from partners but that work will need to be intensive as soon as the proposals from the Collaborative are agreed by Scottish Government.
- The Nurse Director noted her ongoing and continuing responsibility in the role for care homes and that this would not change with the new arrangement in ensuring quality controls for patients.
- It was noted that there is a separate Care Home Oversight Collaborative for Argyll and Bute with collaborative working with North Highland in the area of infection control via Public Health.
- It was noted that care home residents were at the centre of the initiatives and that service users and their families were helping to steer the direction.
- The risks around the new arrangements were discussed and it was clarified that the models developed in the response to Scottish Government were intended to reduce the risks around a collaborative way of working. It was added that the pandemic had seen the development of a more positive and trusting relationship with care homes and that this had led to productive working with earlier recognition shared of the issues.

leaving you to to wait and we're we're a bit running behind, but if you could give us your presentation, not much appreciated.

The Committee:

- **AGREED** to accept **substantial** assurance from the report.

3.3 Dental Services position paper

The report noted the current situation and actions being taken to mitigate, current reduced access to Primary Care Dental Services detailing a deterioration in access to Primary Care Dental Services, increasing concerns about the sustainability of Primary Care Dental Services, provided information about ongoing national reform of Primary Care Dental Services, and proposed a level of limited assurance to the Committee.

The Director of Dentistry noted that it was disappointing to be bringing little in the way of good news to the Committee and commented that the situation in Highland with regard to lack of access to primary care dental services was a national matter.

- It had been acknowledged that the system of administration for General Dental Services required reform, and that services were still recovering slowly from the impact of COVID where dental services were suspended in the main leading to significant backlogs of treatment and practises effectively looking at the future viability.
- He noted that it is often thought that health boards have a statutory obligation to provide General Dental Services but that this is not actually the case. Access to emergency dental services for unregistered patients is provided but in terms of General Dental Services, health boards are only required to maintain a list of dentists who provide or are contracted to provide the service.
- In terms of local pressures, there had been three recent practice closures across the region and ongoing deregistration of patients was sitting at about 1% of the total number of NHS deregistrations. However, many patients are being retained on a temporary lists awaiting recruitment of a dentist to their practice. In terms of private practices, Bupa had made a national corporate decision to withdraw many practises from the NHS.
- Around 16% of practices in the region were currently delivering less than 50% of the pre COVID level of activity.
- The dental helpline for the partnership area dealt in the last year with approximately 13,000 calls, and it was anticipated that this would increase.
- Workforce recruitment and retention was one of the main issues for patient access to services and a reason as to why practises may be deregistering patients.
- Current data showed that early career dentists were not committing to the NHS. The Director of Dentistry had spoken to some recently qualified dentists who had gone straight from training into private practice with no intention of working in the NHS.
- COVID had led to a delay in graduating dental students for a year, which was a temporary blip, but this had knock on effect for vocational training. In addition, the pandemic had led a number of dentists to change their work life balance reducing availability.
- More than 50% of practices in the region were now corporate dentists and these had also experienced significant issues around recruitment in spite of their greater buying power.
- It was felt that the key to progress was Scottish Government reform of Primary Care Dental Services. Final information was awaited from the government following a period of engagement with the main stakeholder, the British Dental Association, about what reform may look like but this review currently only covered payment reform with other areas to follow and progress had been slow.
- Provision of care for priority group patients is handled by the PDS (Public Dental Service) and the impact on the PDS was becoming significant due to the need to support emergency dental services and support services where GDP dentistry was not currently available.
- Recruitment to PDS has been very difficult with a general lack of suitable applicants for a number of roles.
- Scottish Government had made Scottish Dental Access initiative grants available to extend and establish dental practises. Two bids had recently been accepted in Alness and Inverness.
- Initiatives to improve recruitment and reduce barriers to recruitment of dental professionals are outwith the control of NHS Highland. They sit at national level and with the UK General Dental Council.

- Where it had not been possible to recruit dentists, there had been some successes with the recruitment of dental therapists recently. This was supported by the School of Dental Therapy at UHI in Inverness with a new cohort of students due to graduate soon. The scope of practise of a dental therapist is less than a dentist and they are required to work to prescription, but approximately 60% of NHS work can be carried out by a dental therapist.
- But yet another barrier that sitting at at Scottish Government level at at this moment in terms of action, need to ensure that our help lines have the resilience to deal with increased calls that are public dental service look at or EDS and being able to meet demand for services and we utilise where there is any public dental service capacity bearing in mind that we're currently running at 25%.
- If planned reforms of dentistry are not accepted by practitioners general dental services could see further deterioration and risk overwhelming the health board's public dental service.
- There is evidence from oral health inspections of school children of deterioration and widening health inequalities.

During discussion,

- It was clarified that there is no waiting list maintained by Primary Care for patients looking to be newly registered in the region and that an idea of figures is gained via calls to the helpline for patients wanting to register as new or those who have been deregistered.
- The issue of public messaging was raised and it was confirmed that work is underway in partnership with other health boards to provide clear messaging about what NHS dentistry can offer in light of the stated aims of Scottish Government to eventually provide free dental treatment and to avoid issues around self-dentistry.
- The potential for the Board to 'buy-in' independent and private dentistry was discussed and it was noted that this sector is suffering similar issues around recruitment to NHS dentistry.
- It was noted that the difficulties in local recruitment were not especially affected by the remote and rural geography of the region and that it reflected a national picture. In addition, any impact on the specific circumstances of Highland from the reform process is currently unknown.
- The Director of Dentistry commented that there was a very effective oral health promotion team across Highland and Argyll and Bute in conjunction with a series of national programmes including the highly successful Child Smile programme. Colleagues liaise with care homes, schools and nurseries, and there was an active fluoride varnishing programme supported via NHS Highland.
- The pay reforms were discussed and it was noted that Scottish Government's current preference was for a blended model based on treatment allowances and capitation. That's probably not the professions preferred model and we'll wait to see how that plays out. I'm not party to those discussions. Those are between the stakeholders.
- Workforce planning had shown that that there would be a shortfall of new dentists by 2030. It was felt by the Director of Dentistry that dental complementary professionals such as dental therapists were underused and that Highland was in a very good position with the School of Dental Therapy in Inverness which graduates about 11 students per year. Changes to regulation would need to be ensured to support more dental therapists if the scope of their work is to widen.
- The PDS had been recruiting more dental therapists due to a shortfall in dentists and that this had worked well in dealing with priority groups but there would still need to be more brought in to the service.
- The Director of Dentistry noted that currently health boards had limited control over General Dental Services and only ensured the maintenance of a GDS list and provided emergency dental services. It was thought that this area would form the third part of the general reform process. Practices with NHS patients were required to offer the full range of NHS care.

The Committee:

- **AGREED** to accept **limited** assurance from the report.

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

3.4 Self-Directed Support: Personal Assistant rates for Direct payment, Option 1's

The report provided an update to the Committee of the significant progress towards establishing a co-produced reference hourly rate for Options 1's in partnership with the SDS Peer Support Group by establishing a fair, transparent, and mutually understood personal assistant hourly rate for Option 1s, and recommended implementation of the new proposed reference hourly rate(s) from Monday 3 July 2023, noting the additional cost commitment for this financial year of £0.750m based on the current service user profile.

J Bain provided an overview of the report for the Committee and noted that the SDS Highland Peer Support Group consisted of recipients of SDS and family members involved in organising Option 1's with a current membership of about 12 supported by a couple of officers from NHS Highland. The prosed figure was arrived at in part by recognising the difficulty of recruiting and retaining staff across health and social care and current rates of inflation. The growth in Option 1's highlighted an unavailability of other options but also showed a need for more independence and decision making ability from patients.

The Chair noted the significant cost attached to the proposals against the backdrop of current cost pressures and invited discussion.

- It was commented that the Joint Officer Group had found Option 1 to be the most cost-effective for many people. In house services and commissioned external services were found to be more expensive, and there had been a significant reduction over the last two years for external care home hours of provision.
- Rates for bespoke packages were discussed. The SDS Peer Support Group had recognised the complexity of this issue but that a base rate to set the framework for packages more widely and to address recruitment issues in making the work more attractive would be desirable.
- It was noted that the starting point for the pay model was the UK Home Care Association rate for care at home packages in conjunction with a consideration of the overheads for individuals with a premium for travel. It was added that robust standard operating procedures were in place to ensure that if packages were not delivered that the monies were recoverable. It was thought that reclaimable monies for the current year would be between £¾ million and £1 million.
- The Chair summarised from the discussion that there was a desire to support the proposals in principle but that there was a difficulty around recommending the proposals when it was not certain where the money would come from.
- It was noted that Option 1 is not the only available option to be rolled out for individuals but that Option 1 enabled access to other areas such as Day Care services.
- G O'Brien noted that the Committee would need to be mindful of adding to the cost burden of the Board and the Partnership and that it would need to be clarified if the Committee has the deciding vote in recommending the proposals.
- The Chief Officer noted that the proposals would go to the Senior Leadership Team when it next met.
- N Wright noted the difficulty of seeing purely financial benefits arising from the proposals but that the outcomes would be qualitative and impact on various areas of the service as shown through items such as the IPQR.
- The Chief Officer noted that a number of transformational and efficiency programmes were in process and would return soon to the Committee.
- The Committee accepted moderate assurance from the paper and supported the recommendations in principle but noted that it could not recommend the proposals in full without the Senior Leadership Team and Joint Officer Group having considered the proposals and without a consideration of the financial position of the Partnership.

The Committee:

- Accepted **moderate** assurance from the report, and
- **Noted** its support for the proposals in principle but added that
- The Committee it could not recommend the proposals in full without the Senior Leadership Team and Joint Officer Group having considered the proposals and without a consideration of the financial position of the Partnership.

3.5 IPQR Dashboard Report

The report set out performance indicators used to monitor progress and evidence the effectiveness of the services that North Highland provides aligned to the Annual Delivery Plan. An increase in Care At Home unmet need was shown and an increase in delayed discharges since the last report, with figures for care home occupied beds remaining static. Psychological therapies waiting times showed improvements with reduced waits.
Following a request at the last meeting detail of unmet need in terms of waiting times was added to the data presented.

During discussion, the following areas were raised:

- It was asked if it was possible to show the balance for Care At Home unmet need in in terms of getting waiting times down versus new assessments of need and how decisions are made around priorities. The Chief Officer noted the multifaceted nature of the issue but that this was an area that should be reflected upon in terms of data. D Mackenzie commented that multidisciplinary teams were involved in making daily decisions around facilitating patient flow and avoiding inappropriate admissions and that this had provided early insights into community needs.
- It was noted that of data documented by hand that this could include anything that was not reported directly to government which may include community mental health data and non-reportable specialties.
- J McCoy requested that the following information might be included in the next iteration of the IPQR:
  - To include total number of beds for each area in North Highland care homes or the percentage occupied;
  - To include numbers for each hospital in North Highland regarding delayed discharges so as to better see trends, and to add lines to the graph for each hospital to help give a clearer picture for assurance;
  - To include trend data for North Highland Community Hospital delayed discharges from the information collected so far;
  - To include more detail, trends and optimal wait times for ongoing waits for non-reportable specialities;
  - To show trend data around reasonable wait times for each service on Community wait lists.

The Committee:

- **NOTED** the report.

3.6 Chief Officer's Report

The Chief Officer's report provided project updates for North Skye Healthcare, the Lochaber redesign, and Caithness Redesign. The HSCP Annual Performance Plan was noted and answers regarding the plans for the Ross Memorial Hospital were outlined. News of NHS Highland colleagues who had received awards in the Kings Honours list were announced which included an MBE for Cathy Shaw, Lead Advanced Practitioner for the Remote and Rural Support Team (West) and the Hospital at Home Team Skye with NHS Highland, has

been recognised and awarded an MBE for services to nursing in rural Scotland. Dr Miles Mack, a GP with Dingwall Medical Group, was recognised and awarded an OBE for services to general practice

M Stevenson raised the following questions regarding the Ross Memorial Hospital:

- What steps or measures are being planned within the RMH to address and resolve the fire compliance issues that pose a significant organisational risk?
- Is there an organisational commitment to oversee the reconfiguration of existing services on the RMH site?
- Why is it that Estates, as a support service, are leading the NHS strategy instead of the clinical personnel who should be guiding the strategy while support services follow?
- And if this is not the case then my next question is….
- Given that Estates have not yet actively pursued the reconfiguration project; Funding has not been secured, and Layout plans have not been developed, what exactly are the intentions of Estates at this point of the project?
- Is there an intention to evaluate the entire RMH building and services rather than solely focusing on fire compliance works, including a potential decision to close the RMH?
- The district manager who has been overseeing the reconfiguration of works was unable to give assurances to stakeholders recently that work is progressing, so where should stakeholders be looking for assurances that the work is progressing within RMH?
- Which stakeholders as mentioned on Wednesday, other than patient groups, are involved in the reconfiguration of the RMH works?
- Has there been any consideration given to relocating the GW patients to Invergordon Hospital, which is a newer and more suitable building, and if not, why not?
- Previous Questions still awaiting answers, which I would like to bring up at this time.
- What is the name of the project manager appointed by Estates, that was mentioned at the HHSCC meeting on 26 April 2023?
- Despite assurances made during the HHSCC meeting on 11 January 2023 that the HRU would remain unaffected by any changes, it appears that the situation has changed. What guarantees can be provided to ensure the safety of the remaining 5 Inpatient rheumatology beds from closure?
- Where there is a need for works to relocate the GW beds to the HRU, how will the active Rheumatology services be able to continue without interruption?
- Where will the Rheumatology outpatients and Infusion services be temporarily relocated to in order to ensure uninterrupted continuity of the service as promised from the senior leadership team earlier this year?

The Acting Chair and the regular Chair noted the valid questions raised and commented that he did not believe there was any deliberate stonewalling around the information. He commented that there was an engagement group set up to deal with the Ross Memorial Hospital and that this was a better forum than the current Committee in which to receive assurances about the work in question.

- The Chief Officer clarified that the Estates Department do not make decisions around which projects to invest in and that they respond to requests. She noted that the Assistant Medical Director had visited the hospital the previous week and that the Chief Executive was due to visit with the Chief Officer and that they were completely engaged with the project.
- The Chair requested that the Chief Officer pick up the issues to ensure M Stevenson receives the necessary responses.
- M Stevenson noted that she felt that there had been some unnecessary delays in response to the issues.

The Committee:

- **NOTED** the report.

4 HEALTH IMPROVEMENT

District Reports

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

- A Clark noted that it would be useful to consider how best to address this item in response to the recent Internal Audit on Community Planning and the context of system pressures.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Committee Work Plan

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

- In discussion it was suggested that a rethink was needed to address health improvement and Community Planning within the context of highly pressured agenda.
- The Chief Officer proposed a development session be held on community planning which would address both service redesign programmes and locality issues, and the recent Internal Audit report on community planning.
- G O'Brien noted that on his return to chairing duties he would consider future agendas and the work plan with the Chief Officer.
- It was suggested that the duration of the next meeting be extended to cover what would be a very full agenda.

The Committee
– **noted** the planned revisions and **agreed** the Work Plan for 2023-24 in its current form.

6 AOCB

A development session was scheduled for 19 July from 1pm to consider Transformational Change and Health and Social Care.

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 30 August 2023** at **1pm** on a virtual basis.

The Meeting closed at 5.20pm

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HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE ROLLING ACTION PLAN

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

	Item	Action / Progress	Lead	Outcome/Update
04/09/2019	**Clinical Governance**	Agreed detailed report on ASC Clinical & Care Governance to be submitted to future meeting.	**S Steer/Chair**	Chair to meet with Chair of CCG, and CO to determine route forward. Report back March committee meeting.
03/03/2021	**Staff Experience Item**	Suggestion: Team involved in savings on PMO workstreams. Other suggestions to be discussed with L Bussell's team.	**R Boydell/L Bussell**	To be included in future Development Sessions (~4 in 2023).
15/01/2023	**Integrated Children's Report**	Interim 6-month update	**P Cremin/T Gervaise/I Kyle**	Added to Workplan: September committee

Agenda Item 2.1

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**30 August 2023**
Title:	**HHSCC Finance Report – Month 3 2023/2024**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer, Highland Health & Social Care Partnership**
Report Author:	**Elaine Ward, Deputy Director of Finance**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to a:

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

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

- Effective

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This report is presented to enable discussion on the Highland Health & Social Care Partnership financial position at Month 3 2023/2024 (June 2023)

2.2 Background

NHS Highland submitted a financial plan to Scottish Government for the 2023/2024 financial year in March 2023. This plan identified an initial budget gap of £98.172m. A savings programme of £29.500 was proposed - £4.113m of this being related to Adult Social Care. No funding source has at this time been identified to close the residual gap of £68.672m. This report summarises the NHS Highland financial position at Month 3, the Highland Health & Social Care Partnership financial position at Month 3, provides a forecast through to the end of the financial year and highlights the current savings position.

2.3 Assessment

There is an ongoing need for the HHSCP to identify significant savings and cost reductions in order that financial balance can be achieved. This challenge comes against the backdrop of an increasing demand for services, the development of the National Care Service and the ongoing fragility of service provision due to recruitment challenges and rising costs.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	X	None	

Comment on the level of assurance

It is only possible to give limited assurance at this time due to the limited progress on savings delivery and the ongoing utilisation of locums and agency staff. The development of robust savings plans is currently progressing and once in place should support an increase in the level of assurance.

3 Impact Analysis

3.1 Quality/ Patient Care

Achievement of a balanced financial position for NHS Highland in 2023/2024 is predicated on closing the initial budget cap of £68.672m.

The impact on quality of care and delivery of services is assessed at an individual scheme level using a Quality Impact Assessment tool.

3.2 Workforce

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

3.3 Financial

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

3.4 Risk Assessment/Management

There is a risk NHS Highland will overspend on its 2023/2024 revenue budget by more than £55.788m in this forecast as this assumes the cost improvement programme is delivered in full. The forecast is also dependent on assumptions around funding and expenditure. The Board continues to look for opportunities both locally and nationally to bring the recurrent cost base down.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

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

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

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

- Executive Directors Group – via monthly updates and exception reporting
- Discussion at relevant Senior Leadership Team meetings
- Monthly financial reporting to Scottish Government

3.9 Route to the Meeting

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

- Community SLT

4 Recommendation

- **Discussion** – Committee discuss the Highland Health and Social Committee finance report at month 3.

4.1 List of appendices

The following appendices are included with this report:

- Appendix 1 – Adult Social Care Summary

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**30 August**
Title:	**HHSCC Finance Report – Month 3 2023/2024**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer Highland Health & Social Care Partnership**
Report Author:	**Elaine Ward, Deputy Director of Finance**

1 NHS Highland 2022/2023 Financial Plan

1.1 NHS Highland submitted a financial plan to Scottish Government for the 2023/2024 financial year in March 2023.

1.2 This plan identified an initial budget gap of £98.172m. A savings programme of £29.500 was proposed - £4.113m of this being related to Adult Social Care. No funding source has at this time been identified to close the residual gap of £68.672m.

1.3 This report summarises the NHS Highland financial position at Month 3, the Highland Health & Social Care Partnership financial position at Month 3, provides a forecast through to the end of the financial year and highlights the current savings position.

2 NHS Highland – Period 3

2.1 For the three months to the end June 2023 NHS Highland has overspent against the year-to-date budget by £20.656m and is forecasting a £55.788m overspend at financial year end.

2.2 This forecast includes additional funding allocated to all Boards by Scottish Government to support the financial position. NHSH received £8.030m Sustainability and NRAC parity funding and £6.590m New Medicines funding and assumes delivery of the savings target in North Highland and the significant majority of the A&B IJB target; forecast savings delivery totals £28.754m.

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

Table 1 – NHS Highland Summary Income and Expenditure Report as at 30 June 2023 (Month 3)

Current Plan £m	Summary Funding & Expenditure	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
1,147.755	**Total Funding**	278.741	278.741	-	1,147.755	-
	Expenditure					
440.799	HHSCP	109.135	113.143	(4.009)	445.848	(5.049)
286.617	Acute Services	73.373	79.817	(6.444)	302.101	(15.483)
162.890	Support Services	34.562	44.117	(9.555)	197.195	(34.305)
890.306	**Sub Total**	**217.070**	**237.077**	**(20.008)**	**945.144**	**(54.838)**
257.449	Argyll & Bute	61.671	62.320	(0.649)	258.399	(0.950)
1,147.755	**Total Expenditure**	**278.741**	**299.397**	**(20.656)**	**1,203.542**	**(55.788)**

3 HHSCP – Period 3

3.1 The HHSCP is reporting an overspend of £4.009m at the end of Period 3 with a year end overspend of £5.049m forecast.

3.2 The year to date position includes slippage of £5.733m against the CIP with the forecast assuming achievement against plan by the end of the financial year.

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

Table 2 – HHSCP Financial Position as at 30 June 2023 (Month 3)

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
246.338	NH Communities	62.601	64.500	(1.899)	250.669	(4.331)
48.259	Mental Health Services	12.330	15.061	(2.732)	51.822	(3.563)
147.241	Primary Care	35.719	35.726	(0.006)	149.073	(1.831)
(1.040)	ASC Other includes ASC Income	(1.515)	(2.144)	0.628	(5.716)	4.676
440.799	**Total HHSCP**	**109.135**	**113.143**	**(4.009)**	**445.848**	**(5.049)**
	HHSCP					
268.364	Health	66.495	70.503	(4.009)	273.413	(5.049)
172.434	Social Care	42.640	42.640	-	172.435	-
440.799	**Total HHSCP**	**109.135**	**113.143**	**(4.009)**	**445.848**	**(5.049)**

3.4 A breakdown across services within North Highland Communities is detailed in Table 3.

Table 3– North Highland Communities as at 30 June 2023 (Month 3)

Current Plan £m's	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
73.062	Inverness & Nairn	18.481	18.314	0.166	74.986	(1.924)
53.062	Ross-shire & B&S	13.712	13.707	0.005	53.448	(0.387)
47.198	Caithness & Sutherland	12.076	12.194	(0.118)	48.019	(0.821)
55.851	Lochaber, SL & WR	14.227	14.167	0.060	55.899	(0.048)
5.147	Management	1.029	3.070	(2.041)	6.248	(1.101)
6.210	Community Other AHP	1.597	1.505	0.092	6.010	0.200
5.808	Hosted Services Includes Midwifery	1.480	1.543	(0.063)	6.059	(0.251)
246.338	**Total NH Communities**	**62.601**	**64.500**	**(1.898)**	**250.669**	**(4.331)**

3.5 A year to date overspend of £1.898m is reported within NH Communities with this forecast to increase to £4.331m by financial year end.

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

- £0.658m of ongoing service pressures within Enhanced Community Services and Chronic Pain
- £0.242m of equipment costs in respect of new beds,etc.
- Ongoing locum/ agency costs across all areas.

3.7 Table 4 breaks down the position within Mental Health Services.

Table 4– Mental Health Services as at 30 June 2023 (Month 3)

Current Plan £m's	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
22.907	Adult Mental Health	5.805	7.153	(1.246)	24.956	(2.049)
12.982	CMHT	3.181	3.530	(1.020)	12.316	0.666
6.555	LD	1.543	1.842	(0.315)	8.149	(1.594)
5.814	D&A	1.800	2.536	(0.151)	6.401	(0.586)
48.259	**Total Mental Health Services**	**12.330**	**15.061**	**(2.732)**	**51.822**	**(3.563)**

3.8 Mental Health Services are reporting a year to date overspend of £2.732m with this forecast to increase to £3.563m by financial year end.

3.9 Locum and agency costs continue to be the main driver of the forecast position due to recruitment challenges and increased acuity of patients.

3.10 Primary Care are currently reporting an overspend of £0.006m with this forecast to increase to £1.831m by year end. Table 5 details the breakdown across services.

3.11 Locum costs within 2C practices and prescribing continue to drive the forecast position. A pressure of £1.000m within prescribing is a result of

both increased volume of prescribing and increasing costs.

Table 5 – Primary Care as at 30 June 2023 (Month 3)

Current Plan £m's	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
51.796	GMS	13.094	13.077	0.018	52.629	(0.833)
62.967	GPS	15.503	15.759	(0.255)	63.972	(1.005)
23.707	GDS	5.239	5.023	0.217	23.579	0.128
4.883	GOS	1.272	1.264	0.008	4.884	(0.001)
3.889	Primary Care Management	0.611	0.604	0.007	4.010	(0.121)
147.242	**Total Primary Care**	**35.719**	**35.726**	**(0.006)**	**149.074**	**(1.831)**

4 Savings Programme

4.1 The HHSCP has a savings target of £10.659m (including ASC) for 2023/2024. At this stage in the financial year detailed plans are being developed to deliver this target and the forecast position assumes delivery of the CIP in full by financial year end.

4.2 Table 6 provides a breakdown of the schemes currently being developed.

Table 6 – Breakdown of current HHSCP CIP schemes in development

Division	No of Schemes	Full Year Savings Estimate £'000s
NH Community Service	9	693.797
Mental Health	15	1,217.000
Primary Care	3	800.000
Unit Wide	7	190.000
ASC	3	1.390
TOTAL	**37**	**2,902.187**

4.3 At the end of month 3 £0.395m of savings have been delivered. The forecasting assumption at this stage of the financial year is that the CIP will be delivered in full by 31 March 2023. This assumption will be reviewed monthly linked to the development of delivery plans. There is a risk associated with delivery and there is a continued focus on the development of plans and moving these through to delivery.

5 Non-ASC Allocations

5.1 At the end of month 3 a number of non ASC allocations are still to be confirmed – the working assumption is that these will be received at a level in line with 2021/2022. Scottish Government are intending to bundle smaller allocations and, where possible, baseline from 2024/2025. The main allocations relating to Alcohol & Drug Partnership funding and Mental Health Outcomes are still to be confirmed.

6 Recommendation

- Highland Health & Social Care Committee members are invited to discuss the month 3 and forecast financial position as presented in the paper.

Appendix 1

Services Category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Outturn £000's	YE Variance £000's
Older People - Residential/Non Residential Care						
Older People - Care Homes (In House)	20,776	5,568	4,990	578	19,380	1,397
Older People - Care Homes - (ISC/SDS)	33,680	8,420	8,814	(394)	34,715	(1,036)
Older People - Other non-residential Care (in House)	1,509	391	420	(29)	1,618	(109)
Older People - Other non-residential Care (ISC)	1,289	322	401	(79)	1,543	(254)
Total Older People - Residential/Non Residential Care	**57,253**	**14,700**	**14,625**	**76**	**57,256**	**(3)**
Older People - Care at Home						
Older People - Care at Home (in House)	17,870	4,580	4,248	331	17,020	851
Older People - Care at home (ISC/SDS)	16,325	4,088	4,675	(587)	18,099	(1,774)
Total Older People - Care at Home	**34,195**	**8,668**	**8,924**	**(256)**	**35,119**	**(924)**
People with a Learning Disability						
People with a Learning Disability (In House)	4,793	1,206	1,002	204	4,411	382
People with a Learning Disability (ISC/SDS)	35,365	8,870	8,590	280	38,656	(3,290)
Total People with a Learning Disability	**40,158**	**10,076**	**9,592**	**484**	**43,067**	**(2,909)**
People with a Mental Illness						
People with a Mental Illness (In House)	572	145	122	24	526	46
People with a Mental Illness (ISC/SDS)	7,436	1,850	2,604	(754)	7,529	(93)
Total People with a Mental Illness	**8,008**	**1,995**	**2,726**	**(731)**	**8,055**	**(47)**
People with a Physical Disability						
People with a Physical Disability (In House)	928	239	138	101	586	342
People with a Physical Disability (ISC/SDS)	7,000	1,764	1,851	(86)	7,603	(604)
Total People with a Physical Disability	**7,927**	**2,003**	**1,988**	**14**	**8,189**	**(262)**
Other Community Care						
Community Care Teams	9,624	2,392	2,180	212	8,924	700
People Misusing Drugs and Alcohol	301	76	33	43	117	184
People Misusing Drugs and Alcohol (ISC)	90	22	39	(17)	131	(41)
Housing Support	5,647	1,412	1,380	31	6,027	(380)
Telecare	1,507	233	201	32	1,471	36
Carers Support	423	334	337	(3)	1,162	(740)
Total Other Community Care	**17,592**	**4,469**	**4,170**	**299**	**17,832**	**(240)**
Support Services						
Business Support	2,040	528	459	69	1,841	198
Management and Planning	5,784	333	340	(7)	1,596	4,189
Total Support Services	**7,824**	**860**	**799**	**62**	**3,437**	**4,387**
Care Home Support/Sustainability Payments	**-**	**-**	**10**	**(10)**	**227**	**(227)**
Total Adult Social Care Services	**172,958**	**42,771**	**42,833**	**(62)**	**173,182**	**(223)**
Total ASC less Estates	**172,434**	**42,640**	**42,640**	**-**	**172,435**	**-**

Agenda Item 3.1

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**30 August 2023**
Title:	**Primary Care Update**
Responsible Executive/Non-Executive:	**Pam Cremin, Chief Officer**
Report Author:	**Jill Mitchell, Interim Deputy Chief Officer**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.
- NHS Board/Integration Joint Board Strategy or Direction

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This report provides Committee with an update in relation to primary care.

2.2 Background

The primary care division covers General Practice, Dental and Community Optometry services across North Highland.

2.3 Assessment

Community Optometry

Community Glaucoma Service

The Community Glaucoma Service (CGS) is a new national NHS service in Scotland that provides a means by which patients who have lower risk glaucoma or ocular hypertension, and who have been under the care of the Hospital Eye Service, may be discharged to receive care from CGS accredited providers in the community.

The roll out of the Community Glaucoma Enhanced Service was due to commence in NHS Highland Summer 2024. Roll out is dependent on number of Community Optometrists completing the NHS Education for Scotland Glaucoma Award Training (NESGAT). Cohort 3 of this training is due to complete in March 2024.

Currently there are 9 Accredited Providers who have signed up to the Enhanced Service for the provision of the Community Glaucoma Service and 8 Accredited Clinicians. There are 3 accredited clinicians in NHS Highland who are currently NESGAT accredited and the remaining 5 are in Cohort 3 of NESGAT.

Recently the Scottish Government Eyecare team have requested NHS Highland to support roll out of the Community Glaucoma Service ahead of the planned roll out of date of summer 2024 across the Kintyre peninsula as there is sufficient Accredited Providers and an Accredited Clinician in the area who is NESGAT accredited. NHS Greater Glasgow currently provides the Hospital Eye Services (Ophthalmology) for patients residing in the Argyll & Bute HSCP area and has recently rolled out CGS across several HSCP areas. There is clearly huge benefit to these patients in terms of being able to be seen locally.

We are about to commence discussions with NHS Highland e-Health Department regarding the roll out of the National Ophthalmology Electronic Patient Record (Open Eyes) initially for the Accredited Providers in the Kintyre area of A&B and these discussions will also widen to include various stakeholders (SG Community Eyecare team, NES Digital, NHS GGC, A&B Head of Strategic Planning & Performance etc.) moving forward.

Stroke/TIA Pathway

We are currently engaging with the Stroke Team to develop a clear pathway for Community Optometrists to follow in the event of a diagnosis/suspicion of a recent Stroke/TIA.

Dental Services

Registrations

Three Dental Practices (Invergordon, Alness, Tain) are accepting new adult and child NHS patients, with Fort William/Glencoe Dental Practices now accepting new child NHS registrations.

Payment Reform

The Scottish Government has now shared information on proposed NHS General Dental Services payment reform, to be implemented from 1st November. This

information has been shared widely with dental teams. This is a significant change for Dental Practices, which simplifies current payment systems and increases treatment fees that can be claimed by dentists. It is hoped that these changes will stabilise access to NHS dental services. Some patient charges for dental treatment will increase, although the maximum NHS patient charge remains unchanged.

Scottish Dental Access Grant Funding

NHSH has received one further application for Scottish Dental Access Initiative grant funding to open a new 2/3 Surgery Dental Practice in Inverness, this will be formally assessed by NHSH colleagues on Monday 21st August. If the application is supported, funding will be released by the Scottish Government to support establishing this new Practice.

General Practice

Board-managed GP Practices

A further GP practice transferred to Board management in July 2023. Armadale Medical Practice had both GP partners retire and no new GMS provider was secured. There are a significant number of GP vacancies across the Board-managed practices across 6 practices (Scourie, Kinlochbervie, Durness, 3 Harbours Caithness, Alness & Invergordon).

Lease Assignation

The new GP Contract premises directions provide the opportunity for GP practices to request a lease assignation from partners to the Board. An application process has been developed and all applications require to be approved by NHSH Asset Management Group (AMG). Several practices have expressed an interest and discussions are on-going for completed paperwork to progress to AMG.

Premises Maintenance

There are various premises issues across the region with significant maintenance backlog work.

Culloden Medical Practice and Culloden Surgery

Culloden Medical Practice and Culloden Surgery are currently declining patient registrations. Their patient lists remain open, with no formal closure requested to date. Issues are due to the practice building operating beyond originally intended capacity. The GP partners jointly own the building. No solutions from NHS Highland have been identified at present due to lack of capital funding for development. As premises owners, the practices are able explore their own solutions.

NHS Highland will continue to assign patients until a list closure is requested and agreed. Meeting between Primary Care and practice teams planned for late August.

2.4 Proposed level of Assurance

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

Recruitment challenges remain across Dental and General Practice services.

3 Impact Analysis

3.1 Quality/ Patient Care

General practice vacancies require locum deployment which creates budgetary cost pressures whist maintaining local service provision.

3.2 Workforce

The number of vacant GP posts across 2C practices remain around 12WTE.

3.3 Financial

Locum expenditure is an area of scrutiny in line with the efficiency and transformation programme. Significant work has been undertaken on a locum rate card and a centralised booking process is being implemented to provide more corporate oversight. Use of expensive agency locums are under review to reduce reliance.

3.4 Risk Assessment/Management

Workforce and finance risks are noted in the primary care risk register which is reviewed monthly.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

Recruitment is continually under review across all aspects of primary care.

3.7 Other impacts

N/A

3.8 Communication, involvement, engagement and consultation

This report has been compiled specifically for the purpose of reporting and updating HHSCP Committee.

3.9 Route to the Meeting

As above.

4 Recommendation

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

4.1 List of appendices

The following appendices are included with this report:

None

DISTRICT REPORTS

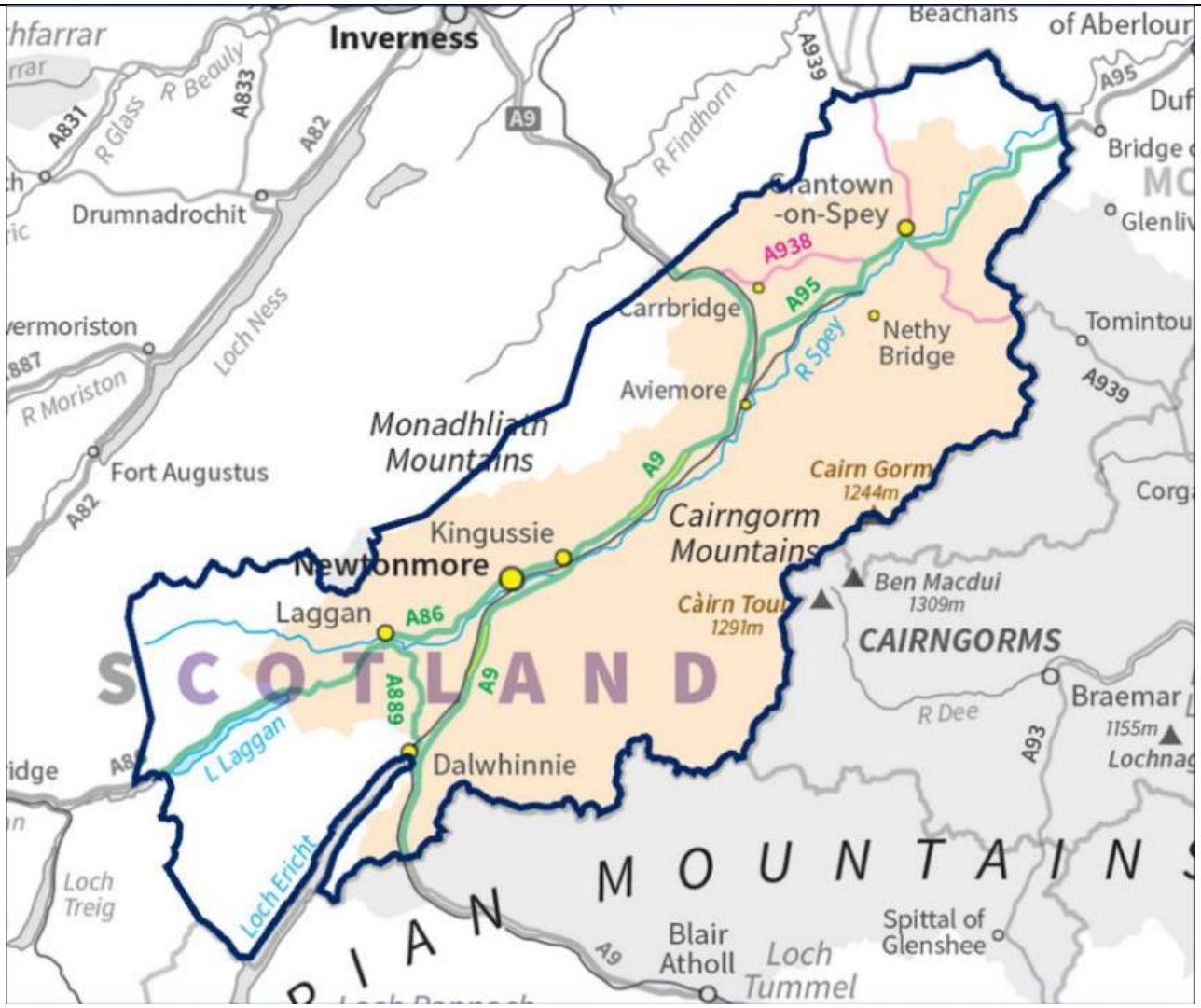
NHS HIGHLAND Community Directorate

District Profile

District: Badenoch and Strathspey

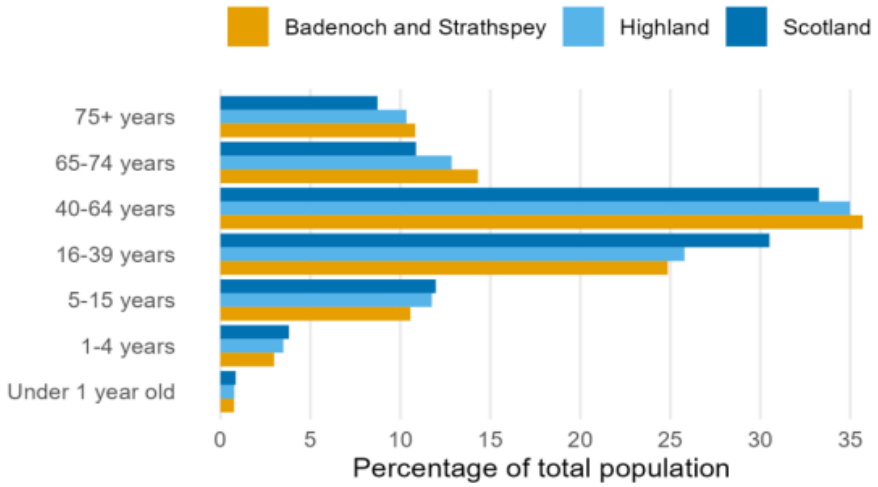
Manager: Gill Davidson

Locality Demographics
This information provides an overview of Badenoch and Strathspey's current and future population structure. It also provides information about the population dynamics of Badenoch and Strathspey and areas within Badenoch and Strathspey, the geography, and the life circumstances of people living in the area. All data are presented for Badenoch and Strathspey and, where available, intermediate zones or neighbourhoods within Badenoch and Strathspey. Comparisons are made to the Highland local authority and Scotland.



- The partnership area of Badenoch and Strathspey includes the settlements of Aviemore, Grantown-on-Spey, Kingussie, Nethy Bridge and Newtonmore. The area covers much of the western part of the Cairngorms National Park.
- Just over a quarter of the population (27%) live in the remote small town of Aviemore. Almost three in four people (73%) live in areas classified as rural.
- As of 2021, Badenoch and Strathspey has a population of 14,041 people. 14.3% of the population are children aged 0-15 years, 60.6% are aged 16-64 years and 25.1% are people aged 65 years and over.

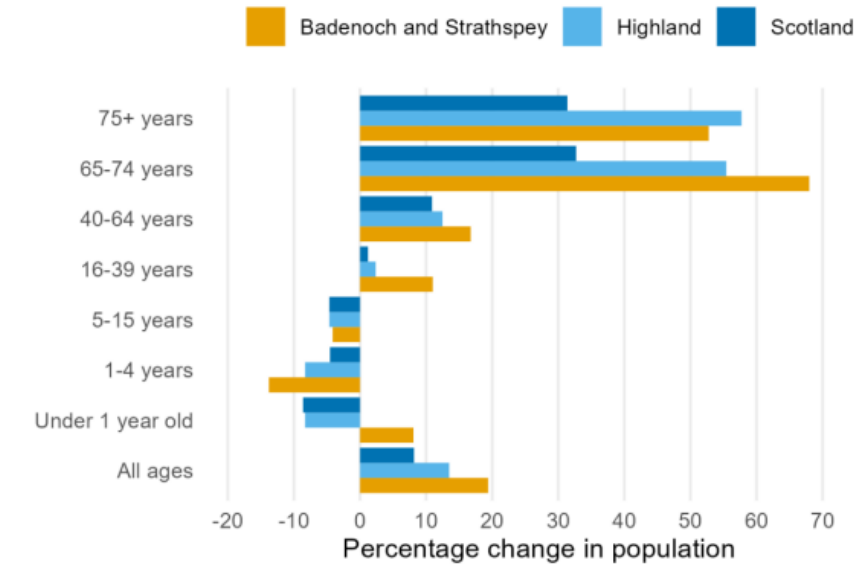
Figure 1: Percentage of the population by age group



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

- The age profile of the Badenoch and Strathspey population is similar to Highland.
- The population of Badenoch and Strathspey increased by 19% in the period from 2002 to 2021.
- Over this period, there was a 61% increase in the 65+ age group and a 6% reduction in the population aged under 16 years.

Figure 3: Percentage change in the population by age group, 2002 to 2021

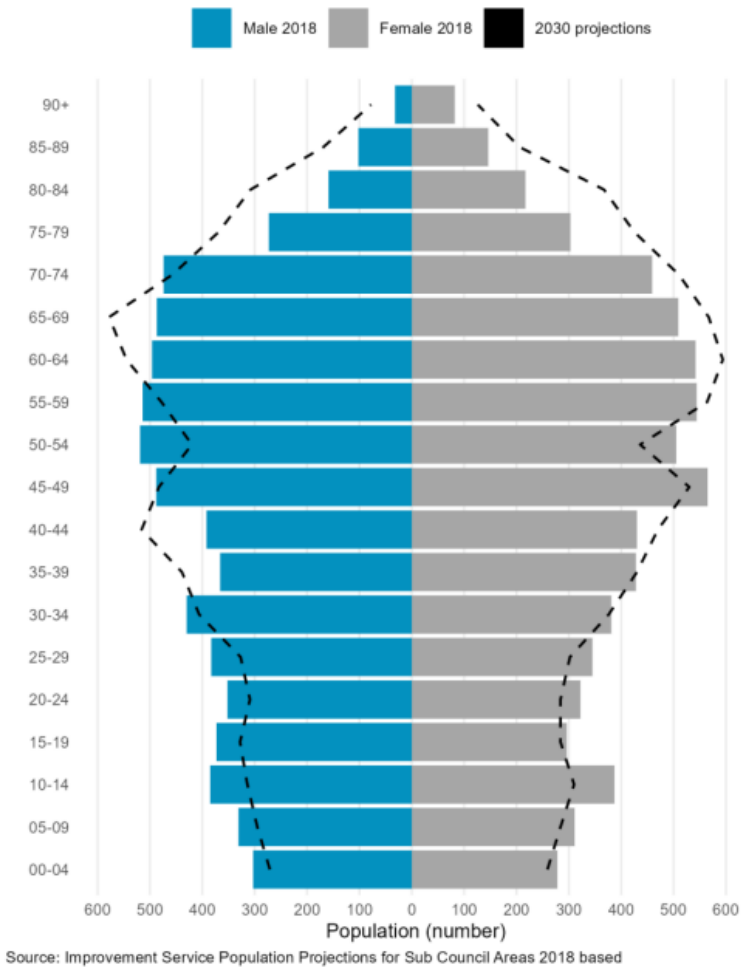


Source: National Records of Scotland, Small Area Population Estimates 2021

- The ratio of 2.4 people of working age (16-64 years) to older people (age 65 years and over) is lower in Badenoch and Strathspey than in Highland and Scotland.
- There were 85 live births to Badenoch and Strathspey residents in 2020.
- Birth rates have decreased over the last decade in both Badenoch and Strathspey and Highland. The birth rate in Badenoch and Strathspey has historically been slightly lower than in Highland.
- Birth rates are not significantly different in the small areas of Badenoch and Strathspey.
- The mortality rate in Badenoch and Strathspey has consistently been lower than that of Highland.
- Following the pattern seen in Highland and Scotland, improvement in the mortality rate in Badenoch and Strathspey has stalled6 . It is a significant concern that a sentinel measure of population health and social progress is not improving.

- Population projections are informed by past trends in births, deaths and migration. NHS Highland, Public Health Intelligence team 2022 4
- The annual number of deaths in the area exceeds the number of births, and population growth depends on net migration gain.
- The latest available population projections estimate that the overall population of Badenoch and Strathspey will increase between 2018 and 2030.
- The number and proportion of people in the 65-74, 75-84 and 85+ age groups are projected to increase, whereas the population aged 0-15 years and 45-64 years are projected to decrease.
- Projected demographic changes indicate that the ratio of people of working age to people aged 65 years and older will further decrease.
- SIMD 2020 identifies no data zones in Badenoch and Strathspey that are in the 20% most deprived small areas in Scotland. All the small areas of Badenoch and Strathspey have national deprivation ranks in quintiles three or four.
- In SIMD 2020, 6.8% of the population of Badenoch and Strathspey were identified as being income deprived and 4.6% of the working age population were employment deprived.
- Rural deprivation is a significant concern. Those identified as income or employment deprived are found in all intermediate geography areas

Figure 11: Estimated population in 2018 and projected population in 2030



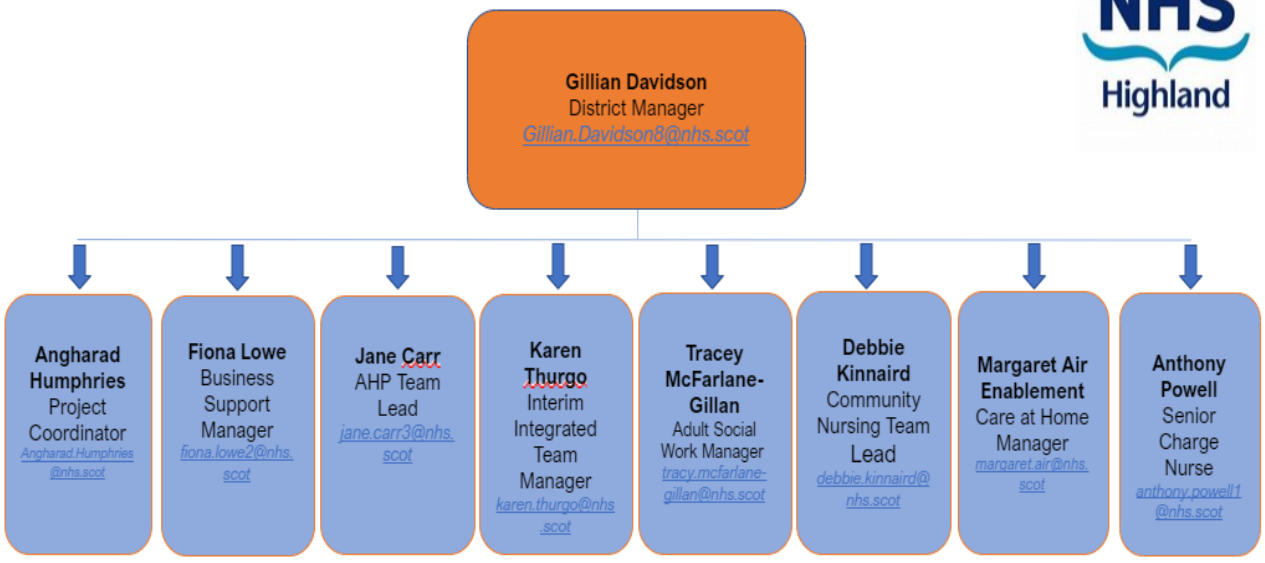
Source: Improvement Service Population Projections for Sub Council Areas 2018 based

Services provided and current workforce

Services managed within Badenoch & Strathspey as at 27/02are:

- AHP Services
  - Occupational Therapy
  - Physiotherapy
- Social Work
- Care at Home / Reablement
- Care Homes
  - Grant House, Grantown upon Spey
  - Wade Centre ,Kingussie
  - Mains House, Newtonmore (Transfer date 1st April 2023)
- Community Hospital
  - Badenoch and Strathspey Community Hospital, Aviemore
- Community Nursing
- Day Services
  - Glen Centre, Aviemore (Older Adults)
- Social Work Services
- Single Point of Access

The leadership team comprises the district manager, integrated team manager, Senior Charge Nurse in the Community Hospital, Community Nurse Team Lead, Social Work Team Manager, Care at Home Manager, Care Home managers.



Within B&S Hospital there is an Open Plan Office on the top floor, which hosts the Social Work team, Community Nurses, AHPs, Care at Home, Mental Health, Pharmacy and midwives. Highland Council Services are also based on this floor in a room within the Open plan office. Integrated working works really well in this environment – having everyone under one roof.

There are 3 GP practices in the area – Grantown Health Centre, Aviemore Health Centre and Kingussie Medical Practice. The Aviemore Health is within the Hospital building, and it is this practice that provides medical cover for the inpatient ward.

AHP Services

Badenoch & Strathspey Occupational Therapy & Physiotherapy Service, compromises a team of 18 staff, including the Band 7 AHP Team Lead.

Close working relationships across the two professions.

Provide patient centred care and cover many different clinical specialties – staff are required to work as 'Specialist Generalists'.

OT team is fully integrated covering community and ward caseload seamlessly for patient continuity.

Physiotherapy covers both MSK and Rehab.

Both teams work within the B & S Integrated Health & Social Care Team, OT having the closer links with Care at Home and Social Work due to the nature of their role.

Scope for further development in DWD/D2A, preventative work/prevention of admission as well as input/working alongside care home staff to help improve quality of life for care home residents

Physiotherapy

7 Physiotherapists (3 MSK/4 Rehab) and 4 Physiotherapy Assistants . Total WTE = 7

Provide MSK, Pelvic Health, Rehab Out Patients ,ward in patients, domi visits, Cardiac and Pulmonary Rehab classes.

Physiotherapy Assistants play a huge part in managing patients with falls and frailty, including an in house Otago class which helps to engage/progress patients to HLH classes locally.

Close links with HLH and input into developing Phase 4 Cardiac/Dynamic Health & Wellbeing/Parkinsons classes.

(The FCP – First Contact Practioner service is managed outwith this team but we have good working relationships with our FCP colleagues and while the FCP service is fully staffed, the model

functions relatively well. Patients are often referred by FCPs through to our mainstream Physiotherapy service. This fits with the original vision for the service.)

Occupational Therapy

4 Occupational Therapists and 3 Occupational therapy Assistants. Total WTE = 5.8

The service covers the ward and the community. Staff provide input for a mixed caseload of people with LTC and frailer/older people. OT carry out rehabilitation for people with LTC, functional assessments, minor and major adaptations, assessment/reviews for Reablement packages. Key role in promoting Reablement approach across ward and community.

There is demand for a Housing Practitioner to deal with major adaptations. This would allow the rest of the team to move back to a more rehab focussed model and work more effectively with people with LTC. Potential for more out patient clinics and further development of services for people with neurological LTC, chronic fatigue and similar conditions.

Social Work

The Community Care Social Work Team sits within the Badenoch and Strathspey Community Hospital Integrated Team. The day-to-day work of the team is overseen by the Social Work Team Manager who is responsible to the District Manager. The team compliment consists of one full time Senior Social Work Practitioner, Three full time Social Workers, three Social Work Assistant Practitioners (two part time on 21 hours and one full time) and one Health and Social Care Coordinator.

The work undertaken by the team consists mainly of assessments of the social and care needs of vulnerable adults over the age of 25 within the area of Badenoch and Strathspey. The Personal Option Plan (POP) is the assessment framework currently used to collate, analyse and present a clients information in order to make recommendations of support and meet needs. Both Social Workers and Social Work Assistant Practitioners complete these assessments of needs and carry out regular reviews to make sure needs are continued to be met appropriately. The team is also responsible for following and adhering to the Adult Support and Protection legislation (ASP 2007 Act), following due process to take steps to make sure that the most vulnerable adult clients in our community, care homes or in supported living are kept safe and protected from abuse. Social Workers in the team are responsible for managing, supporting and reviewing clients Welfare Guardianship Orders where the LA hold responsibility. The role of the Health and Social Care Coordinator is as a first point of contact for the intake of referrals into the Social Work Team and can support the integrated team through sign posting and early intervention.

Care at Home/Enablement

Enablement Care at home- currently covering the whole of Badenoch and Strathspey with enablement care packages and in house mainstream care packages, this has been a very challenging year with the Independent Providers pulling out of delivering care in our area. This was due to staffing issues – unable to recruit.

The Enablement care and home service has absorbed all the mainstream packages that leaves little room for the Enablement model to be implemented for those new referrals into the service for which we are registered with the Care Inspectorate. Recruitment has been another challenge; substantive posts are having candidates from other countries and not local people applying for this post.

The service is at capacity and I have asked Jill Brooks, contracts, to take the mainstream care packages to their weekly sector wide meeting on a Friday, to see if there is any interest from the private sector, otherwise the service is grinding to a halt.

There are pockets of capacity that we are looking at due to the number of DDs in Hospital and our unmet needs list, this will mean moving clients' times to fit new clients on the rota. areas of concern are Grantown and surrounding area. Aviemore could be tightened up to create capacity as could Kingussie.

Care Homes

There are 2 NHS run care homes in the area – Wade Centre, Kingussie and Grant House, Grantown. A 3rd is coming on line on 1st April, this will be Mains House, Newtonmore. Mains House is a nursing home, this was previously an Independent care home. The home went into administration in 2021, along with its sister home Grandview which was in Grantown. Grandview closed, and the Mains was placed up for sale as it was deemed a viable business. There was no purchaser found, this is in turn has resulted in Highland Council purchasing the home, and NHSH will take on the running of the home.

Within the 2 care homes there are what are known locally as Heather beds. Wade Centre Care Home has one flex-use bed and Grant House has two flexi use beds, known as the Heather Beds. The beds are utilised as flexible in use as possible for residents of the Badenoch and Strathspey District. The criteria for admission into one of these beds would be for – Rehab for a period of up to 2 weeks, requiring additional support for a short period of time, End of Life Care and Emergency Respite. These beds are well utilised through the valley.

Wade Centre

The Wade Centre situated in Kingussie is an eleven Bed Unit which consists of eight permanent bedrooms , two respite rooms and one Heather bed to facilitate emergency situations.
Purpose Built , The Wade centre provided Day Care facilities prior to Covid Pandemic.

Staffing Issues is still compromised although Recruitment is improving , To provide a safe Environment the Wade centre has and continues to Rely on in house staff to cover extra , Bank staff to support and CRT when all options are Exhausted.

Grant House

Grant House Care Home

We are a 19-bed care home but due to staffing we are at present unable to open to full capacity.
The care home is run by an interim manager and recently 2 new deputy managers.
We have 11 rooms in use at present with a Heather bed and palliative care bed for the community use.
We have two respite beds one of which have recently opened up for use again.

Over the last few years, we have found recruitment of staff to be difficult especially during the pandemic and the months after.
The Care response team are helping us recently through a challenging time, but with having a strong team everyone worked together to ensure our residents needs are met.

We currently have recruited 2 new staff and from the middle of march we should see a difference in staffing.

Community Hospital

The Badenoch and Strathspey Community Hospital is situated in Aviemore and was opened in September 2021 following the closure of the districts two existing Community Hospitals in Kingussie and Grantown-on-Spey. The Community Hospital site houses the Aviemore Medical Practice, an Outpatients Department, Out of Hours Service, Scottish Ambulance Service, the Districts Integrated Team and a 20 bedded Inpatient Ward.

The Inpatient ward is made up of 20 individual rooms with en suite facilities. There is also an Inpatient Physio gym and patient day room which leads out to an enclosed inpatient garden. The ward provides a range of care provision for the locality including rehabilitation, palliative care, treatment of acute and chronic conditions as well as well as occasional day case admission for IV infusions and blood transfusions. The medical cover for the ward is provided by the Aviemore GP Practice.

There is an X-ray facility within the hospital which is staffed on a Monday and Thursday.

The Outpatient Department houses the Dental and Podiatry Services as well as rooms available for visiting services and consultants

Community Nursing

There is one Community nursing team located in the Community hospital managed by the District Nurse Team Lead the team is divided into 2 areas each supported by a band 6 District Nurse (one of the Band 6 is a development post with them almost completed their diploma in Community nursing).
The community team provides preventative, reactive and maintenance clinical care to patients in the community and also runs a daily ITR clinic for secondary care generated work. We also manage highly complex patients with co-morbidities and treatments including chest drains, nephrostomy tubes, IV antibiotics. A highly satisfying part of our role is also providing end of life support to individuals, and their families, who wish to die at home.
The team also provides support to the 4 care homes in our area and also the Care @ Home service. The Team Lead also attends ASP meetings as Nominated Officer for Health.

Day Centre

The Glen Centre in Aviemore is a daycare /support service registered with the Care inspectorate for maximum 20 older adults.
We provide a service Monday to Friday at present with the aim to offering a service at the week-ends also. The Glen Centre aims to provide a service which will assist and enable all to enjoy and enhance quality of life. We provide a safe, supportive and stimulating environment where attenders can enjoy lunch and afternoon tea .Staff support with appropriate physical and personal care needs when required. We can also support with accessing additional services and resources if needed. We involve attenders & relatives/carers and other health professionals so together we can construct a comprehensive care plan and review process. We ensure good practice is followed and regularly reflect and evaluate success by organizing/providing: Attenders meetings, Care planning and reviewing, A varied choice of activities and outings ,Newsletters , Questionnaire's . At present our staffing is adequate for the service we provide .Recruiting staff has been problematic at times in the past ,but this has improved and there are no staffing issues at present.

SPOA

The Single Point of Access provides a Single Point of Contact for service users, professionals and the public. They sit within the Open Plan Office and are invaluable to the day to day running of the District. They field the calls for nearly all of the Integrated Team – Care at Home have a direct line into their service.

Finance & Performance

The budget for 2022/2023 for Badenoch & Strathspey District is £11,879,621 of which £7,539,919 relates to Adult Social Care (ASC) while £4,339,702 relates to Health. At the time of writing an underspend of £601,599 was predicted - £279,464 in Health and £322,095 in ASC. Which can mostly be attributed to the large number of vacancies throughout the services.

Financial Position – M9

Annual Budget £000	Division	Budget YTD £000	Actual YTD £000	Variance YTD £000	F'cast Outturn £000	F'cast Variance £000
370	B+s Central	281	70	211	133	236
1,597	B+s Hospital	1,199	1,260	-61	1,678	-81
541	B+s Ahps	407	372	34	496	46
111	B+s Other Community	83	195	-111	237	-126
949	B+s OOH	712	672	40	905	43
772	B+s Community Nursing	581	453	128	611	160
4,340	**Health**	**3,264**	**3,022**	**241**	**4,060**	**279**
7,540	ASC	5,666	5,391	275	7,218	322
7,540	**ASC**	**5,666**	**5,391**	**275**	**7,218**	**322**
11,880	**Total B&S**	**8,930**	**8,413**	**516**	**11,278**	**602**

Health Forecast – M9

	YTD £000s	Forecast £000s	Comments
Cost Pressures - please list			
Pay Pressures - unfunded i.e maternity/unfunded posts	-130.237	-185.121	Community ward staffing pressures, excluding the additional £60k Winter Plan funding
Other non-pay	-111.054	-107.072	Aviemore/Grantown Medical agreements
Offsets and Compensation Underspends			
Vacancies	265.986	328.12	Recruitment issues throughout B&S
Other non pay	216.403	243.537	Redesign fund awaiting allocation

ASC Forecast – M9

	YTD £000s	Forecast £000s	Comments
Cost Pressures - please list			
Other non-pay		-15.01	ISC
Offsets and Compensation Underspends			
Vacancies - ASC	252.828	337.105	Recruitment Issues throughout B&S
Other non pay	22.422		

Additional
B&S secured an additional £60,000 funding via the winter plan, this was to release the staffing pressures currently facing the community ward. Funding was available from December 2022 – March 2023.

Opportunities and Developments

We are in the process setting up a Home to Assess Service. This is a service that was piloted in Mid Ross and we are looking to replicate this in B&S. The focus will be enabling individuals to be discharged from hospital sooner with their rehabilitation being provided in their home by Senior Development Workers from the Enablement/Care at Home Team. The Recruitment process has just started for this service and it is anticipated it will be up and running by Summer 2023.

Community Engagement

Community Planning Partnership (CPP)
The B&S CPP meets on a 3 monthly basis and is chaired by Boyd Robertson – NHS Highland. The meetings are held on a quarterly basis, they are well attended from the various agencies and organisations within the area.

Independent Sector
There is now (from the 1st April 2023) only one Independent Care Home in the area – Lynemore at Grantown-on-Spey. This is a 40 bedded Nursing Home. The SW and DN team work closely with the Care Home, providing support, guidance, reviewing of the clients and joint working with the provider to provide the best outcomes possible for the clients. The Care Home does prefer their clients to be self funders.

Richmond Fellowship provide the bulk of support to our younger adults in the area. The SW Team have close links with the provider, there are weekly catch ups. This Provider is currently under LSI – Large Scale Investigation, concerns were raised in regards' to their practice and they are being supported by NHS Highland to bring their practice up to a standard that is acceptable.

Highland Council
Locality meetings occur once every 6 weeks, the local councillor attends these meetings. There are close links with Highland Council through the Care for People Group.

Voluntary Sector
The Voluntary Sector are active in the B&S area, NHSH work closely in partnership with them. VABS – Voluntary Action in Badenoch and Strathspey is a local organisation whose mission is to help the people of B&S to improve their quality of life through voluntary action. They support third sector organisations (community and voluntary groups, social enterprises throughout the area. The Community car scheme is a lifeline for those in the Valley. Public transport is sporadic.

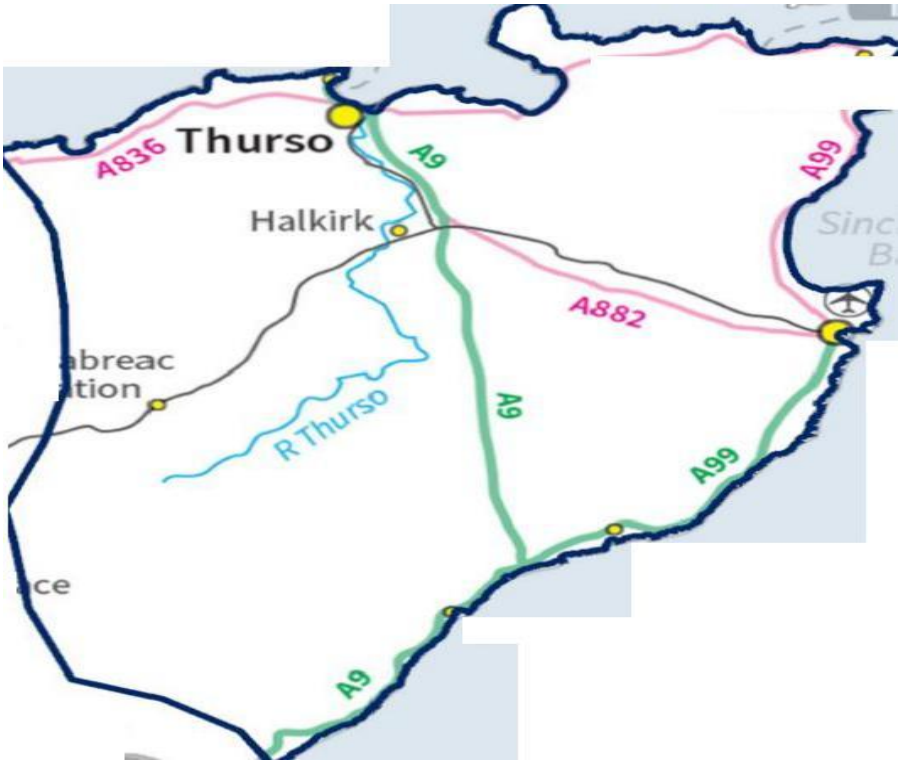
Completed by: Gill Davidson Date: 28/3/2023

District Profile

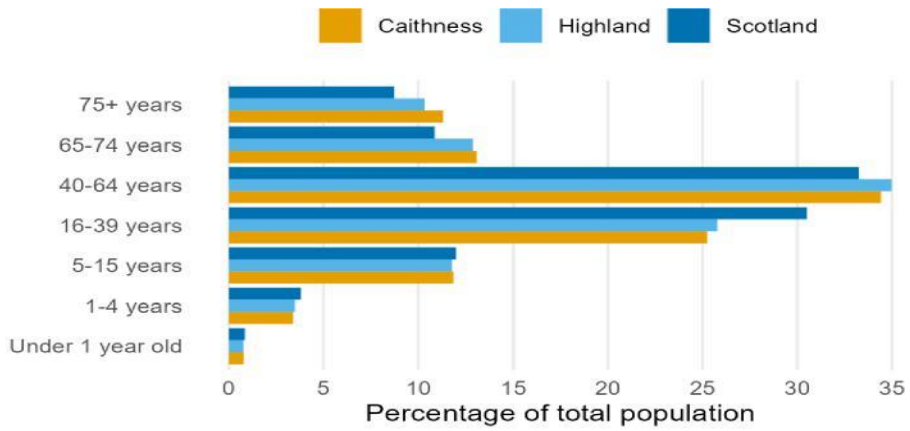
District: Caithness

Manager: Christian Nicolson

Locality Demographics

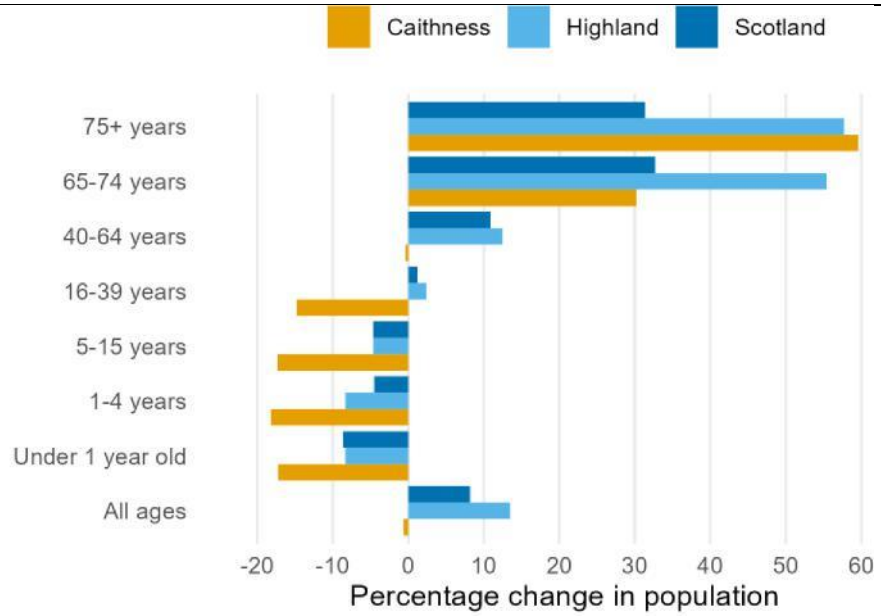
For information: The latest estimates are based upon the 2011 census, with an adjustment made annually for births , deaths and migration. Future estimates will be rebased on the 2022 census when the results become available. The population projections used in this report were produced by the Improvement Service (IS) and are based upon Housing Market Areas (HMAs) defined by the Argyll and Bute Council and the Highland Council.
 	
Caithness
 
 	
As of 2021, Caithness had a population of 25,347 people. Of these, 16.0% were children aged 0- 15 years, 59.7% were people aged 16-64 years and 24.3% were people aged 65 years and over. The age profile of the Caithness population was similar to Highland as a whole
 	
• Just over half the population (54%) live within the very remote small towns of Wick and Thurso. Almost one in two people (46%) live in very remote rural areas
• The population of Caithness decreased by 0.7% from 2002 to 2021. The total population increased to a high in 2011, then decreased between 2012 and 2020, followed by an increase in 2021.
• The patterns of population change differed by age group
  ○ There was a 42% increase in the 65+ age group between 2002 and 2021.
  ○ Compared to Highland or Scotland, Caithness has seen a larger percentage decrease in the population aged 0-15. The reduction in this age group has mainly occurred since 2008.

    - The working-age population (16-64 years) has decreased by 7.0%, contrasting with Highland overall, where this age group increased by 8.0%.
- The ratio of people of working age (16-64 years) to older people (age 65 years and over) is lower compared to Highland and Scotland overall.
    - There were 197 live births to Caithness residents in 2020. The birth rate has decreased over the last decade in Caithness and Highland. There is variation in birth rates annually and between small areas in Caithness.
    - The death rate in Caithness decreased from 2002-2004 to 2010-2012. The death rate has since stalled and follows a pattern seen in Highland and Scotland.
    - The death rate in Caithness for the most recent three-year period was higher than Highland's and lower than in Scotland. There is variation in age-sex standardised mortality rates in the area. The death rates in the Caithness Northwest area were significantly lower than in Scotland.
    - Population projections are informed by past trends in births, deaths and migration. Pre-pandemic trends inform the current projections.
- 2018-based population projections estimate that the overall population of Caithness will decrease between 2018 and 2030.
- The population will continue to age. The number and proportion of people aged 65-74, 75-84 and 85+ are projected to increase, whereas the population aged 0-15, 16-44 and 45-64 years are projected to decrease.
    - The impact of long-term demographic changes will mean that the ratio of people of working age to people aged 65 years and older will further decrease. This pattern has implications for staffing and recruitment.
    - The SIMD 2020 identifies four data zones in Caithness that are in Scotland's 20% most deprived small areas. These are Wick Pultneytown South, Wick Hillhead North, Wick South Head and Wick South.
- A similar proportion (9.6%) of the population of Caithness live in the most deprived SIMD quintile in Scotland, compared to Highland (9.2%) overall. Most of the population (64.4%) live in quintile three and quintile four areas.
    - Rural deprivation is a concern. In the SIMD 2020, 11.4% of the population of Caithness were income deprived, and 9.6% of the working-age population were employment deprived



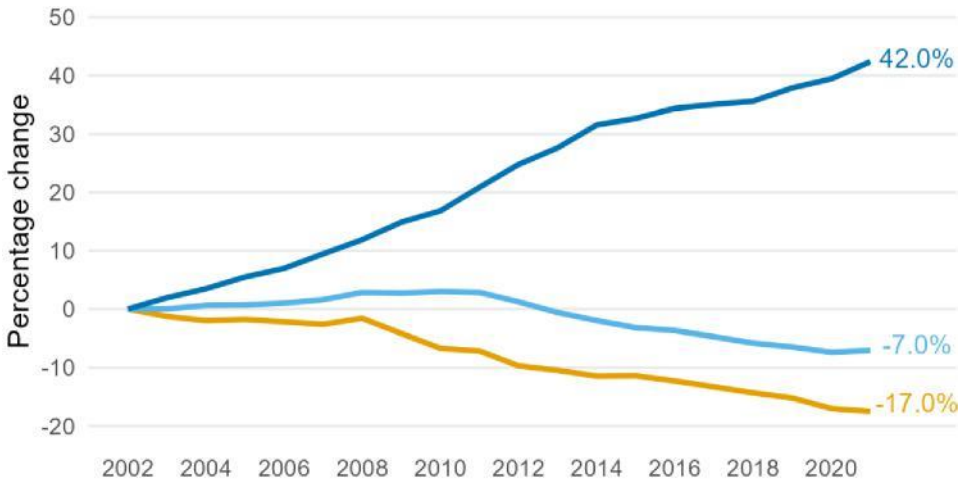
Source: National Records of Scotland, Small Area Population Estimates 2021

Figure: Percentage of the population by age group



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

Figure 2: Percentage change in the population by age group



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

Caithness: Percentage change in the population by broad age group

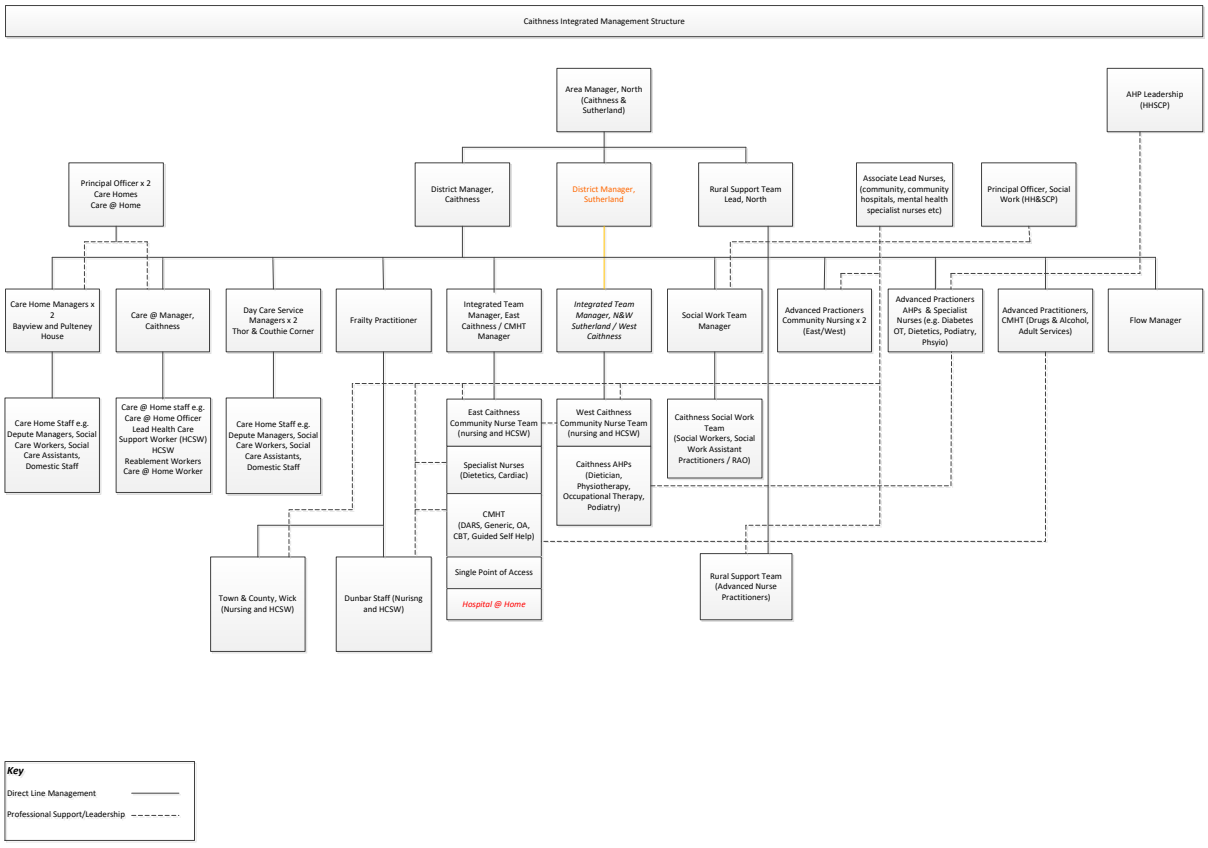
Services provided and current workforce

Services managed within Caithness District as at 21/02/23 are:

- AHP Services
  - Dietetics
  - Occupational Therapy
  - Physiotherapy
  - Podiatry
- Care at Home / Reablement
- Care Homes
  - Bayview House, Thurso
  - Pulteney House, Wick
- Community Hospitals
  - Dunbar, Thurso
  - Wick Town & County

- Community Mental Health Services.
  - Cognitive Behavioural Therapy (Sutherland & Caithness)
  - Drugs & Alcohol
  - Generic / Emergency & Unscheduled Care
  - Guided Self-Help
  - Learning Disabilities Nursing
  - Older Adult
- Community Nursing
  - East Caithness
  - West Caithness
- Day Services
  - Couthie Corner (Bayview) Thurso (Older Adult)
  - Thor House, Thurso (Adults with Learning Disability)
- Specialist Nursing services e.g.,
  - Cardiac/Heart Failure,
  - Diabetes
- Social Work Services
- Single Point of Access

The leadership team comprises the district manager, integrated team managers (east and *west Caithness), frailty practitioner, social work team manager, care at home manager, care home managers, day centre managers and advanced practitioners. They work closely with the Rural Support Team lead. Several advanced practitioner posts are shred across Caithness and Sutherland. See below for structure



*West Integrated Team Manager is “shared” with Sutherland where the post holder is also ITM for North & West Sutherland

AHP Services

Dietetics at present is managed within the district but at 01/04/2023 while remaining in the community directorate will under redesign of structures be managed as part of an overall dietetic service for North Highland Community Division. In terms of Caithness staffing numbers are small with a 1wte B7 Advanced Practitioner whose time is split between clinical and leadership. Approximately 0.8wte clinical for Caithness (inpatient and community) with 0.2wte leadership across the north (Caithness and Sutherland) area. Additionally, there is 0.45wte B6 for Caithness, again covering inpatient and community services. There are links locally to the highland wide work around type two diabetes with 0.4wte equivalent of a Health Improvement Specialist Practitioner based in Caithness (Highland wide the staffing is 2.4wte)

Occupational Therapy service is managed within the district (by the West Integrated Team Manager) and provides service to community and inpatients including the acute service in Caithness General Hospital (CGH). The team itself comprises B7 Advanced Practitioner, B6, B5 and B4. A part-time Trauma OT post is based within the team through funding from the North of Scotland Network. Recruitment in recent years and months has been challenging particularly at B6 level where redesign of posts has had to take place.

Physiotherapy like OT is managed by the Integrated Team Manager for the West and like OT (and the other AHP services) provides services in the community and hospital with staff based at Dunbar and CGH. Physio in Caithness covers all aspects of clinical service including trauma (0.5wte B7 funded via Trauma Network) rehabilitation, outpatient, MSK, cardiac and pulmonary rehab, falls, frailty, and pelvic care. Due to challenges in recruitment to qualified (mainly B6) posts the service in Caithness has recently been supported via agency which has had a significant cost implication. A local redesign of establishment and roles should see the use of agency stopped. There proposal includes additional senior practitioner and leadership at B7 level in Caithness (currently shared with Sutherland) supported by additional support worker hours. There is also a "First Contact Practitioner" service within Primary Care.

Podiatry as with Dietetics will in time "move" to a north highland wide management structure via communities' division but at present is managed by the West Integrated Team Manger in the District. In general recruitment to podiatry services is a challenge but recently the team has been successful in appointing to a full-time B6 post, this in addition to the existing B3 admin, B6 podiatrist and B7 AP post holders (B7 0.2wte of her 1.wte is for leadership across the North Area). 1wte B6 podiatry post remains vacant in Caithness. In addition, there is vacancy in Sutherland along the north coast so patients who can travel are being asked to come to clinic on Thurso. This impacts on the patient in terms of travel outwith district but also on the team in Caithness which is also short-staffed.

Care at Home / Reablement

Care at Home / reablement services are provided across Caithness with a local manager based in Thurso. There are offices located in both Wick and Thurso with Care @ Home Officers, Co-ordinators, and Clerical Assistants. The offices also act as a "base" for the carers. Across Caithness at present there are 10 vacancies across a range of roles (admin, co-ordinator, officer, and carers). These posts are at various stages of recruitment. Long and short-term sickness also make it challenging in an area which is seeing an aging population and increased levels of frailty. In terms of working with the independent sector there are a couple of providers which the services contracts with. They too face similar challenges to the in-house service.

Care Homes

Bayview House, Thurso has 23 beds. At present all beds are used for "long-term" residents but prior to covid there were 22 beds with one permanent respite. Further discussion is required as to whether a bed is returned to respite on a permanent basis
Pulteney House, Wick has 18 beds, again one of which was prior to covid was a permanent respite bed. Further discussion is required as to whether a bed is returned to respite on a permanent basis.

Staffing and recruitment is challenging in both homes with a number of vacancies (eight across both homes for a range of posts such as depute manager, social care workers and assistants). In addition, there is both long and short-term sickness/mat leave.

In addition to the two in-house residential care homes there are three independent providers in Caithness. Two are run by Barchester Care Homes while Riverside is completely independent. The Barchester homes are Pentland View and Seaview which are nursing homes and are registered for 50 and 42 clients respectively. Both have ability for shared rooms. Riverside can accommodate 44 service users and is registered for both residential and nursing care

Community Hospitals
Dunbar, Thurso provides six in-patient beds (though can flex within the constraints of the building and infection control when required and has been operating with seven beds for some weeks) including palliative and end of life. In addition to the inpatient beds there is a Minor Injuries Unit (MIU) and an outpatient department. Outpatient Clinics are held daily for podiatry and physiotherapy and on a regular basis for other services such as Dietetics which can be a combined clinic with the Diabetes Specialist Nurse or Cardiac Nursing (which may be combined with Physio). Consultants from Caithness General and Raigmore use the outpatient department for consultation. Pre-operative appointments area also available at Dunbar.
Wick Town & County provides six in-patient beds (though can flex within the constraints of the building and infection control when required and has been operating with seven beds for some weeks) including palliative and end of life. Town & County has recently been re-awarded following Macmillan Quality Environment Mark following assessment in December. This award is valid for the next three years.

Both Town & County and Dunbar inpatient are "managed" by a Frailty Practitioner, a post developed a little over a year ago. The practitioner is supported by a senior staff nurse at B6 for nursing related issues. Feedback from the staff in both hospitals re this change has been positive with all noting a more rehab type focus. In addition to the role within the community hospitals the post holder carries a community caseload and works alongside the wider multi-disciplinary team (e.g., care at home, community nursing, social work, and specialist nurses) to keep people at home in the community for as long as possible.

Community Mental Health Team
As per the structure for North & West prior to the creation of the Communities Division, Community Mental Health Services in Caithness are managed by the Integrated Team Manager for East Caithness albeit this is likely to change in the coming months with a move of management to the Mental Health and Learning Disabilities Division. Psychiatry and Psychology services are managed centrally and have been traditionally. Staffing in the mental health team is a particular challenge with several vacancies at B6 level in learning disabilities older adult and generic teams. At present there are six vacancies at B6 level (vacancy also at B5 (two) Emergency & Unscheduled Care Practitioner (one) and Support Worker (B3). All are at different stages of recruitment. Positively interviews are scheduled to take place for a support worker for learning disabilities on 10/03/2023 and B6 for Older Adults (two posts) on 16/03/2023. Support via the nursing bank has been made available to the team from locally retired

staff and Inverness based staff. This is available until the end of June 2023 at least. In terms of emergency support and links to acute support via MHAU is available and has been invaluable.
Cognitive Behavioural Therapy while based in Caithness covers the north area (Caithness & Sutherland). The "team" is one member of staff who while managed in the district receives professional leadership via psychology team in Inverness.
Drugs & Alcohol in terms of the team locally is in a good place at present with recent successful recruitment and development for both qualified and support worker staff. There is a vacancy at B6 level, but discussions are ongoing re plans for this. The team is working with other members of the team and partners in Police Scotland to develop processes and pathways for the development of the MAT standards (Medication Assisted Treatment).
Generic / Emergency & Unscheduled Care as noted above there is vacancy in the E&UCP post. In terms of the post itself it is 1wte Mon-Fri which itself is challenging for a requirement which is 24/7. This is challenging to the generic team which as noted about is short of staff in permanent posts.
Guided Self-Help covers Caithness and North Sutherland
Learning Disabilities Nursing at present there is one substantive post holder who is nurse a B6 level. She has been on her own for some time with recruitment challenges for a second B6 post. Establishment review provided additional B3 establishment
Older Adult supports adults >65years. The team is supported by a dementia link worker employed by Alzheimer Scotland.

Community Nursing
Community Nursing in Caithness is provided by two teams **East Caithness** and **West Caithness**. The teams provide preventative, reactive, maintenance and end of life care to patients in the community. The work with the wider MDT to support people to remain at home and improve community pull.

Recruitment has been very challenging in recent times for both teams with absence due to vacancy, sickness etc sitting at approx. ~40%. There are posts at B5 and B6 (Caseload Holder) currently out to advert.

Day Services
Couthie Corner (Bayview) Thurso provides assessed day care for older adults in the Thurso and West Caithness area. It provides social stimulation for clients and respite for carers. The service is delivered from Bayview Care Home which has had an impact on service provision following covid. During covid services were suspended with staff from the day centre providing an outreach service to clients (which necessitated a change of registration with the Care Inspectorate). The service has re-opened on a limited basis in terms of access to space within the care home which has impacted on numbers, but the outreach service has continued.

For Wick and East Caithness, the Laurandy Centre an independent provider with an SLA with NHSH provides assessed day care to older adults

Thor House, Thurso provides assessed day care for adults with learning disabilities from across Caithness. The management of the service will move to the Mental Health & Learning Disabilities Division along with CMHT services. The day centre is housed under the same roof as services provided by Highland Council for children and young adults. Highland Council is currently reviewing the service provided

Out of Hours GP
Monday to Sunday between 18:00 and 08:00 **Out of Hours GP** services in Caithness are delivered via an SLA with Ash Locums. A rotational pool of GPs cover this service. Saturday/Sunday between 08:00 and 18:00 are open for GPs/ANPs to book onto shift via the Highland system. The GPs/ANPs for weekend

day cover can but do not tend to be staff working locally. Ash Locums provides accommodation for their weeknight pool while accommodation can be part of the requirement for staff covering weekend daytime. The service itself operates from CGH (though part of district rather than acute) with GPs supported by a driver. Public Holidays are treated as weekends for Out of Hours cover. When booking a shift GPs can book at "normal" hourly rate, "enhanced" rate or "emergency" rate. There is no continuity across districts re hourly rates.

Specialist Nursing

There are several specialist nurse posts across highland which are managed in different ways. In terms of those which are managed within the district (because of district development and use of district budgets differently to support development) the two are Diabetes and Cardiac Rehab/Heart Failure. In terms of **Diabetes** Caithness has 1wte B6 staff nurse and shares a B7 Advanced Practitioner with Sutherland (who also have a B6) so for the North there is a team of three. The team works alongside colleagues in community nursing, care at home, dietetics etc to support individuals living in the community with diabetes for example there a joint clinic with the dietician. They also provide support to care homes and community hospitals. They do provide an in-reach support service to patients known to them in CGH but cannot provide an emergency response service to acute. For **Cardiac Rehab/Heart Failure** Caithness has a 0.6wte B6 post. The post holder works with colleagues in physiotherapy etc to provide joint clinics. The establishment is historic establishment which has not been reviewed for some years. Senior Nursing leadership in the Community Division will support and establishment review in July which will cover a larger geography than Caithness.

Social Work

Social Work, work with people to find solutions. This may be helping protect vulnerable people form harm or abuse or supporting people to live independently. Social Workers work with clients, their families, and others around them. At time of writing there were 14 Adult Support & Protection active in Caithness, eight live at stage 1&2 and six live at state 4 onwards. There are a total of 84 Guardianships of which 37 are local authority Guardianships. Social Work in Caithness have an SLA with Highland Council to part fund a full-time social worker post which has a "housing" related focus. The social worker while employed by NHSH spends their time working with both the social work and housing teams. This post is in year two of its SLA. A recent restructure has seen the appointment of a Team Manager (the team was previously managed by Integrated Team Managers). The post of Senior will should be out to advert imminently. A Social Work Assistant Practitioner took up post on 20/02/23. A full-time Social Worker is due to commence in April. Despite this there remain issues and challenges with a mix of full and part-time vacancies at social worker level.

Single Point of Access

Like other parts of Highland Caithness employs **Health & Social Care Coordinators** working across the Integrated Teams. As part of the Caithness Redesign (a whole system redesign of adult services) there is work to develop their roles as part of a single point of access. Work to develop pathways and processes continues while challenges remain in terms of access to digital and shared systems. As part of the redesign an eHealth Facilitator is working with the team to support.

Other

As part of the redesign and in keeping with national and regional flow work Caithness has worked to develop new roles. As mentioned previously the post of Frailty Practitioner was appointed to in late 2021. In the summer of 2022, a **Flow Manager** was appointed for the North Area. A senior level posts the post holder works with the community teams, community hospitals, RGH and DGH to support flow. Following this appointment similar appointments were made to other parts of NHS Highland

While not managed as part of the district team in the North there is also a **Rural Support Team** (RST) which covers the North. The Team which consists of ANPs supports across the spectrum of community and hospital services.

Primary Care was until NHS Highland's restructure part of the district in the sense that 2C or Salaried Practices were managed via the district. Following the restructure in late 2021/2022 the management transferred to the Primary Care Division and Primary Care Managers. The three salaried practices in Caithness (Riverbank in Thurso, Riverview in Wick and Lybster) recently merged to become the "three harbours" practice. There are GMS practices in Dunbeath, Wick (Pearson), Canisbay & Castletown and in Thurso/Halkirk. As a district we work closely with all in terms of community nursing, care at home etc. Thurso/Halkirk, Canisbay & Castletown and Riverbank provide GP services to the Dunbar in Thurso.

Finance & Performance

The budget for 2022/2023 for Caithness District is £18,659 of which £5,142 relates to Health while £13,517 relates to Adult Social Care (ASC). At the time of writing an underspend of £351k was predicted which relates in large part to underspends due to staffing vacancy.

For more information see slides relating to Month 9 (December 2022)

Financial Position M9

Current Plan £000	Division	Plan YTD £000	Actual YTD £000	Variance YTD £000	F'cast Outturn £000	F/cast Variance £000
1,127	AHPs	852	793	59	1,048	79
565	Management	467	354	112	449	115
1,366	Nursing	1,028	1,055	(27)	1,402	(36)
1,763	Hospitals	1,324	1,432	(109)	1,907	(145)
1,095	Mental Health	790	583	207	820	275
48	Community	36	84	(49)	101	(54)
830	OOHs	623	592	31	789	41
36	Primary Care	24	3	21	8	28
0	Caithness CAC	0	0	(0)	0	(0)
6,829	**Sub Total - Health**	**5,142**	**4,897**	**246**	**6,525**	**304**
2,605	Care Homes & Respite	1,949	2,159	(210)	2,885	(280)
725	Community Care	543	555	(11)	741	(15)
702	ASC Management	537	434	102	565	136
1,996	Care at Home	1,498	1,416	83	1,885	110
11,954	ISC/SDS	8,990	8,847	142	11,903	51
17,982	**Sub Total - ASC**	**13,517**	**13,412**	**106**	**17,980**	**2**
24,811	**Total for Caithness District**	**18,659**	**18,308**	**351**	**24,505**	**306**

Health Forecast– M9

Health Analysis of Position	YTD £000s	Forecast £000s	Anticipated Spend 23/24	Comments
Cost Pressures - pay cost pressures	60.29	80.38	80.38	All Pay Pressures - maternity, sickness cover and use of agency for vacant posts
Utilities	0.46	15.91	15.91	Increase in electricity and gas costs and no increase in budgets
Drugs	9.64	12.86	12.86	Majority overspends from Dunbar Hospital
Other non-pay	74.25	88.04	88.04	Various overspends including Surgical Sundries, Clinical Equipment, Cleaning, Post and Carriage
Savings Underachieved				
Housekeeping	36.50			Savings achieved in advance
Covid Costs -				
Other Additional Staff Costs	44.03	44.03	44.03	Costs for CAC Nurses who were in FTC until September 2022
Underspends				
Vacancies	325.86	448.63	448.63	Vacant Posts in AHPs and Mental Health+49:61
Other non pay	71.94	96.54	96.54	Transport, purchase of healthcare, travel and rates

ASC Analysis of Position	YTD Varianc £000s	Forecast Var £000s	Anticipated Sp £000s	Comments
Cost Pressures				
Pay Pressures - unfunded i.e maternity/unfunded posts	92.19	122.92	122.92	4 B3 CAH Staff for Overnight Care
Utilities	11.48	15.30	15.30	Overspend of Heat and Light in the care homes
Other non-pay	68.97	91.96	91.96	Surgical Appliances, provisions and Property Maintenance in care homes
ASC packages	160.56	75.39	75.39	
Underspends				
Vacancies - ASC	41.42	55.23	55.23	Vaccancies within the care homes
Other non pay	76.56	102.08	102.08	T & S Savings, Social Work HealthCare,

Caithness has been successful (along with Skye) in receiving funding for a Hospital at Home pilot. In total funding of £248, 499 has been received for the period 01/01/2023 to 31/12/2023. ATRs have been approved for a B7 ANP, a B5 Nurse, 0.5wte OT and B4 Co-ordinator. We are working with the Pharmacy Team in CGH to provide additional hours to the team there and working with clinical colleagues re Clinical Support. A challenge and delay to the project was the AfC matching process whereby without having had H@H in Highland previously there were no suitable job descriptions. New job descriptions have been developed but have not yet been banded therefore posts are being advertised without the correct descriptors.

Opportunities and Developments

As has been previously mentioned elsewhere in this report the Caithness Redesign is ongoing. This is a whole system redesign of health and social care services for adults. While the focus is on the delivery of services via “local care model” with new ways of working, workforce development etc there will be as part of the resign two new build hubs (Wick & Thurso) which will act as a base for the integrated teams, provide 24/7 beds (residential and in-patient community), day services and GP services will also be provided form the hubs. A redevelopment of CGH will also be part of the process.

Some of the work done as part of the redesign in terms of workforce has been highlighted in this report e.g., Flow Co-Ordinator and Frailty Practitioner. The Hospital at Home service as described above also forms part of the future development the local care model. Other developments/tests of change are listed below

Overnight Care

A pilot project to provide overnight care support in Wick and East Caithness staffed by B3 Health & Social Care Support Workers took place between February 2022 and December The service provided a rapid response to non-medical emergencies by providing older people and those with complex care needs with additional support within their own homes in order to prevent hospital admissions, premature care home admissions, facilitate early hospital discharges and enable people to live independently in their own homes for as long as possible. Most importantly, the team support family members to keep their loved ones at home with them and provide support to those caring for their loved ones. The aims and objectives of the services are in line with the local care model, discharge without delay, home first initiatives of the Scottish Government, supported by the Board of NHS Highland. The service was operational between the hours of 10:00pm and 7:00am seven days a week. Staff were employed via the Care at Home service.

Up until end of August 2022 the service had supported 44 individuals (seven on a one-off basis, 30 over a short-term basis and seven who required longer-term support). Referrals came via community nursing, occupational therapy, hospital, ED, social work, and OOH GP.

The Tables below show current costs and the future costs of continuing the service in both the East and West Caithness.

Costs for Service in East from 14th Feb – 30th Sep 2022

	2020-21	2021-22	Total Cost
1 WTE B3	2,402	21,159	23,561
1 WTE B3	4,127	21,076	25,203
1 WTE B3	3,553	18,835	22,388
1 WTE B3	4,127	21,194	25,321
			96,473

Costs for East Caithness Annually

	2022-23 3 Months	2023-24 12 Months
Staff Costs	40,000	160,000
Fuel Costs	1,500	6,000

IT Costs	30	120
Total	41,530	166,120

Costs for West Caithness Annually

	2022-23 3 Months	2023-24 12 Months
Staff Costs	40,000	160,000
Fuel Costs	1,500	6,000
IT Costs	1,030	120
Total	42,530	166,120

Ongoing funding was not secured, and the service ceased at the end of December 2022. It is known that at least some of those supported at home via the overnight service were subsequently admitted to hospital.

Step-up Beds

Pulteney House in was for many years the base for adult day care (delivered via Alzheimer Scotland). When this closed several years ago the area of the building became redundant. Via funding from Highland Council (owners of the building) it has been possible to develop this space to provide two ensuite rooms, a living room and kitchen area to be used as "step-up" beds. The purpose of which will be to avoid non-acute hospital admissions. Admissions will be for a short (approx. 72 hour) assessment by the MDT and will support the work of the Decision-Making Team (daily meeting). Work is ongoing to identify staffing requirements for the home directly.

Community Engagement

Community Planning Partnership (CPP)

The Caithness CPP is a strong active group which is chaired by HIE colleagues and meets on a quarterly basis. Sub-Groups are in place who meet on a more regular basis and are responsible for taking forward actions.

Independent Sector

Regular meetings take place with Care at Home Independent Sector providers. Four weekly review meetings are in place which includes Contracts, along with weekly allocation meetings with our local team.

Regular meetings also take place with the independent care home providers in Caithness, these are held between the DM and Contracts and incl. others as appropriate e.g., Social Work Team Manager

Highland Council
Informal meetings take place on a regular basis between reps of NHS Highland and Highland Councillors. At these meetings there is discussion re progress regarding redesign and an opportunity for councillors to question/feedback from local constituents.

The Ward Manager sits on the local Care for People Group.

Association of Community Councils
Quarterly meetings (Feb, May, Aug & Nov) of the Association of Community Councils are attended by the District Manager

Caithness Health Action Team (CHAT)
Meetings are held bi-monthly with representatives of NHS Highland (acute, primary and community divisions) and CHAT.

Enhancing Community Services
'Here for Caithness' pop-up hubs were first held in Spring of 2022. The fist was held in Wick and was followed by events in Thurso, Lybster and Halkirk. The 'Here for Caithness' is a series of community pop-up hubs which highlight all the ways in which the community can help its population. Colleagues from NHS Highland, other organisations and 3rd Sector representatives attend to help the local community in Caithness understand what community led support is available to them from the various community groups that exist locally.

We aim to enable people to explore the wide range of options and services available to them in their community. These are drop-in events which will allow people to come along at a time and chat to those in attendance. This allows us to highlight all the different ranges of support available, not only from organisations such as the NHS or Council, but also voluntary groups who can also provide support and advice.
The events have been advertised via NHS Highland social media accounts, the general practice and by the local community groups and organisations involved. The community pop up hubs are part of the Community Led Support project, which was part of a Scottish Government initiative for which Caithness has been designated as a pilot site.

Dates for 2023 have been set and will be advertised widely

Other
As part of the ongoing work around communication and engagement for the Redesign a "diary of activities" and events is kept and a schedule of meetings to attend an update on. These includes woman's health group, community events and agricultural shows.

Completed by: Christian Nicolson Date: 21/02/2023

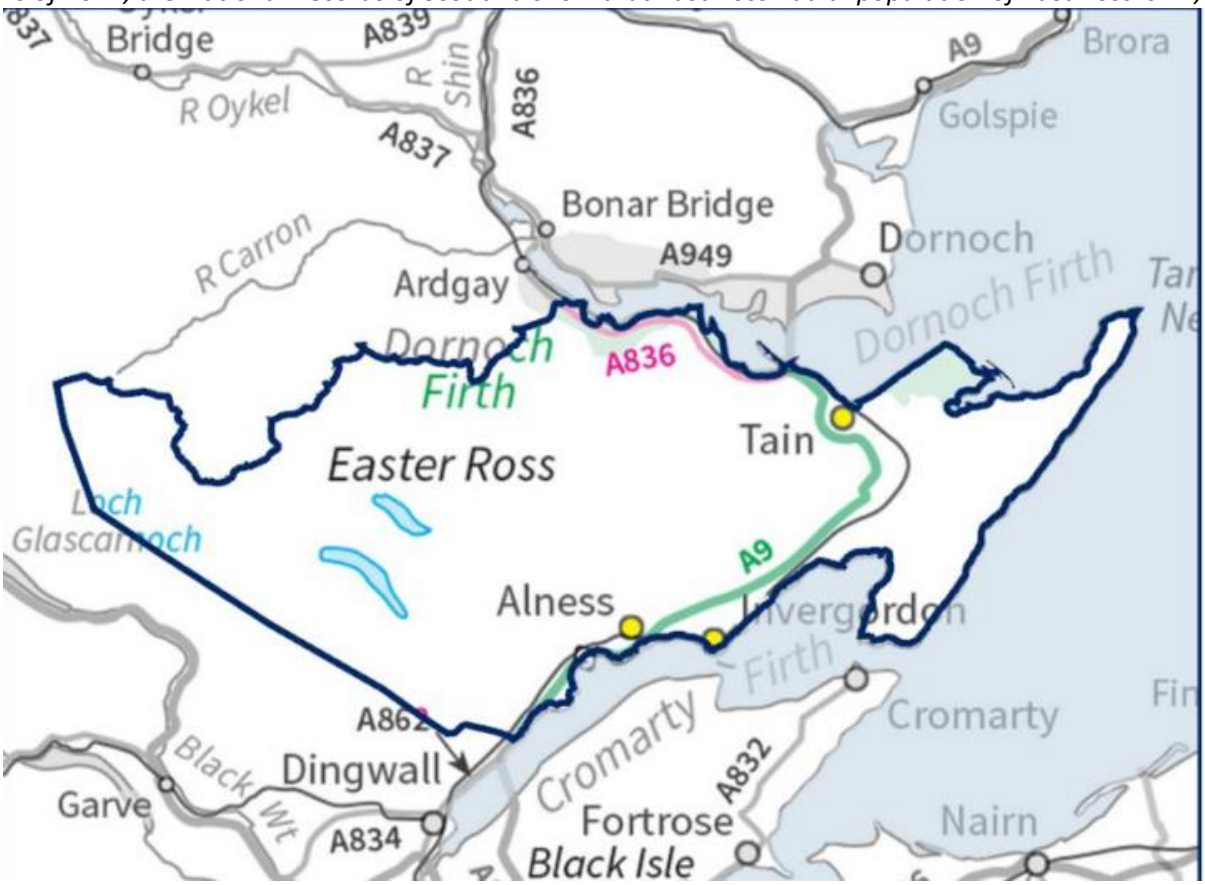
District Profile

District: East Ross

Manager: Kate Kenmure

Locality Demographics

As of 2021, the National Records of Scotland show that East Ross had a population of East Ross is 22,258.

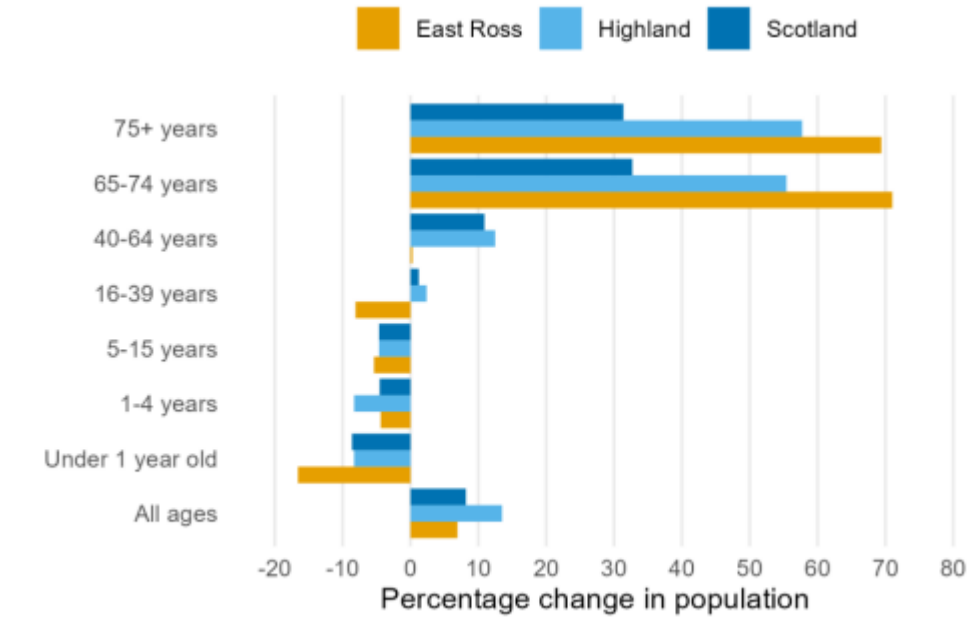


Current estimated population by age group,2021

Age Band	East Ross	Highland	Scotland
All ages	22,258	238,060	5,479,900
Under 1 year old	176	1,842	46,782
1-4 years	935	8,321	208,655
5-15 years	2,937	27,967	656,085
16-39 years	5,638	61,405	1,671,841
40-64 years	7,335	83,301	1,822,676
65-74 years	2,962	30,598	595,578
75+ years	2,275	24,626	478,283
85+ years	604	6,691	131,309
0-15 years	4,048	38,130	911,522
16-64 years	12,973	144,706	3,494,517
65+ years	5,237	55,224	1,073,861

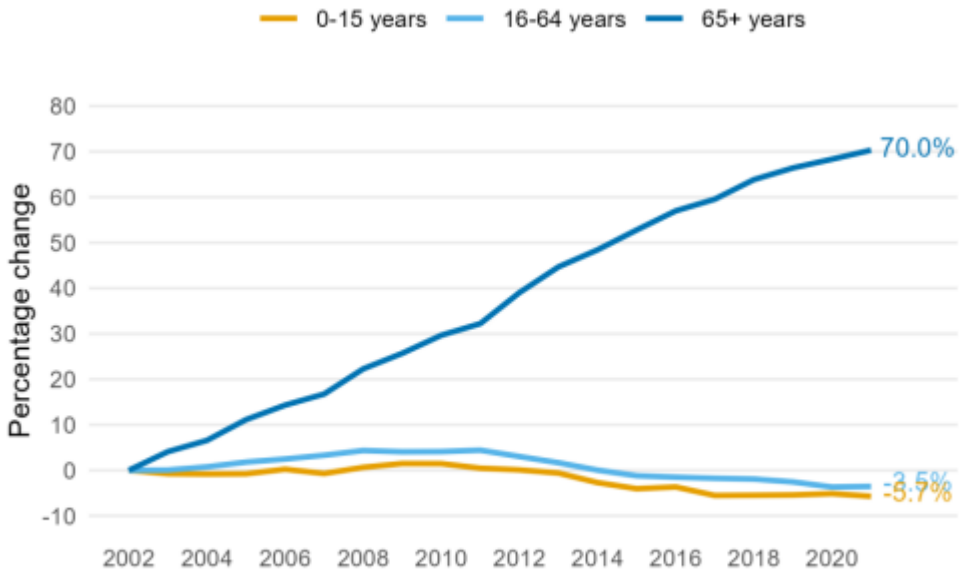
Source: National Records of Scotland, Small Area Population Estimates 2021

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



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

East Ross: Percentage change in the population by broad age group

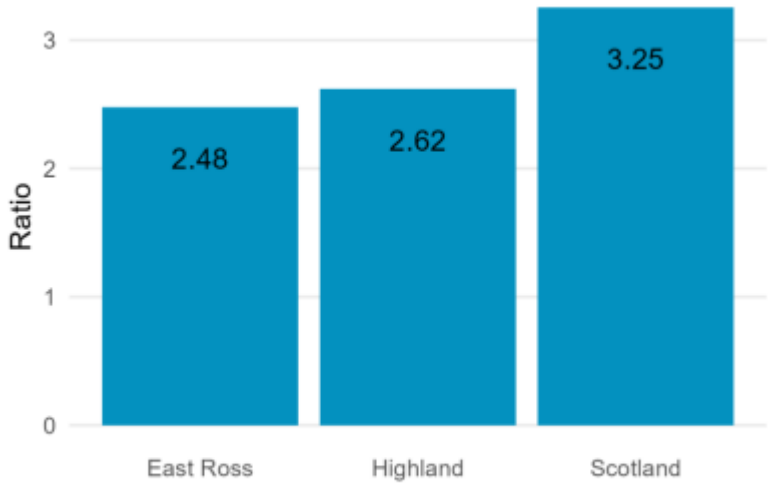


Source: National Records of Scotland, Small Area Population Estimates 2021

The latest available population projections estimate that the overall population of East Ross will decrease between 2018 and 2030.

The number and proportion of people in the 75-84 and 85+ age groups are projected to increase, whereas the population in all other age groups are projected to decrease.

People of working age (16-64 years) for every person 65 years and older 2021



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

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

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

Common long-term conditions include cardiovascular diseases, cancers, neurological disorders, mental health disorders and musculoskeletal disorders5 .The prevalence of many conditions and the number of people with frailty will likely increase as the number of older people increases. Rates of cancer registrations have remained relatively constant, indicating earlier diagnosis and treatment may have driven previous improvements in premature deaths from cancer. Hospitalisations due to coronary heart disease (CHD) show decreases over time. Chronic obstructive pulmonary disease (COPD) rates have fallen in recent years. Both remain significant causes of poor health.

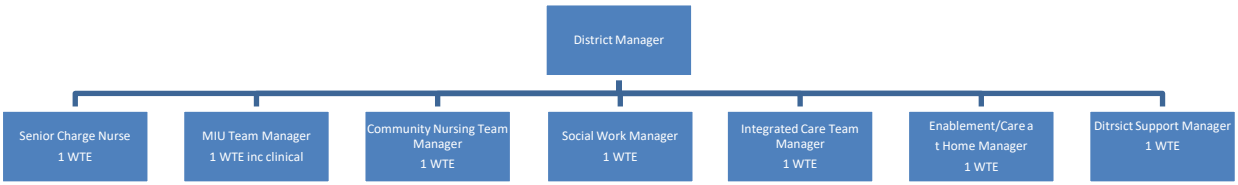
Services provided and current workforce

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

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

Podiatry, X-ray, CMHT, drug & alcohol recovery service, pharmacy, dental, midwifery and the general practice, whilst also based in the hospital are managed outwith the district management structure.

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



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

	Mon-Fri	Sat/Sun	Team Establishment		Issues
			Qualified WTE	Unqualified WTE	
Ward	24 hour	24 hour	22.47	21.88	Staffing remains the main issue with 5 WTE RN posts slow to fill. GP cover following the end of the SLA has still to be resolved with Consultant and ANP cover stable at present

Minor Injury Unit	0800-1800 (1800-0800 – OOH Service)	Reverts to OOH service	1.61	0.0	MIU staffed by ANPs – no cover in the budget for AL and sickness which is mainly cross cover by ANPs in OOH
Community Nursing	08.30-16.30	08.30-16.30 Reduced Staffing	11.82	2.32	Experienced B6 retiring later this year, returning to a B5 post. I HCSW retiring Feb24. No additional funding for ITR and treatment room run from 2 bases – Tain & Invergordon Recent vacancy was out to advert 3 times before successfully recruited
Out of Hours	1800-0800	24 Hours	10.06	5.66	This service will be part of the OOH redesign and at present is East and Mid Ross service covered by a combination of GPs and ANPs. There has been increasing demand on this service over the a number of years
Enablement Team	08.00-21.00	08.00-21.00 Reduced Staffing(no manager/scheduler)	2.0	21.62	1.68 WTE vacancies with recruitment. Continuing to support ISP packages. Plans in place for contingencies
Social Work	09.00-17.00	Covered by OOH Social Work team	9.8	1.6	1 WTE qualified social worker on maternity leave, 1 PT (28 hours) unqualified on maternity leave and 1 WTE HCSW on long term leave.
Occupational Therapy	08.30-16.30	Unavailable	4.66	2.36	0.6 WTE B6 on maternity leave, not covered. Sutor ward staffed by one band 5 OT only.
Physiotherapy	08.30-16.30	Unavailable	3.52	1.93	0.6 WTE B6 maternity leave not covered. 1 WTE B5 advertised x3. No suitable applicants
Admin/Portering	08.30-17.00	Reduced staffing		9.91	Supporting ITR clinics takes up significant resource.

Services Provided

Ward

Sutor Ward is a 28 bed inpatient ward overseen by a Senior Charge Nurse. The ward plays a key role in ensuring community flow with the beds full the majority of the time (graph highlighted further below). The service provides rehabilitation and end of life care, with admissions generally coming directly from Raigmore. Community admissions can be accepted if agreed by DMT. The ward is

covered by an ANP Monday - Friday with some daily support from GP. There is a weekly consultant led ward round, generally led by Dr Martin Wilson, Consultant Physician. Qualified nursing staffing regularly runs below WFP requirements and B5 shifts filled where possible with a B2/3. It is a regular occurrence for the ward to be short of a B5 as a result of uncovered elements of maternity leave and short term sickness/COVID.

MIU

MIU is ANP led with a receptionist. This cover is from 8am-6pm Monday to Friday. On Mon, Tues, Wed and Thursday they also have the support and resource of a reporting radiographer from 09:30-13:00. The ANP works autonomously and is MIU trained. They see, treat and discharge. MIU calls are directed to the department from the Highland HUB via flow navigation if staffed. On occasion there are walk-in patients, but all patients are advised to call 111 to be seen.

Out of Hours

OOHs runs from Monday to Friday 18:00-08:00 hours and then Saturday and Sunday24/7. Monday to Friday the cover may be by GP or ANP. There are two clinicians between the hours of 21:00-12midnight and outwith these hours there is one clinician and a driver. On Saturdays and Sundays there is a combination of GPs and ANPs on a variety of shifts but again after 12midnight the department is covered by a single clinician and driver.

OOHs cares for over 80,000 patients, covering a large geographical area spanning from Edderton to the start of Achnasheen and half of the Black Isle. We see all presentations of illness and deal with advice calls, palliative care calls, FNC calls, Home visits and appointments.

Community Nursing

The Community Nursing team provides preventative, reactive and maintenance clinical care to patients in the community. The elderly age profile and care homes in the area are above average. The team leads on End of life Care and are well above the national average supporting patients to die at home. There has been a real shift from secondary care to the community to provide high end complex clinical care. This impacts on team resource to provide care and also training to upskill on new procedures.

Ongoing workforce planning evidences the increased complexity and dependency of client group requiring the knowledge and skills of three band 6 nurses. Services requires to be reactive with minimal opportunity for any waiting lists. The aim is to avoid hospital and care home admissions and expedite timely discharges.

We provide a community nurse lead treatment room In Tain Health Centre not provided by practice nurse services. Patients are seen close to home, avoiding the need to attend secondary care.

Two Investigation and **T**reatment **R**oom services (**ITR)** is covered by the community nursing team in Tain and Invergordon. Both ITR clinics run from 0900-1300 Monday - Friday Clinician AL, absence etc is not resourced leaving extra pressure on community team and other services. There is a small budget for ITR administrator support but no funding for nursing staff.

The number of patient facing visits and palliative/EOL care has doubled since pre covid increasing pressure on current staffing resources.

Physiotherapy

The physiotherapy service covers various aspects of clinical service delivery. It includes inpatient rehabilitation to the 28 bed unit, cardiac rehabilitation and pulmonary rehabilitation, falls and frailty intervention, community rehabilitation and neurological rehabilitation. Service is currently provided by part time clinical specialist physiotherapist, 3 part time qualified staff and 2 part time non registered staff.

The physiotherapy service in East Ross has been under established for some time and red on RAG rating for both staffing and service delivery for well over a year. Recruitment to vacant posts has been extremely challenging and no new staff has been able to be recruited for around 18 months due to a lack of relevant applications. However, even if the department was fully staffed to its current establishment, the service would not be covered safely. Despite establishment setting work highlighting the need for a number of additional staff, no resource has been provided for this leading to increased pressure on staff and their own well being as well as growing waiting lists.

Staffing establishment:

B7 0.6 wte
B6 0.6 wte - on maternity leave and not covered
B6 0.8 wte
B6 0.72 wte
B5 1 wte - advertised x 3 times as either this post or 0.8 wte B6 but no suitable candidates applied on any occassion.
B4 - 0.45 wte
B3 - 0.6 wte

Occupational Therapy

The number of referrals for Occupational Therapy in East Ross is extremely high and the waiting list is consistently over a year for some people.

OT staffing in other districts appears to be more fairly distributed and East Ross has been under established for years. At present, the 28 bedded unit which includes a number of complex cases, is staffed by a Band 5 only. There is no support staff who can be allocated to the ward due to demands in the community and although Band 6 staff support where they can, they are also needed in the community. The risk is huge and the staff are increasingly finding that they are unable to provide rehabilitation due to lack of resource. The AHP lead has moved into the Integrated Team Manager role but previously had some clinical responsibility as an OT. This was never replaced so the team are short of this also.

Establishment for East Ross OT is as follows:

B6 - 1 wte
B6 - 1 wte
B6 - 0.8 wte - on maternity leave and unable to appoint a replacement
B5 - 1 wte
B4 - 1 wte
B4 - 1 wte
B4 - 0.6 wte

Enablement/Care at Home Team

The team currently has 2x31.5h vacancies. We recently took back inhouse a number of packages due to withdrawal of a support provider from the Invergordon and Barbaraville area. We have submitted a business plan to develop a care and support team which will

be separate from our enablement team - awaiting outcome to start recruitment. We have seen a large increase in EOL referrals which can have an impact on our ability to respond quickly to re-ablement support packages.

Social Work

The Social Work Team currently consists of 13 staff with 2 staff on maternity leave-1 FT social worker and 1 PT RAO (28 hours). We have recruited a FT 14 month SWAP to provide maternity cover. We have one FT SW vacancy and as we have been unable to recruit, we are now recruiting a trainee. We have a HCSW who is on long term sick leave and this post was funded for 12 months as a pilot scheme due to end on 19.01.24.

We have 71 Guardianships currently with 34 of these being LA which require an allocated social worker to act in the role of welfare guardian. 37 private guardianships require annual supervision by a qualified social worker. It is anticipated this number will increase due to the local demographic of an ageing population and complexities associated with profound learning and physical disability. There are high numbers of ASP inquiries.
East Ross has 5 care homes housing 191 beds. The recent loss of a 36 bed nursing home has had significant impact on patient flow.
The Team promote the SDS options available to support people and utilise Option 1 wherever possible. However within the East Ross area there are ongoing recruitment and retention difficulties in all sectors of adult social care including personal assistants (self directed support option 1) and housing support.

Independent sector care homes within East Ross housing 151 beds

No of Care Homes	Client Group	No of Beds
4	Older People	163
1	Mental Health	28

General Practices

East Ross has 3 general practices, Tain & Fearn, Tain & District and Alness & Invergordon, providing care for all of the population. The local GPs work closely alongside the hospital services linking in with the integrated team, inpatient ward, Minor Injury Unit/PCEC and all other services within the building.

Integrated Working/Complexity within the District

The teams provide integrated services to a population of approximately 22,000, the majority of whom, but not all, are registered with the local general practices. An ever increasing complexity of care is required, and whilst we as far as possible aim to ensure the Home First principles are embedded, and implement the recommendations in the NHSH Enhancing Community Health and Care Model, this is challenging within our current resource and taking in to account our geography.

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

Teams are linking to ensure our vulnerable people list is updated on an ongoing basis and

that ACPs and personal contingency plans are in place for everyone included on the list.

We work very closely with our local GP colleagues linking in around palliative and end of life care along with routine core services. Dying at home remains the first choice for the majority of patients who are coming to the end of life. East Ross has a high proportion of elderly population, and the community caseload is complex with workload continuing to increase.

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

The hospital also provides outpatient clinics as detailed below:

CMHT	Diabetic Retinopathy	Podiatry
Physiotherapy	X-ray	Alzheimers
Psychiatry	Pain Management	Cardiac/Heart Failure
Diabetes	Ultrasound	Retinal Screening
Older Adult	Highland Hospice	MS
Childrens Services	Paediatrics	SLT
Dietetics/Weight Management	Epilepsy	Learning Disability
Midwifery	Psychology	Parkinsons Disease
Viral Hepatitis	Sexual Health	Deaf Services

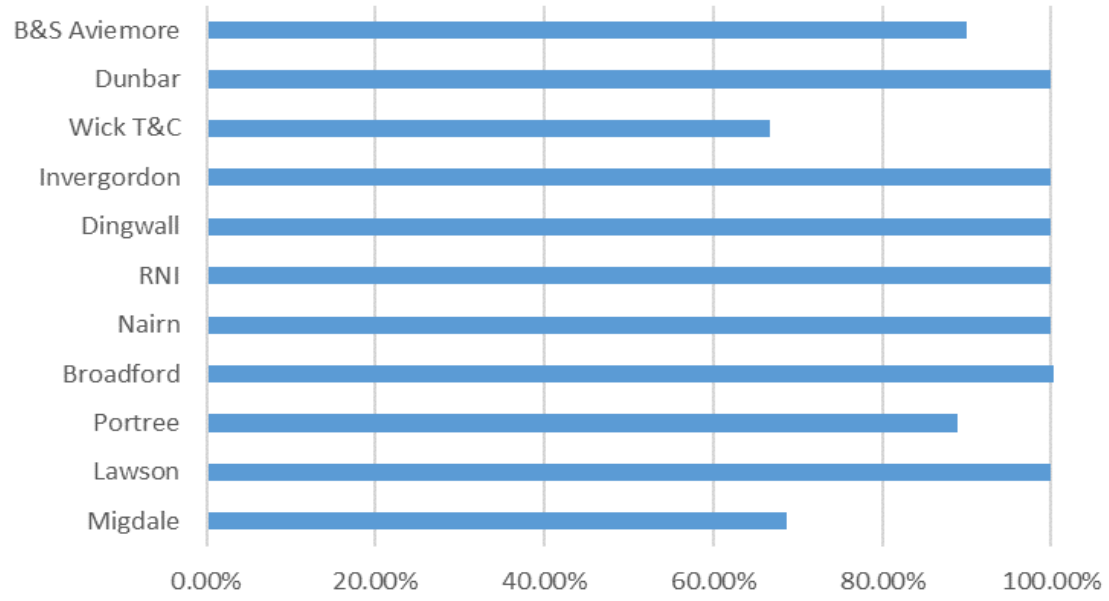
With the rollout of the Primary Care Modernisation as detailed in the GP contract we are seeing pressure on availability of both clinic and administration space as we have the additional need for pharmacotherapy, First Contact Practitioner, Primary Care Mental Health Services and Community Link Worker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

Finance & Performance

Finance

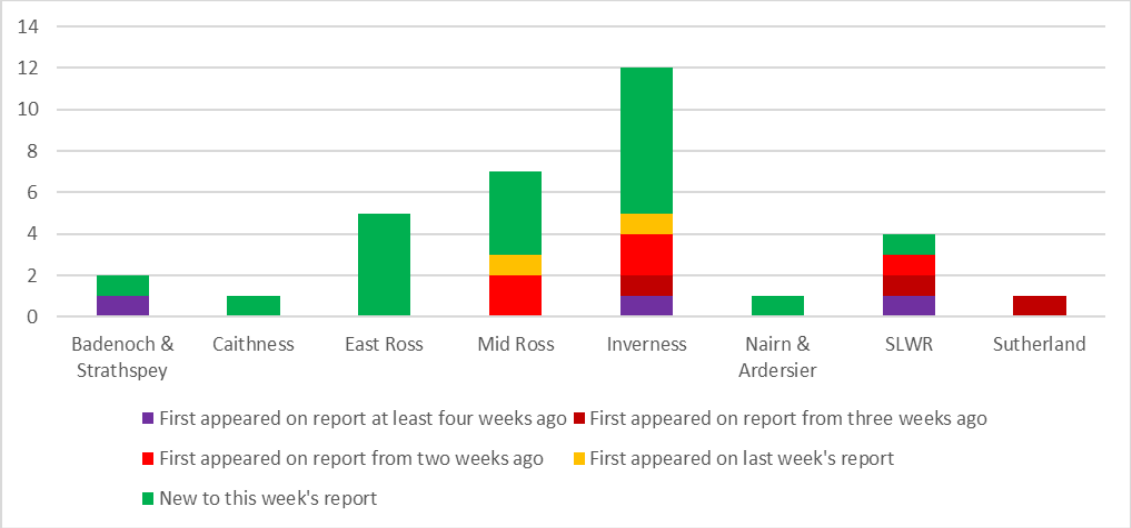
The budget for 22/23 for the District is c£21m. At the time of writing the projected year end is being forecasted at a £0.578m overspend. This overspend can be broken down into Health £0.173m and ASC £0.405m. The Health year end variance mainly relates to unfunded posts within the OT, Admin, community nursing and Integrated care budgets.

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



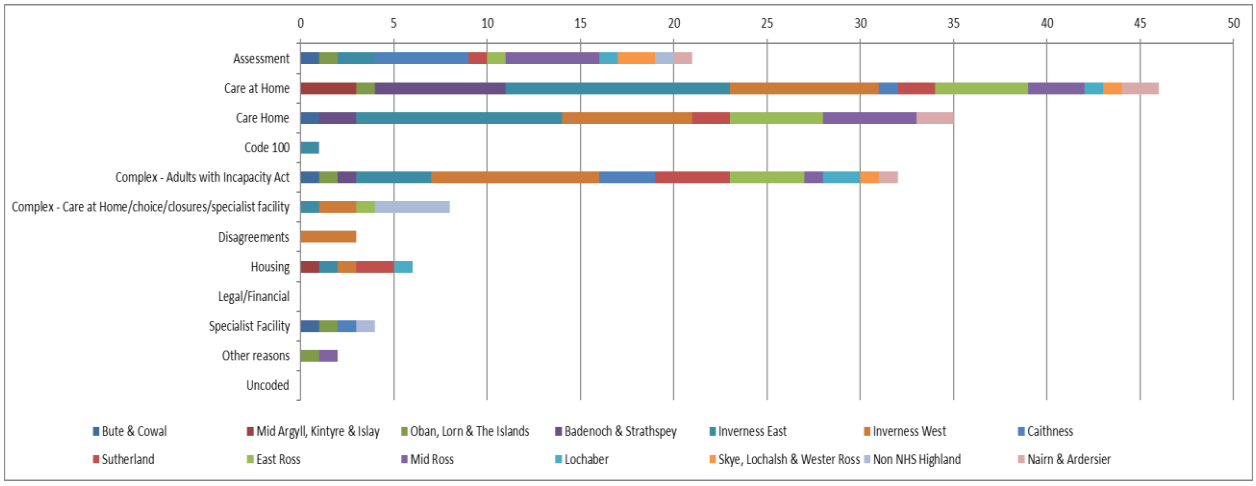
The hospital runs at capacity 100% of the time.

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



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

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



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

Unmet Need Hours by Locality

EAST ROSS CARE AT HOME 18/08/2023		
	No. of Clients	Total Hours
Enablement Referrals	4	35.25
Awaiting Transfer to Mainstream (receiving in-house C@	20	155.05
Triaged to Mainstream (unmet)	32	291.28
Totals	**56**	**481.58**
Current enablement Clients	9	76.99

	Hospital		Community	
	No of Clients	Total Hours	No of Clients	Total Hours
Enablement Referrals	0		4	35.25
Awaiting Transfer to Mainstream	N/A	N/A	20	155.05
Triaged to Mainstream	5		27	34.83
Totals	**5**	**0**	**51**	**225.13**

Mainstream DHD Total Hours	**43.16**
Reablement DHD Total Hours	**0**
Total DHD Hours	**43.16**

Despite the withdrawal of Providers from East Ross described further below in this report, The District has managed to maintain a level of control of the unmet need and plans are in

place to improve the unmet need, and allow for contingencies should further providers reduce or withdraw their services.

Opportunities and Developments

The District is compact and services are contained within 2 facilities (Invergordon Hospital and Tain Health Centre). This allows for close working relationships within the Integrated Team. There are opportunities to work across professional boundaries for the wellbeing and support of complex and frail patients.

The withdrawal of indEpendant providers has afforded us the opportunity to realign our care at home provision and refocus our enablement service to support early discharge and possibly Discharge to Assess.

Financial constraints in this and coming years will possibly slow the progress of redesign and this will be an ongoing challenge.

ITR and CTAC services will be a priority development this year given the increase in demand and the benefits to individual patients to getting this service close to home.

Community Engagement

Links to the CPP and the CC are being forged at this time but have been neglected and non functioning for some time. This is being rectified and hopefully will be reinvigorated in the near future.

Completed by: Kate Kenmure Date: 21/8/2023

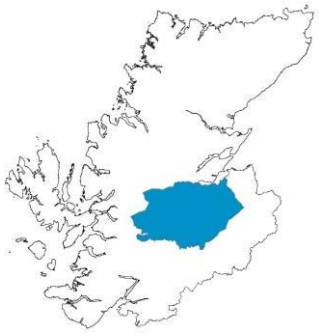
District Profile

District: **Inverness**

Manager: **James Merriman**

Integrated Team Mangers: Janet Alexander/Linda Moir

Locality Demographics



HIGHLAND COMMUNITY PARTNERSHIP PROFILE

INVERNESS

POPULATION

Figure 1: Population pyramid 2015

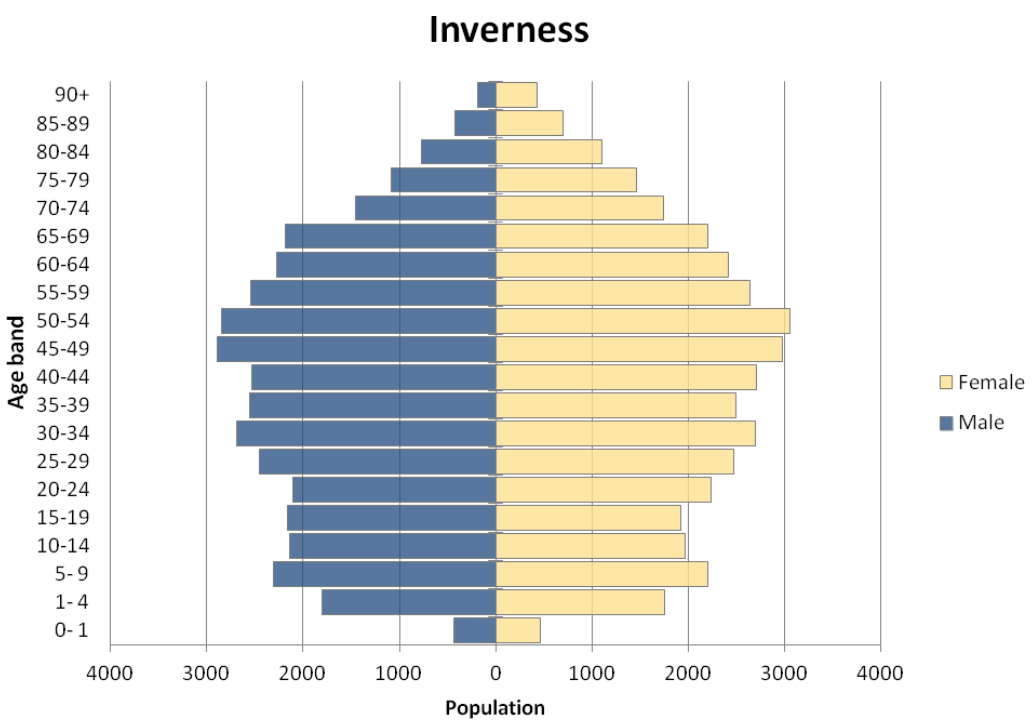


Figure 2: Population by age group 2015

Age group	Inverness		
	Male	Female	Persons
00-15	7,120	6,772	13,892
16-29	6,279	6,238	12,517
30-44	7,766	7,899	15,665
45-59	8,266	8,664	16,930
60-74	5,909	6,356	12,265
75-84	1,855	2,571	4,426
85+	609	1,139	1,748
Total	**37,804**	**39,639**	**77,443**

Data source: National Records of Scotland 2015 Small Area Population Estimates (SAPE). Best fit of data zone to Highland

Figure 3: Percentage of population by age group

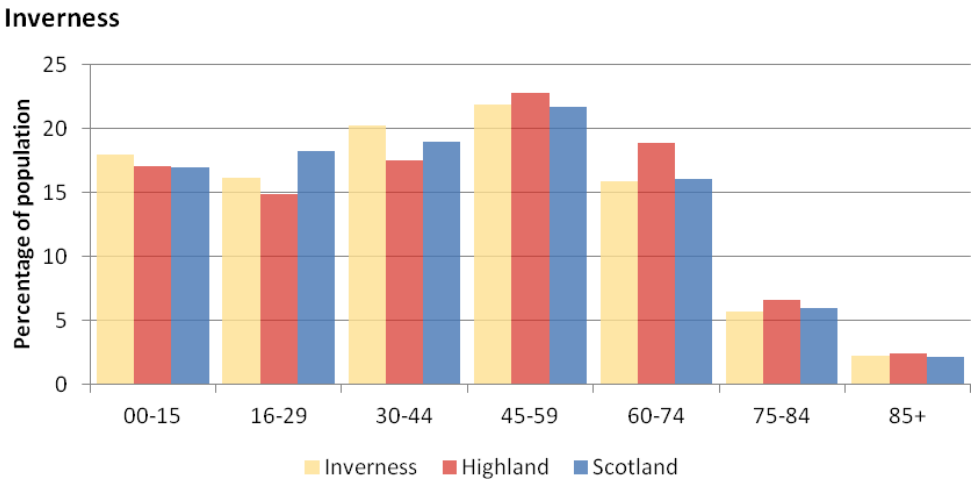


Figure 4: Percentage of population by age group

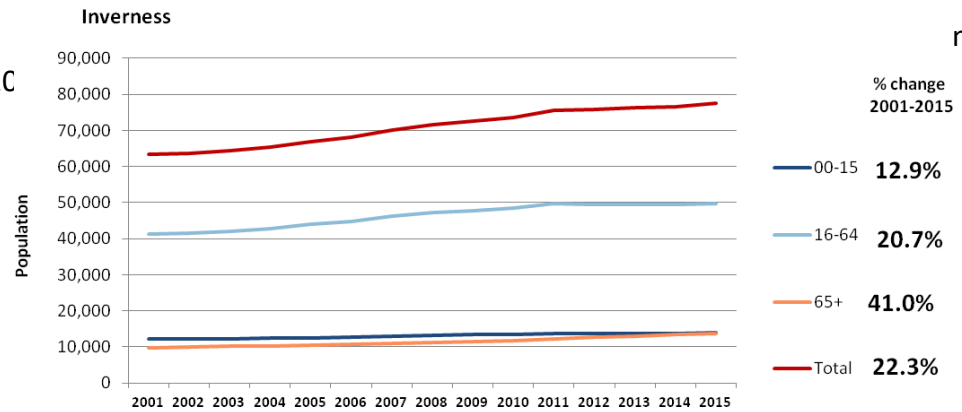
Age group	Inverness			Highland	Scotland
	Male	Female	Persons	Persons	
00-15	18.8	17.1	17.9	17.1	17.0
16-29	16.6	15.7	16.2	14.8	18.2
30-44	20.5	19.9	20.2	17.5	18.9
45-59	21.9	21.9	21.9	22.7	21.7
60-74	15.6	16.0	15.8	18.8	16.0
75-84	4.9	6.5	5.7	6.6	6.0
85+	1.6	2.9	2.3	2.4	2.2
Total	**37,804**	**39,639**	**77,443**	**234,110**	**5,373,000**

Data source: National Records of Scotland 2015 Small Area Population Estimates (SAPE). Best fit of data zone to Highland Community Partnership

POPULATION CHANGE OVER TIME

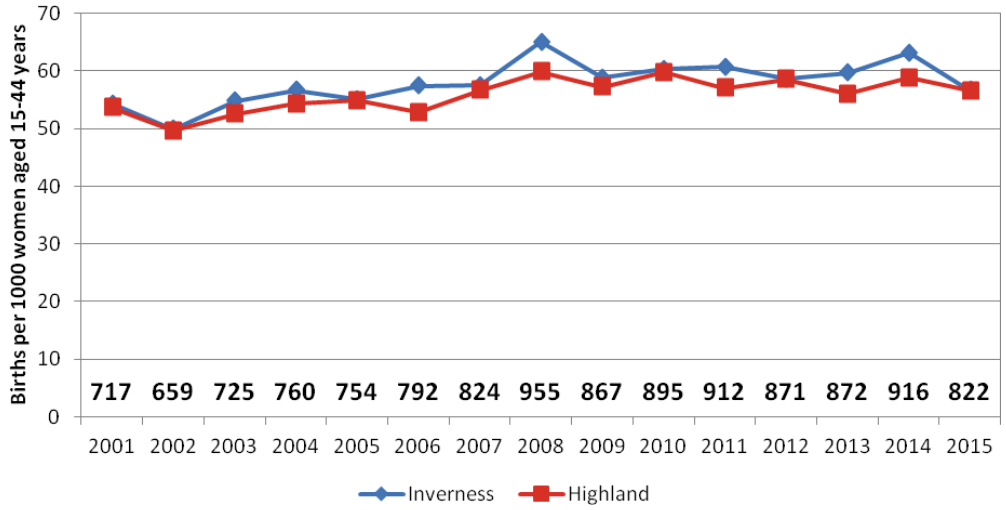
Figure 5: Population over time

Data mates (SAPE). Best fit of data zones 20



BIRTH TRENDS

Figure 10: Number of births and fertility rate per women aged 15-44 years

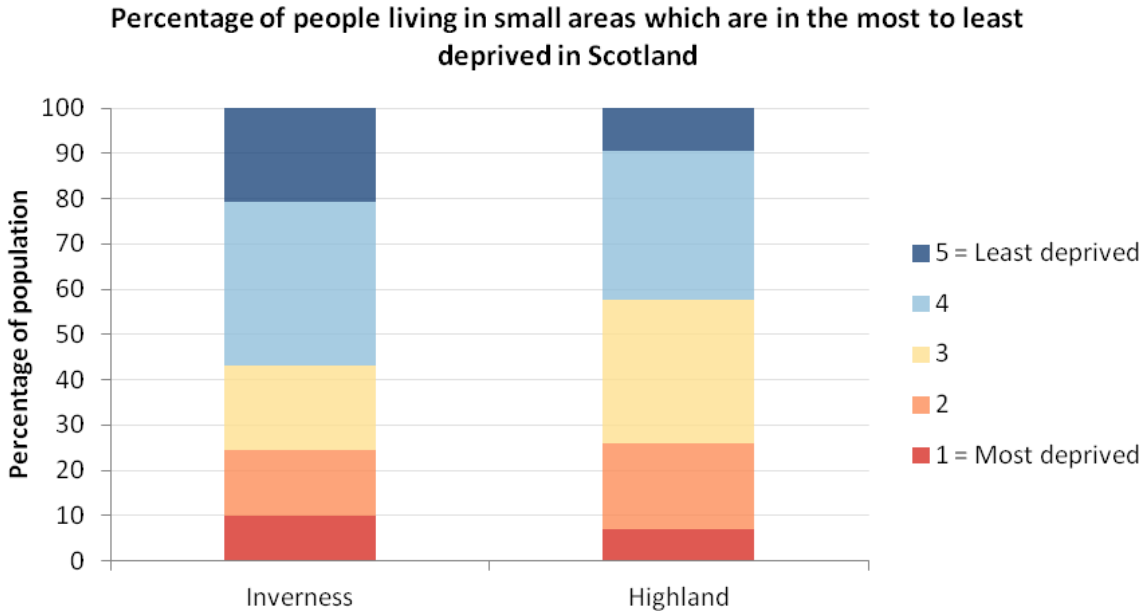


Number of births annually shown above the x-axis.

Data source: NRS vital event recording and NRS Small Area Population Estimates (SAPEs). Based upon best fit between data zones 2001 and 2011 and Community Partnership areas

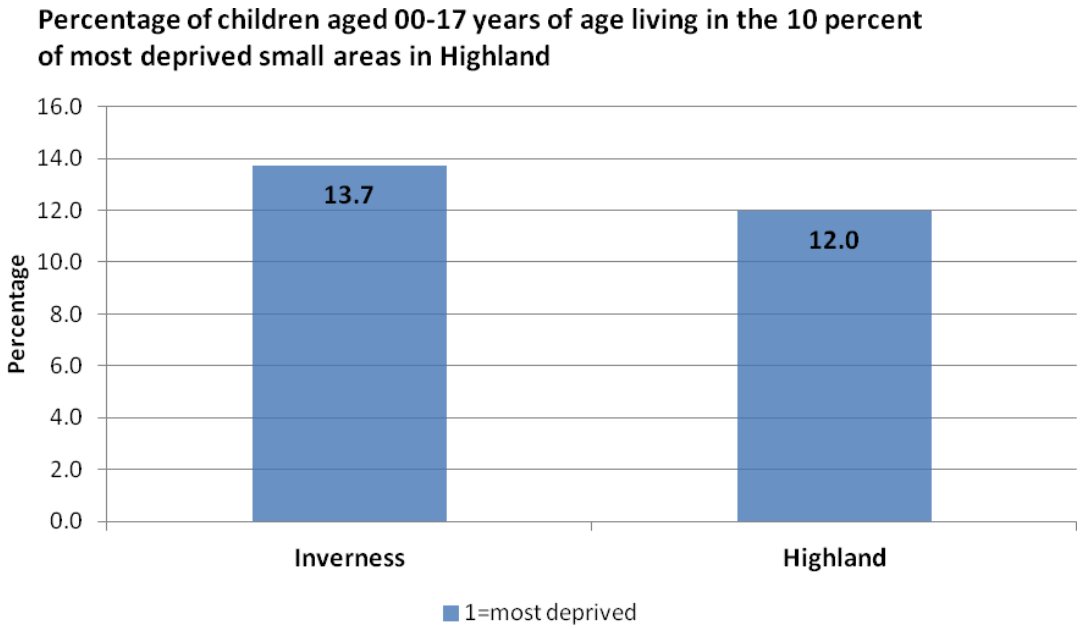
DEPRIVATION

Figure 11: Scottish Index of Multiple Deprivation 2016



Data source: National Records of Scotland 2015 Small Area Population Estimates (SAPE) and Scottish Index of Multiple Deprivation (2016) Best fit of data zone (2011) to Highland Community Partnership

Figure 12: Children living in the most deprived areas in Highland

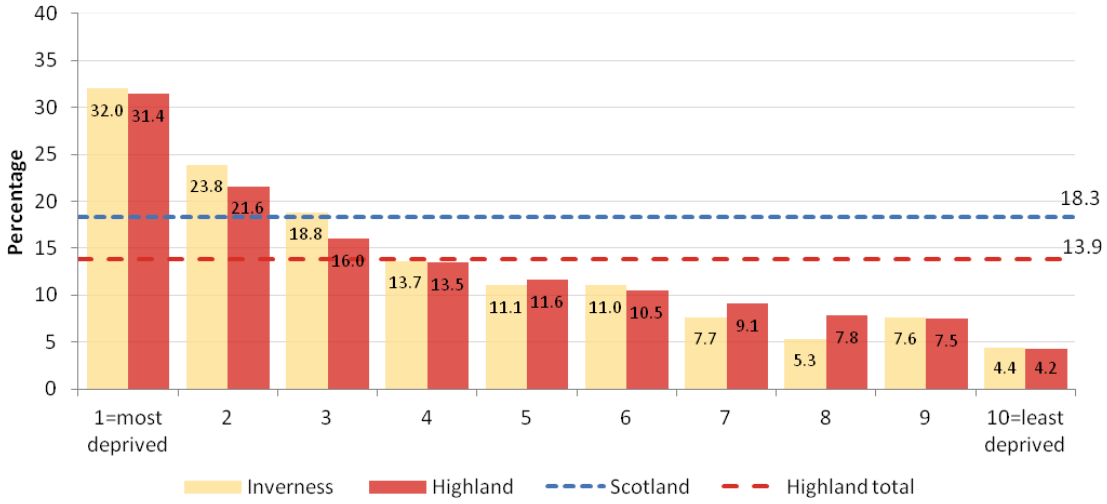


Data source: National Records of Scotland 2015 Small Area Population Estimates (SAPE) and Scottish Index of Multiple Deprivation (2016) Best fit of data zone (2011) to Highland Community Partnership

DEPENDENT CHILDREN LIVING IN POVERTY

Figure 13: Estimated number and percentage of children under 20 years of age living in poverty defined by tax credit receipt and stratified by decile of deprivation within Highland

Children living in poverty - total number of dependent children aged under 20 years of age in families receiving



Child Tax Credits (<60 % median income) or Income. Data source: HMRC. Deciles of deprivation based upon SIMD 2016 within Highland Council distribution

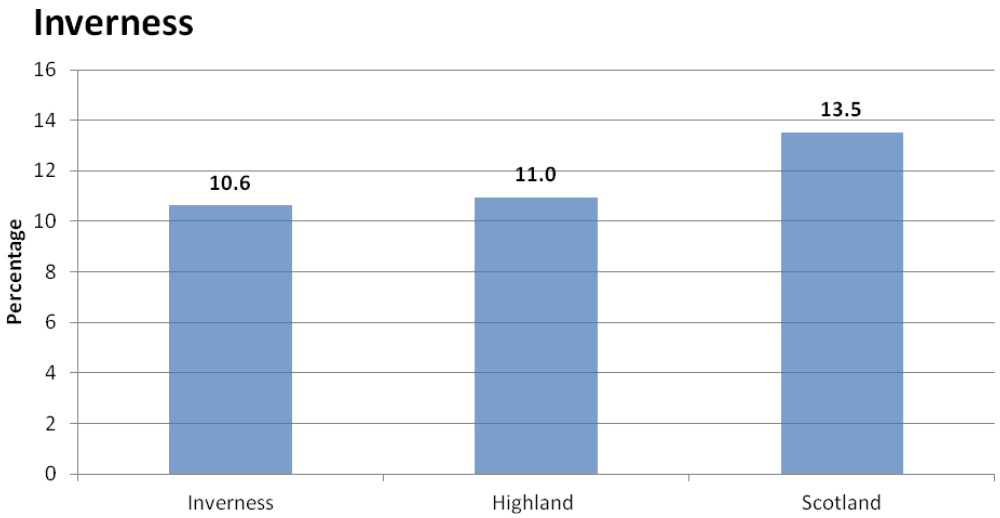
Figure 14: Number and percentage of children under 20 years of age living in poverty defined by tax credit receipt and stratified by decile of deprivation within Highland

	Estimated number and percentage of dependent children under 20 years of age in poverty by decile of deprivation in Inverness Community Partnership				Percentage of all children in Inverness in poverty
	Number of children	Percentage	lo 95% CI	up 95% CI	
1=most deprived	688	32.0	29.7	34.5	34.4
2	440	23.8	21.7	26.2	22.0
3	107	18.8	15.4	22.7	5.4
4	99	13.7	11.1	16.6	5.0
5	47	11.1	8.1	14.7	2.4
6	124	11.0	9.2	13.1	6.2
7	140	7.7	6.4	9.0	7.0
8	69	5.3	4.1	6.7	3.5
9	132	7.6	6.4	9.0	6.6
10=least deprived	152	4.4	3.7	5.2	7.6
total	1998	13.2	12.6	13.8	100

Children living in poverty - total number of dependent children aged under 20 years of age in families receiving Child Tax Credits (<60 % median income) or Income. Data source: HMRC. Deciles of deprivation based upon SIMD 2016 within Highland Council distribution

ADULT POPULATION IN RECEIPT OF OUT OF WORK BENEFITS

Figure 15: Percentage of the population in receipt of out of work benefits



Estimated number of Community Partnership working age population in receipt of benefit (May 2016) = 5195

Data source: DWP Small area statistics (Snapshot May 2016) – Working age population claiming out of work benefits includes claimants of key out of work benefits, not only jobseekers allowance (JSA). Each claimant is counted once. Population denominator NRS SAPE 2014

LIFE EXPECTANCY AT BIRTH

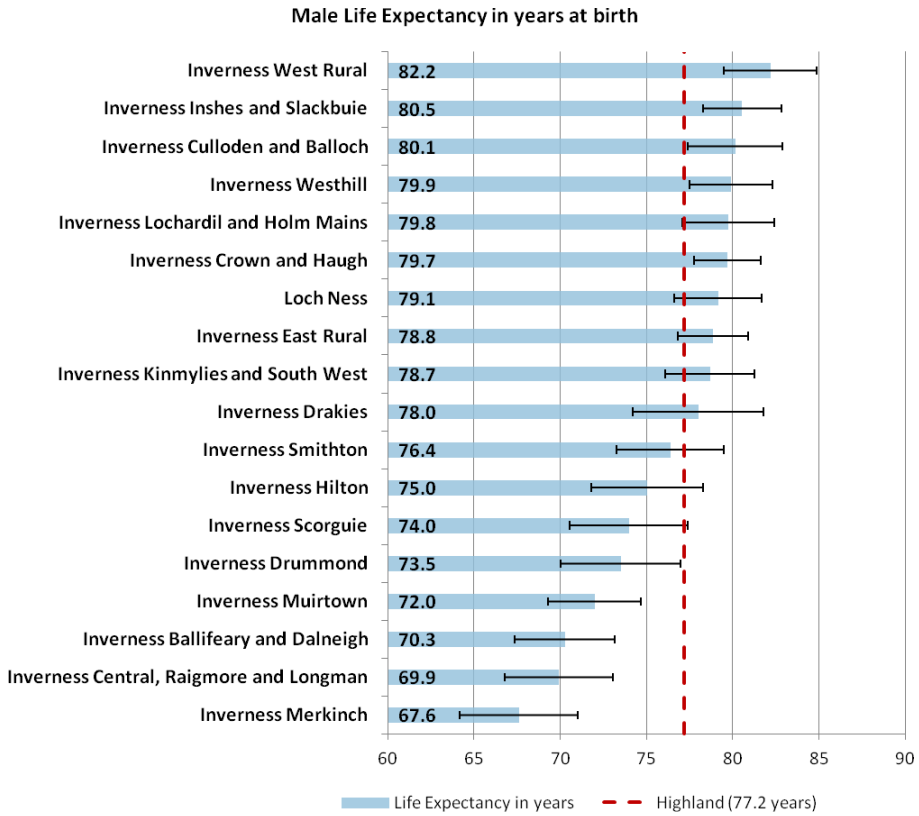
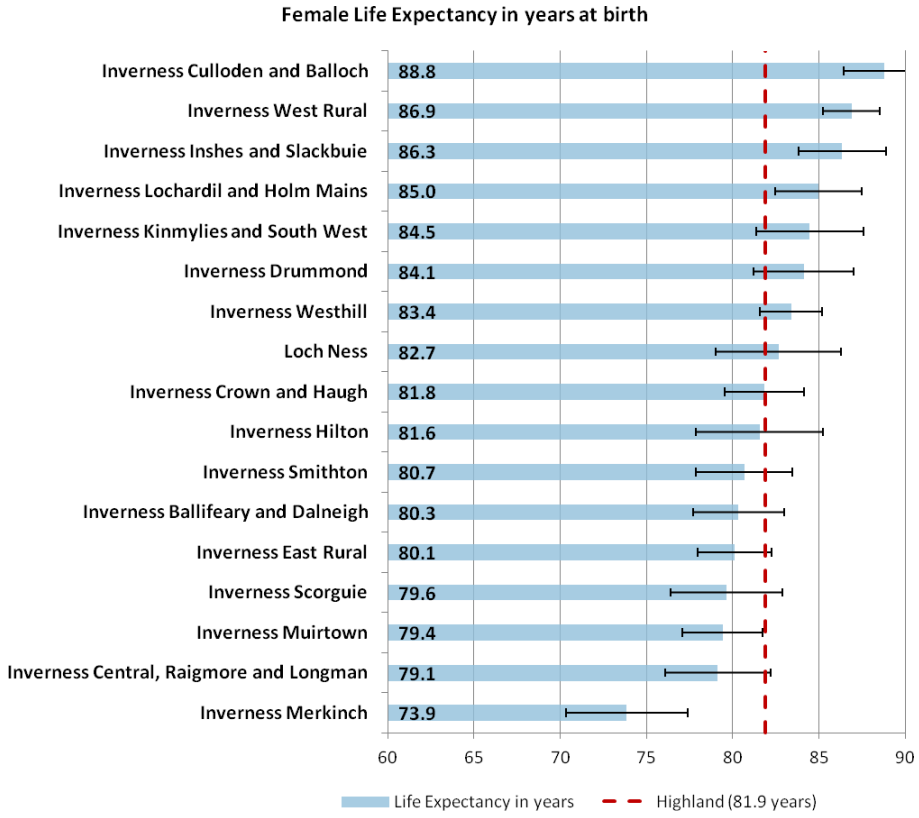


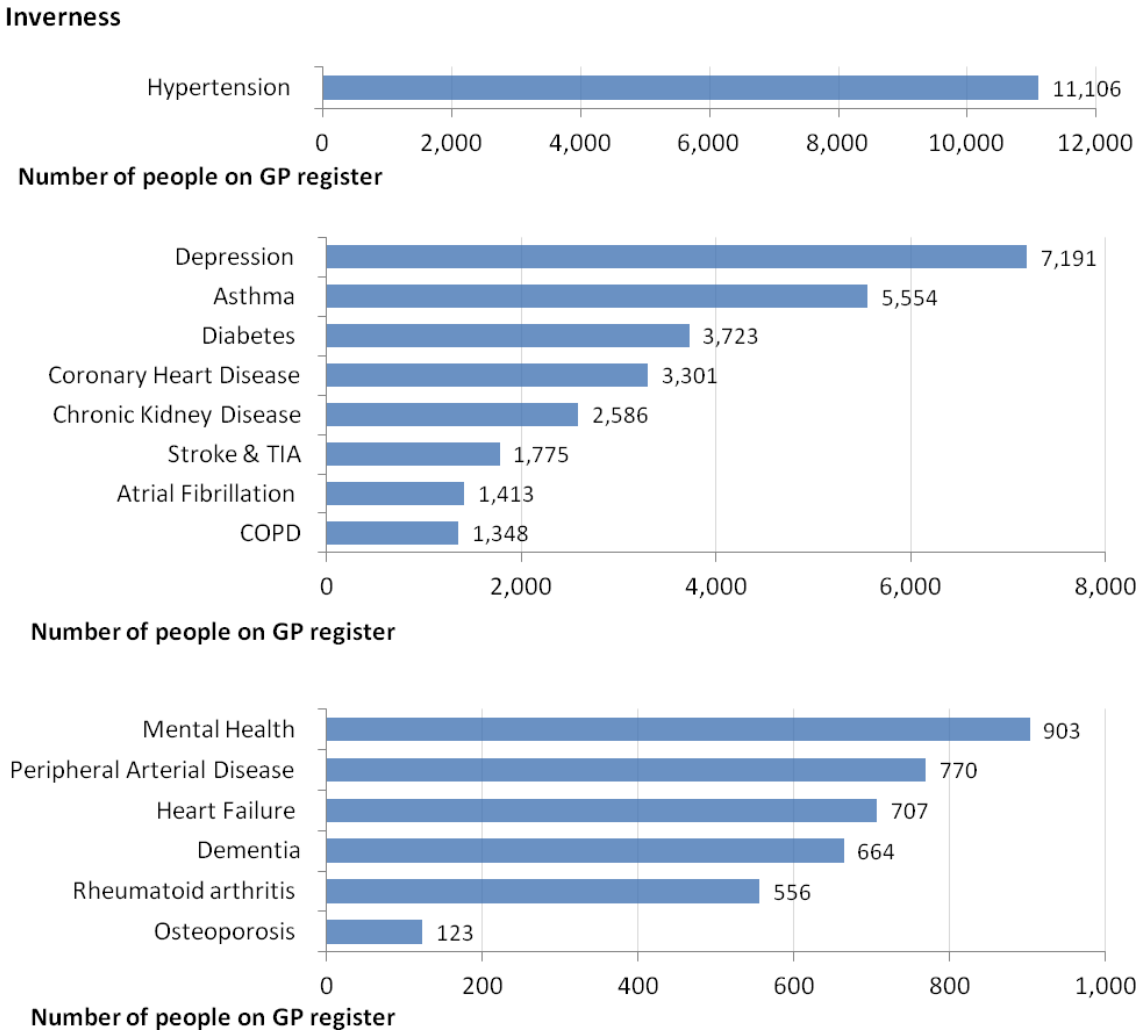
Figure 16: Inequalities in male and female life expectancy by Intermediate Geography (2009-2013)



Data source: ScotPHO Health and Wellbeing Profiles Data for the five year period 2009-2013.

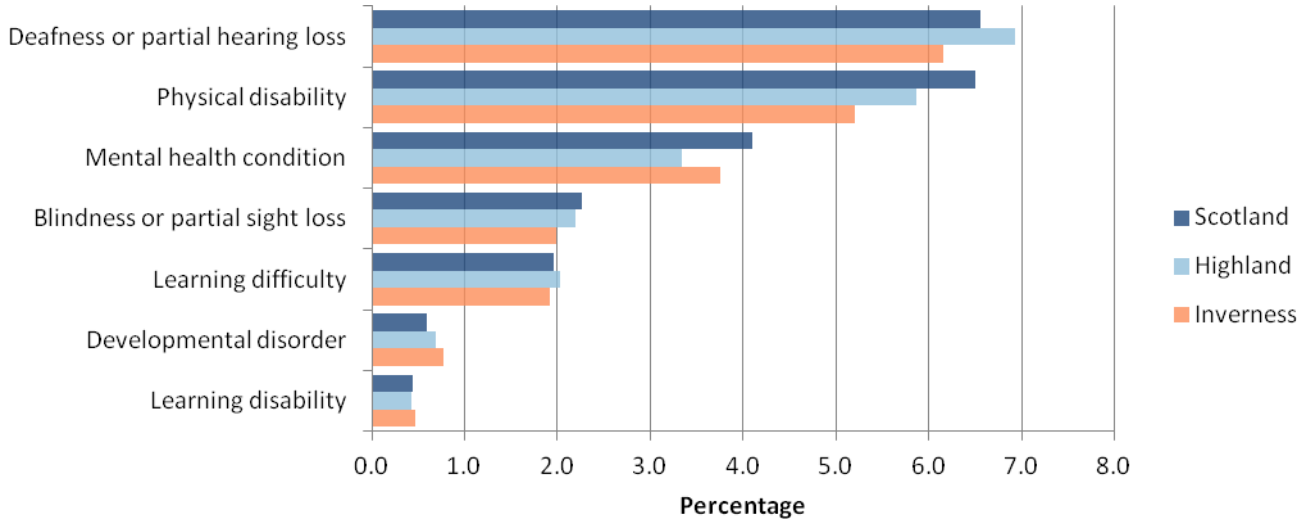
NUMBER OF PEOPLE WITH HEALTH CONDITIONS

Figure 17: Number of people with chronic disease



Data source: General Practice Quality & Outcomes Framework (QOF) for April 2015 - March 2016 – based upon reported practice prevalence within the Community

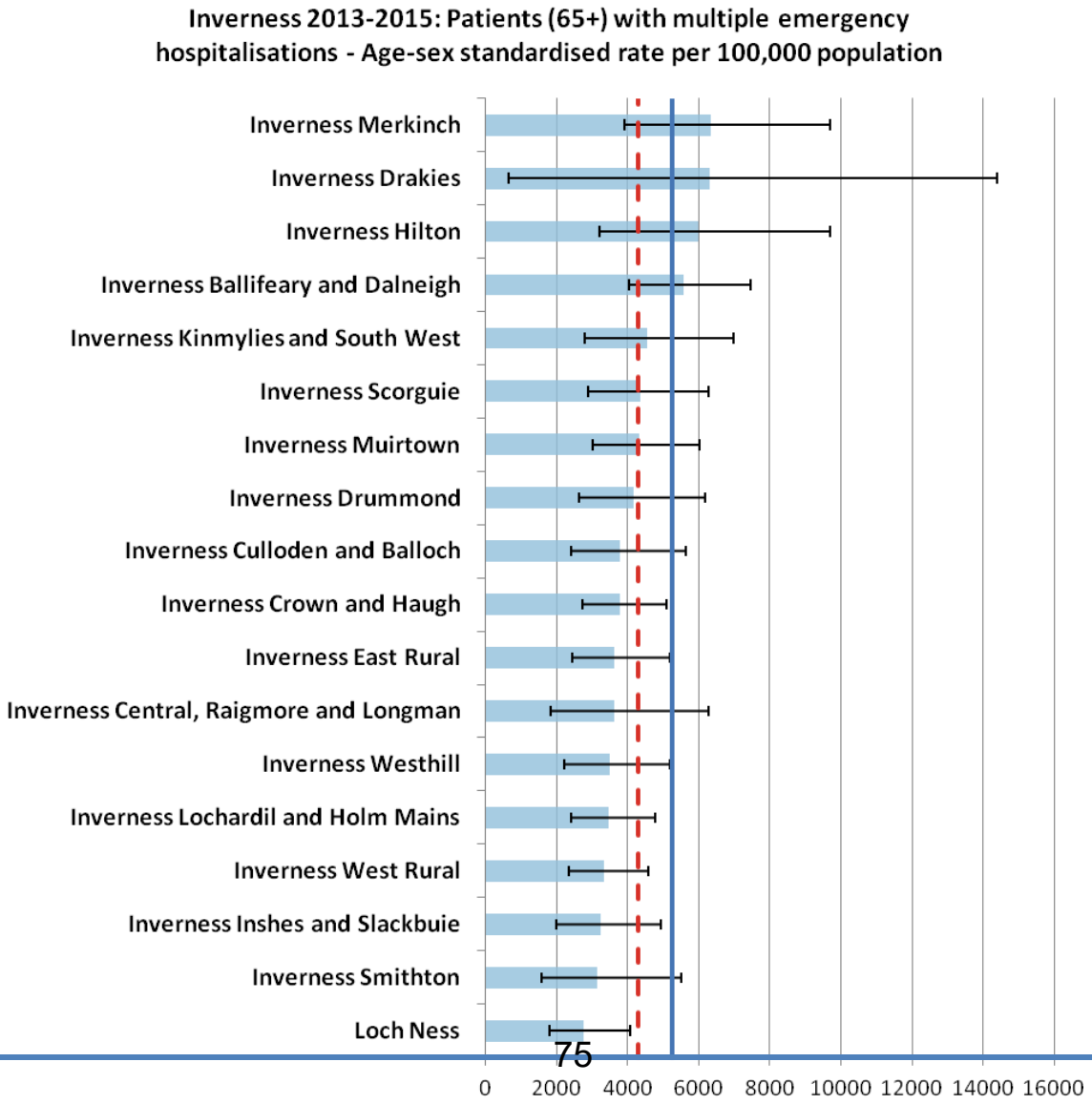
Figure 20: Percentage of the population with self-reported long-term conditions



Data source: Census 2011 – Nature of long term conditions. Created from Census Table CT0033f

EMERGENCY HOSPITAL ADMISSIONS

Figure 23: Patient 65+ with multiple emergency hospital admissions by Intermediate Geography



Services provided and current workforce

The District of Inverness, covering the Urban City area and Rural areas of Drumnadrochit, Cannich, Foyers, Farr and Old Tornagrain.

The services delivered in Inverness Include:

- Community Hospital Ward with 12 beds based in the RNI
- An Older Aged Adult Residential Care home with 24 beds, 6 of which are used for Bed Based Intermediate Care – Ach an Eas
- A Day Service based at the Mackenzie Centre
- 4 Social Work Teams
- 2 District Nursing Teams
- Community Occupational Therapy
- Community Physiotherapy
- Enablement Team delivering Care at Home
- Investigation and Treatment Room supporting work generated by Secondary Care based at the RNI

The Inverness District Professions and Services are providing Health and Social Care to people when they are in need of this. The Teams work closely to enable the delivery of high quality and effective integrated services.

The delivery of this is in a variety of ways including but not exclusively:

- Social Work professionals doing highly complex and urgent assessment and interventions to over 25 years olds with a variety of Mental and Physical Health needs.
- Reablement – supporting people at home, delivering person centred care plans
- Care Home – Providing high quality social care to older aged adults, as measured by the Care Inspectorate, in a homely setting
- Day Care Services – providing building based and outreach support to a multitude of people in need and supporting informal carers
- Multi-disciplinary rehabilitation on a community Hospital Ward, maximising function and achieving complex discharges
- Outpatient post-secondary care services
- District Nursing assessment and treatment to highly complex individuals and
- Providing highly specialised Occupational Therapy assessment and treatment

- Providing highly specialised Physiotherapy assessment and treatment
- Assessment of and for Covid positive patients

Current Workforce

Staff in post

	Column Labels							
	Bank		Fixed Term		Permanent		Total Count of Payroll Number2	Total Sum of WTE
Row Labels	Count of Payroll Number2	Sum of WTE	Count of Payroll Number2	Sum of WTE	Count of Payroll Number2	Sum of WTE		
Female	74	0.00	6	5.39	185	143.24	265	148.63
Male	6	0.00			14	12.86	20	12.86
Grand Total	**80**	**0.00**	**6**	**5.39**	**199**	**156.10**	**285**	**161.49**

Age Profile

Headcount (excluding bank staff)

Overall in each age group

Over 65	5	2.44%
Over 60	41	20.00%
Over 55	87	42.44%
Over 50	111	54.15%

Headcount/WTE

	Headcount	WTE
Ach An Eas Home {E Inv}	35	25.85
District Nursing Team {Inv East}	26	22.27

East Inv District Rural Team {Adult SC}	10	8.53
East Inv District Urban Team {Adult SC}	13	12.30
Mackenzie Centre {E Inv}	14	12.68
Occ Therapy Team {Inverness}	30	25.85
Physiotherapy {RNI}	16	12.43
Reablement - E Inv {East Inverness}	34	23.03
Reablement - W Inverness {West Inv}	24	15.54
Single Point of Access {Inv}	3	3.00
Total	**205**	**161.49**

The use of the daily management boards across the integrated teams and completion of the workforce planning tool which highlighted the deficit in staffing levels. An uplift was required to deliver a safe service for the current population and patient demographic. There is an increasing number of people receiving support with complex care needs from medical devices to rehabilitation.

Social Work leadership has looked at the number of adults in Highland and are aiming for 1.5 Social Workers per 1000 people.

Finance & Performance

See below the District Budgets for East Inverness and West Inverness respectively. Note the overspends (red) predominantly in Adult Social Care and underspends (black) within Health Teams, mainly due to vacancies in staffing.

Cost Centre	Annual Budget	Year To Date		
		Budget	Actuals	Variance
HHS207 - Rni Occ Therapy	843,356	843,356	675,447	167,909
HHX153 - Inv Single Point Of Access	61,325	61,325	60,499	826
HHX223 - Inverness East Dn Team	1,598,141	1,598,141	1,537,282	60,859
HHY219 - Inverness Clinical Governance	900	900	0	900
HHZ122 - Southside Nursing Home	2,900	2,900	2,082	818
HHZ123 - Cradlehall Nursing Home	7,276	7,276	6,151	1,125
HHZ126 - Inverness Gramp Nh Kingsmills	9,000	9,000	11,723	(2,723)
HHZ136 - Culduthel Care Home	2,846	2,846	3,455	(609)
HHZ140 - Castlehill Care Home	3,000	3,000	7,257	(4,257)
HWA733 - Ach-an-eas	1,356,308	1,356,308	1,401,943	(45,635)
HWA750 - R&n Care - Op - Isc - E Inv	6,599,514	6,599,514	7,079,606	(480,092)
HWA760 - Cah Team - Inverness East	65	65	8,773	(8,708)
HWA764 - Sds - Op - Inverness East	532,513	532,513	632,048	(99,535)
HWA766 - Cah - Op - Isc - Inv East	2,847,322	2,847,322	3,092,311	(244,989)
HWA767 - Home Based Respite Op - E Inv	106,469	106,469	111,567	(5,098)
HWA780 - Mackenzie Centre	659,172	659,172	564,474	94,698
HWA800 - Lunch Clubs	11,159	11,159	(2,799)	13,958
HWA817 - Day Care - Op - Isc - E Inv	945	945	0	945
HWA835 - Sds - Ld - E Inv	2,130,230	2,130,230	1,952,638	177,592
HWA837 - Day Care - Ld - Isc - E Inv	79,523	79,523	75,556	3,967
HWA838 - Home Supp - Ld - Isc - E Inv	6,530,460	6,530,460	6,785,207	(254,747)
HWA839 - R&n Care - Ld - Isc - E Inv	929,274	929,274	1,079,116	(149,842)
HWA870 - Aids To Daily Living - Inv	161,199	161,199	103,448	57,751
HWA875 - Sds - Pd- E Inv	712,977	712,977	821,522	(108,545)
HWA877 - Day Care - Pd- Isc - E Inv	42,095	42,095	16,620	25,475
HWA878 - Home Supp - Pd- Isc - E Inv	240,397	240,397	288,907	(48,510)
HWA879 - R&n Care - Pd- Isc - E Inv	323,783	323,783	396,727	(72,944)
HWA888 - R+n Care - D+a - Isc - E Inv	0	0	160	(160)
HWA890 - Reablement - Inverness	2,304,422	2,304,422	2,071,995	232,427
HWA912 - Carers Support - Inv East	442,215	442,215	442,215	(0)
HWA932 - Housing Support Isc Inv East	1,794,938	1,794,938	1,643,845	151,093
HWB895 - E Inv District Urban Team	648,044	648,044	550,164	97,880
HWC895 - E Inv District Rural Team	556,952	556,952	513,671	43,281
HWW809 - Meals At Home - Inbs	5,003	5,003	0	5,003
HWW818 - Overnight Care Service	218,909	218,909	218,468	441
Total	**31,762,632**	**31,762,632**	**32,152,078**	**(389,446)**

Cost Centre	Annual Budget	Year To Date		
		Budget	Actuals	Variance
HHS103 - Rni York Day Ward	108,385	108,385	80,171	28,214
HHS202 - Rni Admin	38,259	38,259	40,637	(2,378)
HHS204 - Rni Physiotheraphy	560,952	560,952	515,165	45,787
HHS238 - Rni Ward 1	1,346,011	1,346,011	1,346,013	(3)
HHS240 - Rni Medical	167,984	167,984	128,544	39,441
HHT104 - Abban Street Clinic	471	471	187	284
HHX109 - Volunteer Transport Scheme	5,465	5,465	21,124	(15,659)
HHX143 - Virtual Ward	64,445	64,445	64,445	0
HHX202 - Inverness Locality Admin	167,325	167,325	147,624	19,701
HHX205 - Inverness Management	775,664	775,664	127,395	648,269
HHX206 - Inverness District Hub	70,456	70,456	63,463	6,993
HHX224 - Inverness West Dn Team	1,341,186	1,341,186	1,367,960	(26,774)
HHX225 - Investigation + Treatment Room	128,497	128,497	109,977	18,520
HHZ119 - Fairfield Nursing Home	542	542	0	542
HHZ120 - Highview House Nursing Home	11,491	11,491	15,246	(3,755)
HHZ127 - Highland Hospice	816	816	943	(127)
HKW024 - Blue Badge And Housing	22,550	22,550	17,840	4,710
HTB139 - Inverness Cac	918	918	152,975	(152,057)
HTB165 - Rapid Response Team	0	0	474,772	(474,772)
HTB175 - C19 Rm - Op Comm Treatment	30,232	30,232	30,231	1
HWE750 - R&n Care - Op - Isc - W Inv	6,963,491	6,963,491	7,119,506	(156,015)
HWE764 - Sds - Op - Inverness West	334,335	334,335	460,584	(126,249)
HWE766 - Cah - Op - Isc - Inv West	2,319,715	2,319,715	2,514,072	(194,357)
HWE767 - Home Based Respite Op - W Inv	125,813	125,813	89,203	36,610
HWE817 - Day Care - Op - Isc - W Inv	1,130	1,130	0	1,130
HWE835 - Sds - Ld - W Inv	464,175	464,175	402,241	61,934
HWE837 - Day Care - Ld - Isc - W Inv	64,350	64,350	63,108	1,242
HWE838 - Home Supp - Ld - Isc - W Inv	4,344,904	4,344,904	4,659,156	(314,252)
HWE839 - R&n Care - Ld - Isc - W Inv	1,154,183	1,154,183	1,091,396	62,787
HWE875 - Sds - Pd- W Inv	453,294	453,294	385,285	68,009
HWE878 - Home Supp - Pd- Isc - W Inv	114,502	114,502	114,787	(285)
HWE879 - R&n Care - Pd- Isc - W Inv	558,081	558,081	612,084	(54,003)
HWE912 - Carers Support - Inv West	134,789	134,789	134,789	(0)
HWE932 - Housing Support Isc Inv West	1,609,212	1,609,212	1,574,962	34,250
HWF895 - W Inv District Rural Team	508,746	508,746	421,300	87,446
HWG895 - W Inv District Urban Team	481,877	481,877	372,990	108,887
Total	**24,474,246**	**24,474,246**	**24,720,176**	**(245,930)**

Opportunities and Developments

Services need to move upstream as indicated by the life curve with a focus to preventative care, support and rehab and the need for housing solutions. We need services for unscheduled care and intermediate care needs, where a rapid response can be delivered at the time of need inclusive of bed based intermediate care, D2A, prevention of admission, front door frailty strategies, SAS collaborative approaches and development of hospital at home models. These are the things that we are taking on probably from secondary care/ooh/ What is the change in service look like in terms of demand.

2002-2018 saw an 18.5% increase in population across inverness with the largest demographic being 65-90 yr old. The trend in housing is 300 houses completed annually with a ratio of 2 people

per household. The estimated population growth by 2032 is 13000 addition houses, if current trends hold that will be a 26000 increase in population.

Potential Developments

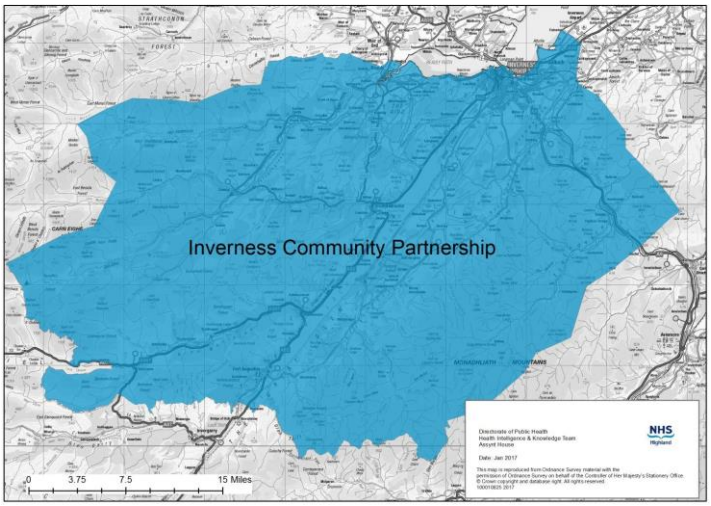
1. Implementation of 7 day week working.
2. Increased social care capacity to prevent hospital admission and support timely discharge by providing access to alternate options to support people in crisis. For example, our Day Services in the Mackenzie Centre 7 days a week and extended hours and Intermediate beds (step up step down beds).
3. Expansion of Social Work team to meet the demands of increasing Social Care needs and the expansion of both in house and Independent Sector.
4. Ach an Eas care home staffing needs.

Community Engagement

The Inverness District Community Planning Partnership has 2 NHS core members and 2 non-core members, one from the Executive Team and 1 from Mental Health. We meet quarterly and have a Inverness District Plan which is accessible by all partners. The plan is below and there are 3 main aims of this:

1. Poverty Reduction
2. Mental Health and Wellbeing and Access to Services
3. Community Safety and Resilience

COMMUNITY PARTNERSHIP LOCALITIES

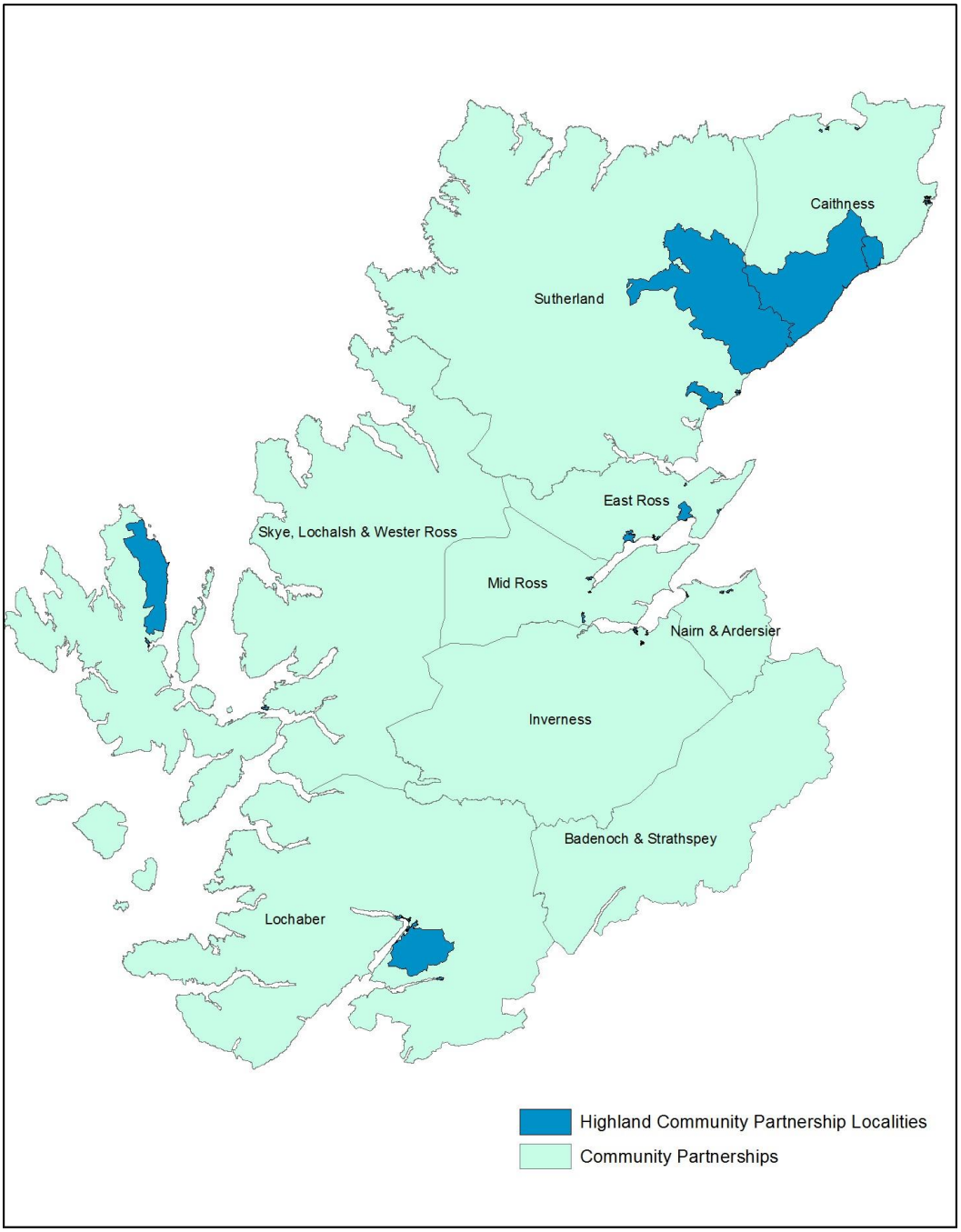


In August 2016 the Highland Community Partnership agreed on a number of communities within the nine Partnerships to be the focus for specific actions to reduce inequalities. Each of the Community Partnerships needs to develop plans for these areas to support implementation of the Community Empowerment Act in Highland. The areas were primarily selected using the Socio-Economic Performance (SEP 2015) Index developed by the Hutton Institute.

The SEP combines twenty indicators that reflect the performance of small areas (data zones) across four themes (Wealthier/Fairer, Healthier, Safer/Stronger and Smarter). The underlying data comes from three sources: Scottish Neighbourhood Statistics, Census 2011 and from the Scottish Index of Multiple Deprivation (2016). Lower scores on the SEP indicate poorer performing areas.

The map below provides an overview of the data zone areas identified in Highland. The areas identified within this Community Partnership are shown in the table below.

Community Partnership	Zone code	Data zone name
Inverness	S01003860	Inverness Merkinch North
Inverness	S01003862	Inverness South Kessock
Inverness	S01003793	Inverness Hilton South
Inverness	S01003855	Inverness Merkinch South
Inverness	S01003839	Inverness Raigmore North
Inverness	S01003833	Inverness Central North West
Inverness	S01003796	Inverness Hilton West
Inverness	S01003845	Inverness Merkinch Telford
Inverness	S01003797	Inverness Hilton East
Inverness	S01003849	Inverness Merkinch East
Inverness	S01003801	Inverness Hilton North
Inverness	S01003790	Inverness Hilton South West



Highland Community Partnership: Locality areas

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NHS Highland

Directorate of Public Health
Health Intelligence & Knowledge Team
Assynt House

Date: Jan 2017

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Poverty Reduction – Key Objective:** More People in Inverness will live a life free from the experience of Poverty					
	Identified need		Actions	Lead/Who	How will the impact be
A	Information about services and facilities are readily accessible using a range of communication methods	**A1**	Work with local radio to promote ICP and a range of our services to reach members of the community who are not digitally aware		
		A2	Promote the Worrying about Money Leaflet in a variety of different settings and with different services as well as within our organisations to staff and employees		Number of people accessing services
		A3	Deliver Money Counts courses to a range of organisations and services that work with community groups/vulnerable people		Number of Course's delivered Attendee numbers

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Poverty Reduction – Key Objective:** More People in Inverness will live a life free from the experience of Poverty					
	Identified need		Actions	Lead/Who	How will the impact be
B	Improve access to food provision within the local community	**B1**	Create more sustainable Food provision through the implementation and use of Food Larders/Fridges		Number of Food Larder/Fridges created
		B2	Encourage and support groups in setting up community growing initiatives within the local area using available green spaces.		Number of new growing projects
C	To support those who are currently inactive in the labour market into training, volunteering, and employment.	**C1**	To work with the HEP & LEP to identify the numbers of people who are inactive in Inverness City & Area and understand the barriers that are preventing them to gain employment		Potential Measures: - Barriers to employment identified - Strategies to remove barriers are created and implemented Number of unemployed individuals in Inverness City and Area decreases

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Poverty Reduction – Key Objective:** More People in Inverness will live a life free from the experience of Poverty					
	Identified need		Actions	Lead/Who	How will the impact be
		C2	Analyse the current levels of take up of apprenticeships across Inverness City and Area and highlight areas of under representation, then create a plan to target those areas most in need to improve take up.		Potential Measures: - Overall number of active apprenticeships increases - Under-represented/skills gap area apprenticeships increase Number of businesses offering apprenticeships increase
		C3	In partnership with the LEP Formulate a plan to address the identified gaps and barriers from C1 and C2		Potential Measures: Plan is created and implemented
D	Support individuals already in employment to flourish.	**D1**	Identify what support is available to help those in work to access training, opportunities and benefits which will allow them to become more resilient and access the right work for their circumstances and stage of life		Potential Measures: - 'Map' of existing support is created and shared with partners/businesses/organisations

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Poverty Reduction – Key Objective:** More People in Inverness will live a life free from the experience of Poverty					
	Identified need		Actions	Lead/Who	How will the impact be
					- Gaps in support identified and potential solutions to address them identified and implemented Number of individuals accessing further education and training in Inverness City and Area increases.
E	Enabling the Skills Development partnership to be more effective in serving customers	**E1**	Building our collective capacity by sharing our intelligence insights into (the skills system partners) labour market threats and opportunities		Potential Measures: - Summary of data and intelligence is shared between partners every [insert interval here] Clear 'map' of threats and opportunities is regularly refreshed to enable timely and appropriate responses to be identified and deployed by partners

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Poverty Reduction – Key Objective:** More People in Inverness will live a life free from the experience of Poverty					
	Identified need		Actions	Lead/Who	How will the impact be
		E2	Quarterly briefings at strategic points within the year to be held		Potential Measures: - More opportunities for collaboration and co-operation are identified More collaborative and co-operative work takes place
F	Support Families in a whole family approach to improve attendance and attainment for young people in Inverness City and Area	**F1**	Ascertain the whole family factors contributing to low attendance rates in the area		
		F2	Engage with families to understand their needs and the barriers affecting them		
		F3	Map existing services and provision available to support the needs and address barriers to educational engagement		

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Poverty Reduction – Key Objective:** More People in Inverness will live a life free from the experience of Poverty					
	Identified need		Actions	Lead/Who	How will the impact be
		F4	Source funding to resource unmet needs		
		F5	Create a plan and implement (Partnership) projects the address the needs of local families and remove barriers to school attendance for 5 – 16-year-olds		

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Mental Health and Wellbeing – Key Objective:** People in Inverness City and Area will benefit from good mental health and wellbeing					
	Identified need		Actions	Lead/Who	How will the impact be
A	Support activity in Inverness to improve Mental Health and wellbeing in children and young people	**A1**	Create and Promote Inverness Children's mental health subgroup as part of the ICP to take forward suggestions made by children and young people.		Action created by group working this
		A2	Bring together and support the role and function of youth development officers and local key stakeholders.		
B	Local people will have a better understanding of mental health and Wellbeing	**B1**	Promote mental health and wellbeing, through awareness of support and resources available including information, education and training courses delivered by stakeholders		Number of courses that have been delivered ALISS is kept up to date with the resources available
C	People in Inverness can benefit from activities that improve mental health and wellbeing	**C1**	Work with ALISS (a Local Information System for Scotland) – to encourage Inverness Community Organisations and Groups to become participating members of the ALISS Service.		No of workshops run by ALISS Continued promotion of the ALISS service

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Mental Health and Wellbeing – Key Objective:** People in Inverness City and Area will benefit from good mental health and wellbeing					
	Identified need		Actions	Lead/Who	How will the impact be
					ALISS is kept up to date with the resources available
		C2	Work with NHS Highland Public Health and HTSI to encourage community organisations and groups to participate in the Highland directory being developed locally		Create a Highland Third Sector Directory
D	People in Inverness are able to be more physically active	**D1**	Support the development and outcomes of the Active Highland Strategy.		

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Access to Services – Key Objective:** People in Inverness City and Area will experience fewer barrier to accessing local services					
	Identified need		Actions	Lead/Who	How will the impact be
A	Communities and groups need safe spaces to use to deliver activities at no or reduced costs	**A1**	Identify local building resources which may be made available at reduced or nil cost to community organisations which are delivering activity which contributes to reducing outcome inequalities		
B	Explore the idea of community hubs to provide information and direct access to relevant services	**B1**	Using established community spaces - encourage services to work within these spaces in an informal way to reach those who are most in need.		
C	Communities will have access to more support to literacies and digital skills	**C1**	Bring the partners together to map what out what is happening to help develop communities in becoming more digitally aware and develop digital skills accordingly.		
D	Community Groups, Social Enterprises and Businesses in	**D1**	The priorities and support from Public and Third Sector organisations are mapped, shared and promoted between partners.		Potential Measures: - More private and third sector organisations are aware of who

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Access to Services – Key Objective:** People in Inverness City and Area will experience fewer barrier to accessing local services					
	Identified need		Actions	Lead/Who	How will the impact be
	Inverness City and Area can access timely and appropriate support to enable them to fulfil their aspirations				can help them at the various stages of their journey. Partners are aware of where to signpost organisations for support
		D2	Promote Scottish Government 'One-Stop Shop' for support 'Find Business Support' https://findbusinesssupport.gov.scot/		Potential Measures: - More private and third sector organisations are aware of who can help them at the various stages of their journey. Partners are aware of website to signpost to

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Community Safety and Resilience – Key Objective:** People in Inverness City and Area will benefit from living in strong, safer and more resilient communities					
	Identified need		Actions	Lead/Who	How will the impact be
A	Target prevention-based Road Safety activities to those most at risk	**A1**	Local Contribution to national targets & Initiatives	**THC**	Reporting on what has been delivered
		A2	Identify local issues and road safety hotspots within the local communities	**THS/CAG Leads**	Reporting on what has been done in response to what was reported

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Community Safety and Resilience – Key Objective:** People in Inverness City and Area will benefit from living in strong, safer and more resilient communities					
	Identified need		Actions	Lead/Who	How will the impact be
B	Keeping Communities safe in a Digital world through awareness raising and training	**B1**	Ensure communities have an awareness of online fraud, bullying/harassment and exploitation of vulnerable individuals and groups	**Police**	Produce annual report on what has been done. Report figures on fraud reported to Police
C	Reduce the risk of Water related harm by raising awareness and initiatives	**C1**	Seasonal Led initiatives to reduce water incidents	**SFRS**	Delivery of risk reduction activities
		C2	Identify and respond to any community identified emerging risk or hazards	**SFRS/CAG Leads**	Reporting on what has been identified and actions as a result
D	Increase Public Safety, confidence and Wellbeing through multi-agency collaboration	**D1**	Support and develop local initiatives to reduce anti-social and violent behaviours	**Police**	Operation Respect
		D2	Multi-agency visibility to provide reassurance and confidence to the public	**Police**	Operation Respect
		D3	Identification and support for vulnerable groups and individuals	**NHS**	Community Mental Health

INVERNESS AREA LOCALITY PLAN – WIDER AREA PRIORITIES					
Priority: **Community Safety and Resilience – Key Objective:** People in Inverness City and Area will benefit from living in strong, safer and more resilient communities					
	Identified need		Actions	Lead/Who	How will the impact be
		D4	To develop local initiatives in response to emerging threats to public safety	**ICP**	Identification of what the threats are and actions as a result
E	To reduce the risk of harm within the Home through intervention and increased identification of those most at risk	**E1**	Targeted risk reduction by means of intervention for those most as risk	**NHS/Adult Social Care**	Identification of vulnerable people and asking Partner Agencies for actions.
		E2	Promote referral pathways amongst partners to assist those most at risk	**NHS/Adult Social Care**	Development and measuring use of pathways
F	Support Community led action to build local resilience and capacity	**F1**	Support the development of the Highland Resilience Network	**HTSI/Locality Leads**	The Highland Resilience Network website will be developed
			Establish the mechanisms to activate The Highland Resilience Network	**HTSI/ICP**	Pathways will be identified by the end of 2024

Completed by: James Merriman

District Profile

District: Lochaber

N.B Lochaber is defined by Scottish Government and Highland Council geographical boundaries and is reported as such in NHS Highland 's Public Health Profile.

Lochaber District in terms of NHS Highland is expected to cover the area from Urquhart Castle through Invermoriston in the north including Fort Augustus (Inverness areas) and areas past the southern boundary of Lochaber (Argyll and Bute). Different services have different area boundaries, and these are sometimes unclear as they do not reflect the corporate or geographical area defined in reports.

Therefore, all demographic information does not include the Fort Augustus and other areas outside of the Lochaber geographical boundary. Public Health have been unable to split that information out from their records to date despite requests as the information from Scottish Government is reported in geographical tranches. The extra information is included in Inverness, Skye and Lochalsh and Argyll and Bute Districts.

Manager: Karen-Anne Wilson

Locality Demographics
The latest estimates are based upon the 2011 census for Lochaber only, with an adjustment made annually for the number of births, deaths and an estimate of migration. Future estimates will be rebased on the 2022 census when the results become available. The population projections used in this report were produced by the Improvement Service (IS). They are based on Housing Market Areas (HMAs) defined by the Argyll and Bute Council and the Highland Council. **Lochaber (Public Health Map)**

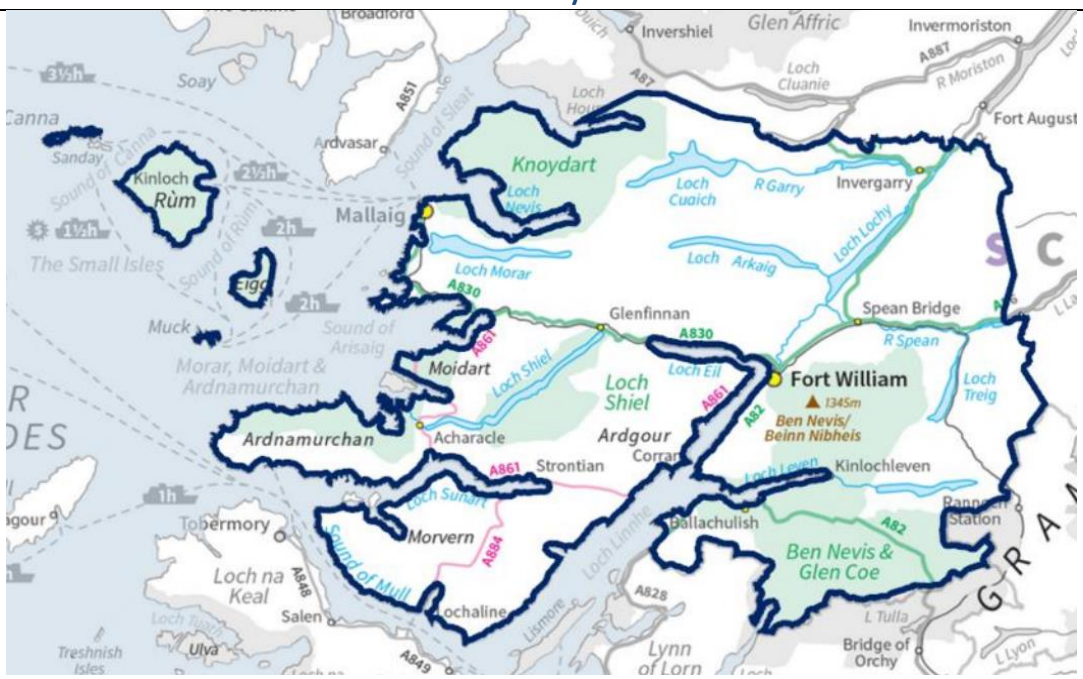


Fig 1 Geographic Public health Profile for Lochaber

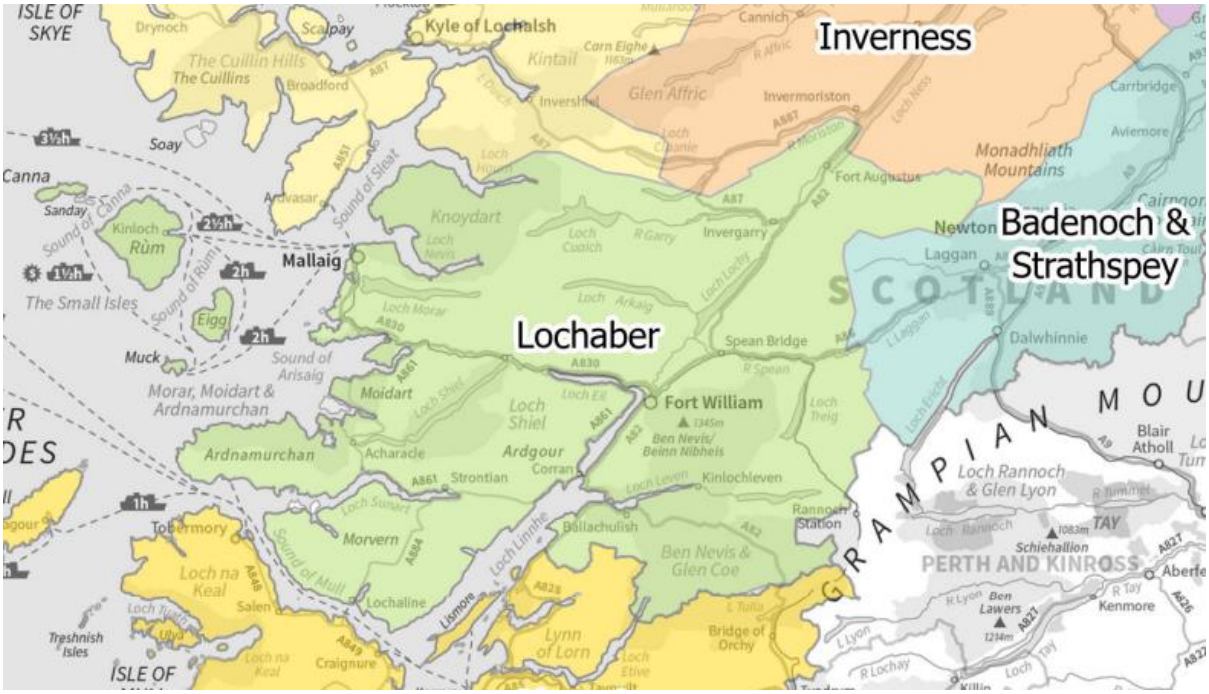


Fig 2 NHS Highland boundaries for Lochaber including Fort Augustus and surrounding areas.

As of 2021, Lochaber has a population of 20,042 people. 16.3% of the population are children aged 0-15 years, 61.9% are aged 16-64 years and 21.8% are people aged 65 years and over. The age profile of the Lochaber population is similar to Highland. The partnership area of Lochaber includes the settlements of Fort William, Spean Bridge, Mallaig and Kinlochleven. The area covers the island populations of the Small Isles.

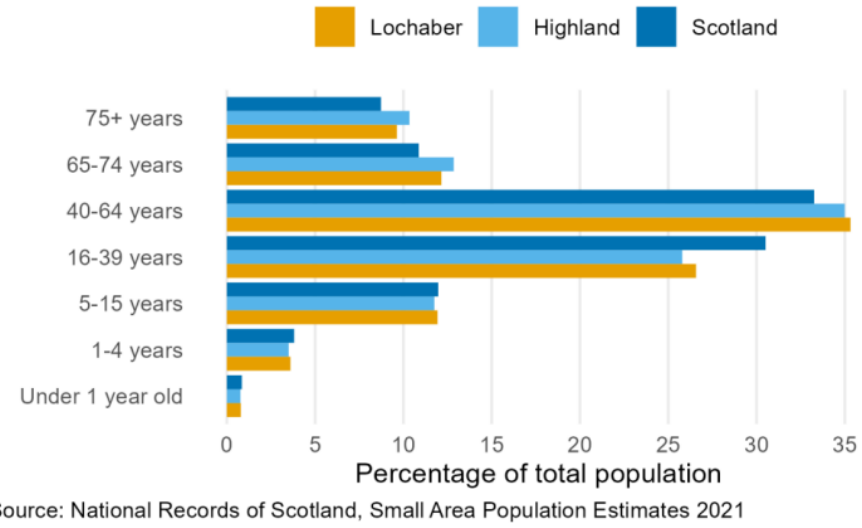
Current estimated population by age group 2021

Age Band	Lochaber	Highland	Scotland
All ages	20,042	238,060	5,479,900
Under 1 year old	158	1,842	46,782
1-4 years	722	8,321	208,655
5-15 years	2,392	27,967	656,085
16-39 years	5,326	61,405	1,671,841
40-64 years	7,078	83,301	1,822,676
65-74 years	2,435	30,598	595,578
75+ years	1,931	24,626	478,283
85+ years	519	6,691	131,309
0-15 years	3,272	38,130	911,522
16-64 years	12,404	144,706	3,494,517
65+ years	4,366	55,224	1,073,861

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

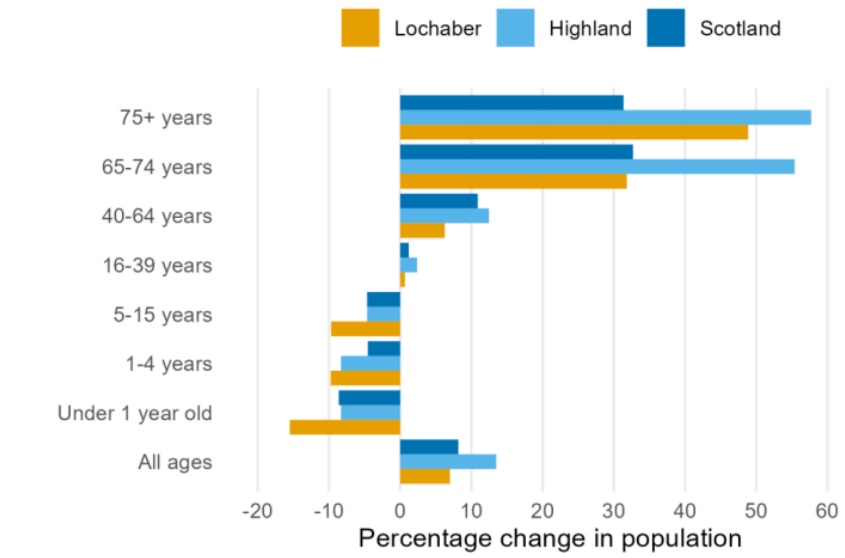
Fig 3 NRS Population Estimates 2021

Percentage of Total Population by age group



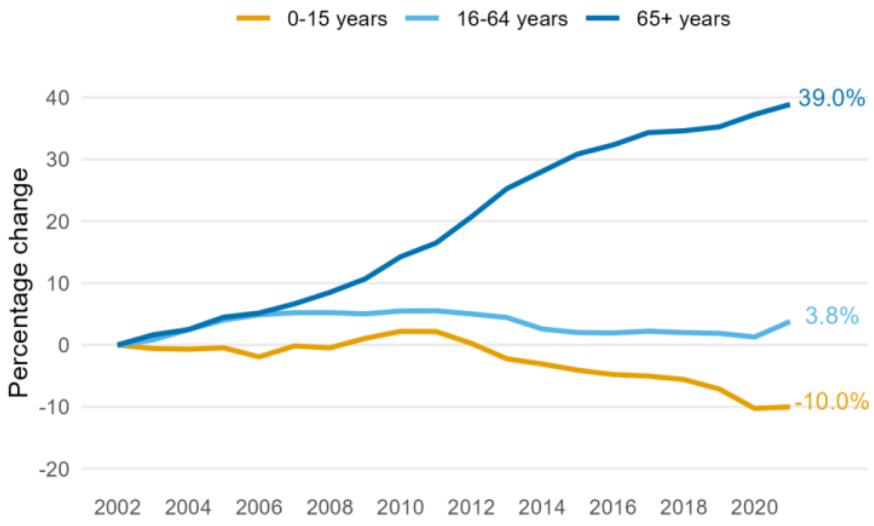
Source: National Records of Scotland, Small Area Population Estimates 2021

Fig 4 Percentage Change in Population by age group 2020 to 2021



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

Fig 5 NRS Small area Population Estimates 2021

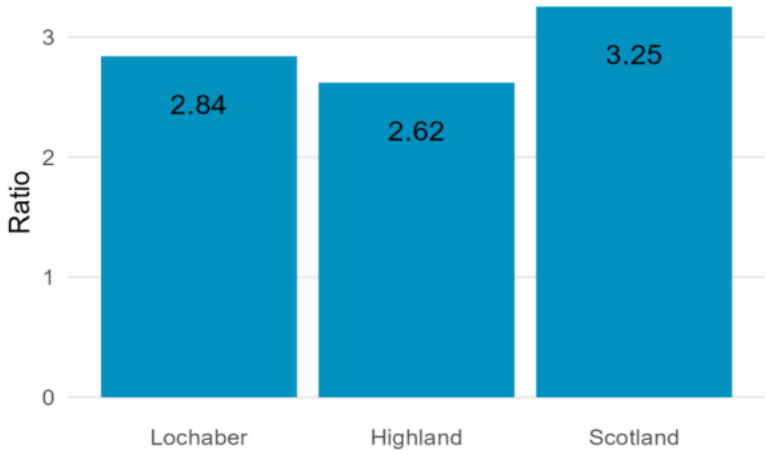


Source: National Records of Scotland, Small Area Population Estimates 2021

Fig 6 NRS Population Estimates 2021

It is estimated that the overall population of Lochaber will decrease between 2018 and 2030 and that the population will continue to age. The number and proportion of people in the 65-74, 75-84 and 85+ age groups are projected to increase, whereas the population aged 0-15 years and 45-64 years are projected to decrease.

People of working age (16 0 64 years) for every person 65 years and older in 2022

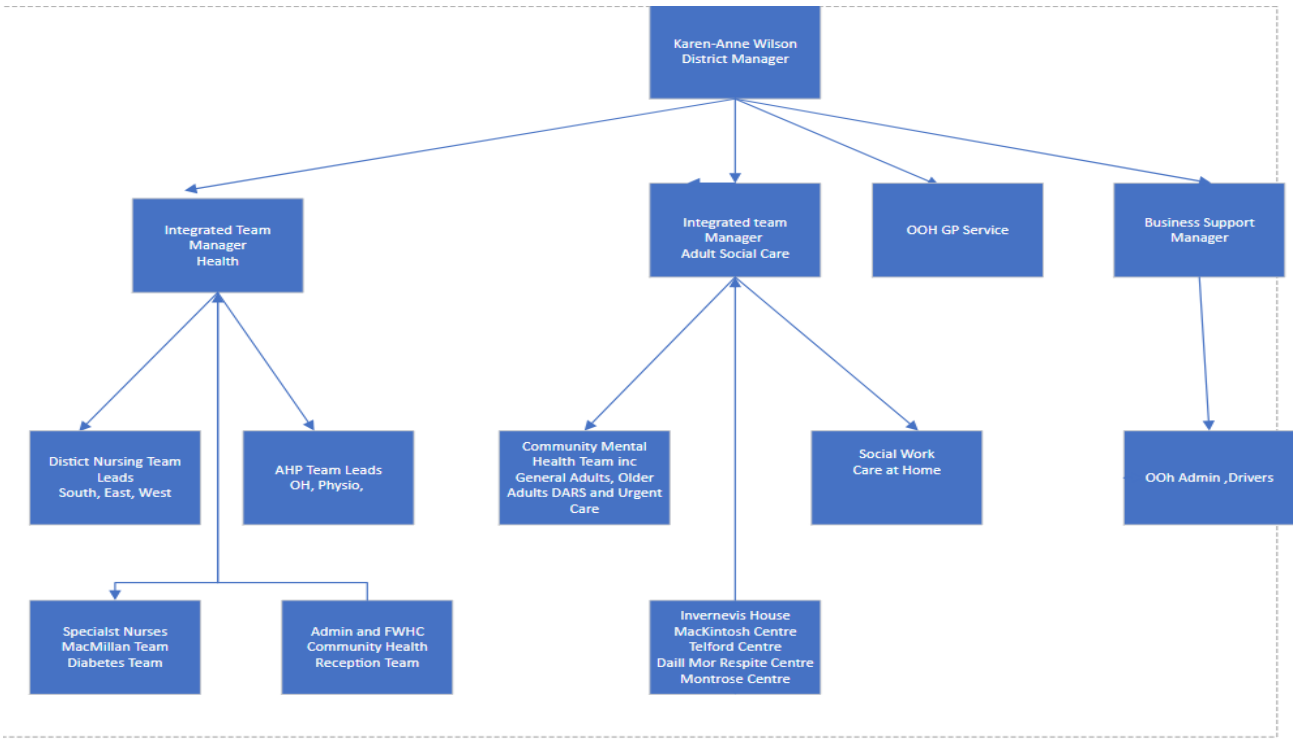


Source: National Records of Scotland, Small Area Population Estimates 2021

Fig 7 NRS Lochaber (geographical area estimates)

The impact of long-term demographic changes will mean that the ratio of people of working age to people aged 65 years and older will further decrease. This pattern has implications for staffing and recruitment. There are two documents appended which show the highlands and islands population projections for Lochaber in contrast to the National Records of Scotland information. The Highland's and Islands enterprise (HIE) population data is more encouraging as it takes into account the effect of the outdoor activities bringing young people into the area who are often willing to stay in Lochaber providing accommodation can be found. (*Lochaber plus population plus projections and report (HIE 2018)).*
Again, these figures are for the geographical boundaries of Lochaber.

Services provided and current workforce



Lochaber Teams

Team	Full Complement	Vacancies	Current LTS	Recruitment challenges
Social work	15 staff	1	1	Hope to be fully established in October 2023 for first time in over three years.
Physiotherapy	13	2	1	Current locums to be pulled due to financial reasons leaving team two more physio's short when current contracts run out.
Occupational Therapy	10	0	0	
Care at Home	93	16	5	Inc C@H Officer LTS. Vacancies across all areas. Regularly collapsing services to ensure everyone has some visits.
District Nursing East	25	4	2	Recruitment an issue.
District Nursing South and West	16	1	1	Recruitment and Accommodation an issue
Diabetes Nurses	3	3	0	Cover being provided from elsewhere
Learning Disability Nurses	2	0	1	Charge Nurse LTS
Mental Health Older Adults	3	0	1	
Mental Health General	6	4	0	Agency nurse use has used funding and unable to advertise for established posts until next financial year (re accountant).
Mental Health DARS	3	0	0	
Mental health urgent Care	3	1	0	
ITR	1	0	0	27 hours funding, no non-pay funding so costs in DN budget for non-pay. No holiday cover or sickness cover.
Health Promotion	2	0	0	Smoking cessation and some alcohol brief interventions but no-one to hand over to if complex.
MacMillan Cancer and Palliative Care	9	3	1	Recruitment on going. Also delivers chemo service and outlier for doing this in Scotland.
OOH Fort William	21	5	0	Agency overnight cover 365 days. Bank GP cover weekends, drivers and admin contracted staff.
Management	5	0	0	1 member of staff replaced in Lochaber following succession of continued failed redeployments (since 2018)
Administration	8	0	0	Supports Podiatry and Dietetics teams no longer managed by District meanwhile district admin bank services have to withdraw because of lack of funding and costs and senior staff now answering phones etc.
Daill Mhor House	10	3	2	Unable to staff appropriately so currently closed.
Invernevis House	58	5	2	Normal recruitment churn made more difficult and costs incurred due to one month to leave and 4-6 months to replace.
MacKintosh Centre	26	11	2	Currently moving to temporary cessation of services due to recruitment delays unable to fill posts within reasonable times.
Telford Centre	26	3	2	Recruitment difficulties.
Montrose Centre	10	0	1	

	367	63	21	

Lochaber has moved to change the professional leads in the teams to Team Leads. This is to enhance professional governance, promote team working and prevent the split of responsibilities between the sole ITL in 2021 and the District Manager with the professional leads. Staff report the new way of working has more than proved itself and led to better working relationships across the District with staff being confident their professional lead and Integrated Team Manager have designated areas of responsibility and collaboration.

Absence rates have been driven down by application of Return-to-Work interviews for example which were not happening when one ITL had responsibility for around 150 staff who directly reported to her. The new arrangements mean that teams are operating much better, and time is not being split with different decisions being taken or the same decision needing two authorisations e.g holidays. One team remains with a professional lead as they were not willing to make the change although all new Team Leads have been employed as a Team Lead. In fact, there is one Team Lead (Admin) and one professional lead (OT) that have been in place since 2021, all other staff are new, or promoted posts.

Care Homes have had one deputy manager in place in 2021 that is still in post and one Deputy who has moved to a Manager post. The rest have been recruited and recruitment is ongoing for a Fixed term Manager to cover maternity leave at the MacKintosh while recruitment goes on to try and reopen the Home.

There has been a long period of settling down with this new format however it is starting to show both savings and efficiencies as budgets are being properly reviewed and a lot of work has been done with the accountants to return charges to other areas e.g 70K in Invernevis charges last year with another 20K unable to be reclaimed. This is because Invernevis was being used to place staff that had never worked there for some unknown reason. However regular review of this budget has proved invaluable as this is still happening but being identified and dealt with much, much quicker.

With the centralising of teams and the degradation of Integration, Cardiac rehab, Podiatry, Community Maternity services, Podiatry, Dietetics, as well as the management of GP surgeries has moved beyond the District Team and as such the links are less than previously. Community Mental Health Services will move shortly including Montrose Centre, DARS and Mental Health and will be managed by a central team.

The challenges are in recruitment mainly. With full teams anything is possible but the current rate of staff leaving in one month and not being replaced as the process from leaving to starting someone is 4-6 months. This is closing Care Homes and is stopping Care at home from running services. This is causing a huge risk for staff and services and is contributing to the resignation of existing staff who are fed up covering shifts above their contracts. The demographics of current Care Home Teams for example show many staff in the 50's 60's and 70's who are no longer able to pick up a large amount of extra work to keep Care Homes open.

This is exactly the situation in Daill Mor and MacKintosh just now. Staff who picked up shifts previously simply wish their work life balance back even if it means Care Homes close. They have done a huge amount to keep these Homes open through Covid and it is to be expected that reductions in hours and resignations would follow.

Finance & Performance

The budget for 2023/2024 for Lochaber District is detailed below as at Month 4.

Annual Budget £000	Division	Budget YTD £000	Actual YTD £000	Variance YTD £000	F'cast Outturn £000	F/cast Variance £000	Prev Mth Outturn £000	Movement Variance £000
372	Community Services	124	114	10	341	31	31	0
112	Management	40	149	(110)	113	(1)	(1)	0
1,017	AHP	347	404	(57)	1,069	(52)	(52)	0
916	Mental Health	311	348	(37)	930	(14)	(14)	0
1,289	OOH	433	401	31	1,219	69	69	0
2,134	Community Nursing	725	641	84	1,874	261	261	0
5,839	Sub Total - Health	1,980	2,058	(78)	5,546	294	294	0
4,392	Care Homes & Older People Other Care	1,487	1,524	(37)	4,459	(67)	(67)	0
584	Community Care for Adults	195	171	24	497	87	87	0
593	ASC Management	215	265	(50)	546	47	47	0
3,097	Care at Home	1,048	939	109	2,898	199	199	0
8,061	ISC/SDS	2,714	3,032	(318)	8,795	(734)	(611)	(122)
16,727	Sub Total - ASC	5,659	5,932	(273)	17,195	(468)	(346)	(122)
22,566	Total for - Area	7,639	7,989	(351)	22,741	(175)	(52)	(122)

Pay Pressures:			
HJJ010 Community MH	(26,711)	(14,139)	using agency for 2 B6s
HEZ118 Management	(5,063)	(20,881)	B6 unfunded post due to being on secondment & budget used elsewhere
HEJ009 Ft Wm HC	(3,639)	(10,428)	Overestablished B3
HJJ026 Physio	(40,807)	(49,483)	Agency covering B6 vacancy approved to end Aug
HEZ023 OOH Transport team	(7,456)	(27,940)	Sickness in Transport team
HEZ118 - Vacancy target	(40,307)	0	
	(123,983)	(122,870)	
Vacancies:			
HEB018 Macmillan Nursing	59,823	175,623	Various posts available to recruit B2, B5 & B6.
HBG009 Sth & East Nursing	15,326	49,716	2.5 B5s, 1.6 B6 & 0.8 B4 avail to recruit
HGF009 West Nursing	29,330	90,102	One B3 on LTS not being paid, going to put out FTC to Dec 23 & avail to recruit 0.7 B5
Various	37,800	78,143	
	142,279	393,584	
	(86,183)	(44,727)	
Per YTD	18,296	270,713	
	-104,479.02	-315,440.82	

ay Pressures:			
IVL723 Invernevis	(67,387)	(208,784)	Overestablished at B2 by SWTE between here and bank shown above
IVL725 Mackintosh	(4,409)	(14,077)	B7 vacant from M4, considering part paying a B8a (cost pressure is £1555 per month
IWE736 Telford	(26,357)	(49,020)	1 B2 LTS From M12 £13k YTD cost pressure
IVL951 Lochaber ASC savings	(67,271)	0	Vacancy target now in districts
	(165,424)	(271,882)	
acancies:			
IVL721 Dail Mhor	86,732	267,969	Sickness and travel time for Dail mhor staff travelling to mackintosh or invernevis
IVL760 Care at Home	126,069	231,405	B4 RAOs est 6 months funding to be drawn down
IVL823 Montrose	14,867	48,776	working under establishment at 7.76 with establishment of 10.36.
IVL895 District team	19,395	76,195	1 B4 and 2 Grd 4 ATRs out to advert struggling to recruit.
arious	2,332	236	
	249,395	624,580	
	83,971	352,699	
er YTD	83,971	352,699	
	0.06	0.10	

The main overspends relate to ISD/SDS and a temporary weekly award of around 6K is a large part of this for a client who cannot get care in the local area. The overspend on SDS is probably attributable to the reduction in local care at Home and some clients have gone to SDS so that packages can be made available. There is no way to predict spend in this area particularly in light of covid and the higher dependency levels we see coming out of covid.

Unmet Need (as at 07/08/23 CAH DD report)

CAH Wait List for New Service	49 (321 hours)
CAH Wait List >6 months (Critical)	1 (Lochaber B)
CAH Wait List <6 months (Substantial)	9 (Lochaber A) 3 (Lochaber B)
Unmet Need Hours (Lochaber)	420 hours
Existing Requests for Service	8
New Requests for Service	5

There are over 300 hours at recruitment or working through recruitment currently for Care at Home. Clearly if staff were to fill these 300 hours then the unmet need would reduce. In the meantime we continue to promote SDS as a way of reducing some of the delayed discharge issues from the local RGH.

Opportunities and Developments

As part of the Lochaber redesign opportunities are being explored by the community through Buchans Associates.

The current work in Lochaber is through a Hospital at Home bid to Scottish government. This will include a physio and nurses to keep people at home. A new SPOC team of HSCC has been created to give a robust receiving area for calls and a proposal for an OT aligned to Care at Home but reporting from a professional perspective to the OT professional lead should ensure we are able to see people earlier, and put aids into reduce the immediate need for services. A TEC lead is also being explored so that low level devices such as Alexa can be used for reminders and medication prompts etc.

Frances Hines from RD&I is collaborating with the Lochaber Team to look at the art of the possible.

A Palliative Care room is being added at Invernevis House to increase the offer to the public and to Invernevis residents to die with dignity in a room with an adjoining sitting room and kitchen where family can stay and support at this time. This has been funded from our Cancer and Palliative Care Team in memory of a local NHS highland member of staff from Belford Hospital. Samantha Butler was instrumental in making the case for this unit this unit will be open in a few months to honour her battle with cancer and make “Sams’s Place”, an occasional option for people, much easier and more comfortable for them and their families if they wish to use it.

The Hospital at Home team will work with the Care at Home team and new OT to specifically target people who are about to be in crisis and prevent admission to hospital or follow them home to support them in the first few days or weeks out of hospital. Traditional care at home is in short supply so discharging, assessing in the right place and providing the right level of care based on need once settled at home will mean better outcomes for clients and the care at home service. Families will be encouraged to participate in the care and the standard four times a day package to get out of hospital may decrease to fully encourage these clients to be the best they can be.

The enhanced SPOC team will provide signposting to the 3rd sector and other areas that people can go to, to live better lives and delay referral to statutory services for as long as possible. It may also mean that families know about respite and aids for daily living that will not mean they get to a crisis and then refuse to take relatives home as that is happening more regularly. If that crises can be delayed or prevented, then our services may be able to assist more clients at home for longer.

The new Daily Decision Making Team meetings with the RGH are proving successful as the hospital are required to participate in a way that makes the District contribution much more valuable and gets people home more quickly than before.

Community Engagement

Community Planning Partnership (CPP)

The District Manager sits on the Community Planning Partnership and contributes to the Caol Community Plan and the Kinlochleven Plan. The District Manager also sits on the Fort William 2040 board, Fort William Community Action Group, Urram Board as an advisor and the Care and Repair service Board again as an advisor. The District Manager is also involved with Lochaber Housing Association through the Management Group.

Independent Sector

Care at Home became a fully Lochaber service in August 2023 with the registration now sitting in the district. Meetings with the independent Care Sector have yet to involve the District Management Team but that should now start as the service splits completely from the West service.

The District Manager has regular meetings with the local independent Care Homes and is involved in discussions about admissions and attends feedback from the Care Inspectorate.

Highland Council

The District Manager attends a council meeting for Ward councillors regularly so they can be updated on what we are doing. This is organised by the Ward Manager and has meant good links with Highland Councillors including inviting them to the Lochaber Redesign meetings and then regularly getting in touch to ask about matters involving their ward residents.

Association of Community Councils

The District Manager attends community council meetings when invited. Recently that has been Urram (Ardnamurachan peninsula), Morar, Arisaig and Mallaig and others when requested. Members of other groups are met when requested e.g 3 Glens community company to discuss Fort Augustus Surgery use and Community Led support in the area.

Enhanced Community Services

Lochaber District Meetings happen every two months and invite Primary Care and all services that operate in the District including community link worker groups to speak at these meetings. The District has also tasked staff with providing a community directory to include ECS and provide better links than is currently in place.

Lochaber Outreach

Our Montrose Centre LD Team moved to outreach during Covid and now operate a vintage cafe in fort William three days a week. A green fingers project and reclamation of furniture are also part of their offering to their clients and the tearoom in particular is well attended locally and is providing work experience for our clients they may one day be able to use independently.

Completed by: Karen-Anne Wilson District Manager Date: 20th August 2023.

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POPULATION AND DEMOGRAPHIC PROJECTIONS FOR LOCHABER

Executive Summary
November 2018

CONTEXT
ECONOMIC & SOCIAL RESEARCH

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Overview

There are a number of major development projects currently under way in Lochaber. These projects are being delivered across housing, infrastructure and industry, which will have a significant impact on the Lochaber area. Arguably most high-profile of these is the GFG Alliance (Liberty) purchase of the Lochaber aluminium smelter, and the proposed development of an alloy wheel factory on an adjacent site, which is expected to lead to the creation of up to 400 jobs.

There will be a number of implications for service planning and prioritisation as a result of these developments. Therefore, ekosgen and Context Economics were commissioned by Highlands and Islands Enterprise (HIE) to undertake detailed socio-economic profiling, and revised population projections for Lochaber. The study included steering group representation from Highland Council and NHS Highland.

Socio-economic context

The population of Lochaber has decreased in recent years, by around 1% to just over 19,800 in 2016. This has been driven by a decrease in the working age population (-3%), whilst the older population has increased – by +13% for those aged 65-84, and +18% for residents aged 85+.

Future projections estimate that Lochaber's population will continue to decrease over the next 20 years, by around 7%. In contrast, there will continue to be an increase in people aged 65 and above. However, there is a disparity between past population projections and mid-year estimates that suggests that forecast decreases are over-estimated. Adjusted NRS population projections indicate that the decrease may only be in the region of -1%.

The employment rate in Lochaber is high. At 89%, it is above the regional and national average (78% and 73% respectively), indicating a tight labour market. The most highly represented sectors in the workforce are accommodation and food services, and retail. It is estimated that between 2016 and 2027 employment in the Highland area will increase by 2,500 (2%), and across the administrative and support service activities, construction and professional, scientific and technical activities sectors in particular.

Lochaber schools are currently at around 80% capacity. School rolls are projected to increase overall. This forecast growth is concentrated within the Lochaber High School catchment area, where capacity is forecast to reach around 95%.

Housing completions are projected to significantly increase in the short-term, with 895 houses forecast for completion by 2022. This increase could be sustained in the long-term if demand is maintained.

Current intelligence

There is a range of planned major private and public sector investment in Lochaber with the proposed new alloy wheel manufacturing facility in Fort William, new West Highland College Science and Technology Centre and the replacement of the Belford Hospital, as well as additional investment planned and underway to increase the number of houses in the Fort William area, almost all social/affordable housing.

This planned investment represents a 'policy on' scenario, which will have implications for existing population projections of the Lochaber area. Current 'policy off' population projections are not considered suitable or appropriate for service planning purposes, given the extent of planned investments, and the under-estimation of populations in the Highlands and Islands by long-term projections. Although a number of the investments are still provisional, there is enough certainty around proposals to take into account 'policy on', rather 'policy off' projections. This is reflected in the fact that some projections are already taking planned developments into account. Notably, this extends to the school roll data where the forecasts for school roll numbers already account for some of the private and public investment planned.

Scenarios for population growth

Taking into account the planned investment, as well as the adjusted NRS population projections, creates more realistic projection scenarios. In turn, this will be of greater benefit and use for future investment and service planning. There are some caveats to the scenario modelling set out in this section, since information available to the review is partial. The population forecasts use the latest intelligence available for a policy on scenario, however there are a number of assumptions inherent in the projections. Three impact scenarios have been considered:

- A **Low impact** scenario that considers the effect of the proposed Liberty investment only;
- A **Medium impact** scenario that considers the effect of the proposed Liberty investment, plus some, public sector investment –the West Highland College Centre for Science and Technology; and
- A **High impact** scenario, which considers a higher impact from the Liberty investment, plus additional public sector investment – the planned capital build at the new Belford hospital, plus significant housing investment.

These overall effects of each scenario on the population of Lochaber across the period 2018-2041 in terms of net change are set out below.

Table 1: Lochaber Population change scenarios, 2018-41

Scenario	Policy-off (unadjusted)	Policy off (adjusted)	Low impact	Medium impact	High impact
Change (N)	-1,100	-157	+612	+1,925	+3,263
Change (%)	-5.6%	-0.8%	+3.1%	+9.7%	+16.3%

Source: ekosgen/Context Economics calculations based on adjusted NRS projections

The major private and public sector investment planned will have a significant impact on the population of Lochaber over the forecast period to 2041. The effects of the investment in the new wheel manufacturing facility alone could reverse the (adjusted) forecast population decline of almost -1% and lead to an increase of around 3% in the population of Lochaber (612 persons). Factoring in the new College Centre for Science and Technology, including associated additional spend from attracted and retained students, and from additional construction worker spend, may result in a population increase of almost 10%, or 1,943 persons. When the new Belford Hospital and housing construction investment is included, the population increase may rise to over 16%, an increase of 3,263 persons. This is without additional private sector investment that may be levered in following the initial wheel plant investment.

Table 2: Anticipated economic impacts associated with forecast population change

Employment impacts	Expenditure impacts	Salary impacts

Between 724 and 870 net additional and retained jobs
• Up to 475 direct jobs arising from the new Liberty facility
  o Up to 400 direct new jobs;
  o Up to 75 new jobs backfilled by those taking up employment at the new facility
• 20 direct jobs at West Highland College Centre for Science and Technology
• Up to 181 FTE construction jobs retained locally
• Up to 86 induced jobs based on expenditure associated with re-locators
• Up to 77 induced jobs based on expenditure associated with additional students and construction workers
	Between £5.7 million and £7.3 million additional local annual spend
	• Up to £4.1 million annual additional spend in the local economy arising from the new Liberty facility
	• Up to £0.8 million annual additional spend from College staff and students who stay long term in the area
	• Up to £2.4 million annual additional spend from construction workers
		• Increase of around £13.5 million in total salaries in Lochaber
		• Uplift in average salaries of between 1% and 2% across the whole Lochaber area

Source: ekosgen/Context Economics calculations

Policy implications

The three 'policy on' scenarios will have a number of consequences for Lochaber's demographic profile. Most important is that there will be a shift to population increase, driven by retention and attraction of workers, and an associated increase in birth rates. Population growth at this scale will require planning by all partners and agencies to ensure that their needs are met, which is likely to include further housing requirements. However, there are a number of dependencies and uncertainties relating to the projections.

There are a number of recruitment challenges in an already tight labour market. There will need to be adequate recruitment support to ensure that there is a net increase of workers across the Lochaber economy. Talent attraction is therefore critical to this, and in ensuring that opportunities through the Liberty projects and other developments in the area are attractive in comparison to employment and career opportunities in other sectors, elsewhere in the region and more widely in Scotland.

It is important that the mix of housing delivered both in the short and longer term meets the housing needs of Lochaber's existing and anticipated future population – and affordable housing is a critical component of this. The higher growth scenarios may also require more housing, and this should be factored into future iterations of the local development plan, and housing need and demand assessments.

Transport is an important consideration for developments in Lochaber. New activity and additional workers and residents will mean more people and goods moving around and through the area, which will increase pressure on the transport network. Digital connectivity and other infrastructure such as water and sewerage capacity are also important considerations, particularly for higher growth scenarios.

The retention and re-location of workers, and associated increase in the birth rate, will mean increased demand for services, exacerbating the pressure on health and social care services from an already ageing population, and from issues associated with health inequality. NHS Highland will need to cater for this additional demand alongside meeting need from existing issues.

Currently schools in Lochaber are operating below capacity. Existing projections indicate that roll numbers will increase in the Lochaber High School catchment area. However, school rolls could be significantly boosted if new workers and households are attracted in to the area and existing residents remain, with demand likely to be focused in Fort William. Consideration should be given to how these scenarios may impact on school roll projections, and the potential demand for school places. There are also implications for tertiary education. The new Centre for Science and Technology at West Highland College will boost provision, playing a crucial role in meeting talent retention and attraction objectives through expanded education provision.

There is strategic added value in the successful delivery of the Liberty investment and other public sector developments, which will bring a wider set of benefits. These developments will improve confidence, stimulate new business activity and act as 'anchors' to attract greater levels of inward investment. Partners on the Lochaber Delivery Group should work to ensure that these wider benefits are maximised.

In addition to existing developments, there are a number of significant projects and opportunities in the pipeline. These include the development of a deep-water facility at Corpach Port, provision of a mains gas network, and the ambitions of the Fort William 2040 Masterplan, which will offer significant economic development potential and have implications for employment and potentially housing, infrastructure and service provision. It is important that, along with current projects, the potential benefits of other developments are also realised.

Maximising opportunities

The scenarios set out here are encouraging, but growth is not guaranteed. An effective policy response from Lochaber project partners is required to enable current and future development. Wherever

possible, partners should provide strategic support and act to de-risk investment, by helping to remove any barriers to development, for example meeting high up-front infrastructure costs in relation to housing developments. This will help realise the opportunities presented to Lochaber.

To realise these growth scenarios, there is a need to maximise the number of workers re-locating. This is to take advantage of new employment opportunities through development such as the Liberty alloy wheel plant, and also to take up opportunities created or arising elsewhere in the local economy, as well as to address existing skills challenges. It is therefore important to sell and promote the benefits of Fort William and the wider Lochaber area. A programme of positive communications around the quality of life and opportunity presented by Lochaber's development plans should be put in place.

Adequate business support for start-up and growth companies should be in place. This should be allied to servicing the new investments, and taking advantage of related opportunities. There will also be a need to meet increased demand for services from households. Partners should ensure that businesses are best placed to respond to these opportunities.

Local FE and HE provision has a critical role to play in ensuring the right training and skills delivery to retain and attract workers. Local career progression pathways must be maximised, to provide as many career opportunities as possible to Lochaber's residents, and to young people in particular.

There should also be long-term planning and support for housing and infrastructure. Securing public sector investment to de-risk housing sites will enable a greater degree of private sector investment, where there is a limited amount currently, especially from volume housebuilders. This can ultimately help to secure a higher-specification and broader mix of housing, e.g. for first time buyers, family housing, down-sizers, etc. This will help to overcome a number of housing barriers faced by young people in particular. It will also potentially lead to a more balanced pattern of growth in Fort William, and reduce the reliance on windfall housing completions.

HIE, HI-TRANS and Highland Council, in conjunction with other partners should also make the specific case for transport investment to the Scottish Government. The recently completed pre-STAG appraisal for Fort William is the first part of this process. There is a clear opportunity to ensure that future iterations of the National Transport Strategy and Strategic Transport Project Review contain scenarios that reflect the challenges and opportunities present in Lochaber.

Finally, the Liberty investment and planned public sector investment should be seen as the start of the long-term renaissance and regeneration of Fort William and the Lochaber area. The investments, on which the population projections in this report are based, could be just the start of an ongoing long-term programme of investment and growth for the Lochaber area.

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POPULATION AND DEMOGRAPHIC PROJECTIONS FOR LOCHABER

November 2018

CONTEXT ECONOMIC & SOCIAL RESEARCH

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CONTENTS

1 INTRODUCTION

OVERVIEW

1.1 In June 2018, ekosgen and Context Economics were commissioned by Highlands and Islands Enterprise (HIE) on behalf of the Lochaber Delivery Group to undertake a detailed socio-economic profiling of Lochaber, including population projections for the period 2017 to 2041. Steering group representation included Highland Council and NHS Highland. The study was undertaken in the context of a number of major development projects, across housing, infrastructure and industry, which will have a significant impact on the Lochaber area. This includes the GFG Alliance (Liberty) purchase of the Lochaber aluminium smelter, and the proposed development of an alloy wheel factory on an adjacent site, which is expected to lead to the creation of up to 400 jobs.

1.2 The purpose of the study is to provide an analysis of how these changes will impact on local demographics, labour market, wage levels and service delivery. There will be a number of implications for service planning and prioritisation as a result of these developments, and the findings will be used to inform the planning process. They will also be used in proposition development for the area.

OBJECTIVES

1.3 The objectives of the study are to:

- Develop a comprehensive socio-economic baseline for the Lochaber area, providing comparisons with the wider Highlands and Islands region;
- Analyse the socio-economic context for the Lochaber area, outlining historic trends and proposed developments and how these may impact on future growth of the region in the period to 2040;
- Provide a range of population projection estimates by age band for the Lochaber area, taking account of development plans and looking at the short, medium and longer term;
- Assess the likely impact of developments on the wider labour market, including on average wage levels for the Lochaber area; and
- Consider broader implications of these developments, trends and projections on local service provision in Lochaber, in the short, medium and longer-term, reflecting the type, nature and scale of provision that might be required to meet the needs of a growing population base in the years ahead.

STUDY APPROACH

1.4 The study methodology was based around three strands of activity:

- Consultation: Consultations were carried out with ten stakeholders from key strategic organisations in the area. Details of stakeholders consulted with are provided at Appendix 1.
- Desk research: Desk research consisted of a policy and programme review followed by gathering and analysis of data sources on current and projected population figures, past and planned house building and current and projected school rolls.
- Projection modelling and impact analysis: From the data gathered and analysed, and using the information gained from the consultations, impact analysis and projection modelling was carried out, using the baseline analysis from the desk research to calculate the potential impact of the Liberty development and other associated activities in the Lochaber area.

REPORT STRUCTURE

1.5 The report is structured in the following way:

- **Chapter 2** contains a socio-economic profiling of the Lochaber area ;
- **Chapter 3** sets out current intelligence on existing projections and perspectives on potential additional investment projects;
- **Chapter 4** presents revised population projection models, detailing scenarios for different growth profiles for Lochaber based on the Liberty investment and other scenarios involving different levels of additional public sector investment; and
- **Chapter 5** sets out our conclusions and implications for strategic policy to inform delivery.

1.6 The following appendices are also included

- **Appendix 1** sets out the stakeholders and key informants consulted with to inform this study;
- **Appendix 2** provides additional detail on Lochaber's population structure, and expected changes to this; and
- **Appendix 3** contains a comparative analysis of population projections and mid-year estimates.

2 SOCIO-ECONOMIC PROFILE AND CONTEXT

Headline messages

- The population of Lochaber has declined in recent years, driven by a decrease in the working age population, whilst the older population has increased.
- Future projections estimate that Lochaber's population will continue to decrease over the next 20 years, but there will continue to be an increase in people aged 65 and above. However, there is a disparity between population projections and mid-year estimates that suggests that forecast decreases are over-estimated.
- Employment rates in Lochaber are high, and are above the regional and national average, indicating a tight labour market.
- Housing completions are projected to significantly increase in the short-term, and this could be sustained in the long-term if demand is maintained.
- Lochaber schools are currently at around 80% capacity. School rolls are projected to increase overall. This growth is concentrated within the Lochaber High School catchment area.

INTRODUCTION

2.1 This chapter sets out the socio-economic profile of Lochaber. It is based on the data gathered and analysed as part of the desk research. It is important to note that this chapter sets out the baseline 'policy off' scenario, i.e. not taking account of the anticipated impacts from the Liberty development or public sector investments. The chapter starts by providing information regarding current population trends and workforce profile in the area. It then goes on to give an overview of existing projections in the area for population, employment, school rolls and housing completions.

SOCIO-ECONOMIC PROFILE

Overview of Lochaber

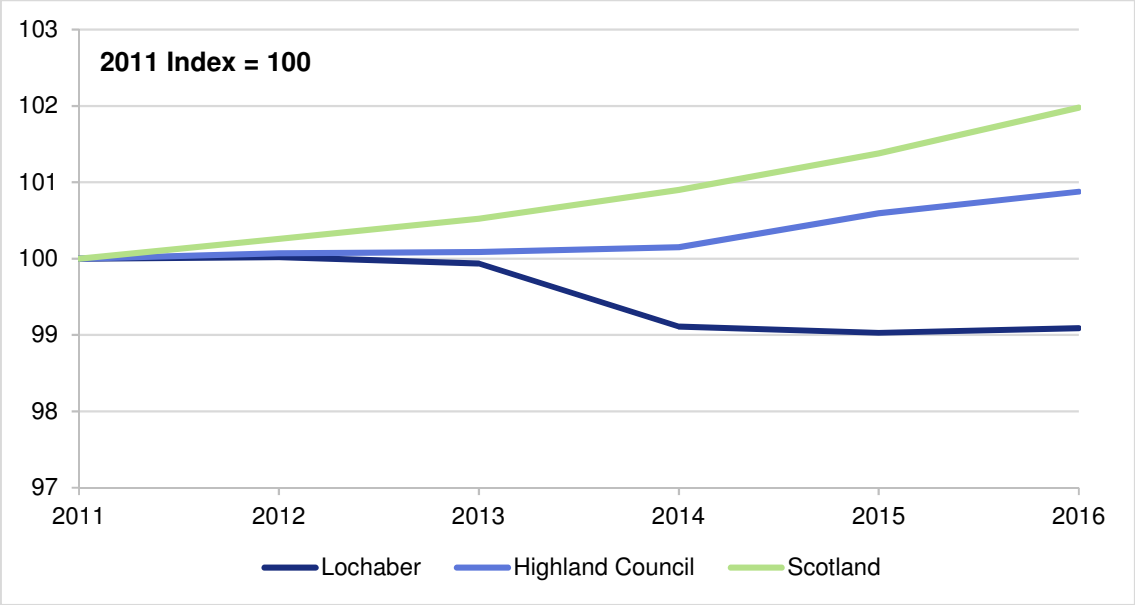
2.2 Lochaber is a large area in the West Highlands, which is known for its scenery and is a major centre for tourism and outdoor activities. Fort William is the main urban centre and has a population of around 10,000. Outside of Fort William there are a number of rural, fragile areas that have more limited connectivity and access to infrastructure. The population is ageing and has been declining. Lochaber has also experienced particularly high rates of out migration of young people. Employment is particularly concentrated in the retail and accommodation and food services sectors, reflecting the importance of tourism for the area.[1]

Population trends

2.3 In mid-2016 Lochaber's population was estimated to be just over 19,800 representing a 1% decrease since 2011. Lochaber accounted for 8% of the total population of Highland Council area. Over the same period there was a 1% increase in the Highland population to 234,770, and a 2% increase nationally (Figure 2.1).

[1] HIE (2018) *Lochaber Labour Market and Skills Review*

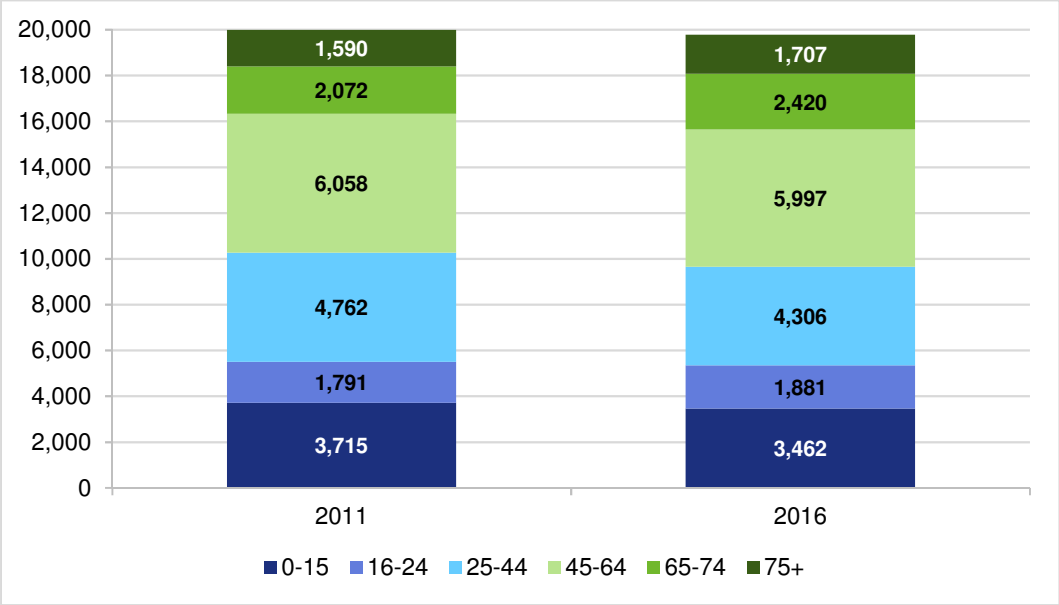
Figure 2.1: Index of population, 2011-2016



Source: National Records of Scotland (2018)

2.4 Figure 2.2 shows the population age structure of Lochaber in 2011 and 2016. In line with the national picture, the population is ageing – from 2011 to 2016 there was a 13% increase in 65-84 year olds and an 18% increase in residents aged 85+. Within most other age groups there was a decrease, except for 16-24 year olds where there was a 5% increase. In total, the working age population (16-64) in Lochaber decreased by 3% between 2011 and 2016. In terms of population structure, this meant that in 2016, 17% of Lochaber's population was aged 15 or under, 62% were of working age (16-64) and 21% were aged 65. Over half (51%) of the population was female, although there has been a greater decrease in the female population since 2011 at 1.6%, compared to a 0.2% increase for males.

Figure 2.2: Lochaber population structure, 2011 and 2016



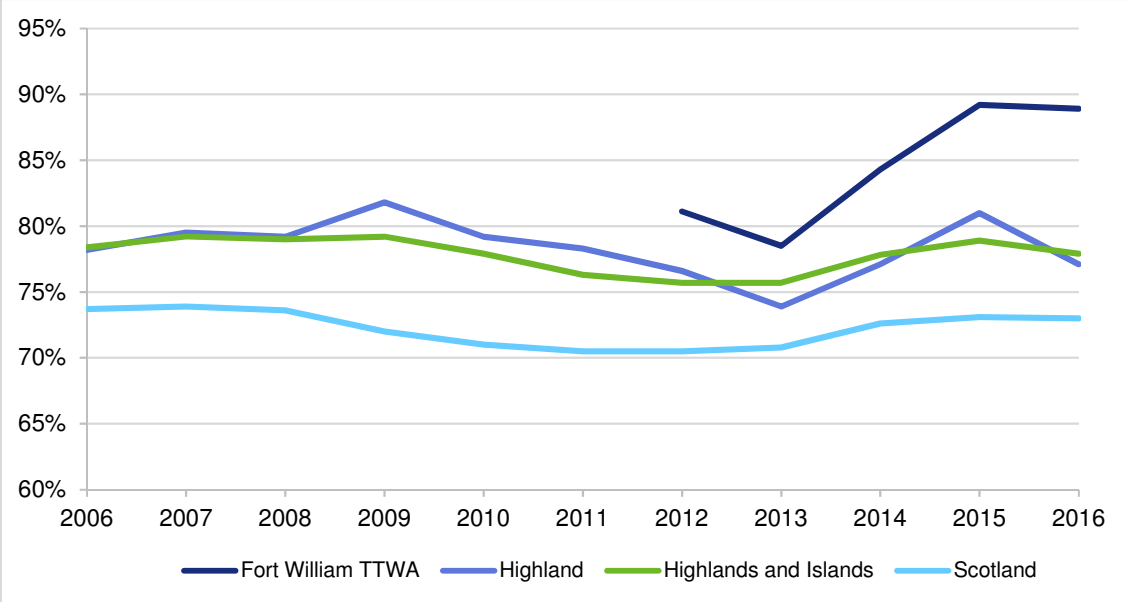
Source: National Records of Scotland (2018)

Workforce profile

2.5 In 2016 the working age population of Lochaber was estimated to be just over 12,000, representing a 3% decline since 2011. As mentioned above Lochaber's working age population was

62% of the total population in 2016, the same as across Highland Council area, but slightly below the Scottish national average of 64%. In the Fort William Travel to Work Area (TTWA) there was a total working age population of approximately 10,000 in 2016 and an employment rate of around 89%, higher than both the wider Highland Council area (78%) and national (73%) averages (Figure 2.3). Whilst this figure should be treated with some caution as it is based on a small sample of the Annual Population Survey, data have consistently shown the Fort William TTWA to have an above average employment rate and anecdotal evidence supports these findings. There has been an upward trend in the employment rate in the area, with an eight percentage point increase from 2012 to 2016.

Figure 2.3: Employment rate, 2006-2016



Source: Annual Population Survey (2018) and Regional Skills Assessments (2018)

2.6 Reflecting the high level of employment, unemployment claimant rates are low in the Lochaber area, at just 1% of the working population[2]. Total unemployment is estimated to be similar to the Highland Council rate of 4%. Similarly, it is estimated that the rate of part-time working are in line with the Highland Council average of 29%, which is above the national rate of 25%. Data showing the qualifications profile of Lochaber's population is incomplete due to a small sample size, but it is estimated that 30% of the working age profile hold qualifications at NVQ Level 4 or higher, whilst 13% hold no qualifications.[3] By comparison Regional Skills Assessment data shows that 9% of the working age population across Highland Council area hold no qualifications, whilst 42% hold qualifications at SCQF Levels 7-12 (SCQF Levels 8-12 are at NVQ Level 4 or higher).[4]

2.7 The most common sectors for people to work in are accommodation and food services (17%) and retail (14%). This reflects the importance of tourism to the area. By comparison with the national average, the most concentrated sectors in the area are accommodation and food services (location quotient of 2.31[5]), arts, entertainment and recreation (location quotient of 1.95) and transportation and storage (location quotient of 1.44).

[2] HIE (2018) *Lochaber Labour Market and Skills Review*

[3] Ibid.

[4] Skills Development Scotland (2018) *Regional Skills Assessments*

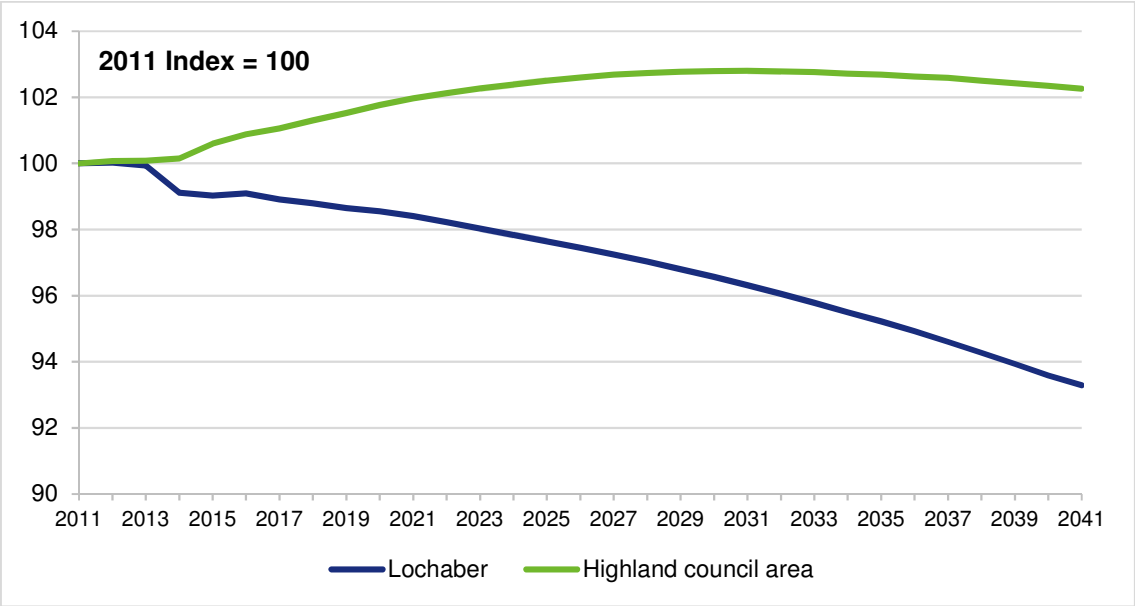
[5] Location quotients compare sectoral employment with the national average, with a location quotient greater than one indicating a higher than national average concentration.

EXISTING PROJECTIONS

Population projections

2.8 The National Records of Scotland (NRS) population projections for the Lochaber area from 2011 to 2041 estimate that the population will decline by 7% over the period (and will decline by 5.6% between 2018-41), compared with a 2% increase across the Highland Council area from 2011 to 2041 (Figure 2.4). Within the overall projections, it is estimated that there will be decreases in all age groups up to 65, whilst there will be a 37% increase in 65-84 year olds and the number of people aged 85+ will nearly triple. People aged 65+ will account for almost one third of the Lochaber population by 2041 (see Appendix 2). The working age population in Lochaber is projected to decline by 19%, compared with 12% across Highland Council area.

Figure 2.4: Index of NRS population projections, 2011-2041

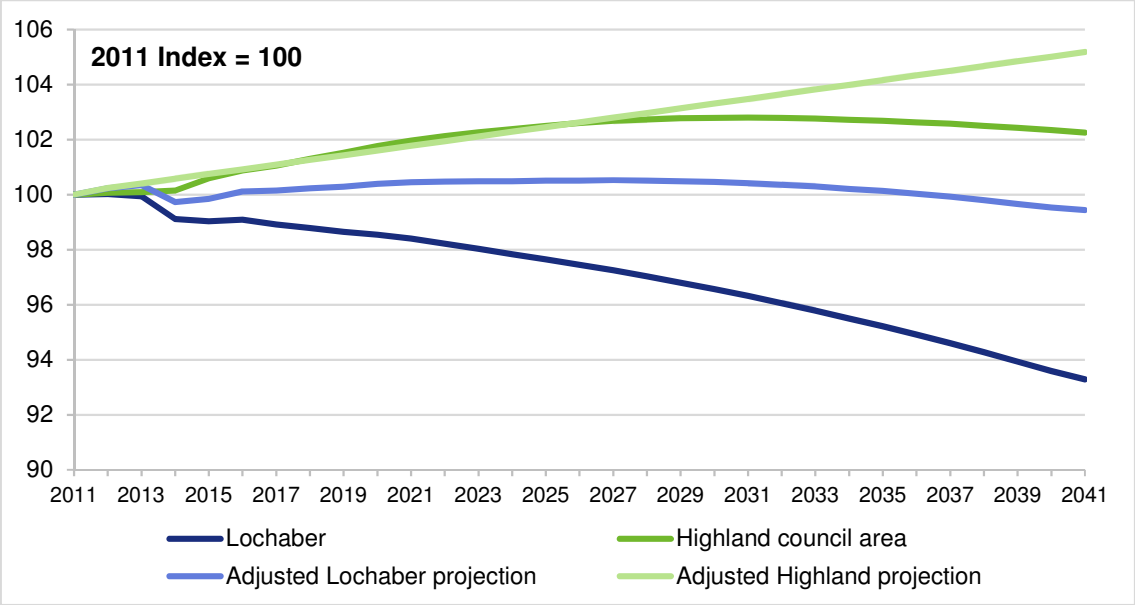


Source: National Records of Scotland (2018)

2.9 However, analysis of NRS data on population projections and mid-year population estimates shows that population projections consistently overestimate the rate of population decrease in the Highland Council area, and elsewhere in the region (see Chapter 4, paragraphs 4.3 to 4.8). Consequently, we have developed a set of adjusted population projections, in consultation with HIE and Lochaber Project Board partners. These have been calculated based on an average 6.1% difference between population projections and mid-year population estimates, to account for overestimation of population decrease. These adjusted calculations project a 0.8% decrease in the Lochaber population under a 'policy off' scenario, and a 5% increase in the Highland Council area population from 2011 to 2041 (Figure 2.5)[6] For the period 2018-2014 this also equates to a 0.8% decrease in the Lochaber population, and a 3.8% increase for the Highland Council area.

[6] From 2018 this is an adjusted increase of 3.8%

Figure 2.5: Index of adjusted NRS population projections, 2011-2041



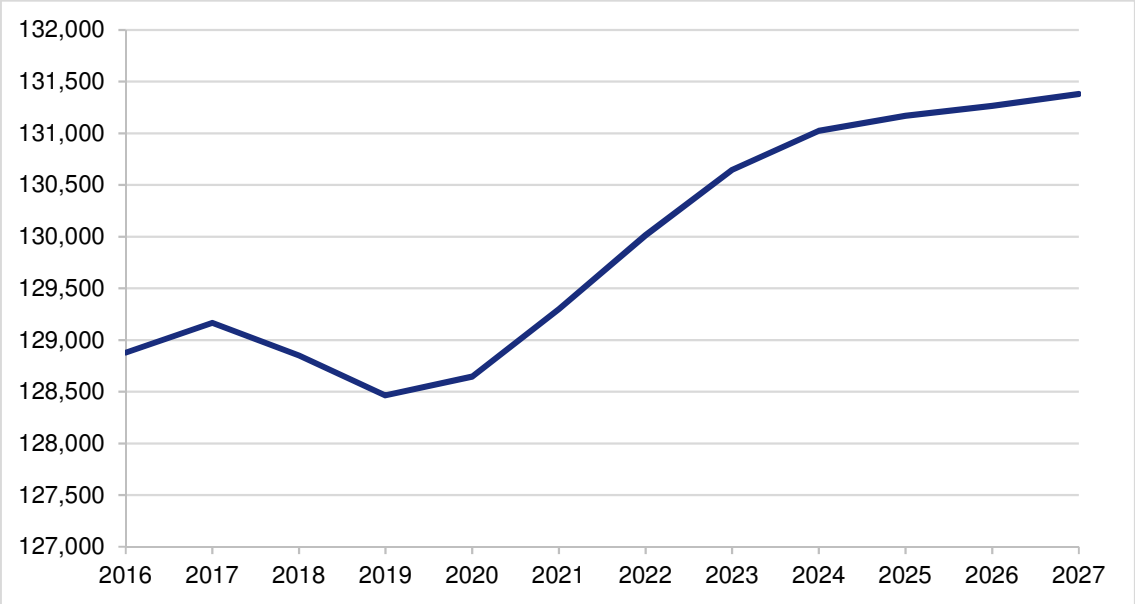
Source: ekosgen adjustment of NRS figures (2018)

Employment forecasts

2.10 Employment projections are not available at the Lochaber level but projections for the Highland Council area are provided in the Regional Skills Assessment produced by Skills Development Scotland, based on Oxford Economics forecasting. It is estimated that between 2016 and 2027 employment in the area will increase by 2,500 or 2% (Figure 2.6). However, there is expected to be a total employment demand of over 43,000 workers (both replacement and expansion) across the Highland Council area by 2027.

2.11 Particular sectors that are expected to see a significant increase in employment in the area include Construction (15% increase), Administrative and support service activities (14% increase) and Professional, scientific and technical activities (13% increase).

Figure 2.6: Employment in Highland Council area, 2016-2027

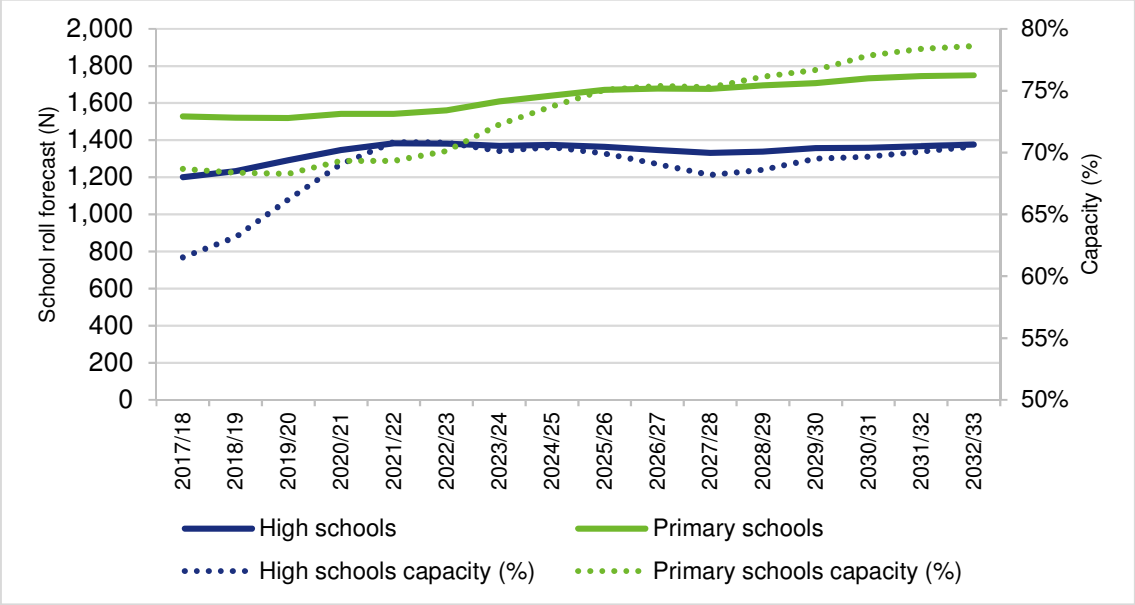


Source: Regional Skills Assessments (2018)

School roll forecasts

2.12 In total there are four high schools and 26 primary schools in the Lochaber area. Figure 2.7 illustrates that overall projections for the Lochaber school roll at primary and high school level from 2017/18 to 2032/33. Presently schools in Lochaber are at less than 80% of capacity. It is estimated that there will be a 15% increase in secondary school pupils and a 14% increase in primary school pupils. These school roll forecasts include some assumptions based on data from the Housing Land Audit (see below), programmed completion rates for Local Development Plan site allocations, GP registration figures, and Placing Request applications, as well as calculate intake numbers for Gaelic and Denominational schools.[7] As such, they are considered to be reasonably accurate projections.

Figure 2.7: Lochaber school roll forecasts, 2017/18-2032/33

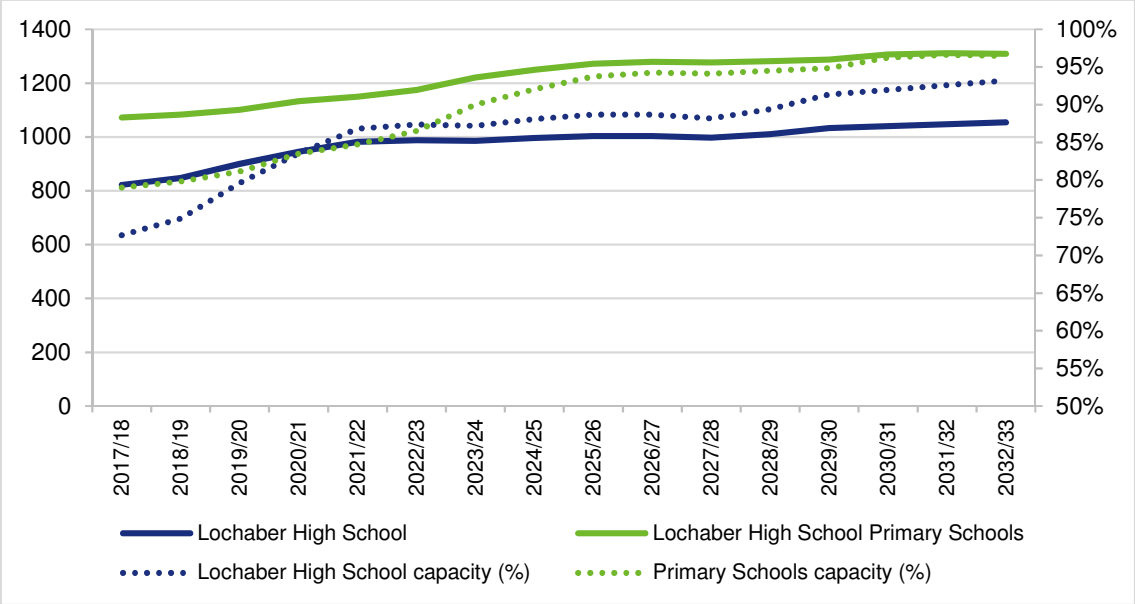


Source: Highland Council (2018)

2.13 Figures 2.8 and 2.9 show that there are significant differences in the school roll projections between different catchment areas. Some schools are close to capacity, whilst others are not. The overall increase is largely driven by Lochaber High School and the primary schools in its catchment area, which have by far the highest pupil numbers. The high school is projected to reach 93% capacity and the primary schools 96% capacity by 2032/2033. This is likely to reflect the fact that 85% of planned house building in the Lochaber area from 2018-2022 is based in Fort William. The concentration of home building in Fort William is set to continue into the long term with 98% of planned builds from 2023-2028 and 100% from 2028-2033 being based in the town. The projected increase in pupils in the catchment area is 28% for the high school and 22% for the primary schools. The other three high schools (Mallaig, Ardnamurchan and Kinlochleven) and their catchment primary schools are projected to remain below capacity, with some significantly below capacity. Several schools are projected to experience a decline in pupil numbers.

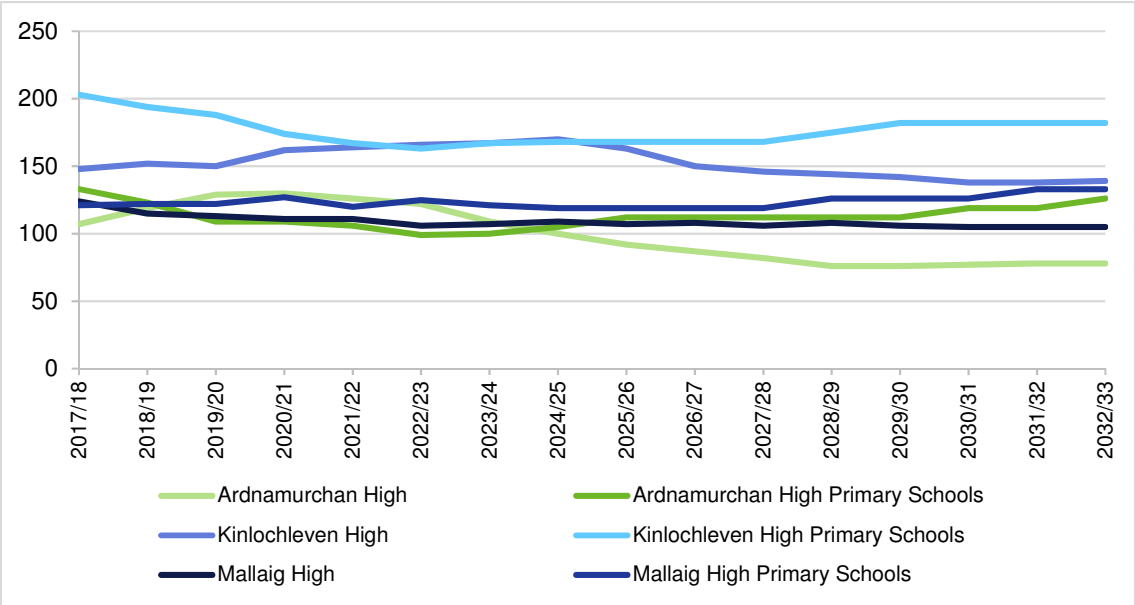
[7] https://www.highland.gov.uk/downloads/file/19257/school_roll_forecast_methodology_september_2017

Figure 2.8: Lochaber school roll forecasts: Lochaber High School catchment area, 2017/18-2032/33



Source: Highland Council (2018)

Figure 2.9: Lochaber school roll forecasts: Ardnamurchan, Kinlochleven and Mallaig High Schools catchment areas, 2017/18-2032/33



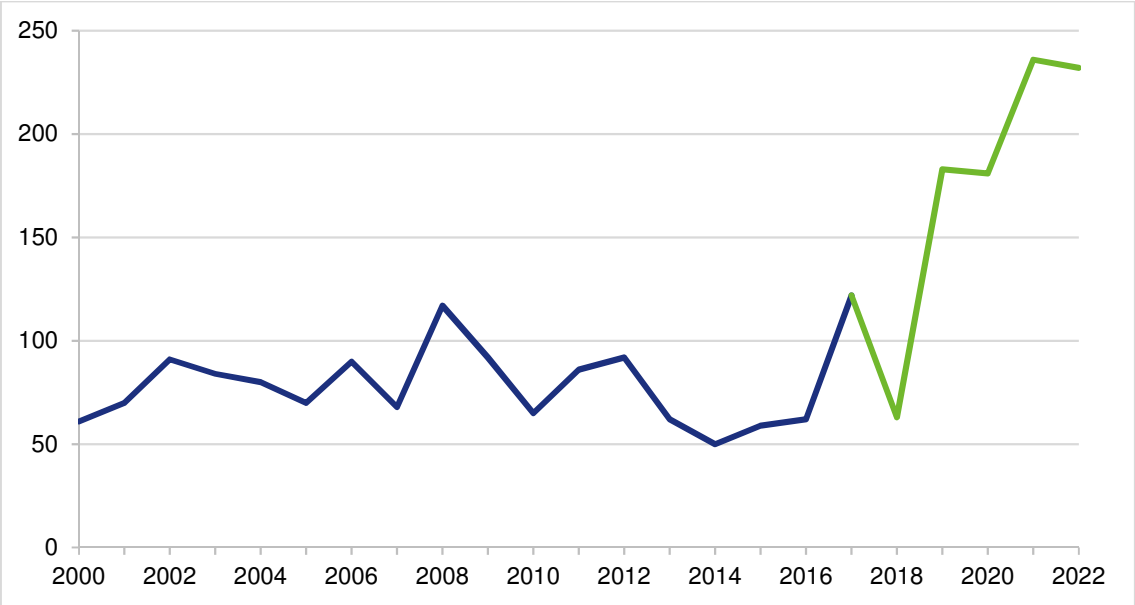
Source: Highland Council (2018)

Housing completions and programmed projections

2.14 The Highland Council's Draft Housing Land Audit 2018 provides data on completions and programmed projections for new housing developments. From 2000 to 2017 there were 1,421 housing completions in the Lochaber area, equating to an annual average of 79. As Figure 2.10 demonstrates, there is a projected short term increase in completions in the period to 2022, which is a step-change in completions compared to historic trends. There are also longer term projections of a lower level of completion for the period to 2033. These are more difficult to forecast, which is understandable given the relatively short-term nature of the housing development pipeline: these are the *known* programmed completions. It is anticipated that these forecasts will increase as more housing development comes online, and completions are programmed into future Housing Land Audits. The uplift in the period to

2022 could be sustained over the longer term if demand continues. 'Windfall' completions also comprise a significant proportion of completions in Lochaber. This suggests that there is potential for future completions to be higher than currently forecast.

Figure 2.9: Housing completions in Lochaber, 2000-2022



Source: Housing Land Audit (2018)

3 CURRENT INTELLIGENCE

Headline messages

- Major private sector investment is planned with the proposed new alloy wheel manufacturing facility in Fort William.
- There is also major public sector investment planned, including a new West Highland College Science and Technology Centre and the replacement of the Belford Hospital.
- Further investment is planned and underway to increase the number of houses in the Fort William area, almost all social/affordable housing.
- Further private sector investment may be realised on the back of the proposed alloy wheel manufacturing plant.
- The timing of the planned private and public sector investment is not certain in all cases, although there is likely to be very major investment in the next 2-4 years.
- The planned investment represents a 'policy on' scenario, which will have implications for the population projections of the Lochaber area over the current forecast period to 2041.

INTRODUCTION

3.1 There is a considerable level of private and public sector investment planned or under consideration in Lochaber. The exact level of investment, and in particular the timing of these investments, is not clear in all cases, and is subject to change and modification. Nonetheless, for some of the proposed investments, there is more certainty and clarity. This section provides commentary on the planned and proposed investments in Fort William and the immediate surrounding area in the coming years.

3.2 The available intelligence on the latest status of public and private investment has a bearing on the anticipated population levels in the Lochaber area, as well as the population profile. Views on how the proposed investments are likely to affect the socio-economic baseline described in Chapter 2 are therefore also captured in this section.

PERSPECTIVES ON INVESTMENT PROJECTS

Private sector investment

GFG Alliance/Liberty House Group

3.3 The 2016 announcement of the £330 million deal for investment in Fort William by the GFG Alliance, was the most significant proposed investment in the area for several decades. The proposal is for a new alloy wheel manufacturing facility, designed to make use of the proximate aluminium smelter, now operated by Liberty British Aluminium. The capital expenditure for the facility alone is estimated as £70m.

3.4 The initial announcement was for 400 jobs at the alloy wheel manufacturing facility. During the course of this study the language used has been 'up to 400', indicating that the full 400 jobs may not be required. It is expected that 200 workers will be required within a short timeframe, i.e. with 6-12 months of the new plant opening, with expectations at the time of reporting that consent for the factory will be 2019, and that the facility may be completed in 2021. This is anticipated to take place over two recruitment phases of 100 workers each, the first phase in advance of opening, with employment growth more slowly thereafter.

3.5 At the time of reporting, the intention was for a contractor to be on site in early 2019, although there remained some uncertainty as to the start date for the actual plant construction, and the actual timing as to when Liberty would be on site. There were still a number of pre-planning conditions to be satisfied which were being worked through.

3.6 Full details of the composition of the workforce at the new facility are not available. However, indications are that around a third may be managers and professionals, a third skilled, notably product and process engineers, advanced maintenance and supervisory roles, and a third lower skilled, although this may vary as the project develops.

3.7 To meet their recruitment needs, Liberty are planning to recruit their workforce from the UK, including from the local area[8]. It is expected that employees, particularly those in higher paid positions, may be prepared to commute significant distances locally. In addition, it is anticipated that many workers will re-locate to the area to take positions at the new wheel factory, or to take up other opportunities in the local economy that become available, boosting the population of the area significantly.

3.8 The workforce requirements at the liberty plant will draw on a range of sectors where people may have relevant skills (construction, engineering, etc.). Liberty's approach is to target workers with adaptable skills (i.e. a 'train and change' approach), and they expect women to form a major part of the workforce. Liberty anticipate that it will be the recruitment of operatives that will be the greatest challenge for the business, with an expectation that it will be easier to attract higher paid workers (as in their experience, re-locators are typically the main wage earner).

Other private sector investment

3.9 There are a number of other large businesses in the Fort William area, including BSW, Nevis Range, Newco and the existing Liberty Group-owned smelter. A detailed review of business and investment plans of these companies was outwith the scope of the study. However, these will need to meet the ongoing challenges of retaining their workforce, recruitment of new staff and increasing their competitiveness, to ensure sustainability or growth. The smelter itself has recruited around 50 persons in the last 12-18 months (as those in their 50s take retirement packages) which has already caused displacement from other employers in the area.

3.10 Liberty is also aware of the need to ensure the existing smelter operation is effective and maintained. There is recognition that the workforce needs of the smelter will need to be taken into consideration when developing a recruitment strategy for the new wheel manufacturing facility.

3.11 There are also longer-term investment proposals, which may also impact on the economic performance and service needs of the Fort William and Lochaber area. These include the potential for establishing a mains gas network, for which a feasibility study is underway, and to develop Corpach deep-water port, which has the potential to be developed for in-bound raw materials and possibly the export of bulk goods.

The health sector

3.12 The major investment with respect to the health sector is the planned new hospital to replace the existing Belford Hospital. The new hospital is expected to be a capital project costing in the region of £20-£30 million. Latest intelligence suggests that construction on the hospital may commence in 2021, with completion and the opening of the hospital in 2022/3.

[8] A comparison was made with commuting journey times into London which are commonly 90 minutes, time that would enable one to commute to Fort William from almost as far as Inverness. Therefore 'local' in this context includes areas within a 60-75 minute travel time to work.

3.13 Overall, Health and Social Care provision is particularly challenging in remote and rural areas. This is a result of the dispersed nature of the population, and older demographic compared to urban areas, and transport issues. Further, NHS Highland faces recruitment difficulties and higher than average vacancy rate for posts outside of its Raigmore Hospital workforce.

3.14 The recruitment challenges faced by NHS Highland are particularly acute in Lochaber. Across the Belford's establishment of 10 consultant posts, including three general surgeons, three consultant physicians and three anaesthetists, there were eight vacancies (47%).[9] In addition, there are 80 posts that need to be filled across Lochaber each year as a result of staff turnover. Despite these vacancies, there is not currently expected to be a significant change in the total numbers employed. However, the composition of the workforce may change. The Belford hospital development is at the centre of a wider service redesign, in response to changing need and demand, demographic change, and technological development. As a rural general hospital, there will continue to be a high demand for services placed on the Belford hospital, including specialist facilities (e.g. in relation to accommodating mountain rescue admissions). Replacing its estate to ensure ongoing functional suitability is therefore imperative.

3.15 What remains clear is that Lochaber is experiencing the increasingly complex challenges associated with an ageing population, and health inequalities that are being seen elsewhere. Currently one in five are over the age of 65 but this is expected to increase to almost one in three in the Lochaber area by 2035. The area also has particularly high incidences of respiratory, cardiac and alcohol misuse-related illness.

Education

3.16 The major new development in relation to education is the planned investment for West Highland College to create a new £12-£15 million Centre for Science and Technology. The headline numbers proposed in the Business Plan are: 150 full-time students and 250 part-time students. These are additional students to the current West Highland College numbers of circa 3,500 across its Fort William and Portree campuses and eight learning centres, which represents an increase of around 10% in student numbers.

3.17 The Centre is expected to include a broader and more advanced curriculum and facilities, along with construction, engineering and wider design and ICT/digital course provision.[10] The College considers there to be significant potential demand amongst local construction and engineering companies, and are therefore looking to support required Continuing Professional Development (CPD) and other forms of skills and training development, not least Modern Apprenticeships. Indeed, the College has already undertaken employer engagement work to gauge levels of interest and ensure provision meets local business needs.

3.18 At present, modelling of student numbers by age or by other characteristics has not been carried out. However, the College expects that the up to two thirds may come from the local area, which may play a significant role in helping to retain young people who currently the leave the area to attend College.

[9] As of August 2018

[10] Outline Business Case, July 2017. Specifically, the WHC Centre for Science and Technology has four aims:

- To deliver FE/HE curriculum in Science, Technology, Engineering and Mathematics (STEM) subjects, linked to local business needs, and offering progression to further study from school-based learning to technician and degree levels.
- To play a key part as a regional hub for the UHI School of Health
- To deliver commercial courses in STEM subjects, offering Continuing Professional Development (CPD) opportunities to businesses and people in work.
- To inspire and boost interest among children, young people and the wider community in technology, design and science and professional careers in these areas.

3.19 The plans for the new Science and Technology Centre also include a Centre for Health Science/School of Health (which may provide some training ward facilities for the new Belford Hospital) and additional student accommodation.

3.20 There has already been considerable investment in the schools in Lochaber, which has increased local capacity and enhanced the local schools offer. Further investment in schools may also occur into the medium term, including the possible expansion of the Gaelic primary school and/or a new primary school at Blar Mhor.[11]

Housing

Social housing

3.21 There has been, and continues to be, major investment in housing in Fort William, the main focus of housing investment in Lochaber, as well as some investment elsewhere in the area. This is almost entirely affordable/social housing development led by the public sector, with no large scale private sector investment planned at present. The key planned social housing developments are the Blar Mhor site, expected to be 250 houses, and at Upper Achintore, at c.400 houses. A number of smaller housing developments are also under construction or have recently been completed, including 60 homes at the former Lochyside school site, and 21 houses at the former distillery. There is approximately £50 million of investment in housing development projects in the short term.

3.22 The Blar Mhor site is the most advanced. Phase 1 is expected to see 115 houses, a mix of 1, 2 and 3 bedroom properties, although the precise mix is not yet clear. These are all expected to be affordable or mid-market rental homes. The site is the large former Tesco site, now in public ownership following its purchase by Highland Council in 2015. The site is expected to include the new Belford Hospital and West Highland College's new Centre for Science and Technology; the new Police station, already on an adjacent site, is to be accompanied by the proposed housing.

3.23 For Upper Achintore, the 400 units are again affordable housing units. The timescales for development here are less clear, and these may slip beyond the short-term programmed completions; given the need for further site investigation works, it may be 12-18 months before construction commences. The development is being brought forward by Lochaber Housing Association, with LINK as the development partner. Latter phases may include some private housing.

3.24 There is certainly demand for social housing, stakeholder consultations identified that there are around 800 people currently on Highland Council's waiting list. This is a high number even allowing for the fact that many place themselves on the list just in case a better property becomes available.

Private sector housing

3.25 In terms of the private sector, the key indicator for volume housebuilders is the rate of change in the second hand market, and their profit margins after costs. In the case of the second hand market, private developers have not yet seen enough movement to encourage them to invest.

3.26 The principle barrier for private sector housing developers in the Fort William area are infrastructure costs. These largely relate to the increased costs of peat removal. The sites for development are limited given the Nevis range and the Mamores to the East and South of Fort William, and Loch Linnhe and Loch Eil to the West. However, even with available sites, private sector developers cannot get the 20%-25% margins they are seeking, and which they can achieve elsewhere. The cost–to-value ratio is not sufficient. The lack of a major local construction sector also drives up their costs and reduces their margins. That said, anecdotal evidence from stakeholders indicate there has been a recent upturn in private sector housing developer interest, in light of the scale of proposed total public and private sector investment.

[11] West Highland and Islands Local Development Plan Proposed Action Programme, May 2017.

3.27 There is certainly a perception amongst businesses that housing is a barrier to their recruitment. The Chamber of Commerce has recently conducted a survey on the issue with its members. Evidence of the lack of housing acting as a barrier to recruitment would help strengthen the case for increased public sector investment in housing and/or site assembly.

3.28 The Liberty Group themselves have expressed a desire to provide housing for their workforce. However, their sites are not currently considered viable for housing, and there would need to be a joint venture with the public sector if they were to release any government funding to support these proposals.

Transport

3.29 A Strategic Transport Study for Fort William (pre-STAG appraisal report) has been completed and published[12]. This provides a baseline, and in line with STAG guidance, defines the transport issues for the area. It also provides a strong case for change to the Fort William transport network, setting out a shortlist of options for more detailed consideration. These include a new A82-A830 link road (possibly including a link road to Caol), an integrated travel hub at Banavie, improvements to public transport services and the sustainable (walking and cycling) travel network in the area, and travel information and behaviour change initiatives. Subject to Transport Scotland progressing the next stages of the STAG for Fort William, these major road infrastructure and transport investments can form part of the mix of solutions to overcome transport capacity issues in Lochaber.

3.30 Although the STAG process has not yet progressed beyond the pre-appraisal report stage, there is an increasing recognition of the range and scale of investment (both public and private) likely to come forward in the Lochaber area. There is also a recognition of the growth in tourism across the west Highlands, and the effects this has on the volume of traffic in the area, e.g. on the A82 through Fort William.

3.31 No decisions have as yet been made; however, the forthcoming update to the Scottish Government's Strategic Transport Projects Review provides an opportunity to make the case for national investment in Fort William's transport network. There is also the potential for proposed transport investments to be incorporated into the Local Development Plan process.

OBSERVATIONS ON EXISTING PROJECTIONS

3.32 The general view amongst stakeholders is that the current 'policy off' population projections are not suitable or appropriate for service planning purposes, given the extent of planned investments. Although a number of the investments described are still provisional, there is enough certainty around proposals for stakeholders to want to take into account 'policy on', rather 'policy off' projections.

3.33 The desire to take into account the 'policy on' is reflected in the fact that some projections are already taking planned developments into account. Notably, this extends to the school roll data where the forecasts for school roll numbers already account for some of the private and public investment planned.

3.34 The view is also strongly expressed that the NRS long-term projections persistently under-estimate the populations in the Highlands and Islands. This specific feedback has been factored into the population projections in the next section.

3.35 It would also be helpful for specific employment projections to be generated, based on industrial sectors, and accounting for expansion and replacement demand. This is not readily available, or easily generated at sub-local authority level; however given the unique circumstances in Lochaber some sub-local authority employment forecasts under a 'policy-on' scenario may be helpful.

[12] https://www.highland.gov.uk/download/meetings/id/74111/item_10_-_fort_william_strategic_transport_study

4 SCENARIO MODELLING FOR GROWTH

Headline messages

- The major private and public sector investment planned will have a significant impact on the population of Lochaber over the forecast period to 2041.
- The effects of the investment in the new wheel manufacturing facility alone could reverse forecast population decline of -0.8% and lead to a 3.1% increase in the population of Lochaber (612 persons) over the period to 2041.
- Factoring in the new College Centre for Science and Technology, including associated additional spend from attracted and retained students, and from additional construction worker spend, may result in a population increase of 9.7%, or 1,943 persons.
- With the new Hospital and housing construction spend included, the population increase to 2041 may rise to 16.3%, an increase of 3,263 persons. This is without additional private sector investment that may be levered in following the initial wheel plant investment.
- Population growth at this scale will require planning by all partners and agencies to ensure that their needs are met, which is likely to include further housing requirements.
- The population forecasts use the latest intelligence available for a policy on scenario, however there are a number of assumptions inherent in the projections.

INTRODUCTION

4.1 This section seeks to develop more realistic, and therefore more helpful, projections for the Lochaber area. Chapter 3 sets out investment that is planned by both the private and public sectors, and the extent to which this means that the existing 'policy off' projections are not credible. Taking into account the planned investment creates more realistic projections, which in turn will be of greater benefit and use for future investment and service planning.

4.2 There are some caveats to the scenario modelling set out in this section, since information available to the review is partial. In some instances, this is because no further information is available at this stage or in other instances, the level of detail required is not available. This has required a number of assumptions to be made in developing the scenarios; these are set out in the commentary.

ADJUSTING FOR NRS PROJECTIONS

4.3 The previous chapter indicated that a number of stakeholders in the Highlands and Islands consider the NRS population projections to be overly pessimistic, and that they routinely under-estimate the long-term population, a point of view borne out by the analysis set out in Chapter 2 (Paragraph 2.8 and Figure 2.5).

4.4 The NRS mid-year population estimates are based on historic trends. They take into account birth rate, death rates and net migration, i.e. the difference between in-migration and out-migration. It is the in-migration data that is generally regarded as an under-estimate in the Highlands and Islands, and so records higher levels of net out-migration than should be the case.

4.5 Migration estimates are derived from three key sources of data: National Health Service Central Register (NHSCR); Community Health Index (CHI); and International Passenger Survey (IPS). The NHSCR is used to calculate moves between NHS Board areas within the UK, with migration at council area and below estimated using anonymised data from the CHI. The IPS provides information on overseas moves into and out of Scotland, and on asylum seekers.

4.6 Appendix 3 presents analysis into the differences in the NRS long-term population forecasts and the actual population. This has been produced in detail for the Highland and Eilean Siar local authorities. The analysis highlights that the 2002-based estimate for 2015 (latest data at the time of the analysis) under-estimated the actual 2015 mid-year estimate in Highland by some 15.9%, and in Eilean Siar by 19.6% (as set out in Table 4.1). The 2004-based estimates were slightly more accurate, but still these under-estimated the population by 7.4% and 9.6% respectively.

Table 4.1: Comparison of NRS population projections and mid-year estimates, Eilean Siar and Highland

Year estimate for 2015	Population estimate for 2015	Actual mid-year estimate 2015	Under-estimation (N)	Under-estimation (%)
Eilean Siar				
2002 estimate for 2015	22,638	27,070	4,432	19.6%
2004 estimate for 2015	24,707	27,070	2,363	9.6%
2006 estimate for 2015	26,103	27,070	967	3.7%
2010 estimate for 2015	25,827	27,070	1,243	4.8%
2012 estimate for 2015	26,037	27,070	1,033	4.0%
Highland				
2002 estimate for 2015	201,967	234,111	32,143	15.9%
2004 estimate for 2015	218,007	234,111	16,103	7.4%
2006 estimate for 2015	226,872	234,111	7,238	3.2%
2010 estimate for 2015	231,799	234,111	2,311	1.0%
2012 estimate for 2015	230,010	234,111	4,100	1.8%

Source: HIE analysis of NRS population projections and mid-year estimates

4.7 It is not possible to accurately assess the under-estimation in long-term population projections for Lochaber, given the levels of uncertainty associated with those forecasts, however neither is it right to assume the NRS population forecasts (currently available to 2041) fairly reflect the policy-off scenario.

4.8 What we have assumed therefore – and this is a key assumption – is that the NRS population forecasts for Lochaber under-estimate the population by 6.1%, or 1,230 persons, over the period 2011 to 2041.[13] Adjusting for this suggests the overall population in Lochaber would decline by -1% by 2041, rather than the forecast -7% (as set out at Figure 2.5).[14] **Given what we know about Highland and Eilean Siar – where a 12-year population forecast was more than 10% below the actual mid-year estimates – our NRS adjustment of 6.1% over 30 years for Lochaber may be a conservative adjustment**.

[13] This is a cautious adjustment, given there is no definitive basis for adjusting the NRS projections. The 6.1% adjustment is based on the midpoint of the 2004 and 2006 under-estimations for 2015 for Highland and Eilean Siar.

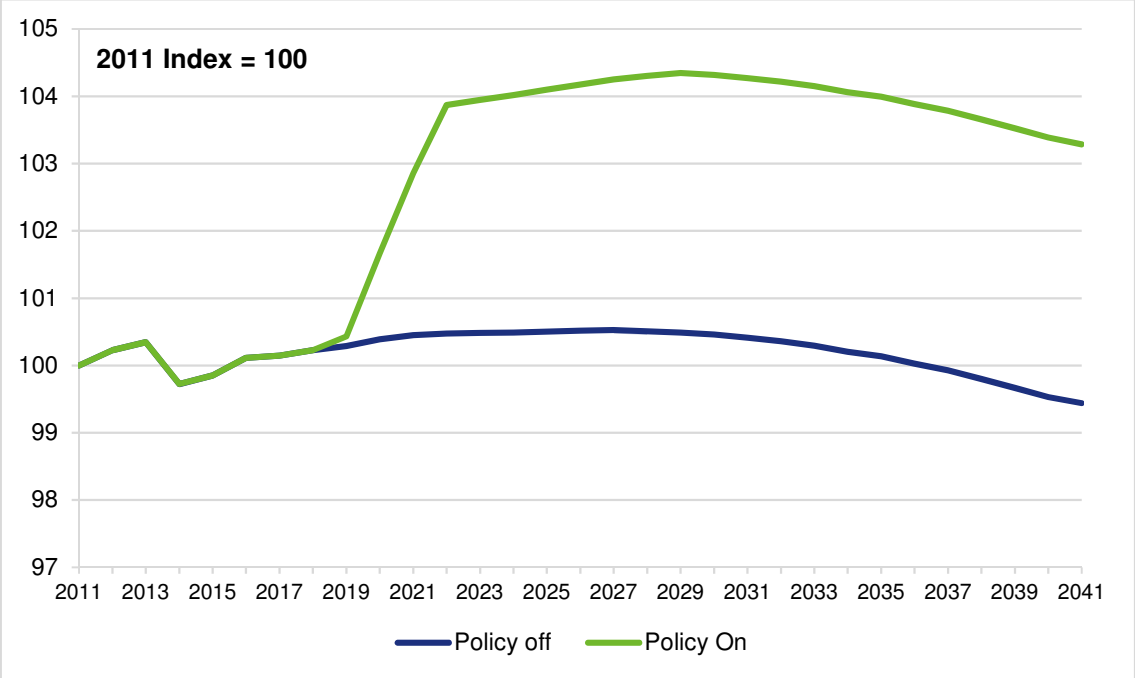
[14] Note, for clarity: the decline is -1% (adjusted) and -7% non-adjusted *2011-2041*; the decline is -0.8% (adjusted) and -5.6% (non-adjusted) *2018-2041*. The following scenarios consider change over the period 2018-2041.

LOW IMPACT: LIBERTY INVESTMENT ONLY

4.9 Chapter 3 indicates the range of private and public investment planned for Lochaber. However, if we consider the impact of the proposed Liberty investment only, we can see the long-term effects on population.

4.10 The new wheel manufacturing development alone could see the total population increase by +3.1% (612 persons) over the period 2018 to 2041, compared to the NRS adjusted policy off scenario, which indicates a population decline of -0.8%. The +3.1% increase compares to a population decrease of -5.6% based on unadjusted NRS projections.

Figure 4.1: Population projection scenario, Liberty investment only



Source: ekosgen/Context Economics calculations based on adjusted NRS projections

4.11 Given that much of the existing intelligence is based on partial knowledge, including understanding of what the actual composition of the workforce at the new Liberty facility will be, there is a degree of uncertainty regarding where these employees will be drawn from and their age profiles. Consequently the forecasts adopt a number of assumptions, for example in relation to birth rates.[15]

Liberty investment only assumptions:

- That there will be demand for 300 workers at the Liberty wheel manufacturing facility – 225 of these jobs will be filled by those directly relocating to work in the alloy wheel factory or to backfill jobs that arise elsewhere in the economy, and 75 by those staying in the area to take up jobs in the wheel factory or elsewhere (who would otherwise have left). It is assumed that 100 of those that relocate will have families (based on half of those working in the alloy wheel factory having families, and a third of those taking up posts in other parts of Lochaber's economy having families), as will half of those retained. Of these 300, the rate of jobs take up will be 100 per year over the period 2020 to 2022;

[15] It should be noted that because there is little intelligence regarding the likely age and sex of in-migrants, assumptions on fertility rates are subject to a degree of uncertainty.

- That the average number of people with the relocating or retained main employee is 2.3, i.e. those with families have an average of 3.3 per household, compared to approximately 2.2 for Scotland and the Highland Council area as a whole[16];
- That there is a modest short-term (10-year) increase in births per 1,000 population (25 per 1,000 versus national average Scotland 11.3 per 1000), associated with families moving into the Lochaber area;
- That there is a very modest uplift in the death rate towards the end of the forecast period;
- That there are 86 jobs induced by the additional spend, both from the additional and retained Liberty plant workers, and from the additional posts in other parts of the Lochaber economy. We have adopted a modest assumption that there are 1.5 persons attracted/retained in the area per 1 induced job (in this scenario 129 in total), with the induced jobs profiled over a 10 year period; and
- That there are 83 construction jobs (10 year Full Time Equivalents (FTEs)) that are additional to the area, based on the Liberty investment build, profiled from 2019-21. This is based on the assumption that 15% of the 555 temporary construction jobs become permanent jobs in the Lochaber area.[17] The 555 construction jobs uses £126,000 turnover per employee (from the Scottish Annual Business Statistics) and is based on £70 million of capital investment. It is assumed half of the 83 permanent construction jobs are taken up by those new to the area (over the assumed three-year capital build period 2019-2021) and half are taken up by those retained in the local area (over the same period).

4.12 In reality, the effects on the population of Lochaber arising from the Liberty investment alone may be higher than these stated. There are a number of modest assumptions, including a key one that just 225 workers relocate to Lochaber, when this figure may be higher if a greater proportion relocate and fewer are recruited locally. What we also know is there is considerable additional planned investment in Lochaber which will increase the local population further. The following scenarios reflect planned public investment at different levels.

[16] https:///statistics.gov.scot/home

[17] It is noted that this assumption of 15% of the temporary construction workers becoming permanent residents in the Lochaber area may require some supportive policies/actions to encourage larger construction companies to establish a permanent base e.g. the establishment of a regional construction office in Lochaber.

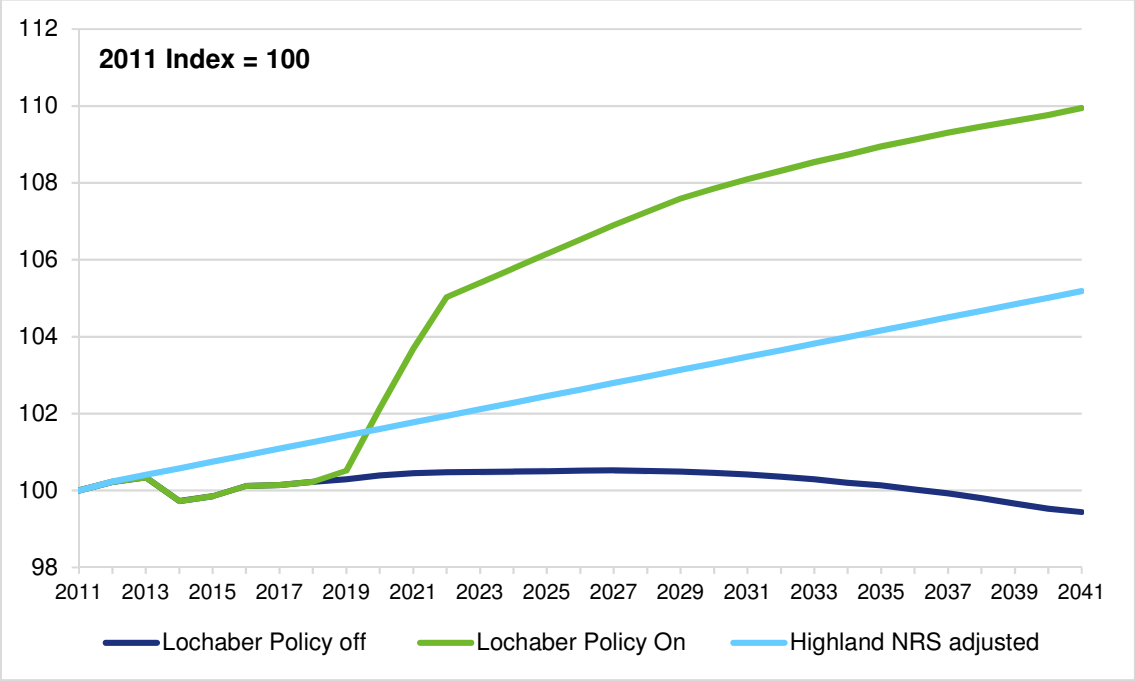
MEDIUM IMPACT: LIBERTY AND SELECTED PLANNED PUBLIC INVESTMENT

4.13 The medium impact scenario also presents the forecast impact once the NRS adjustment of 6.1% over the 2011-2041 period has been applied. It also takes into account some, but not all, of the planned public sector investment, that is, the proposed £12-£15 million West Highland College Centre for Science and Technology. Under the medium impact scenario (2018-41), there is:

- An increase in population in the Lochaber area of +9.7%, or +1,925 (the Lochaber medium impact policy on scenario); compared to:
    - The Lochaber 'policy off' scenario of -0.8%, or -157; and
    - The Highland 'policy off' scenario (also NRS adjusted) of +3.8%.

4.14 The medium impact scenario shows a population increase in percentage terms more than double that for the Highland Council area as a whole. As indicated earlier, the NRS adjusted Highland Council-wide projection is a policy off scenario, and does not include the effect of the Liberty investment, or other planned investment in the Highland Council geographic area.

Figure 4.2: Population projection scenario, Liberty (base) plus selected planned public sector



Source: ekosgen/Context Economics calculations based on adjusted NRS projections

4.15 There are again a number of key assumptions for these forecasts.

Liberty and selected planned public investment assumptions

- The Liberty investment assumptions remains as above, which indicates 225 re-locators, 100 with families, and 75 retained, again half with families;
- That the new College Centre for Science and Technology has a total of 20 additional staff (based on the latest West Highland College estimates), from 2020;
- That of the 150 extra full-time students expected at the new Centre for Science and Technology, 15% of these are retained in the area long-term per annum each year from 2020 and over the forecast period to 2041, (23 persons per annum) and of the 150, 5% are attracted to the area to stay long-term (8 persons per annum over the forecast period to 2041);

- That of the 200 extra part-time students, 10% each year are retained in the area long-term, (20 persons per annum 2020 to 2041) and 2% are attracted to the area to stay long-term (4 persons per annum);
- That there is an increase in births per 1,000 population to 33 per 1,000 versus 11.3, which is the national average. This reflects the increase in the number of younger people retained/attracted to the area as a result of the College development and expansion, as well as the increase in births as a result of families moving in the area for work;
- That the induced spend generates an additional 102 jobs (154 persons in total), based on the additional/retained Liberty workforce, the additional spend from new workers elsewhere in the Lochaber economy, plus the additional spend by College staff and the additional/retained College students; and
- 98 FTE construction jobs, arising from the £82 million capital investment in the College (£12 million) and Liberty build programmes (£70 million), and again assuming 15% of 651 temporary construction jobs created are retained long-term in Lochaber.

HIGH IMPACT: LIBERTY (GROWTH) AND FULL PUBLIC INVESTMENT

4.16 The High Impact scenario assumes that there is a greater impact from the Liberty investment on the local population, and assumes that more of the planned public sector investment occurs. The high impact scenario therefore factors in the planned capital build of the new Hospital, and also considerable investment in housing (assumed to be £50 million, although in reality this may be higher still).

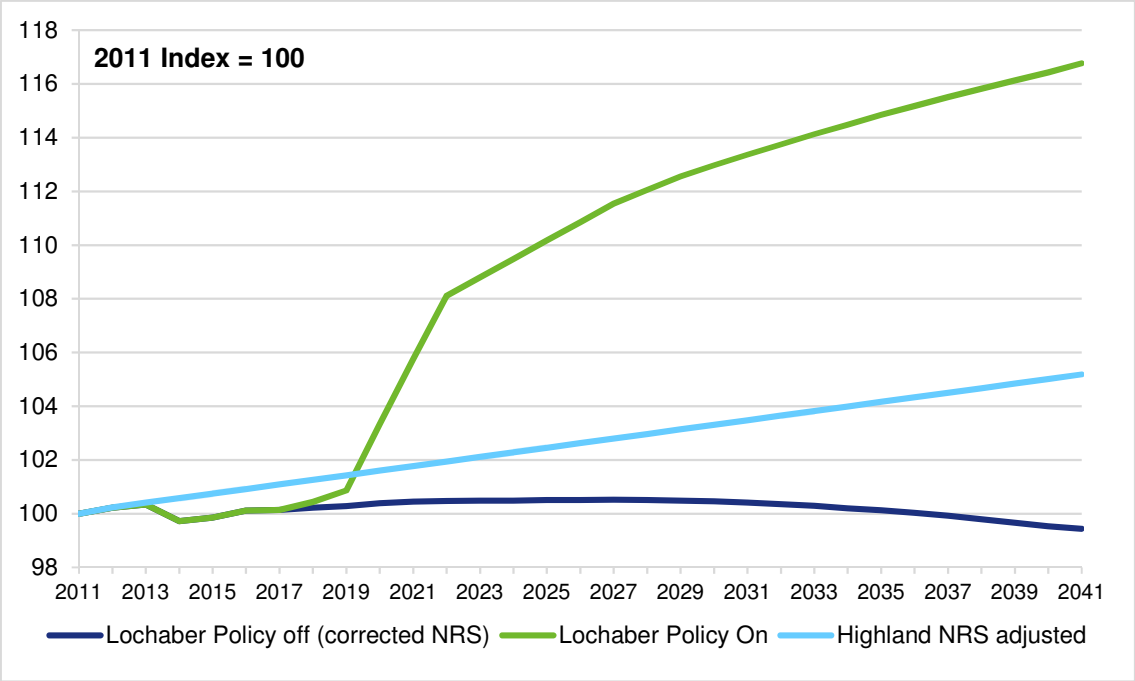
4.17 It is worth noting that whilst this is termed the High Impact scenario, it still *does not* take into account further potential investment. This includes, for example, the potential provision of mains gas across the town, or the development of Corpach port. Additionally, it does not factor in any major transport investment and development.

4.18 Nonetheless, considering the Liberty investment, the College, the Hospital and planned housing development alone, we can see under the High Impact scenario (2018-2041) that:

- There is an increase in population in the Lochaber area of +16.3%, or +3,263 (the Lochaber high impact policy on scenario); compared to:
    - The Lochaber 'policy off' scenario of -0.8%, or -157; and
    - The Highland 'policy off' scenario (also NRS adjusted) of +3.8%.

4.19 The high impact scenario shows a population increase in percentage terms of more than four times that for the Highland Council area as a whole. Again, the NRS adjusted Highland Council-wide projection is a policy off scenario, and does not include the effect of the Liberty investment, or other planned investment in the Highland Council geographic area.

Figure 4.3: Population projection scenario, Liberty (growth) plus full public sector



Source: ekosgen/Context Economics calculations based on adjusted NRS projections

Liberty (growth) and full public investment assumptions

4.20 The key assumptions are that:

- There are 400 workers required for the wheel factory, profiled over the three year period 2020-2022, - 325 relocating to work directly in the alloy wheel factory and taking up employment elsewhere in the Lochaber economy (to replace local workers recruited to work at the factory), and 75 retained in the local area working at the facility who would otherwise have left the area;
- The high growth scenario assumes two thirds of those retained and relocating as a result of the alloy wheel factory have families, higher than the 50% assumed in the other scenarios;
- That the new College centre has a total of 20 additional staff (based on the latest West Highland College estimates), from 2020;
- That the additional 150 full-time College students leads to 20% being retained long-term each year (30 per annum, over the period 2020 to 2041) and leads to 10% being attracted to stay in the area long-term (15 persons per annum over the same period);
- That the 200 additional part-time students leads to 10% being retained long-term each year (20 per annum over the same 2020-2041 period) and leads to 5% being attracted to stay in the area long-term (10 persons per annum);
- That the new Hospital is developed, but that there is no net change in the total workforce, or profile of the workforce;
- That there is an increase in the number of births per 1,000 of the population (34 per 1,000 versus 11.3 national average), as per the medium growth scenario;
- That there are 118 induced jobs arising from Liberty workers' additional spend plus that from those taking posts elsewhere in the Lochaber economy, at 1.5 persons per job, a total of 177 persons. This is higher than the medium growth scenario given that more of the Liberty workforce are expected to relocate to Lochaber under this scenario;
- That there are 77 induced jobs from additional College spend by the long-term attracted and retained students, plus the College staff and from additional construction worker spend, 115 persons in total;
- 181 FTE construction workers, again based on 15% of the construction workforce retained locally and based on £152 million in capital investment, comprising £50 million housing, £20 million for the new Hospital, £12 million for the College and £70 million Liberty. The construction workers attracted and retained in the area are profiled over a 10-year period for the housing and hospital construction, and over five years for the Liberty and College construction.

4.21 As with the low and medium impact scenarios, many of the assumptions are conservative, even under this High Impact scenario. For example, the scale of the capital build investment may well be closer to £200 million over 10 years (the estimate of £50 million for housing is at the conservative end of the spectrum), and it may well be that more than 15% of the construction workforce is retained permanently in the Lochaber area.

INITIAL IMPACT ASSESSMENT

4.22 The increase in population in the Lochaber area is expected to translate into very considerable net economic impacts for the local area. There will be both significant numbers of net additional new jobs, and a considerable injection of expenditure into the local community.

Employment impacts

4.23 In terms of employment impacts, the following can be anticipated:

- Between 375 and 475 direct jobs arising from the new Liberty facility, including additional posts created elsewhere in the Lochaber economy. Liberty anticipate recruiting their workforce from the UK, including the local area, although the balance between locally recruited persons and re-locators will not be fully known until Liberty has completed its workforce recruitment. However, it is expected that the jobs created by local workers recruited will be backfilled;
- 20 direct jobs at the new West Highland College Centre for Science and Technology – this is the estimated number of additional staff required;
- 181 FTE construction jobs – as per the High Impact scenario above this is based a total of £152 million of capital build investment (£102 million Liberty/College/NHS + £50 million housing), and assuming 15% of all construction jobs are retained locally;
- 86 induced jobs, based on the expenditure associated with 225 Liberty plant related re-locators; rising to 118 jobs (for 325 re-locators), and including the induced jobs arising from the spend by those in posts in other parts of the economy; and
- 62-77 induced jobs, arising from the additional long-term additional College students staying in the local area, and arising from the additional spend by construction workers. The range indicates the difference between smaller and greater numbers of full-time and part-time students staying on in the local area post-study.
- This provides net additional and retained jobs of between 724 and 870 jobs

4.24 It is also worth noting that this does not include further additional jobs possible through subsequent private sector investment, for example at Corpach Port. Neither does it explicitly take into account additional jobs that may be created in the supply chain. The new wheel manufacturing facility is unlikely to have a significant supply chain, other than a small number of maintenance jobs and additional services jobs in catering and sundries, although any such jobs created will increase the number of net additional jobs. Similarly, further jobs may be created in the supply chains for construction companies and others involved in delivering the large capital build programme anticipated.

Expenditure impacts

4.25 The annual additional expenditure in the Lochaber area is expected to comprise:

- £3.0-£4.1 million annual additional spend in the local economy arising from the new Liberty facility and posts elsewhere in the economy – again this is based on 225-325 re-locators and 75 persons retained. The annual expenditure figure assumes that the Liberty workforce is a third professional/ managers (at an average annual gross salary £40,000); a third are skilled workers (at £30,000 per annum[18]); and a third are lesser skilled (at £20,000 per annum, based on a modest uplift on the average factory worker pay of £18,465 per annum[19]). We have

[18] £30,292 is the average annual gross salary for a mechanical engineer in Glasgow https://www.payscale.com/research/UK/Location=Glasgow-Scotland%3a-Glasgow/Salary

[19] https://www.payscale.com/research/UK/Job=Factory_Worker/Hourly_Rate

assumed that 30% of wages are spent locally, and have assumed one part time worker for each additional Liberty employee.

- £0.3 million College (staff only) rising to £0.8 million for students who stay long-term in the local area having been attracted or retained post study. We have not taken into account the additional annual spend from additional/retained College students whilst they are studying;
- £2.4 million annual additional spend from construction workers, at an average of £25,000 per annum gross, and based on 15% of the total construction workforce retained locally, as per the population projection scenarios. We have not included any expenditure associated with temporary construction workers;
- Which provides total ongoing net additional local annual spend of somewhere between £5.7 million and £7.3 million.

4.26 The additional annual expenditure in the local economy is therefore likely to exceed the upper end of the range above of £7.3 million. In particular, with as many as 1,200 construction jobs created to deliver the £152 million in capital build works over the next 10 years, there will be additional expenditure in the local area from temporary construction workers, over and above the 15% who may stay on in the area into the longer term.

Salary impacts

4.27 The additional employment set out in the scenarios above is likely to have an impact on average salaries in the area. The average (median) salary in Ross, Skye and Lochaber in 2017 was £20,836, based on Annual Survey of Hours and Earnings (ASHE) data.[20] Assuming the direct employment impacts above –additional employees at Liberty at the occupational balance set out plus employment created elsewhere in the local economy as a result of the Liberty development, additional college staff, and construction employment retained in the Lochaber area – then there will be an increase of around £17.3 million in total salaries in Lochaber, which equates to an uplift in average salaries of between 1 and 2% across the whole Lochaber area.

[20] No data on salaries is available below either the Highland Council or the Ross, Skye and Lochaber constituency areas

5 CONCLUSIONS AND IMPLICATIONS

INTRODUCTION

5.1 As the analysis has demonstrated, there are a number of opportunities that can be capitalised upon to improve the economic and demographic outlook for Lochaber. However, there are undoubtedly challenges and implications that will need to be addressed in order to realise ambitions for the area.

5.2 The key implications relate to where new workers to the area – and workers who choose to stay to take advantage of new opportunities – will live; what the impact on service provision will be; and what the projected increase in population and employment will mean for transport, traffic management and other essential infrastructure.

POLICY IMPLICATIONS: POLICY OFF

5.3 As the report sets out, the 'policy off' scenario shows that, even taking adjusted NRS projections into consideration, the population of Lochaber is forecast to decline over the period to 2041. Trends to date indicate that the population structure will also continue to age which will have a number of implications for service delivery.

5.4 An ageing population structure means an increase in demand for health and social care services. This will be compounded by a shift in the dependency ratio (the ratio between those of working age, and children and pensioners), and the lag between expected increases in life expectancy, and healthy life expectancy. More people will be living longer with ill health and, therefore, with increased and changing health and care support needs. This will put increasing pressure on public expenditure and demands on services such as Personal and Nursing Care, which has already increased significantly in recent years.

5.5 Along with an ageing population, projections indicate a decrease in demand for school and other education services. Outside of Fort William, Lochaber's schools are not operating at full capacity, and a reduction in demand for places will exacerbate this. The 'policy off' scenario indicates continued out migration, especially those of working age, a trend that has been a feature of the Lochaber economy over the recent decades. Between 2011 and 2016, Lochaber's working age population decreased by around 3%.

POLICY IMPLICATIONS: POLICY ON SCENARIOS

5.6 The three 'policy on' scenarios detailed in Chapter 4 will have a number of consequences for the area's demographic profile. The most important of these is that for all three scenarios, there will be a shift from population decrease to population increase. This will be driven by an increase in the working age population as a result of retention and attraction of workers in Fort William and the wider Lochaber area and associated increase in birth rates. This will have a number of policy and service provision implications and the principal ones are discussed in the following sections.

Dependencies and uncertainties

5.7 There are a number of dependencies and uncertainties around the 'policy on' projection scenarios. Many of these are linked to the proposed Liberty development.

5.8 At the time of writing, the proposals for the new alloy wheel processing plant have not met all planning conditions, so development cannot commence. However, these conditions are anticipated to be in place by early 2019 which would enable construction to start shortly afterwards, with production coming on stream during 2021/22, scaling up to full capacity by mid-2020s.

5.9 The opening of the new processing plant will bring a number of recruitment challenges – the Lochaber labour market is already tight. The high employment rate means that recruitment from the local area is challenging, though it is acknowledged that, in some sectors at least, there is a degree of underemployment.

5.10 The Liberty development – and subsequent industrial/sector developments – will necessarily attract workers from other sectors. This is a particular concern for engineering, where there is already a shortage of skills, and strong competition for engineers in the region. As well as engineering companies, employers in other sectors such as aquaculture have struggled to fill engineering vacancies. While the scenarios make a number of assumptions net increases in employment, there is clearly a potentially negative impact on the local and regional economy – not least on Liberty's likely supply chain of contractors. There is therefore a degree of uncertainty as to whether Liberty will manage to recruit large numbers locally. However, the Liberty development is a significant employment opportunity, and one which may attract and retain young people in the local area. A greater number of young people choosing to stay in or move to the area to work may offset any negative impact from Liberty's recruitment in the local area.

5.11 It is also not certain that Liberty will succeed in meeting its targets for recruiting re-locators. This is in part due to whether the employment opportunities are attractive in comparison with other sectors and locations in the Highlands and Islands, and further afield. Talent attraction is therefore critical to its overall success, and in ensuring that opportunities through the Liberty projects and other developments in the Lochaber area are more attractive in comparison.

5.12 The age profile of re-locating recruits in the 'policy on' scenarios is not certain, and has not been factored into scenarios. The population projections that we have based the scenarios on are not sufficiently detailed to include age groups of people. The age profile of re-locators is important as it will determine the specific need for services, schools, housing types and so forth. For example, whereas a younger worker with a family would require a larger family home, places at a local school, and possibly employment for another adult in the household, an older worker may require a smaller home, but could place more demand on health services over time, particularly over a longer time period. However, there is limited information regarding the likely age and sex of in-migrants, so assumptions on fertility rates are subject to a degree of uncertainty. Nevertheless, Highland Council and Lochaber Deliver Group partners should closely monitor population trends to identify any changes in the area's age profile, so that service provision can be adequately planned on accurate information.

Housing

5.13 Without accurate information on the profile of new workers and residents, it is difficult to plan the right mix of residential properties. However, it is critical to have affordable, attractive housing that meets the needs of current and potential residents to attract and retain workers and take advantage of new employment opportunities. This can contribute to addressing demographic challenges faced by the area, and the region. Poor availability of suitable, affordable housing for young people is a key barrier to employment – and a driver of out-migration from the region. Those relocating to the area for work will include those with families, and ensuring a sufficient supply of family and aspirational housing should be part of the considerations.

5.14 It is important that the mix of housing delivered both in the short and longer term meets the housing needs of Lochaber's existing population, but also anticipates the likely profile of workers who migrate into the area. Workers in different age groups will also result in different longer-term impacts on the housing market – different rates of churn, upsizing, downsizing, etc.

5.15 Housing construction and its associated employment has been factored in to the projections of the high impact 'policy on' scenarios, but even here only in a modest way. The central focus of the projections has been on developments that will drive a significant increase in *permanent* employment. It is also assumed that existing housing development is factored into the current employment and population estimates. Construction in itself may attract and retain workers in the area at rates well above

those in the high impact policy on scenario, where we assume 15% of those employed in additional construction work are attracted/retained. As well as providing initial construction employment opportunities, the additional housing may also in itself enable people to stay, find more permanent employment or start a business.

5.16 The higher growth scenarios may also require more housing, and this should be factored into future iterations of the local development plan, and housing need and demand assessments. A higher volume of anticipated demand could unlock greater private sector investment in housebuilding: it may attract volume housebuilders, who currently have limited interest and activity in Lochaber, and the Highlands and Islands as a whole.

5.17 Windfall developments form a considerable component of housing completions in Lochaber, so there is a question of how best to factor this into the housing pipeline. This is particularly important given that the Liberty project, and other developments, may stimulate a higher rate of windfall housing growth. Re-locating workers, especially those on higher salaries, may see self-build as a viable housing solution, particularly in the absence of other options. Such windfall developments may occur both in Fort William itself, but also in surrounding communities.

Infrastructure

5.18 Transport is an important consideration for developments in Lochaber. New activity and additional workers and residents will mean more people and goods moving around and through the area – therefore there will be more vehicles on Lochaber's roads. The area's transport network is a particular constraint in terms of capacity, and pressure on interchanges. Stakeholders agree that it is not just a peak-season, peak-time challenge for Lochaber and the Highland Council area; however, this has not been reflected in national strategic transport planning to date.

5.19 The Liberty development is likely to attract workers from the wider Lochaber TTWA which will increase pressure on the transport network. However, proposed shift and delivery patterns for the new Liberty plant mean that travel flows would largely fall outside of normal peak hours, which may minimise the impact.

5.20 The area's existing water and sewage treatment infrastructure is adequate and can accommodate future housing and industrial development. However, sewerage pipe capacity may be a constraint in the long-term, particularly in high-growth scenarios. This should be an area of consideration for Highland Council, Scottish Water and partners to ensure that an essential component of development infrastructure can meet potential future demand.

5.21 Digital connectivity is increasingly critical for businesses, service provision and of course for individuals and households. It can prove to be a decisive factor in making an area an attractive proposition to remain in or locate to. There have been considerable improvements in digital connectivity across the region in recent years.

5.22 The Inverness and Highland City Region Deal's ultrafast broadband plans mean that there is potential to ensure that Lochaber is more capable of attracting and retaining workers. It can also potentially offset a lack of amenities available in Lochaber in comparison to elsewhere in Scotland. HIE, Highland Council and partners should continue to work to maximise the potential of broadband roll-out across the region.

Health services

5.23 An ageing population such as Lochaber's will put pressure on health and social care services. The retention and re-location of workers will mean increased demand for services, exacerbating this pressure. GP and dental registration will increase. The anticipated increase in the birth rate, even in the short term, will likely mean more demand for maternity provision. These issues are faced across

the UK, but the challenge can be more acute in rural areas, where services are more expensive to deliver, and staff can be harder to recruit and retain.

5.24 NHS Highland will need to cater for this additional demand alongside meeting need from existing issues – age-related health and social care requirements, as well as those associated with health inequality and deprivation in Lochaber. Given the recruitment and retention challenges NHS Highland currently faces, there is a clear need for a more strategic approach to filling vacancies, and reducing staff turnover. This should form part of the redesign of services in the area, alongside the redevelopment of the Belford hospital.

Education

5.25 Currently schools in Lochaber are operating below capacity. Existing projections indicate that roll numbers will increase in the Lochaber High School catchment area, and remain constant elsewhere, since they assume some levels of development in the Lochaber area. However, school rolls could be significantly boosted if new workers and households are attracted in to the area and existing residents remain. In the short term, this increased demand is likely to be focused in Fort William, and in the Lochaber High School catchment area. Despite there being some assumptions on population growth built into school roll projections, a higher growth scenario will push demand close to – or above – school capacity.

5.26 Highland Council should give consideration to how these scenarios may impact on school roll projections, and the potential demand for school places. It is difficult at this stage to predict the profile of households who may move in to the area. It would therefore be helpful to consider the impact of a range of scenarios on school rolls, and so plan provision, building in flexibility where possible.

5.27 There are also implications for the provision of tertiary education. We know that the lack of availability of subjects and courses is a major barrier to retaining more young people. Though there has been some recent progress in curriculum development and networking of courses across UHI's partner institutions through remote learning opportunities, the establishment of a new Centre for Science and Technology at West Highland College will boost provision, and will retain, and potentially attract, students to the area. It will therefore play a crucial role in meeting talent retention and attraction objectives through expanded education provision.

Wider economic activity

5.28 The Liberty investment is not expected to require a significant local supply chain when the processing plant becomes operational. There is therefore a need for adequate recruitment support to ensure that there is a net increase of workers across the Lochaber economy. This will help to maintain the supply chain workforce, particularly where there are recognised skills shortages in specific roles, e.g. engineering.

5.29 Conversely, the Liberty development and other 'policy on' activities will undoubtedly provide wider economic opportunities, such as in maintenance and service provision. There is a requirement for the necessary support to maximise the opportunity for local business start-up and growth, and also to support recruitment and training needs. HIE and partners should consider ways in which this can best be achieved. Consideration should also be given to the potential to attract service companies to locate operations near Liberty, and expand the business base in Fort William and Lochaber.

5.30 The Liberty development, along with other major developments in Lochaber, will also mean a short-term requirement for construction workers which will bring a temporary boost in local employment. It may also mean an increase in demand for accommodation and other services. Previous research around housing markets and stimulating housing development in the region, and the attitudes and aspirations of young people, has shown that there is a relatively limited supply of rental properties in the area. Long term rentals can be difficult to find as holiday rentals servicing the demand from the tourism industry are more lucrative for landlords.

5.31 Recently, portakabins have been used as temporary accommodation for some construction projects in Lochaber and indeed elsewhere. Providing a more permanent solution, such as increasing rental opportunities, can help to capture greater economic impact from temporary employment.

5.32 At the same time as the new Liberty plant becomes operational, its existing smelter must be sustained, including its workforce. There is a risk that workers in the smelter will seek employment in the new alloy wheel plant. This movement of workers may be inevitable. Consequently, there needs to be a strategic, multi-agency approach to ensuring that no employer, sector or operation is detrimentally impacted in the longer term.

5.33 There is strategic added value in the successful delivery of the Liberty investment and other public sector developments, which will bring a wider set of benefits. These developments will improve confidence, stimulate new business activity and act as 'anchors' to attract greater levels of inward investment. The Lochaber project partners should work to ensure that these wider benefits are maximised.

5.34 In addition to existing developments, there are a number of significant projects and opportunities in the pipeline. These include the potential for the development of a deep-water facility at Corpach Port, and the provision of a mains gas network which, if taken forward, will offer significant economic development potential and have implications for employment and potentially housing, infrastructure and service provision. It is important that, along with current projects, the potential benefits of other developments are also realised.

5.35 Wider still are the ambitions associated with the masterplanning for Fort William for 2040. FW2040 envisages a wide range of ancillary improvements and investment in the area, from waterfront improvement, to environmental projects, to public realm. Given the level of proposed public and private sector investment, these additional projects to knit developments together and create additional foci will improve the quality of the experience of Fort William for residents and visitors alike, helping to 'bed in' the major investment proposals.

MAXIMISING OPPORTUNITIES

5.36 The scenarios presented in this report are encouraging, but growth is not guaranteed. An effective policy response from the Lochaber Delivery Group partners is required to enable current and future development. Wherever possible, partners should provide strategic support and act to de-risk investment, by helping to remove any barriers to development, for example meeting high up-front infrastructure costs in relation to housing developments. This will help realise the opportunities presented to Lochaber.

5.37 To realise the growth scenarios that the report sets out, there is a need to maximise the number of workers re-locating. This is to take advantage of new employment opportunities through development such as the Liberty alloy wheel plant, and also to take up opportunities created or arising elsewhere in the local economy, as well as to address existing skills challenges. It is therefore important to sell and promote the benefits of Fort William and the wider Lochaber area. A programme of positive communications around the quality of life and opportunity presented by Lochaber's development plans should be put in place.

5.38 Adequate business support for start-up and growth companies should be in place. This should be allied to servicing the new investments, and taking advantage of related opportunities. There will also be a need to meet increased demand for services from households. Partners should ensure that businesses are best placed to respond to these opportunities.

5.39 Local FE and HE provision has a critical role to play in ensuring the right training and skills delivery to retain and attract workers. Local career progression pathways must be maximised, to provide as many career opportunities as possible to Lochaber's residents, and to young people in particular.

5.40 There should also be long-term planning and support for housing and infrastructure. Securing public sector investment to de-risk housing sites will enable a greater degree of private sector investment, where there is a limited amount currently, especially from volume housebuilders. This can ultimately help to secure a higher-specification and broader mix of housing, e.g. for first time buyers, family housing, down-sizers, etc. This will help to overcome a number of housing barriers faced by young people in particular. It will also potentially lead to a more balanced pattern of growth in Fort William, and reduce the reliance on windfall housing completions.

5.41 HIE, HI-TRANS and Highland Council, in conjunction with other partners should also make the specific case for transport investment to the Scottish Government. The recently completed pre-STAG appraisal for Fort William is the first part of this process. There is a clear opportunity to ensure that future iterations of the National Transport Strategy and Strategic Transport Project Review contain scenarios that reflect the challenges and opportunities present in Lochaber.

5.42 Finally, the Liberty investment and planned public sector investment should be seen as the start of the long-term renaissance and regeneration of Fort William and the Lochaber area. The investments, on which the population projections in this report are based, could be just the start of an ongoing long-term programme of investment and growth for the Lochaber area.

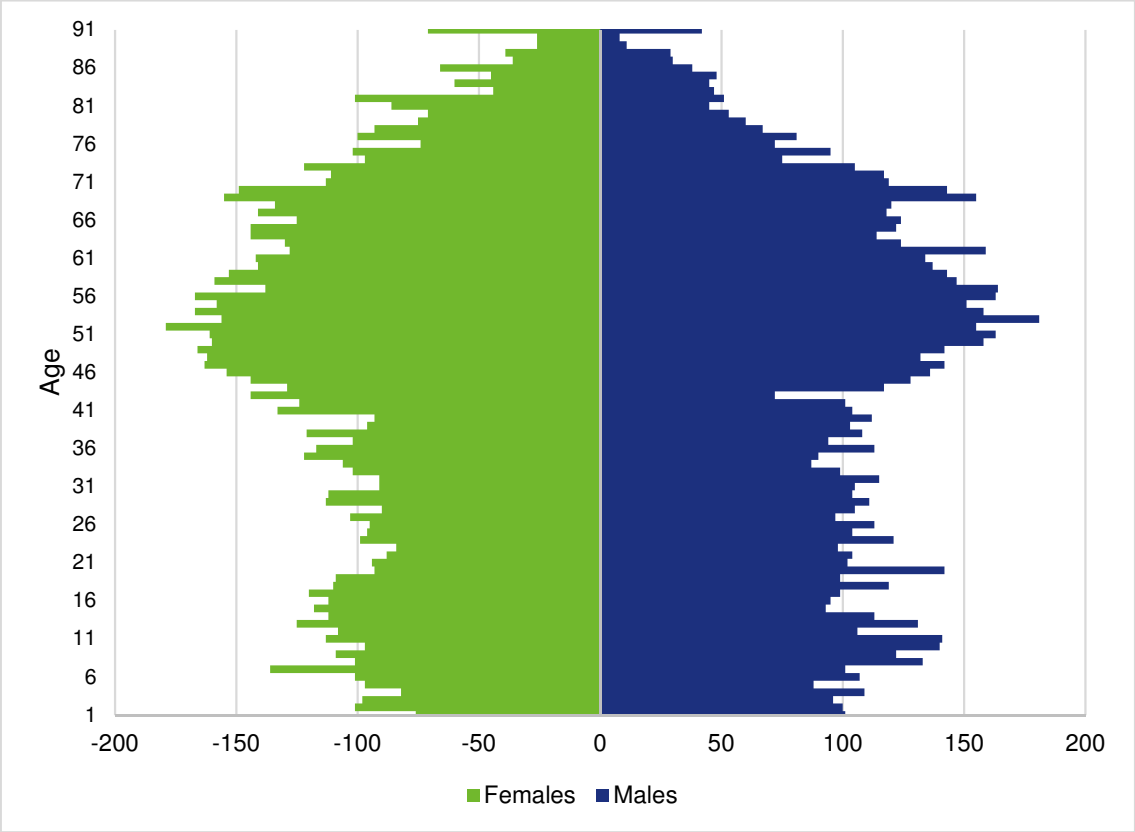
APPENDICES

APPENDIX 1: CONSULTEES

Consultee	Job title	Organisation
Lesley Benfield	Chief Executive	Lochaber Chamber of Commerce
Stuart Black	Director for Development and Infrastructure	Highland Council
Scott Dalgarno	Development Plans Manager	Highland Council
Dot Ferguson	Ward Manager	Highland Council
Brian King	Managing Director	Liberty
Ged Kilcoin	Recruitment and Talent	Liberty
Marie Law	District manager	NHS Highland
Allan Maguire	Head of Development and Regeneration	Highland Council
Matt Simpkinson	West Highland College	West Highland College
Tim Stott	Principal Planner	Highland Council
David Torrance	Senior Transport Planner	Transport Scotland

APPENDIX 2: POPULATION STRUCTURE IN LOCHABER

Figure A2.1: Population structure in Lochaber, 2016



Source: National Records of Scotland (2018)

Figure A2.2: Index of Lochaber population change by age group, 2011-2041

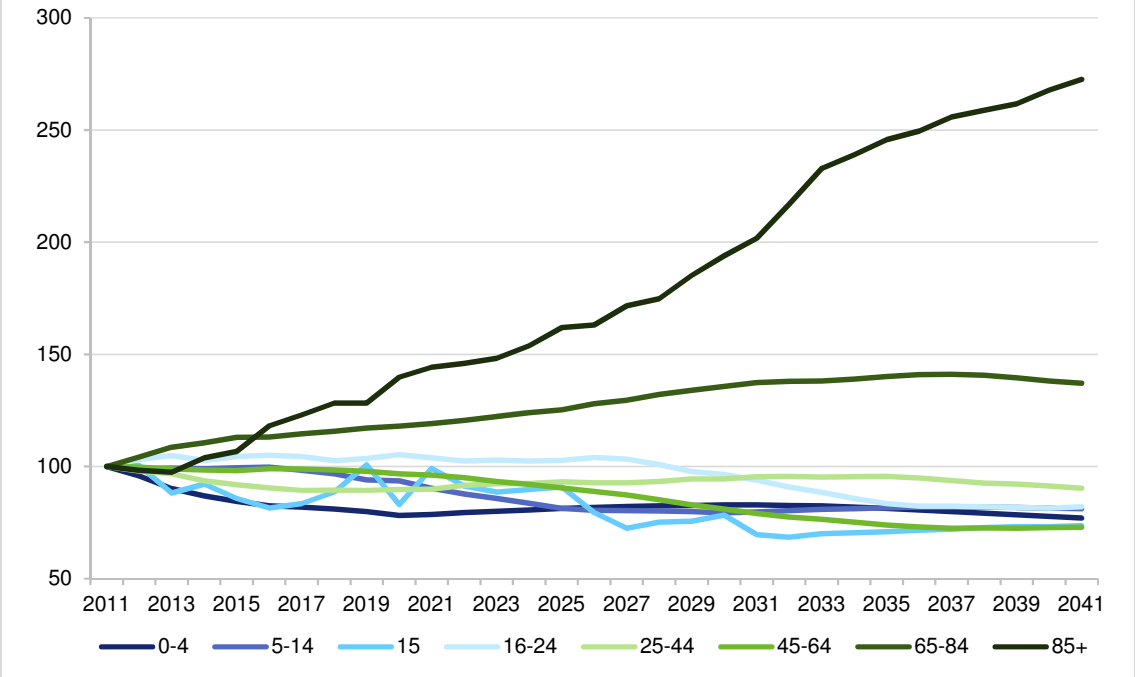
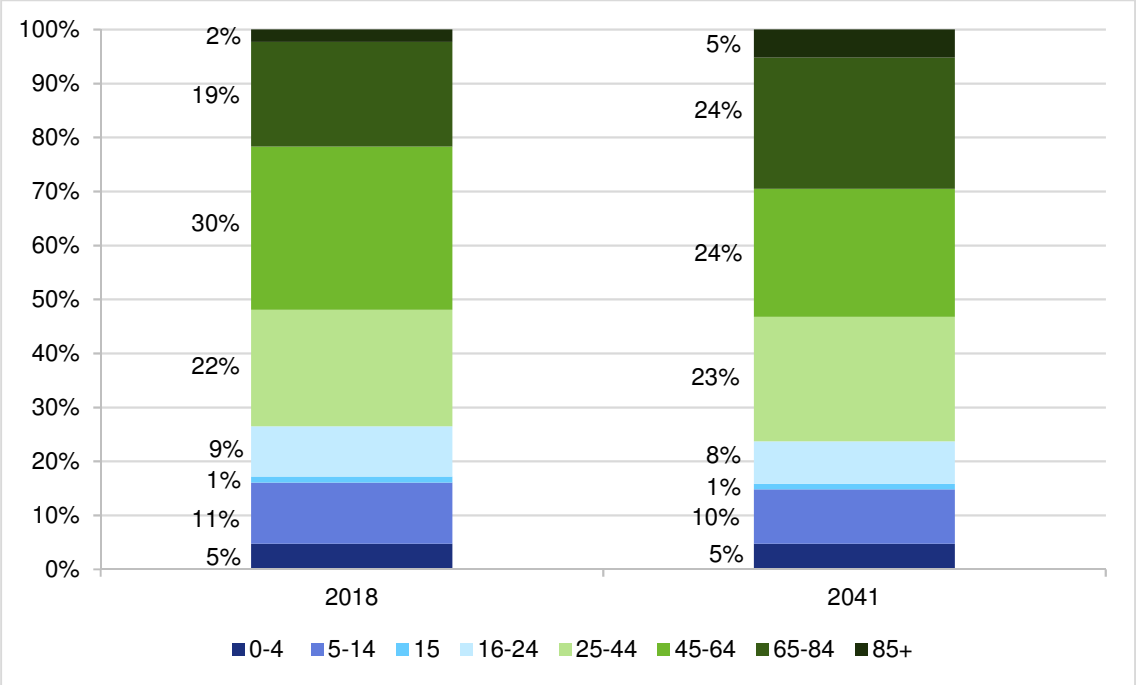


Figure A2.3: Change in population structure by age group in Lochaber, 2018-2041

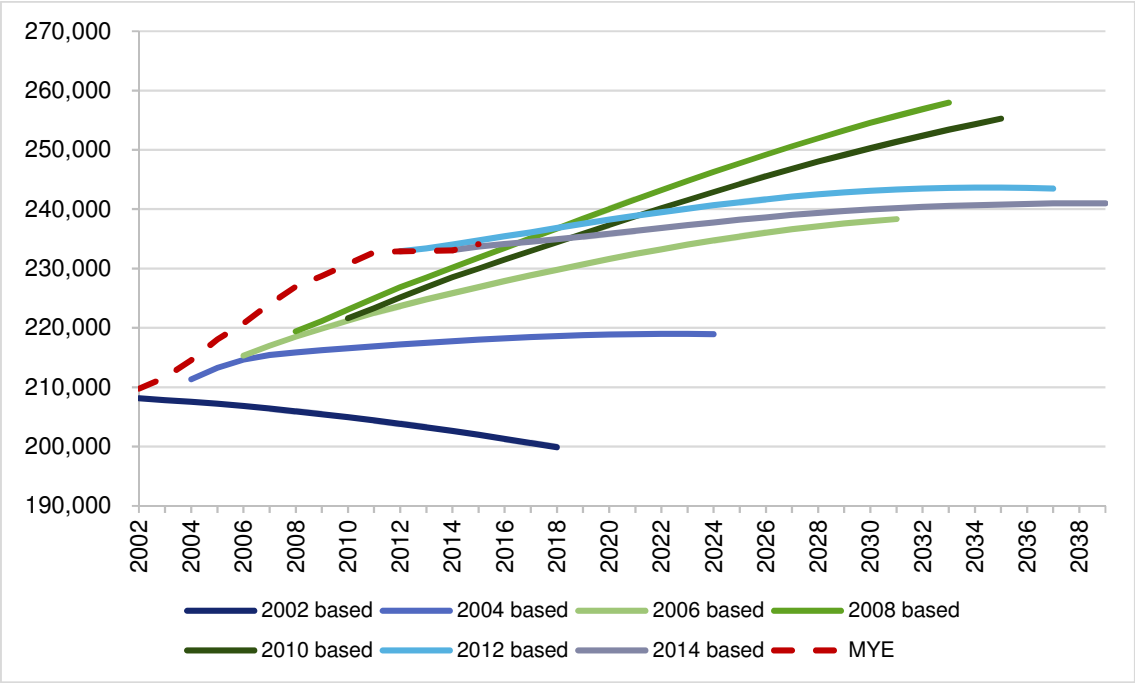


Source: National Records of Scotland (2018)

APPENDIX 3: PROJECTION/MID-YEAR ESTIMATE ANALYSIS

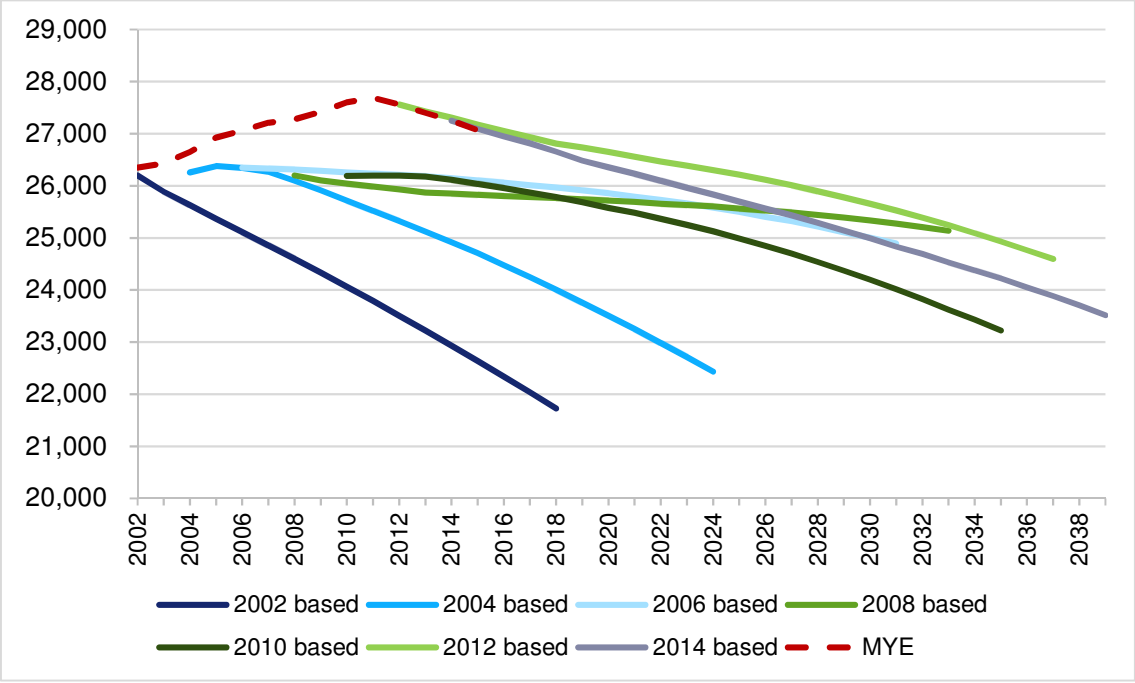
The following presents the HIE analysis of long-term population projections, for two areas in the Highlands and Islands. The first is for the Highland Council area, the second for Eilean Siar.

Figure A2.1: Population projections v. mid-year estimates, Highland



Source: HIE analysis of NRS population projections and mid-year estimates

Figure A2.1: Population projections v. mid-year estimates, Eilean Siar



Source: HIE analysis of NRS population projections and mid-year estimates

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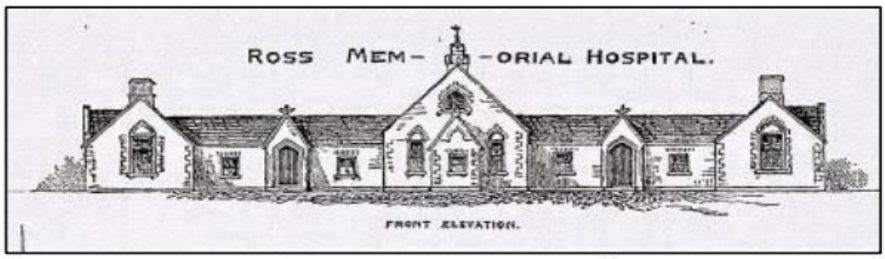
Highlands and Islands Enterprise
Iomairt na Gàidhealtachd 's nan Eilean

District Profile



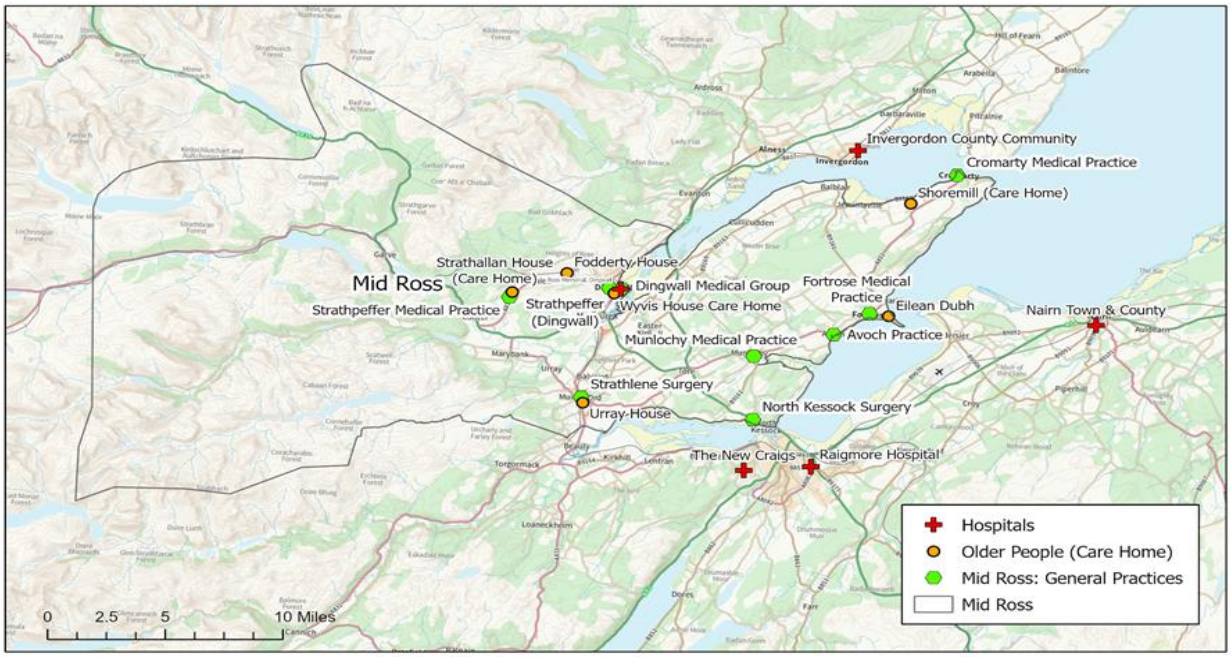
Original Front Elevation[88]

District: Mid Ross District

Manager: Kenny Rodgers

Locality Demographics

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



Mid Ross Health and Social Care Services

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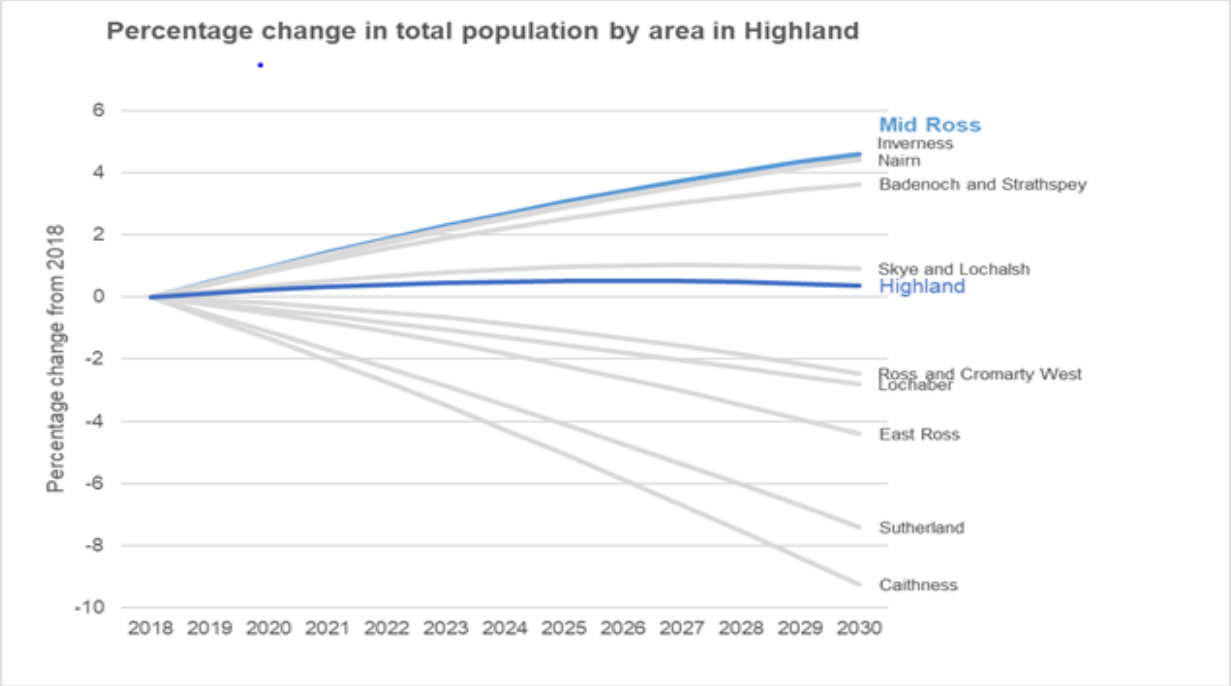
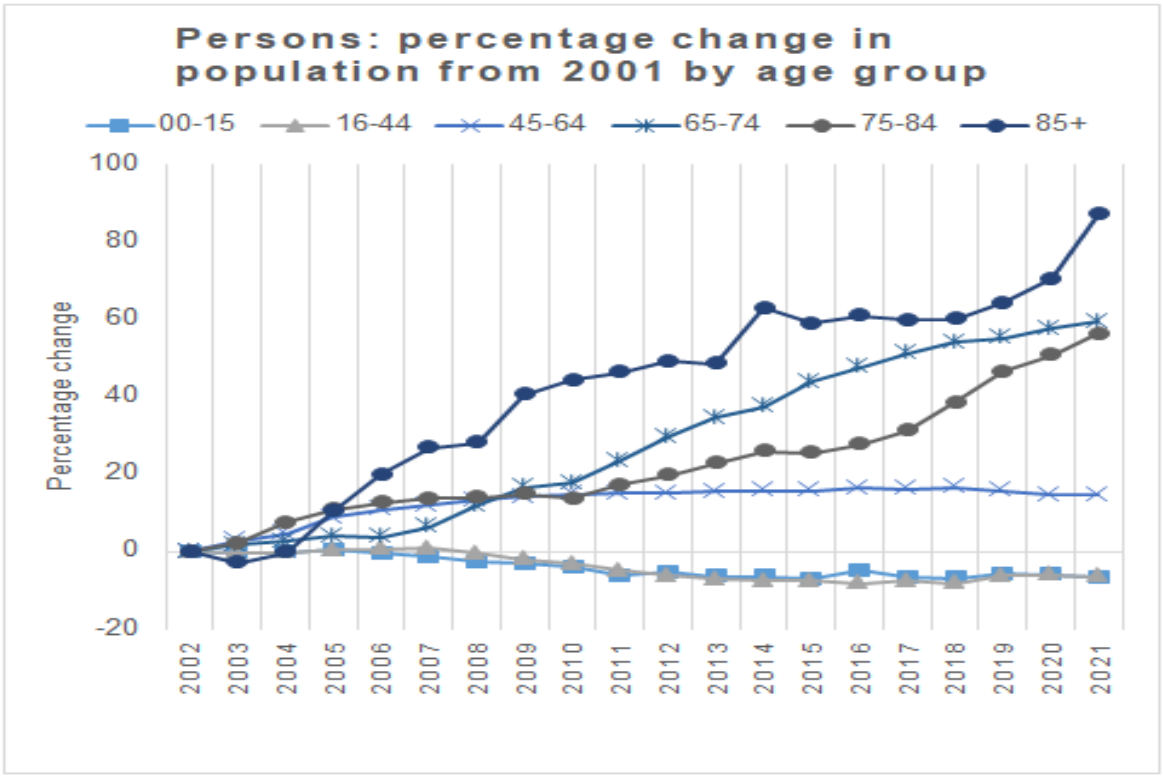
Directorate of Public Health
Public Health Intelligence Team
Larch House, Inverness

Date:

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



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



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

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

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

Services provided and current workforce

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

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

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

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

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

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

The Assess at Home service has been developed from within the enablement service and primarily focuses on a functionally based assessment which a rehabilitation first approach to support people to be discharged home from hospital with the right care at the right time or to prevent the need for admission to hospital.

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

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

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

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

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

Urgent works are required to improve fire compliance in both wards to the standards expected by Scottish Fire and Rescue Service (SFRS). Capital Funding was earmarked in the NHS Highland capital plan however this has since been rescinded. This issue has been escalated within NHS Highland for resolution as the status quo is not acceptable to the NHS Fire Advisor or SFRS.

HAI (Hospital Acquired Infection) audits have highlighted an increasing number of essential works over the last few years such as compliant wash hand basins and internal maintenance / decoration that have not progressed. These concerns have been escalated by auditors to NHS Highland committees as a concern in terms of non-compliance with infection control issues.

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

There continues to be a strong demand for clinical accommodation at Ross Memorial however there are not enough clinical rooms to meet demand and some buildings on site are earmarked for closure by Estates team.

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

There is currently no strategic plan in place for the future of Ross Memorial Hospital.

Protecting our local hospital

I had the pleasure of visiting the Ross Memorial Hospital in Dingwall where I was able to meet with and listen to staff. I had the opportunity to see first-hand some of the fantastic facilities the hospital has to offer. This includes the rheumatology unit - one of the few of its kind in Scotland. The Ross Memorial is also home to the only DEXA scanner (used to measure bone density) in the Highlands and serves patients from across Dingwall, the Black Isle and further west encompassing communities between Dingwall and Achnasheen. The Ross Memorial was built in 1873. Despite the challenges of working in an ageing hospital, the original hospital building allows health care staff to deliver vital community services that strive to meet the demands and challenges of the Mid-Ross area.

The local team have done a tremendous job in reducing delayed discharge because they know their patients and other healthcare teams. My commitment is to protect the hospital at all costs - and hopefully see a new hospital built on the site.

Finance & Performance

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

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

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

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

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

We are fortunate in Mid Ross to commission care at home services from 6 providers, all covering different geographical areas. We have a good working relationship with these providers and we work

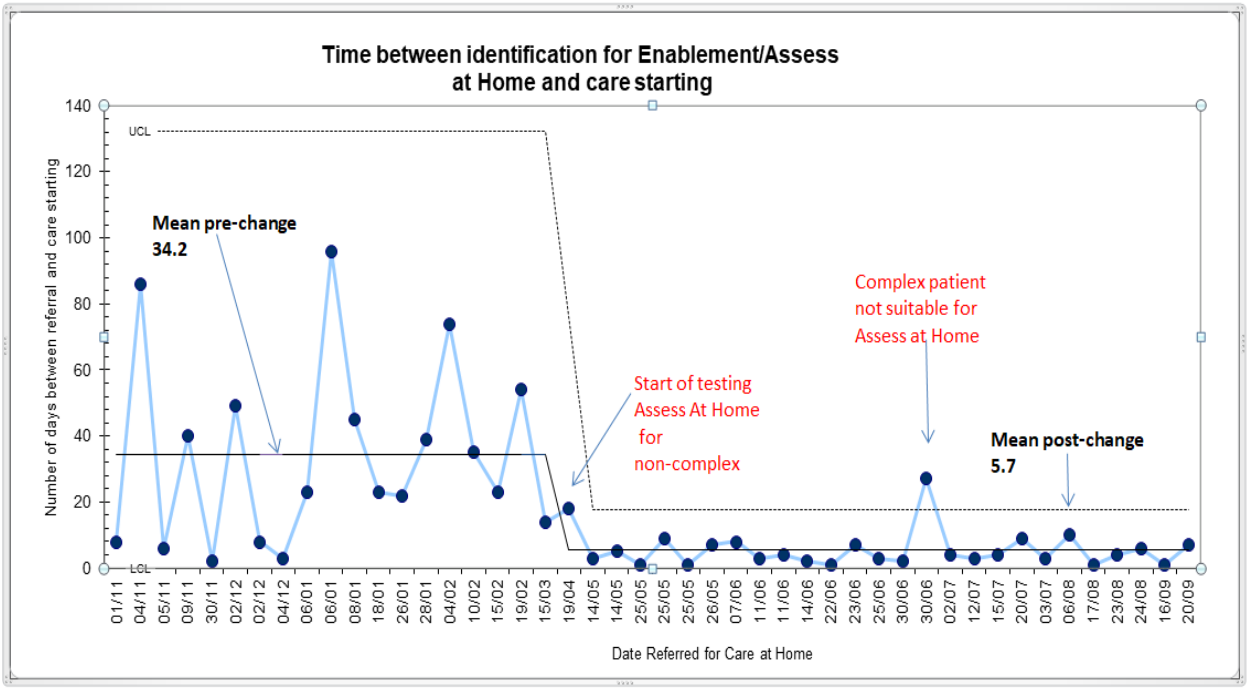
together to manage the existing care capacity to ensure that capacity is maximised and travel time minimised.

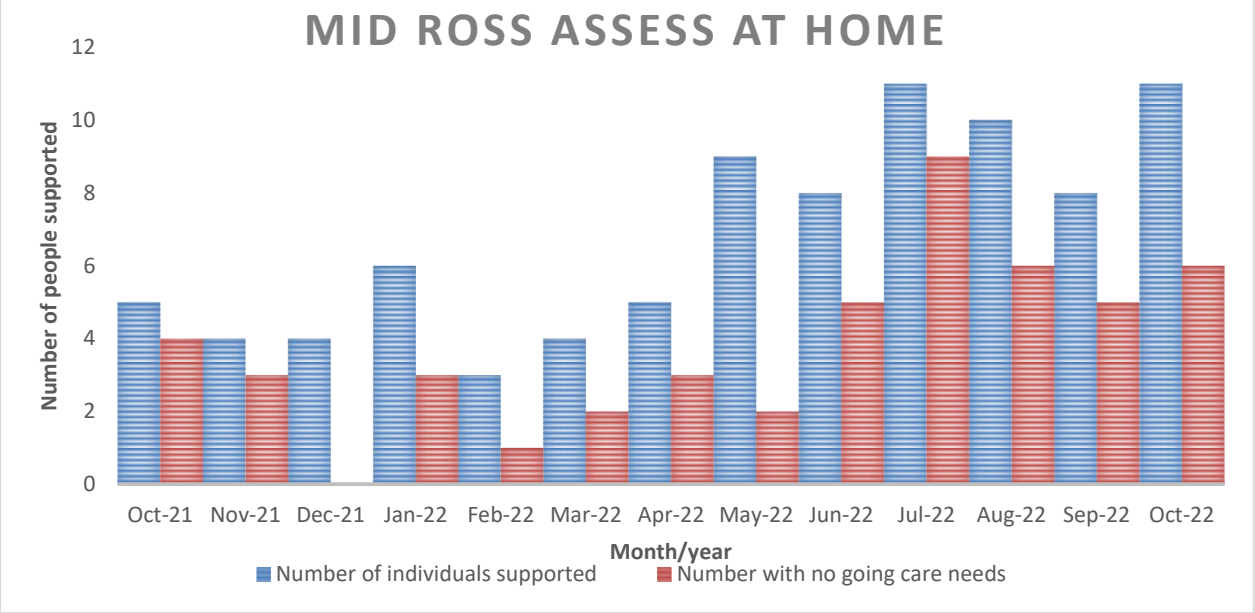
We have been working with our local communities and care providers to identify ways of increasing care provision using local people encouraged by their communities to enter the care profession. This approach is working well with Eilean Dubh Homecare on the north Black Isle and Top Care on the south Black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

Opportunities and Developments

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

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

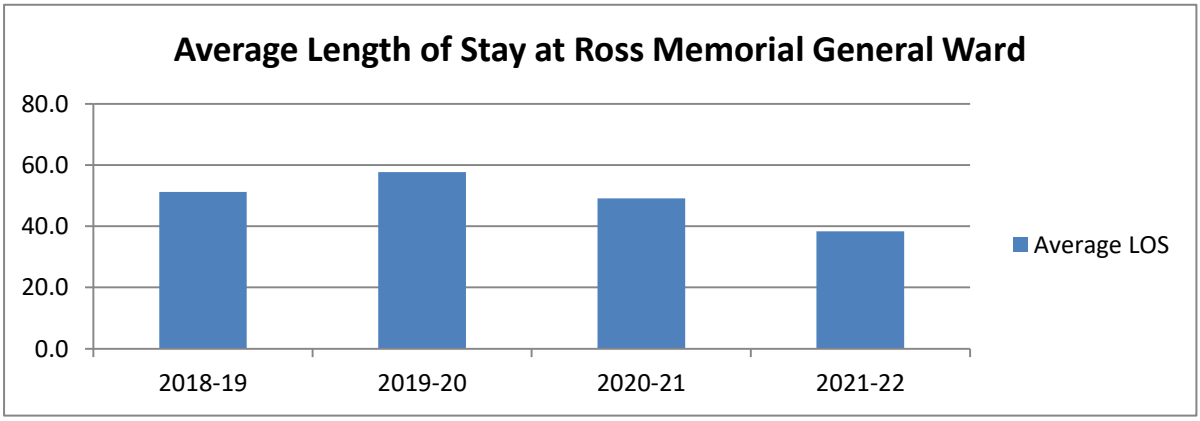




Mid Ross District has been developing a Discharge without Delay model that identifies and 'pulls' patients from the acute hospital into community services and seeks to plan care early in the acute phase of an individual's admission to minimise delay of assessment and discharge. Through use of community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

The use of the inpatient general ward beds at the Ross Memorial has been a key driver in improving patient flow and supports the integrated team to rehabilitate patients prior to returning home with an appropriate discharge plan. It also allows comprehensive multi-disciplinary team working to ensure complex discharges are well planned. Activity shows that generally, Mid Ross has 9 patients in Ross Memorial and 5 patients in County Community Hospital Invergordon at any given time indicating that the bed capacity best fit is around 14 beds.

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



Community Engagement

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

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

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

What Works Well

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

What Works Not So Well

- Local demands for the reopening of the Minor Injury Unit
- Strong concern about the condition of the Ross Memorial Hospital and fear of possible reduction in services.
- Access to GP services
- Availability of home care to meet current and future care needs – demographic and recruitment issues.
- Would like more access to outpatient services locally at Ross Memorial

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

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

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

Afterward

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

In 1938, there was a survey of all Scottish hospitals and this coincided with visits to the Ross Memorial by personnel from the Department of Health. Their joint visit of the hospital was not encouraging for its

future. It was considered by 'no means an up to date hospital and could never be so'. There were said to be drainage problems due to its low altitude so that the drains apparently backed up at high tide. The main building was overcrowded and its 'but and ben arrangement and bitty organisation made it difficult to operate.

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

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

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

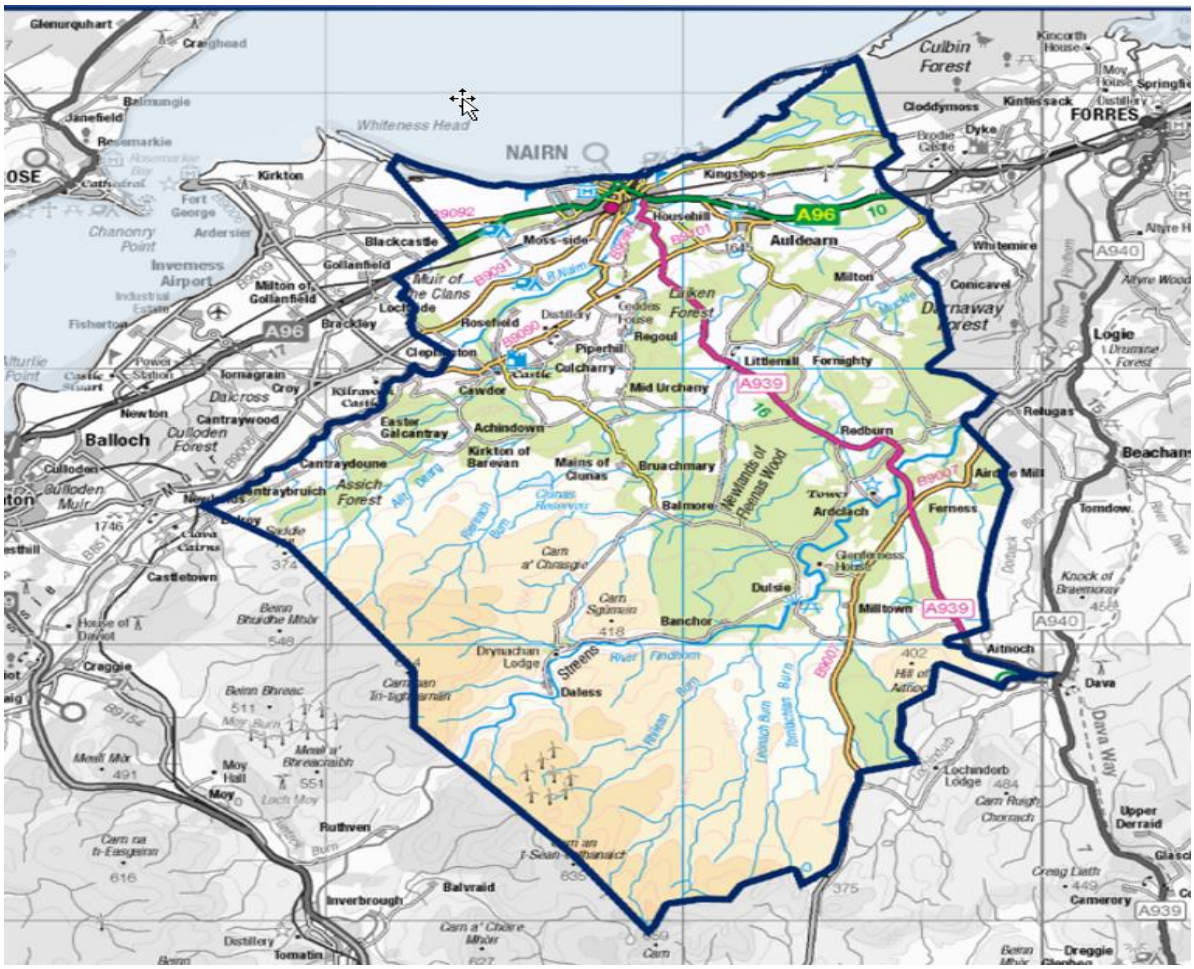
District Profile

District: Nairn

Manager: Ros Philip

Locality Demographics

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

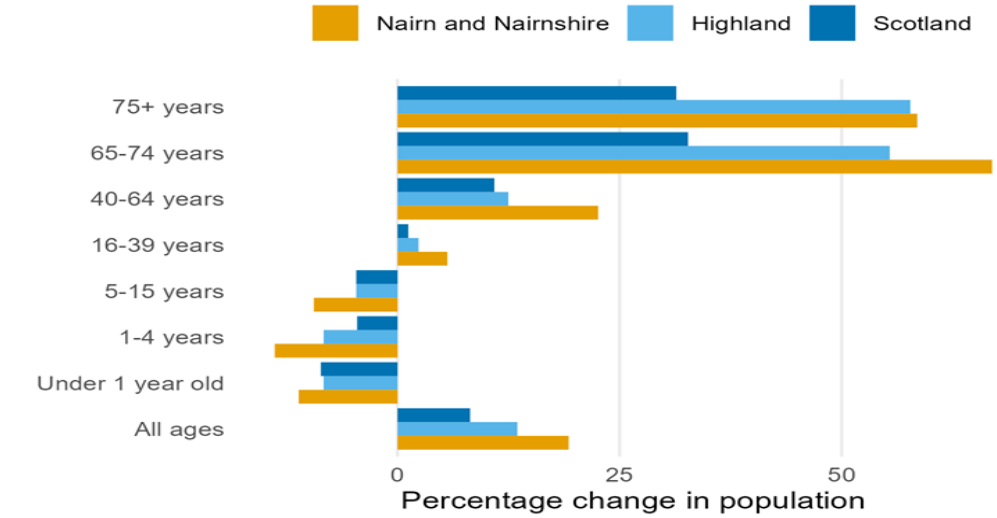


Current estimated population by age group,2021

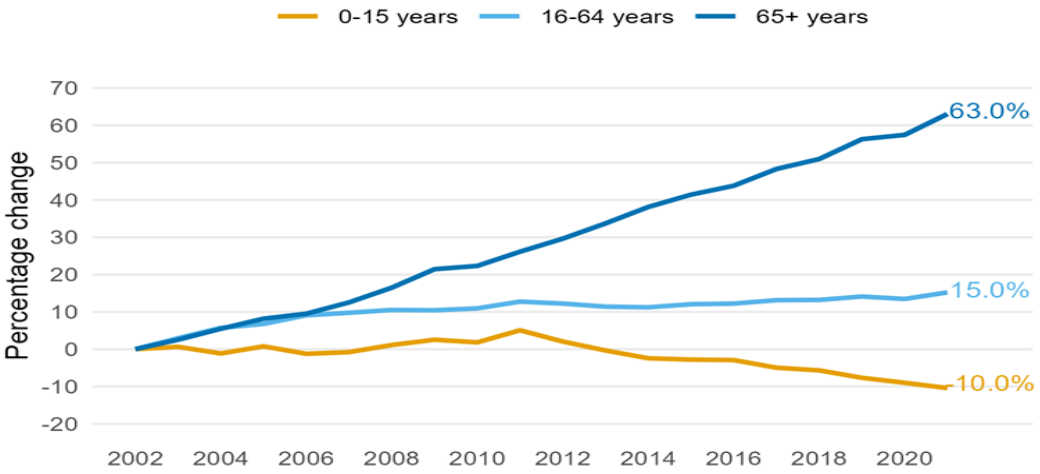
Age Band	Nairn and Nairnshire	Highland	Scotland
All ages	13,670	238,060	5,479,900
Under 1 year old	88	1,842	46,782
1-4 years	418	8,321	208,655
5-15 years	1,511	27,967	656,085
16-39 years	3,223	61,405	1,671,841
40-64 years	4,879	83,301	1,822,676
65-74 years	1,958	30,598	595,578
75+ years	1,593	24,626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

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

Percentage change in population by age group, 2002 to 2021



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

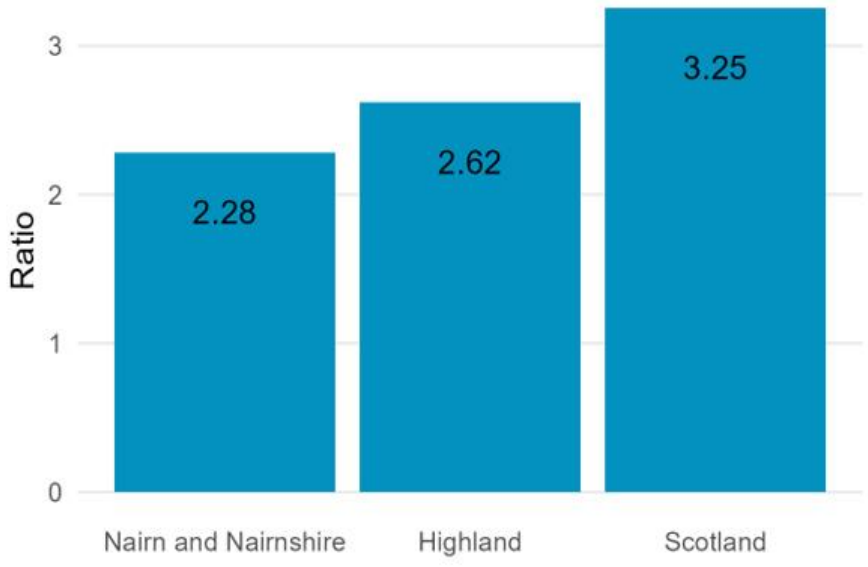


Source: National Records of Scotland, Small Area Population Estimates 2021

It is estimate that the overall population will increase between 2018 and 2030 and that the population will continue to age. The number and proportion of people in the 65-74, 75-84 and 85+ age groups are projected to increase, whereas the population aged 0-15 years and 45-64 years are projected to decrease.

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

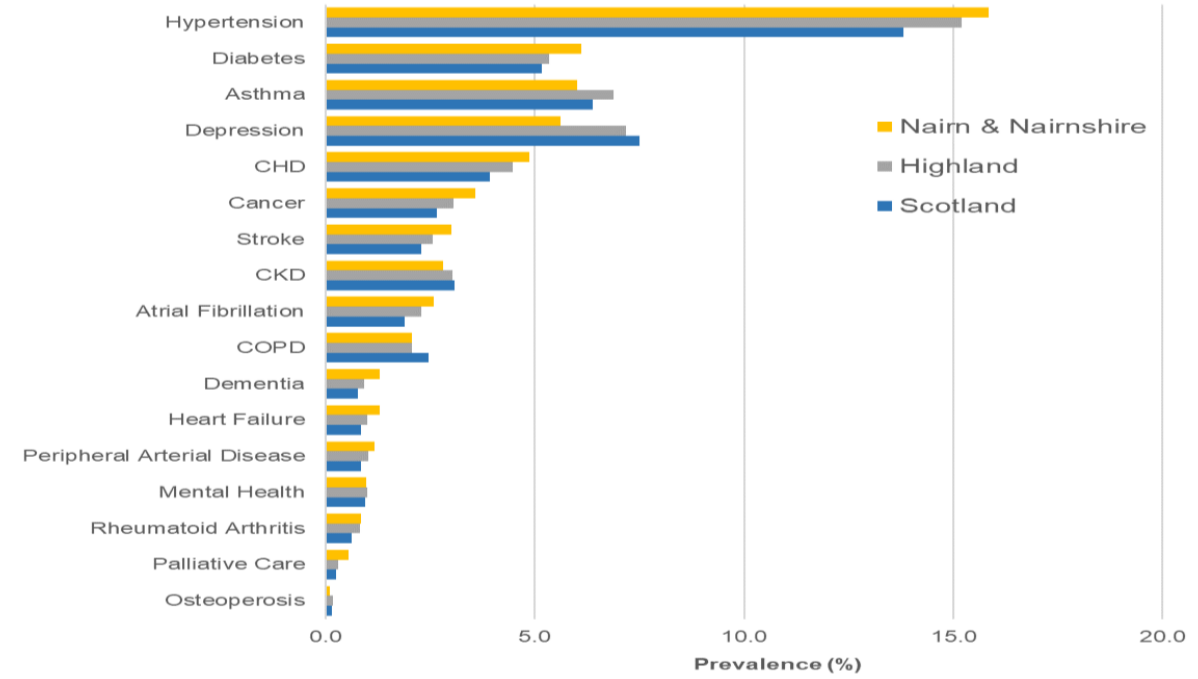
People of working age (16-64 years) for every person 65 years and older in 2022



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

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

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



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

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

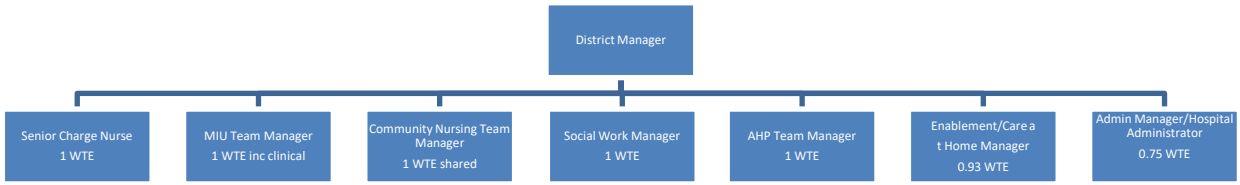
Services provided and current workforce

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

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

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

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



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

	Mon-Fri	Sat/Sun	Team Establishment		Issues
			Qualified WTE	Unqualified WTE	
Ward	24 hour	24 hour	14.21	10.71	1.53 WTE qualified maternity leaves only partial cover picked up.
Minor Injury Unit	24 hour	24 hour	6.07		Unsuccessful in WFP 0.71WTE. Career break imminent with no applicants.
Community Nursing	08.30-16.30	08.30-16.30 Reduced Staffing	8.72	0.96	Increasing complexity and caseload with up to 60 visits per day being undertaken by the nurses. Team also provide ITR clinic demand exceeds resourced capacity. Admin post vacancy unable to appoint to date impacting on Team as no capacity in district to provide admin outwith the admin heavy resource required to support ITR clinics. Post out to advert again.
Enablement Team	08.00-21.00	08.00-21.00 Reduced Staffing(no manager/scheduler)	15.4	0.8 WTE (2 posts)	1.68 WTE vacancies out to recruitment. Continuing to support ISP packages. Plans in place for contingencies.
Social Work	09.00-17.00	Unavailable	5	4.87	1 WTE qualified maternity leave and 1 WTE unqualified on long term leave. No HSCCs from 6/12/2022
Occupational Therapy	08.30-16.30	Unavailable	2.58	2.53	1.44 WTE qualified out to recruitment. (1 qualified reducing from January 2023 + utilising Band 5 hours as unable to fill B 5 post).

Physiotherapy	08.30-16.30	Unavailable	2.15	1.6	0.7 WTE qualified unable to recruit. Only 1 qualfied staff member available for rehabilitation service currently (who is the AHP Team Manager).
Admin/Portering	08.30-17.00	Reduced staffing		5.08 (6 are part time)	Supporting ITR clinics takes up significant resource.

Services Provided

Ward

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

MIU

Nairn MIU is nurse led with a GP on call for support if required. In hours Mon-Fri the on call GP is available from the Practice via the emergence mobile. Out of hours the GP is available on the emergency mobile from home although they are in attendance at weekends and several GPs stay in the hospital overnight when on shift. The MIU staff support the ward night shift 7 nights a week. This involves being present on the ward once all MIU work is complete (returning to MIU to see patients as required), covering breaks, assisting with patient care and being included in staffing numbers to ensure fire safety overnight.

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

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

Community Nursing

The Community Nursing team provides preventative, reactive and maintenance clinical care to patients in the community. The elderly age profile and care homes in the area

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

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

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

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

Physiotherapy

The Nairn physiotherapy service covers all aspects of clinical service delivery. This includes inpatient rehabilitation to the 16 bed unit, medical out patients, MSK, Pelvic dysfunction, Cardiac rehabilitation and Pulmonary rehabilitation, Falls and Frailty intervention and Community rehabilitation. Service is currently provided by the AHP Lead, 2 part time qualified staff and 3 part time non registered staff.
Resource was taken from mainstream physiotherapy to fund the development of FCP service. Whilst this was a good opportunity for staff and service development, it led to a shortfall in funding for mainstream physiotherapy services. Patient flow into MSK services has reduced from GP referrers but all other referring sources have continued to grow. The Band 6 rehab staff member resigned at the end of August 2022. As this is a part-time post it has been difficult to recruit which has resulted in services having to stop including falls, cardiac and pulmonary rehabilitation and community rehabilitation will be severely reduced causing significant delays that will impact on admission prevention and discharge support. The WFP undertaken had recommended an additional 1.5 WTE B6 and 1 WTE Band 4, however this was not resourced.

Occupational Therapy

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

Enablement/Care at Home Team

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

Social Work

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

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

Independent sector care homes within Nairn housing 196 beds

No of Care Homes	Client Group	No of Beds
4	Older People	88
1	Older People/Learning Disability	42
1	Learning Disability/Physical Disability/Severe and Complex	43
1	Mental Illness	23

General Practice/s

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

Integrated Working/Complexity within the District

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

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

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

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

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

The hospital also provides outpatient clinics as detailed below:

CMHT	Diabetic Retinopathy	Podiatry
Physiotherapy	X-ray	Alzheimers
Psychiatry	CAB	Cardiac/Heart Failure
Childrens Services	Paediatrics	SLT
Dietetics/Weight Management	Epilepsy	Learning Disability
Midwifery	Psychology	Parkinsons Disease
Viral Hepatitis		

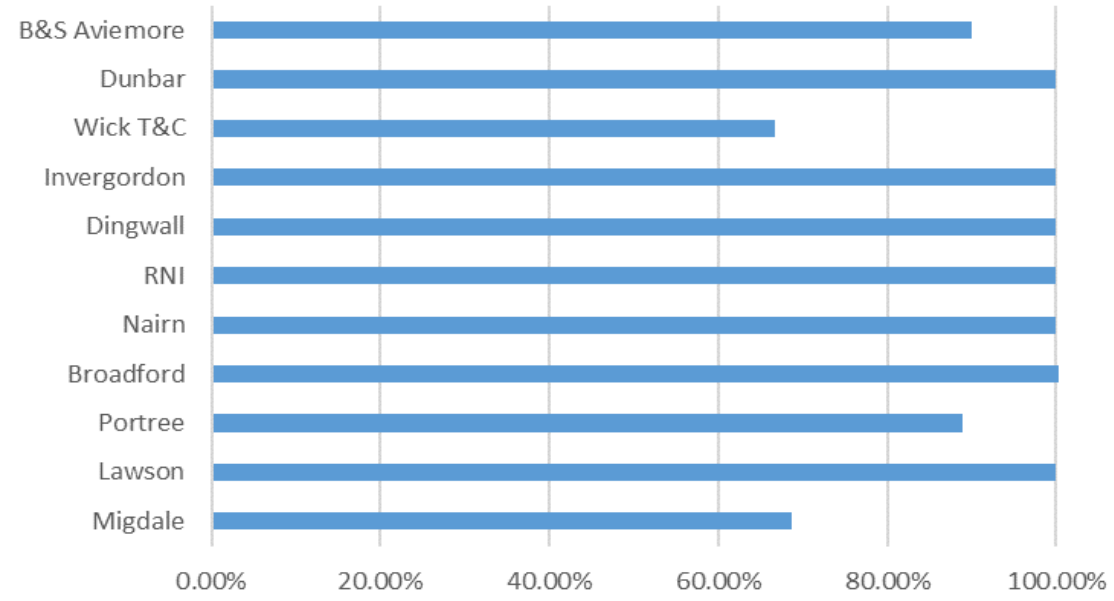
With the rollout of the Primary Care Modernisation as detailed in the GP contract we are seeing pressure on availability of both clinic and administration space as we have the additional need for pharmacotherapy, First Contact Practitioner, Primary Care Mental Health Services and Community Link Worker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

Finance & Performance

Finance

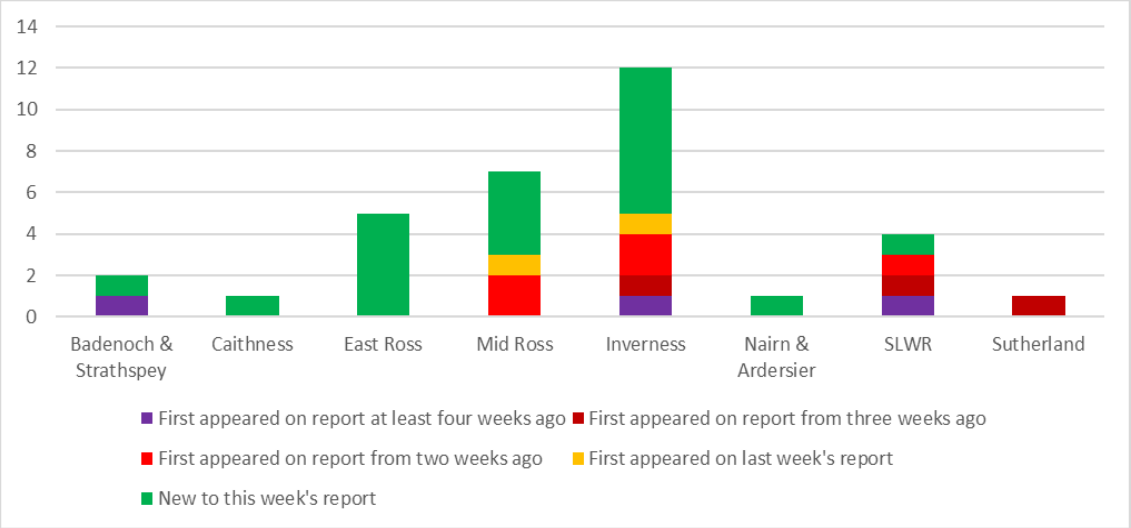
The budget for 22/23 for the District is £13.178m of which £0.045m relates to hospital and community services, and the balance of £0.865m being ASC. At the time of writing the projected year end is being forecasted at a £0.447m overspend. This overspend can be broken down into Health £0.119m and ASC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

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



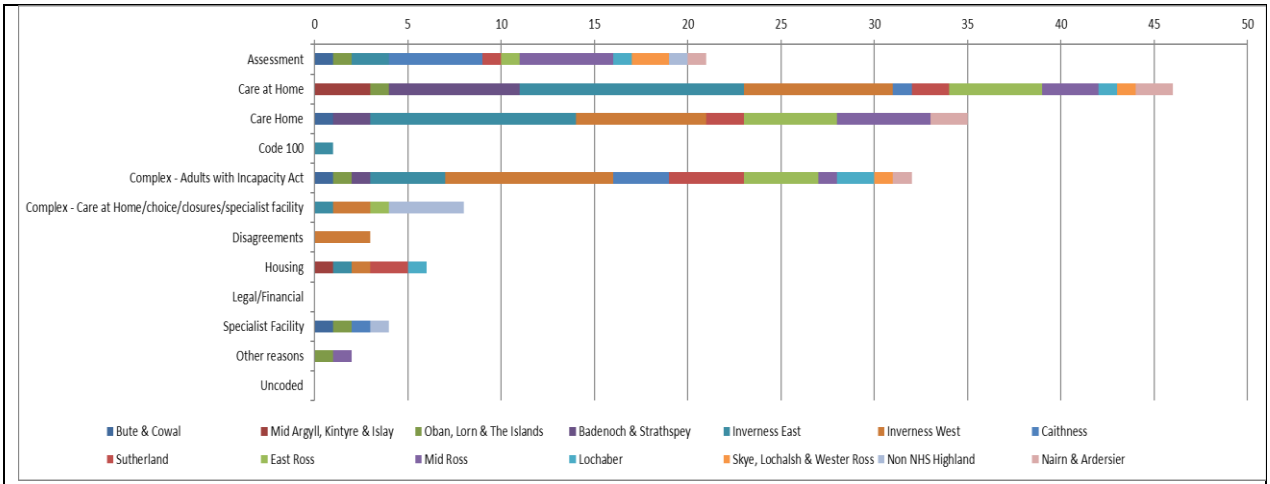
The hospital runs at capacity 100% of the time.

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



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

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



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

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

Insert current unmet need here – care at home

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

Opportunities and Developments

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

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

Clinical Bridge

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

Currently within this "virtual ward" we have included patients who are inpatients at Nairn but are not DDs, patients who are recently discharged from hospital as well as

patients who are on end of life care, or who have Just in Case medications in their home. The plan is to develop this further in liaison with the general practice and the integrated team to include other vulnerable patients. The Bridge allows each team to add in their actions to allow the other teams to identify what is in place and what is outstanding. Maximising the potential is dependent on improving the Bridge connectivity, as well as our ability to staff vacant HSCC posts who will be responsible for inputting information.

Care at Home Redesign

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

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

FIT Homes

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

We expect priority will be given to individuals:

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

The NHS, Highland Council and the Albyn Housing Society are the 3 partners who will be involved in considering allocations of the Homes. Meetings are ongoing on these

considerations and it is likely there will be agreement to maintain a balance of needs within the FIT Homes cluster to keep a self- supporting environment alongside care and support provision.

Community Engagement

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

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

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

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

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

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

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

The Adult Plan had completed all the actions allocated with the direction from NCPP to

focus on the Community Led Support (CLS) HUB.

CLS

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

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

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

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

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

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

Completed by: Date:

District Profile

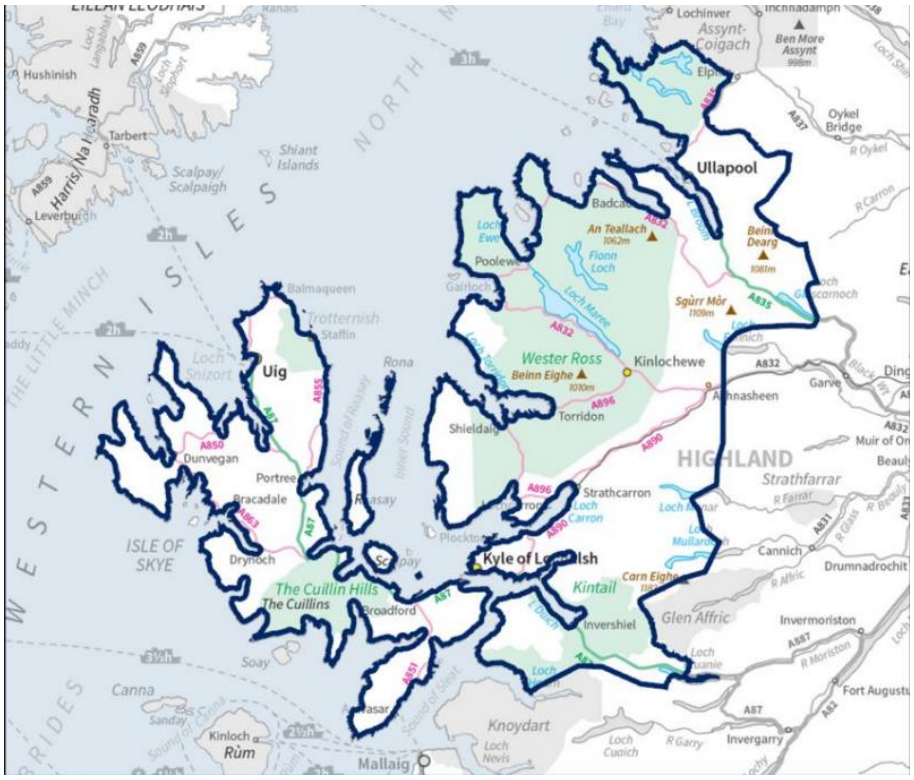
District: Skye, Lochalsh and Wester Ross

Manager: Kate Earnshaw / Dawn Pridham

Locality Demographics

This information provides an overview of Skye, Lochalsh and Wester Ross current and future population structure. It also provides information about the population dynamics of Skye, Lochalsh and Wester Ross, the geography, and the life circumstances of people living in the area.
All data is presented for Skye, Lochalsh and Wester Ross and where available, intermediate zones or neighbourhoods within Skye, Lochalsh and Wester Ross. Comparisons are made to the Highland local authority and Scotland.

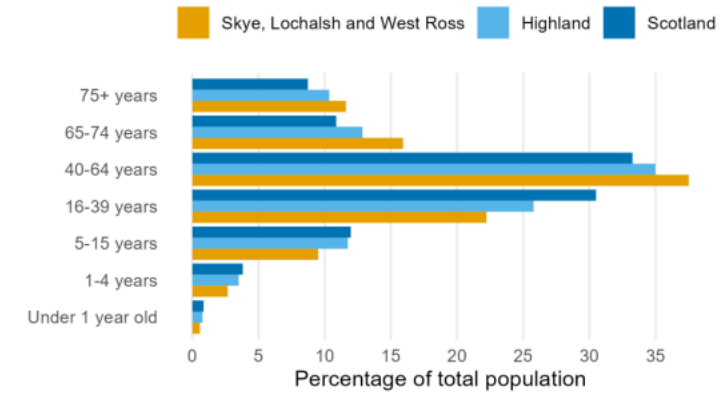
Population & Health Profiles (scot.nhs.uk))



- The partnership area of Skye, Lochalsh and West Ross includes the settlements of Broadford, Gairloch, Kyle of Lochalsh, Portree and Ullapool. The area covers the island populations of Isle of Ewe, Isle of Raasay, Rona / Ronaigh (Skye), Scalpay (Skye), Isle of Skye and Soay.
- Just under a third of the population (32%) live within the partnerships settlement areas of Portree, Ullapool, Broadford, Gairloch and Kyle of Lochalsh. All of the population (100%) live in areas classified as very remote rural.

- As of 2021, Skye, Lochalsh and West Ross has a population of 19,944 people. 12.8% pf the population are children aged 0-15 years, 59.7% are aged 16-64 years old and 27.5% are people aged 65 years and over.

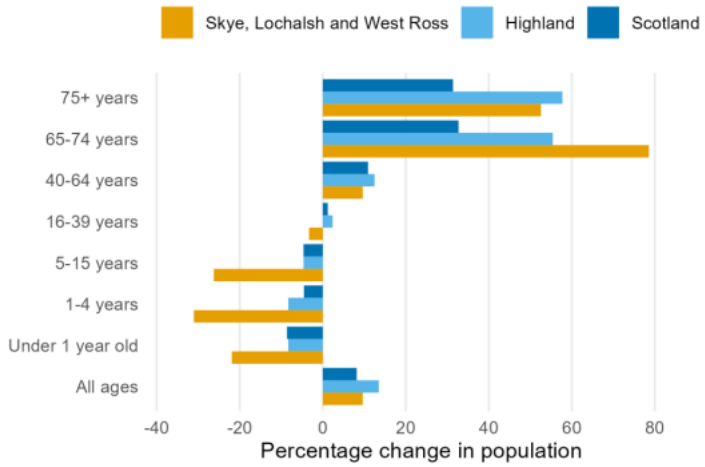
Figure 1: Percentage of the population by age group



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

- The age profile of the Skye, Lochalsh and West Ross population is older than Highland.
- The population of Skye, Lochalsh and West Ross increased by 9.6% in the period from 2002 to 2021.
- Over this period, there was a 67% increase in the 65+ age group. The population aged 16 - 64 increased by 4% and the population under 16 years decreased by 27%.

Figure 3: Percentage change in the population by age group, 2002 to 2021

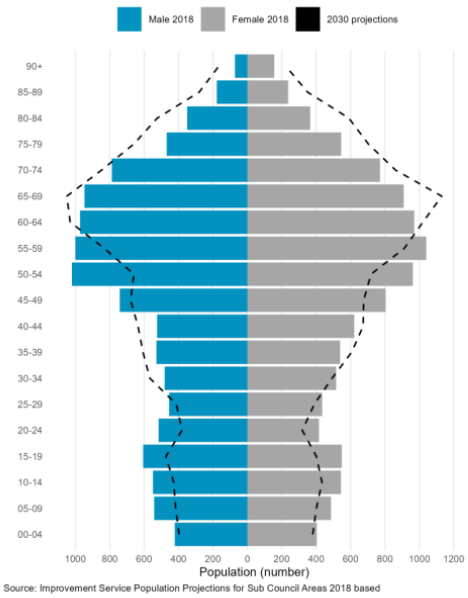


Source: National Records of Scotland, Small Area Population Estimates 2021

- The ratio of 2.2 people of working age (16-64 years) to older people (age 65 years and over) is lower than Highland and Scotland.
- There were 111 live births to Skye, Lochalsh and West Ross residents in 2020.
- The birth rate has decreased over the last decade in both Skye, Lochalsh and West Ross and Highland.
- The mortality rate in Skye, Lochalsh and West Ross has consistently been lower than that of Highland. Variations in the mortality rates in the area are not significant.
- Following the pattern seen in Highland and Scotland, improvement in the mortality rate in Skye, Lochalsh and West Ross has stalled6 . It is a significant concern that a sentinel measure of population health and social progress is not improving.
- Population projections are informed by past trends in births, deaths and migration. NHS Highland, Public Health Intelligence team 2022 4

- The annual number of deaths in the area exceeds the number of births, and population growth depends on net migration gain.
- The latest available population projections estimate that the overall population of Skye, Lochalsh and West Ross will decrease between 2018 and 2030.
- The number and proportion of people in the 65-74, 75-84 and 85+ age groups are projected to increase, whereas the population aged 0-15 years, 16-44 years and 45-64 years are projected to decrease.
- Projected demographic changes indicate that the ratio of people of working age to people aged 65 years and older will further decrease.
- SIMD 2020 identifies no data zones in Skye, Lochalsh and West Ross that are in the 20% most deprived small areas in Scotland. The majority of the population (82.3%) live in areas ranked in quintiles 3 and 4 of national deprivation.
- In SIMD 2020, 7.6% of the Skye, Lochalsh and West Ross population were identified as being income deprived and 6.0% of the working-age population were employment deprived.
- Rural deprivation is an important concern. Those identified as income or employment deprived are found in all intermediate geography areas.

Figure 11: Estimated population in 2018 and projected population in 2030



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

Services provided and current workforce

SERVICES MANAGED WITHIN SLWR DISTRICT 01/08/23 ARE AS FOLLOWS:

- AHP Services
  - Occupational Therapy
  - Physiotherapy
  - Podiatry
  - Radiology (including Sonography)

- Care at Home
  - North Skye & Raasay Team

- South Skye & Lochalsh Team
- West Ross Team
- Reablement Team

- Care Homes
  - Home Farm, Portree
  - An Acarsaid, Broadford
  - Strathburn, Gairloch
  - Lochbroom, Ullapool

- Hospital Services
  - Broadford Hospital (community Hosptial + 1)
    - Emergency Department
    - In patients
    - Out patients
    - Chemotherapy / Infusion service
    - Renal Service
    - Pre Op Assessment service
    - Minor Surgery services
    - Radiography
    - Sonography
    - Echo Clinics
    - Physiotherapy
    - Occupational Therapy
    - Community Midwifery Unit
    - Advanced Practitioner Service
    - Rural Emergency Physicians
    - SAS base
    - Medical Records / Administration
  - Portree Hospital (Community Hospital)
    - In patients (GP support Mon – Friday 8 – 6pm; Weekends UCC and REP's Broadford)
    - Out patients
    - Medical Records / Administration
    - Urgent Care Centre

- Community Mental Health Services.
  - Severe and enduring
  - Drugs & Alcohol
  - Emergency & Urgent Care Practitioner
  - Guided Self-Help
  - Learning Disabilities Nursing
  - Older Adult

- Community Nursing
  - North East Skye
  - North West Skye
  - South Skye
  - Mainland
  - Lochcarron, Torridon and Applecross
  - Gairloch & Aultbea
  - Ullapool & Achiltibuie

- Day Services

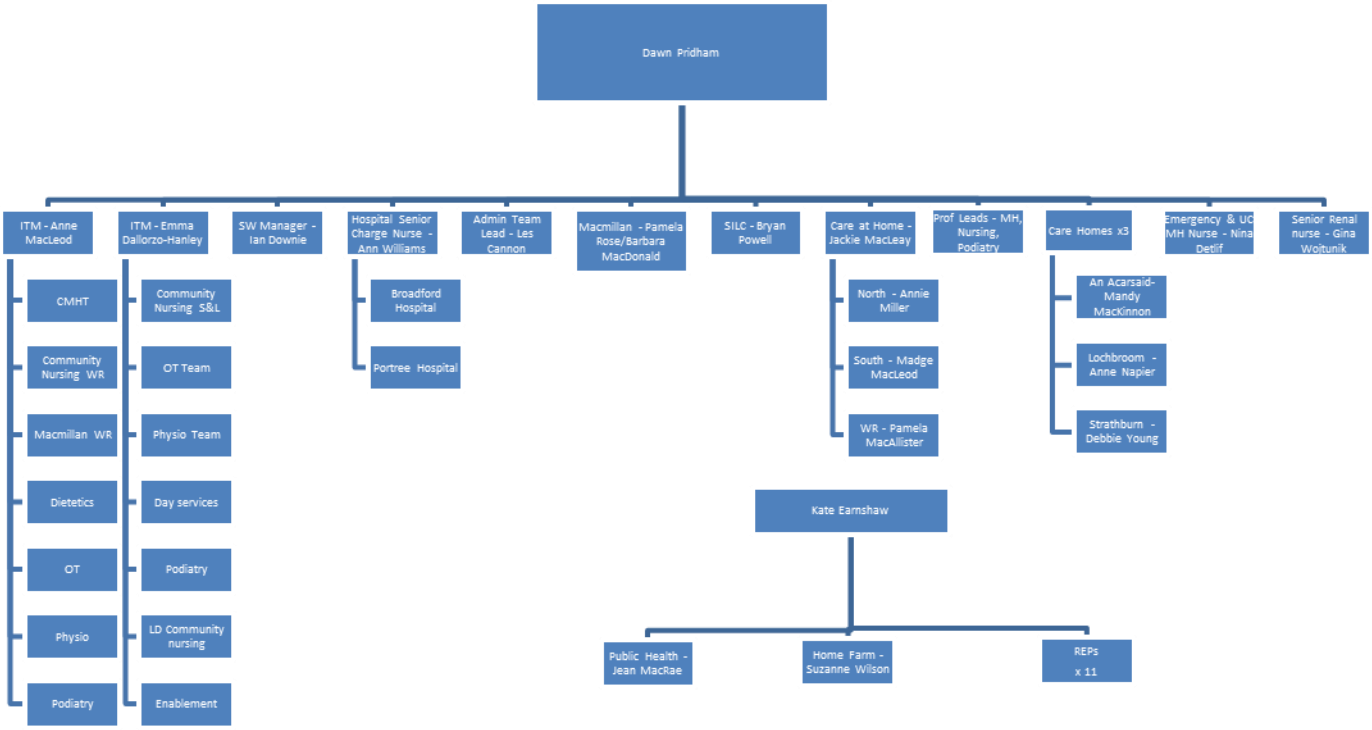
- Aird Ferry, Dornie (Older Adult)
- Tigh na Drochaid, Portree (Older Adult)
- Tigh na Drochaid, Portree (Learning Disabilities)

- Specialist Nursing services e.g.,
  - Advanced Practitioner District Nursing; Mental Health; Public Health Practitioner – Health Improvement Advisors

- Social Work Services
  - North Skye Team
  - South Skye and Lochalsh Team
  - West Ross Team

- Support Independent living in the community (Learning Disability Outreach/In reach services)
  - Single Point of Access
  - Admin Team

The leadership team comprises the district manager, integrated team managers (Skye, Localsh and West Ross), social work team manager, care at home manager, care home managers, day centre managers and advanced practitioners. They work closely with the Clinical Lead for the Rural Support Team. See below for structure



The main challenges in the district are recruitment and retention of staff across all sectors and affordable accommodation for incoming staff to the area. We have significant challenges in Home Farm Care Home and Hospital in patient care with a high number of vacancies. We have set up a Skye Recruitment Group involving community members to look at innovative ways in trying to address some of these issues.

AHP Services

Occupational Therapy service is managed within the district (by Integrated Team Manager) and provides service to community and inpatients including the acute service in Broadford and Portree Hospitals. The team itself comprises

B7 Advanced Practitioner, B6's, B5 and B4. Recruitment in recent years and months has been challenging particularly at B6 level where redesign of posts has had to take place.

Physiotherapy like OT is managed by the Integrated Team Managers and provides services in the hospitals and domiciliary as required. Physio covers all aspects of clinical service including rehabilitation, outpatient, MSK, cardiac and pulmonary rehab, falls, frailty, and pelvic care. There is also a "First Contact Practitioner" service within Primary Care.

Podiatry will in time "move" to a north highland wide management structure via communities' division but at present is managed by the Integrated Team Manager in the District. In general recruitment to podiatry services is a challenge but recently the team has been successful in appointing to a full-time B6 post ensuring the team is at full establishment. B6 podiatrist x 2 and B7 AP post holders (B7 0.2wte of her 1.wte is for leadership across the West Area).

Care at Home / Reablement

Care at Home / reablement services are provided across the District with a local manager based in Broadford. There are offices located in Ullapool, Broadford and Portree with Care @ Home Officers, Co-ordinators, and Clerical Assistants. The offices also act as a "base" for the carers. Across the district we have vacancies in all teams, with significant pressures in Raasy, North Skye and South Skye. Long and short-term sickness also make it challenging in an area which is seeing an aging population and increased levels of frailty. In terms of working with the independent sector there are a couple of providers which the services contracts with in West Ross only and these have limited hours. They too face similar challenges to the in-house service.

Care Homes

Home Farm has 35 beds only 23 open currently. At present all beds are used for "long-term" residents but prior to covid one of these had been used for respite. Until the staffing situation within the home is stabilised and safe beds will remain closed and no respite reinstated.
An Acarsaid has 10 beds, One bed is step up step down and one respite bed.
Strathburn has 14 beds, one bed respite – due to staffing this has been temporarily closed
Lochbroom has 11 beds, one emergency respite bed.

Staffing and recruitment is challenging in all the homes with a number of vacancies (for a range of posts such as depute manager (LBH), nurses (HF) social care workers and assistants). In addition, there is both long and short-term sickness/mat leave. An SBAR has recently been submitted to senior management for Home Farm recruitment challenges.

In addition we have one independent provider in Aultbea (Isle View) which has 25 beds. Two recent closures of care homes across the district have seen a reduction of 50 care home beds being lost.

Hospital Services

Broadford Hospital is a non-bypass facility and the main hospital on Skye. Inpatient beds 24 (4 rooms dedicated renal rooms). Currently due to extreme staffing challenges we have 12 beds operational with an additional 2 beds to cover emergency department admissions. The hospital is over 2 floors with in-patients being on the upper floor and all other services including the emergency department being based on the ground floor. The staffing ratio should be 2 x RGN and 2 x HCA days including Senior Charge Nurse and Staff Nurse Monday – Friday. The actual ratio's are often 1 x RGN and 1 x HCA with the SCN and SSN having to fill in to ensure safe cover. There are currently vacancies for RGN's x 5.47 WTE and HCA 6.32 WTE. Renal services have 1.56 WTE vacancy. There is a high use of agency to cover all the gaps in the rota.
The Emergency Department based on the ground floor is run as a separate unit and works with the Advanced Practitioners who cover both the ED in Broadford and Urgent Care in Portree. The medical team are Rural Emergency Physicians who cover both the ward; ED and minor injury clinics.
Portree Hospital is a community facility with 12 beds (currently only 7 – 9 open) due to staffing challenges. The current vacancies in Portree are 2.17 WTE RGN's and 1.84 WTE HCA's. The urgent care centre is based in Portree for

North Skye and is covered by the Advanced Practitioners. A new model for OOH and unscheduled care has been proposed following on from the Sir Lewis Ritchie (SLR) report which is being implemented in a phased basis as follows:-

- Phase 1 – Weekends and Public Holidays 9 – 6pm cover Portree Urgent Care
  - Broadford ED x 7 day cover 8am – 20.30 hours
- Phase 2 **(current)** – Friday – Monday (4 days) – 8 am – 2030 hours Portree Urgent Care
  - Broadford ED x 7 day cover 8am – 2030 hours
- Phase 3 – (April 2024) 7 day cover Portree – 8am – 2030 hours Portree Urgent Care
  - Broadford ED 24/7

The original business case for the new hospital in Broadford was based on in-patients in Portree ceasing and all in-patient care moving to Broadford. SLR report that focussed on OOH recommended that Portree remained open until an appropriate alternative was found for North Skye. This has put significant pressure on the district resulting in beds remaining closed on both sites, affecting community pull and flow.

Community Mental Health Team and Learning Disability services

As per the structure for North & West prior to the creation of the Communities Division, Community Mental Health Services in Skye, Lochalsh and West Ross are managed by the Integrated Team Manager for West Ross albeit this is likely to change in the coming months with a move of management to the Mental Health and Learning Disabilities Division. Psychiatry and Psychology services are managed centrally and have been traditionally. Staffing in the mental health team is a particular challenge with a vacancy at B6 level in generic mental health team in Skye. Given the geographical spread across the district the team are very stretched in delivering services. The Emergency and urgent care mental health practitioner is based in Broadford hospital and is the conduit between acute and community services.

Guided Self-Help covers West Ross and Lochalsh only, no service in Skye.

Learning Disabilities Nursing establishment is stable, with the B5 post holder just returned from maternity leave.

Older Adult supports adults >65years. The team is supported by a dementia link worker employed by Alzheimer Scotland in Skye. The dementia link worker in West Ross is employed 50/50 between Alzheimer Scotland and the District.

Supporting Independent Living in the Community (SILC) is an outreach support service for people with learning disabilities living in their own tenancies based in North Skye. The team support 14 individuals with varying needs in all aspects of daily living and housing support.

Community Nursing

Community Nursing in Skye Lochalsh and West Ross. The teams provide preventative, reactive, maintenance and end of life care to patients in the community. They work with the wider MDT to support people to remain at home and improve community pull.

Recruitment has been very challenging in recent times for a number of the teams with absence due to vacancy, sickness etc. sitting at approx. ~40%. There are posts at B5 currently out to advert. Caseload holder posts (B6) have been especially challenging with no applicants applying with the District Nursing qualification. This has resulted in the district creating development posts. Over the past 5 years, 4 such posts have been supported to gain their DN qualification and currently one other B5 CN is undertaking this process

Day Services

Tigh na Drochaid, provides assessed day care for older adults in the North Skye area. It provides social stimulation for clients and respite for carers. There are 30 registered places. The day service also has services for people with learning disabilities although this has moved to a more in reach model of support using TnD as a base for the start of the day only.

Aird Ferry, provides assessed day care for older adults in the Lochalsh area, providing social stimulation for clients and respite for carers. There are 12 registered places.

Kyleakin Connections is a day service for people with Learning Disabilities run by the Third Sector and based in Kyleakin, Lochalsh area.

Out of Hours

Skye, Lochalsh OOH services are via the PCEC in Broadford Hospital which is a 24/7 service and supported by the REP's and Advanced Practitioners based in the Emergency Department. North Skye provision is through the Urgent Care Centre, based in Portree Hospital – please refer to hospital services section for operational hours.

West Ross OOH services

- The current service for the Ullapool area runs Monday to Sunday between 18:00 and 08:00 Out of Hours GP services are delivered via an SLA with Ash Locums. A rotational pool of GPs cover this service. Saturday/Sunday between 08:00 and 18:00 are open for GPs/ANPs to book onto shift via the Highland system. The GPs/ANPs for weekend day cover can but do not tend to be staff working locally. Public Holidays are treated as weekends for Out of Hours cover. When booking a shift GPs can book at "normal" hourly rate, "enhanced" rate or "emergency" rate. There is no continuity across districts re hourly rates. This is in place until the Rural Support Team (Advanced Practitioners) are in a position to pick this service up. Currently they have staff in training but should be ready by the new financial year.
- Gairloch area is currently covered by the local GP practice Monday – Thursday and then OOH locum GP's Friday – Monday am, booked via the Highland Hub. The practice have recently served notice to NHSH so a new model has been put to the SLT for an RST OOH service from April 2024.
- Lochcarron area is covered 7 days a week by the RST (Advanced Practitioner) team, based in Lochcarron and covering all surrounding areas – Torridon; Kishorn; Shieldaig and Achnalt.
- Applecross area is covered by the single handed GP or locum GP's when she is on leave. Two weekends a month the RST Advanced Paramedic Practitioner covers from Friday – Monday am.
- Glenelg Ooh is covered by the GP practice (2 x GP's) with locum support as required.

Specialist Nursing

When the integrated teams were established professional leadership was seen as vital in ensuring good governance and quality standards were maintained. Posts were developed for Mental Health and District Nursing, B7. SLWR also has B7 Public Health Practitioner who supports the health improvement and public health agendas. Working collaboratively with the third sector and other key partners in co-productive developments and intiatives. She also manages and supports the Health Improvement advisors for the West (x 3 PT posts including one admin post).

Social Work

Social Work, work with people to find solutions. This may be helping protect vulnerable people form harm or abuse or supporting people to live independently. Social Workers work with clients, their families, and others around them. The team are one but have a west ross and Skye Lochalsh teams due to the geographical coverage. They operate one duty social work service. The team cover ASP; AWI; Guardianships; LSI's; as well as their standard work. A recent restructure has seen the appointment of a Team Manager, previously this had been an Advanced Practitioner role (the team was previously managed by Integrated Team Managers). Also development of Senior Practitioners, one for each area. A remodelling of the district team has also introduced Referral and Assessment Officers to support the routine work and reviews. A full-time Social Worker is due to commence in October in Skye. Despite this there remain issues and challenges with a mix of part-time vacancies and long term absences at social worker level.

Single Point of Access

Like other parts of Highland SLWR employs Health & Social Care Coordinators working across the Integrated Teams 1 WTE Skye and .6 WTE for West Ross.

Admin Team

Out admin team covering both medical records; ward clerks and health centres/service points are the backbone to local community services but have been under significant pressure with a number of posts vacant at the time of

writing (0.4 WTE Portree Ward Clerk and 0.6 WTE Medical Records Portree). High turnover in admin roles is common often leaving gaps between posts being filled.

Other

Rural Support Team

While not managed as part of the district the RST cover both acute and GP services both in hours and OOH's and work closely with the integrated services and hospitals. The Team which consists of ANPs and APPs work at an advanced level (B7).

Primary Care was until NHS Highland's restructure part of the district in the sense that 2C or Salaried Practices were managed via the district. Following the restructure in June 2021 the management transferred to the Primary Care Division and Primary Care Managers. The six salaried practices in SLWR are (Applecross, Torridon, Glenelg, Broadford, Sleat and Carbost). There are GMS practices in Portree, Dunvegan, Kyle, Gairloch & Ullapool. As a district we work closely with all in terms of community nursing, care at home etc. The practices in Portree, Gairloch and Ullapool all support and work closely with their local care homes. Portree practice also have a SLA for covering Portree Hospital Mon – Friday 8am – 6pm for in-patient care.

Finance & Performance

Skye, Lochalsh & Wester Ross Financial Performance SUMMARY - MONTH 4 JULY 2023/2024

OFFICIAL

SKYE, LOCHALSH & WESTER ROSS FINANCIAL PERFORMANCE SUM

Overall Rag Rating
GREEN

Current Plan £000	Division	Plan YTD £000	Actual YTD £000	Variance YTD £000	F'cast Outturn £000	F/cast Variance £000	Prev Mth Outturn £000	Movement Variance £000
2,302	Hospital Services: Hospital costs & Medical staff	761	680	81	2,068	235	235	0
3,186	Hospital Services: Nursing	1,078	1,100	(22)	3,451	(265)	(265)	0
2,884	OOHs	973	899	74	2,922	(38)	(38)	0
2,312	Community: Nursing Incl Macmillan	786	734	52	2,351	(39)	(39)	0
197	Community: Health Centres and Nursing Homes	79	90	(11)	229	(32)	(32)	0
1	Management	5	234	(229)	(53)	54	54	0
1,029	Allied Health Professionals	364	417	(53)	1,201	(172)	(172)	0
1,106	Mental Health	376	337	39	991	116	116	0
23	Primary Care	8	7	1	17	6	6	0
13,040	Sub Total - Health	4,430	4,498	(68)	13,176	(136)	(136)	0
6,389	Care Homes & Respite	2,141	2,197	(57)	6,345	44	44	0
1,013	Community Care for Adults	343	262	81	770	242	242	0
728	ASC Management	248	276	(28)	530	198	198	0
3,241	Care at Home	1,098	1,058	40	3,272	(32)	(32)	0
7,317	ISC/SDS	2,459	2,584	(125)	7,900	(583)	(311)	(272)
18,687	Sub Total - ASC	6,289	6,377	(88)	18,818	(130)	142	(272)
31,728	Total for - Area	10,719	10,875	(156)	31,994	(266)	6	(272)

MONTH 4 SAVINGS

	Target £000s	YTD Target £000s	Achieved YTD £000s	Variance £000s
Workstreams	463	154	77	**77**
Housekeeping				**0**
ASC Workstream	261	87		**87**
Total	**724**	**241**	**77**	**165**

LOCUM/ AGENCY/ BANK SPEND

	In Month £'000	YTD £'000
Locum	40	93
Agency (Nursing)	197	629
Bank	37	173
Total	**274**	**895**

Opportunities and Developments

Skye was successful (along with Caithness) in receiving funding for a Hospital at Home pilot. The pilot commenced in March 2023 and has been very positive currently saving over 100 hospital bed days to date. This is the first Remote and Rural pilot. It is hoped that the pilot will be continued and further funding bid has been submitted to the Scottish Government.

Sir Lewis Ritchie was commissioned by NHSH to look at out of hours for North Skye. His report published in 2018, set out 15 recommendations which were fully accepted with commitments given by NHSH to implement. A number of these recommendations have been completed e.g. Raasay Nursing service; Glenelg GP cover; Review of evacuation services for Raasay; Centre of Excellence and Digital innovation. Co-production was a key theme which has continued in the remaining groups which are focusing on Portree Urgent Care; workforce challenges and Community Beds. A number of other recommendations have been merged as they were clearly linked e.g. first responders; rapid response SAS; NHS 24; housing. A steering group chaired by our local counsellor with community reps meets 3 monthly with the work streams meeting as required. An offshoot of these meetings has been the development of the Skye Recruitment group who are looking at ways to encourage applications across the services. The below meeting is an example of the discussions ongoing and RAG status.

SLR\N Skye Improvement & SLR Delivery Group notes and update on SLR Recs 6.6.23.docx

Community Engagement

The SLWR CPP has not met in over 3 years. All community engagement work is primarily through the SLR work streams and recruitment group work which is ongoing.

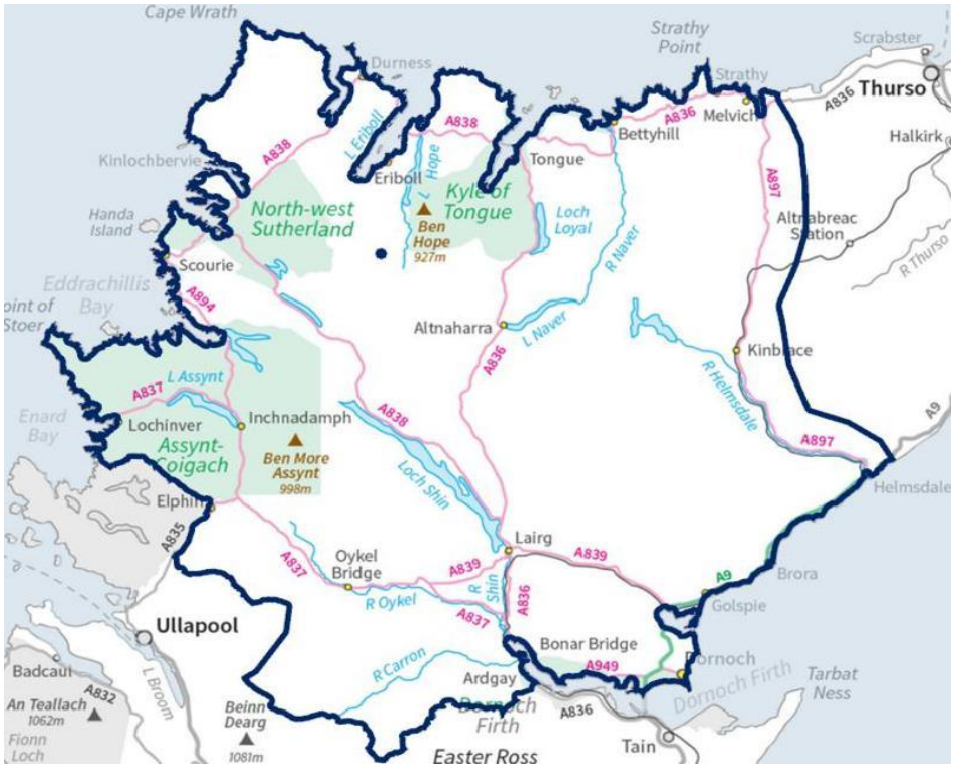
Completed by: Kate Earnshaw Date: 17.8.23

District Profile

District: Sutherland

Manager: Kate Kenmure

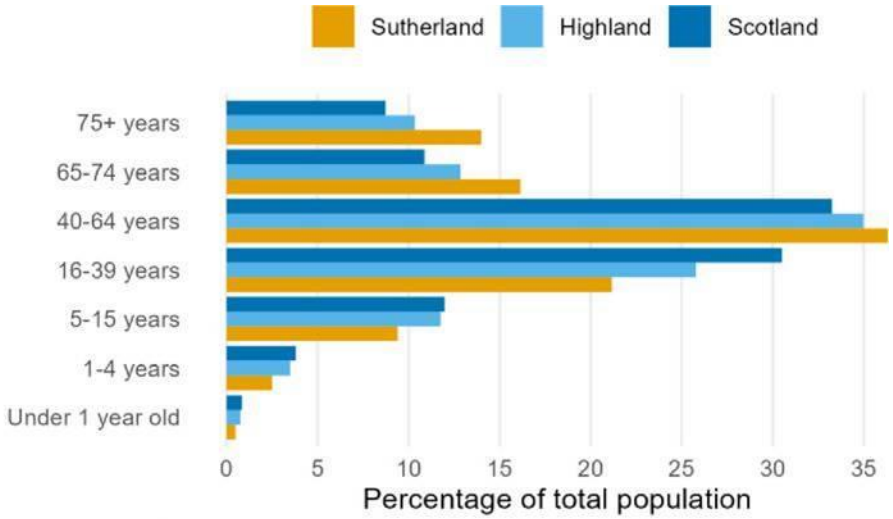
Locality Demographics
For information: The latest estimates are based upon the 2011 census, with an adjustment made annually for births , deaths and migration. Future estimates will be rebased on the 2022 census when the results become available. The population projections used in this report were produced by the Improvement Service (IS) and are based upon Housing Market Areas (HMAs) defined by the Argyll and Bute Council and the Highland Council.



- As of 2021, Sutherland has a population of 13,142 people. 12.4% of the population are children aged 0-15 years, 57.5% are aged 16-64 years, and 30.1% are people aged 65 years and over.
- Just under a third of the population (31%) live in settlement areas of Brora, Dornoch and Golspie. All of the population (100%) live in areas classified as very remote rural.
- The age profile of the Sutherland population is older than Highland.

- The population of Sutherland increased by 2% over the period from 2002 to 2021.

- Over this period, there was a 38% increase in the 65+ age group. The population aged 16-64 decreased by 3% and the population under 16 decreased by 27%.
- The ratio of 1.9 people of working age (16-64 years) to older people (age 65 years and over) is lower than in Highland and Scotland.

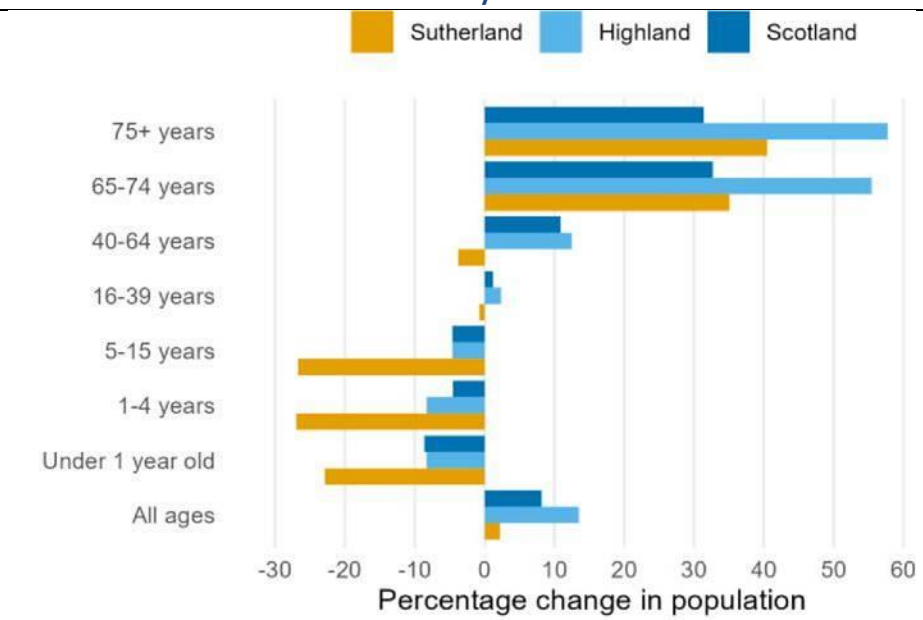


Source: National Records of Scotland, Small Area Population Estimates 2021

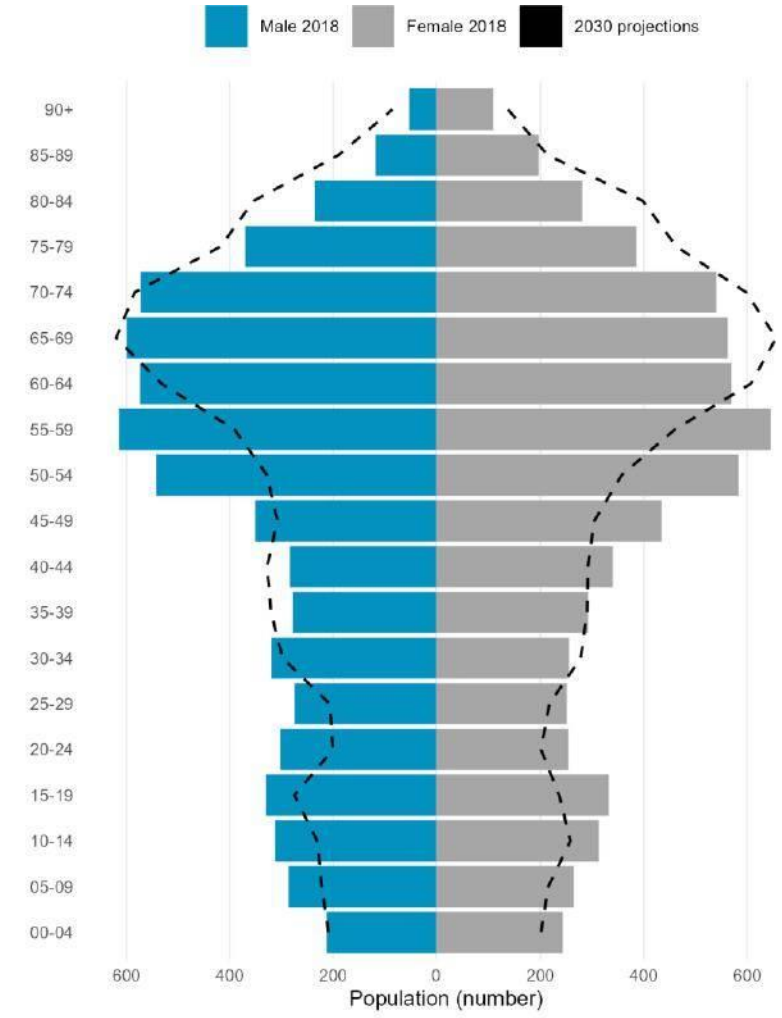
- There were 60 live births to Sutherland residents in 2020.
- The birth rate has decreased over the last decade in Sutherland and Highland.

- The mortality rate in Sutherland has consistently been lower than that of Highland.
- Following the pattern seen in Highland and Scotland, improvement in the mortality rate in Sutherland has stalled[6]. It is a significant concern that a sentinel measure of population health and social progress is no longer improving.

- The annual number of deaths in the area exceeds the number of births, and population growth depends on net migration gain.
- The latest available population projections estimate that the overall population of Sutherland will decrease between 2018 and 2030.
- The number and proportion of people in the 65-74, 75-84 and 85+ age groups are projected to increase, whereas the population aged 0-15 years, 16-44 years and 45-64 years are projected to decrease.
- Projected demographic changes indicate that the ratio of people of working age to people aged 65 years and older will further decrease.



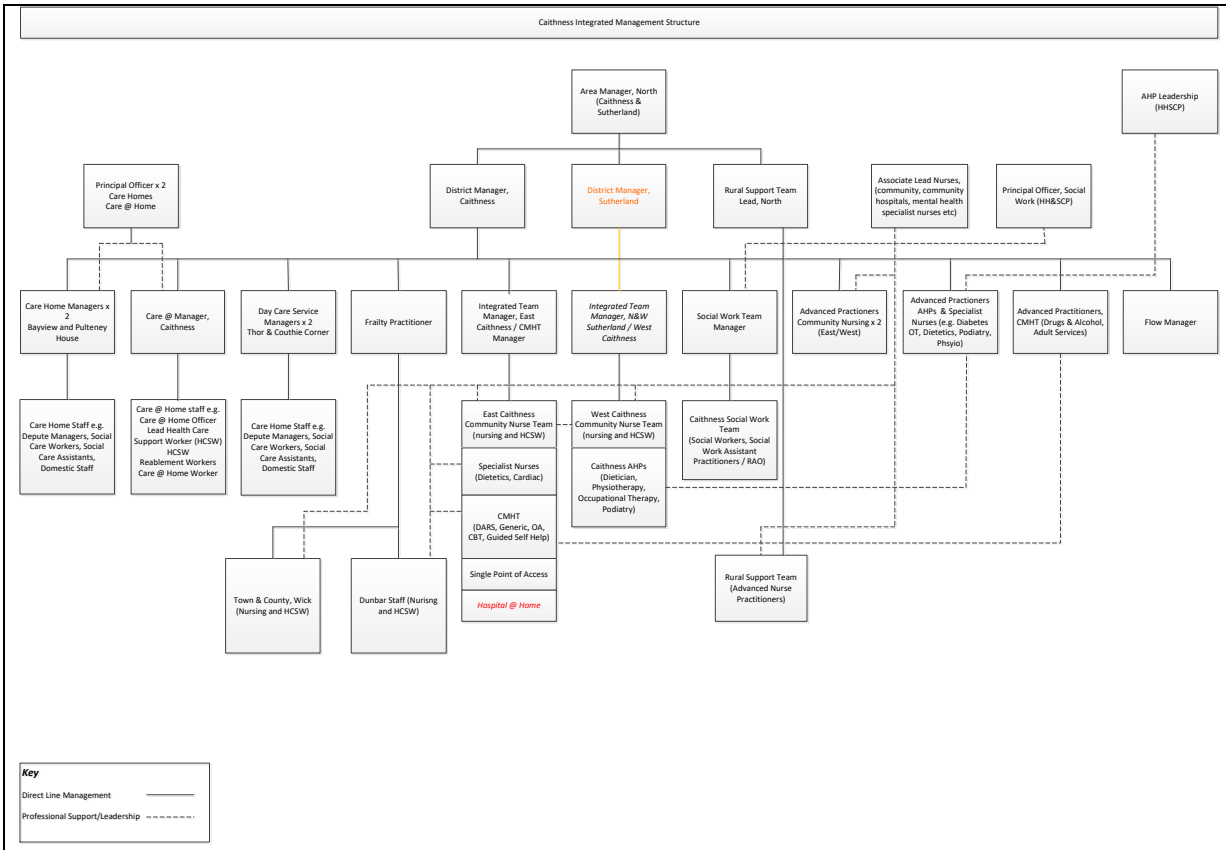
Source: National Records of Scotland, Small Area Population Estimates 2021



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

- SIMD 2020 identifies no data zones in Sutherland that are in the 20% most deprived small areas in Scotland. The majority of the population(83.8%) live in areas ranked in quintiles 2 and 3 of SIMD.
- In SIMD 2020, 9.8% of the population of Sutherland were identified as being income deprived, and 7.6% of the working-age population were employment deprived.
- Rural deprivation is an important concern. Those identified as income or employment deprived are found in all intermediate geography areas.

Services provided and current workforce
Services managed within Sutherland District as at 21/02/23 are: ○ AHP Services ○ Dietetics ○ Occupational Therapy ○ Physiotherapy ○ Podiatry ○ Care at Home / Reablement ○ Care Homes ○ Seaforth House, Golspie ○ Melvich Care Home, Melvich ○ Caladh Sona Care Home, Talamine ○ Community Hospitals ○ Migdale Hospital ○ Cambusavie Unit, Lawson Memorial Hospital, Golspie ○ Community Mental Health Services. ○ Cognitive Behavioural Therapy (Sutherland & Caithness) ○ Drugs & Alcohol ○ Adult Generic ○ Guided Self-Help ○ Learning Disabilities Nursing ○ Older Adult ○ Community Nursing ○ East Sutherland ○ West Sutherland ○ North Sutherland ○ Day Services ○ Health and Wellbeing Hubs in Brora, Helmsdale, Kinlochbervie, Bonnar Bridge, Lochinver ○ Specialist Nursing services e.g., ○ Cardiac/Heart Failure, ○ Diabetes ○ Social Work Services ○ Single Point of Access The leadership team comprises the district manager, integrated team managers (East and North & West Sutherland), Senior Charge Nurses in each Community Hospital, Social Work Team Manager, Care at Home Manager, Care Home managers and Advanced Practitioners. Several advanced practitioner posts are shred across Caithness and Sutherland. See below for structure



AHP Services

Dietetics at present is managed within the district but at 01/04/2023 while remaining in the community directorate will under redesign of structures be managed as part of an overall dietetic service for North Highland Community Division. In terms of Sutherland staffing numbers are very small with a 0.6wte B6 practitioner. There are links locally to the highland wide work around type two diabetes and the orth Area Health Improvement Practitioner.

Occupational Therapy service is managed within the district by the Integrated Team Managers and provides service to community and inpatients in both Community Hospitals. The team itself comprises B7 Advanced Practitioner (new), B6 and B4. Recruitment in recent years and months has been challenging particularly at B6 level where redesign of posts has had to take place with a recent B7 post put in place to bolster leadership. There is also a B7 post who works in specialist housing post attatched to THC team.

Physiotherapy like OT is managed by the Integrated Team Managers and, like OT, provides services in the community and hospitals with staff based at Lawson Memorial and Migdale Hospitals as well as in North and West Sutherland integrated team. Physio in Sutherland covers all aspects of clinical service including rehabilitation, outpatient, MSK, cardiac and pulmonary rehab, falls, frailty, and pelvic care. Due to challenges in recruitment to qualified (mainly B6) posts the service in Sutherland has recently been supported via agency which has had a significant cost implication. There is a senior practitioner and leadership role at B7 level which was for both Caithness and Sutherland. This role has been redesigned recently and will be only for Sutherland to support staff and increase capacity. There is also a "First Contact Practitioner" service within Primary Care.

Podiatry as with Dietetics will in time "move" to a north highland wide management structure via communities' division but at present is managed within the District. In general recruitment to podiatry

services is a challenge with a vacant post in the North/West Sutherland which we have been unable to recruit to. Some patients are seen in Caithness if they live in North Sutherland and the podiatrist in Wester Ross is providing a service in West Sutherland. The B7 AP post holder (B7 0.2wte of her 1.wte is for leadership across the North Area).

Care at Home / Reablement

Care at Home / reablement services are provided across Sutherland with a local manager based in Golspie along with the Care @ Home Officer, Co-ordinator, and Clerical Assistant. The office also acts as a "base" for the carers. The staffing in the North and West of Sutherland is challenging with vacancies leading to unmet need in the community. A project to look at remote support worker roles may help recruitment and retention but is only at the beginning of the process.

Capacity and demand within this service has been under scrutiny recently with delayed discharges continuing to be an issue due to unmet need particularly in North and West Sutherland.

Care Homes

Caladh Sona is a 6 bed care home on North Coast in remote rural area of Melness with increasing issues in recruitment of all staff groups but particular band 4 Social Care Workers who lead shifts, and hotel services domestic services workers. Recruitment is not an issue that affects Caladh Sona in isolation on North Coast – hospitality industry has and continues to have similar struggles in recruiting staff, and some business within Tongue have increased their rates of pay to attract staff.

Agency staff are used regularly with support from CRT when there is availability, and as of July 22, 2 x B5 nurses have been sourced from agency on 3 month contracts (rolling) with accommodation provided, but this is clearly not sustainable in the medium term, nor financially viable.

Melvich care home is in Melvich, further along the north coast. It is also a 6 bedded unit with similar staffing. Both Agency and CRT are used to ensure staffing stability with recruitment continuing to be an issue.

Caladh Sona was originally a 3 bed house with garage used by the warden for the sheltered housing units, but converted into a care home some 30 years ago, with no ensuite facilities and one shower for the use of all the residents. Over the years a replacement build for Caladh Sona has been raised, and in 2007 following a public meeting with Leader of HC, and the then Director of Social Work, the Caladh Sona Action Group emerged within the local community, and campaigned against any closure of Caladh Sona without a replacement built locally. In 2015 consultations with NHSH/HC and local communities regarding a replacement build for both care homes on North Coast (Melvich & Caladh Sona) began with the outcome of a care hub in Tongue. It is anticipated that the hub will be functional in 2026 as of Dec 2022. Planning permission will be sought for the plans and recently at a local drop-in session the plans and timetable was presented to the wider public.

Melvich Care Home was similarly transferred over from Highland Council at Integration and although a larger facility is still in need of upgrade and modernisation.

Seaforth House is a 15 bedded residential care home in Golspie which was transferred over to NHS Highland at Integration. There have been some staffing challenges with turnover significant but recruitment is healthy.

Community Hospitals

There are 2 community hospital within Sutherland, one in Golspie (Cambusavie)and one in Bonar Bridge (Migdale).

Cambusavie Unit, Lawson Memorial Hospital Golspie is a 16 bedded unit. The unit mainly covers Rehabilitation, palliative care and end of life care as well as GP assessment function to reduce need for an acute bed.
In addition to the inpatient beds there is a Minor Injuries Unit (MIU) and an outpatient department. Outpatient Clinics are held daily for podiatry and physiotherapy and on a regular basis for other services such as Dietetics which can be a combined clinic with the Diabetes Specialist Nurse or Cardiac Nursing (which may be combined with Physio). Consultants from Caithness General and Raigmore use the outpatient department for consultation. There are procedures taking place from ENT, Gynaecology, orthopaedics and Chronic Pain as well as clinics.

Migdale Hospital in Bonnar Bridge consists of 2 10 bedded wards and 2 beds which can be used in either ward areas. Kylscue ward is a traditional community hospital ward to support rehab, end of life care and GP assessment beds. Strathy ward was an older adult mental health assessment ward and has been temporarily closed during the pandemic. Part of it is being currently used as community hospital provision with no decision made to its long term future. A consultation was undertaken with the community and an overwhelming opinion that the facility was needed and should be used as a community hospital.

Community Mental Health (Psychology/Psychiatry provided via Mental Health Directorate)
As per the structure for North & West prior to the creation of the Communities Division, Community Mental Health Services in Sutherland are managed by the Integrated Team Managers albeit this is likely to change in the coming months with a move of management to the Mental Health and Learning Disabilities Division. Psychiatry and Psychology services are managed centrally and have been traditionally. Staffing in the mental health team is a particular challenge with several vacancies at B6 level in learning disabilities, older adult and generic teams. At present there are vacancies in Learning disability, older adult CPN (Sutherland wide) and the generic vacancies in North Sutherland)

Cognitive Behavioural Therapy while based in Caithness covers the north area (Caithness & Sutherland)

Community Nursing
There are 3 community nursing teams – East, North and West. There is an Advance Practitioner in each team who supports the staff, provides supervision and act an expert practitioner in the area. The team is managed by the ITM while the AP is managed by the District manager.
The community team provides preventative, reactive and maintenance clinical care to patients in the community. The elderly age profile and care homes in the area are above average. The team also provide end of life care to support individuals who wish to die at home. They manage highly complex patients with co- morbidities in the community.

Day Services
There are no registered daycare services in Sutherland with the resources allocated to Health and Wellbeing Hubs managed by the 3rd sector. These hubs are based throughout Sutherland and provide social interaction and lunch for both elderly and people with a learning disability. They are supported, if they need personal care, with support workers allocated from the ASC budget. The funding for these Hubs are through an SLA and have not been increased since integration in 2012.

Specialist Nursing
There are several specialist nurse posts across highland which are managed in different ways. In terms of those which are managed within the district (because of district development and use of district budgets differently to support development) the two are Diabetes and Cardiac Rehab/Heart Failure. In terms of **Diabetes** Sutherland has 1wte B6 staff nurse and shares a B7 Advanced Practitioner with Caithness (who also have a B6) so for the North there is a team of three. The team works alongside colleagues in community nursing, care at home, dietetics etc to support individuals living in the community with

diabetes for example there a joint clinic with the dietician. They also provide support to care homes and community hospitals. They do provide an in-reach support service to patients known to them in the community Hospitals but cannot provide an emergency response service. For **Cardiac Rehab/Heart Failure** Caithness has a 0.4wte B7 post. The post holder works with colleagues in physiotherapy etc to provide joint clinics. The establishment is historic establishment which has not been reviewed for some years. Senior Nursing leadership in the Community Division will support and establishment review in July which will cover a larger geography than Caithness.

Social Work

The social work team has benefited form an investment from the Scottish Government and is a stable team with no recruitment issues. The numbers of ASP cases are small but the large number of elderly people ensures that POA, guardianships as well as long term care assessments make the team very busy.

Single Point of Access

To encourage and support streamlining of service access Sutherland has a single point of contact for service users, professionals and the public. With the commencements of the DMTs the role of the HSSC Co-ordinator has become pivotal to the management of flow between Secondary care, community hospitals and community services.

RST (managed via RST Manager but part of community division)

The rural support team based in the North Sutherland will provide OOH services when recruited. At present OOH services are provided by locum GPs North and West Sutherland while a consortium manages the East Sutherland OOH service. It is based at Lawson Memorial Hospital.

Primary Care formerly part of District now division on own

Finance & Performance

Projection M9

Current Plan £000	Division	Plan YTD £000	Actual YTD £000	Variance YTD £000	F'cast Outturn £000	F/cast Variance £000
918	AHPs	685	571	113	767	151
655	Management	527	393	134	541	113
1,190	Nursing	893	1,056	(162)	1,406	(216)
3,142	Hospitals	2,328	2,650	(323)	3,480	(338)
789	Mental Health	593	474	118	631	158
(258)	Community	(194)	(217)	23	(289)	31
1,070	OOHs	803	876	(73)	1,168	(98)
13	Primary Care	7	5	2	11	2
7,518	**Sub Total - Health**	**5,640**	**5,808**	**(168)**	**7,715**	**(197)**
2,447	Care Homes & Respite	1,833	2,021	(187)	2,696	(250)
232	Community Care	172	66	106	102	129
557	ASC Management	459	472	(14)	576	(18)
1,728	Care at Home	1,297	1,343	(45)	1,788	(60)
5,946	ISC/SDS	4,462	4,504	(42)	6,044	(98)
10,910	**Sub Total - ASC**	**8,224**	**8,405**	**(181)**	**11,207**	**(297)**
18,429	**Total for Sutherland**	**13,864**	**14,214**	**(349)**	**18,922**	**(494)**

Health Forecast M9

Health Analysis of Position	YTD Variance £000s	Forecast Variance £000s	Anticipated Spend £000s	Comments
Cost Pressures				
Pay Cost Pressures	300.67	313.76	313.76	Staff Overspends due to use of agency and staff sicknesses
Pay Pressures - unfunded i.e maternity/unfunded posts	26.75	35.67	35.67	
Utilities	0.17	0.19	0.19	Total Overspend on Heat and Fuel
Drugs	10.71	9.71	9.71	Drugs overspend relating to Migdale/Lawson and OOH
Other non-pay	89.11	130.68	130.68	Surgical Sundries Overspend accumulated 38K and paramedical supplies 12k, misc - 74K Strathy GP Cover Invoices
Travel	55.46	73.94	73.94	Travel and Transport - Car Lease over spends, Other various travel overspends
Savings Underachieved				
Housekeeping - HDL160	41.36			Savings achieved in advance
Covid Costs				
Other Additional Staff Costs	29.94	29.94	29.94	CAC Costs
Offsets and Compensation				
Vacancies	244.41	316.16	316.16	Vaccancies within AHPs, Mental Health
Other non pay	59.22	80.80	80.80	This is Partly Strathy Savings (74K) as ward closed but offset by having 4 beds reopened

ASC Projections

ASC Analysis of Position	YTD Variance £000s	Forecast Variance £000s	Anticipated Spend 23/24 £000s	Comments
Cost Pressures				
Pay Cost Pressures	98.73	131.65	131.65	Maternity/Agency/sickness Costs less unfunded post and CAH costs below
Pay Pressures - unfunded i.e maternity/unfunded posts	47.08	62.76	62.76	CAH Manager
Utilities	23.97	31.96	31.96	Care Home Overspend on Heat and Light
Other non-pay	45.62	60.83	60.83	Cleaning, Surgical Sundries and General Services
Travel	7.38	9.84	9.84	CAH Teams
ASC packages	55.32	115.88	115.88	Care package line from North & West and East Caithness Cah Team
Care at Home	58.78	78.38	78.38	
Offsets and Compensation Underspends				
Vacancies	40.20	53.60	53.60	Trouble Recruiting Staff in Care Homes
Other non pay	115.30	141.13	141.13	Underspends in Transport, Paramedical supplies and Property Maintenance

What savings can be achieved

- Discussion around the overnight service, savings are in hospital admission avoidance and early admission into a care home due to a lack of overnight care.
- Rural Support Worker for the North Coast which will encourage recruitment retention and focus on patient centred care.
- **Additional Workforce Requirements**
- How are these to be funded? – Ageing population in Sutherland, very historic budget in CAH, an establishment review is needed to determine if staffing meets demand.

Investment Requirement

- Investing in Community Services which would be CAH, OT, Physio and District Nursing
- This is to allow people to manage complex medical conditions in their own home, therefore reducing the need for hospital admissions
- Investment in the OOH service (GP budgets) which is being discussed at the assurance board
- Community Hospital Investment in expanding services to support the local community

- **Co-dependencies**
  - Supporting people to stay in their own homes will reduce the number of admissions and length of stay in Raigmore

Opportunities and Developments

A pilot of an overnight community service comprising of a Registered nurse and support working evaluation well and was shown

- to prevent admission to hospital if safe and suitable to provide Hospital at Home.
- To facilitate seamless hospital discharges
- To provide palliative care/End of Life care in the patients chosen place of death.
- To reduce Long Term Care admissions.

Rural Support Workers in North Sutherland will allow a more reactive service to ensure the population of the area get the service/ care they need to stay in their own community (either in the local care home or in their own home)

Community Engagement

Community Planning Partnership (CPP)
The Sutherland CPP is a strong active group which is chaired by our police colleagues which meets on a quarterly basis. Sub groups are in place who meet on a more regular basis and are responsible for taking forward actions. This includes Fuel and food poverty subgroups, Emotional wellbeing, Transport and Housing subgroups.

Independent Sector
Regular meetings take place with our Care at Home Independent Sector providers for East Sutherland. Four weekly review meetings are in place which includes Contracts, along with weekly allocation meetings with our local team. We have strong links with our providers, and whilst there has been delay in some pick up of packages with one particular provider, we anticipate some improvement.
There are no Providers in the North and West Sutherland.

Highland Council
The District Manager meets monthly with the local Councillor. The Ward Manager sits on the local Care for People Group.

Community Councils
The Community Councils in Sutherland are invited to and frequently attend and engage with the Sutherland Community Planning Partnership. Although the District Manager is not routinely invited to the community councils they are very receptive if contacted and happy to invite the District Manager to attend to discuss any issues .

Completed by: Kate Kenmure Date: 21/2/2023

Health and Social Care Committee

Committee:	**Health and Social Care Committee**
Date:	**August 2023**
Report Title:	**Integrated Children's Services Plan 2023 - 2026**
Report By:	**Chair Integrated Children's Services Planning Board**

1. Purpose/Executive Summary

1.1 This report introduces the Community Planning Partnership's Integrated Children's Services Plan 2023 – 2026.

1.2 The report provides (Appendix 1) the Highland Integrated Children's Services Plan for 2023 - 2026 for noting by this committee.

2. Recommendations

2.1 Members are asked to:

i. Note the work undertaken by the Integrated Children's Service Plan Board in producing the Highland Integrated Children's Services Plan 2023 - 2026.
ii. Note and provide comment on the plan which has been approved by the Community Planning Partnership Board

3. Implications

3.1 Resource – The intention is to deliver the next iteration of the plan within existing resource. Further resource implications may be identified within the duration of the plan (2023 - 2026)

3.2 Legal – There is a statutory requirement for partnerships to produce an ICS plan every three years as outlined at 4.1 of this report. The plan will have a focus on meeting the requirements of the United Nations Convention on the Rights of the Child as at 7.4.

3.3 Community (Equality, Poverty, Rural and Island) – The next iteration of the ICS plan is will be delivered through the Community planning partnership infrastructure and will be

aligned to the aspirations of the Highland outcome improvement plan with a focus on community resilience and participation as at 7.1.

3.4 Climate Change / Carbon Clever – None

3.5 Risk – None

3.6 Gaelic – None

4. Background and Context

4.1 In February 2014 The Scottish Government passed the Children and Young People (Scotland) Bill. The Bill places duties on public bodies to coordinate the planning, design and delivery of services for children and young people with a focus on improving wellbeing outcomes, and report collectively on how they are improving those outcomes.

4.2 In December 2019, Scottish Government wrote to each of the strategic leads for Integrated children's services planning issuing new guidance to support the development of ICS plans across Scotland. This guidance determined that children's services plans should be embedded within Community Planning Partnerships. This guidance also provides the structure and framework for our 2023 - 2026 plan.

5 Developing the plan

5.1 Over the last 18 months considerable work has been undertaken to draft this iteration of the Highland Children's services plan. The well-established integrated children's services planning board has met monthly during the last 12 months and has worked effectively in determining the themes and priorities. In addition, during this period the board have hosted a series of workshops to agree the change ideas articulated within the plan and developed the Joint Strategic needs assessment which determined the priorities for this plan.

5.2 The board membership comprises;

- Head of community support and engagement – The Highland Council
- Principal Educational Psychologist – The Highland Council
- Head of Health Improvement, Public Health - NHS Highland
- Head of Education – The Highland Council
- Lead Officer – Child Protection Committee
- Independent Chair – Child Protection Committee
- Executive Chief Officer(Health and social care) and Chief Social Work Officer – The Highland Council
- Child health Lead – The Highland Council
- Superintendent, Partnerships – Police Scotland
- Head of Children & Justice Social Work Services – The Highland Council
- Director of Public Health – NHS Highland
- Head of Operations Women and Children`s Directorate – NHS Highland
- Nurse Director – NHS Highland
- Programme Manager – Family wellbeing programme

- Director of Children & Families (Aberlour) – Third sector
- Deputy Chief Officer HTSI – Third Sector
- Chief Officer, Inspiring Young Voices – Third Sector
- Youth Work Manager, Youth Highland – Third Sector

6 The Plan

6.1 The plan outlines our priorities for improvement to ensure that services are integrated for service users including children, young people and their families, that we make the best use of resources and are meeting our aims to safeguard, support and promote wellbeing, early intervention and prevention.

6,2 The plan has been developed to ensure it reflects the National Performance Framework Outcomes and incorporates a comprehensive evidence-based joint strategic needs assessment. This assessment includes analysis of quantitative and qualitative evidence and data relating to both service performance and child wellbeing.

6.3 The plan is supported by a performance management framework which determines clear indicators for monitoring and evaluating the effectiveness of outcomes in responding to and addressing children's wellbeing needs.

6.4 The plan has been developed through a lens of embedding children's rights articulated within the United Nations Convention on the Rights of the Child and reflects the values and principles of Getting it right for every child. It also reaffirms our commitment to 'Keeping the Promise'

6.5 Where pre-existing partnership groups exist, these have been brought together into the children's service planning framework to improve continuity and prevent duplication. These groups include the Highland Child Protection Committee, The Promise Board and Highland Alcohol and Drug Partnership.

6.6 Pre-existing HOIP delivery groups have discreet sub groups for integrated children's services including those with a focus on poverty and mental health.

6.7 The plan is consistent with the Highland Outcome improvement Plan 2017—2027 (HOIP) which shares a focus on working together to reduce inequalities in Highland.

6.8 Both plans aim to tackle the issues that lead to inequalities, to make the Highlands a fairer place, so that everyone has the opportunity to enjoy the benefits of our region. We endeavour to do this by listening to our communities and working with them to make Highland an even better place to live, work and play.

7 A Life Course Approach

7.1 Our objective is to improve outcomes for Highland's Infants, Children and Young People through local delivery of services and provide support by considering the needs of their families across a life course from pre-birth to young adulthood. In taking a life course approach we can more readily identify opportunities to minimise risk and enhance the protective factors through evidence-based interventions.

7.2 A significant feature of this plan is our aspiration to develop community scaffolding for our supports through our community-based whole family wellbeing programme. This programme aims to reduce inequalities and improve the health and wellbeing outcomes of the Highland Population through improving cohesion, co-ordination and collaboration of whole family support within Highland's Communities. Working to the founding principles of this plan, communities will be supported by a partnership programme team lead by a programme manager and supported by locality coordinators.

Designation: Chair of the integrated children's services planning board

Date: September 2023

Author: Ian Kyle

Highland Community Planning Partnership | Com-pàirteachas Dealbhadh Coimhearsnachd na Gàidhealtachd

Highland Children and Young People's Needs Assessment

June 2023

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Acknowledgements

The Highland Children and Young People's Needs Assessment has been produced by NHS Highland Public Health Intelligence on behalf of the Highland Integrated Children's Services Planning Board and Highland Community Planning Partnership. We would like to thank colleagues across the partnership for providing data, advice and guidance in the development of this report.

If you require this document in an alternative format, such as large print or on a coloured background, please contact us by emailing nhsh.publichealthintelligence@nhs.scot.

Version	Issued	Summary of changes
1	30/03/2023	Final draft with additional content on young carers and neurodiversity to be confirmed
2	22/06/2023	Final version with additional content on young carers and updated cover page

Distribution	Method
Highland Integrated Children's Services Planning Board, Public Health Directorate, Public Health Intelligence intranet pages	Email and intranet link

Contents

1. Introduction

This report aims to provide an overview of the population health and wellbeing needs of children, young people and families in Highland. It forms part of a programme of work undertaken in spring 2023 to inform the Highland Integrated Children's Services Plan 2023-2026 priorities and planning.

A health needs assessment (HNA) assesses a population's unmet health and healthcare needs to support planning and commissioning services. The definition used by the National Institute for Health and Care Excellence (NICE) is as follows[1]:

> A systematic process used by NHS organisations and local authorities to assess the health problems facing a population. This includes determining whether certain groups appear more prone to illness than others and pinpointing any inequalities in terms of service provision. It results in an agreed list of priorities to improve healthcare in a particular area.

This report has been completed as a rapid 'desk-based' HNA, drawing together information gathered from local and national sources. It utilises epidemiological and comparative approaches to explore trends and inequalities in outcomes for children and young people.

A rapid report of this type cannot provide a complete picture of the population needs of children and young people. Instead, it gives an overview of key points to help understand the population's needs and contribute to the planning and improvement of services.

2. Main Points

- Highland has a declining population of children and young people. Population projections forecast a continued reduction in the size of the population of children and young people.
- Highland has a significant remote and rural geography and a high proportion of areas in the most access deprived in Scotland. One in three children and young people under 18 reside in remote rural areas.
- The provision of services across the Highland geography is challenging. Statutory services, third sector organisations and other community groups should work collaboratively to improve the outcomes of Highland's children and young people.
- In Highland, most income deprived people live in places not identified among the most deprived areas by the SIMD. This distribution is a significant consideration for policy, strategy and the spatial targeting of resources.

- Tackling child poverty is a national priority. It is a complex task to measure child poverty, particularly in rural areas, accurately. Work should be undertaken to improve data sources that provide detail at a local level.
- Adverse childhood experiences are associated with poor educational, social, physical and mental health outcomes. Risk factors for childhood adversity are often co-occurring and interlinked. Actions identified should recognise the importance of different approaches and the connections between risk factors.
- There have been decreasing numbers of births in Highland, and the trend is expected to continue.
- Teenage pregnancies have fallen markedly, but this long-standing national priority has room for further improvement.
- Recording and reporting complex social factors and vulnerabilities in the maternity record are essential. Data capture about vulnerable women should continue to be improved.
- Preventative activity pre-conception and during pregnancy should be strengthened, and prevention explicitly considered as a part of service and pathway design or redesign.
- Identifying early child development problems is essential for understanding individual and collective developmental support needs. Early identification gives the best opportunity to support children and families to improve outcomes.
- There is strong evidence that breastfeeding is one of the most preventative health measures for children and mothers, with short-term and long-term benefits. Actions to improve breastfeeding uptake should be prioritised.
- Immunisation programmes for children are effective at protecting children from serious infectious diseases. There is a need to promote and improve the uptake of childhood vaccination.
- There is a need to support children and young people to maintain a healthy weight throughout childhood.
- Oral health improvement activities should continue with work to prevent dental caries in children, focusing on initiatives to reduce oral health inequalities.
- Preventing harm from substance use among young people is a long-standing national and local priority. Evidence based work to prevent and delay alcohol, tobacco and other drug use among young people should be prioritised.

- Children and young people's mental health and emotional wellbeing are critical concerns. Actions should ensure children and families receive support and services appropriate to their needs, including access to specialist CAMHS services.
- Schools should continue focused work to improve attendance, support children and young people with additional support for learning needs and promote inclusion.
- All children and young people should be supported to fulfil their potential through educational attainment and positive destinations upon leaving school.
- Processes to identify and support children and young people at risk of harm must continue to be improved.
- Learning from child death reviews should inform service delivery improvements and identify emerging trends that could influence the wider children's service strategy.

3. Population

Those commissioning and providing for the local health, educational and social needs of children and young people need to be aware that demands vary with the size of each annual population cohort and the cumulative sum of the individuals making up consecutive age groups.

As a result of birth rates and migration, the absolute number of children and young people of different ages living in Highland changes each year.

In Scotland, the definition of a child varies in different legal contexts. Statutory guidance supporting the Children and Young People (Scotland) Act 2014 and the United Nations Convention on the Rights of the Child 1989 include all children and young people under the age of 18 years[2] [3]. The following section extends this definition to cover those aged 18 to 24.

3.1. Population of children and young people

In 2021, 59,586 children and young under 25 years living in Highland comprised 25 percent of the area's population (Figure 1).

Children in their first year of life make up less than one percent of the total population of Highland and Scotland.

Figure 1: Children and young people living in Highland and Scotland by age group in 2021[1]

	Highland		Scotland	
	Number	**Percentage**	**Number**	**Percentage**
under 1 year	1,842	0.8	46,782	0.9
01-04	8,321	3.6	208,655	3.9
05-11	17,239	7.4	416,545	7.7
12-17	15,866	6.6	352,999	6.3
18-24	16,318	6.8	444,357	8.4
under 18	*43,268*	*18.2*	*1,024,981*	*18.7*
Total of children and young people	59,586	25.0	1,469,338	26.8

Source: National Records of Scotland, Mid-year population estimate for 2021
1 Percentage of the total population of the area

3.2. Population change

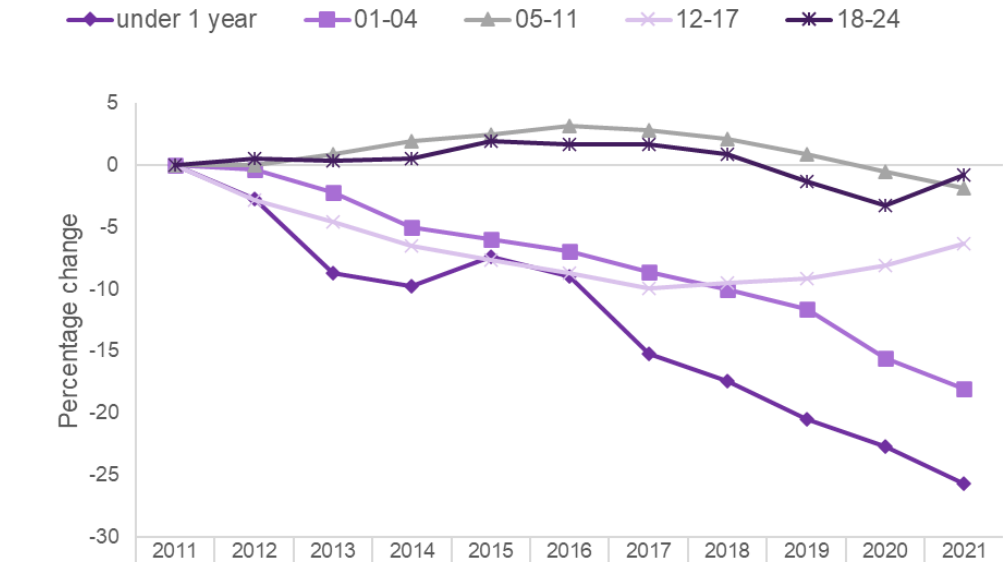
Over the last ten years, the population of children and young people under 24 in Highland has decreased from 63,587 to 59,586 (- 6.3 percent). There are substantial reductions in the number of children in the youngest age groups resulting from a sustained decline in annual births (Figures 2 and 3). We discuss birth trends in detail in section 5. Birth rates are at similarly low levels in the Scottish population, with a consequent notable decline in younger children (Figure 4).

Figure 2: Number of children and young people living in Highland in 2011 and 2021 by age group

	Age						Total of children and young
	under 1 year	01-04	05-11	12-17	18-24	under 18	
2011	2,480	10,148	17,562	16,945	16,452	47,135	63,587
2021	1,842	8,321	17,239	15,866	16,318	43,268	59,586
Percentage change	**-25.7**	**-18.0**	**-1.8**	**-6.4**	**-0.8**	**-8.2**	**-6.3**

Source: National Records of Scotland, Population Estimates Time Series

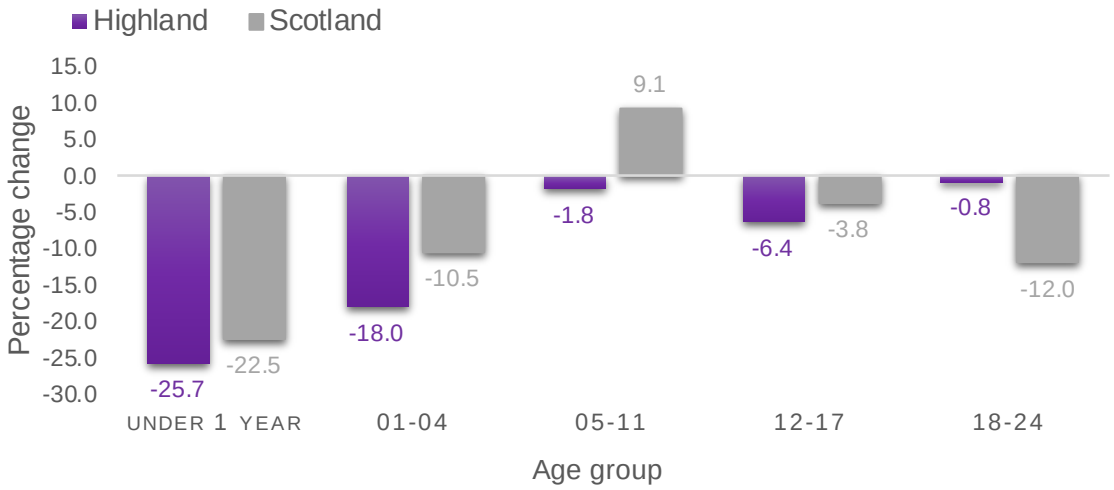
Figure 3: Percentage change in the number of children and young people living in Highland between 2011 and 2021 by age group



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
under 1 year	0	-2.7	-8.8	-9.8	-7.4	-9.0	-15.2	-17.4	-20.5	-22.7	-25.7
01-04	0	-0.4	-2.2	-5.1	-6.0	-6.9	-8.6	-10.1	-11.6	-15.6	-18.0
05-11	0	0.0	0.8	1.9	2.4	3.2	2.8	2.1	0.9	-0.5	-1.8
12-17	0	-2.8	-4.6	-6.6	-7.7	-8.7	-10.0	-9.5	-9.2	-8.1	-6.4
18-24	0	0.5	0.4	0.5	1.9	1.6	1.6	0.9	-1.3	-3.3	-0.8

Source: National Records of Scotland, Population Estimates Time Series

Figure 4: Percentage change in the number of children and young people living in Highland and Scotland between 2011 and 2021

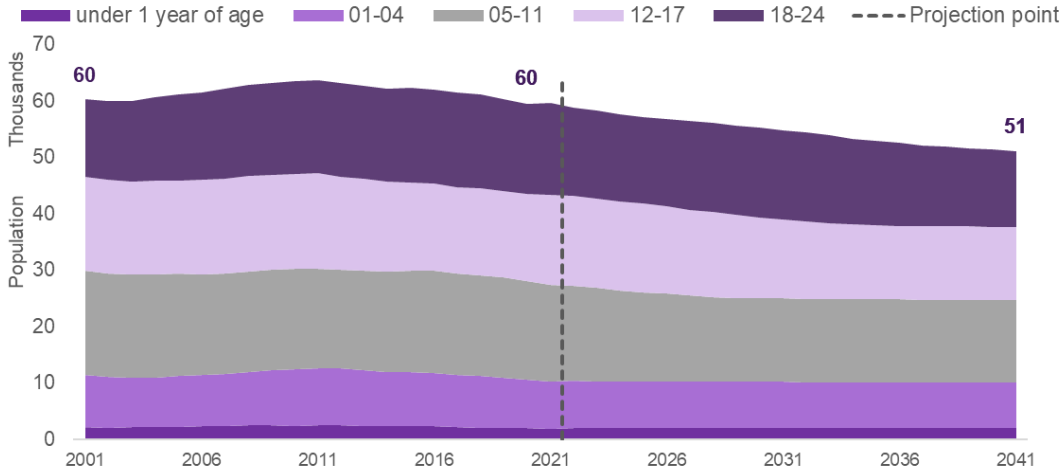


Source: National Records of Scotland, Population Estimates Time Series

3.3. Population projections

The 2018-based population projections for Highland forecast a continued reduction in the size of the population of children and young people (Figure 5 and Figure 6).

Figure 5: Estimated and projected population of children and young people living in Highland by age group, 2001 to 2041



Source: National Records of Scotland, Population Estimates Time Series Data and Population Projections for Scottish Areas (2018-based)

Figure 6: Estimated and projected population of children and young people living in Highland by age group, 2011, 2021 and 2031[1]

	under 1 year of age	01-04	05-11	12-17	18-24	Total	under 18 years of age
2011	2,480	10,148	17,562	16,945	16,452	63,587	47,135
2021	1,842	8,321	17,239	15,866	16,318	59,586	43,268
2031	1,991	8,141	14,819	13,997	15,794	54,742	38,948

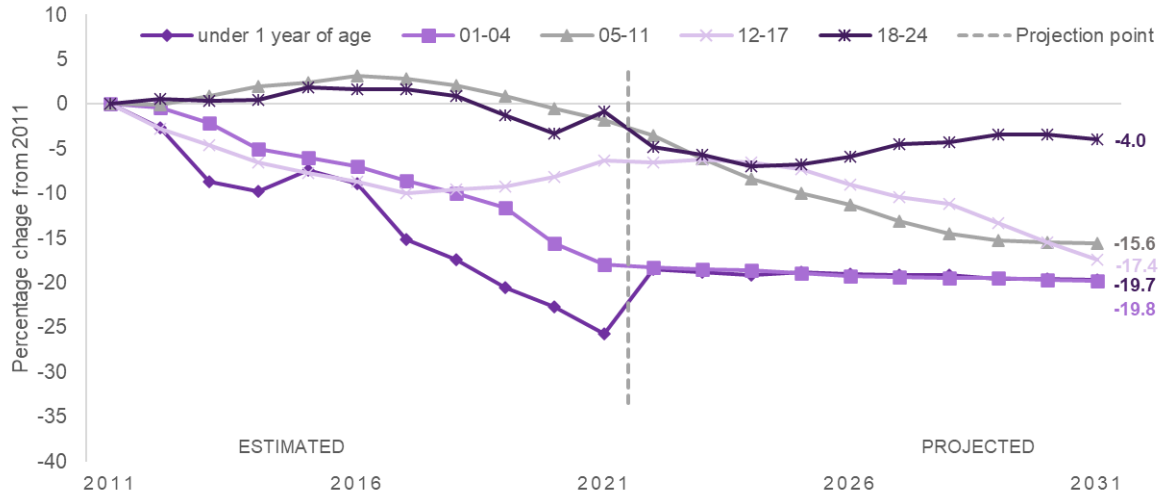
Source: National Records of Scotland, Population Estimates Time Series Data and Population Projections for Scottish Areas (2018-based)

Lower birth rates are the key factor contributing to the continued projected decline in the population of children and young people living in Highland. The birth rate assumptions informing the 2018-based projections underestimate the further decreases in recent years.

A consequence is a disjuncture between the estimated and the projected population that is most apparent in the population under one year old between 2021 and 2022 (Figure 7). As the successive birth cohorts of the projection age from this point, there is in-built inflation of the future population of children and young people across the projection course in all age groups.

If more recent birth trends continue, the expectation should be a smaller population of children and young people living in Highland than currently projected.

Figure 7: Percentage change in the estimated and projected population of children and young people living in Highland by age, 2011 to 2031



Source: National Records of Scotland, Population Estimates Time Series Data and Population Projections for Scottish Areas (2018-based)

3.5. Remoteness and rurality

The Scottish Urban Rural Classification (SGURC) is consistent with the government's core definition of rurality, which defines settlements of 3,000 or fewer people as rural. It also classifies areas as remote based on drive times from settlements of 10,000 or more people[4]. Using population thresholds and access criteria creates layers of sophistication in the classification (Figure 8).

We focus on the population of Highland children and young people who potentially live at a distance from service points in our major population centres in remote and rural areas. These places include villages, islands, peripheral coastal communities, and small towns in remote and very remote locations.

Figure 8: Scottish Government Urban Rural Classification (8-fold)

Area Class	Definition
1. Large Urban Areas	Settlements of over 125,000 people
2. Other Urban Areas	Settlements of 10,000 to 125,000 people
3. Accessible Small Towns	Settlements of between 3,000 and 10,000 people and within a 30-minute drive time of a settlement of 10,000 or more
4. Remote Small Towns	Settlements of between 3,000 and 10,000 people and with a drive time between 30 and 60 minutes to a settlement of 10,000 or more
5. Very Remote Small Towns	Settlements of between 3,000 and 10,000 people and with a drive time of over 60 minutes to a settlement of 10,000 or more
6. Accessible Rural Areas	Areas with a population of fewer than 3,000 people and within a drive time of 30 minutes to a settlement of 10,000 or more
7. Remote Rural Areas	Areas with a population of fewer than 3,000 people and with a drive time of between 30 and 60 minutes to a settlement of 10,000 or more
8. Very Remote Rural Areas	Areas with a population of fewer than 3,000 people and with a drive time of over 60 minutes to a settlement of 10,000 or more

Source: Scottish Government Urban Rural Classification 2020

In Highland, one in three children and young people under 18 years reside in remote rural areas, with one in five living in very remote rural areas. In contrast, one in twenty children lives in remote rural areas in Scotland, with one in forty living in very remote rural areas (Figure 9 and Figure 10).

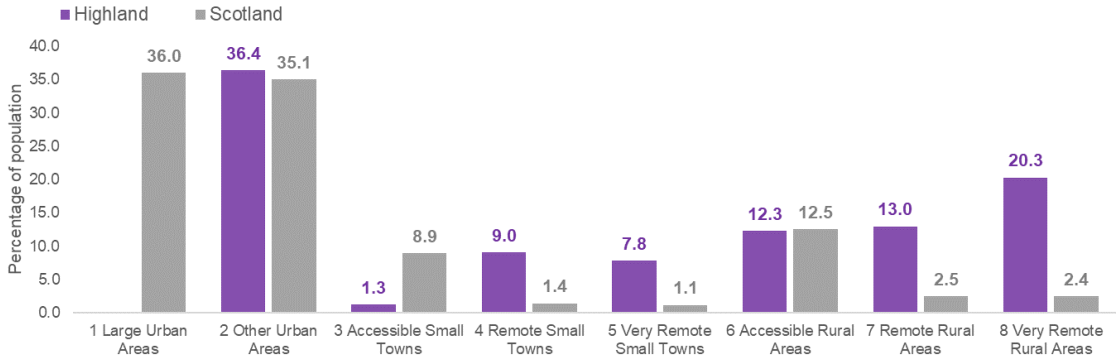
The table below shows the population under 18 years of age, but the distribution of children and young people is similar across the SGURC by age group in Highland (Figure 11).

Figure 9: Percentage of the population aged under 18 years of age living in urban and rural areas in Highland and Scotland in 2021

	Highland		Scotland	
	Population	*Percentage of population*	Population	*Percentage of population*
1 Large Urban Areas	0	*0.0*	369,243	*36.0*
2 Other Urban Areas	15,736	*36.4*	359,554	*35.1*
3 Accessible Small Towns	542	*1.3*	91,712	*8.9*
4 Remote Small Towns	3,905	*9.0*	14,335	*1.4*
5 Very Remote Small Towns	3,383	*7.8*	11,725	*1.1*
6 Accessible Rural Areas	5,311	*12.3*	128,027	*12.5*
7 Remote Rural Areas	5,604	*13.0*	25,360	*2.5*
8 Very Remote Rural Areas	8,787	*20.3*	25,025	*2.4*
Total	**43,268**	***100***	**1,024,981**	***100***

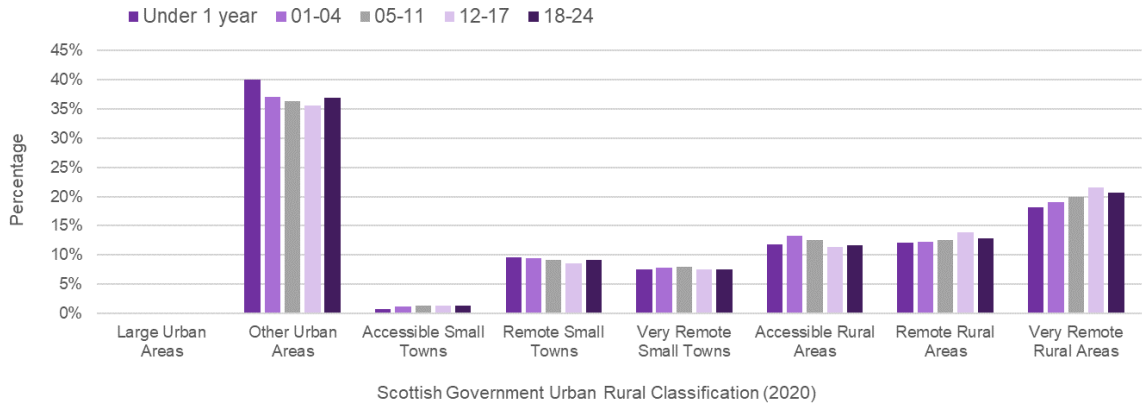
Source: Scottish Government Urban Rural Classification 2020 and NRS Small Area Population Estimates for 2021

Figure 10: Percentage of the population aged under 18 years of age living in urban and rural areas in Highland and Scotland in 2021



Source: Scottish Government Urban Rural Classification 2020 and NRS Small Area Population Estimates for 2021

Figure 11: Percentage of the population of children and young people living in urban and rural areas in Highland by age group in 2021



Source: Scottish Government Urban Rural Classification 2020 and NRS Small Area Population Estimates for 2021

Policy concerns in rural and remote areas often focus on economic regeneration, employment, rural prices and poverty, housing and fuel poverty, and population ageing, particularly the retention of young adults in such communities[5]. The needs of children and younger people living in these areas are often less directly recognised.

Common issues experienced by children and young people, at varying intensity levels with increasing remoteness and rurality, are the impacts of poor transport infrastructure, limited local choices, isolation from peers and lack of opportunity to socialise outside school, and poorer digital connectivity. Remote and rural areas are also potential places where children and young people who differ from their peers because of protected characteristics are at higher risk of social isolation[6].

Research also points to the benefits of living in remote and rural areas, with people reporting a stronger sense of belonging and community than urban populations, better neighbourhood environments and higher levels of subjective wellbeing[7]. A recent community consultation in Caithness described good community spirit, the quiet and scenic landscape and smaller classes in primary schools[6].

For organisations working in rural and remote locations, challenges to supporting children and young people are funding and achieving economies of scale in services, the availability of suitable premises and recruiting and retaining staff[8].

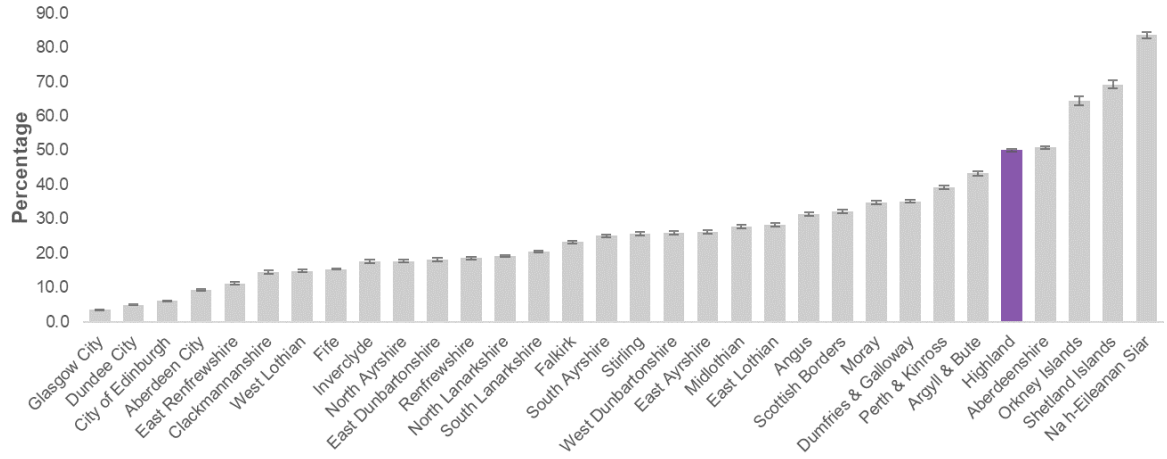
3.6. Access

Rural areas have worse access in terms of distance to services, including health, public health and social care services. Transport is essential for children and young people to access education, health services, employment, shopping and leisure. Access problems compound other disadvantages, including higher daily living costs in rural and remote places[5].

The Scottish Index of Multiple Deprivation access domain identifies that fifty percent of children and young people live in the twenty percent most access deprived areas in Scotland, with residents experiencing longer travel times to local services and poorer digital access. The Highland area has many places among the very most access deprived nationally[1].

[1] Travel time indicators include drive times and public transport times. Drive times to GP surgery, Post Office, Retail Centre, Primary School, Secondary School and Petrol Station. Public transport times to GP surgery, Post Office and Retail Centre.

Figure 12: Young people living in the most access deprived quintile, aged 00-25 years in 2020



Source: ScotPHO Community Profiles – SIMD 2016, Scottish Government and Public Health Scotland

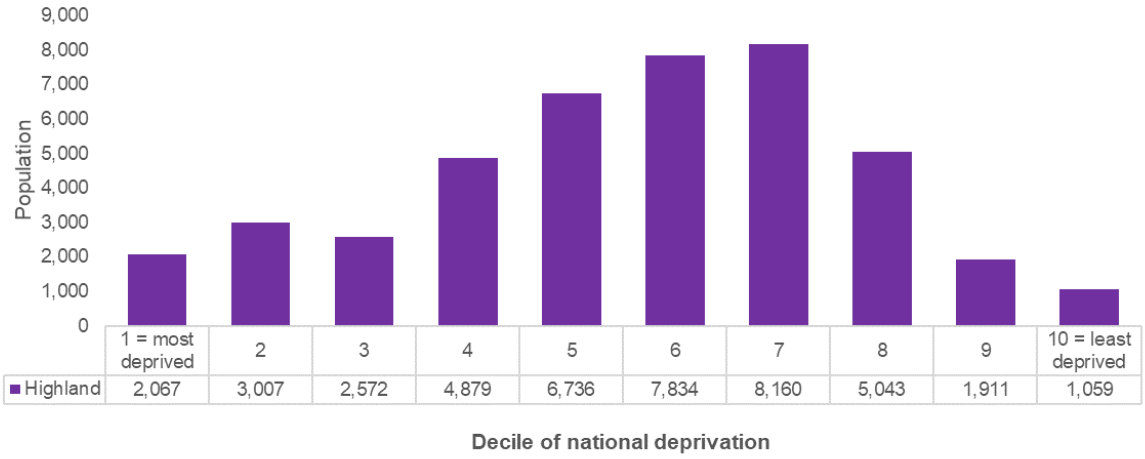
4. Social context and inequalities

4.1. Deprivation

National and local organisations can use the Scottish Index of Multiple Deprivation (SIMD) to identify areas of need and to allocate funding and resources. The SIMD combines 33 indicators across seven domains – income, employment, health, education, housing, geographic access and crime – into a single index for 6,976 small areas (data zones) with similar populations of around 800 people. Each data zone is ranked according to the overall SIMD score. For analysis and making funding decisions, ranks can be grouped into categories such as quintiles, deciles or the 15 percent most deprived areas in Scotland[9].

Figure 13 shows a decile distribution of children and young people by national SIMD ranking. The majority of the Highland population lives in areas ranked in deciles five to seven nationally. Targeting the most deprived ten percent would direct resources towards around 2,000 children and young people.

Figure 13: Number of children and young people aged under 18 years of age living in Highland in 2021 by national decile of the Scottish Index of Multiple Deprivation



	1 = most deprived	2	3	4	5	6	7	8	9	10 = least deprived
Highland	2,067	3,007	2,572	4,879	6,736	7,834	8,160	5,043	1,911	1,059

Source: Scottish Index of Multiple Deprivation 2020v2 and National Records of Scotland Small Area Population Estimates 2021

There are 312 data zones in Highland, with 22 recognised as being in Scotland's most deprived 15 percent of areas (N =1,046). These 22 areas are seven percent of Highland data zones and two percent of the national total[10]. The locations have similar levels of deprivation as some of Scotland's most deprived urban areas.

Nearly eight percent of Highland's children and young people live in these 22 areas. Most of this population lives in areas classified as urban (Inverness or Fort William) or remote and very remote small towns. A single remote rural area in the Seaboard area of East Ross is identified. Only 171 children and young people are estimated to live in this area, two percent of the total population under 18 in remote rural Highland (Figure 14).

Figure 14: The population of children and young people under 18 years of age who live in areas of Highland classified as the most 15 percent deprived in Scotland by the Scottish Urban Rural Classification

	Number living in the most deprived 15 percent of areas in Scotland	Percentage of the population living in the most deprived 15 pecent of areas in Scotland	Percentage of the population of the SGURC who live in the most derpived 15 percent of areas in Scotland	Percentage of the total population	Population total
1 Large Urban Areas	0	0.0	0.0	0.0	0
2 Other Urban Areas	1,849	53.8	11.8	4.3	15,736
3 Accessible Small Towns	0	0.0	0.0	0.0	542
4 Remote Small Towns	868	25.3	22.2	2.0	3,905
5 Very Remote Small Towns	547	15.9	16.2	1.3	3,383
6 Accessible Rural Areas	0	0.0	0.0	0.0	5,311
7 Remote Rural Areas	0	0.0	0.0	0.0	5,604
8 Very Remote Rural Areas	171	5.0	1.9	0.4	8,787
Total	**3,435**	**100**	**7.9**	**7.9**	**43,268**

Source: Scottish Index of Multiple Deprivation 2020v2, National Records of Scotland Small Area Population Estimates 2021 and the Scottish Government Urban Rural Classification 2020

The use of small areas in the SIMD helps to identify concentrations of deprivation potentially hidden in more extensive administrative geography, such as a Community Partnership or Council Ward. However, the Scottish Government acknowledge that the tool has limitations in rural areas where data zone populations are less socially and economically homogenous[11].

The index also does not capture important aspects of the deprivation experience in rural areas, such as social isolation and population loss. Therefore, the metric can overlook people and households experiencing multiple deprivations in remote or rural areas. It is important to remember the official guidance to users of the SIMD that 'not everyone living in a deprived area is deprived, and not all deprived people live in deprived areas'[9].

In Highland, more income deprived individuals live in places not identified among the most deprived areas by the SIMD[12]. Spatial targeting needs to consider the utility of the SIMD for that purpose and, if necessary, use other data sources in conjunction.

4.2. Child poverty

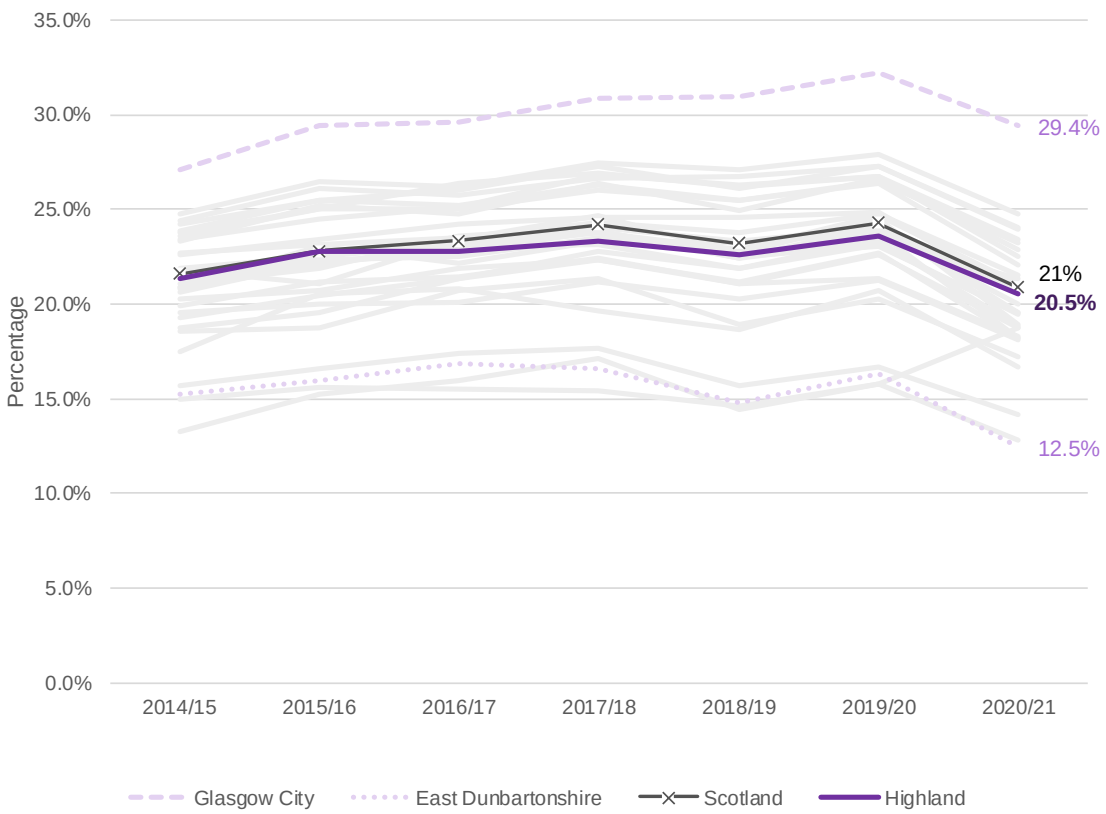
The challenges to tackling child poverty were set out in the Child Poverty (Scotland) Act 2017 and re-iterated in the latest national delivery plan for 2022 to 2026, Best Start, Bright Futures[13].

Children living in poverty are more likely to have health issues, including mental health problems, gain fewer qualifications, experience stigma and bullying at school and be at higher risk of being care experienced[14].

Research shows that 53 per cent of children in Scotland have experienced poverty in the last 12 years. Families move in and out of poverty and can easily be pushed into poverty[15].

Around one in five children under 16 live in relative poverty (below 60 percent of median income after housing costs) in Highland. This figure is comparable to Scotland as a whole (Figure 15)[16].

Figure 15: Percentage of children aged under 16 years living in income poverty after housing costs by Local Authority in Scotland

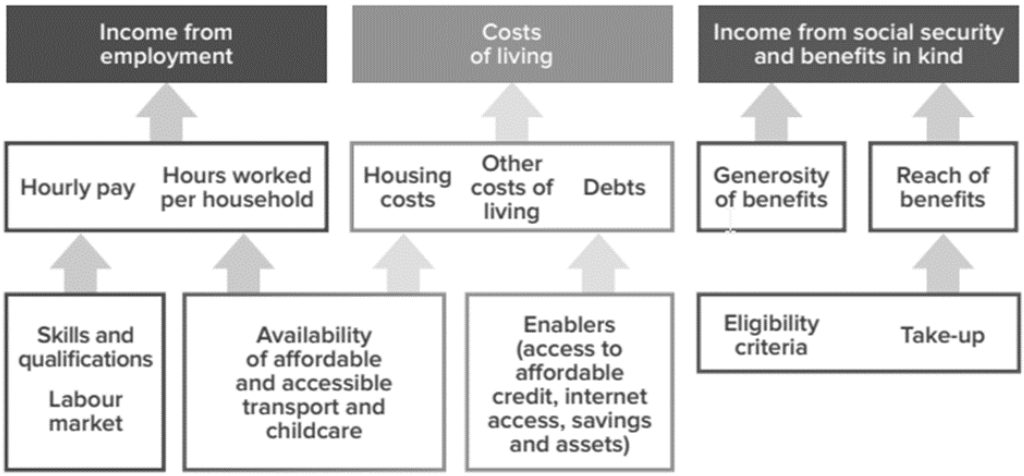


Source: End Child Poverty Coalition

The COVID-19 pandemic significantly impacted low-income households in Scotland[17]. However, the latest figures produced by the End Child Poverty Coalition suggest a reduction in relative poverty can be observed in 26 of 32 local authority areas in Scotland, including Highland. For 2020/21, the report estimates that Scotland had the lowest child poverty rate in the UK at 21 percent.

The Scottish Government's investment in the new Scottish child payment and other Social Security payments will have influenced the positive trends[18]. Local interventions to tackle child poverty and its impacts will have also contributed. For Highland, these were last reported in 2020/21.

Figure 16: Drivers of child poverty reduction



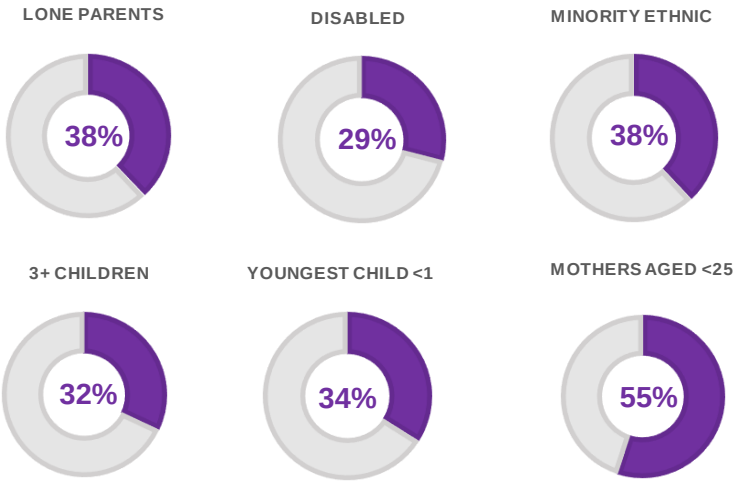
Source: Scottish Government. Best Start, Bright Futures: tackling child poverty delivery plan 2022 to 2026

While these figures are welcome, there is rising concern that the continuing cost of living crisis will likely result in more children and their families in poverty. The Resolution Foundation estimated that the typical working-age household across the UK would be around £1,100 worse off in 2022. The Institute for Fiscal Studies estimated that, by October 2022, the inflation rate faced by the least affluent ten per cent of households could be as much as 75 per cent higher than that faced by the most affluent ten percent[19]. Significant increases in food and energy costs form a larger part of low-income households' budgets.

The priority of policy focuses on children at greatest risk of poverty where the mother is less than 25, lone parent families, ethnic minority families, families with three or more children or a child under one and families where someone in the house is disabled (Figure 17).

Almost 90 percent of all children in poverty in Scotland live within these six priority family types, and these families will often experience multiple combinations of disadvantages.

Figure 17: Priority families in relative poverty in Scotland; percentage of children aged under 16 years living in income poverty after housing costs



Source: Scottish Government. Best Start, Bright Futures: tackling child poverty delivery plan 2022 to 2026

Particularly in rural areas, it is a complex task to accurately measure child poverty, profile the population in at-risk groups and describe the factors related to changes, such as social security, income from employment and the cost of living. Currently, data sources that provide detail at Local Authority and Community Partnership are limited[20].

4.3. Free school meals

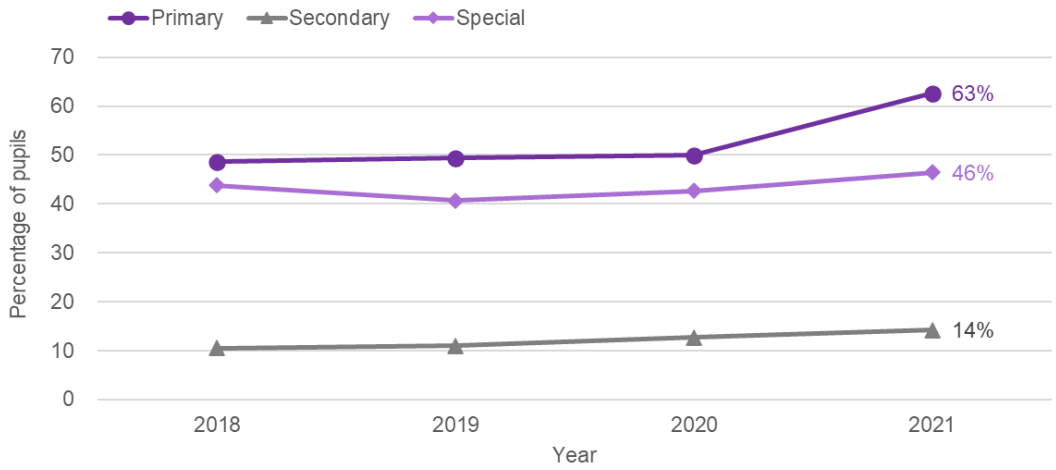
Free school meals (FSM) are considered a critical tool for mitigating the adverse health effects of child poverty among low-income families. Children receiving free school meals obtain a higher proportion of their daily energy and nutrient intake from their school meals than those who pay. Free school meals may improve health and wellbeing and reduce health inequalities.

Receipt of free school meals is considered a marker of poverty due to its restrictive eligibility criteria. Children who receive FSM are more likely to be living in low-income households. However, evidence suggests that many poorer families are slipping through the FSM net due to restrictive eligibility thresholds, leading to greater levels of food insecurity among children[21].

In 2021, 63 percent of primary school and 46 percent of secondary school pupils were registered for free school meals in Highland (Figure 18). Free school meal registrations are affected by changes to the eligibility criteria and the economic circumstances of pupils and their parents.

20

Figure 18: Proportion of pupils with free school meals by sector in Highland



Source: Scottish Government School Education Statistics

4.4. Housing and homelessness

A secure, nurturing environment is vital to the wellbeing of children and families. Housing plays an important role in improving health and wellbeing and reducing health inequalities through several routes, including affordability; quality; fuel poverty; and housing as a home within a community[22]. The location of a dwelling, its physical characteristics and the experiences of its inhabitants influence physical, mental and social health[23].

In 2021 there were an estimated 110,743 households in Highland, an increase of 8,365 (eight percent) since 2011. The average household size in Highland has decreased by seven percent from 2.24 people in 2011 to 2.09 in 2021. In Scotland, the average household size in 2021 was 2.12 people[24].

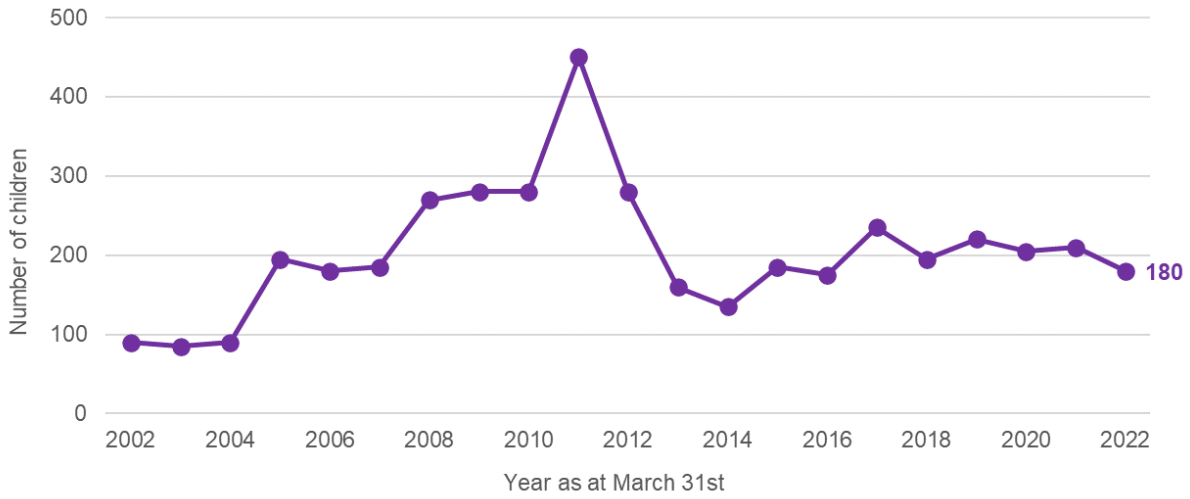
The 2018-based household projections for Highland forecast a three percent reduction in households with children between 2018 and 2028. Households with children are projected to comprise 20-25 percent of all households in 2028. In comparison, households with those aged 65 years and over are expected to make up 30-35 percent of households.

The causes of homelessness and the adverse effects on health and wellbeing are well evidenced[25]. Poverty, a lack of affordable housing, restrictions on access to, and levels of, social security support are all factors; these often interact with individual and interpersonal vulnerabilities such as mental health problems or relationship breakdown.

Preventing homelessness will always be the best option. If prevention is not possible, the duration of homelessness should be minimised, and suitable temporary accommodation provided.

In Highland, 180 children were in temporary accommodation at the end of March 2022 compared to 210 in 2021 (Figure 19). The number of children in temporary accommodation in the last five years has been stable.

Figure 19: Number of children in temporary accommodation in Highland, 2002 to 2022



Source: Scottish Government Homelessness in Scotland, Table 28

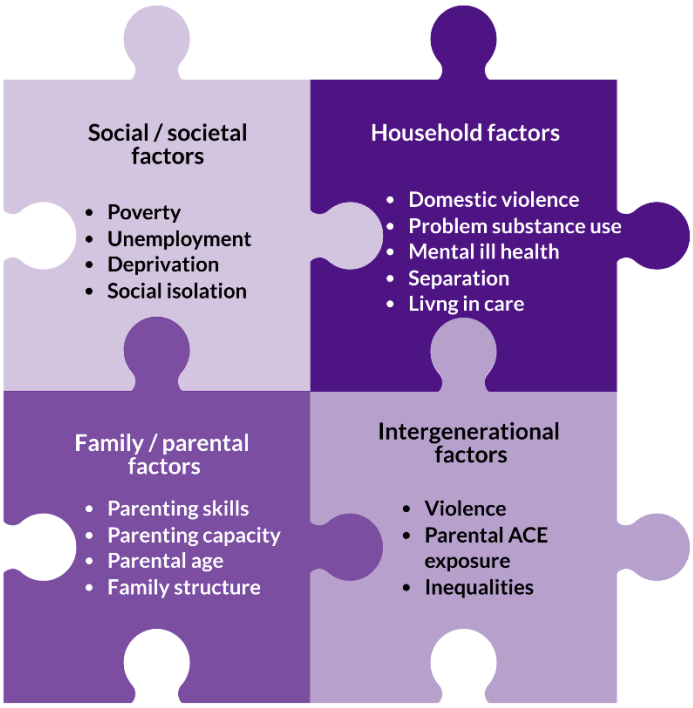
4.5. Adverse childhood experiences

The term adverse childhood experiences (ACEs) describe a wide range of stressful or traumatic experiences that babies, children and young people can be exposed to while growing up[26].

Adverse experiences often cluster in children and young people's lives and are associated with poor educational, social, physical and mental health outcomes across the life course. Evidence from population studies has found that the health and social risks associated with childhood adversity increase with the number of ACEs people report[27]. In Scotland, just over one in seven adults have reported experiencing four or more adverse childhood experiences[28].

The risk factors associated with the increased likelihood of experiencing abuse, trauma and stress in childhood are varied (Figure 20). The Institute of Health Equity summarised interacting risk factors for adverse childhood experiences as the social context in which families live, parenting and family structure, and household factors[29]. These risk factors are often co-occurring and interlinked. Usually, the cumulative effects of a combination of factors rather than a single issue lead to a child's experience of adversity and stress.

Figure 20: Interlocking model of risk factors for adverse childhood experiences



Source: Based on UCL Institute of Health Equity

The impact of childhood adversity can be offset by safe, secure, responsive adult relationships that buffer the effects of stress and adversity and support the development of resilience, a key mechanism to make sense of and recover from threat and fear.

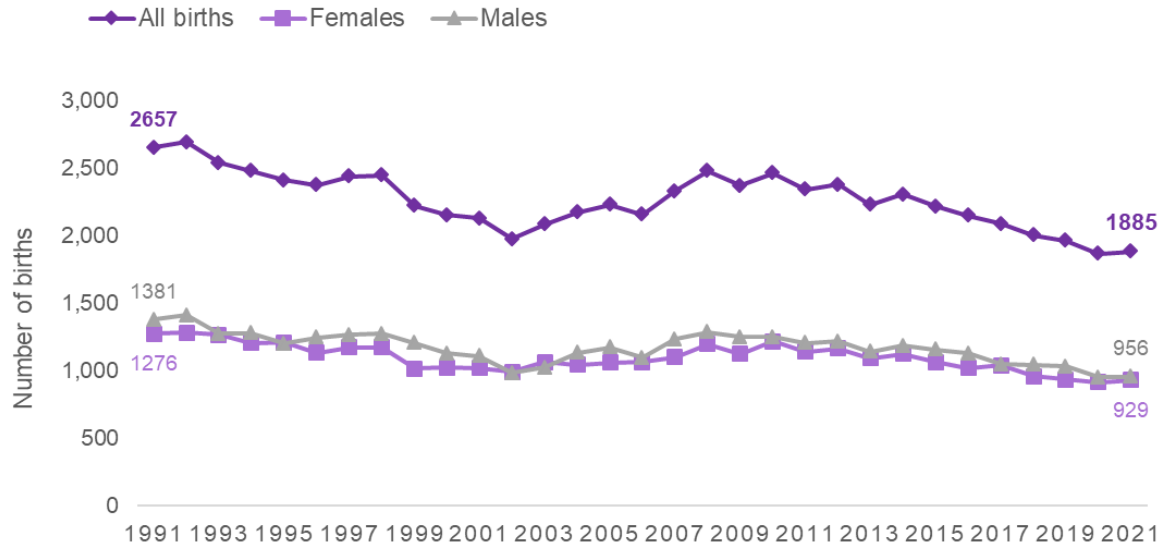
A public health report on adverse childhood experiences, resilience and trauma in Highland was undertaken in 2018[27]. Understanding and responding to childhood adversity and trauma remains a public health priority.

5. Pregnancy and birth

5.1. Births and fertility rate

There were 1,885 live births registered to Highland residents in 2021, slightly more than in 2020 (Figure 21). The number of children born nationally and locally in recent years is historically low.

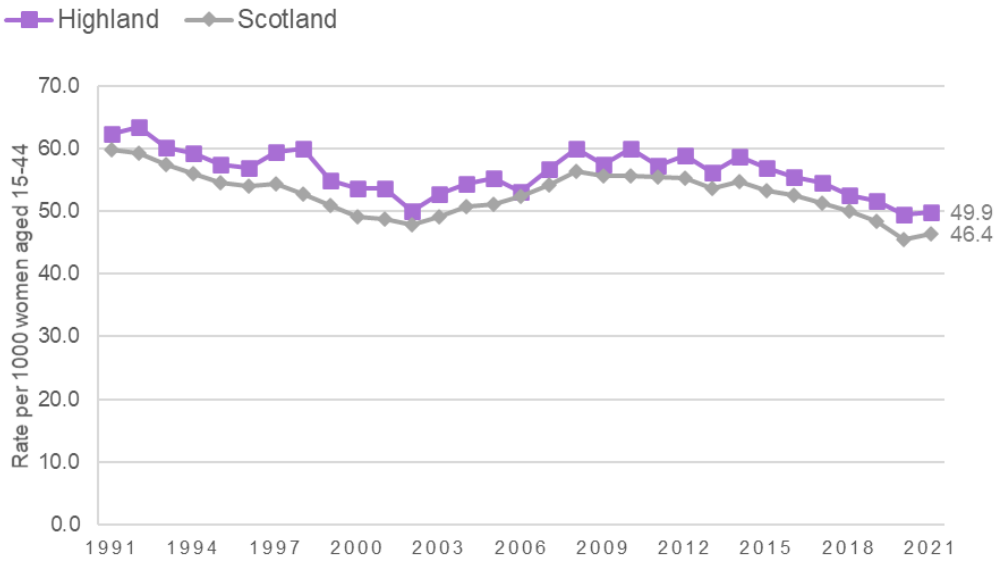
Figure 21: Annual number of live births in Highland by sex, 1991-2021



Source: National Record of Scotland Births (Time Series)

Annual birth rates in Highland are consistently higher than Scotland's but closely follow the national pattern, with the current decline starting from 2008 (Figure 22).

Figure 22: General Fertility Rate, total live births per 1,000 women aged 15 to 44 years, in Highland and Scotland, 1991-2021



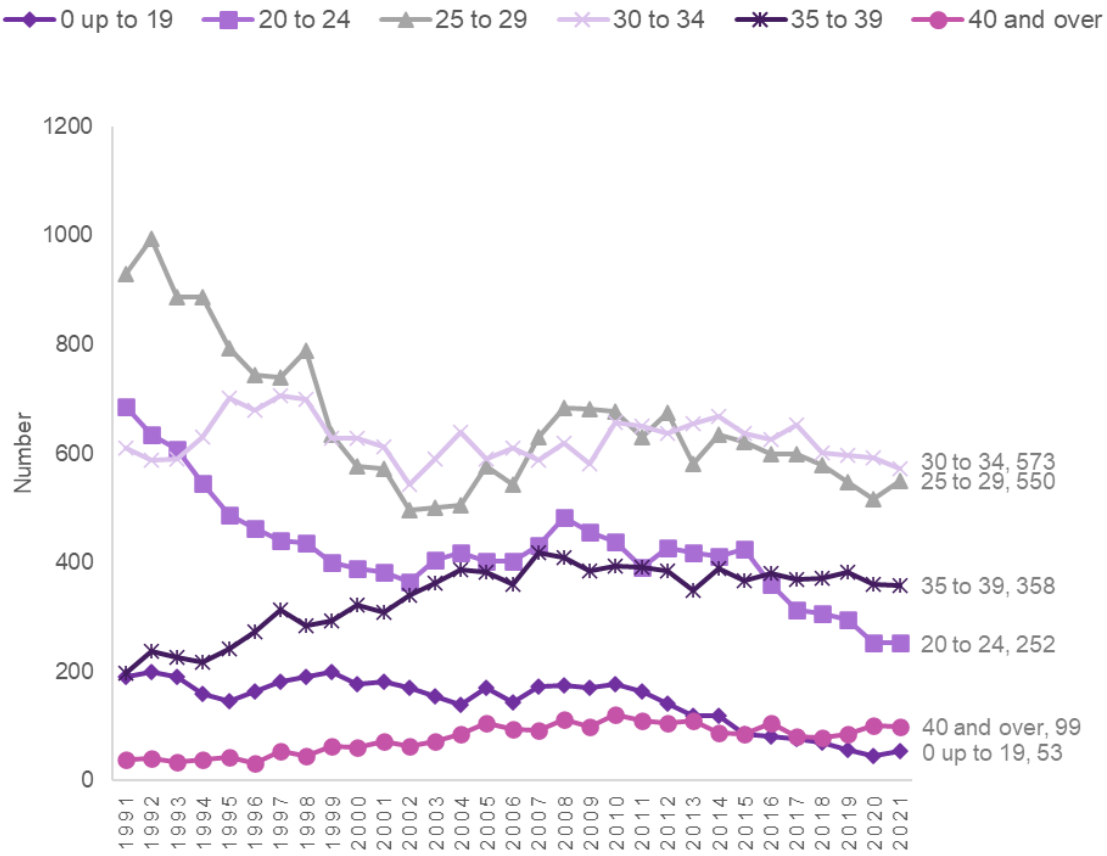
Source: National Record of Scotland Births (Time Series)

5.2. Births by the age of the mother

The decline in the number of births in the 1990s resulted primarily from women in their twenties postponing having children. From 2001 until 2008, there was a rise in the number of births. Increases are noted in women in their twenties having children, coupled with an increase among women in their 30s and 40s who had perhaps postponed starting a family (Figure 23).

However, since 2008 there has been a decline in the number of births, possibly explained by women leaving motherhood until later in life, women having fewer children and periods of economic uncertainty. The beginning of the recent fall coincided with the banking crisis and financial crash.

Figure 23: Births to Highland residents by mother's age, 1991-2021



Source: National Record of Scotland Births (Time Series)

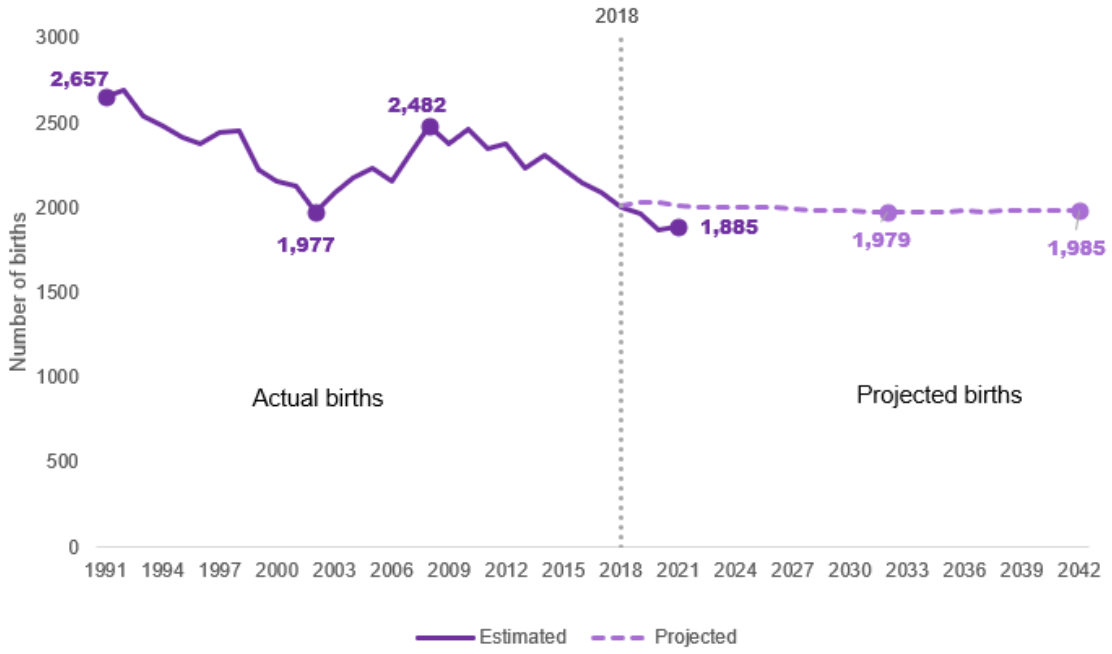
Currently, around 100 women aged 40 or older who are residents of Highland give birth each year. According to the Royal College of Midwives, older women are more likely to require increased resources. Older mothers are more at risk of pre-eclampsia, miscarriage and complicated pregnancies that could result in forceps or caesarean section for delivery.

More recently, the immediate impact of the COVID-19 pandemic did not modify recent birth trends (Figure 21, Figure 23).

5.3. Projected number of births

In Highland, the annual number of births per year was projected to remain between 1,970 and 2,000 (Figure 24). However, the actual number of births has further reduced in recent years. The current projection may be overly optimistic. There has been a fall in inward migration in the principal years of family formation following Brexit, and the trend of mothers waiting until they are older before having families continues.

Figure 24: Actual and projected number of births in Highland, 1991 to 2042



Source: National Record of Scotland Births Time Series, Population Projections for Scottish Areas (2018-based)

5.4. Teenage Pregnancy

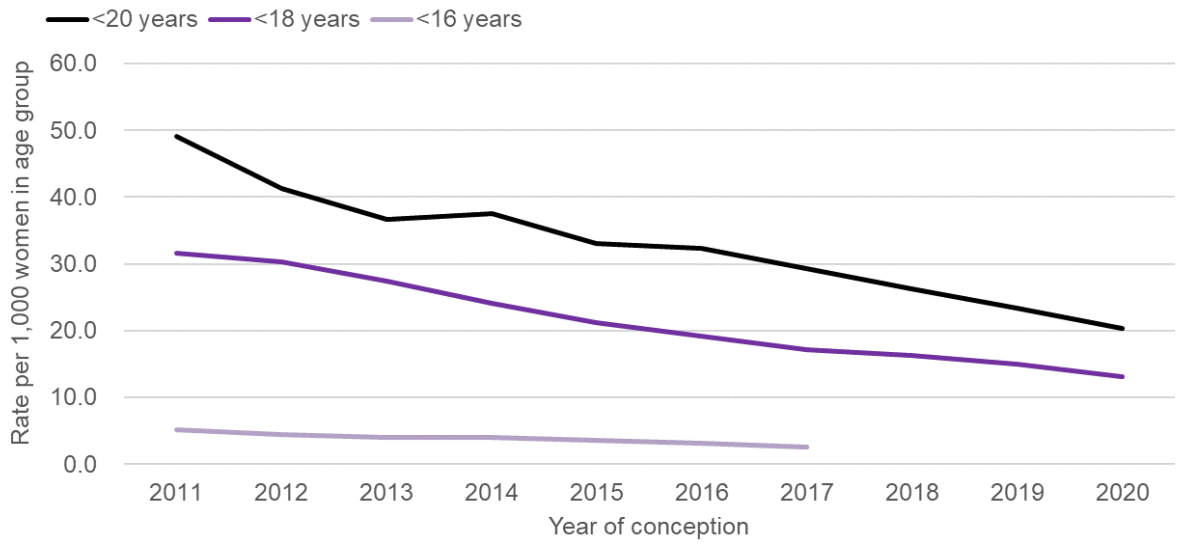
Many teenage women experience unintended or unwanted pregnancies, although this may be a planned, positive life choice for some women. Reducing unintended teenage pregnancy has been a long-standing priority for the Scottish Government.

Evidence from the Family Nurse Partnership in 2022 highlighted that younger mothers are more likely to live in deprived areas. This group has increased risks associated with deprivation and adverse outcomes in pregnancy, including higher smoking and preterm birth rates[30].

Since 2011 overall teenage pregnancy rates per 1,000 women in the under-20 age group have fallen almost 59 percent (from 49.1 in 2011 to 20.3 in 2020). In terms of the total number of teenage pregnancies, there were 319 in 2011 compared to 120 in 2020.

Due to small numbers, the number and rates of teenage pregnancy in the under-16 and under-18 age groups have been aggregated into three-year periods. They show similar rates of decline (Figure 25).

Figure 25: Teenage pregnancy by age group at conception in Highland, 2011 to 2020[1,2]



Source: NRS birth registrations & Notifications of abortions performed under the Abortion (Scotland) Regulations 1991. Public Health Scotland.
1 Rates of pregnancies in women under 16 and 18 years are for three year periods. Rates are calculated using the female population aged 13-15, 15-17 and 15-19.
2 The under 16's values have been suppressed due to the potential risk of disclosure from 2016-2018

5.5. Antenatal care

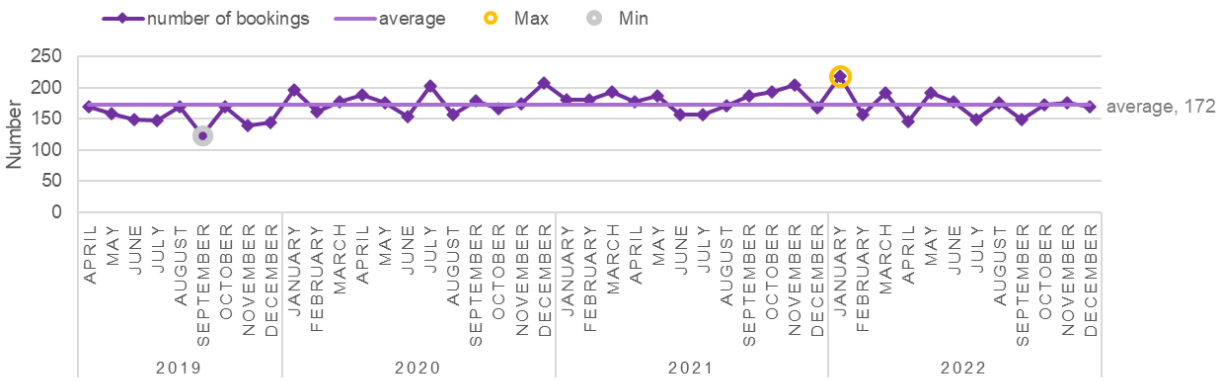
Early access to high-quality antenatal care improves long-term health outcomes for mothers, babies and families. The booking appointment is the midwife's first contact with a pregnant woman to assess her needs and to arrange an early pregnancy scan and antenatal screening.

Women at the most significant risk of poor health outcomes are the least likely to access and benefit from antenatal healthcare.

There were 2,070 pregnancies booked for maternity care by Highland residents in 2022, an average of 173 a month. The maximum number of bookings in a month during the period shown in Figure 26 occurred in January 2022 (218).

Understanding variations in booking numbers and changes in the demography of women booking is essential for planning antenatal services and services for those of reproductive age. The order of this variation will be larger in areas with smaller populations booking for maternity care across Highland.

Figure 26: Number of Highland pregnancies booked for antenatal care by month, April 2019 to December 2022[1]



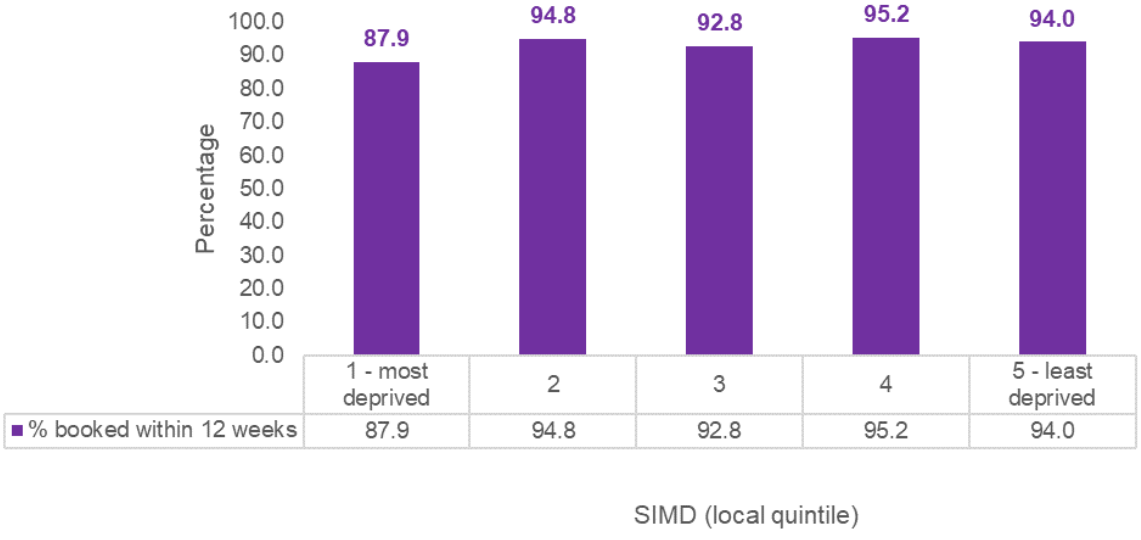
Source: Public Health Scotland Antenatal Booking Collection (ABC)
[1] Some women may have more than one pregnancy during 12 months

Women are encouraged to book before they are 13 weeks pregnant and, ideally, before ten weeks. The NICE guideline on antenatal care recommends that the booking appointment ideally occurs within ten weeks[31]. In 2022, 93 percent of pregnancies in Highland were booked by 12 weeks of gestation.

Early access to antenatal services is a current Scottish Government Local Delivery Plan (LDP) LDP standard[32]. The standard states that at least 80 percent of pregnant women in each deprivation quintile of the Scottish Index of Multiple Deprivation (SIMD) will be booked for antenatal care by the 12th week of gestation.

In Highland in 2022, pregnant women from more deprived areas were less likely to be booked within 12 weeks than pregnant women living in areas in the least deprived quintile (Figure 27).

Figure 27: Percentage of Highland pregnancies booked within 12 weeks by SIMD in 2022



Source: Public Health Scotland Antenatal Booking Collection (ABC)

5.6. Vulnerability factors during pregnancy

Antenatal care with complex social factors

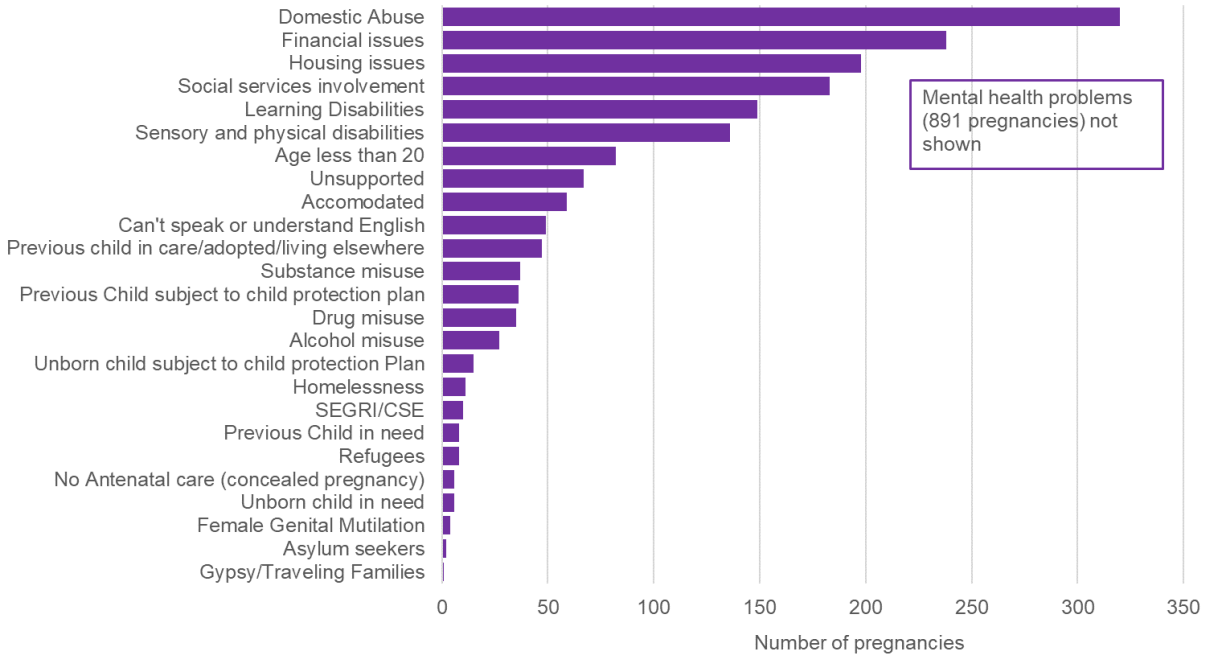
Pregnant women presenting for antenatal care with a complex social factor or vulnerability are most at risk of poor pregnancy outcomes[33]. Complex social factors in pregnancy include poverty; homelessness; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; and domestic abuse. Screening during pregnancy will determine local needs and how these might be met.

In 2022, around 60 percent (1,250) of the pregnancies booked in Highland had at least one complex social factor or vulnerability reported on the BadgerNet maternity record. In 71 percent of pregnancies with a vulnerability recorded, the most common issue was a mental health problem. Mental health includes a family history of mental health problems, a previous mental health history and a current concern within the pregnancy.

The next most common concerns recorded in 2022 were domestic abuse, financial issues, housing and accommodation issues, social services involvement, disabilities, language difficulties and problematic substance use (Figure 28).

The needs of all pregnant women with a vulnerability recorded must be considered. Recording complex and multiple social factors and vulnerabilities is essential for service planning. The vulnerability criteria in the BadgerNet vulnerability report are changing to include pregnancies with the criminal justice system or prison involvement.

Figure 28: Antenatal bookings with a vulnerability reported during pregnancy, 2022



Source: BadgerNet Maternity
Mental health problems are not shown to help with the reading of other categories

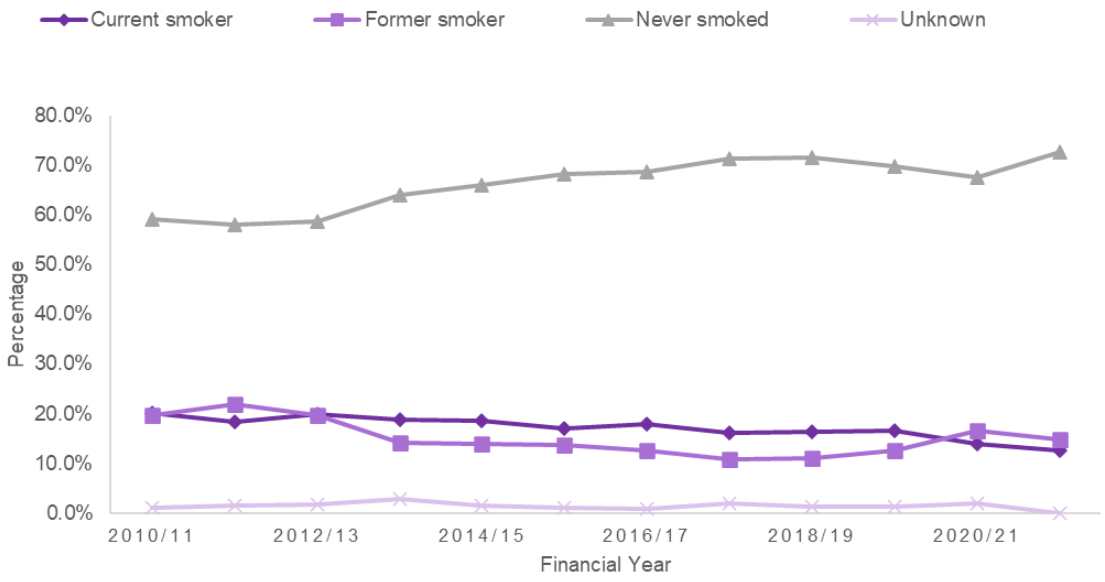
Smoking in pregnancy

Smoking during pregnancy is harmful to both mother and baby. Maternal smoking is associated with preterm and low birth weight babies and increased risk of miscarriage, stillbirth and Sudden Infant Death Syndrome (SIDS). It also increases the risk of the baby developing many respiratory conditions, attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes[34].

Smoking rates during pregnancy are lower than in the past. Still, over 13 percent of women in NHS Highland are recorded as smoking at antenatal booking. The smoking rate at booking means that over 230 infants a year are born to mothers who smoke (Figure 29).

Smoking at antenatal booking is self-reported and consequently may under-report smoking prevalence.

Figure 29: Percentage of women by smoking status at antenatal booking in Highland, 2010/11-2021/22[1]

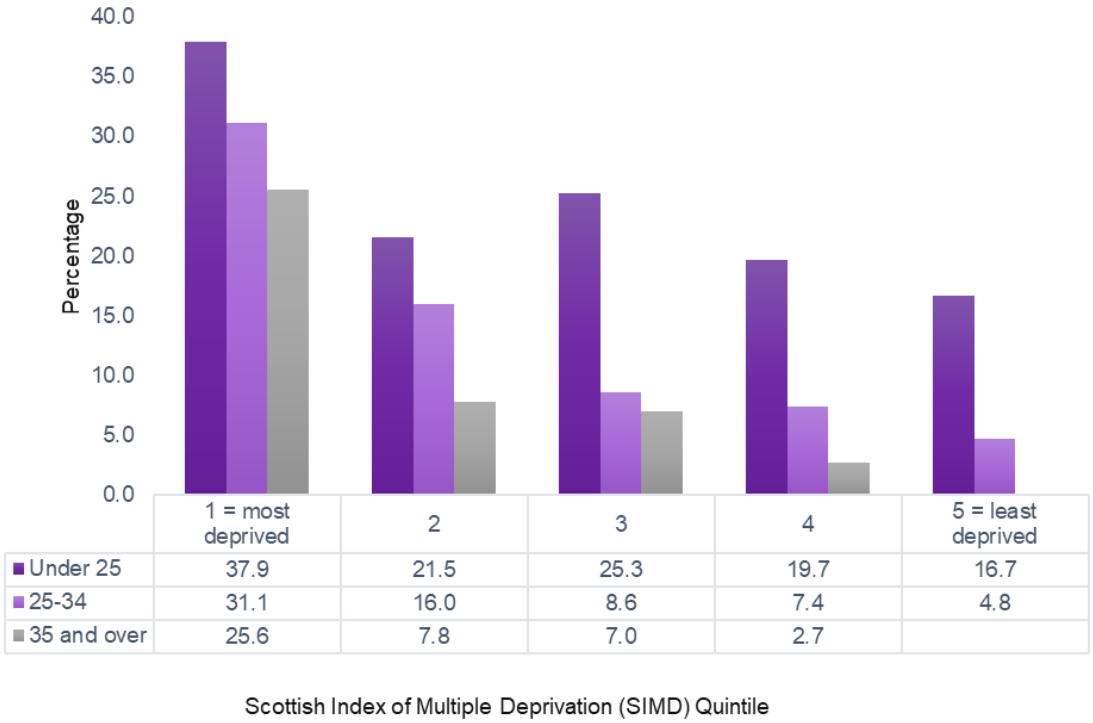


Source: Public Health Scotland (SMR02) Open Data
[1] Women who delivered in 2010/11 to 2021/22

Deprivation and age are key risk factors for smoking. There are also marked differences between women of different ages and socio-economic groups in smoking behaviour during pregnancy (Figure 30). Infants born to smokers are much more likely to become smokers themselves, which perpetuates cycles of health inequalities.

Giving every child the best start in life must include protecting babies from the damage of tobacco smoke, both before and after birth. Smoking remains a significant challenge to population health and the NHS.

Figure 30: Percentage of women resident in Highland smoking at antenatal booking by age group and SIMD quintile, 2021/22[1]



	1 = most deprived	2	3	4	5 = least deprived
Under 25	37.9	21.5	25.3	19.7	16.7
25-34	31.1	16.0	8.6	7.4	4.8
35 and over	25.6	7.8	7.0	2.7	

Source: Public Health Scotland (SMR02) Open Data
[1] Women who delivered in 2021/22

Alcohol and drug use in pregnancy

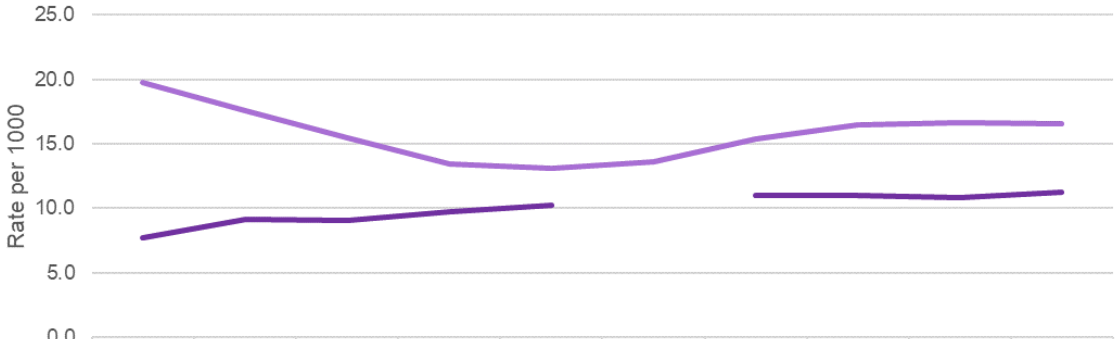
Alcohol and substance use are part of the 'complex social factors' covered by the NICE guidance on antenatal care for pregnant women[33]. Problem substance use causes serious harm to fetal development. National estimates suggest that around one percent of pregnant women will be problem drug users, and a further one percent problem alcohol users, although some may use both[35]. Women who use drugs and alcohol during pregnancy experience stigma, as do their families and communities.

Problem substance use is often associated with socio-economic deprivation and maternal health problems, including poor nutrition, smoking, mental health problems, complications from chronic infection, domestic abuse and homelessness. The effects of alcohol and drugs on the baby include intrauterine growth restriction, preterm delivery, fetal alcohol syndrome, fetal alcohol spectrum disorders, increased rates of stillbirth, neonatal death and sudden infant death. These outcomes are multifactorial and are also affected by socio-economic deprivation.

Information on alcohol and drug use is collected as part of maternity recording but is based upon self-report, and data should be interpreted cautiously.

The rate of pregnancies recording drug use in Highland in 2019/20 - 2021/22 was 11.2 per 1,000 maternities (Figure 31). The rate is equivalent to drug use in around 20 pregnancies a year in Highland. The Scottish rate was 16.6 per 1,000, and reported rates are consistently higher nationally.

Figure 31: Rate per 1,000 maternities recording drug use in Highland[1] and Scotland, 2010/11-2021/22



	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16	2014/15-2016/17	2015/16-2017/18	2016/17-2018/19	2017/18-2019/20	2018/19-2020/21	2019/20-2021/22
Highland	7.7	9.2	9.1	9.7	10.2		11.0	11.0	10.9	11.2
Scotland	19.8	17.6	15.4	13.5	13.1	13.6	15.4	16.5	16.7	16.6

Source: Public Health Scotland (SMR02) Open Data
[1] No data reported for Highland in the extract for 2015/16/ - 2017/18

Maternal Body Mass Index at booking

A high body mass index (BMI) during pregnancy increases the risk of complications for both mother and baby. Obesity in pregnancy is associated with an increased risk of miscarriage, stillbirth and recurrent miscarriage. Possible adverse outcomes are maternal blood clots, gestational diabetes, postpartum haemorrhage, pre-eclampsia, and extended labour. While other risk factors will contribute, risks for the baby include congenital disorders, fetal macrosomia, growth problems, childhood asthma and childhood obesity.

In 2021/22, over 50 percent of Highland women giving birth were overweight or obese at the time of booking (Figure 32).

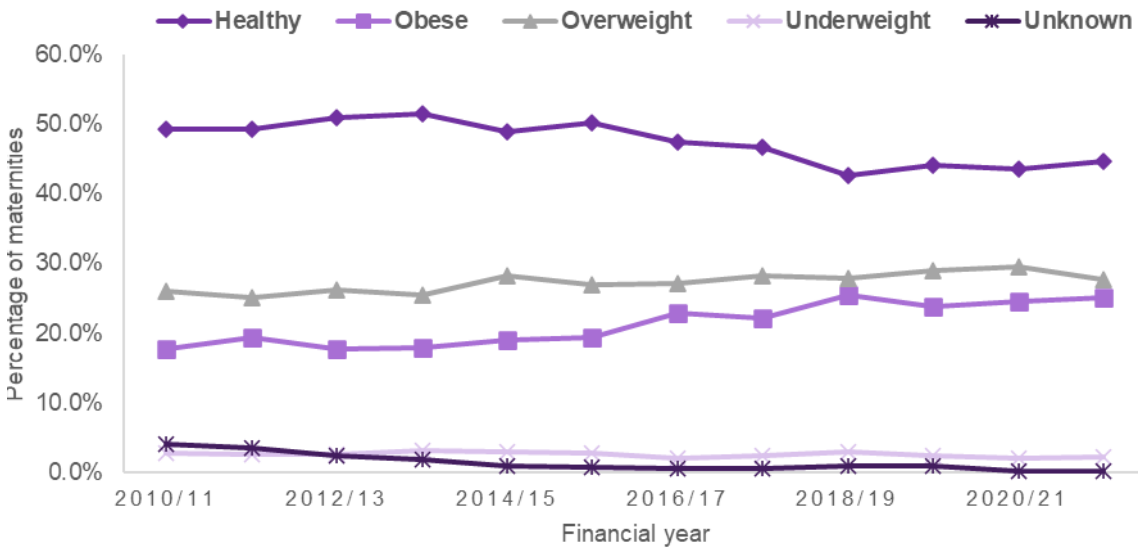
Figure 32: Number and percentage of maternities in Highland by BMI group in 2021/22

	Maternities	Healthy	Obese	Overweight	Underweight	Unknown	Total
2021/22	number	813	456	505	42	5	1,821
	percentage	44.6	25.0	27.7	2.3	0.3	100

Source: Public Health Scotland (SMR02) Open Data

The proportion of women who are overweight or obese is increasing (Figure 33).

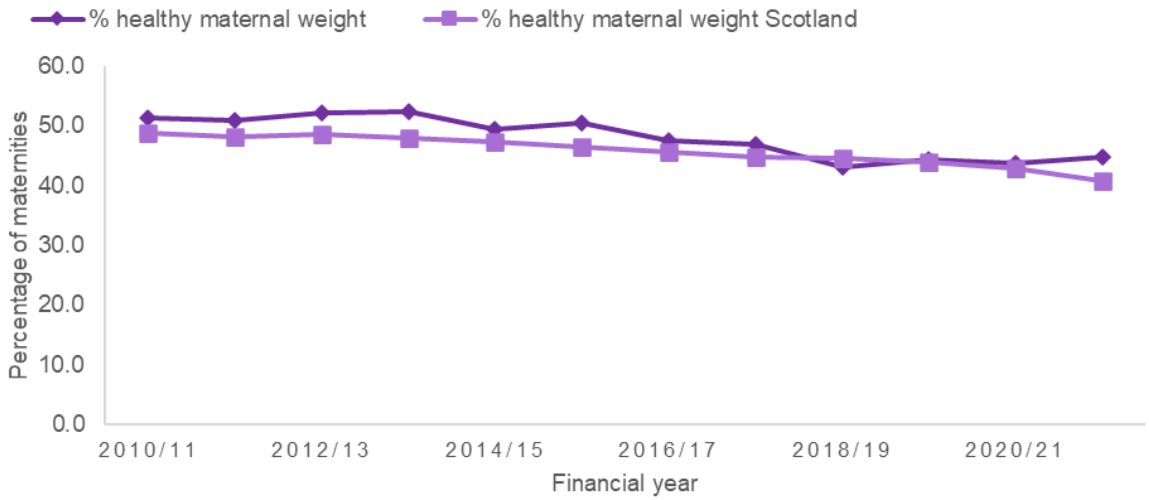
Figure 33: Percentage of maternities by BMI group in Highland, 2010/11 to 2021/22



Source: Public Health Scotland (SMR02) Open Data

The long-term trend to have fewer pregnancies of a healthy weight are similar in Highland and Scotland (Figure 34).

Figure 34: Percentage of maternities of healthy weight in Highland and Scotland, 2010/11 to 2021/22



Source: Public Health Scotland (SMR02) Open Data

A high level of maternal obesity has implications for maternity and neonatal service provision. Increased resources are needed to care for these mothers. There is a higher use of caesarean section associated with obesity[36].

5.7. Gestation

Gestation refers to the number of weeks pregnant a woman is when she delivers her baby.

- Babies are 'due' at 40 weeks gestation.
- Those born between 37 and 41 weeks are referred to as born 'at term'.
- Babies born at less than 37 weeks are considered preterm or premature.
- Babies born at 42 weeks or over are considered post-term or over-due.

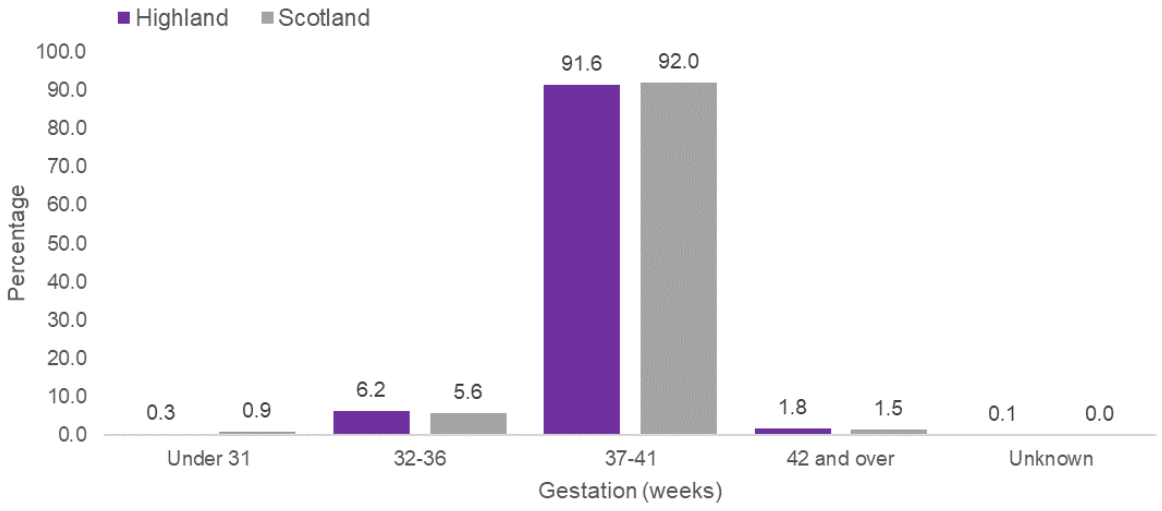
Gestation at delivery strongly influences the health of babies. Babies born preterm can have multiple difficulties in the days and weeks following birth. The consequences of being born too early can continue to affect health and development throughout childhood and adult life.

Known risks for preterm delivery

- Maternal poverty, deprivation and stress.
- Low or high maternal age or BMI.
- Maternal smoking, alcohol or drug misuse.
- Previous preterm deliveries.
- Multiple pregnancy (twins or more).
- Maternal health issues or infections arising during the pregnancy.

In Scotland, being born too soon is the principal reason babies require admission to neonatal care and the single most significant cause of death in early infancy[36].

Figure 35: Gestation in weeks of live singleton births in Highland and Scotland in 2021/22

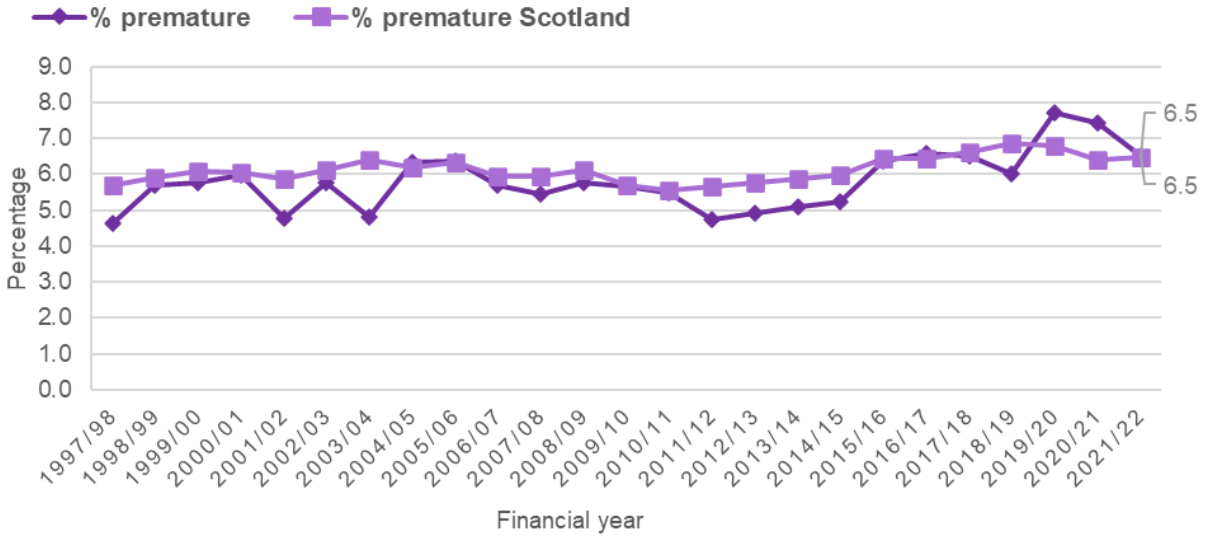


Source: Public Health Scotland (SMR02) Open Data

In Highland and Scotland in 2021/22, 6.5 percent of live singleton babies were born prematurely (Figure 35). Babies from multiple pregnancies are much more likely to be born prematurely. Instances of multiple pregnancies are relatively low and vary in Highland from

year to year. Highland and Scotland's preterm singleton birth rate has generally increased (Figure 36).

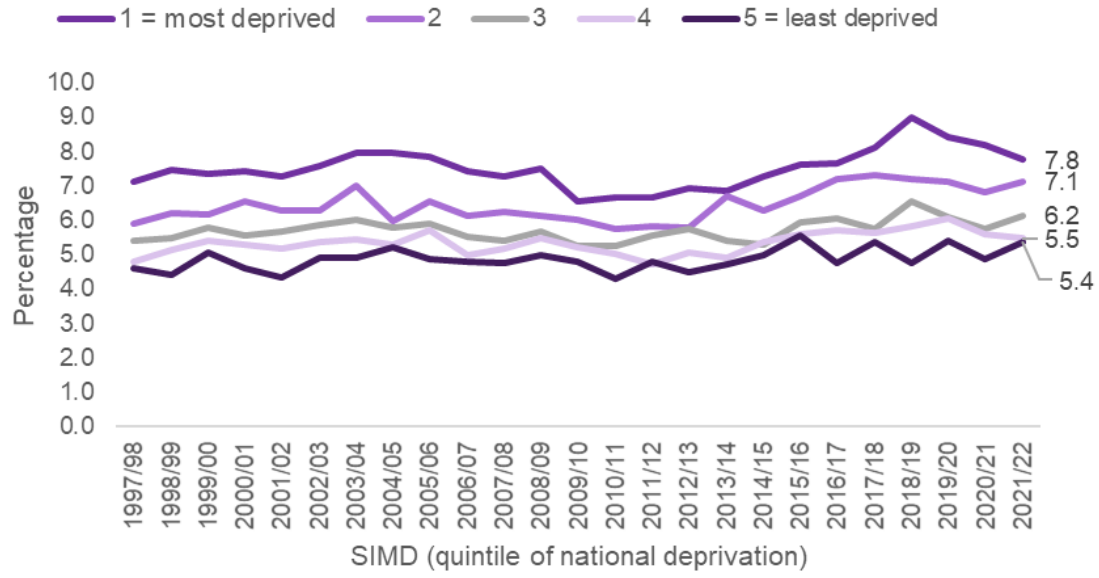
Figure 36: Percentage of premature births (under 37 weeks of gestation) in Highland and Scotland,1997/98 to 2021/22



Source: Public Health Scotland (SMR02) Open Data

Preterm birth rates are generally higher in younger and older women. In Highland in 2021/22, 9.5 percent of births to women under 25 were premature. In women over 35 years, this was 7.2 percent, and in women aged 25-34, 5.4 percent. Rates of prematurity are consistently higher in women living in deprived areas (Figure 37).

Figure 37: Percentage of premature births (under 37 weeks gestation) by SIMD in Highland, 1997/98 to 2021/22



Source: Public Health Scotland (SMR02) Open Data

5.8. Birth weight

Birth weight is the first weight of the newborn measured immediately after birth, and a weight lower than 2500 grams is considered low birth weight (LBW). Babies weighing 2500 grams and 3999 grams at birth are considered to have a 'normal' birthweight, and a birthweight of 4000 grams or more is considered larger than average or macrosomic.

Many factors that increase the risk of premature birth also increase the risk of growth retardation in the womb and LBW. Risk factors contributing to low birth weight can include a mother's young age, multiple pregnancies, previous LBW infants, poor nutrition, heart disease or hypertension, drug addiction, alcohol misuse, and insufficient prenatal care. Environmental risk factors include smoking, lead exposure, and other types of air pollution.

Low birth weight infants may be more at risk for many health problems compared to infants of normal weight. Some babies may become sick in the first six days of life (perinatal morbidity) or develop infections. Other babies may even suffer from longer-term issues such as delayed motor and social development or learning disabilities.

Low birth weight is a headline indicator for monitoring health inequalities in Scotland.

Risk factors for high birth weight include maternal obesity, significant pregnancy weight gain, and maternal diabetes.

The primary complications of foetal macrosomia occur because of birth injuries and traumatic deliveries. There is a risk of obesity, metabolic complications and hypoglycemia at birth for the baby.

In 2021/22, 4.6 percent of live singleton babies born to Highland residents had low birth weights, and 13.6 percent of babies were macrosomic (Figure 38).

Figure 38: Birthweight of live singletons born to residents of Highland and Scotland in 2021/22

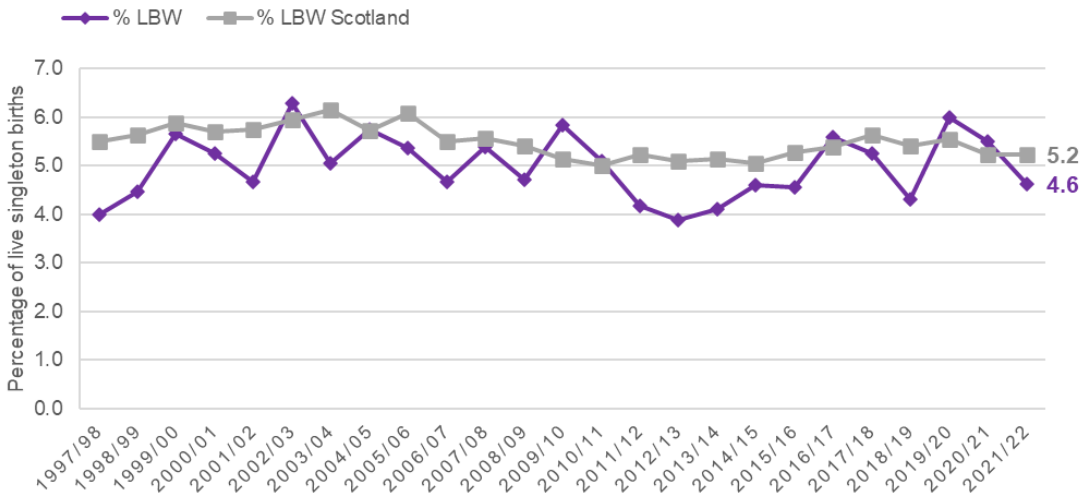
		<1500g	1500-2499g	2500-3999g	4000g+	Not Known	Total live singleton births
Highland	Number	4	79	1,472	244	0	1,799
	Percentage	0.2	4.4	81.8	13.6	0.0	100
Scotland	Number	373	2,036	37,652	5,919	23	46,003
	Percentage	0.8	4.4	81.8	12.9	0.0	100

Source: Public Health Scotland Births in Scotland 2022, Table 6.5

While the proportion of singleton babies born preterm has increased over time, the proportion of singleton LBW babies has been relatively consistent (Figure 39). An explanation is that

babies born at any gestation have, on average, become slightly heavier over the same period[36].

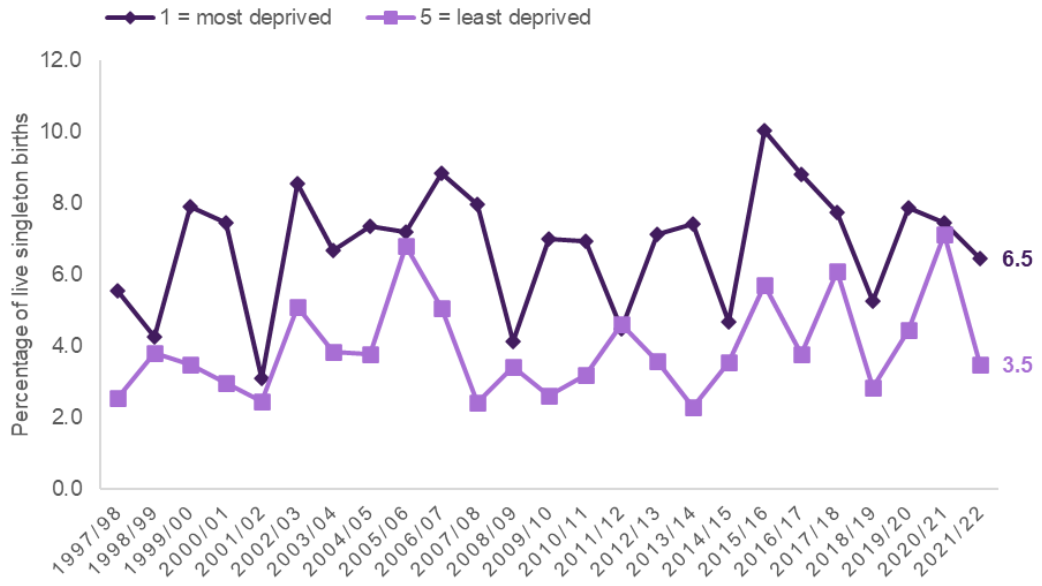
Figure 39: Live singleton births with low birth weight born to residents of Highland and Scotland, 1997/98 to 2021/22



Source: Public Health Scotland (SMR02) Open Data

The relationship between low birthweight and deprivation is consistent over time in Highland, with higher proportions of singleton LBW babies born to mothers resident in the most deprived areas (Figure 40).

Figure 40: Live singleton births with low birth weight by deprivation in Highland, 1997/98 to 2021/22



Source: Public Health Scotland (SMR02) Open Data

6. Infancy and Early Years

6.1. Child health reviews and developmental delay

Child health reviews provide the opportunity to assess children's health, development, and wider wellbeing alongside giving health promotion advice and parenting support.

Review programmes occur at a Health Visitor's first visit, 6-8 week review, 13-15 month review, 27-30 month review and 4-5 years review[37].

13-15 Month Review	**27-30 Month Review**
The review is carried out around 13-15 months of age by a Health Visitor. The process started in April 2017 and is offered to all children. Examples of information collected include development (social, behavioural, communication, gross motor, vision, and hearing), physical measurements (height and weight) and diagnoses/health issues. Identification data such as name, address, GP are also checked and updated.	A Health Visitor carries out the 27-30 months review. This review process started in April 2013 and is offered to all children (previously, only children requiring structured additional or intensive support were invited for a review at this stage). The information collected is similar to the 13-15 month stage.

The Child Health Systems Programme Pre-School (CHSP Pre-School) supports the delivery of the child health programme by facilitating the call and recall of children at review points and recording the findings and outcomes of the child health review.

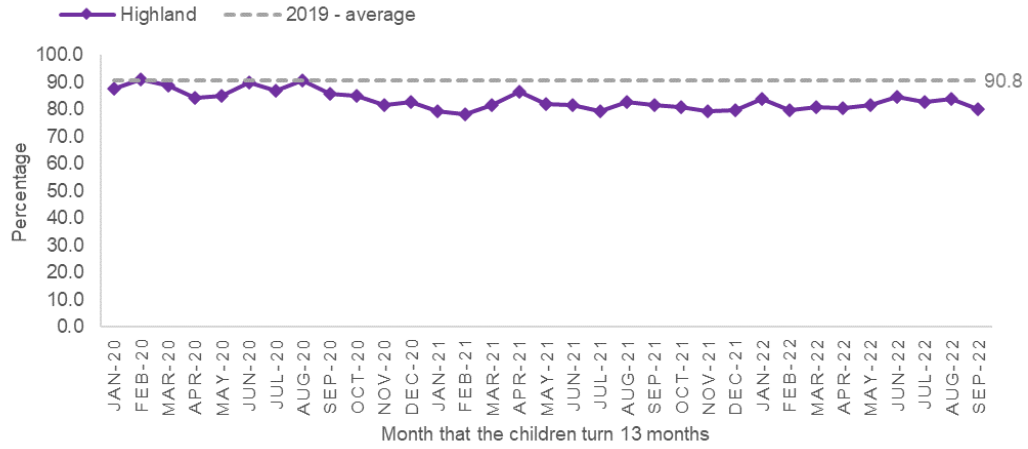
Child health review coverage

It was essential that children received their routine health reviews during the COVID-19 pandemic and that their data was submitted to the CHSP Pre-School.

The review process was generally sustained at a high level. However, coverage at both 13-15 month and 27-30 month review points remains lower than in 2019 in Highland, with no evidence of a trend.

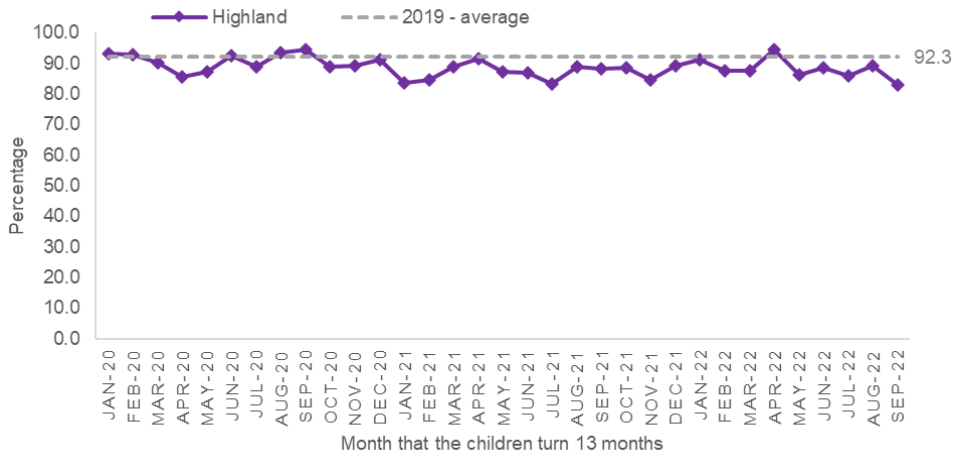
The charts below show that the reviews for a minority of children currently happen later in life.

Figure 41: Children in Highland recorded as receiving their 13-15 month review by 17 months of age or younger



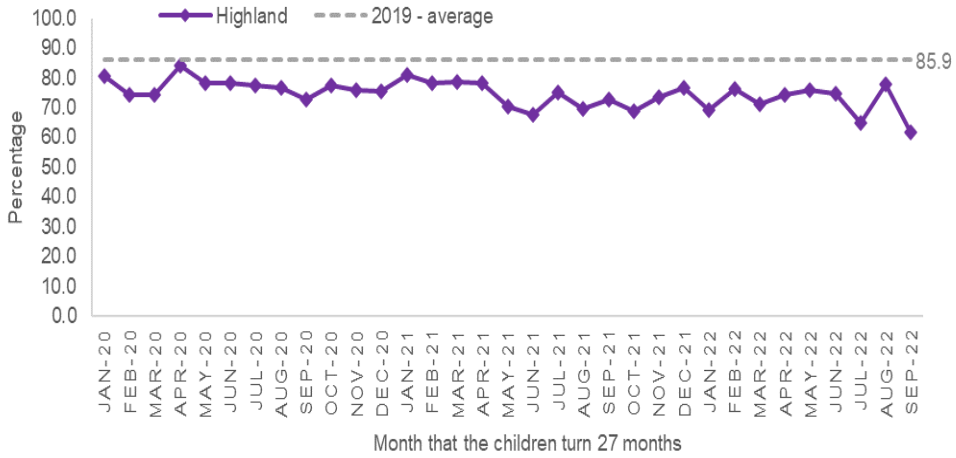
Source: Public Health Scotland, COVID-19 Wider Impact on the Healthcare System Dashboard

Figure 42: Children in Highland recorded as receiving their 13-15 month review by the date information was extracted (20 February 2023)



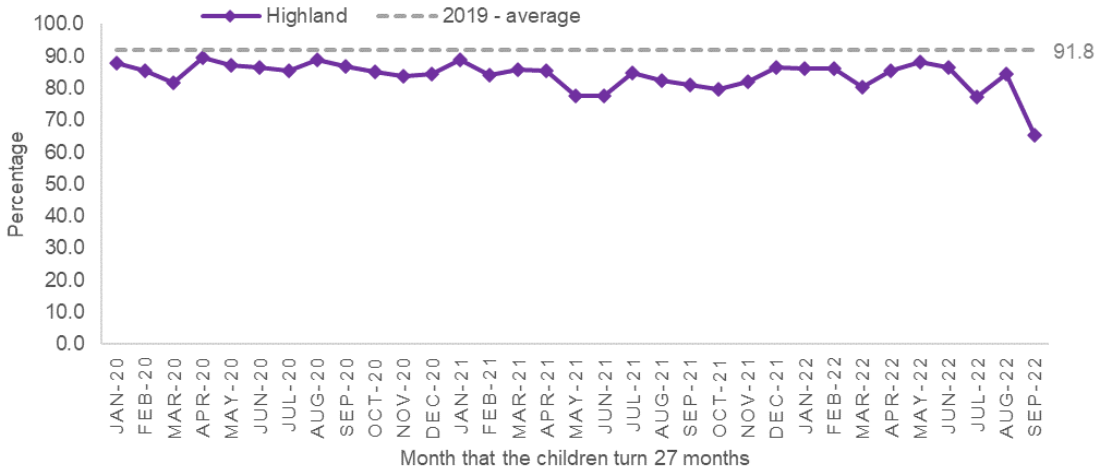
Source: Public Health Scotland, COVID-19 Wider Impact on the Healthcare System Dashboard

Figure 43: Children in Highland recorded as receiving their 27-30 month review by 31 months of age or younger



Source: Public Health Scotland, COVID-19 Wider Impact on the Healthcare System Dashboard

Figure 44: Children in Highland recorded as receiving their 27-30 month review by the date information was extracted (20 February 2023)



Source: Public Health Scotland, COVID-19 Wider Impact on the Healthcare System Dashboard

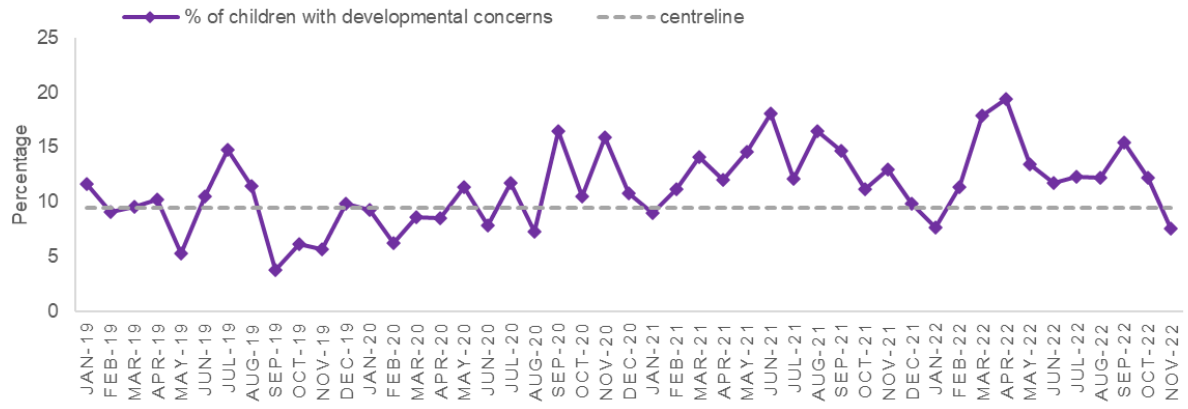
6.2. Early child development

Biological factors (such as being born prematurely) and environmental factors (such as the parenting and opportunities for play and exploration children receive) influence early child development[38].

Identifying early child development problems is crucial as they are strongly associated with long-term health, educational, and social difficulties. Early identification gives the best opportunity to support children and families to improve outcomes.

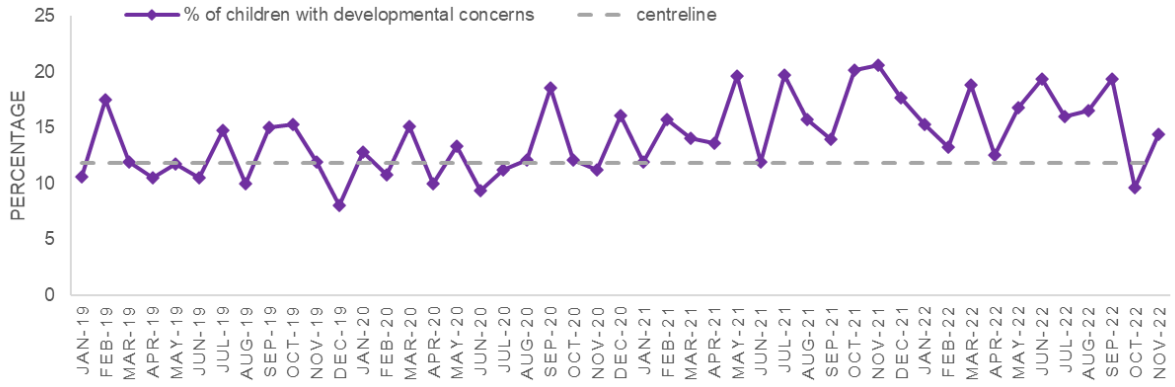
There has been a sustained increase in the proportion of children experiencing a developmental concern at their 13-15 month and 27-30 month reviews in Highland. These increases can be seen from the data points above the centreline from February 2021 (Figure 45) and after July 2021 at 27-30 month review (Figure 46).

Figure 45: Percentage of children living in the Highland HSCP with one or more developmental concerns recorded at the 13-15 month review



Source: Public Health Scotland, COVID-19 Wider Impact on the Healthcare System Dashboard
The centreline is the monthly median from January 2019 to March 2020.

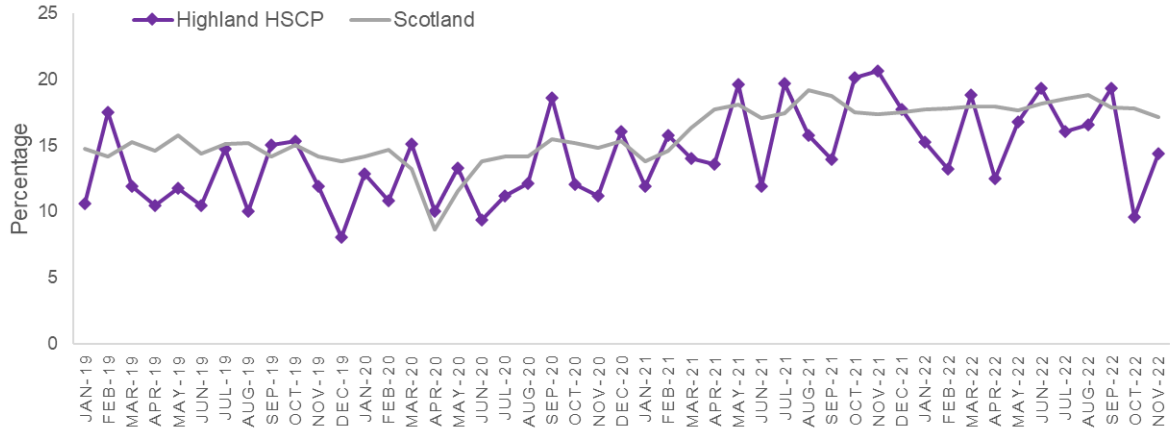
Figure 46: Percentage of children living in Highland with one or more developmental concerns recorded at the 27-30 month review



Source: Public Health Scotland, COVID-19 Wider Impact on the Healthcare System Dashboard
The centreline is the monthly median from January 2019 to March 2020

The upward trend to a new higher level is also observed in Scotland at 27-30 months (Figure 47) and occurs at 13-15 months[39].

Figure 47: Percentage of children living in Highland and Scotland with one or more developmental concerns recorded at the 27-30 month review



Source: Public Health Scotland, COVID-19 Wider Impact on the Healthcare System Dashboard

Nationally the increase in the number of children with more than one developmental concern is seen across all quintiles of deprivation at 27-30 months. In Scotland, the proportion of children identified with concerns about development in the speech, language and communication, emotional/behavioural, personal/social, and problem-solving domains is higher in 2021 and 2022 than in the previous two years at both review points.

The sustained increase in developmental delay both locally and nationally coincides with limitations on social contact to control the transmission of COVID-19. Monitoring these children and future cohorts at their review points remains essential for understanding individual and collective developmental support needs.

6.3. Infant feeding

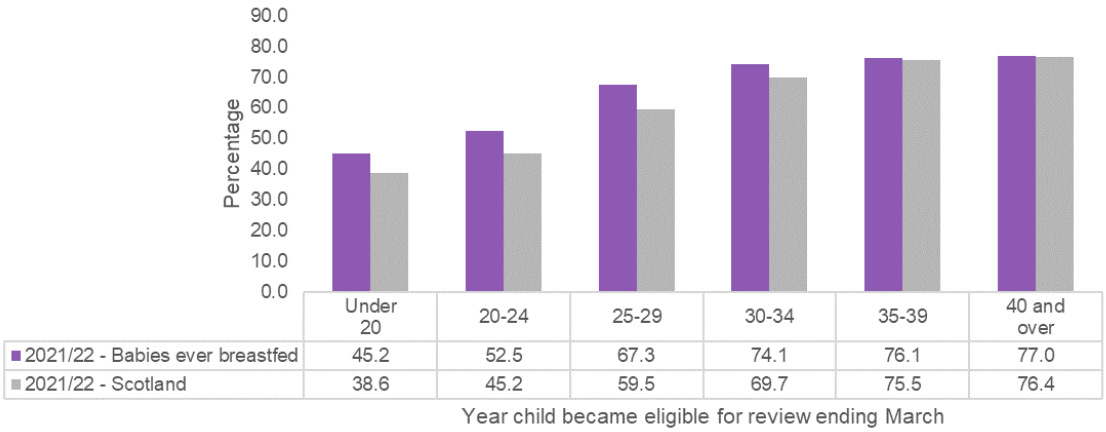
Breastfeeding is part of the natural reproductive process and an essential public health activity that should be encouraged. There is strong evidence of the short-term and lifelong health benefits of breastfeeding for both mothers and infants[40]. There is clear economic evidence that investing in improving breastfeeding practices are cost saving preventative actions[41]. The Scottish Government has adopted as policy World Health Organisation guidance recommending exclusive breastfeeding for the first six months of an infant's life. However, breastfeeding rates in Scotland remain low compared to those of comparable countries.

Breastfed infants have a lower risk of infection, particularly those affecting the ear, respiratory tract and gastrointestinal tract. Breastfeeding women have lower risks of breast cancer, epithelial ovarian cancer and hip fracture later in life[42]. There is increasing evidence that breastfeeding helps protect against becoming overweight or obese over the life course[43]. Infant feeding patterns are strongly determined by many demographic variables, including age, deprivation, and ethnicity and are known to be influenced by smoking behaviour.

Infant feeding data is available from Health Visitor reviews collected for child health surveillance. The source can be used to monitor breastfeeding initiation, duration and exclusivity. Infant feeding patterns are strongly determined by demographic variables, including age, deprivation, and ethnicity and are known to be influenced by smoking behaviour.

In Highland, 69 percent of babies born in 2021/22 started breastfeeding. Younger women are less likely to have begun breastfeeding by the time of the first Health Visitor review (Figure 48).

Figure 48: Breastfeeding initiation recorded at First Visit by maternal age in Highland and Scotland in 2021/22

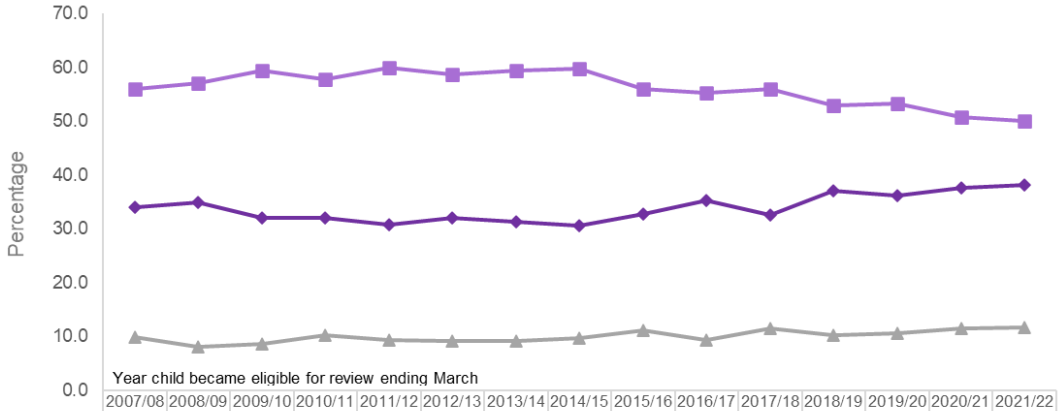


	Under 20	20-24	25-29	30-34	35-39	40 and over
2021/22 - Babies ever breastfed	45.2	52.5	67.3	74.1	76.1	77.0
2021/22 - Scotland	38.6	45.2	59.5	69.7	75.5	76.4

Source: Public Health Scotland Infant Feeding Open Data

By 6-8 weeks of age, in 2021/22, 38 percent of babies were still exclusively breastfed, and 12 percent were mixed breast and formula fed (Figure 49). Adding exclusive breastfeeding and mixed feeding, half of Highland babies received breast milk at 6-8 weeks of review. The modest improvement in babies breastfed from 2014-15 primarily results from an increase in women in their twenties exclusively breastfeeding.

Figure 49: Infant feeding at health visitor 6-8 week review in Highland

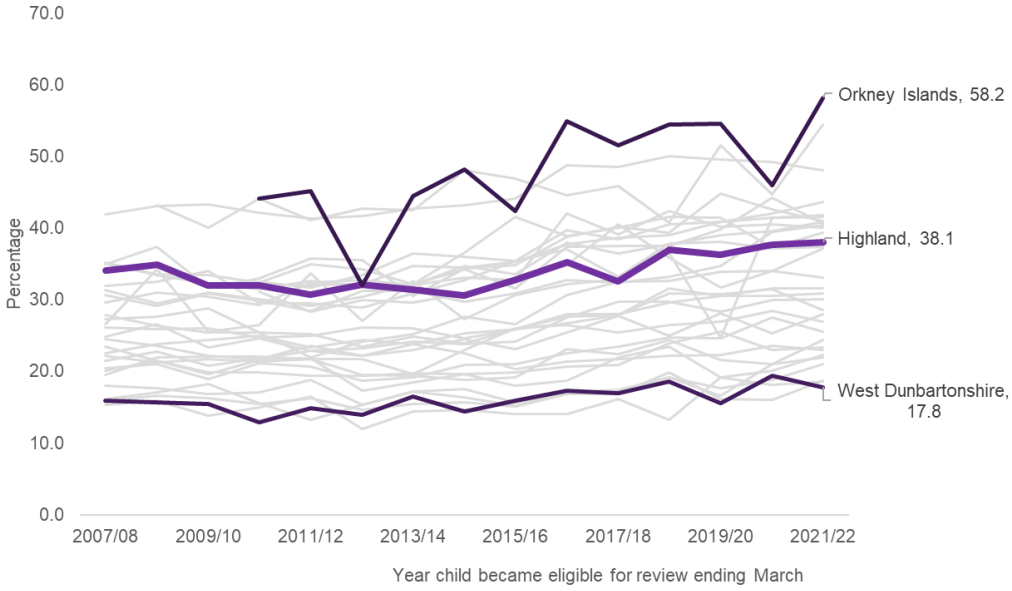


	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Exclusive breast	34.0	34.9	32.0	32.0	30.7	32.1	31.4	30.5	32.8	35.3	32.6	37.0	36.2	37.7	38.1
Formula	56.1	57.0	59.4	57.8	59.9	58.8	59.4	59.8	56.1	55.3	56.0	52.8	53.2	50.8	50.1
Mixed breast and formula	9.9	8.0	8.6	10.3	9.4	9.2	9.2	9.6	11.1	9.4	11.4	10.2	10.5	11.4	11.7

Source: Public Health Scotland Infant Feeding Open Data

Highland currently has relatively 'mid-table' breastfeeding rates compared to other council areas in Scotland (Figure 50).

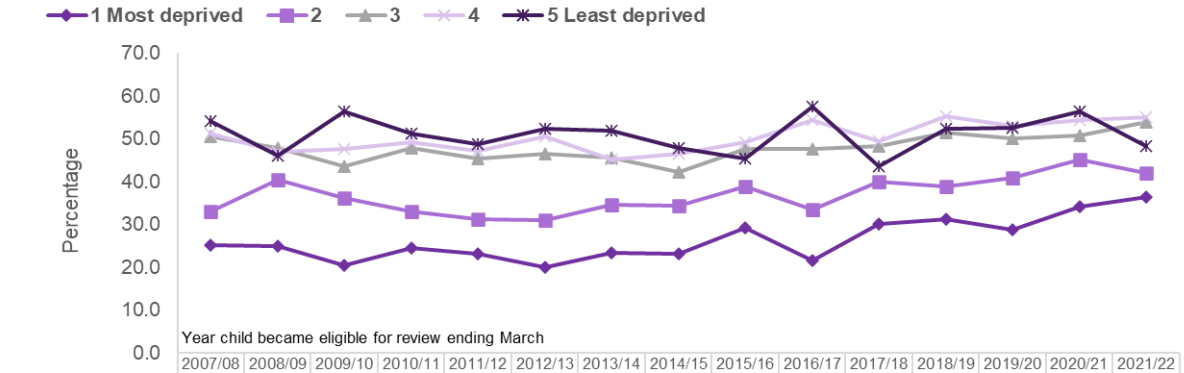
Figure 50: Percentage of babies exclusively breastfed at 6-8 week review by local authority area of residence



Source: Public Health Scotland Infant Feeding Open Data

Breastfeeding is more common among women who live in less deprived areas (Figure 51). From 2012/13, an increasing trend in the proportion of babies breastfed at 6-8 weeks in the more deprived areas in Highland can be seen. Consequently, over time, there has been a reduction in the inequalities gap in breastfeeding. This pattern is also observed nationally and is influenced by the association between the age of mothers and deprivation. However, breastfeeding remains a significant factor in inequalities in health; not being breastfed is both a cause and consequence of social inequality.

Figure 51: Overall breastfeeding (exclusive or mixed) by deprivation level (SIMD) in Highland at 6-8 weeks review



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
1 Most deprived	25.1	24.9	20.4	24.4	23.2	20.0	23.2	23.1	29.1	21.6	30.1	31.2	28.7	34.1	36.5
2	33.0	40.5	36.1	33.1	31.1	30.9	34.5	34.3	38.8	33.4	39.9	38.9	40.9	45.1	41.9
3	50.5	47.9	43.5	47.8	45.5	46.4	45.5	42.1	47.6	47.5	48.3	51.4	50.1	50.8	53.9
4	51.2	47.0	47.6	49.1	47.1	50.5	45.1	46.4	49.1	54.3	49.4	55.3	53.0	54.4	55.0
5 Least deprived	54.1	46.0	56.4	51.2	48.8	52.4	51.9	47.9	45.4	57.6	43.5	52.2	52.6	56.4	48.4

Source: Public Health Scotland Infant Feeding Open Data

6.4. Childhood Immunisations

Immunisation programmes for children are effective in reducing the burden of disease. They aim to protect the individual child from many serious infectious diseases and prevent the spread of disease in the wider population[44].

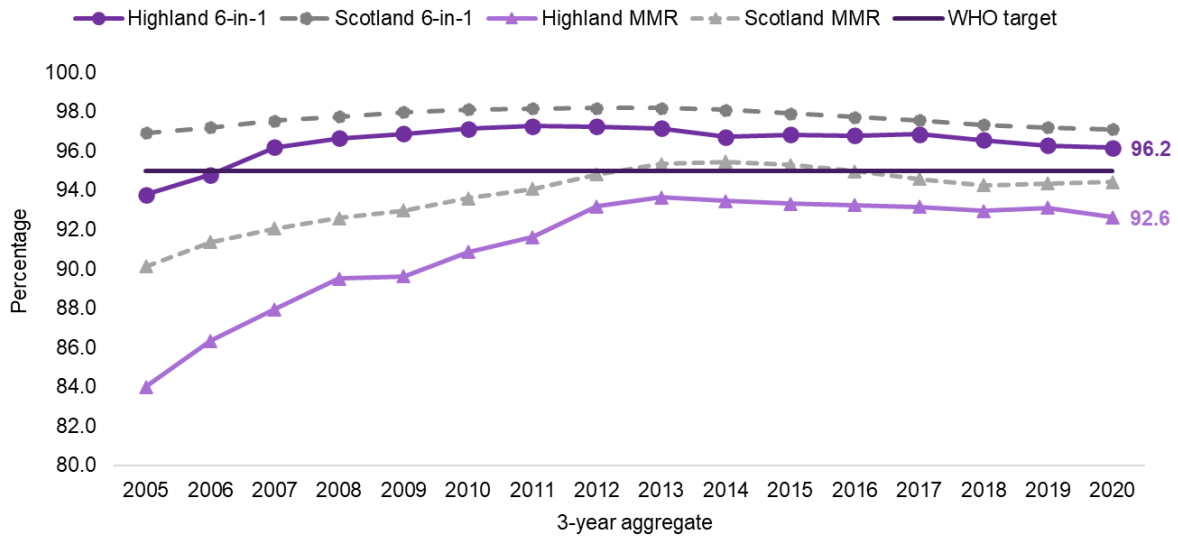
The European Region of the World Health Organization (WHO) recommends that on a national basis, at least 95 percent of children are immunised against diseases preventable by immunisation and targeted for elimination or control. These include diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib), measles, mumps and rubella.

There is an expectation that all UK routine childhood immunisations that are evaluated up to five years of age achieve the 95 percent coverage in line with the WHO target. Immunisation uptake rates are monitored at 12 months, 24 months, five years and six years of age.

In Highland, uptake of the 6-in-1 vaccine at 24 months has consistently achieved 95 percent coverage, though, since 2012/14, there is evidence of a decreasing trend (Figure 52).

The uptake of the MMR vaccine at 24 months has decreased and was consistently below the national coverage rate.

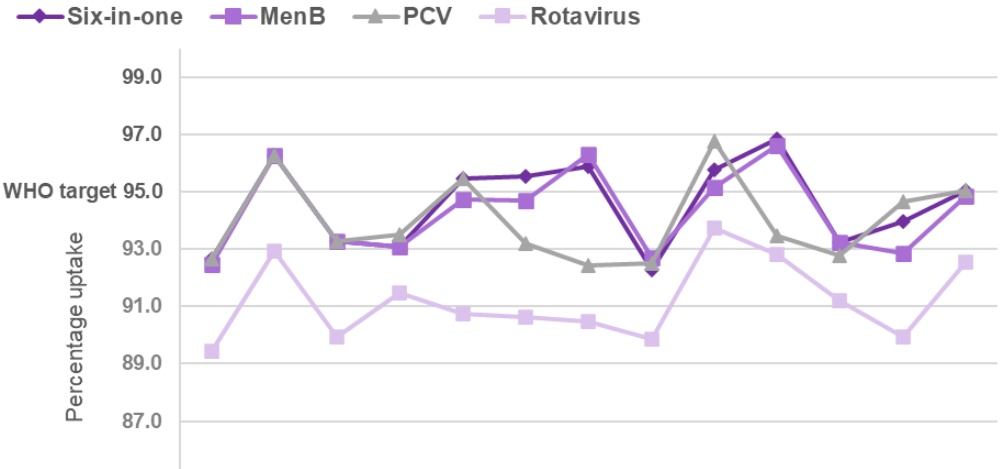
Figure 52: Childhood immunisation uptake (6-in-1 and MMR) at 24 months in Highland and Scotland



Source: Scottish Public Health Observatory Online Profiles

Childhood immunisation services continued during the COVID-19 pandemic to ensure children remained protected and to prevent a resurgence of serious infectious diseases, including diphtheria, whooping cough, and measles. Quarterly uptake rates of routine childhood immunisations at 12 months in Highland remained high, except for rotavirus, which averaged 91 percent uptake (Figure 53).

Figure 53: Primary childhood immunisations uptake rates at 12 months in Highland by quarter



	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3
Six-in-one	92.7	96.3	93.3	93.1	95.5	95.5	95.9	92.3	95.8	96.9	93.2	94.0	95.0
MenB	92.5	96.3	93.3	93.1	94.7	94.7	96.3	92.7	95.2	96.6	93.2	92.9	94.8
PCV	92.7	96.3	93.3	93.5	95.5	93.2	92.4	92.5	96.8	93.5	92.8	94.6	95.0
Rotavirus	89.5	92.9	89.9	91.5	90.8	90.6	90.5	89.8	93.7	92.8	91.2	90.0	92.5

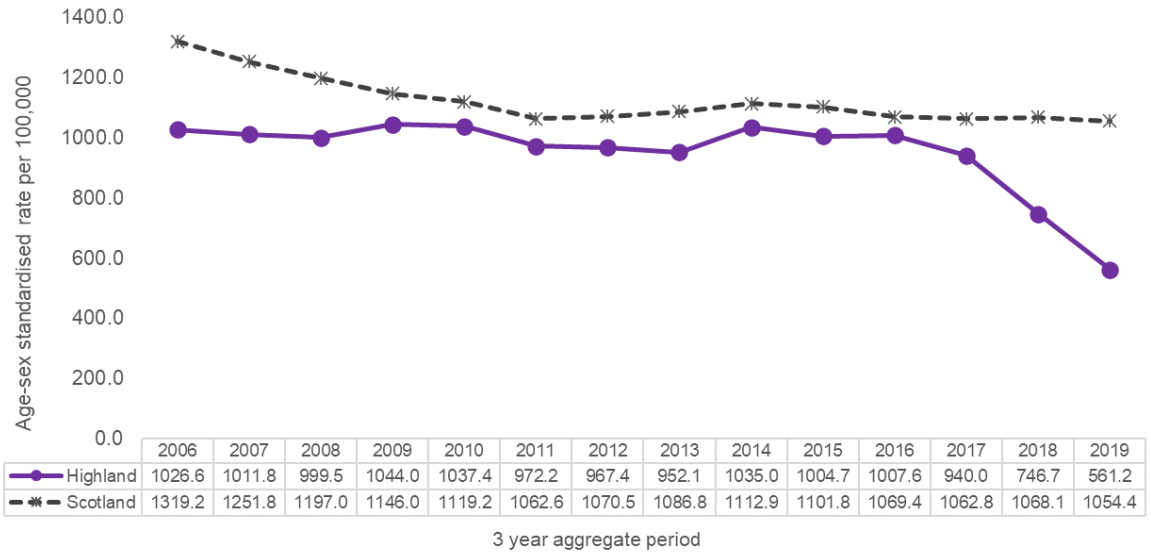
Source: Public Health Scotland Childhood Immunisation Open Data

6.5. Unintentional injuries in the under 5's

Unintentional injury is a source of harm to children and young people[45]. Children are particularly vulnerable; unintentional injury is a leading cause of emergency hospital admission and death in children. The term 'unintentional injury' is used to reflect the fact that many such events can potentially be prevented[46].

In Highland, around 120 children under five are admitted to a hospital annually due to unintentional injury. Rates in the last two periods have been impacted by the COVID-19 pandemic, with periods of lockdown resulting in decreased injuries (Figure 54, Figure 55).

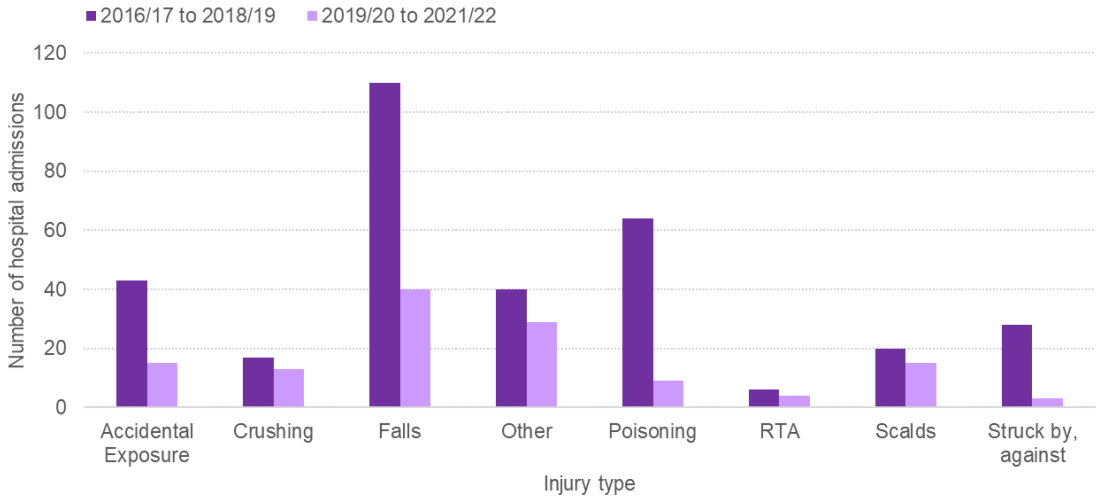
Figure 54: Unintentional injuries in under 5s in Highland and Scotland



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Highland	1026.6	1011.8	999.5	1044.0	1037.4	972.2	967.4	952.1	1035.0	1004.7	1007.6	940.0	746.7	561.2
Scotland	1319.2	1251.8	1197.0	1146.0	1119.2	1062.6	1070.5	1086.8	1112.9	1101.8	1069.4	1062.8	1068.1	1054.4

Source: Scottish Public Health Observatory Online Profiles
Emergency hospital admissions for unintentional injury in children under five; three-year rolling average number and directly age-sex standardised rate per 100,000 population.

Figure 55: Emergency hospital admissions as a result of an unintentional injury by injury type for children aged under 5 in Highland



Source: Public Health Scotland Unintentional Injuries Open Data
Emergency hospital admissions for unintentional injury in children under five; three-year aggregate number.

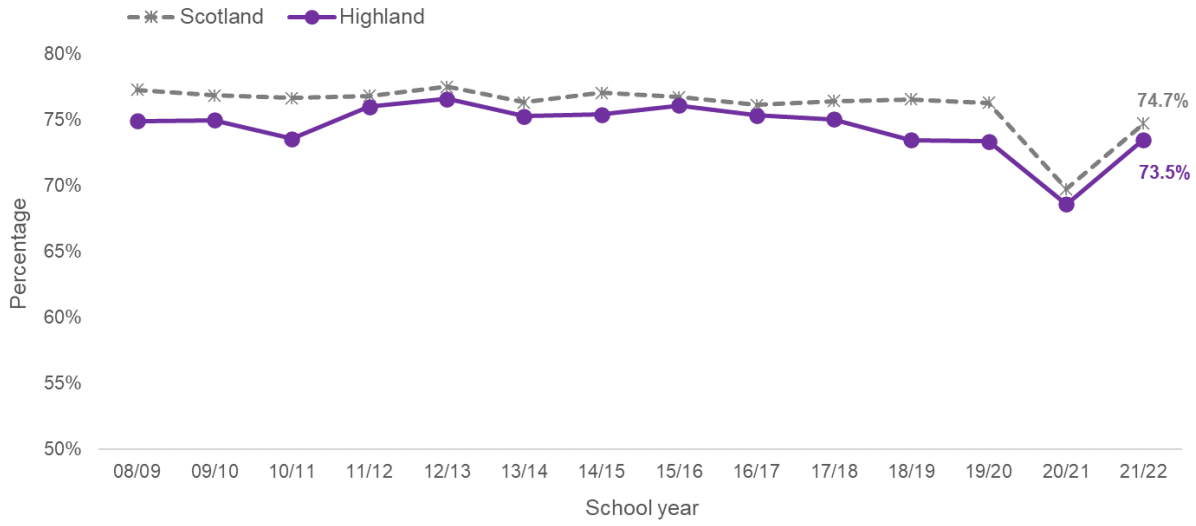
7. Primary school age

7.1. Child healthy weight

Monitoring healthy weight in childhood is a way of seeing how well the needs of children are being met. Maintaining a healthy weight throughout childhood is associated with many health and wellbeing benefits. Obesity and being overweight in childhood are associated with health problems in later life, including type 2 diabetes and cardiovascular disease. The early years are critical for establishing good nutrition and healthy eating habits and for reducing the likelihood of children becoming overweight or experiencing obesity in later life.

Child height and weight are measured in Primary 1 children and used to monitor those at risk of unhealthy weight. In the school year 2021/22, 73.5 percent of Primary 1 children in Highland measured had a healthy weight compared to 74.7 percent in Scotland (Figure 56). Child healthy weight rates in Highland are decreasing and consistently lower than in Scotland. Coverage was not complete in 2019/20 and 2020/21 due to COVID-19.

Figure 56: Percentage of Primary 1 children with a healthy weight in Highland and Scotland

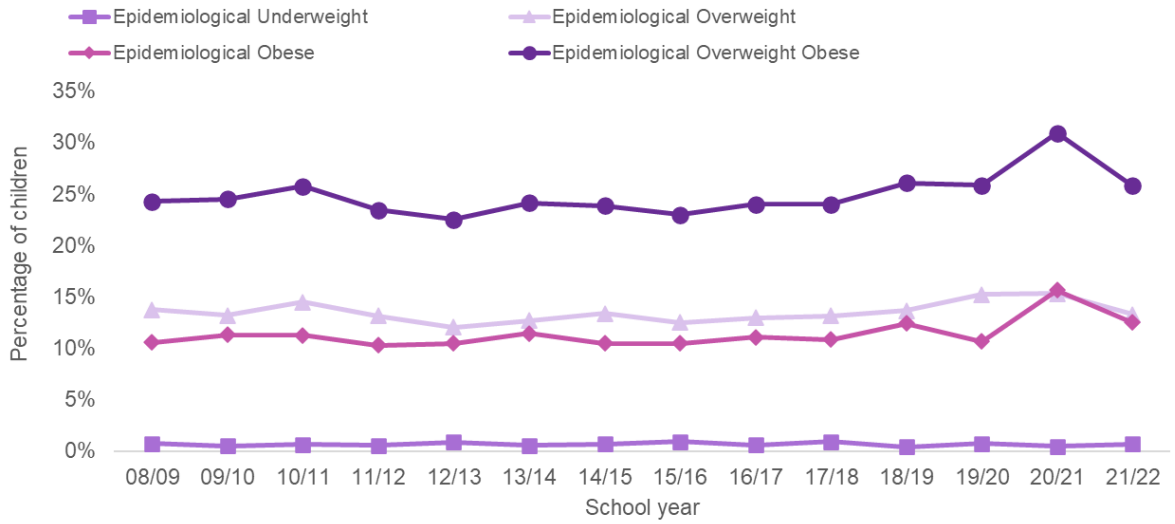


Source: Child Health Systems Programme School (CHSP-S), Public Health Scotland
Children in Primary 1 receiving a review whose BMI falls within the epidemiological threshold for healthy weight (BMI>2nd and <85th centile).
Coverage was lower in 2019/20 and 2020/21 due to COVID-19.

In Highland, as in Scotland, the proportion of children at risk of overweight or obesity increased markedly in 2020/21. Nationally and locally, the BMI distribution of Primary 1 children in 2021/22 appears more similar to pre-pandemic years than in 2020/21, with around one in four children already at risk of overweight or obesity (Figure 57).

The risk of unhealthy weight is linked to deprivation, with prevalence higher in the most deprived areas of Highland.

Figure 57: Trend in selected BMI measures (epidemiological categories) in Highland



Source: Child Health Systems Programme School (CHSP-S), Public Health Scotland
Children in Primary 1 receiving a review whose BMI falls within epidemiological categories: underweight (BMI ≤ 2nd centile), overweight (85th-<95th centile), obese (≥ 95th centile), overweight and obese combined ((≥ 85th centile).

7.2. Oral health

Good oral health is essential for general wellbeing and eating, speaking, and socialising properly. Poor oral health can be associated with pain, disfigurement, infection, school absences and poor nutrition and weight. Dental caries is one of the most common diseases of childhood, yet it is entirely preventable. Dental neglect can be an indicator of other unmet needs.

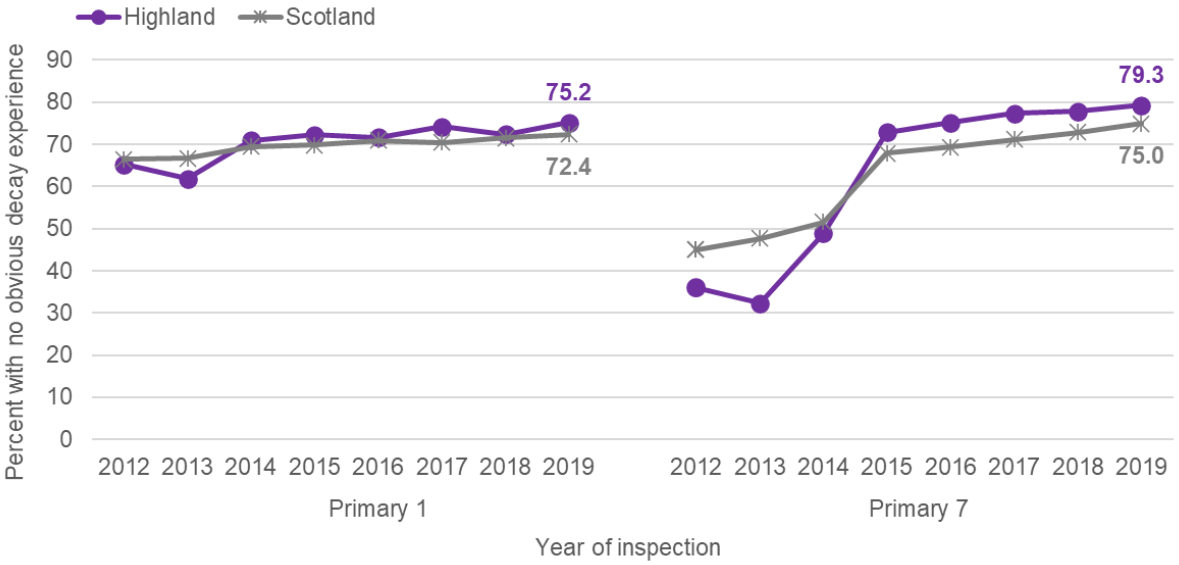
The National Dental Inspection Programme (NDIP) in Scotland has two levels. All children in Primary 1 (P1) and Primary 7 (P7) receive a basic inspection. In alternate years a detailed epidemiological examination of a representative sample of P1 or P7 children is undertaken.

In the school year 2021/22, public health measures to limit the transmission of COVID-19 affected the inspection programme. These included more limited school access and transferring some dental staff to other duties. NHS Highland was only able to provide a partial submission[47].

In Highland, the proportion of P1 children with no obvious decayed, missing or filled teeth has shown improvement, rising from 65 percent in 2012 to 75 percent in 2019. The levels of dental decay in P7 children showed a sharp improvement from 2012 to 2015, followed by a more gradual improvement in oral health. In 2019, 79 percent of P7 children in Highland schools had no obvious dental decay experience (Figure 58).

Oral health improvement activities through the Childsmile Programme should be the focus of initiatives to reduce oral health inequalities.

Figure 58: Percentage of Primary 1 and Primary 7 children with no obvious dental decay experience in Highland and Scotland



Source: National Dental Inspection Programme (NDIP) database, Public Health Scotland
No obvious dental decay experience means no obvious decayed, missing and filled primary teeth.

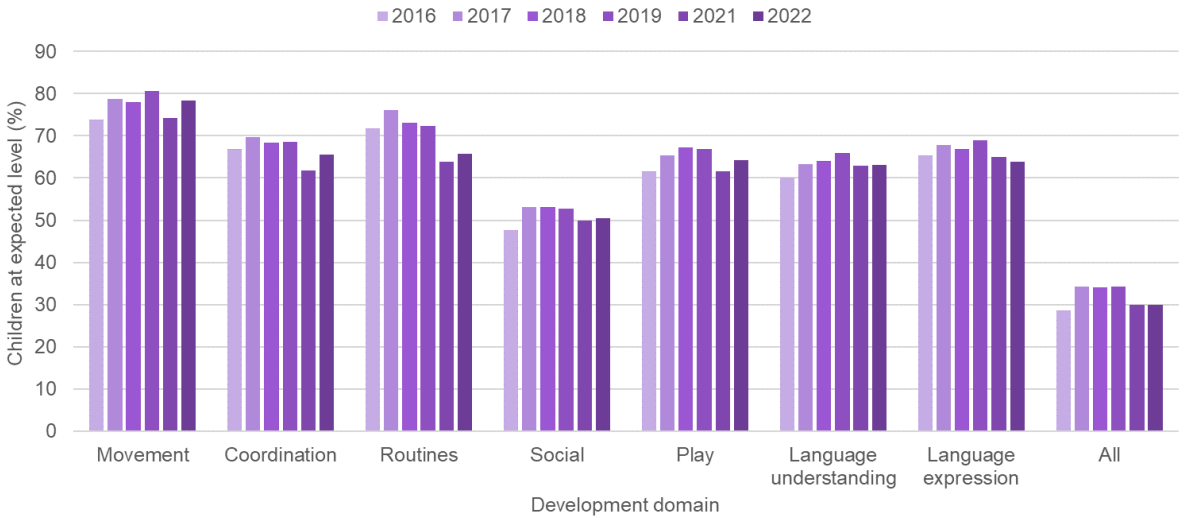
7.3. Developmental overviews at the primary transition

The Highland education service has used developmental overviews since 2015 to track children's skills and development. The developmental overviews are based on a strengths-based tool that assesses children's development in seven domains: movement, coordination, routines, social, play, language understanding and language expression.

Every child should have a developmental overview updated in the months before transitioning to primary school. These overviews provide schools with general transition information and the first sight of patterns of strengths and need in a class environment. The developmental overviews also support tracking an individual child's development, identifying and clarifying concerns, supporting requests for advice or assistance, and signposting to supporting services and initiatives.

The proportion of children achieving the expected level of development was lower in all domains in 2021 compared to the period 2017 to 2019 (Figure 59). In 2022, the desired levels of language understanding and expression had not improved on the 2021 level. Monitoring these children and future cohorts remains essential for understanding individual and collective developmental support needs.

Figure 59: Trend in developmental overviews at the transition to primary school in Highland, 2016 to 2022



Source: Highland Council Educational Psychology Service
Data was not collected in 2020 due to COVID-19.

8. Secondary school age

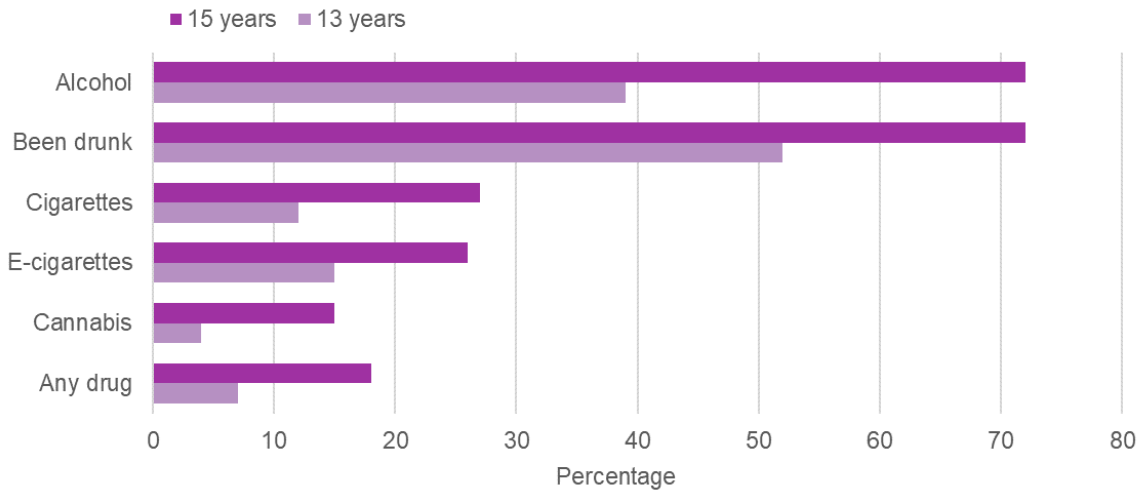
8.1. Substance use

Preventing harm caused by alcohol, tobacco and other drugs among young people is a national[48] and local priority[49] and central to the Getting it Right for Every Child (GIRFEC) approach to improving outcomes and supporting the wellbeing of children and young people[50]. Collectively, the avoidable harm from these substances is a major influence on preventable ill health across the life course.

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) is a long established survey used to measure long-term trends in young people's smoking, alcohol and drug use behaviours[51]. SALSUS 2018 was the latest survey providing local authority level results. The survey aimed to achieve a representative sample of pupils from Secondary 2 (S2) and Secondary 4 (S4) pupils in local authority and independent schools. Pupils in S2 are referred to as 13-year-olds and S4 pupils as 15-year-olds.

Key prevalence measures show that most pupils do not use substances regularly (Figure 60). For both age groups, drinking alcohol in the last week remains more common than smoking one or more cigarettes in the last week (regularly) or having used drugs in the last month.

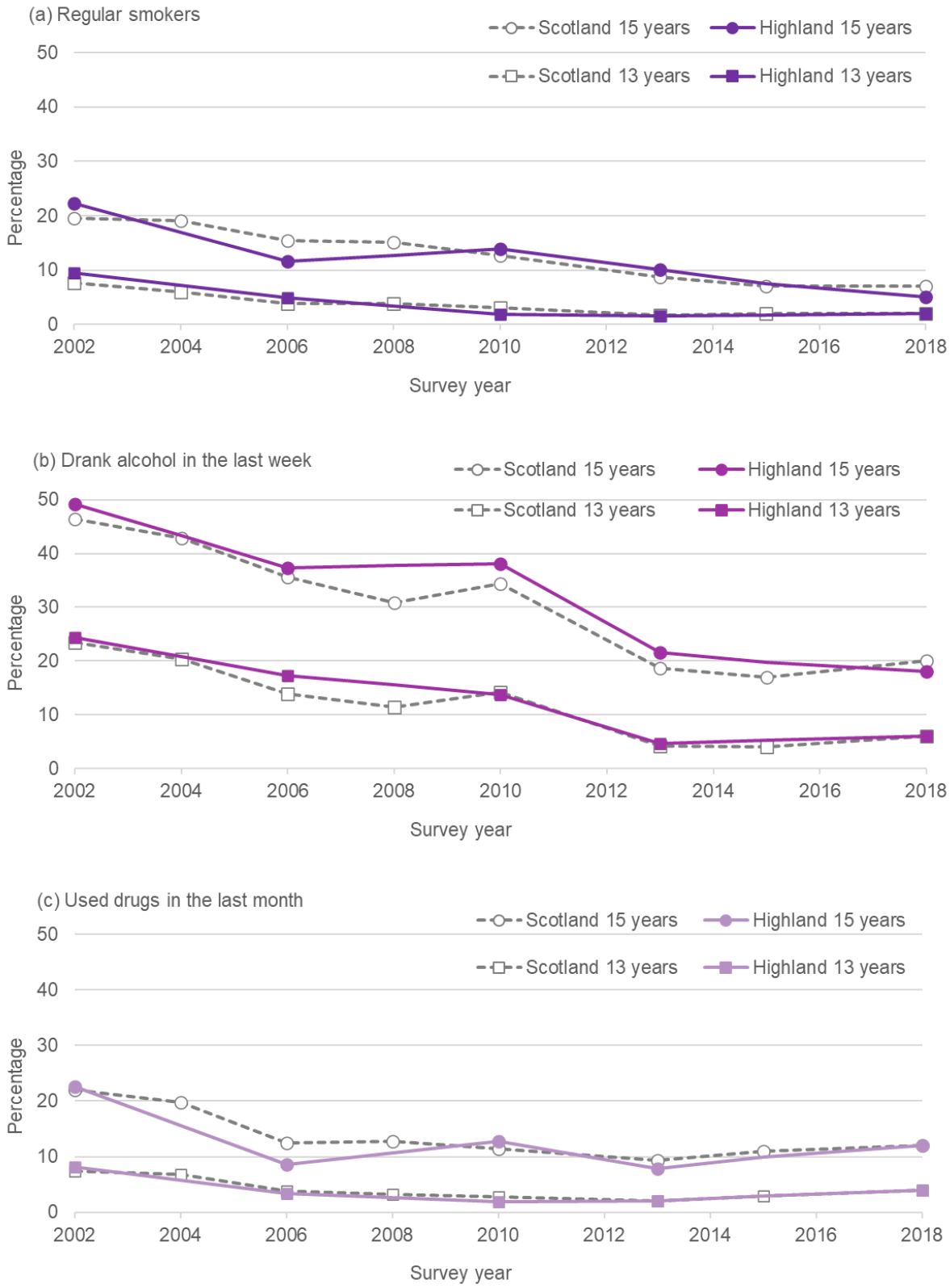
Figure 60: Proportion of pupils reporting ever having used substances by age in Highland, 2018



Source: Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)

In both cohorts, the prevalence of cigarette smoking has declined over time since 2002 (Figure 61). In 2018, increases in drinking in the last week among 13-year-olds and using drugs in the last month among 13-year-olds and 15-year-olds were reported in Highland. Findings from the 2018 survey show that, of 15-year-olds, around three in four pupils had tried alcohol and had ever been drunk, one in four had ever tried smoking cigarettes or using e-cigarettes, and one in five had used drugs, including cannabis.

Figure 61: Trends in the proportion of pupils (a) smoking regularly (b) drinking alcohol in the last week (c) using drugs in the last month



Source: Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)

Problematic use of drugs and alcohol is associated with multiple risk factors and vulnerabilities. The evidence highlights children and young people most likely to develop problems with alcohol and drugs as including: care experienced children, homeless younger people, young offenders, children who have experienced trauma, children and young people in families with problem drug use, children experiencing deprivation, and younger people not in work or education[52].

Planet Youth, also known as the Icelandic Prevention Model, is an evidence based primary prevention approach that aims to reduce and delay alcohol, tobacco and other drug use among young people. The approach works by increasing protective factors for substance use, the kind of things that, if part of a young person's life, can reduce the risk. Examples of protective factors include:

- In families, protective factors include having clear boundaries, parents disapproving of their child using substances, and families that spend time together.
- With peers, protective factors include friends that don't use substances and avoid other risky behaviours.
- For schools, protective factors include being motivated to learn and to feel safe at school.
- For leisure time, protective factors include being involved in structured activities, having meaningful use of time, and being involved in communities.

Highland is one of five Planet Youth model pilot sites across Scotland. Highland has five secondary schools involved in the pilot. Findings from a survey of 356 S4 pupils on Highland undertaken in Autumn 2021 highlight that behavioural harms continue to start early for many young people (Figure 62).

Figure 62: Findings from the Highland Planet Youth survey, 2021

Source: Planet Youth

8.2. Mental health and wellbeing

The mental health of children and young people has been identified as a concern across Scotland[53]. Supporting children's and young people's mental health and wellbeing benefits the individual and society by preventing problems from arising and intervening early. Support can range from prevention and early intervention activities to specialist services and direct intervention, especially where trauma and adversity impact on mental health and emotional wellbeing.

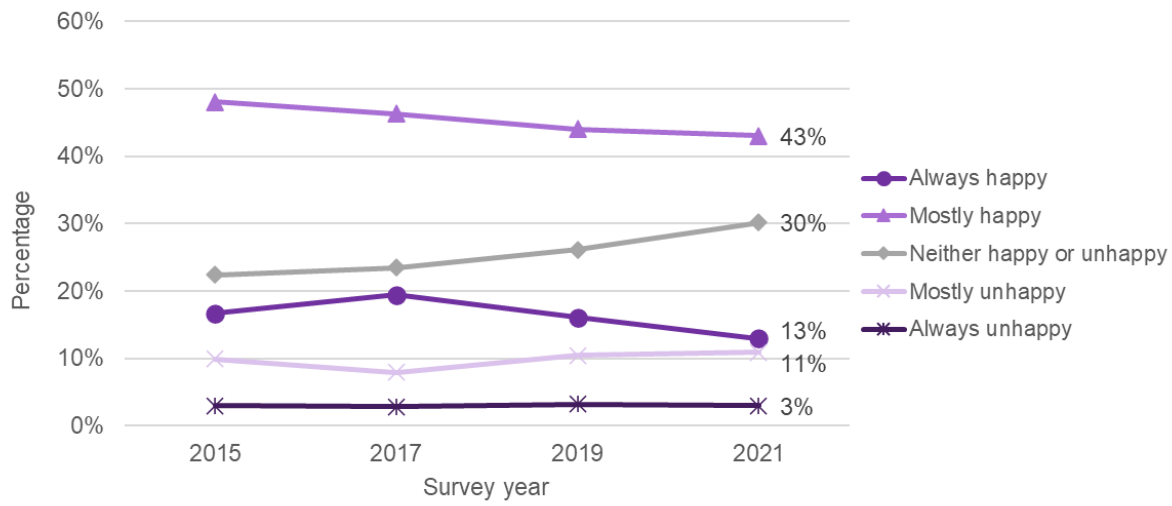
There is evidence that the pandemic has affected the mental health of children and young people. COVID-19 and the restrictions put in place to contain the virus have increased the risk of people experiencing poor mental health and trauma. This includes people living with domestic or child abuse during lockdown, facing poverty, financial hardship and unemployment, severe/chronic illness, and bereavement[54]. The long-term impact of the pandemic has not yet fully developed.

The Highland Lifestyle Survey is a biannual survey completed by pupils in P7, S2 and S4. The response rate in 2021 was 48 percent and has varied between 44 percent in 2017 and 66 percent in 2013.

Data from this survey are used as an ongoing measure of the progress made in schools to support the wellbeing of children and young people in Highland. The next survey is planned for 2023.

Children who responded to the survey in 2021 reported lower levels of happiness compared to pupils in previous years (Figure 63).

Figure 63: Levels of happiness reported in P7, S2 and S4 pupils in Highland, 2015 to 2021

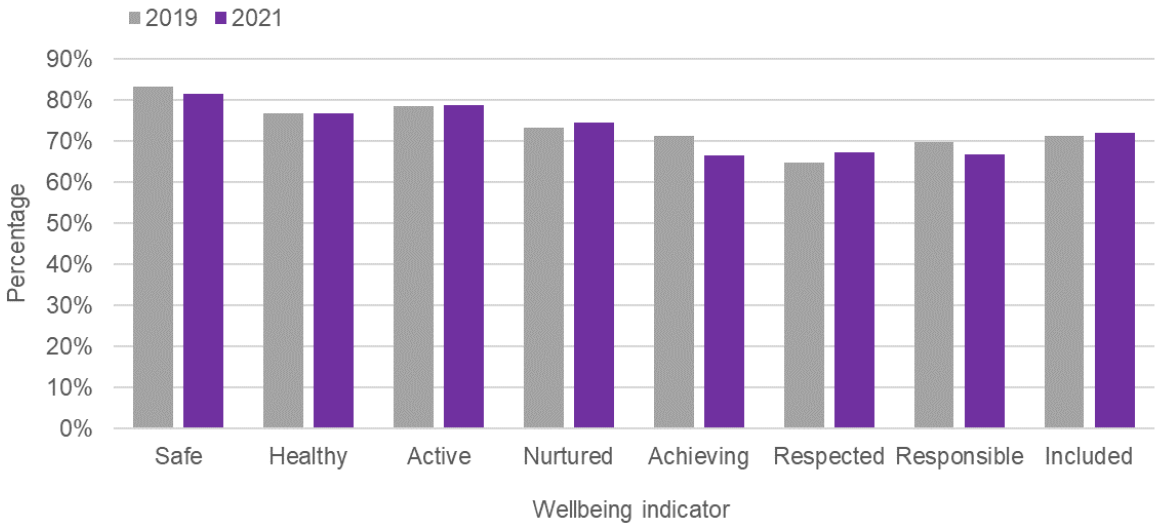


Source: Highland Lifestyle Survey

The Getting it Right for Every Child (GIRFEC) principles use an approach to considering children and young people's wellbeing that is rights-based, strengths-based, and adaptable enough to take account of stage of development and the complexity of each child or young person's life circumstances[50]. The approach uses eight wellbeing indicators (SHANARRI) that, when considered together, give a holistic view of the needs of each child or young person.

The Highland Lifestyle Survey measures and reports the indicators (Figure 64). It should be of particular concern that one in three Highland children do not feel they are achieving.

Figure 64: Percentage of Highland children reporting their wellbeing needs are met using the SHANARRI principles, 2019 and 2021



Source: Highland Lifestyle Survey

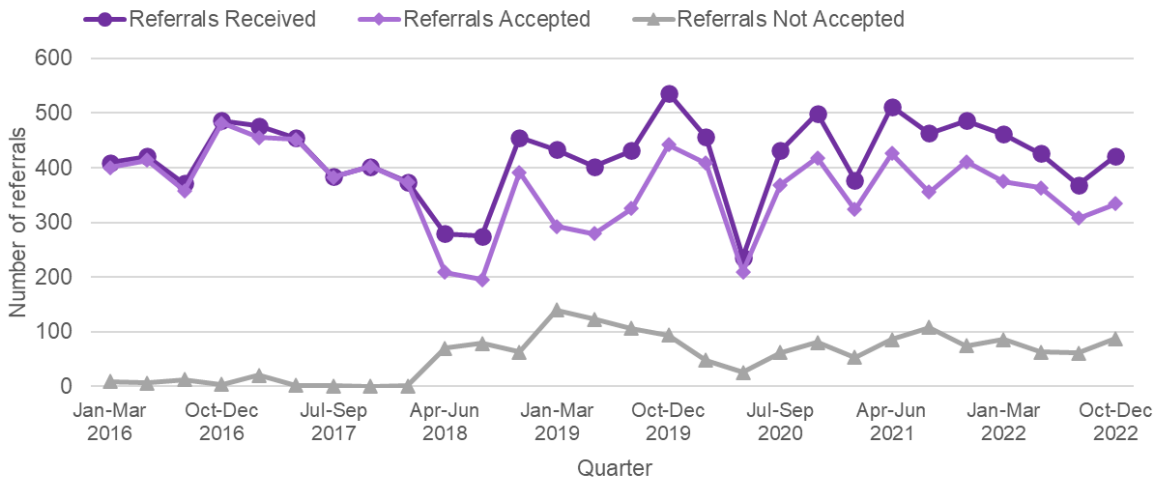
8.3. Childhood and Adolescent Mental Health Services

The Scottish Government aims to make Child and Adolescent Mental Health Services (CAMHS) accessible to children, young people and families[55]. Most children and young people requiring CAMHS are experiencing serious mental health problems. CAMHS also have an important role in supporting the mental health capability of the wider network of children's services. All children and families should receive support and services that are appropriate to their needs.

Referrals to CAMHS have increased in recent years. The lowest number of referrals received in a quarter was during the first national lockdown between April and June 2020 (Figure 65).

55

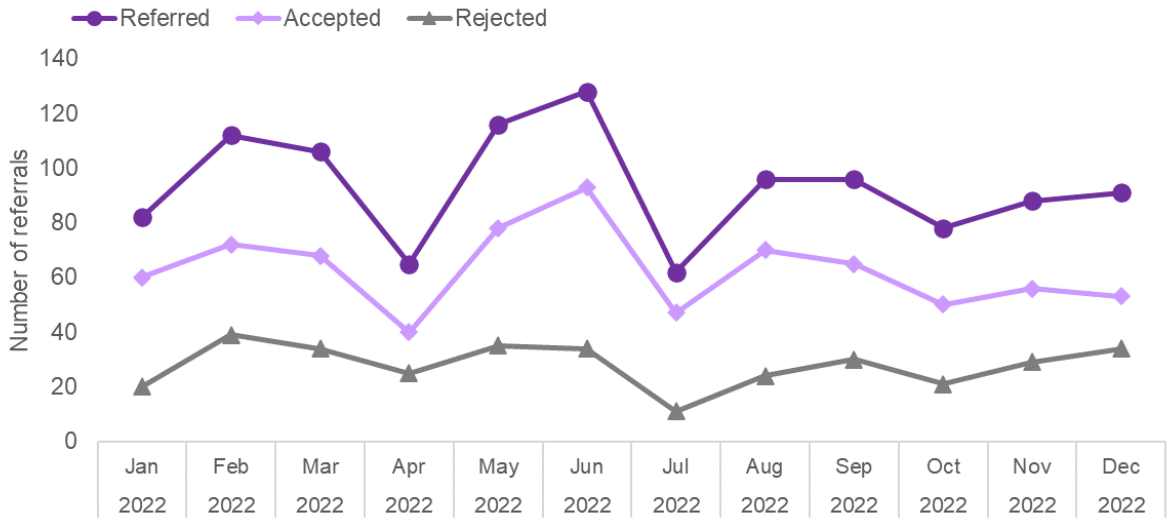
Figure 65: Referrals for CAMHS in NHS Highland by quarter, January 2016 to December 2022



Source: Public Health Scotland CAMHS Open Data

There were 1,120 referrals to CAMHS in Highland in 2022 (Figure 66). The average number of referrals a month was 93 (range 62 to 128). Two in three referrals (67 percent) were accepted onto the waiting list. The majority (76 percent) of referrals in 2022 were for children and young people aged between 12 and 17 years.

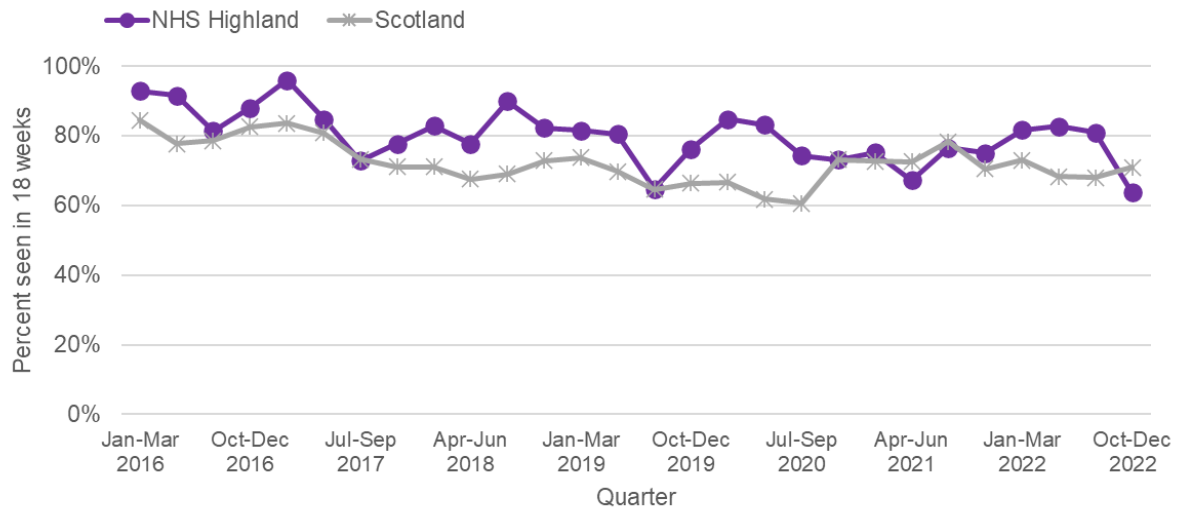
Figure 66: Referrals number for CAMHS in Highland by month in 2022



Source: NHS Highland Management Information

CAMHS have been subject to an 18 week wait target from referral to treatment for specialist services from December 2014. The national target is that 90 percent of young people will commence specialist CAMHS services within 18 weeks of referral. The percentage of children waiting less than 18 weeks from CAMHS referral to starting treatment is generally higher in NHS Highland than in Scotland (Figure 67).

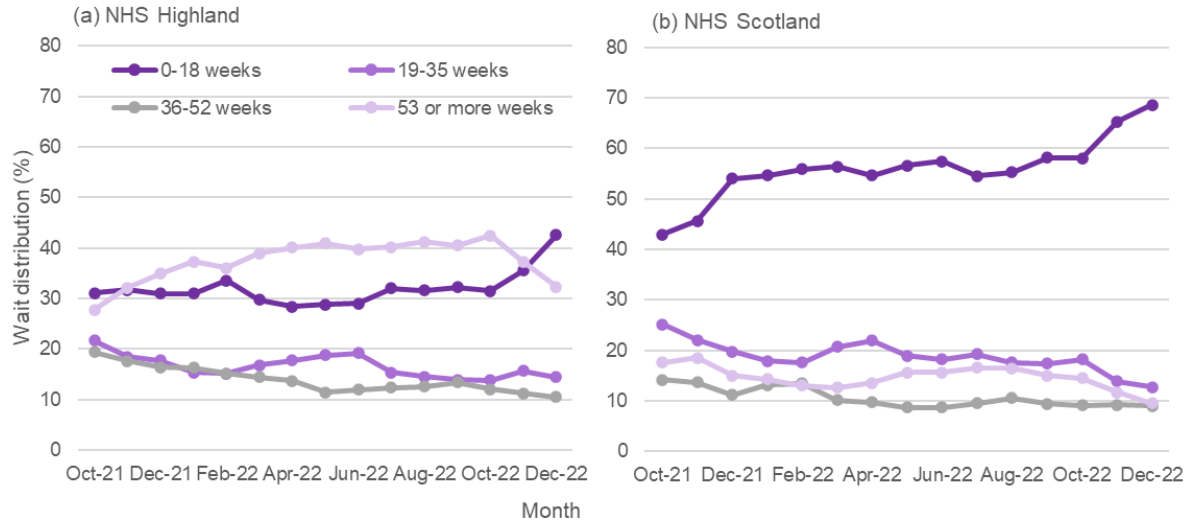
Figure 67: Wait distribution (%) of patients who started treatment for CAMHS in NHS Highland by quarter, January 2016 to December 2022



Source: Public Health Scotland CAMHS Open Data

Some children and young people still face very long waits for CAMHS. Benchmarking shows a higher-than-average distribution of long waits to access services in NHS Highland compared to Scotland (Figure 68).

Figure 68: Wait distribution (%) of patients waiting for treatment for CAMHS in (a) NHS Highland and (b) NHS Scotland by month



Source: Public Health Scotland CAMHS Open Data

In Highland, an improvement plan to support actions to meet the national waiting times standard and service specification for CAMHS set by the Scottish Government has been agreed upon. Achieving and sustaining waiting list targets is required to ensure that children, young people, and their carers do not continue to experience unnecessary delays in treatment.

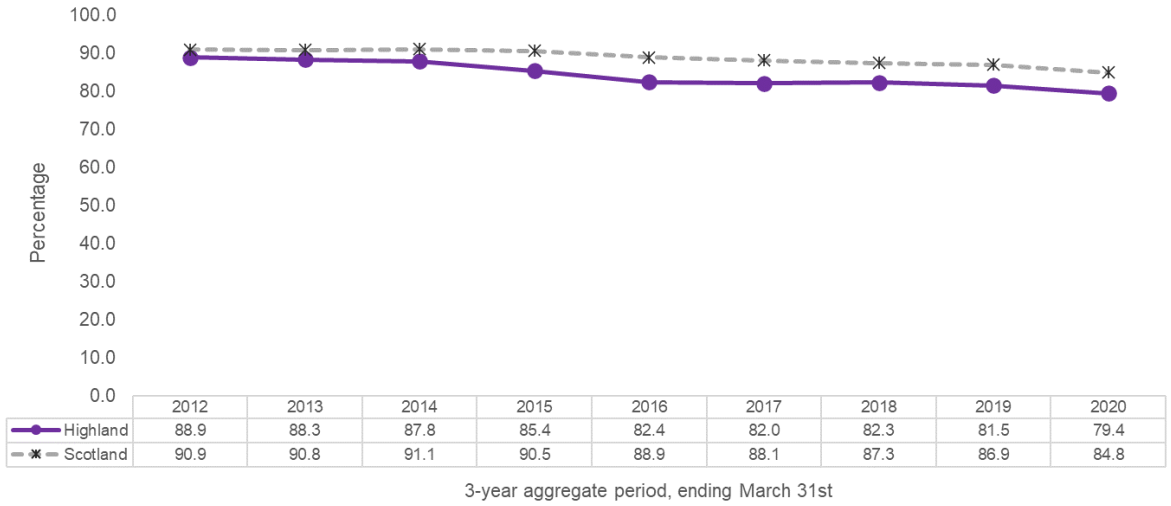
8.4. HPV immunisation

The Human Papillomavirus (HPV) is a common virus which usually has no symptoms. Most people who become infected with HPV clear the virus from their body. Others may develop a range of cancers (including cervical, anogenital and head and neck) in later life. The most common HPV-related cancer is cervical cancer[56].

The schools-based HPV immunisation programme in Scotland started in 2008, with immunisation offered to females in secondary school. The immunisation schedule has changed over time and has been offered to different year groups. In 2019 the immunisation programme became universal, with males in the first year of secondary school eligible alongside females. The programme is currently offered to all pupils in their first (S1) and second (S2) years of secondary school. Eligible pupils who have not started or completed the course of immunisations are given other opportunities to be vaccinated in S3 and S4.

In the three-year period 2017/18 to 2019/20, 79.4 percent of girls in Highland had completed the course of HPV immunisation (Figure 69). Uptake rates in Highland show a decreasing trend and are consistently lower than for Scotland.

Figure 69: Completed course of HPV immunisation in girls by end of S3 school year in Highland and Scotland

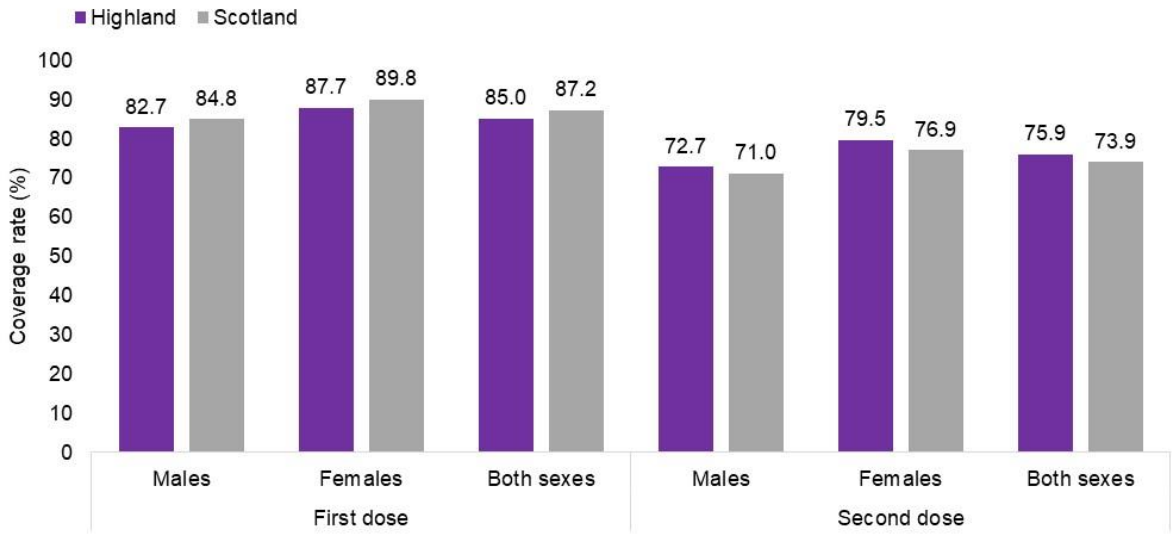


	2012	2013	2014	2015	2016	2017	2018	2019	2020
Highland	88.9	88.3	87.8	85.4	82.4	82.0	82.3	81.5	79.4
Scotland	90.9	90.8	91.1	90.5	88.9	88.1	87.3	86.9	84.8

Source: Scottish Immunisation & Recall System (SIRS), Public Health Scotland, ScotPHO Online Profiles
3-year rolling average number and percentage completed course of HPV immunisation.

HPV immunisation coverage rates by the end of the school year 2021/22 (Figure 70) report coverage for males and females. Disruption to schools during academic years 2019/20 and 2020/21 due to the COVID-19 pandemic has impacted the delivery of the HPV immunisation programmes.

Figure 70: HPV immunisation coverage rates by the end of the school year 2021/22 in Highland and Scotland



Source: Scottish Immunisation & Recall System (SIRS), Public Health Scotland

9. Education and Attainment

9.1. Early learning and childcare provision

Early learning and childcare (ELC) is the term used to describe the full range of early education available in Scotland today. ELC settings offer education and care to children up to school age. They are crucial to helping children succeed and contribute to closing the poverty-related gap in children's outcomes[57].

In 2021, there were 186 early learning and childcare centres in Highland, of which 17 were Gaelic-medium providers (Figure 71). There were 4,092 children registered for ELC, an increase of 3.5 percent from 3,952 registrations in 2020.

Figure 71: Number of Early Learning and Childcare centres and registrations in Highland, 2017 - 2021

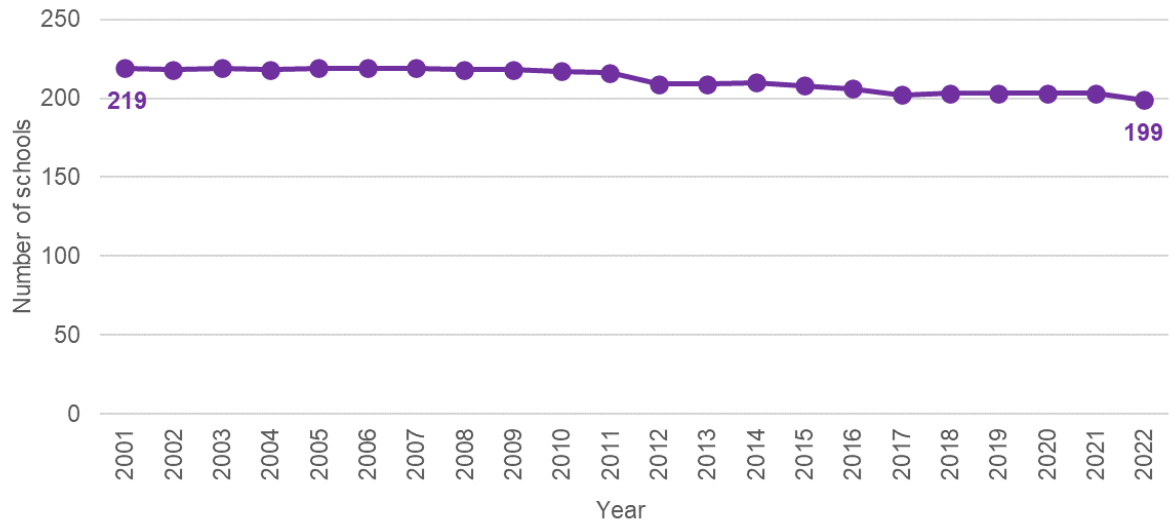
	Number of ELC Centres			Number of GM providers			Number of children in ELC		
Year	Local authority	Partnership	Total	Local authority	Partnership	Total	Local authority	Partnership	Total
2017	137	54	**191**	15	3	**18**	3,018	1,034	**4,052**
2018	137	51	**188**	15	3	**18**	3,142	1,064	**4,206**
2019	139	48	**187**	15	3	**18**	2,951	1,045	**3,996**
2020	140	48	**188**	15	3	**18**	2,832	1,120	**3,952**
2021	139	47	**186**	15	2	**17**	2,953	1,139	**4,092**

Source: Scottish Government School Education Statistics
GM: Gaelic-medium providers

9.2. Teaching provision

In Highland, there are currently 199 schools open. Of these, 29 are secondary schools, 167 are primary schools, and three are special schools (Figure 72).

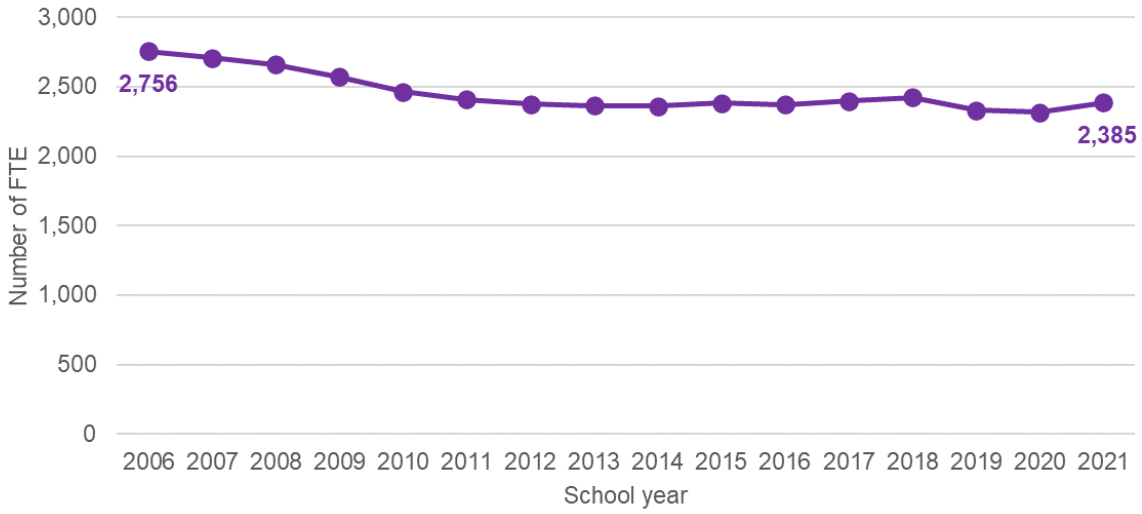
Figure 72: Number of schools in Highland, 2001-2022



Source: Scottish Government School Education Statistics

In 2021, the number of school teachers in publicly funded schools and early learning centres in Highland was 2,385 full-time equivalents (Figure 73).

Figure 73: Number of teachers in publicly funded schools (including ELC), Highland, 2006-2021

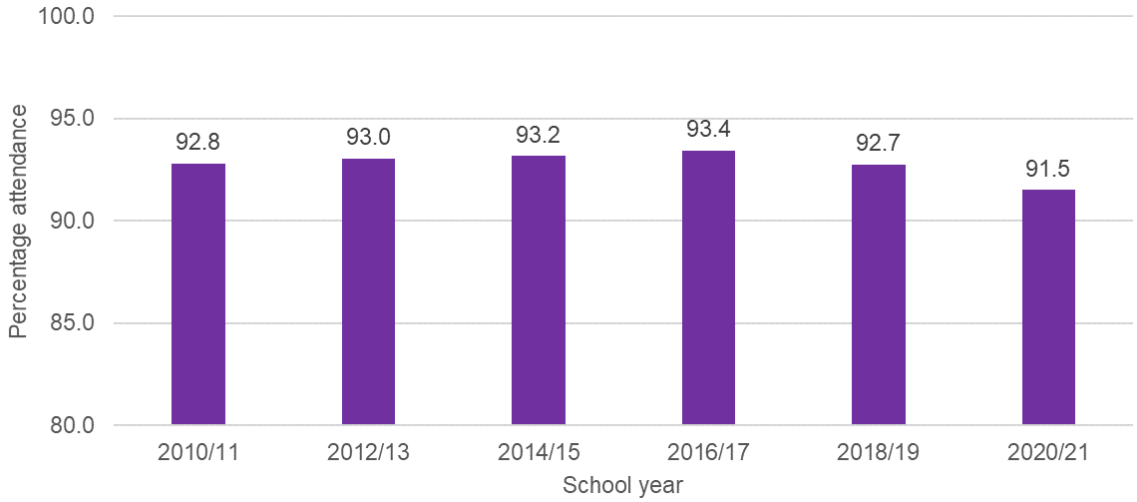


Source: Scottish Government School Education Statistics
Note: Teacher figures are based on the number of full-time equivalents (FTE) as of September of the school year

9.3. School attendance

The school attendance rate in Highland, for both primary and secondary pupils, was 91.5 percent in 2020/21 (Figure 74). Attendance reporting for the 2020/21 school year was significantly impacted by the COVID-19 pandemic and excludes periods of COVID-19 related school closures.

Figure 74: Percentage attendance for schools open in Highland, 2010/11-2020/21



Source: Scottish Government School Education Statistics
Note: Information on attendance and absence is collected biennially.

9.4. Digital Inclusion

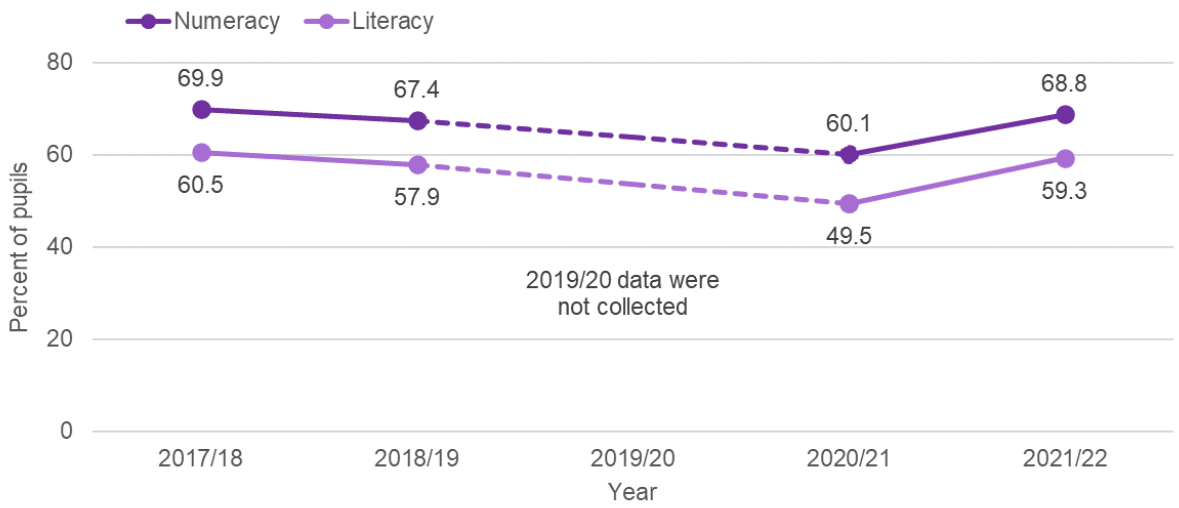
At the end of the school session 2021/22, there were 30,453 pupils in Highland Council Schools. The number of pupils in Primary 6 (P6) to Secondary 6 (S6) classes was 18,692. All pupils from P6 to S6 are issued a digital device, either a tablet or computer.

9.5. Educational outcomes

Primary phase attainment

The achievement of Curriculum for Excellence (CfE) levels provides information on school pupils attainment of expected levels of numeracy and literacy. Literacy comprises three components: reading, writing, and listening and talking. It covers all P1, P4 and P7 pupils. The percentage of primary school pupils achieving the expected CfE levels for numeracy and literacy increased in 2021/22 compared to 2020/21 and 2018/19 (Figure 75).

Figure 75: Percentage of P1, P4 and P7 pupils achieving the expected level of numeracy and literacy, Highland

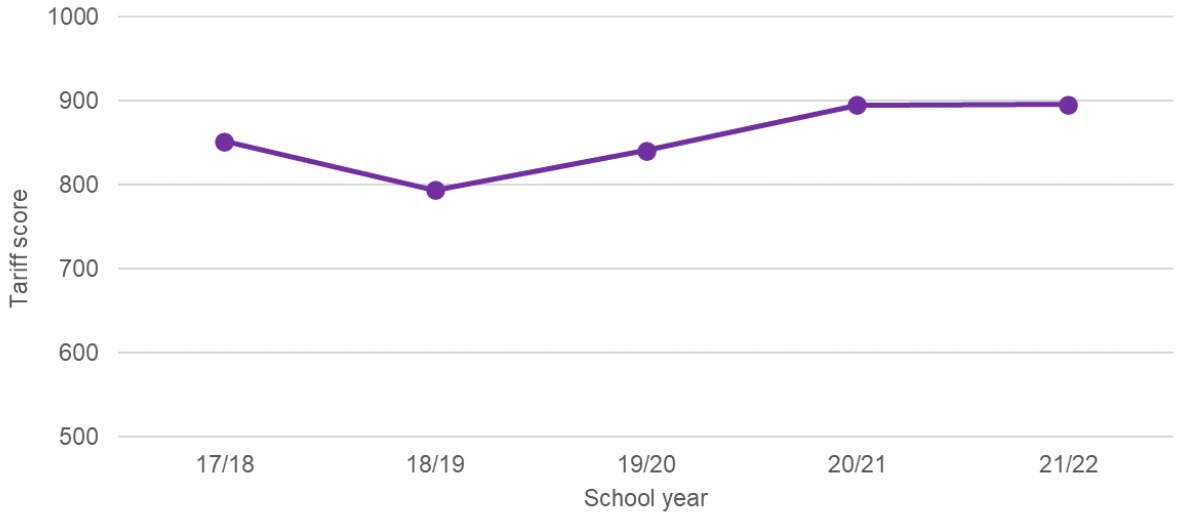


Source: Scottish Government School Education Statistics
Note: Data were not collected in 2019/20 due to the COVID-19 pandemic.

Senior phase attainment

Educational attainment is associated with improved outcomes in later life. The overall tariff scale measures the latest and best achievement in each subject area for national qualifications and wider awards. Qualifications are awarded tariff points based on their Scottish Credit and Qualifications Framework (SCQF) level. In Highland, the average overall tariff score in 2020/21 and 2021/22 has improved from previous years (Figure 76).

Figure 76: Overall Average Tariff Score in Highland

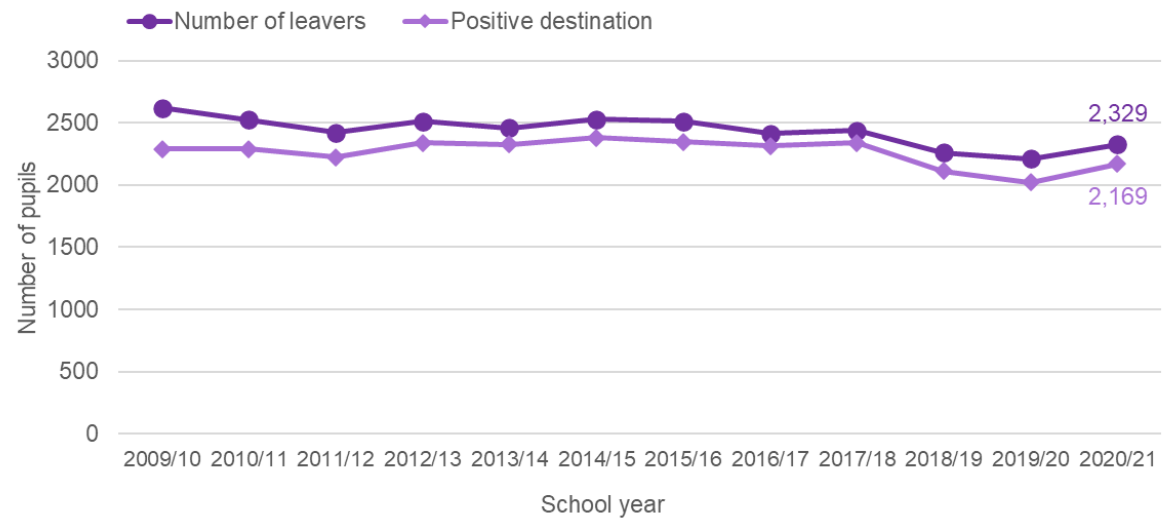


Source: Scottish Government School Education Statistics

Positive destinations

In 2020/21, 93.1 percent of young people leaving secondary school were in a positive initial destination. Positive destinations include higher education, further education, training, voluntary work, employment and activity agreements. The most common initial destinations were higher or further education and employment, with 46.8 percent and 43.7 percent of leavers in these categories respectively.

Figure 77: Number of Highland school leavers in positive destinations

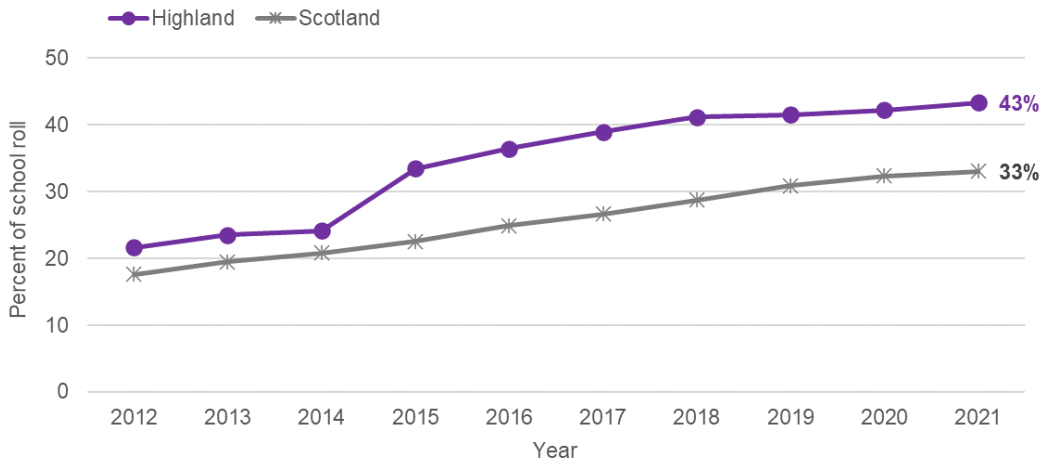


Source: Scottish Government School Education Statistics

9.6. Pupils with Additional Support Needs

In 2021, 43 percent of pupils in Highland schools were recorded with additional support for learning needs (Figure 78). The number of pupils recorded with additional learning support needs has increased since 2015, likely reflecting continued improvements in recording and increases in child-specific needs. The most common reasons for support recorded in 2021 were social, emotional and behavioural problems, dyslexia and other specific learning difficulties, English as an additional language and family issues.

Figure 78: Proportion of school roll with additional support for learning, Highland and Scotland



Source: Scottish Government School Education Statistics

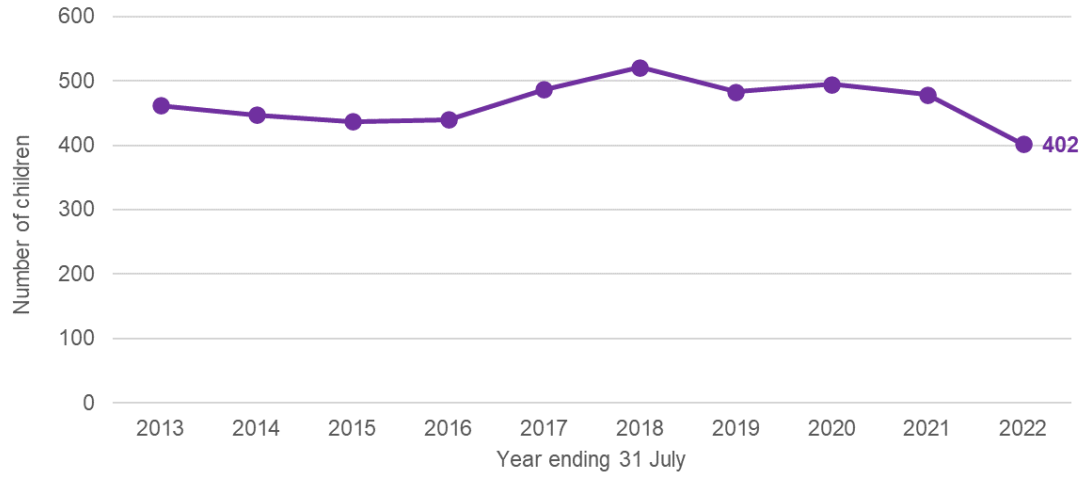
10. Vulnerable children

10.1. Looked after Children

Children may become looked after for various reasons, including abuse or neglect at home, having complex disabilities requiring specialist care, or involvement in the justice system.

In July 2022, there were 402 looked after young children in Highland, representing 0.9 percent of the total population aged 0-17 years. The number of looked after children have broadly decreased since 2018 (Figure 79). This is due to a combination of factors, including COVID-19 stretching services in 2021 and the effects of the early intervention strategy.

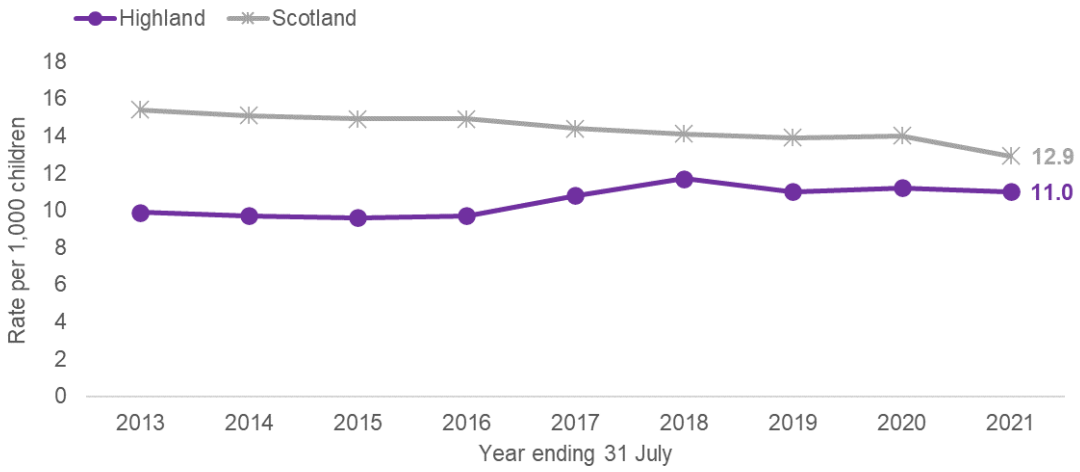
Figure 79: Number of looked after children on 31 July in Highland, 2013 – 2022[p]



Source: Scottish Government Children's Social Work Statistics
Data for 2022 are provisional and subject to change.

Rates of looked after children in Highland show a decreasing trend and are consistently lower than for Scotland (Figure 80).

Figure 80: Rates of looked after children on 31 July in Highland and Scotland, 2013 – 2021

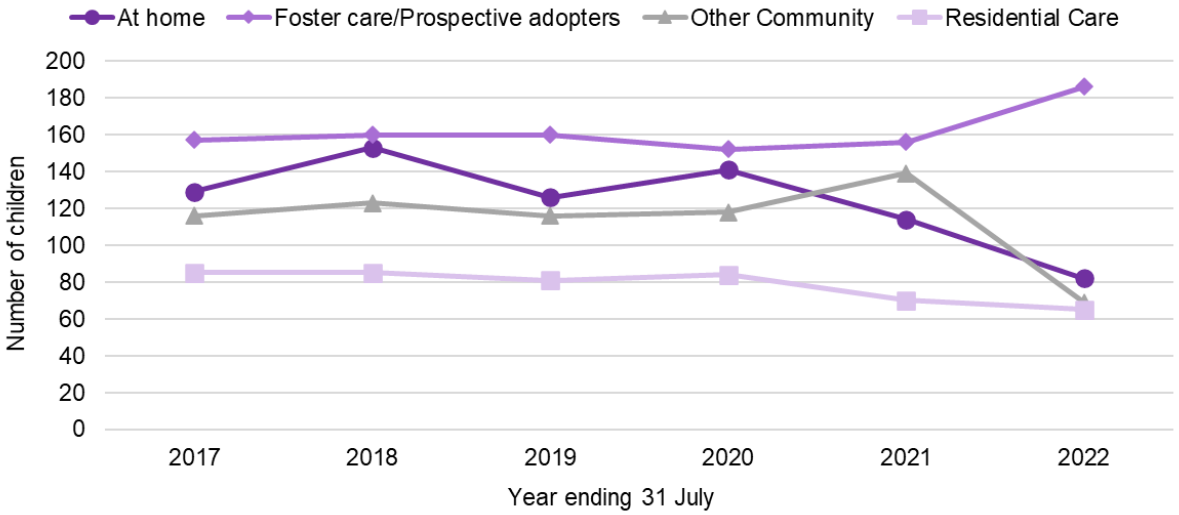


Source: Scottish Government Children's Social Work Statistics, Scottish Public Health Observatory Online Profiles
Rate per 1,000 children aged 0 to 17 years.

There are several types of placements in which looked after children or young people could be looked after, including at home, foster care, with prospective adopters, kinship care (where they are placed with friends or relatives) or residential accommodation.

In 2022, the most common open placement was with foster carers or prospective adopters (Figure 81). The number of looked after children placed at home or in other community placements decreased in 2022. Around 16 percent of placements are in residential accommodation.

Figure 81: Number of looked after children by type of placement in Highland, 2017 to 2022

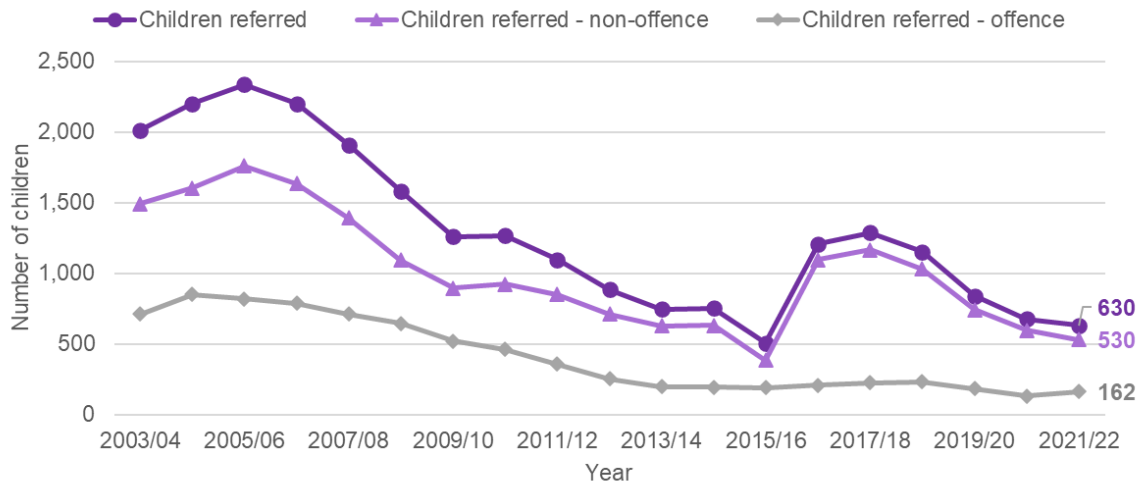


Source: Scottish Government Children's Social Work Statistics
Data for 2022 are provisional and subject to change.

10.2. Scottish Children's Reporter Administration

The Scottish Children's Reporter Administration (SCRA) receives referrals for at-risk children. In Highland, 630 children were referred to the SCRA in 2021/22. Three in four referrals (77 percent) were on care and protection (non-offence) grounds (Figure 83). A small number of children were referred to the Reporter on both non-offence and offence grounds.

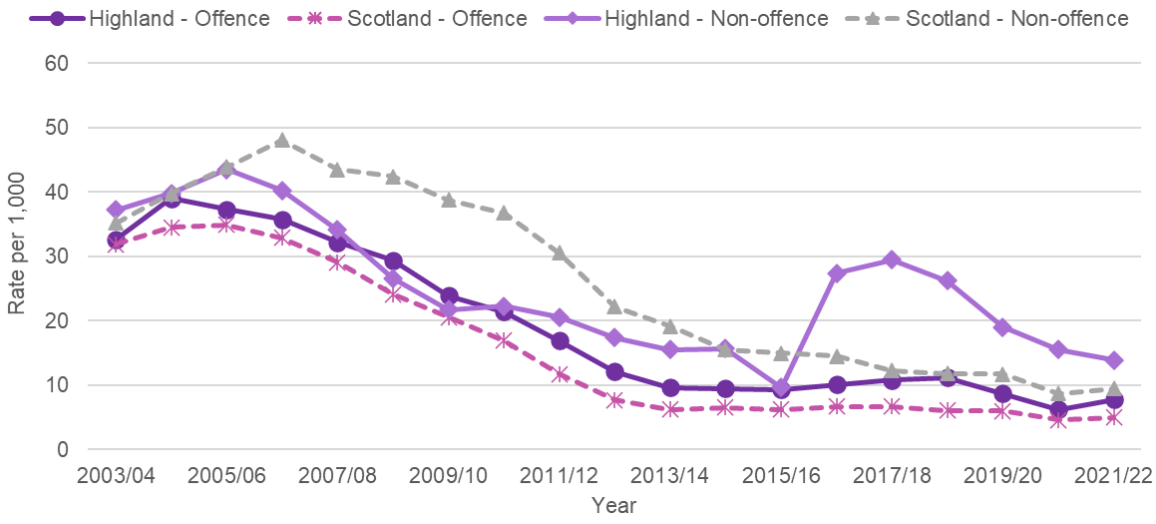
Figure 82: Children referred to the SCRA by referral type in Highland and Scotland



Source: Scottish Children's Reporter Administration (SCRA) Online Statistical Dashboard

Referral rates to the SCRA have decreased since 2003/04, except for an increase in referrals for care and protection in Highland from 2016/17 to 2018/19 (Figure 83). The reasons for the trends in referrals to the SCRA are a complex combination of changes in legislation, changes within the Children's Hearings System, changes in guidance and changes arising from the implementation of Getting it Right for Every Child (GIRFEC).

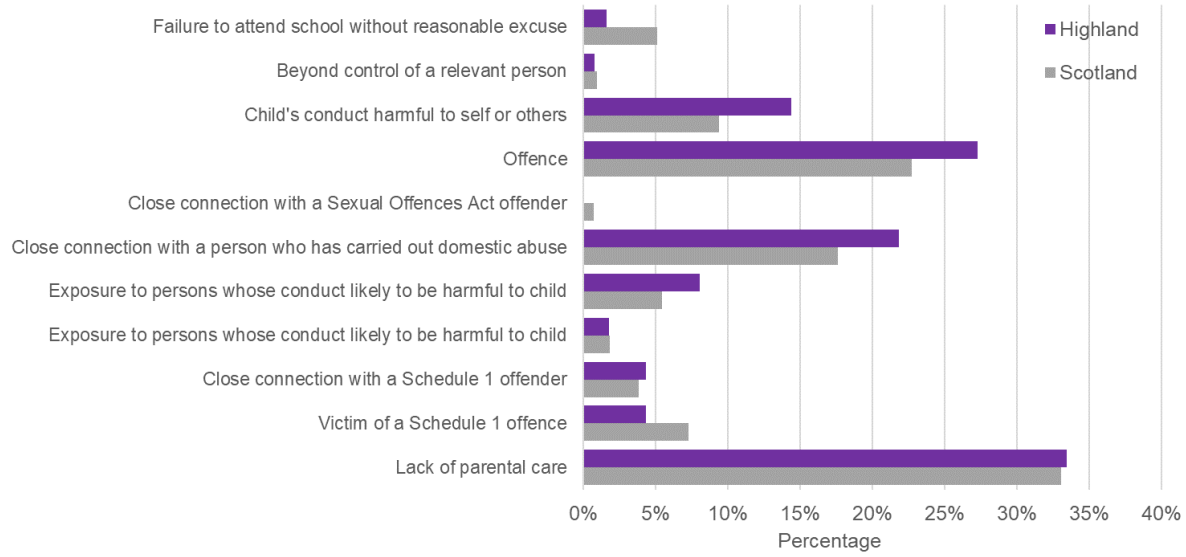
Figure 83: Rate of referrals to the SCRA by referral type in Highland and Scotland



Source: Scottish Children's Reporter Administration (SCRA) Online Statistical Dashboard
Non-offence: Rate per 1,000 population aged under 16 years
Offence: Rate per 1,000 population aged between 8 and 16 years

In 2021/22, the most common ground assigned by Reporters to children referred was lack of parental care, followed by offence, close connection with a person who has carried out domestic abuse and child's conduct harmful to self or others (Figure 84). The police were the main source of referrals to the SCRA. In Highland, 88 compulsory supervision orders (CSOs) were made as a result of children's hearings in 2021/22.

Figure 84: Grounds for referral to the SCRA in Highland and Scotland, 2021/22

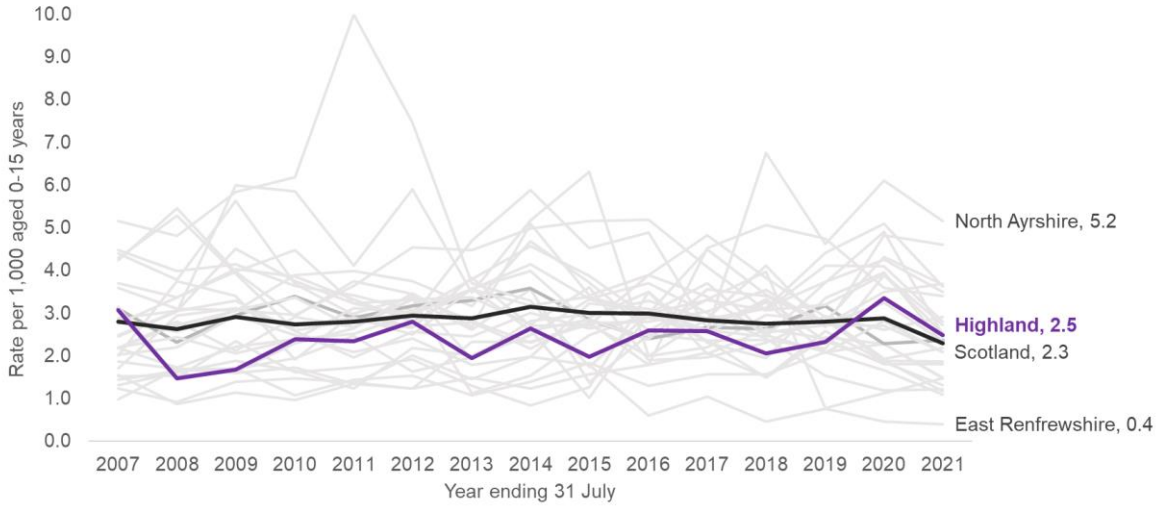


Source: Scottish Children's Reporter Administration (SCRA) Online Statistical Dashboard

10.3. Child Protection

In Highland, there were 96 children on the child protection register on 31 July 2021, a rate of 2.5 per 1,000 children aged 0-15 years. The rate of child protection registrations in Highland shows variability from year to year due to the small number of children involved. The rate of child protection registrations in Highland was not significantly different to Scotland in 2021 (Figure 85).

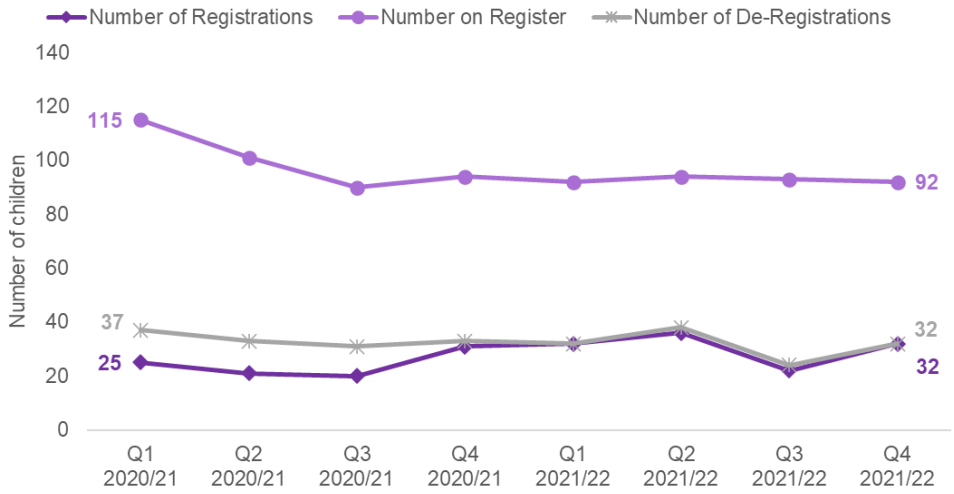
Figure 85: Children on the child protection register by Council area, rate per 1,000 children under 16 years



Source: Scottish Government Children's Social Work Statistics, Table 2.4
Excludes Na h-Eileanan Siar, Orkney Islands and Shetland Islands

Quarterly data presented to the Highland Child Protection Committee shows registrations have been steady since the end of initial lockdown restrictions in 2020 when the number of children on the register was at its highest. At the end of the reporting period, there were 92 children on the child protection register in Highland (Figure 86).

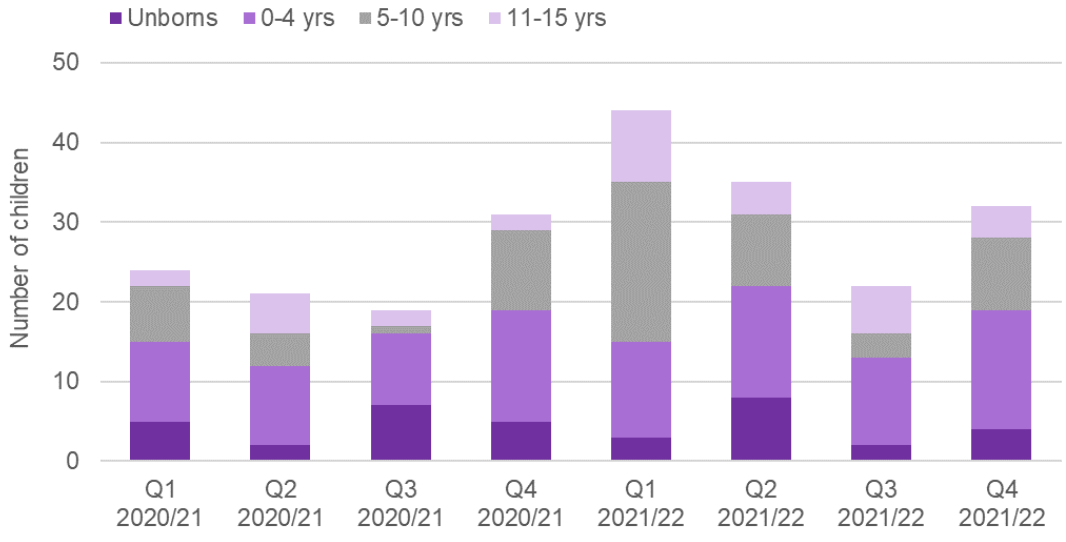
Figure 86: Child protection registrations, de-registration's and register size by quarter, Highland



Source: Highland Council Social Work IT System

Most children on the child protection register in the two-year period 2020/21 and 2021/22 were aged ten years or below (Figure 87). There is variation in the number of registrations in each age category by quarter. There was a slight increase in registrations in the 5-10 and 11-15 age groups in 2021/22. The numbers involved are low overall and would require audit work to understand.

Figure 87: Percentage of children on the Child Protection Register in Highland by age and quarter, 2020/21 to 2021/22



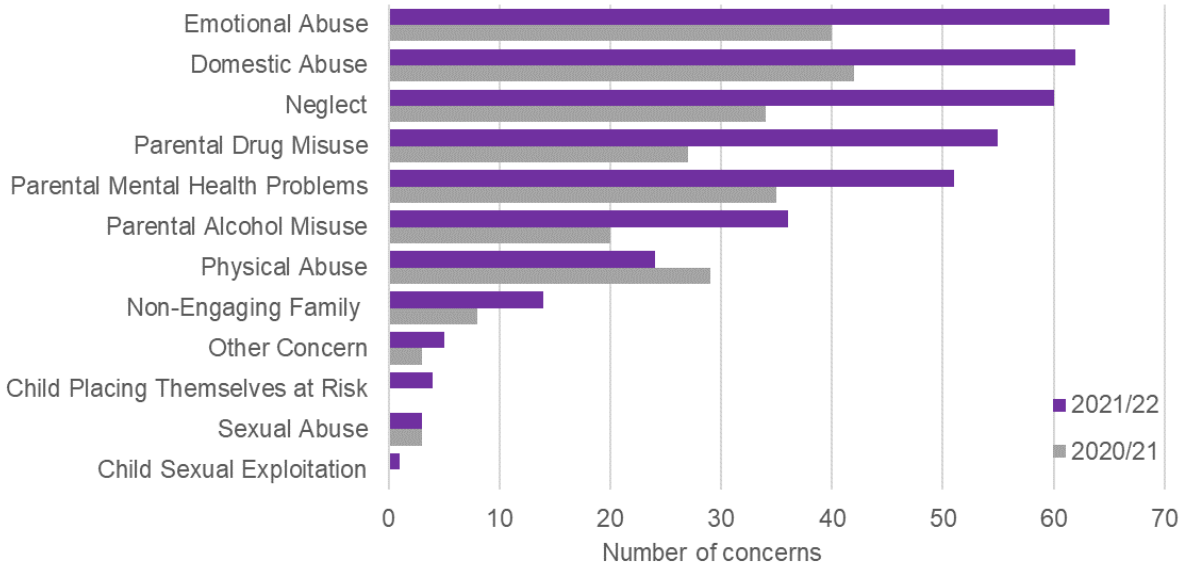
Source: Highland Council Social Work IT System
Age 16-17 years not shown due to small numbers <5

In total, 380 concerns were identified in child protection registrations in 2021/22. Of the concerns identified, the most common were emotional abuse, domestic abuse, neglect, parental drug misuse and parental mental health problems (Figure 88).

Parental factors accounted for most registrations in 2021/22, which increased compared to 2020/21. Registrations as a result of physical and sexual abuse remained at similar levels. The concerns of 'Children placing themselves at risk', 'Child Sexual Exploitation' and 'Other concern' have increased. The numbers involved remain low but may indicate an increasing number of at-risk children within the community.

The total number of concerns identified increased from 248 in 2020/21 to 380 in 2021/22. The increasing number of risks supports practitioner thinking that cases are becoming more complex. Audit work in 2022/23 will enable a more comprehensive look at case complexity.

Figure 88: Concerns identified in child protection registrations in Highland, 2020/21 and 2021/22



Source: Highland Council Social Work IT System

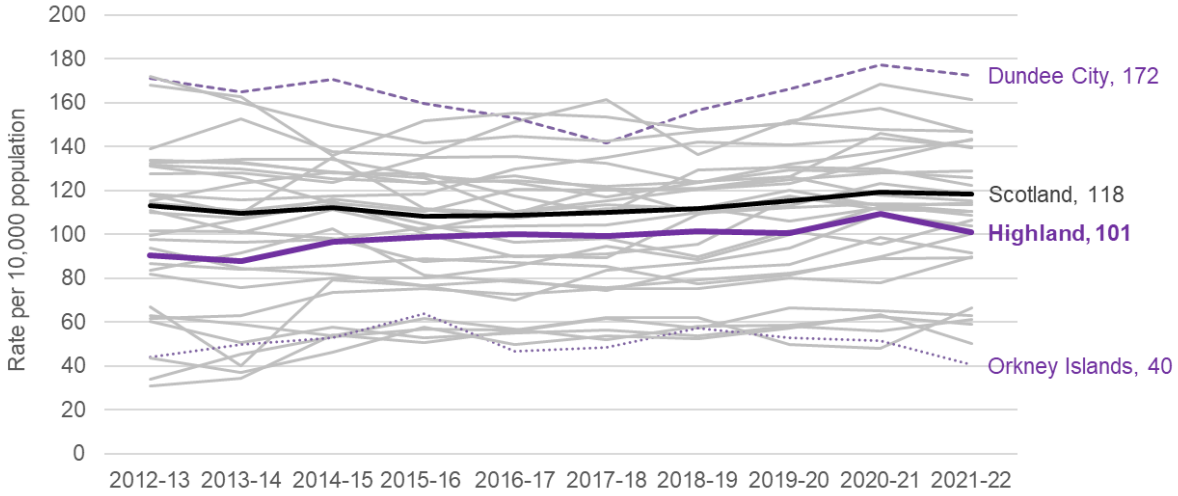
10.4. Gender based violence

A child witnessing domestic abuse is an adverse experience that impacts many childhood outcomes, including mental health problems, the ability to concentrate and socialise, and educational outcomes below the child's potential.

In 2021-22, the police recorded 2,401 domestic abuse incidents in Highland, a decrease of 7 percent compared to 2,576 incidents the previous year. The reported data are likely to be a considerable underestimate of the true extent of the issue. Rates of recorded domestic abuse

are consistently lower in Highland than in Scotland, though they have increased since 2013-14 (Figure 89).

Figure 89: Rate of incidents of domestic abuse recorded by the police per 10,000 population, by local authority, 2012-13 to 2021-22

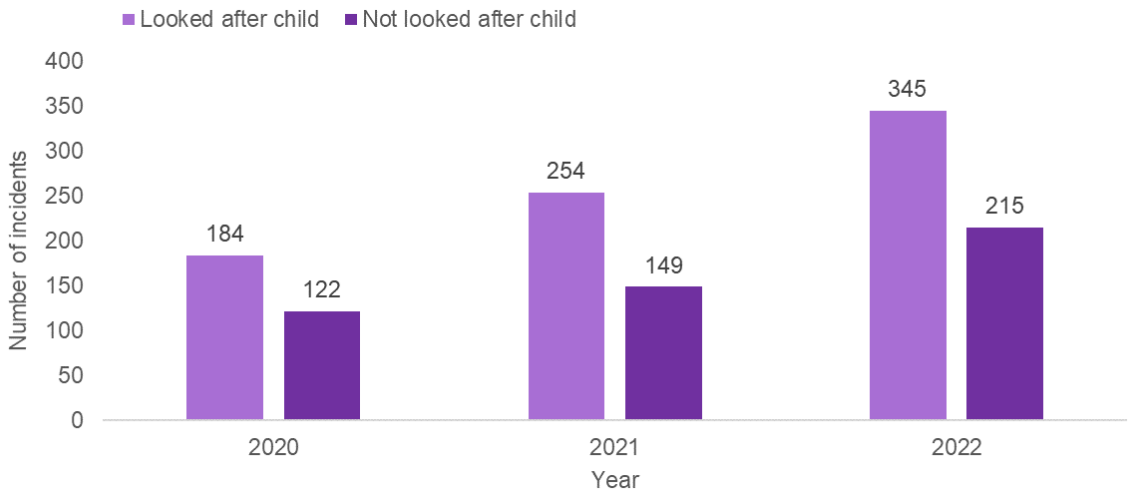


Source: Scottish Government, Domestic abuse recorded by the police in Scotland statistics

10.5. Children missing from home

Police Scotland recorded 1,267 incidents of missing children in Highland in the three-year period 2020 to 2022. Of the recorded incidents, 781 (62 percent) involved looked after children. The number of incidents reported increased in 2022 compared to 2020 and 2021. The numbers reported in 2020 and 2021 are likely affected by periods of lockdown enforced during COVID-19 restrictions (Figure 90).

Figure 90: Number of incidents of missing children recorded by the police[1] in Highland, 2020 to 2022



Source: Police Scotland management report
1. Number of police reports not the number of missing children. Children may be reported as missing on multiple occasions and for different time periods.

10.6. Young carers

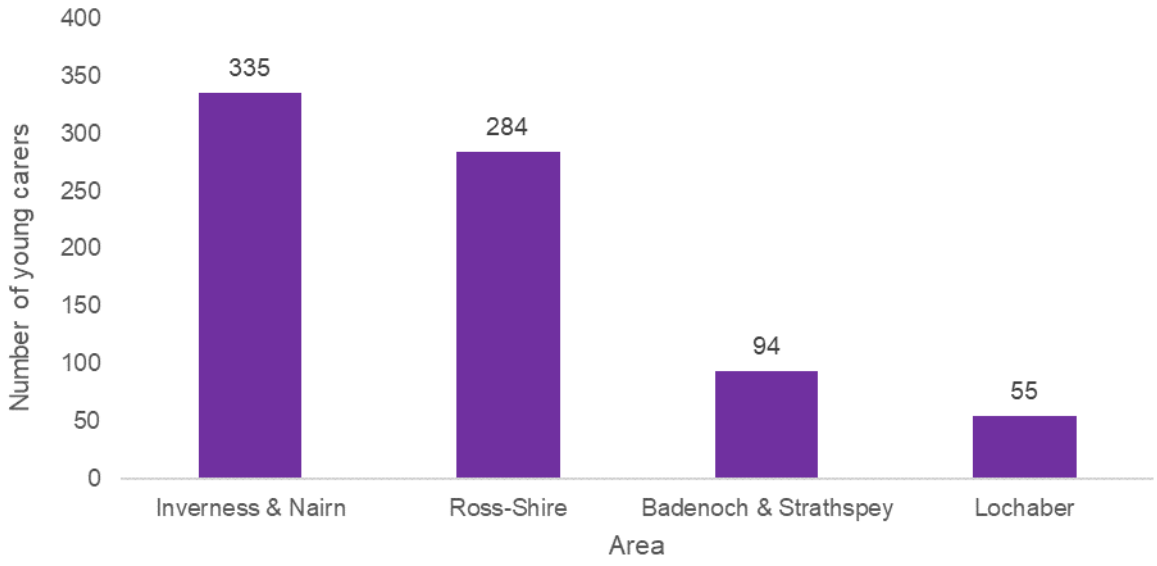
Young carers are those who provide care, assistance or support to family members, friends, neighbours or others because of either long term physical or mental ill health, disability or problems related to old age. The Carers (Scotland) Act 2016 defines young carers as those aged under 18 or who are aged 18 and a pupil at school[58]. The local authority is responsible for identifying young carers in schools in the area.

Evidence suggests that young carers struggle with their everyday lives due to many distinct factors that come with carrying out an unpaid caring role[59]. These can include feeling isolated, being bullied, worrying about the cared-for person when they are away from them, low self-esteem, anxiousness, and feeling tired. All these factors can impact on their mental health, physical health, attendance in school, and their behaviours. By identifying young carers early, they will be given the best possible chance of succeeding in school.

In April 2023, the Highland Lifestyle Survey completed by pupils in P7, S2 and S4 indicated that 9.2 percent of pupils identified themselves as a young carer. Two thirds (68.4 percent) of young carers reported they care for one person, 18.1 percent care for two people and 10.5 percent care for three or more people. The majority of pupils (71.4 percent) who are young carers reported they receive support to help with their caring.

Connecting Young Carers is funded by the Highland Council to provide information, support and respite to young carers in Highland. Young carers referred to the service can access social groups, events, funding, and supportive relationships. In April 2023 there were 768 young carers registered with the service across four areas in Highland (Figure 91).

Figure 91: Number of young carers supported by Connecting Young Carers in Highland, April 2023



Source: Connecting Young Carers management report

10.7. Children with Exceptional Healthcare Needs

Children with Exceptional Healthcare Needs (CEN) is a National Managed Clinical Network to strengthen specialist services for children with complex and exceptional healthcare needs in Scotland.

A child or young person (up to the age of 19) is defined as having exceptional healthcare needs if they:

- have severe impairment recorded in at least four categories together with enteral/ parenteral feeding
  OR
- have severe impairment recorded in at least two categories and require ventilation/CPAP
  AND
- the impairments are sustained and ongoing or expected to last more than six months.

The CEN assessment criteria use six impairment categories for assessing needs: learning and mental functions, communication, motor skills, self-care, hearing, and vision.

In January 2023, 42 children and young people met these criteria in Highland. In addition, many children have chronic and long-term health needs that do not meet the CEN criteria. For instance, 63 children and young people were supported with enteral feeding in January 2023.

10.8. Child deaths

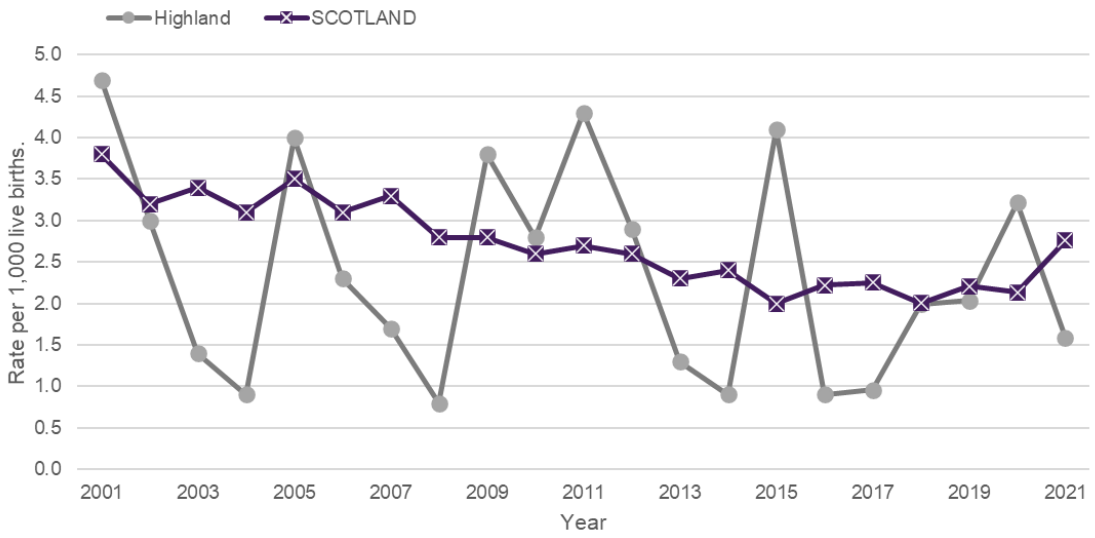
Most deaths during childhood occur during the first year of life, particularly in the first month of life (the neonatal period). Neonatal mortality accounts for about 70 to 80 percent of infant deaths.

Most neonatal deaths are from perinatal causes, particularly preterm births, and are closely related to maternal health and congenital conditions, which disproportionately affect the most disadvantaged in society.

Nationally infant mortality rates have declined, but in more recent years, the downward trend appears to flatten with an increase in the rate in 2021 (Figure 92). Pre-pandemic evidence highlights that from 2016, Scotland's most deprived quintile had already experienced rising infant and neonatal mortality trends[60].

A lack of improvement in this international sentinel indicator should be viewed as a health warning for society.

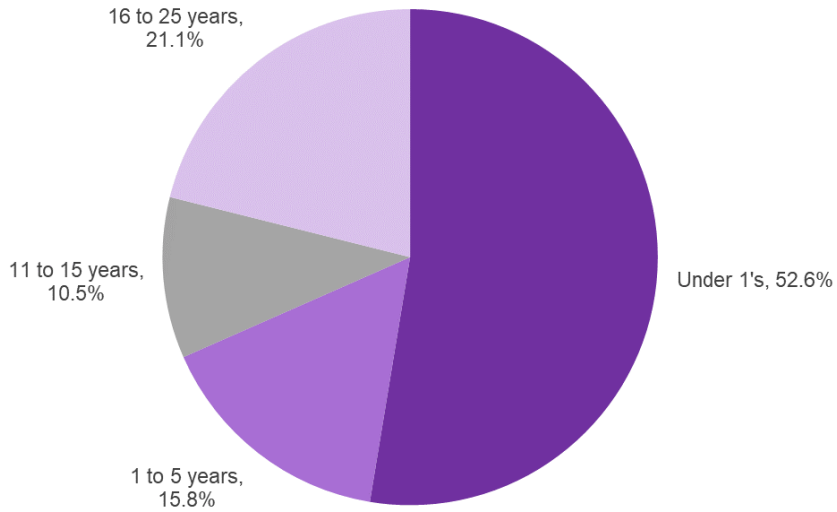
Figure 92: Infant mortality rates per 1,000 live births in Highland and Scotland



Source: National Record of Scotland Vital Events, Table 1.3

In 2021, a child death review panel was set up in NHS Highland to review the deaths of all live-born children up to their 18th birthday or 26th birthday for care leavers receiving aftercare or continuing care at the time of their death. In the year to September 2022, 20 deaths met these criteria (Figure 93).

Figure 93: Age of infant, children and young people's deaths meeting child death review criteria



Source: National Records of Scotland, NHS Highland Child Deaths Review team

The wider understanding and systematic learning from child deaths should be used to inform service delivery improvements and identify emerging trends that could influence the wider child service strategy. Key learning from the first year of the child death review process includes the need for support to die at home, understanding of the care experience and family involvement.

11. Conclusions

This needs assessment summarises outcome data for children and young people in the Highland local authority area. A rapid review of this type cannot provide a complete picture of the population needs of children and young people. It highlights key points to help inform the planning and improvement of integrated children's services in Highland.

The following main points are identified:

- Highland has a declining population of children and young people. Population projections forecast a continued reduction in the size of the population of children and young people.
- Highland has a significant remote and rural geography and a high proportion of areas in the most access deprived in Scotland. One in three children and young people under 18 reside in remote rural areas.
- The provision of services across the Highland geography is challenging. Statutory services, third sector organisations and other community groups should work collaboratively to improve the outcomes of Highland's children and young people.
- In Highland, most income deprived people live in places not identified among the most deprived areas by the SIMD. The distribution of income deprivation is a significant consideration for policy, strategy and the spatial targeting of resources.
- Tackling child poverty is a national priority. It is a complex task to measure child poverty, particularly in rural areas, accurately. Work should be undertaken to improve data sources that provide detail at a local level.
- Adverse childhood experiences are associated with poor educational, social, physical and mental health outcomes. Risk factors for childhood adversity are often co-occurring and interlinked. Actions identified should recognise the importance of different approaches and the connections between risk factors.
- There have been decreasing numbers of births in Highland, and this pattern of decreasing birth numbers is expected to continue.
- Teenage pregnancies have fallen markedly, but this long-standing national priority has room for further improvement.
- Recording and reporting complex social factors and vulnerabilities in the maternity record are essential. Data capture about vulnerable women should continue to be improved.
- Preventative activity pre-conception and in pregnancy should be strengthened, and prevention explicitly considered as a part of service and pathway design or redesign.

- Identifying early child development problems is essential for understanding individual and collective developmental support needs. Early identification gives the best opportunity to support children and families to improve outcomes.
- There is strong evidence that breastfeeding is one of the most preventative health measures for children and mothers, with short-term and long-term benefits. Actions to improve breastfeeding uptake should be prioritised.
- Immunisation programmes for children are effective at protecting children from serious infectious diseases. There is a need to promote and improve the uptake of childhood vaccination.
- There is need to support children and young people to maintain a healthy weight throughout childhood.
- Oral health improvement activities should continue with work to prevent dental caries in children, focusing on initiatives to reduce oral health inequalities.
- Preventing harm from substance use among young people is a long-standing national and local priority. Evidence informed work to prevent and delay alcohol, tobacco and other drug use among young people should be prioritised.
- Children and young people's mental health and emotional wellbeing is a concern. Actions should ensure children and families receive support and services appropriate to their needs, including access to specialist CAMHS services.
- Schools should continue focused work to improve attendance, support children and young people with additional support for learning needs and promote inclusion.
- All children and young people should be supported to fulfil their potential through educational attainment and positive destinations upon leaving school.
- Processes to identify and support children and young people at risk of harm must continue to be improved.
- Learning from child death reviews should inform service delivery improvements and identify emerging trends that could influence the wider children's service strategy.

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Highland Community Planning Partnership | Com-pàirteachas Dealbhadh Coimhearsnachd na Gàidhealtachd

Highland Children's Service Plan 2023 - 2026

Plana Sheirbheisean Chloinne Amalaichte na Gàidhealtachd 2023 -2026

Geography

Highland covers a third of the land area of Scotland, including the most remote and sparsely populated parts of the United Kingdom. The Highlands has the 7th highest population of the 32 authorities in Scotland (235,540) while having the lowest population density at 8 persons per square kilometre.

The total land area including all islands at low water is 26,484 square kilometres. This is 33 per cent the land area of Scotland and 11.4 per cent of Great Britain. It is 10 times larger than Luxembourg, 20 per cent larger than Wales, and nearly the size of Belgium.

Our Partnership

Highland Community Planning Partnership | Com-pàirteachas Dealbhadh Coimhearsnachd na Gàidhealtachd

The Highland Community Planning Partnership brings together public agencies, third sector organisations and other key community groups to work collaboratively with the people of Highland to deliver better outcomes.

The Highland Community Planning Partnership works strategically at a Highland level, through a series of nine geographical local Community Partnerships as well as regional thematic groups. Ultimately these deliver our Local Outcome Improvement Plan.

The Highland Outcome Improvement Plan sets out the vision, purpose and focus for the Highland Community Planning Partnership from 2017-2027. The five core outcomes have been chosen and agreed upon with communities. The partnership believes working towards these outcomes will have a significant impact on reducing inequalities in Highland.

Highland Children's Service Plan sits within a context of the Community Planning Partnership and the Integrated Children's Service Planning Board, strategically leads the improvement of outcomes for all Highland's Children and Families.

This Plan has been developed in collaboration with public sector bodies and third sector organisations and is informed by both the voice and testimony of children, young people and families and the needs of our communities as articulated through our Joint Strategic Needs Assessment (2023).

This Plan articulates how partners work together to provide services which are organised, equipped to deliver high-quality, joined-up, trauma-informed, responsive and preventative support to children and families.

Our Commitment

Keeping the Promise

We will ensure that all Highland's Children and Young People are Safe, Healthy, Achieving, Nurtured, Loved, Respected and Included.

We will support Highland's families with respect, care and compassion, ensuring their voices are integral to all we do.

We will enable and empower families to thrive and to stay together wherever possible

We will tackle poverty and inequalities and will support and enable families to live and thrive together in their communities

Our Commitments in Practice

Our partnership will reflect our commitment in our:

- Physical settings
- Policies and procedures
- Contact with people who access our services
- Activities and interventions
- Workforce experience

Our Principles

- Our partnership is committed to developing a trauma informed and responsive approach to supporting children, young people and their families.
- We will develop services that are informed and shaped by people with lived experience and place the voice of infants, children, young people and families at the heart of service improvement.
- Our Partnership is committed to upholding the rights of infants, children and young people in ensuring they are protected from prejudice and that every child has the opportunity to grow up to maximise their full potential.
- We will strive to uphold the United Nations Convention on the Rights of the Child (UNCRC). This is the global “gold standard” for children’s rights. It sets out the rights that all children have to help them to “be all they can be”. They include rights relating to health, education, leisure, play, fair and equal treatment, protection from exploitation and the right to be heard.

In order to fully understand the needs of our children, young people and families in Highland, and to strategically inform Integrated Children's Service Planning, in 2023 our partnership undertook a Joint Strategic Needs Assessment. Continually assessing and analysis Highland need will be integral to our future planning, ensuring we are data informed and evidenced based in our approach to reshaping service for Highland which meet the needs of the present and set us on a path to improve the outcomes for the future. The full JSNA can be found here

Our Joint Strategic Needs Assessment 2023 Key findings

Around 2% of children under 15 have a Child Protection Plan and 0.9% of Highlands Children are care experienced.

1 in 3 children under the age of 18 live in remote and rural areas

1 in 5 children are affected by poverty

34% of infants are breastfed to at least 8 weeks offering them the best start in life

Highland teenage pregnancies have fallen however preventative activity pre-conception and during pregnancy needs to be strengthened

In our 2021 Lifestyle Survey 70% of young people felt their wellbeing needs were being met through the GIRFEC approach

In our 2021 Lifestyle Survey 30% of young people did not feel they were achieving to their potential

73.5% of children measured starting Primary 1 had a healthy BMI.

75% of referrals to CAMHS are for young people between 12 and 17 years.

In 2021 43% of children were identified as having an additional support for learning needs.

There is an increase in the number of infants with developmental concerns recorded at the 27 month health visitor check

Need to strengthen pre-conception and antenatal support where 11.2% per 1000 maternity cases were using drugs during pregnancy.

46.8% of young people leave school to higher or further education with 43.7% to employment.

Our Joint Strategic Needs Assessment 2023 Summary Analysis

Our Joint Strategic Needs Assessment tells us

- Many of our families are suffering the physical, social, emotional and developmental impacts of the pandemic. Our supports need to be reshaped to meet the need of the present and to be sustainable into the future
- Our focus need to be on early protection, prevention and intervention and to empower whole families to be resilient, self-sustaining and healthy
- Some of our families are living in poverty, one of the most significant determinant of health and wellbeing outcomes
- Our support to care experienced children and young people, and those at risk of harm, needs to be flexible, trauma informed recognising the impact of adverse childhood experience.
- The mental health and wellbeing of our children and young people is under pressure and we need to take a whole system approach to ensuring staged support is available and accessible for all children and young people when they need it.
- Our services need to be delivered in a more local, collaborative and coordinated way to ensure access to support, particularly in remote and rural Highland
- Our services and supports need to be inclusive of the needs of families with protected characteristics
- Outcomes are better for families when they are supported to stay together wherever it is safe to do so

The Voice and Participation of Children and Young People

Our Partnership recognises the necessity for greater active participation of children, young people and families in all aspects of planning and service delivery.

There requires to be a culture shift which secures the Voice and testimony of Highland's families at each place and stage of planning across the whole system.

Through listening to our families, across the lifetime of this plan we will develop a whole system strategy to support the culture change needed, for the benefit of Highland's children, young people and their families.

What is participation?	Participation is the meaningful involvement of children and young people in decision making and planning. Participation takes many forms but must always be inclusive, ensuring that the voices of all children and young people - no matter the challenges they face in their lives - are raised, heard and acted upon.
Why will we take an active participation approach to improving outcome for Highland's families?	We believe that Highland families know what their own and the needs of their communities are. CYP participation is a fundamental human right. Article 12 of the UNCRC states that CYP have the right to be listened to and taken seriously in decision making processes and given all the information they need to form their opinions. With the incorporation of UNCRC into Scots law, we have an obligation to ensure that CYP becomes part of policy and practice in Highland.
How will we make the change?	We will develop our CYP Participation Strategy with associated Implementation Plan is underway and will be completed during year one of ICSP 23 – 26. The participation strategy will be dovetailed with the priorities as set out by the Rights and Participation Improvement Group, embedding participation in practice will be a commitment across all themes in the ICSP.
How will we know we've made a difference?	The Implementation Group will be tasked with coordinating and resourcing support for implementation and will also be responsible for monitoring and evaluating the implementation of CYP participation in practice across the partnership in Highland in 2024 – 26. We will drive forward our plan and evaluate our systems, practices and processes to ensure meaningful participation becomes embedded in all Highland family support.

Integrated Planning
Our Themes

- Poverty
- Child Protection
- Corporate Parenting
- Rights and Participation
- Health and Wellbeing
- Drugs and Alcohol

Our partnership will take a thematic approach to improving outcomes for infants, children, young people and families. These themes have been identified through listening to children, young people and their families and analysis of the data and evidence within The Joint Strategic Needs Assessment (2023).

Priorities have been developed for each of our Integrated Planning Themes and key change ideas articulated within this plan.

In order to deliver on our commitments and planning for Highland families, a number of strategic oversight boards and committees will be accountable for delivery of the priorities and plans using the life course approach. These are:

- Highland's Poverty Group
- Highland's Child Protection Committee
- The Promise Board (Corporate Parenting)
- Highland's Rights and Participation Group
- Highland's Health and Wellbeing Board – including mental health
- Highland Alcohol and Drug Partnership Group

Performance and Outcome Management:
All outcomes within this plan are linked to Highland's Outcome Improve Plan Performance will be measured through the Integrated Children's Service Performance Management Framework and monitored by Highland Integrated Children's Service Planning Board. This Board will provide an annual update to the Community Planning Partnership Board.

GETTING STARTED

GROWING UP

MOVING ON

Our Life Course Approach

Our objective is to improve outcomes for Highland's Infants, Children and Young People through robust integrated planning, local delivery of services and support and by considering the needs of their families across a life course from pre birth to young adulthood.

In taking a life course approach we can more readily identify opportunities to minimise risk and enhance the protective factors through evidence-based interventions.

A life course approach capitalises on the potential to deliver an inter-generational approach to reducing inequalities from generation to generation and improve conditions for daily life.

In this plan we call the period from preconception to school age

GETTING STARTED

The time when children are at Primary School age we call

GROWING UP

The secondary age young people and young adults are considered to be

MOVING ON

Our Priorities
Getting Started: Pre birth – 5 years

Poverty	We will reduce financial barriers on families and mitigate the impact of the cost of living crisis
Child Protection	We will ensure that unborn babies, infants and children in early years get the right help at the right time and are protected and safe
Corporate Parenting	We will honour The Promise by developing a family centred trauma informed approach to support
Rights and Participation	We will ensure children's rights are evident in practice
Health and Wellbeing	We will enable and empower families to good health and develop approaches to codesign support
Drugs and Alcohol	We will develop a whole family approach to drugs and alcohol which effectively recognises and support parents, unborn infants and babies affected by drugs and alcohol

Our Priorities
Growing Up: Primary Years

Poverty	We will reduce financial barriers on families and close the poverty related attainment gap
Child Protection	We will support the development of prevention and early intervention approaches to protect children through their primary years
Corporate Parenting	We will ensure Whole Family Support to ensure all Highland's Children are supported in their local community, to stay with their families wherever possible
Rights and Participation	We will ensure children's rights are evident in practice
Health and Wellbeing	We will support a whole family, whole community, whole system approach to improving the health and wellbeing and develop our partnership workforce in mental health and wellbeing.
Drugs and Alcohol	We will revise and improve the programme of substance use education and prevention in schools and wider settings to ensure it is good quality, impactful and in line with best practice

Our Priorities
Moving on: secondary to young adulthood

Poverty	We will reduce financial barriers on families and mitigate the cost of living crisis
Child Protection	We will ensure young people are protected and their needs and voices are considered particularly those at risk from community harm.
Corporate Parenting	We will ensure there is robust support for care experienced young people to move into adulthood
Rights and Participation	We will ensure children's rights are evident in practice
Health and Wellbeing	We will enable empower and support healthy choices for young adults particularly supporting self management of their own mental health and wellbeing
Drugs and Alcohol	We will support early intervention amongst young people who are at higher risk of developing problem alcohol and drug use due

Integrated Children's Service
Alcohol and Drug Partnership Delivery Plan

Getting Started

Growing up

Moving on

Priority: We will develop a whole family approach to drugs and alcohol which effectively recognises and support parents, unborn infants and babies affected by drugs and alcohol	**Priority: We will revise and improve the programme of substance use education and prevention in schools and wider settings to ensure it is good quality, impactful and in line with best practice**	**Priority: We will support early intervention amongst young people who are at higher risk of developing problem alcohol and drug use due**
Change Idea	**Change Idea**	**Change Idea**
Develop policy and increase awareness across Highland re FASD	Develop the Highland Prevention and Intervention Model and pilot elements of the Icelandic Prevention Mode	Strengthen treatment and support services for young people affected by their own or another's alcohol or drug problem
Develop pre conception information supports	Increase access via the H-SAT to quality and evidence based online resources for young people, parents and professionals	Develop opportunities to support culture change within schools and communities through active sport, nutrition and lifestyle healthy choice
Provide additional support to antenatal care through specialist midwifery D&A post	Develop the role of Highland's Advanced Nurse (Schools) to support Drugs and Alcohol	Develop assertive outreach approach for schools and communities in need

Integrated Children's Service
Child Protection Delivery Plan

Getting Started

Growing up

Moving on

Priority: We will ensure child protection practice is of a high standard and keeps unborn babies and infants in their early years safe from harm.	**Priority: We will develop prevention and early intervention opportunities to protect all children**	**Priority: We will ensure the needs of older children and young people are met, particularly those at risk of Community Harm**
Change Idea	**Change Idea**	**Change Idea**
Review the Child Protection Assessment and Planning Process	Scope, develop and deliver abuse prevention work in Highland	Develop new approach for those involved with Youth Justice Support and at risk of Community Harm
Develop approaches which enable the wider family to be more involved in the child protection planning process	Co-produce child protection materials with children and young people	Ensure the workforce is competent and confident in responding to the needs of older children within the child protection process
Ensure the voices of children in their early years are heard as part of the child protection process	Support the development and roll out of early intervention projects	Strengthen the links between child and adult support and protection, ensuring processes are dovetailed and families and communities remain safe

Integrated Children's Service
Health and Wellbeing Delivery Plan

Getting Started

Growing up

Moving on

Priority: We will enable and empower families to good health.	**Priority: We will support the development of a whole family approach to health and wellbeing**	**Priority: We will enable, empower and support healthy choices for young adults**
Change Idea	**Change Idea**	**Change Idea**
Embed our financial inclusion pathways across Highland	Refocus roles to provide targeted support to support health and wellbeing	Develop early intervention to health and wellbeing initiates in schools
Develop our workforce in the use of alternative methods of listening to the voice of infants	Refresh Highland's Supporting Parents Strategy	Develop the workforce through establishing core health and wellbeing learning
Develop mechanism which ensure the identification of need at key points of transition	Develop Highland's play strategy	Develop health and wellbeing outreach initiatives for young people out of mainstream school and/or interrupted learners or hard to reach groups

Integrated Children's Service
Health and Wellbeing (Mental Health) Delivery Plan

Getting Started

Growing up

Moving on

Priority: We will develop approaches to codesign support and interventions with families	**Priority: We will support the learning of our workforce in mental health and wellbeing**	**Priority: We will support young people to self manage their mental health and wellbeing**
Change Idea	**Change Idea**	**Change Idea**
Mandatory learning for all staff on the impacts of trauma, adverse experience and brain development	Develop a one stop shop, quality evidence based tool kit for mental health	Support staff through additional training to understand the teenage brain with links to emotional literacy and distress.
Develop a programme of support for parents with young children including skill with mental coping strategies	Develop a mental health knowledge and skills framework for staff supporting families in Highland	Co-design initiatives and interventions with young people which enable ongoing conversations about mental health
Develop the pathways for onward support for families in private nurseries, playgroups and early years settings	Refresh and implement the positive relationships guidance in schools	Create a champion model for mental health for highland

Integrated Children's Service
Promise Board Delivery Plan

Getting Started

Growing up

Moving on

Priority: We will develop Whole Family Support for our families who experience care	**Priority: We will ensure there is good support for experienced children to thrive in their childhood**	**Priority: We will ensure there is good planning for young people as they move into adulthood**
Change Idea	**Change Idea**	**Change Idea**
Develop relationships across the partnership between the workforce, children, young people and families.	Develop a shared trauma informed approach across the partnership	Develop single point of contact support for care experienced young people moving into their new home
Empower families through family group decision making	Promote, extend and evaluate "Better Meetings" The practitioners guide.	Improve support at time of transition to further and higher education or employment
Develop imaginative and varied support and prevention for mental health for care experienced infants and families	Develop the Promise ambassador approach across the partnership	Improve partnership working to enable trusted relationships through HECM Model

Integrated Children's Service
Rights and Participation Delivery Plan

Getting Started

Growing up

Moving on

Priority: We will ensure rights of unborn babies and infants are protected and evident in practice	**Priority: We will ensure rights of children are protected and evident in practice**	**Priority: We will ensure rights of young people are protected and evident in practice**
Change Idea	**Change Idea**	**Change Idea**
Implement the Voice of the Infant Best Practice Guidelines and Infant Pledge	Embed children's rights in the curriculum with diversity through picture books, gender bias, decolonisation and differentiation	Track the improvement in views being listened to through the Highland Lifestyle Survey
Support infant's rights through a play strategy and early years pedagogy	Support practice to ensure children's views are included in all Childs Plans	Support young people to co-design and/or create guidance to further children's rights
Track the recover from covid through developmental data	Ensure all children are involved in policy decisions	Improve access to free period products in schools

Integrated Children's Service Poverty Delivery Plan

Getting Started

Growing up

Moving on

Priority: We will reduce the financial barriers in order to increase participation, raise aspirations and address impact of poverty	**Priority: Mitigate the impact of the cost of living crisis**	**Priority: We will raise attainment and close the poverty related attainment gap**
Change Idea	**Change Idea**	**Change Idea**
Develop flexible models of childcare in rural areas	Increase the uptake of sanitary products in schools	Raise aware of the impact of poverty amongst children and young people
Implement the Whole Family Approach to mitigate the impacts of poverty	Develop system for weekend food support	Roll out the Family First approach
Develop financial inclusion pathways	Roll out the cost of school day tool kit	Identity way to provide targeted support within universal services

A Whole System Approach to Family Wellbeing

Cohesion

Coordination

Collaboration

Through the timeline of this plan, we will develop community scaffolding for our supports through our community-based whole family wellbeing approach.

This programme aims to reduce inequalities and improve the health and wellbeing outcomes of the Highland Population through improving cohesion, co-ordination and collaboration of whole family support within Highland's Communities. Working to the founding principles of this plan, communities will be supported by a partnership programme team to:

- Develop cohesion to local support, robust coordination of planning and close collaboration with all stakeholder across the whole locality
- Identify need, build on successes and develop local initiatives
- Strengthen universal and early supports, being needs led and evidence based

Our partnership recognises through our joint strategic needs assessment, and having listened to the voices of our communities, the impact of the Covid Pandemic on Health and Wellbeing. It also recognises some of the strengths and unique challenges to Highland life. We believe the enablement and empowerment of local solutions across the wider geography of Highland will deliver on the aims and objective of this programme and our overarching Highland Outcome Improvement Plan ensuring that Highland is the best place for families to live and thrive.

Governance

The Integrated Children's Service Planning Partnership Board provides oversight to the on-going work and future development of the plan on behalf of the Highland Community Planning Partnership. The Board is directly accountable to the Community Planning Partnership Board.

In order to ensure a robust partnership approach to governance, assurance and performance management, the Integrated Children's Service Board provides additional reporting to

- The Highland Council, and the NHS Highland Board through The NHS Highland Health and Social Care Committee and The Highland Council Health, Social Care and Wellbeing Committee.
- The Public Protection Chief Officer Group, who undertake their statutory responsibility ensuring that appropriate assurance on the development and progress of the plan is received.
- Highland Child Protection Committee and Highland's Joint Monitoring Committee.

Membership of Highland Integrated Children's Service Board :

- Director of Public Health, NHS Highland
- Board Nurse Director, NHS Highland
- Head of Health Improvement, NHS Highland
- Head of Education, The Highland Council
- Executive Chief Officer Health and Social Care, The Highland Council
- Child Health Lead, The Highland Council
- Head of Operations, Women and Children's Directorate, NHS Highland
- Head of community support and engagement, The Highland Council
- Police Scotland, Partnership Superintendent
- Deputy Chief Officer, Highland Third Sector Interface
- Director of Children and Families (Aberlour Trust)
- Principal Educational Psychologist, The Highland Council
- Lead Officer, Highland Child Protection Committee
- Chief Officer Inspiring Young Voices
- Youth Work Manager, Youth Highland

Agenda Item 3.4

NHS Highland

Meeting:	**Highland Health and Social care Committee**
Meeting date:	**30 August 2023**
Title:	**Winter Planning Readiness**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer**
Report Author:	**Pamela Cremin, Chief Officer**

1 Purpose

This is presented to the Board for:

- Assurance
- Awareness

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.
- Annual Delivery Plan
- Annual Winter Plan
- H&SCP Annual Performance Report
- NHS Highland and The Highland Council Joint Strategic Plan 2024 -2027 which is currently in a communication and engagement process.

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

Highland Partnership is developing its approach to Winter Planning Readiness for 2023/24, learning from previous year's approach to winter planning (2022/23 winter plan approach).

2.2 Background

Winter Planning is a task undertaken by NHS Board and integration authorities and is supported by collaboration, engagement, assessment and learning across Scotland.

Draft Winter Priorities and Actions have been outlined by Scottish Government and these were considered at an NHS Scotland Winter Summit held in Glasgow on 22nd August, which was well attended by a number of NHS Highland employees in key roles across urgent and unscheduled care, scheduled care and strategy and performance roles.

The Board is in planning to be prepared for Winter Planning Readiness for 2023/24 by working collaboratively and learning from across Scotland to maximise planning and resilience for the forthcoming winter period.

A presentation is attached that outlines the learning from winter planning approaches in 2022/2023 and the approach to be taken for Highland Partnership to develop and deliver a robust Winter Plan for 2023/24.

2.3 Assessment

Learning from Winter Planning 2022/23: What went well?

- Agreeing clear cross system priorities that were "mission critical for delivery in advance of winter"
- Ensuring accountability for delivery of key actions cross system with senior MDT leadership to facilitate removal of obstacles to progress
- Introduction of OPEL within Raigmore
- Key priorities being mission critical to delivery of transformational change
- Objectivity through system pressures KPI reporting
- Ring fenced in-patient capacity for frail elderly patients in Acute and Community where complex discharge planning could be facilitated
- Ring fenced mixed speciality in-patient surgical bed capacity
- Professional NMAHP led Integrated working: Discharge without Delay

Recommendations to ensure services best support vulnerable communities and achieve positive outcomes for Winter Planning 2023/24:

- Review of data and intelligence – this has been iterative and ongoing in preparation
- Consider learning from other health boards and integration authorities
- Early identification of workforce requirement and targeted prioritisation / retraining of workforce to meet demand
- Recruitment processes and staffing solutions (incl. Volunteer recruitment and engagement with communities and third sector)

- Realtime data to support decision making
- eHealth / digital solutions
- Refreshed patient pathways to be more people and outcome focussed
- Refresh cross system leadership and management support to better support integrated patient pathways and ways of working – joint SLT Consensus Workshop held 23rd August – Action Plan in development for implementation at pace, aligned to 5 Portfolios:
  - Community Urgent Care
  - Flow Navigation
  - Hospital at Home
  - Front Door Flow
  - Optimising Flow
- Clear and understood escalation procedures across the system.
- Regional and national sharing of solutions and support

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

Moderate Assurance is proposed based on the Assessment outlined above at 2.3.

Action Plan from Joint SLT Consensus Workshop held on 23rd August to be developed and articulated. In progress at the time of report writing.

3 Impact Analysis

3.1 Quality/ Patient Care

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

3.2 Workforce

It will be challenging to deliver a robust Winter Plan given the current workforce challenges in terms of vacancies and the ability to align bank staff and agency workforce to maintain continuity of care and service delivery. A number of mitigation plans are in place: workforce redesign and extended roles; workforce deployment; workforce alignment.

3.3 Financial

Early allocation of winter monies, once confirmed; and early plans for spend to enable recruitment.
Impact of increasing agency staffing costs to maintain continuity of care and service delivery. This is a financial risk in terms of cost containment.

3.4 Risk Assessment/Management

Workforce availability for deployment as outlined above at 3.2.

3.5 Data Protection

No personally identifiable data is required to develop and implement Winter Plan

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed. This is a report on progress and process. Winter Plan 2023/24 is not yet developed.

3.7 Other impacts

Already increasing people in hospitals experiencing delayed discharge. People waiting for care at home services. The reduction in care home beds across the independent care home sector. These aspects will make winter planning challenging to deliver for 2023/24. Early planning and mitigation plans are essential and are being developed at pace.

3.8 Communication, involvement, engagement and consultation

- NHS Board Briefing 23rd May 2023.
- A number of NHS Highland delegates attended the National Winter Summit on 22nd August, held in Glasgow to direct and inform us about Winter Planning and to engage with other Boards and integration authorities on what success looks like and how we can collaborate for success.
- Joint Senior Leadership Teams Consensus Workshop held on 23rd August 2023.

3.9 Route to the Meeting

Agenda planning; Emerging issue.

4 Recommendation

- **Assurance** – To give confidence of Winter Planning Readiness for 2023/24 based on learning from previous years and ongoing analysis of winter planning process to date.
- **Awareness** – For information

4.1 List of appendices

The following appendices are included with this report:

- Appendix 1 Winter Planning Readiness 2023/24

Together Stronger

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"Relationships are so important... good care can't exist without good relationships"

NHS Highland Mental Health and Learning Disability Services

Together We Care
with you, for you

NHS Highland

Contents

Hello!

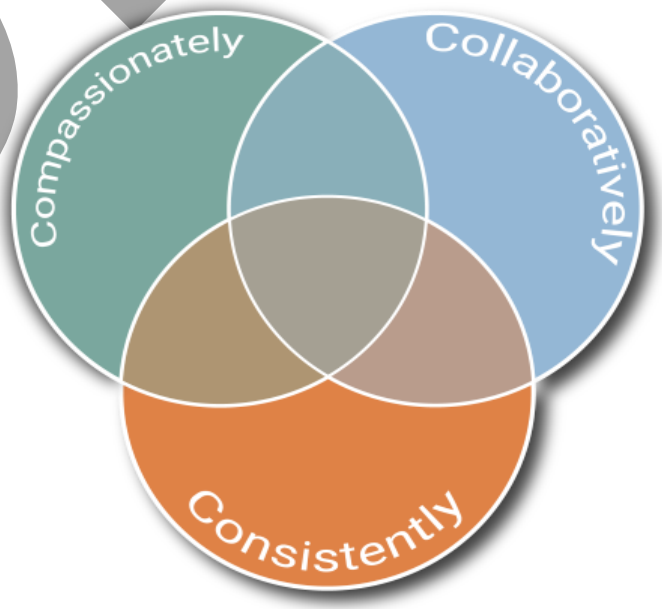
Together Stronger is NHS Highland's approach to delivering Mental Health and Learning Disabilities Services, over the next five years (2023 -2028). It includes all the services and specialities that sit within in the Mental Health & Learning Disability division in the Highland Health and Social Care Partnership (HHSCP).
We talked to a lot of people about what they wanted and needed from Mental Health and Learning Disability services in Highland and recognised that although there are differences relating to what services should be available, there is a shared vision about how services should be experienced by the people involved.
In a world of changing resources and demand, we therefore agreed to create a set of commitments about how we will deliver all of our services. These commitments are there to ensure that people have the best experience that they can, whether that be as an individual receiving care or support, a family member or carer, a member of our workforce or a member of another organisation who interacts with us.

We commit to developing good relationships by working:

Compassionately
by creating relationships based on empathy, respect and dignity

Consistently
by providing high quality services in a fair and equitable way

Collaboratively
by working meaningfully with everyone involved in care equally



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Why
(How and why does this strategy exist?)

The provision of Mental Health & Learning Disability health and social care services across Highland is delivered by a complex network of NHS services, third and independent sector organisations, partners, volunteers, paid / unpaid carers, and those with lived experience.

Together, we must build and develop the care we provide so that there are no gaps in service, no people who cannot access the support they need, when and where they need it. To achieve this, we must build meaningful relationships, where everyone sits around the same table as a valued member and where every voice is listened to equally.

To create this strategy, we engaged with our partners, workforce, carers, communities, and those with lived experience, across our remote and rural geography.

We would like to thank all who engaged with us for their collaboration and for enabling relationships.

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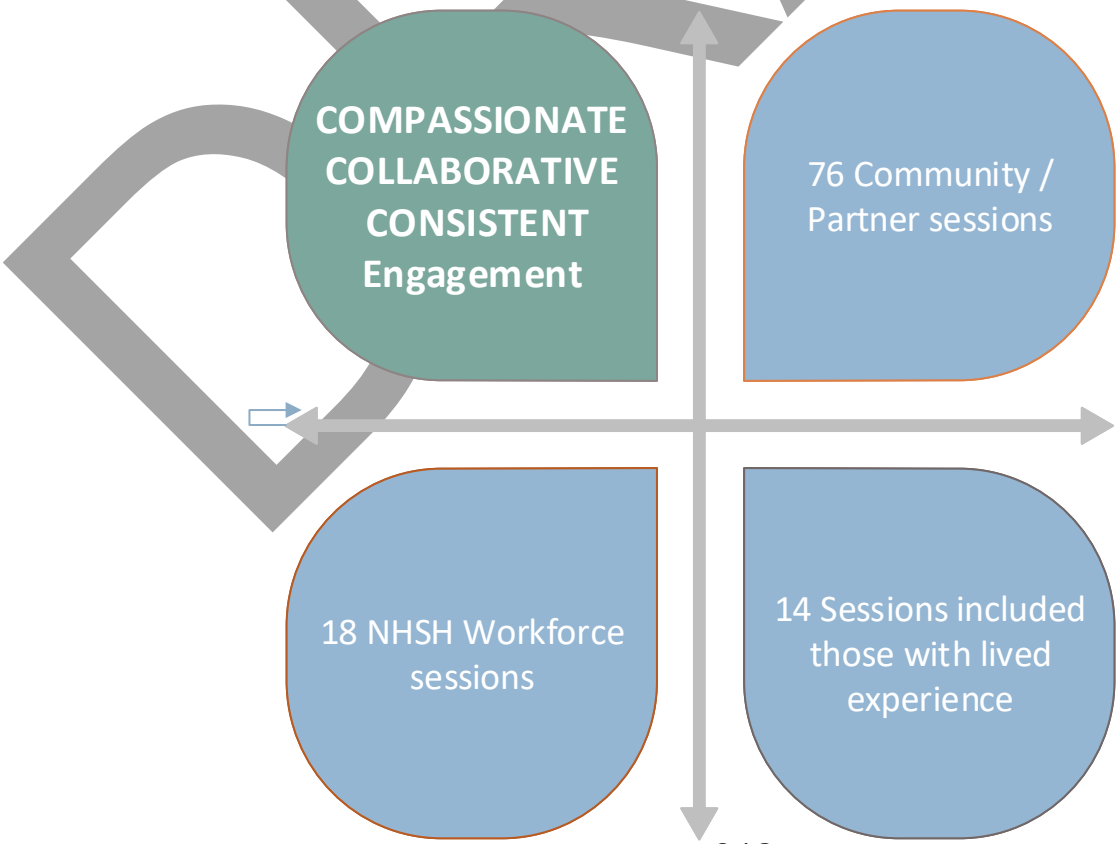

Language
(What do the words we use mean?)

Mental Health

Mental health is a part of our overall health, alongside our physical health. It is what we experience every day, and like physical health, it ebbs and flows daily. Good mental health means we can realise our full potential and feel safe and secure. It also means we thrive in everyday life.

Mental Wellbeing

Mental wellbeing is our internal positive view that we are coping well psychologically with the everyday stresses of life and can work productively and fruitfully. We feel happy and live our lives the way we choose.

Mental Illness

Mental illness is a health condition that affects emotions, thinking and behaviour, which substantially interferes with or limits our life. If left untreated, mental illnesses can significantly impact daily living, including our ability to work, care for family, and relate and interact with others.

Acronyms

We use a few acronyms in this document (we have tried to keep it to a few!). These are:
MH: Adult Mental Health Services
DARS: Drug and Alcohol Recovery Services
OA&D: Older Adult & Dementia Services
LD: Learning Disabilities Services
NC: New Craigs Hospital

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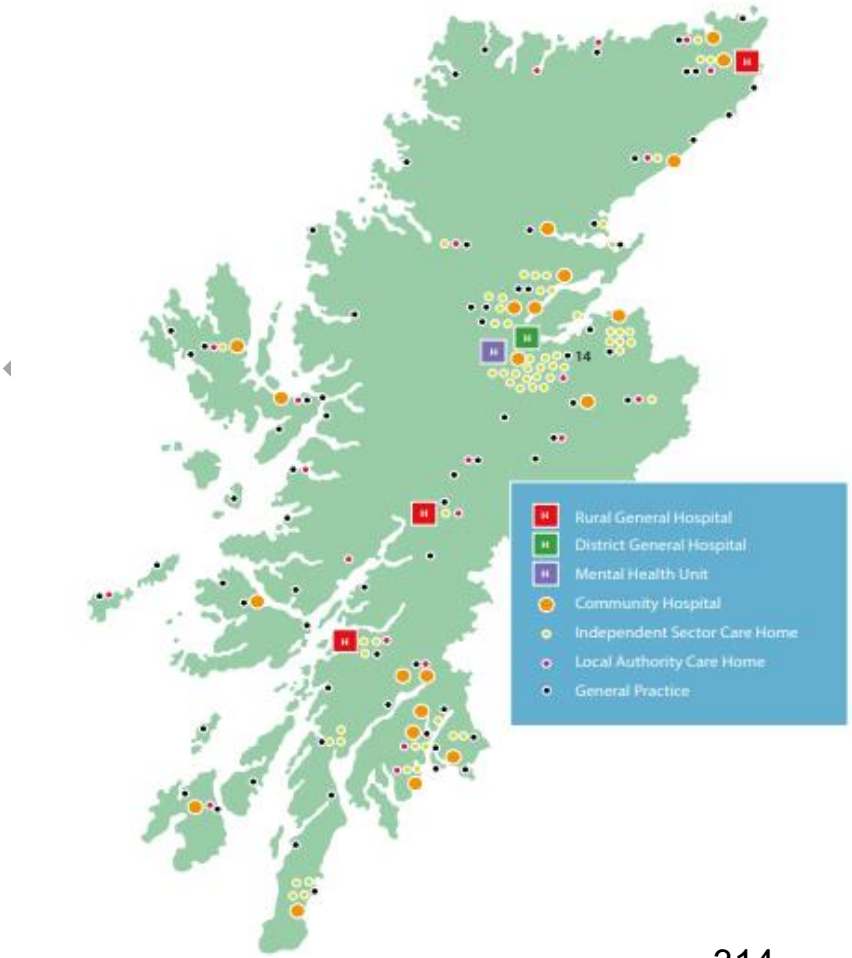
What
(What are the services we provide?)

Our Adult Mental Health and Learning Disabilities services cover a wide range of different services. We work with people over the age of 18 years, who need care both in hospital and community settings.

NHSH Adult Mental Health and Learning Disabilities Services

- Adult Mental Health Services
- Learning Disabilities Services
- Older Adult and Dementia Services
- Drug and Alcohol Recovery Services
- New Craigs In-Patient Services



Our inpatient facilities are based at New Craigs in Inverness, with outpatient facilities in various locations. Our community teams cover all areas of our remote and rural geography. Lots of our services are delivered in partnership with primary care, social care and the voluntary sector.

Who
(Who are we?)

We want to make sure that we have the right people in the right place at the right time, to deliver the health and social care that the people we work with need. We actively recruit to make sure that we can achieve this, and support those staff already in post to develop, grow and achieve their own goals and those of the services. Our Mental Health & Learning Disability Services include:

Community Multi-Disciplinary Teams
Personality Disorder Service
Eating Disorder Service
Highland Adult Autism Assessment Service
ADHD Assessment Pathway
Day Services for Adults with Learning Disabilities
Social Work Transition Team
Social Work Mental Health Team
Mental Health & Learning Disability Specialist Pharmacy Service
Psychological Therapies
Vocational Rehab Service
Centre for Mental Health Recovery
STORM Training Team
Specialist Mental Health & Learning Disability Allied Health Professionals
Business Support and Administrative Teams
Community Multi-Disciplinary Teams
Dementia Stress & Distress Support Team
Forensic Mental Health Team
Mental Health & Wellbeing Primary Care Team
Mental Health Assessment Unit
Perinatal and Infant Mental Health Service
Police Custody and Forensic Medical Services
Prison Healthcare

7% of NHS Highland's employees are employed within the North Highland Mental Health and Learning Disability Services to provide care for our population (thats a total of **727** people!)

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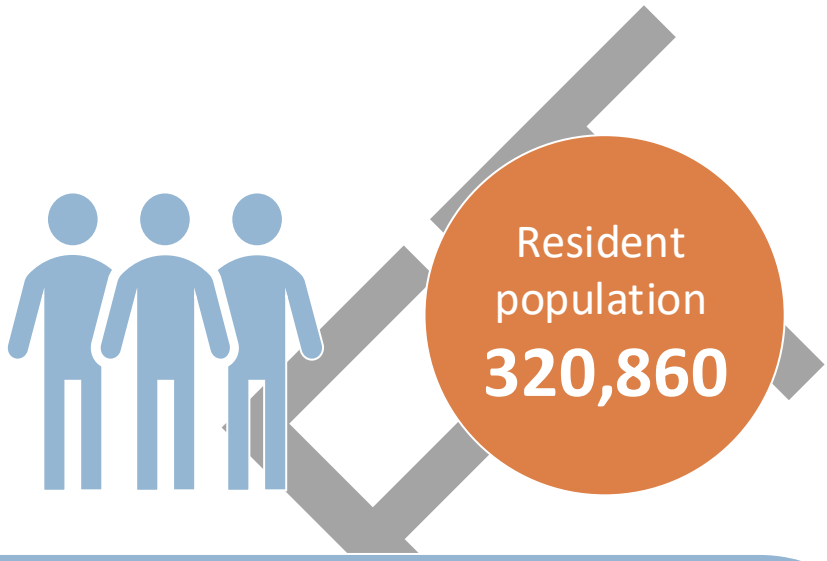
Communities

(What do our communities look like?)

42% of total landmass of Scotland, **8628Km** of coastline



Resident population **320,860**

Over **11,000** adults in Highland live with a mental health condition that requires support from our services.

Over **21,500** adults in Highland live with a mental health condition that does not require support .

Our New Craigs Hospital supported X people last year

Approximately **1600** adults with a learning disability.

Around **1100** of these people live independently.

1 in 12 of those over 65 years have dementia
By 2035 this figure will increase to **1 in 9**

In Highland, 3,733 people with dementia live in their own homes, supported by family, friends or carers.

In 2021 there were **61** alcohol specific deaths. In 2022 there were **42** drug related deaths

Our Drug and Alcohol Recovery service recorded 379 new assessments for people starting specialist alcohol and / or drug treatment last year

Context
(National and local context)

National Context

The services we deliver are guided by a suite of strategies and standards developed by Scottish Government:

Scotland's Mental Health and Wellbeing Strategy
In June 2023 the Scottish Government and COSLA published the long-term vision and approach to improving the mental health and wellbeing of everyone in Scotland. Its vision is **"of a Scotland, free from stigma and inequality, where everyone fulfils their right to achieve the best mental health and wellbeing possible"**. This strategy describes what a highly effective and well-functioning mental health system should look like. It focuses on ensuring that the right support is available, in the right place, at the right time, whenever anyone asks for help.

National Core Mental Health Quality Standards
These standards aim to improve the quality and safety of mental health services across Scotland. They aim to ensure that individuals, families, and carers know what they can expect from mental health services and aim to reduce inequalities in experience and outcomes resulting from unwanted variation in quality of care across Scotland's services. As Scotland's demographics change, further standards will be developed.

Further details of related strategies can be found at the end of this document.

Local Context

One of the strategic objectives of NHS Highland's Board wide strategy, *Together We Care*, is to: "Ensure that both physical and mental health are on an equal footing and reduce stigma by improving access and enabling staff in all services to speak about mental health and wellbeing" (NHS Highland, 2022, P23).

Underpinning this are three priorities:

1. Deliver consistently excellent care that is quality focused, follows best practice, is data driven, efficient, consistent, and supported by the latest digital technologies
2. We will develop integrated local services by working together with local partners to enable people to stay well for longer, help meet growing demand and to coordinate care and prevention
3. We will improve the quality of care delivered to patients receiving enhanced care to support their mental health and develop individualised care planning and the right level of care to those in crisis

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Hearing
(What did we hear?)

We had meaningful conversations with people from across Highland; those who use our services, carers, loved ones, partners, communities and our own workforce. We listened, and the things that you said were most important, focused on service design and relationships. These have been used to create our commitments to you (Page 9 if you want to skip ahead!).

We want to thank everyone who got in touch, everyone who attended the conversation cafes and workshops, our partners, communities, and our colleagues. Without your insight, knowledge, thoughts and opinions, we would not have been able to develop this strategy. We have learned so much from you and promise to continue to develop and grow our relationships as we move forwards together.

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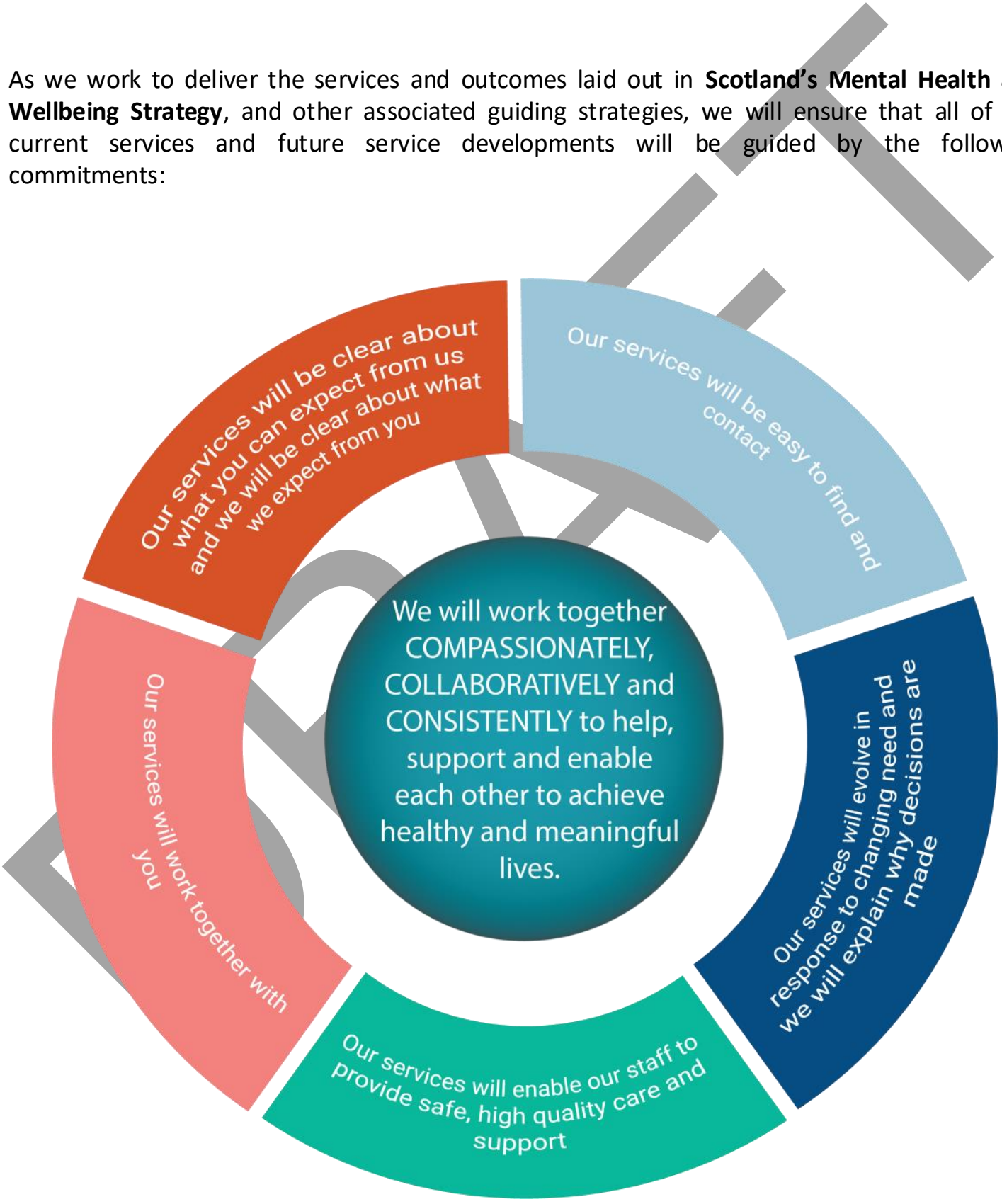
Strategy
(At a glance)

As we work to deliver the services and outcomes laid out in **Scotland's Mental Health and Wellbeing Strategy**, and other associated guiding strategies, we will ensure that all of our current services and future service developments will be guided by the following commitments:



Commitments
(What we will do)

1. Our services will be easy to find and contact
2. Our services will be clear about what you can expect us and we will be clear about what we expect from you
3. Our services will work together with you
4. Our services will enable our staff to provide safe, high quality care and support
5. Our services will evolve in response to changing need and we will explain why decisions are made

1 Our services will be easy to find and contact

Our services should be able to be found by people with no prior knowledge of the system and people should be directed to the service they need by the first person they come into contact with. This is also known as the "no wrong door" principle.

Individuals, their loved ones and carers

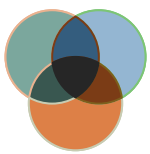
MH	People will be able to access therapy and support in a range of formats including digital or online therapies.
LD	All information will be available in a range of accessible or alternative communication formats. This will include audio, easy read, easy access, Makaton and subtitles.
DARS	All services available to individuals and families affected by alcohol or drug use is available via Highland Alcohol & Drug Partnership (HADP) website: www.highland-adp.org.uk. We will make this information available in other formats too.
OA&D	Access to our services will be straightforward and through a single point of referral. Our contact details will be visible and take you directly to a health or social care team.
New Craigs	New Craigs hospital site will be signposted, fully accessible and user friendly to enable people to find their way about with ease.

NHS Highland

We will continue to grow and develop relationships and pathways between physical and mental health. We will make sure that our workforce understands the role and remit of the Mental Health and Learning Disability services, providing an induction package for every new member of NHSH staff.

Other organisations

We will continue to work in partnership and engage through our NHSH Mental Health & Learning Disability Strategic Partnership Group. We will continue to explore all opportunities to commission services to be delivered in partnership with other organisations. We will create a Strategic Commissioning Plan.



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2 Our services will be clear about what you can expect from us and we will be clear about what we expect from you

The purpose of our services will be made clear from the beginning to all who come into contact with us. We will explain what the service does, why it exists, how it works and who it is for. We will design our services to support you when you are at risk, and we will do this in a way that encourages positive risk taking and protects both you and our staff at times of crisis.

Individuals, their loved ones and carers

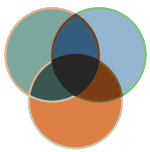
MH	All services will discuss with you, and your loved ones, if you would like, about the care and treatment you can expect to receive. We will also give you guidance about steps you can take to improve your own mental wellbeing.
LD	We will work with you, your loved ones and your carers to enable you to be as independent as possible and to enable you to have access to a wide range of opportunities and everyday experiences.
DARS	As part of the assessment process, we will provide you with relevant information, discussing options and ensuring you are aware of the personal commitment required.
OA&D	Our services will have clear written criteria, which we will promote widely. We will offer evidence-based therapies and clearly define what these are. We will include your loved ones, if appropriate, in all plans.
New Craigs	We will provide you with information about your stay and discuss how to ensure that you can be discharged home, or to the next destination, at the earliest opportunity.

NHS Highland

Each service within the Mental Health and Learning Disabilities Division will create a Service Specification and Plan that will detail the service provided, the criteria for inclusion, the role of staff members and the plans for future development. Our Specialist Pharmacy team are leading the way on this work and have created a template that other services will use. These plans will be shared widely.

Other organisations

We will work together with other organisations to ensure that we can signpost you to other sources of support to enable you to be as independent as possible and fully in control of your own mental health and wellbeing.



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3 Our services will work together with you

We will work with individuals to deliver person centred care. We will respect the preferences, values and goals of each individual. We will work with people, using health and social care services, as equal partners in planning, developing and monitoring their care. We will work within the principles of Realistic Medicine (in both health and social care settings) to ensure you feel empowered to make decisions about your care.

Individuals, their loved ones and carers

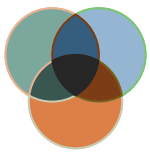
MH	Our health and social care staff will work alongside you to advise and agree the most appropriate therapy or support to meet your needs and support your mental health recovery.
LD	We will listen to hear your goals and desires and work together with your networks to create opportunities to achieve your dreams with the support that you need.
DARS	If you are seeking stabilisation or abstinence from drugs or alcohol, we will work with you and those important to you to identify interventions aimed at supporting you to achieve your desired outcomes.
OA&D	Every person with Dementia cared for by Older Adults Mental Health Services will have the opportunity to complete a "Getting to know me" document. We will develop care and support plans jointly with those who use our services and their families and carers.
New Craigs	We will ensure that inpatient and outpatient wards and clinics are designed to meet your needs in a safe and therapeutic environment

NHS Highland

We will regularly review and evaluate the services we provide by gathering feedback from people that have experienced our services. We will use this feedback to drive our improvement work. We will work together across other NHS Highland to ensure that people receive the support they need in all health and social care settings.

Other organisations

We know that the solution people need or want is not always available within NHS Highland's services and therefore we will continue to work in partnership with other organisations to grow and develop the support they provide in community settings.



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4 Our services will enable our staff to provide safe, high quality care and support

We will support our colleagues to provide the care and support that individuals need, when they need it, in a way that works for them. We will ensure that our staff can progress a meaningful, enjoyable, and rewarding career.

Individuals, their loved ones and carers

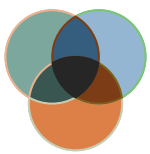
MH	Adult Mental Health services will ensure staff working in our teams, receive the specialist training required to enable people in their recovery and are enabled to follow the principles of the Time, Space & Compassion approach.
LD	Staff across NHSH will be able to access training to ensure they understand the specific needs of people with a learning disability. Staff working within Learning Disabilities services will work within the principles of Positive Behaviour Support (PBS).
DARS	Staff will be trained to deliver a range of medical and psychological interventions aimed at supporting recovery. We will support staff to access training to become Advanced Practitioners and Non-Medical Prescribers.
OA&D	Our staff will have protected time to build the skills and education they need to deliver modern Older Adults Mental Health Services.
New Craigs	We will support staff to deliver optimal care to their patients in a safe, secure and welcoming environment that feels good to be in

NHS Highland

We will ensure that our staff have protected development time. We will create a Workforce Development plan to support service plans and map our future staffing needs. We will embed a Trauma Informed Approach across all of our services.

Other organisations

We will work together to ensure that everyone providing health and social care does so in an equal and inclusive way. We will work together to create an environment for collaboration to enable shared training and staffing opportunities.



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5 Our services will evolve in response to changing need and we will explain why decisions are made

We will respond to changes in strategy, circumstance, and service delivery quickly, as our resources allow. This will mean that we need to design and lead services that can transform quickly and efficiently. We will also respond to changes in individuals needs quickly and ensure that any changes are organised and delivered timely and efficiently.

Individuals, their loved ones and carers

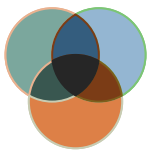
MH	Our service will respond to Scotland's Mental Health and Wellbeing Strategy and the forthcoming Mental Health Quality Standards. We will work in partnership with stakeholders to transform to meet these requirements.
LD	Following the Coming Home report, we will work in partnership with housing and support providers to ensure that people's needs are met in appropriate environments.
DARS	We will continue to redesign and evolve our services to meet the Medication Assisted Therapy (MAT) Standards and work alongside partner agencies to ensure that people are able to access the support they require
OA&D	Our population is aging, and we are required to respond innovatively to increasing demand for our services, including care to stay at home.
New Craigs	We will ensure that inpatient services are flexible and can meet the needs of the people that require inpatient care.

NHS Highland

We will inform other services within NHS Highland of changes we make to our services. We will ensure that our staff are provided with opportunities to participate in national work to ensure that future strategy also reflects the needs of Highland services and residents.

Other organisations

We will share any changes our services make in a timely manner, explaining why these are happening and will enter into conversation about how we can all support each other through these changes.



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Infrastructure

(What we need to achieve our commitments)

There are some things that will enable us to achieve our commitments. These run through everything we do and we will need them to progress in the future. They are things that, no matter where we work or what we do, we need to be aware of, and try to do our best by or utilise to best effect.

Thank you!

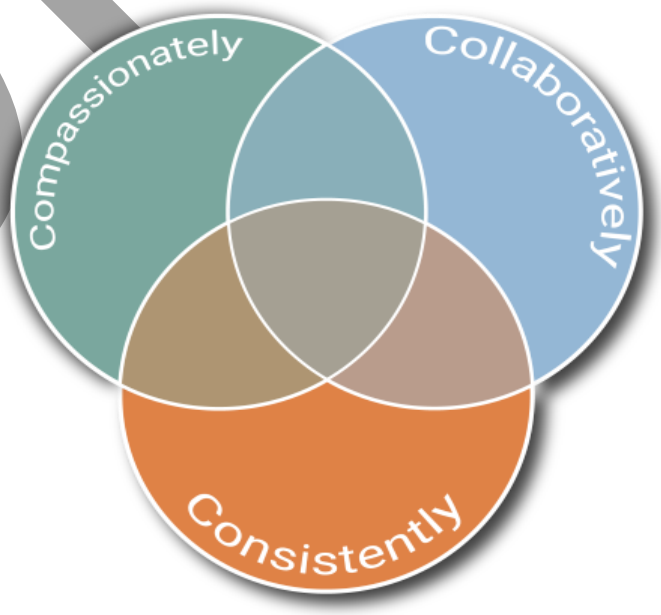
(Want to get involved?)

Thank you to all of those who connected with us, your thoughts, insights, and ideas have enabled us to create our commitments. These will drive us forward over the coming years, shaping the way we provide our services.

To make sure that we are doing everything we can to achieve our commitments, a Mental Health and Learning Disability Strategy Partnership Group has been set up. This group is made up of both NHS Highland leaders and professionals and representatives from organisations across Highland. It is intended that this group will enable collaboration to govern and guide changes we make to our services, ensuring that we work in partnership and that everything we do has the needs of our population and those individuals who need our services at the centre.

If you would like to know more, please get in touch at:
nhsh.mhldstrategyfeedback@nhs.scot

We want to continue to grow and develop, working together across Highland to deliver the right care, at the right time, in the right place for everyone who needs it in a collaborative, caring and consistent way.



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Guidance
(Strategies and guidance)

Scottish Government & NHS Highland policies and programmes in support of this Strategy:

Mental Health and Wellbeing Strategy: Strategy laying out Scotland's approach to improving mental health for everyone in Scotland. www.gov.scot/publications/mental-health-wellbeing-strategy

Coming Home Implementation Report: Improving care for people with complex needs and learning disabilities. www.gov.scot/news/coming-home-implementation-report

Getting it Right for Everyone (GIRFE): A proposed multi-agency approach to health and social care support and services from young adulthood to end of life care. www.gov.scot/publications/getting-it-right-for-everyone-girfe

Dementia in Scotland: Everyone's Story: The new Dementia Strategy for Scotland is a 10-year vision for change. www.gov.scot/publications/new-dementia-strategy-scotland-everyones-story/

National Drugs Mission Plan: 2022 - 2026: National Mission to reduce drug deaths and improve the lives of those impacted by drugs. www.gov.scot/publications/national-drugs-mission-plan-2022-2026

Together We Care - with you, for you: NHS Highland Strategy 2022 -2027. www.nhshighland.scot.nhs.uk/about/publications-and-public-records/together-we-care

Strategic Plan for Adult Services 2024 - 2027: Highland Health and Social Care Partnership Strategic Plan www.nhshighland.scot.nhs.uk/about/highland-health-and-social-care-partnership/publications

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Support
(Support across Highland)

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Crisis Help and Support
If you or someone else is feeling **extremely distressed** you should **call 999 or go straight to A+E.** If the crisis is **not life threatening** call the **GP or NHS 24 on 111**. The NHS 24 Mental Health Hub is available 24 hours a day, 7 days a week, on **111**.

Samaritans
Please contact the Samaritans on **116 123**. Available 24 hours a day, 365 days a year.

Breathing Space
Please contact Breathing Space on **0800 83 85 87**. Weekdays, Monday to Thursday 6 pm to 2 am. Weekend, Friday 6 pm to Monday 6 am.

Mikeysline
Highland wide service. Text based support. **Sunday to Thursday** 6pm – 10pm, **Friday and Saturday** 7pm-7am. Text: **07786 207 755**. WhatsApp: **01463 729 000** Also available on **Webchat – Messenger – Twitter**
For more information go to website: www.mikeysline.co.uk

James Support Group
Highland Wide Service. **24hr helpline** every day. For people bereaved by suicide or anyone having suicidal thoughts. Phone or text: **07563 572 471**
For more information go to website: www.jamessupportgroup.com

Prevent Suicide Highland APP
This easy to use app helps you safety plan should you ever find your self in distress, feeling hopeless or suicidal in the future.
Available on Google Play for Android devices and the Apple App Store for iPhone and iPad.

Further information and resources can be found on the Highland Mental Wellbeing website – www.highlandmentalwellbeing.scot.nhs.uk

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DRAFT

Agenda Item 3.6

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**30th August 2023**
Title:	**Highland Drug & Alcohol Recovery Service (DARS) Summary Report**
Responsible Executive/Non-Executive:	**Pam Cremin, Chief Officer, NHS Highland**
Report Author:	**Teresa Green, Interim Head of DARS, Prison & Custody Healthcare, SARC, NHS Highland**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to:

Medication Assisted Treatment (MAT) standards: access, choice, support (2021)

National Mission on Drug Deaths: Plan 2022-2026 (2022)

Rights, Respect and Recovery (2018)

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

Safe, Effective and Person Centred

2 Report summary

2.1 Situation

Following the launch of the National Mission DARS service delivery has been undergoing improvement work aimed at delivering MAT, being mindful that alcohol use remains the main reason for referral into the specialist service. Progress has been slow, primarily due to existing skill sets across NHS Highland to deliver MAT and

recruitment challenges. It is an improving picture with 2023 seeing continuous improvements across the service as a whole. This report provides a summary of progress to date.

2.2 Background

In 2011, the Scottish Government set a Standard that 90% of people referred for help with problematic drug or alcohol use will wait no longer than three weeks for specialist treatment that supports their recovery. The development of plans to deliver Medication Assisted Treatment Standards (MAT) has supported improvement across the service as a whole.

Working in partnership with Highland Alcohol & Drug Partnership and public health, DARS has a key role to play in the delivery or MAT. A summary of the ten standards is provided below.

Summary of the standards

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

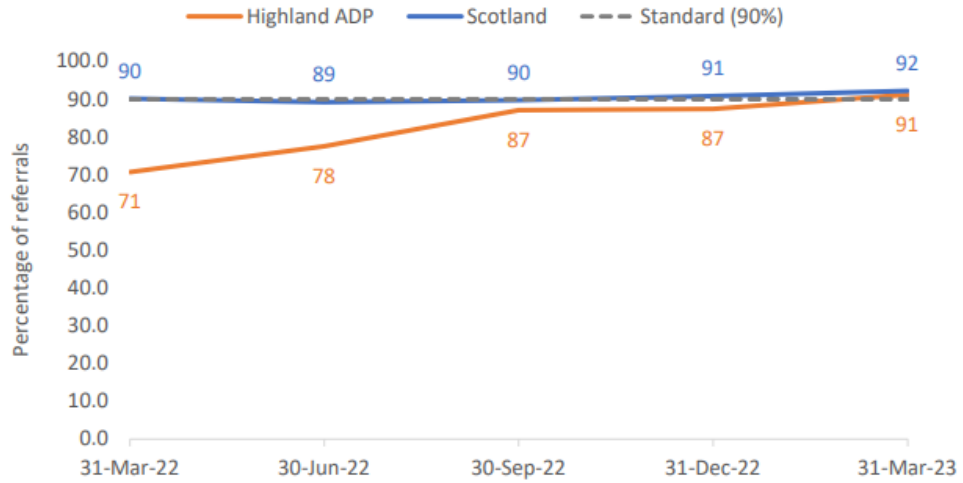
2.3 Assessment

Treatment Waiting Times Standard (Q4 – Jan to Mar 2023)

91.2% of people accessed treatment within 3 weeks from referral against the standard of 90%. This is a slight increase on Q3 from 87.4%. The 90% standard was achieved for 99% of drug treatment clients in Q4. The application of quality improvement

methods linked to the MAT Standards in targeted locality teams, has contributed to the improving position.

Chart 1a: Percentage of referrals waiting 3 weeks or less
Data for: Type of wait = Completed; Area of treatment = Highland ADP; Client type = All.



Source: Drug and Alcohol Treatment Waiting Times (DATWT) database & Drug and Alcohol Information System (DAISy)

Table 1a: Waiting times from referral to first treatment performance against standard for previous five quarters
Data for: Type of wait = Completed; Area of treatment = Highland ADP; Client type = All.

Quarter ending	Number of waits	% Waiting 3 weeks or less
31-Mar-22	233	70.7
30-Jun-22	225	77.5
30-Sep-22	219	87.1
31-Dec-22	179	87.4
31-Mar-23	228	91.2

2.4 MAT Standards

The implementation of the MAT Standards by NHSH DARS is progressing well with monthly reports submitted to Scot Gov since October 2022. This process will be reviewed in Sept 2023. The MAT Standards - National Benchmarking Report (2022/23) was published in June 2023. The RAG status for Highland is as follows:

Area	MAT 1	MAT 2	MAT 3	MAT 4	MAT 5	MAT 6	MAT 7	MAT 8	MAT 9	MAT 10
Highland	P	P		P			P	P		

P = Provisional

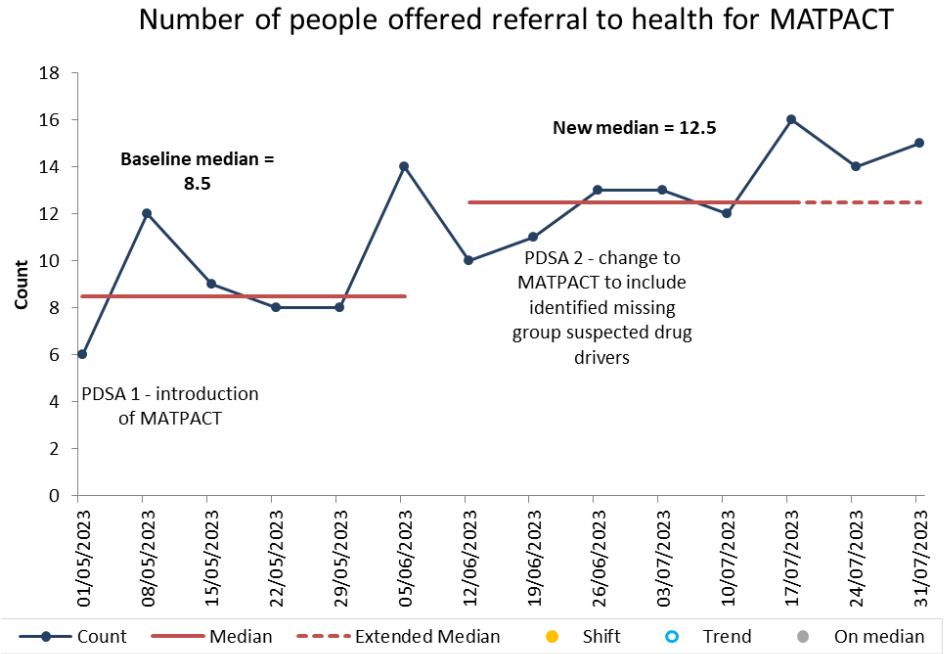
An initial RAG for MAT 6 to 10 was provided. There will be a greater focus on embedding and reporting on these standards in 2023/24. Highland has been in

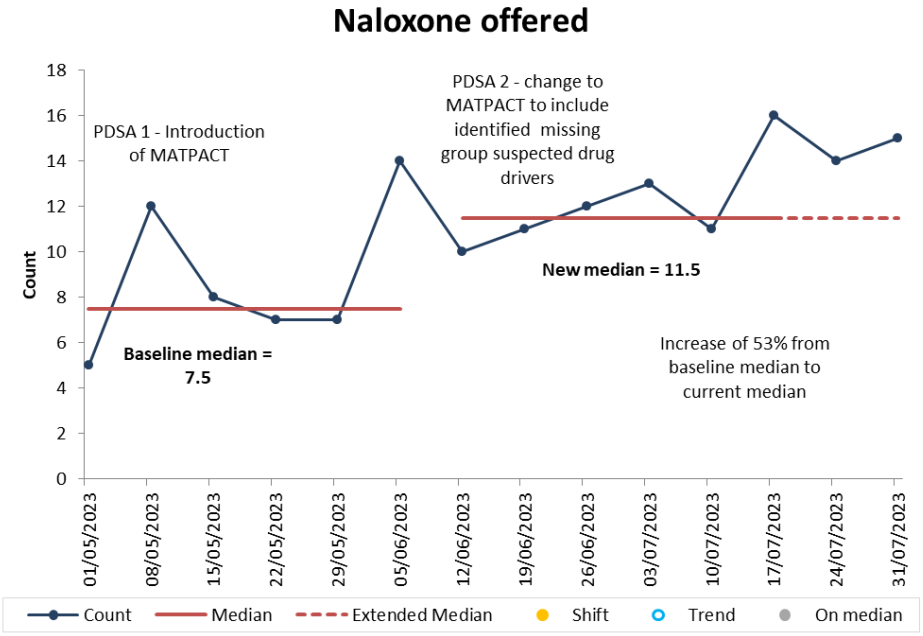
discussion with the MIST (MAT Implementation Support Team, Scottish Government) regarding ongoing national support. Working groups have been established to progress MAT 6,9,10. Locality teams are updating their plans with a number of tests of change progressing well.

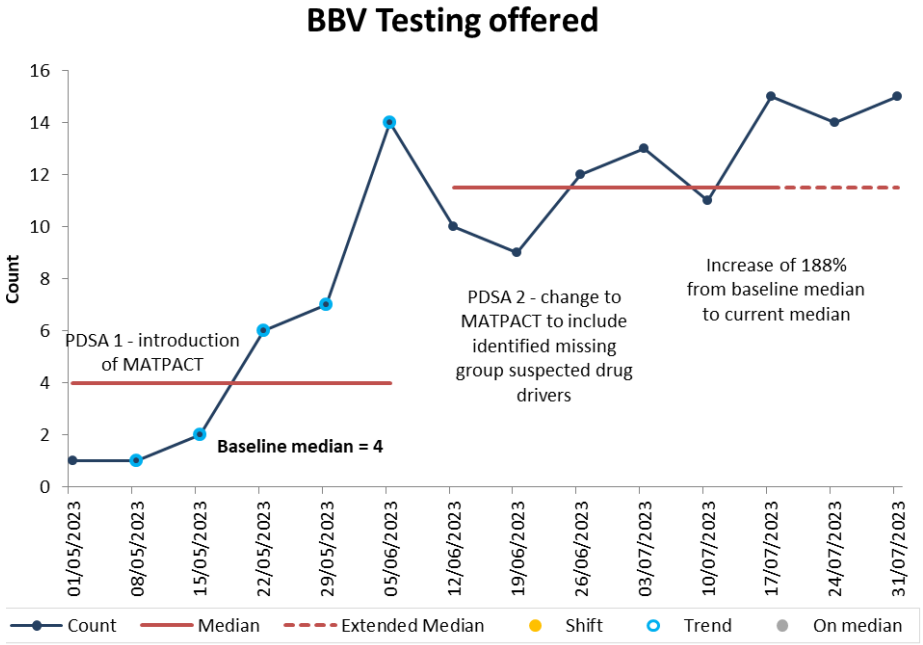
The MAT Implementation Group continues to meet on a monthly basis. The MAT Oversight Group is reviewing its terms of reference informed by the improved RAG status and has a new chair. The group plans to meet on a quarterly basis, going forward.

2.5 MAT Delivery In Custodial Settings

Police Custody Healthcare, have introduced a new toolkit (MATPACT) to encourage and monitor referrals, assess support and tailor interventions. The test of change has enhanced communication with community teams, including the assertive outreach team and contribute to reducing drug deaths through delivery of a range of harm reduction interventions. The team identified that most suspected drug drivers denied drug use and as such were not being referred to custody health care, resulting in missed opportunity for harm reduction. The test of change offered everyone arrested for suspected drug driving MATPACT. The Custody Healthcare Team has the opportunity to present this innovative work at an international conference and is exploring funding sources. MATPACT is being rolled out to HMP Inverness and MIST has expressed interest in rolling out the MATPACT toolkit as a national resource.







2.6 Drug Related Deaths (2022)

At the end of Dec 2022 there were unfortunately an estimated 44 people who died from drug related death in the Highland area reported via National Records of Scotland (NRS) and the national drug related deaths database. Final reconciliation of records is completed, and the NRS report is due for publication on 22/08/23. If the figure remains at 44, this will be an increase from 36 deaths reported in 2021 and the highest figure ever for Highland. HADP and public health are preparing a press release in partnership with the NHS Communications Team in anticipation of media coverage.

Within a remote and rural context, Caithness DARS have developed a new way of working, providing outreach to people at higher risk of harm and death via alerts from partner agencies e.g. Police. The purpose is to offer immediate support to reduce harm and provide a bridge in to treatment as a key protective factor. The trigger checklist developed by Caithness team will be rolled out across the service. MIST has also expressed interest in rolling out the trigger checklist as a national resource.

The assertive outreach team is responding to non-fatal overdoses in the Inverness area. The remit of the team has been extended to cover areas out with Inverness with higher prevalence rates such as Mid and East Ross. The Team plan to broaden the criteria for higher risk of harm based on the test of change in Caithness. The longer term vision is one outreach model across Highland, based on emerging data and outcomes.

The Drug Death Review Group has produced a second 7 Minute Briefing to disseminate learning from drug death reviews to relevant partner agencies. Pregabalin in combination with opiods, benzodiazepines and alcohol appears to have contributed to more recent deaths. A drug alert was circulated via the RADAR system administered by Public Health Scotland on Bromazolam. The information has been adapted and circulated locally in response to a surge in overdose situations in custody.

A public health stay safe messaging campaign for the festival season has been delivered. Radio adverts including recognizing and responding to signs of overdose have been rolled out via MFR, a series of posters and social media messages have also been disseminated with encouragement to download the HOPE App.

The campaign will be adapted for Overdose Awareness Day on 31st August with the Ness Bridge to be lit up in purple, similar to a range of landmarks across Scotland.

2.7 Residential Rehabilitation

The current Highland Residential Rehabilitation Pathway is in the process of review.. This work is being led by DARS in partnership with HADP and Health Improvement Scotland (HIS) . A last 10 clients QI exercise has been initiated by DARS and a joint workshop held with Beechwood House/Crossreach that focused on strengthening the pathway and ensure it aligns with good practice guidance. HIS will provide a report of the survey template completed previously and provide support to establish and progress an improvement plan. It is likely the plan will require submission to Scot Gov this autumn.

2.8 Proposed level of Assurance

Substantial		Moderate	x
Limited		None	

Comment on the level of assurance

MAT 1 relates to same day prescribing where clinically appropriate. Areas in Highland (Lochaber, Ross-shire and HMP Inverness are without specialist prescribers. Original plans to increase Non-Medical Prescribers (NMP) and Advanced Nurse Practitioners (ANP) have been only partially successful. New plans will be progressed though implementation groups.MAT1 Plans to address include recruitment to psychiatry post, specialist pharmacist and GP. A service review will lead to realignment of current unutilised MAT funding to priority areas.

MAT 7 outcomes will lead to MAT being shared with primary care. A steering group has recently commenced. In addition it is anticipated the specialist GP role will support delivery of MAT 7.

MAT 6 & 10 is in relation to the availability of psychological interventions within trauma informed settings. Existing staff capacity, access to training and supervision, coupled with inadequate clinical space / trauma informed rooms are identified issues. A steering group led by DARS specific psychology is underway.

3 Impact Analysis

3.1 Quality/ Patient Care

Quality and patient experience is integral to the successful delivery of MAT. Evidence is being routinely gathered and submitted to MIST in relation to experience. In addition MAT Implementation Group / HADP are exploring ways to increase lived / living experience contribution to service planning

3.2 Workforce

There has been limited success in relation to initial plans to increase specialist functions within the service i.e. prescribers.. In addition there is a gap of DARS specific local leadership in some areas (Skye, Lochalsh and Wester Ross) There will be an internal service review and recommendations to follow.

3.3 Financial

Current DARS position is a predicted £426k overspend in prescribing costs mainly attributing to Buvidal which is no longer funded by SG. Last year there was an SG agreement that it could be funded from slippage in MAT funding with an explicit expectation that an alternative funding stream would be found in 2023-24 onwards. Improvement projects will be explored to reduce costs but this remains a financial risk in abscence of other funding streams.

3.4 Risk Assessment/Management

Each MAT outcome is RAG rated and monitored via MAT Implementation and oversight groups. Progress is reported to MIST on a monthly basis.

3.5 Data Protection

The report does not involve personally identifiable information.

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3.6 Equality and Diversity, including health inequalities

MAT and wider service delivery focuses on addressing health inequalities for a marginalised and stigmatised patient group. It is assumed an impact assessment is not required.

3.7 Other impacts

N/A

3.8 Communication, involvement, engagement and consultation

HADP structures

MAT Implementation Group (monthly)

MAT Oversight Group (Quarterly)

MIST / MATSIN Meetings (monthly)

3.9 Route to the Meeting

Service Update following request from HHSCC

4 Recommendation

Assurance to HHSCC in relation to DARS compliance with national alcohol / drug related policy

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**30 August 2023**
Title:	**North Highland Health and Social Care Partnership - Integrated Performance and Quality Report**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer, HHSCP**
Report Author:	**Rhiannon Boydell, Head of Strategy & Transformation**

1 Purpose

This is presented to the Committee for:

Assurance

This report relates to a:

Annual Delivery Plan

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

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

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

2.1 Situation

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

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

2.2 Background

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

2.3 Assessment

As per **Appendix 1**.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

3 Impact Analysis

3.1 Quality / Patient Care

IPQR provides a summary of agree performance indicators across the Health and Social Care system primarily across Adult Social Care.

3.2 Workforce

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

3.3 Financial

The financial summary is not included in this report.

3.4 Risk Assessment/Management

The information contained in this IPQR is managed operationally and overseen through the appropriate Programme Boards and appropriate Governance Committees

3.5 Data Protection

This report does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document.

3.9 Route to the Meeting

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

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

4 Recommendation

The Health and Social Care Committee and committee are asked to:

- Consider and review the agreed performance framework identifying any areas requiring further information or inclusion in future reports.

- To accept moderate assurance and to note the continued and sustained stressors facing both NHS and commissioned care services.

4.1 List of appendices

The following appendices are included with this report:

- **IPQR Performance Report, August 2023**

Agenda Item 3.8

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**August 2023**
Title:	**Draft Annual Performance Report 2023-2024 Highland Health and Social Care Partnership**
Responsible Executive/ Non-Executive:	**Pam Cremin, Chief Officer NHS Highland**
Report Author:	**Rhiannon Boydell, Interim Head of Strategy & Transformation NHS Highland**

1 Purpose

This is presented to the Board for:

- Awareness
- Discussion

This report relates to a:

- Annual Performance Report
- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

Within the plan, partnership priorities for improvement are set around the following themes:

2 Report summary

2.1 Situation

The Health, and Social Care Annual Performance Report (APR) for the year 2022 follows the requirement by the Public Bodies (Joint Working) Scotland Act, 2014. Submission on the Annual Performance Report as per deadlines of 30th September 2023 respectively.

The Health and Social Care Partnership (HSCP) is responsible in ensuring that our local communities are clear on how health and social care integration is performing. The HSCP has built upon previous years and demonstrates how services have improved and adapted to complement highland communities Primary, across Community, Mental Health, Acute Care, Children and Adult Social Care.

The Annual Performance Report (APR) assures the progress in meeting the priorities and actions and is required to be updated and submitted annually to the Scottish Government.

2.2 Background

The Highland Health and Social Care Partnership delivers health and social care services through a lead agency Partnership Agreement. This consists of The Highland Council act as lead agency for delegated functions relating to children and families and NHS Highland who undertake delegated functions related to adults.

The strategic framework for planning and delivery of health and social care services consists of 9 Health and Well Being Outcomes and a core suite of

integration indicators. The report also provides read across to the NHS Highland Together We Care Strategy, in the appendices.

At the time of writing, further data is to be published by Public Health Scotland. These areas have been identified in the appendices and will be updated prior to publication.

2.3 Assessment

The Annual Report provides an overview of performance at both Health and Social Care Partnership (HSCP) and Scotland level including:

- Assessment of performance in relation to the 9 National Health and Wellbeing Outcomes
- Assessment of performance in relation to integration delivery principles
- Comparison between the reporting year and pervious reporting years, up to a maximum of 5 years. (This does not apply in the first reporting year)
- Financial performance and Best Value

It also includes examples of key achievements during the year.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

Comment on the level of assurance

An Annual performance Report has been produced.eport has been produced..

3 Impact Analysis

3.1 Quality/ Patient Care

Included within the Annual Performance Report

3.2 Workforce

Included within the Annual Performance Report

3.3 Financial

Included within the Annual Performance Report

3.4 Risk Assessment/Management

Not Applicable.

3.5 Data Protection

This does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities.

As there is no change in policy an equality impact assessment is not required.

3.7 Other impacts

Not applicable

3.8 Communication, involvement, engagement and consultation

The report is to be published.

3.9 Route to the Meeting

This has been compiled through with intention leads and senior responsible officers and has been discussed at NHS Highland Executive Directors Group and Community Senior Leadership Team.

The report will go to the Joint Monitoring Committee for final approval prior to publishing.

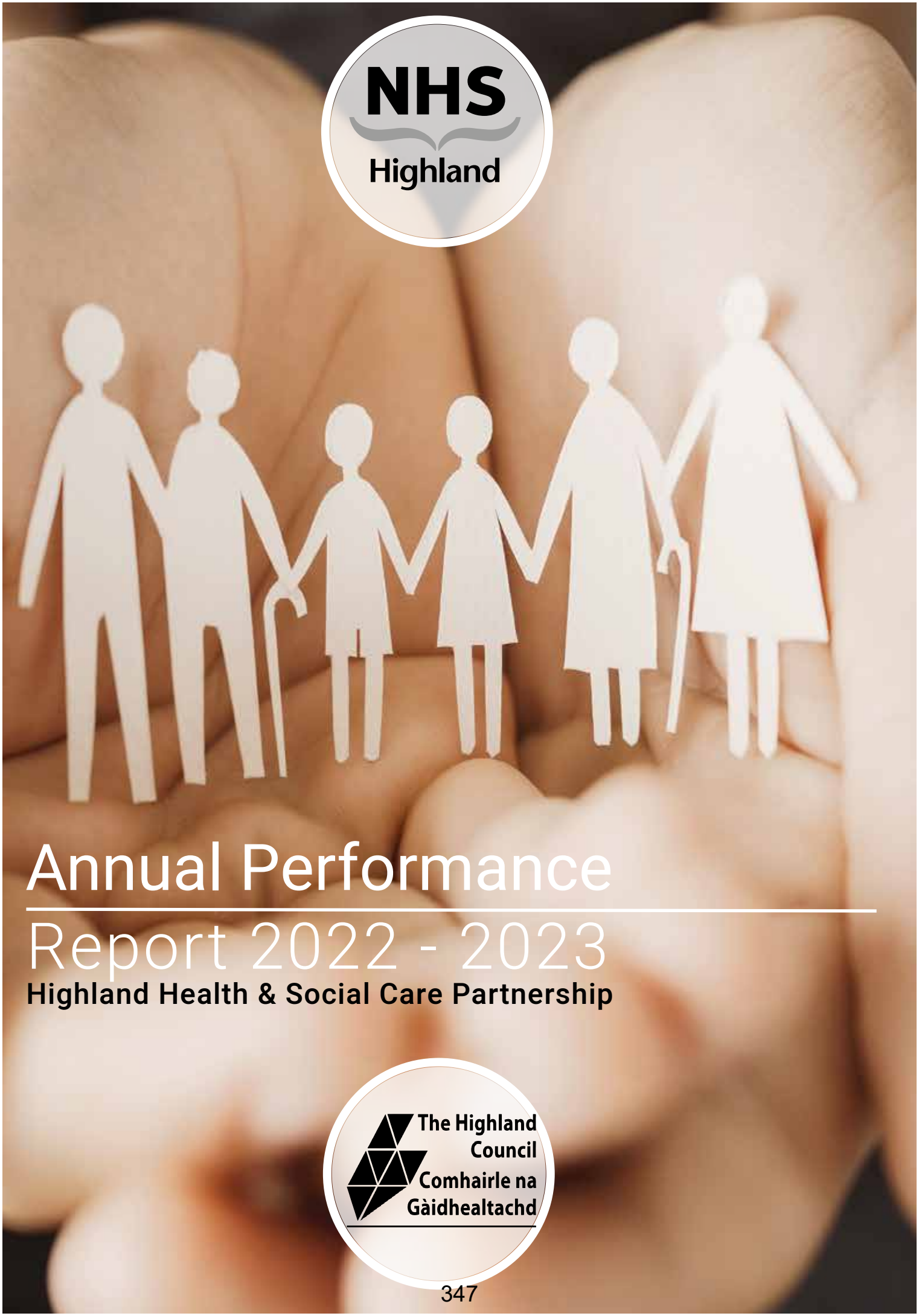
4 Recommendation

Action being requested:

- For awareness and discussion

4.1 List of appendices

The following appendices are included with this report:



Annual Performance Report 2022 - 2023

Highland Health & Social Care Partnership

Contents

Appendices

Foreword

Welcome to the Annual Performance Report (APR) by Highland Health and Social Care Partnership, on the performance of integrated health and social care provision. The report provides us with the opportunity to , celebrate our achievements, share our challenges and reflect on our future delivery of health, social care and wellbeing services, together. We would also like to take this opportunity to recognise the commitment, dedication, person-centred professionalism and resilience of all colleagues working in health and social care, partner agencies, unpaid carers and community volunteers during this challenging period.

As a Partnership, we are committed to developing our services through planning and engagement with our Highland communities. All of our staff, carers and volunteers across Highland are working hard together to improve the health and wellbeing of our population. This report highlights the positive outcomes that the health and social care services are delivering; to everyone using our services, their families and the wider community. Through continuing to ensure people's voices are heard, their needs are understood and effectively met in collaboration with our partners. Thank you to everyone for your continued support and efforts and we look forward to continuing to work with our stakeholders and partners to shape the future of health and social care in Highland.

Pamela Cremin
Chief Officer

NHS Highland

Fiona Duncan
Executive Chief Officer Health and Social Care
Chief Social Work Officer

The Highland Council

Introduction

We welcome the opportunity to share the Health and Social Care Annual Performance Report for the year 2022 as required by the Public Bodies (Joint Working) Scotland Act, 2014. The Health and Social Casre Partnership (HSCP) is responsible in ensuring that our local communities are clear on how health and social care integration is performing. The report highlights the key areas of achievement and challenges that we have faced over the year. 2022 has been challenging, but we have worked hard to continue to provide excellent health and social care services for our Highland communities which consists of Primary, Community, Mental Health, Acute Care, Children and Adult Social Care.

The HSCP has built upon previous years and demonstrates how services have improved and adapted to complement highland communities. There are many examples where performance has been positive and innovative which we aim to maintain. In those areas where there is still work to be done, we are planning our future steps. We have many complex decisions to make around what services will look like in the future. The Health and Social Care Partnership will continue to focus on improving the health and wellbeing as well as delivering an inclusive high-quality service for everyone in Highland. I wish to thank all of our colleagues and partners who continue to provide services to improve the lives of those who live and are cared for in our Highland communities.

Strategic Context and Overview

Highland Health and Social Care Partnership delivers health and social care services through a lead agency Partnership Agreement. The Highland Council act as lead agency for delegated functions relating to children and families, whilst NHS Highland undertakes delegated functions related to adults.

Children's health services are commissioned by NHS Highland and delivered by Highland Council acting as the lead agency. Similarly, adult social care services are commissioned by Highland Council and delivered by NHS Highland. Both partners report through joint arrangements with the governance of the partnership being managed through the Joint Monitoring Committee.

The Partnership covers the Highland Council area and is divided into coterminous districts centred on nine local Community Planning Partnerships.

A Joint Strategic Plan for adults is currently being developed by the Partnership through a Strategic Planning Group including both partners, independent sector and third sector representatives and community representation. This will be a 3 year plan covering the period 2024 – 2027.

The next iteration of the integrated children's service plan is currently being developed by the Integrated Children's Services Planning Board (ICSPB) on behalf of Highland Community Planning Partnership.

In developing this plan, the ICSPB has undertaken a joint strategic needs assessment and the data gathering from this activity will support an evaluation of the performance management framework which underpins the current plan. The strategic needs assessment takes a life course approach which will be reflected in the structure of the 2023 – 2026 plan.

In addition to the joint strategic needs assessment the priorities for this plan have also been driven by the voice and testimony of children, young people and their families.

As the current plan is a two year plan to reflect the impact of the pandemic the ICSPB intends to re-establish its priorities around the themes of the current plan adding a whole system approach to supporting families as a new priority.

Within the plan, partnership priorities for improvement are set around the following themes:

- **Health and wellbeing including mental health**
- **Child poverty**
- **Children's rights and participation**
- **Child protection**
- **Corporate parenting (The Promise)**
- **Alcohol and drugs**
- **Whole family wellbeing**

Performance Management and Governance

The strategic framework for the planning and delivery of health and social care services consists of 9 Health and Well Being Outcomes and a core suite of integration indicators. In NHS Highland adult health and social care services are delivered within the NHS Highland performance governance structure which oversees the delivery of the NHS Highland Strategy and Annual Delivery Plan.

The NHS Highland strategy, Together We Care (TWC) is a Board wide strategy, and clearly communicates the strategic vision, mission, and objectives we need to achieve over the next five years. Whilst our strategy unites our focus and direction, our progress towards achieving its aim is set out and monitored in our Annual Delivery Plans. These plans are fully cognisant of the role and responsibilities of the lead agency Integration Authority (IA)in North Highland and the Integration Joint Board (IJB) in Argyll & Bute

NHS Highland has produced a Performance Management Framework. This aims to ensure that NHS Highland successfully delivers national standards for performance and agreed targets encompassing all areas of our strategy “Together We Care, with you, for you” in line with our annual delivery plans. A service planning framework has also been introduced to provide ownership at service level ensuring appropriate plans are in place with clear oversight and governance. The framework ensures an integrated approach to both performance and quality management.

At board level we have redesigned our Integrated Performance and Quality Report (IPQR). This report gives the board an overview of performance and quality across NHS Highland bi-monthly. It is compiled from data considered at our governance committees along with comments, risks and mitigations from our executive leads. A subsection of the IPQR has been agreed by the Highland Health and Social Care Committee, which receives the report, and assurance on performance against it, at each meeting.

Together We Care
with you, for you

Performance management framework for the integrated children’s services plan. The integrated children’s services partnership recognises that children’s services planning is an ongoing process and central to good planning is ensuring a robust connect between national and local strategic planning. Our performance management framework connects partnership strategic planning within a single framework. This framework provides both the tools for planning, self-evaluation, reporting, performance management and assurance.

The Integrated Children’s Service Planning Board has responsibility for monitoring progress towards achieving the outcomes outlined within the Integrated Children’s Services Plan and utilises a fully developed Performance Framework to achieve this.

Within our planning processes lead officers from partner organisations have been identified for each themed group along with a lead officer for each of the improvement priorities. Partners work together and take responsibility for co-ordinating performance reporting on a regular basis. In addition, our performance is measured through listening to the voices of children, young people and their families, learning from self-evaluation, analysing intelligence and scrutinising an agreed set of qualitative and quantitative improvement measures. This framework is at appendix xxx of this report.

Performance Overview

INTRODUCTION

Over the last year there has been a move from the post-COVID remobilisation of services to focus within the Health and Social Care Partnership on system flow and preparation for winter pressures. From October onwards health and social care services across Scotland experienced an increase in the prevalence of Flu and Covid19 in addition to expected winter illness and system pressures. The Health and Social Care Partnership engaged in collaborative whole system improvement to enhance patient flow through hospitals. A significant challenge during the year affecting system pressures, has been in the commissioned adult care sector.

Key Performance Overview

The key performance overview demonstrates the financial year (April 2022 – March 2023), this ensures that there is data continuity linking previous and new reporting using full year data. The Latest performance against the National Integration indication, ministerial indicator and North Highland IPQR are detailed in the appendix. This data is up to March 2023 year end or the latest available data point. Final updates will be made to the document for the national integration indicators and ministerial pending publication from PHS.

Benchmarking

The benchmark for the National Integration Indicators, making a comparison with the Scottish average has been incorporated into the appendix. This is to allow a performance comparison as there are no national standards or targets in place. There is a table on the appendix that explains the percentage comparison as below;

Benchmarking	
	Better than average
	Average +/- 5%
	Worse than average

*** Note we are awaiting the annual publication for the indicators referenced in the appendix no 11 – 19 below in respect to the National Integration Indicators reported within the National Outcomes. PHS has confirmed 2022 update will not be available until end Jun 2023, an update will then be incorporated into report.***

Performance Management Framework

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

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

ADULT SOCIAL CARE

CARE AT HOME

The Partnership's key objectives for commissioned care at home services during 2022-2023, has been to achieve stable, resilient and assured provision and capacity release / growth.

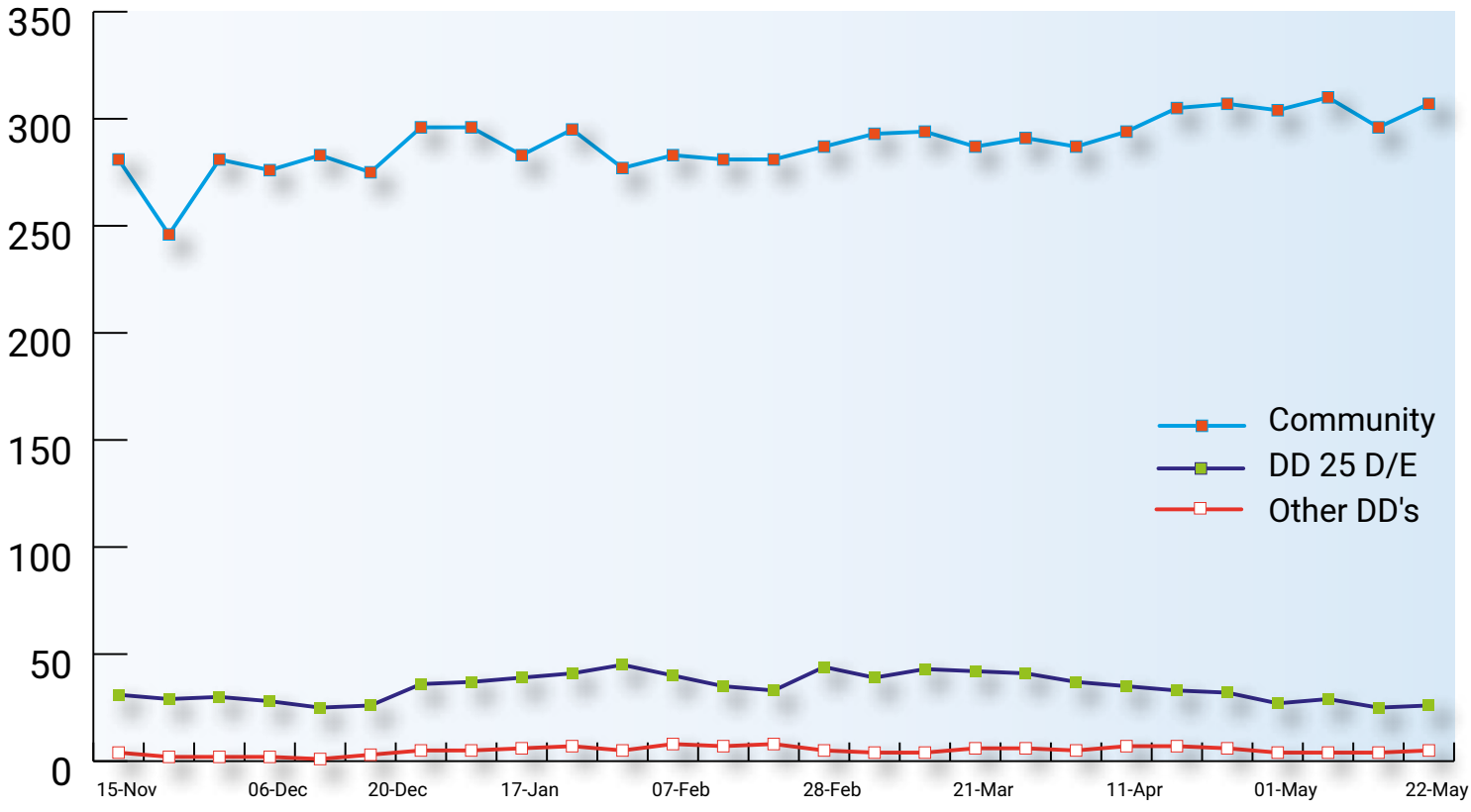
NHSH has been working closely with care at home partners through regular and structured dialogue in order to better understand the current issues and to work together to identify and implement sustainable solutions to address the key issues, summarised as: high attrition and unsuccessful recruitment, impacted by: role pressures; (perception of) sector / role inequity; and fuel costs; staff wellbeing issues specific geographic challenges in rural / remote delivery and the additional costs of providing care at home, as well as the more acute recruitment challenges in these localities.

Over the course of 2022-2023, there has however been a significant reduction of available commissioned services (1,300 hours pw), despite the measures put in place by NHSH to seek to stabilise provision, and ensure capacity release and growth – these being advance payments, and continued UKHCA aligned tariff.

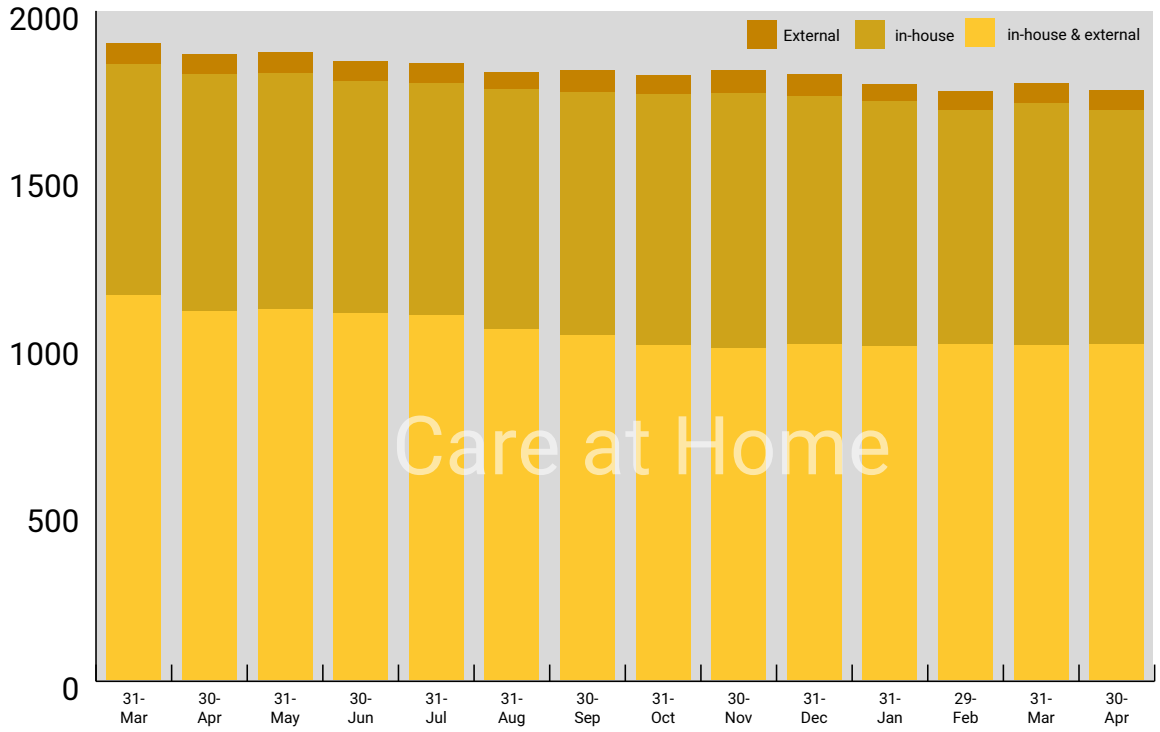
This reduced service capacity is having an impact on the wider health and social care system, and in particular, the ability to timeously discharge patients delayed in hospital.

Going forward into 2023-2024 and critical to achieving sustainability, there is a need to recognise the care at home workforce as equal partners in the wider health and social care system and to actively support the professional and financial recognition of this. This is a key aspiration being set out within the Partnership's Strategic Plan. To support this direction, there is a need to identify and implement more significant interventions to shift direction.

The following graph demonstrates all the North Highland hospital Delayed Hospital Discharges assessed as requiring care at home (identified in the graph as DD 25 D/E), and those waiting in the community. It represents the total number of people waiting for a care package every month.



As demonstrated in the following graph, the overall numbers have continued to fall after a period of significant and sustained reductions during 2021 and 2022. NHS Highland and external care providers continue to operate in a pressured environment. There has not been growth in external care at home, low levels of recruitment and the loss of experienced care staff that continue to be the primary concern expressed by providers.



CARE HOMES

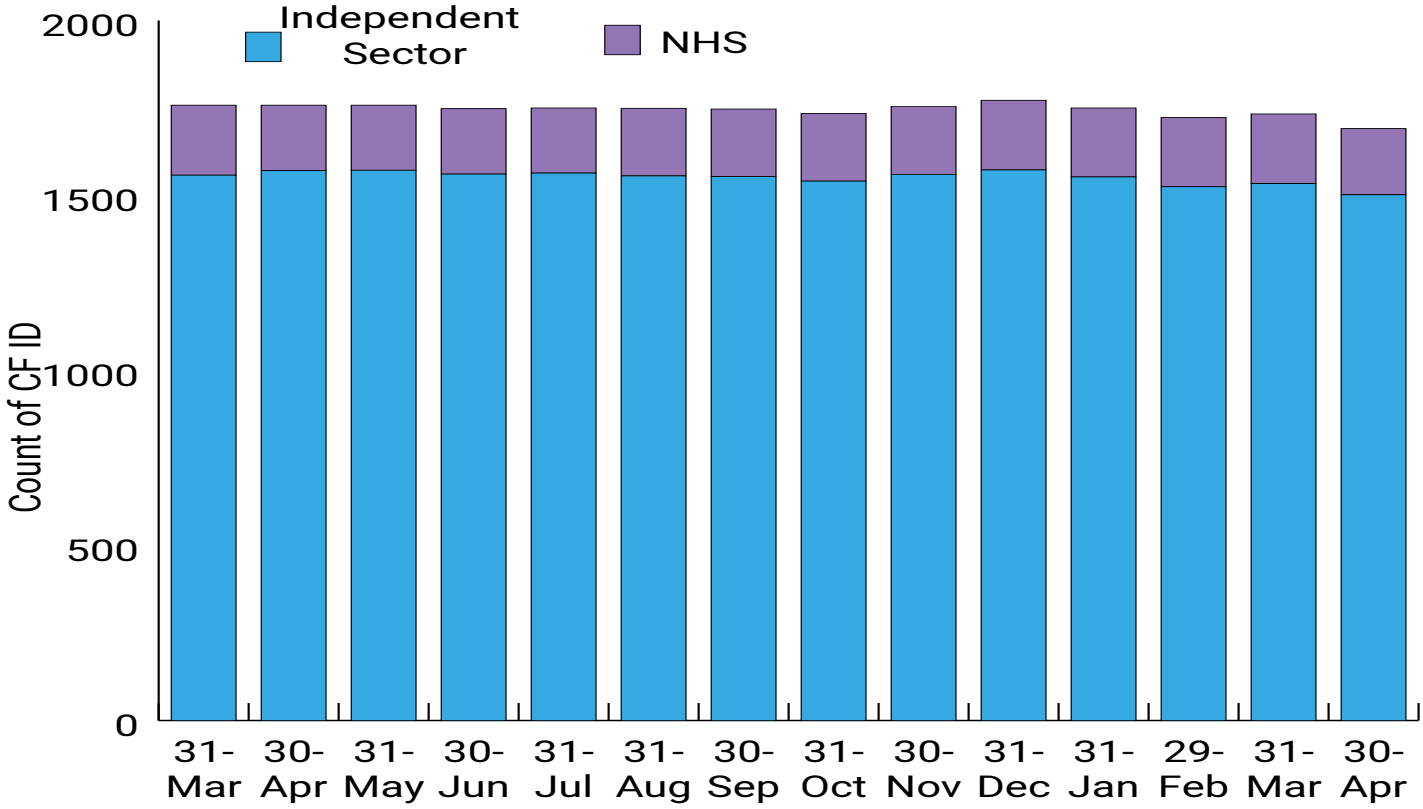
There has been significant independent sector care home fragility over 2022-2023. Since March 2022, there has been 4 independent sector care home closures, with a further closure, announced in March 2023. This will result in a total of 5 care home closures having occurred over a 14 month period, and a loss of 141 care home beds. Also over this period, the Health and Social Care Partnership acquired a care home in administration, in order to prevent the closure of this facility and loss of this provision.

This fragility is attributed to a number of factors, namely the remote, rural and small scale provision in Highland, particularly the difficulties of recruiting and retaining staff in these localities (and across the area), securing and relying on agency use, and the lack of available accommodation which compounds the challenges. The single biggest challenge is the ability to recruit and retain staff, and to be able offer more favourable terms and conditions compared to the NHS and to compete against other workforce sectors, particularly the tourism economy.

Whilst this smaller scale provision reflects Highland geography and population, it presents increased financial sustainability and vulnerability risks, particularly given that the National Care Home Contract rate is calculated on the basis of a 50 bed care home, operating at 100% occupancy. The Partnership continues to make representation to Scottish Government and to Ministers to address this inequality.

This reduced bed availability is having an impact on the wider health and social care system, and in particular, the ability to timeously discharge patients delayed in hospital.

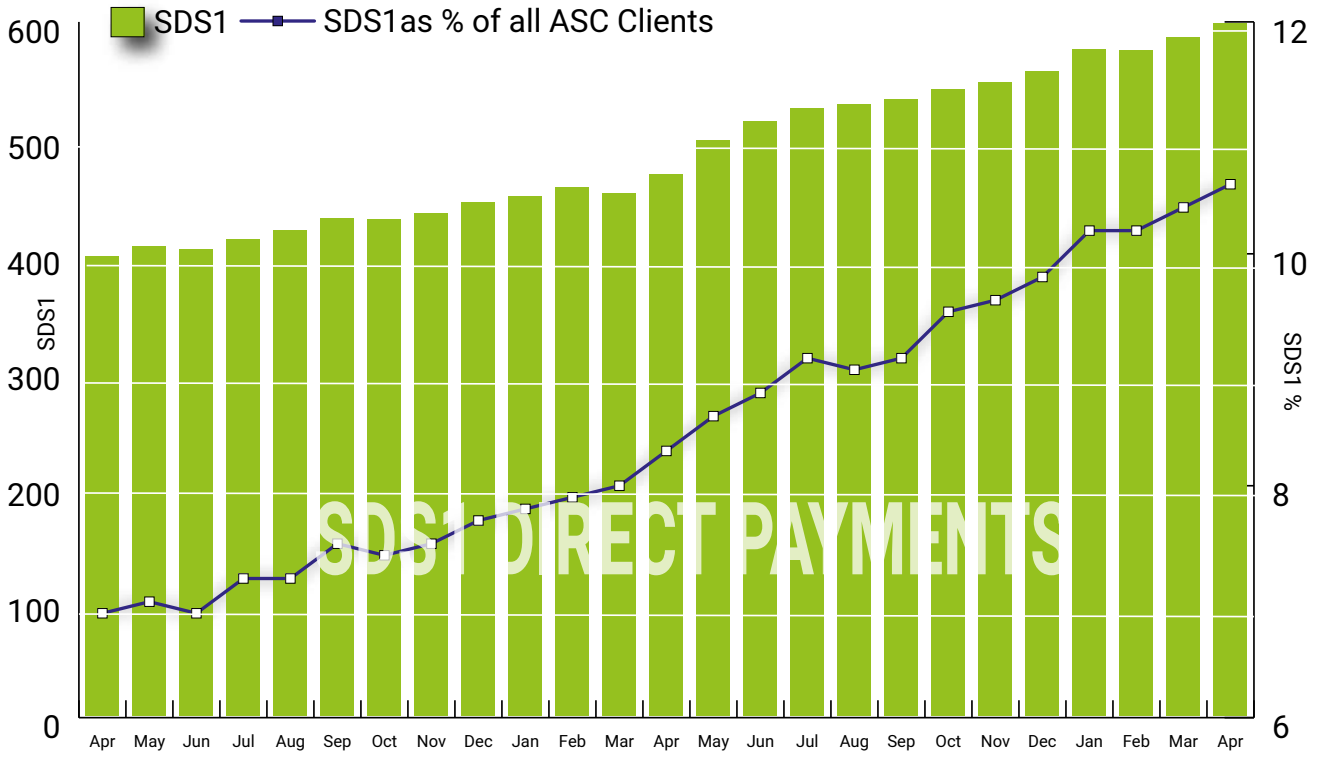
The graph below demonstrates that the total number of independent sectors occupied beds at April 2023 was 1502 which is the lowest for many years. This reduced bed availability is having an impact on the wider health and social care system, and in particular the ability to discharge patients timely from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



The Health and Social Care Partnership are working closely with Highland Council to develop a strategy for care homes and an implementation plan to span the medium to longer term care environment.

ADULT SELF DIRECTED SUPPORT / CARER SHORT BREAKS

There has sustained growth in Option 1, direct payments, for both younger and older adults in some remote and rural areas. There is an overall increase of 201 since March 2021 with further growth expected this year. The increase does highlight the unavailability of other care options and a real market shift as we are unable to commission other care services. There is an increase in Option 1 recipients who can retain and recruit personal assistants, this demonstrates resource pressures that are affecting all aspects of the care delivery.



Plans are now in development to better understand and resolve any process barriers to growing the overall number of ISFs. A restructure of the operation of Option 2's was agreed as a key work stream component within an overall programme for promoting choice, flexibility, and control.

KEY ACHIEVEMENTS IN ADULT SOCIAL CARE

- Development of a case file audit process
- The appointment of an Adult Protection Training Officer and development of a new, comprehensive,
- multi-agency training programme across Highland is now well progressed .
- An increase in learning review activity has enabled increased learning from cases.
- Revision of the Highland Adult Protection Committee improvement objectives which are:
- Providing leadership through building partnership working and promoting and developing ownership of adult protection responsibilities across relevant agencies including the role of health in adult protection work
- Understanding and responding to the strategic context of adult protection and being accountable to stakeholders
- Promoting consistency of good practice through linking legislation and Codes of Practice to local practice and exploring the implementation of Trauma Informed Practice, Supported Decision Making, Chronologies and Interagency Referral Discussions
- Assuring quality across current activity through evaluation and audit work
- Promoting participation in adult protection; ensuring the voices of adults at greater risk of harm and
- their carers are heard and understood
- Sharing learning from reviews
- Promoting the awareness of harm to our communities by engaging cross-sector partners

COMISSIONED CARE HOME SERVICES

Development of a care home closure framework has to guide decision making and ensure consistency of approach to the closure of a care home. This has been developed in response to significant independent sector care home fragility over 2022- 2023. Since March 2022, there have been 4 independent sector care home closures, with a further closure, announced in March 2023, which is currently concluding. This will result in a total of 5 care home closures having occurred over a 14 month period, and a loss of 141 care home beds.

COMISSIONED CARE AT HOME SERVICES

Close working with care at home partners through regular and structured dialogue in order to better understand the current issues and to work together to identify and implement sustainable solutions. The Partnership's key objectives for commissioned care at home services during 2022-2023, has been to achieve stable, resilient and assured provision and capacity release and growth.

CARERS

Operation of an SDS Option 1 Short Breaks scheme which has given unpaid carers the opportunity to tailor a personalised break. This complements the supports that are available to carers via a range of Carer services introduced to mitigate the worst impacts of covid-19. Review of carers services to explore how we will shape our carers services into the future. We have done this by bringing unpaid carers and providers together and we are supported Health Improvement Scotland's iHub to ensure this is a collective and collaborative response to meeting unpaid carers needs locally.

SELF DIRECTED SUPPORT (SDS)

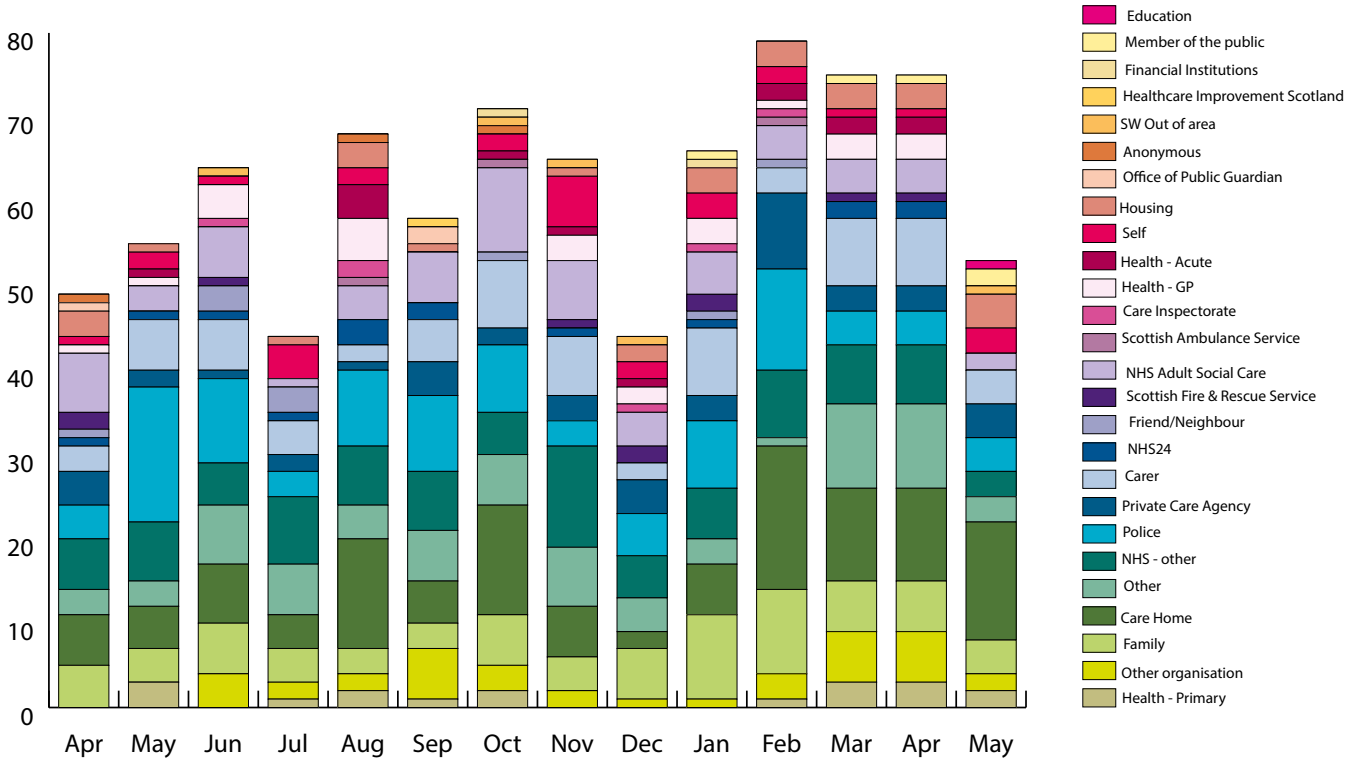
- Review of our Self-directed Support through forming relationships, building trust, sharing intelligence and co-producing new ideas and solutions. We were invited to explain this work nationally at the National SD Collaborative this year and received a visit from the Cabinet Secretary to hear about developments.

We are currently taking a planned, programme approach to:

- Creating more time and capacity – in consultation with workers - via reduced bureaucracy
- Creating greater Worker Autonomy
- Increasing the availability of Independent Support
- Explore new, more flexible commissioning models: Option 2; Alliances, Place-based etc.
- Providing realistic funding for Option 1s, an
- Supporting 'grass roots', systemic self-evaluation and improvement planning

ADULT SUPPORT AND PROTECTION

The following graph demonstrates the number and source of Adult Support and Protection referrals andillustrates that referrals come from multiple sources. Previously the main source was the Police. However as people have become more aware of Adult Protection the numbers of referrals have increased from other sources. The number of referrals that progress to a full investigation following the initial inquiry is approximately 25%.



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

These themes relate to creating an equal working alliance between workers and supported people and increasing the autonomy of workers to realise flexible and creative three-way care planning with trusted providers and supported people. We are planning now to translate the outputs from the work above into creating maximum contractual flexibility to enlist appropriate provision for individuals needing support wherever possible

"We are working with representatives of the local communities in West Lochaber to explore howSDS might be used to offer a rangeof opportunities to reshape social care in the area.
We are aiming that this work might develop into a collaborative, "placed-based" commissioning exercise - pulling the different parts of the system togetherbehind a common purpose. We want to explore how a full range of opportunities can be stimulated andmade available for people in local communities.We are planning to take a "project" approach to this to enlist appropriate organisational support"

"We are working alongside Health Care Improvement Scotland's iHub to help us forge an alliance between unpaid carers and statutoryand community providers to realise the future shape of carer services in Highland. This means that current services and unpaid carers are beginning to work together to develop and share a common goal for carers services. We want to build trust and relationships between the parties: and we want to develop a learning culture where our providers are encouraged to respond flexibly to meeting carer's expressed needs - feeling empowered to try innovative and experimental ways to provide that support."

"We are working with those managing an Option 1 (Direct Payment) and with those with budget responsibilities in Adult Social Care to see if we can describe a fair, equitable and sustainable framework for the calculation of Individual Budgets. We think this should support the exercise of choice by ensuring that the recruitment and retention of Personal Assistants (PA) is a realistic and sustainable option. Work with a local "Peer support group" is well advanced;and a model which recognises the real component costs of employing a Personal Assistant in our urban, rural and remote geographies has been agreed. We anticipate that a new hourly rates will be put in place shortly."

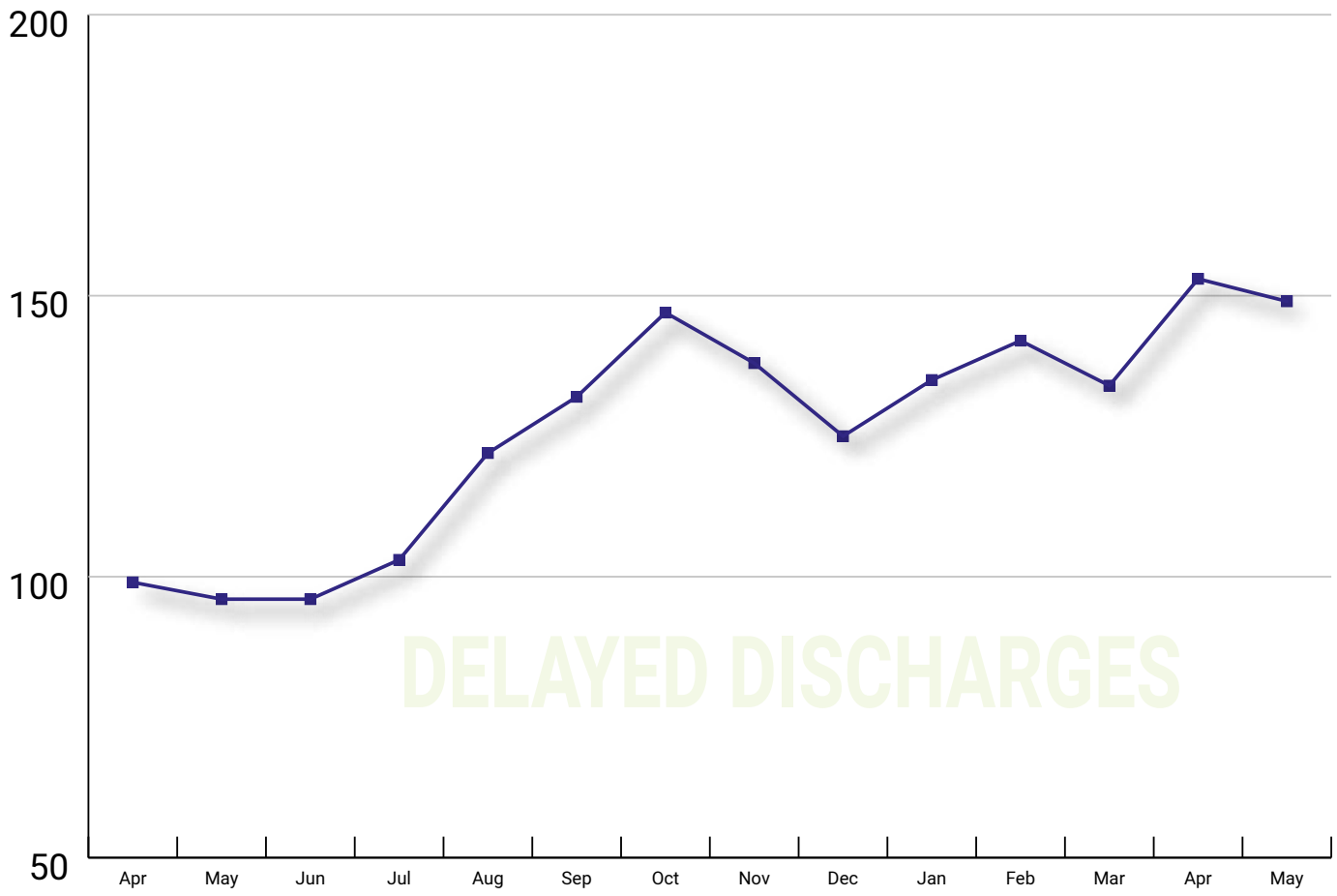
"We are involved in an important Self-evaluation and Improvement project of SDS for Highland in partnership with Social Work Scotland and the iHub. This is part of the National SDS Improvement Plan. We are employing facilitated self-evaluation methodology to co-produce improvements in how social workers and their partners carry out some of their "core" work: increasing their capacity for relationship-based practice and their ability to offer greater choice, control and flexibility in social care."

WHOLE SYSTEM FLOW

DELAYED DISCHARGE

There is no national target for delayed discharges (DDs), but Highland aim to ensure we provide our population care in the right place at the right time.

The following graph demonstrates the total number of delayed discharges every month until May 2023



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

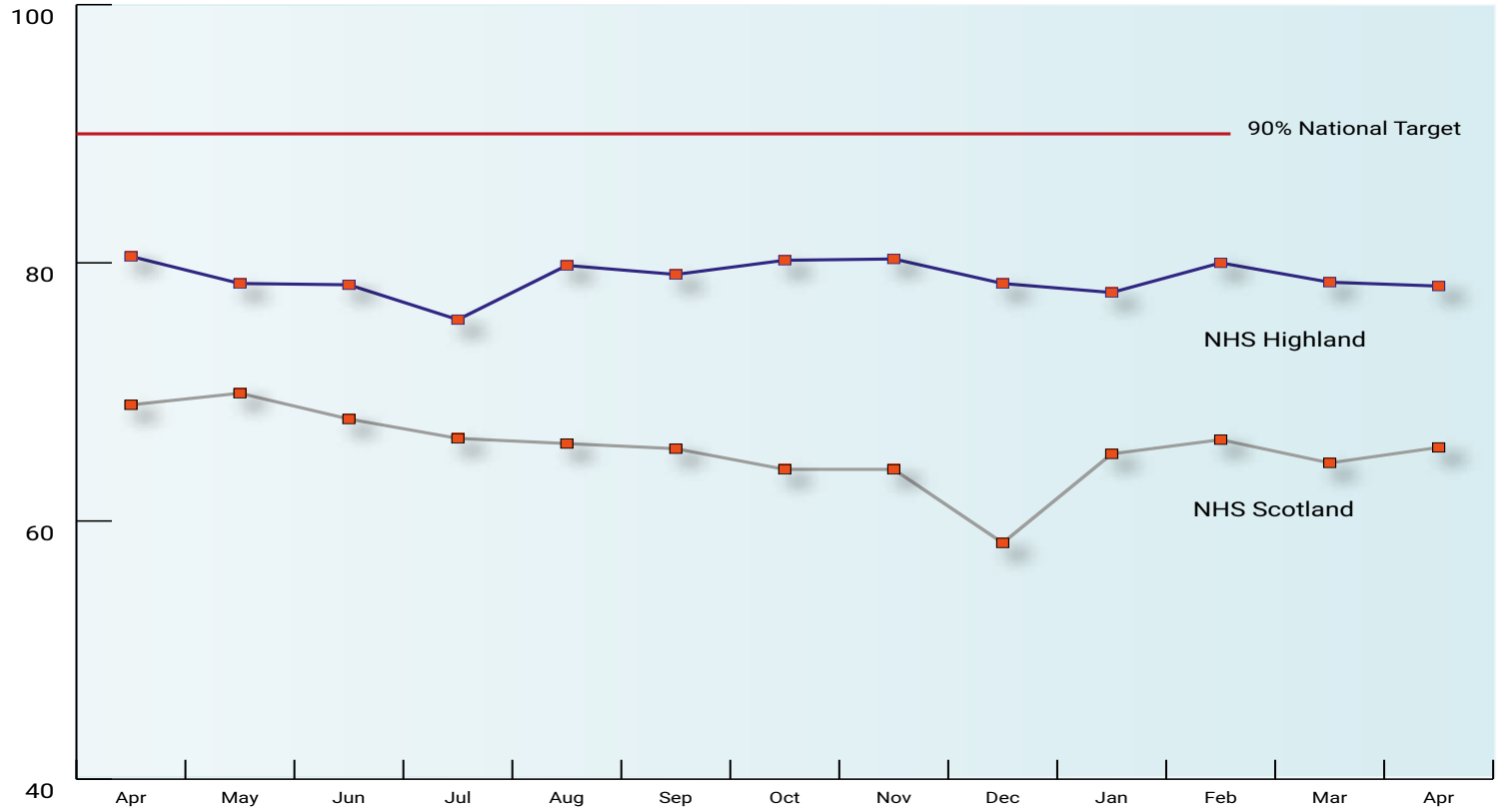
It is recognised that there is a close relationship between the unscheduled care work required across the system and the level of delayed discharges, this is alongside the competing challenges within acute and community services. There has been a need identified for quality improvement work across the organisation and is in Highland we are progressing key developments that are underway.

It is recognised that cross system working is key to ensuring success of this work with benchmarking from other areas to achieve sustainable improvements.

KEY ACHIEVEMENTS IN WHOLE SYSTEM FLOW REDESIGN

WINTER AND SYSTEMS PRESSURES

The 4-hour Emergency Access Standard remains the key indicator and measure of whole system safety and continues to be supported by the Royal College of Emergency Medicine (RCEM),and a wide range of clinical groups. The following graph illustrates that NHS Highland were able to maintain the 4-hour Emergency Access Standard through the year and during the period of winter pressure at a standard above the Scottish national average.



The national standard for A&E waiting times is that new and unplanned return attendances at an A&E service should be seen and then admitted, transferred, or discharged within four hours.

This programme of work included services from the front door of the 4 Emergency Departments through Acute services, Community and Adult Social Care and includes partner agencies such as SAS.

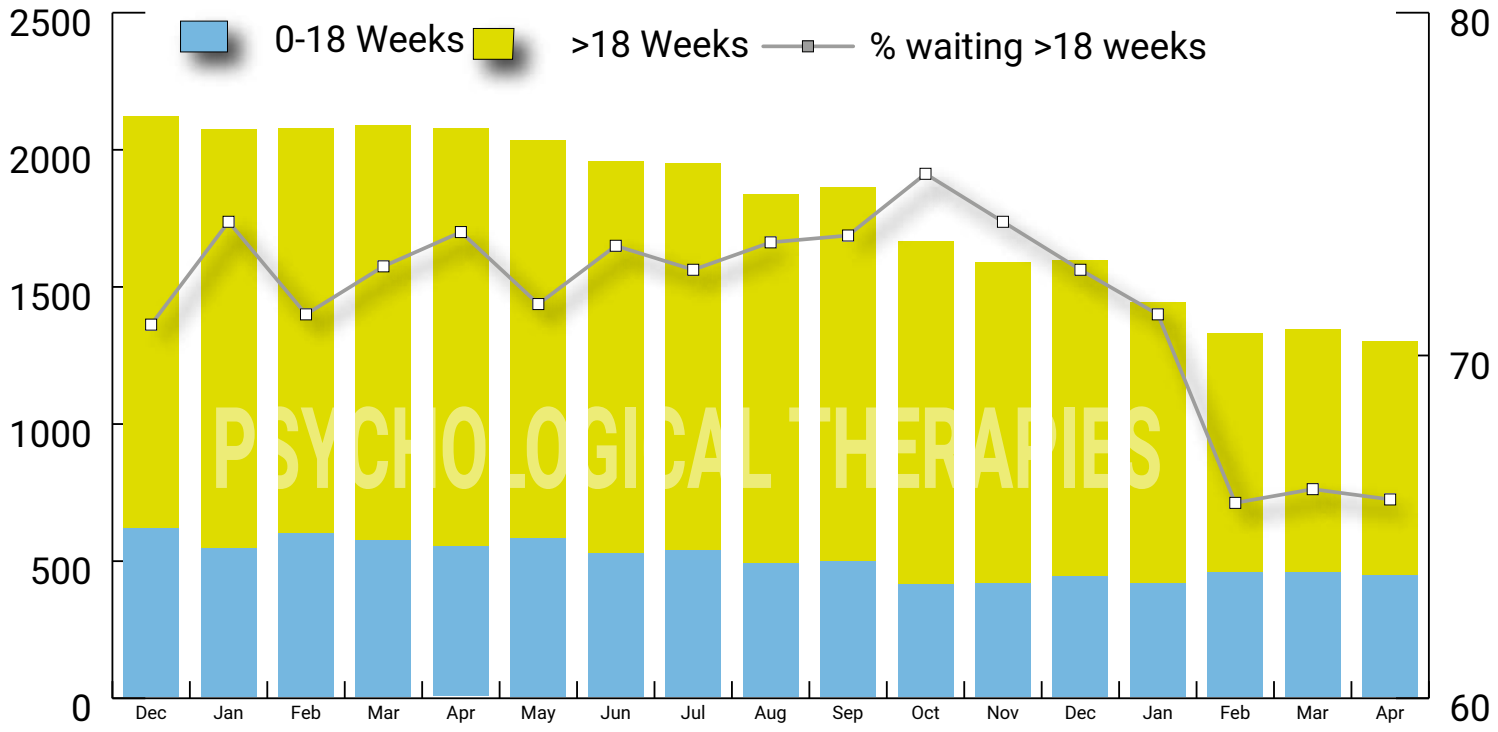
This was established through a “Winter Ready” task and finish group in September to bring together colleagues, 3rd sector and partners as a whole system approach to developing our “Winter Ready Action Plan” (WRAP). Six key priorities were identified to support the system with key actions and outcomes. This allowed us to work collaboratively, system wide to support the development of a mutual understanding of the required outcomes for our population through an integrated approach.

For each of the 6 key themes a set of mission critical actions (54 in total) supported by key performance indicators were developed. Twice weekly tactical meetings were held on Thursdays to ensure accountability and responsibility. Each week a system pressures report was used at the Thursday meetings to examine the whole system across community and acute to understand what mitigations were being put in place to ensure resilience.

KEY ACHIEVEMENTS IN MENTAL HEALTH AND LEARNING DISABILITY

PSYCHOLOGICAL THERAPIES

The national target: 90% of people commence psychological therapy-based treatment within 18 weeks of referral. Psychological therapies services have had longstanding challenges with significant waiting times. There are several factors that have led to this including a lack of any other route for psychological interventions at an earlier stage. It is anticipated that the development of primary care mental health services will help along with the targeted use of community resources and the development of CMHT colleagues to work with their psychological therapy colleagues. It has also been identified that there is a gap in the provision of Clinical Health Psychology this is currently being addressed by the Board and Director of Psychology.



There will always be a need for specialist services and Highland are working to build a sustainable model. Recruitment and retention is a challenge with national recruitment is taking place. There has been successes in developing a neuropsychology service which forms the majority of out current extended waits. The data provided is showing improvement overall with clear trajectories agreed with Scottish Government as we progress with our implementation plan.

DRUG AND ALCOHOL RECOVERY

- The collection of experiential data from people accessing services, family members and practitioners. The data has been thematically analysed with support from Research and Development colleagues and will be used to inform future service developments
- Completion of an evaluation of the Housing First pilot which reported that: “Stable housing alongside rapid access to treatment and support for independent living provides a foundation for improved health and wellbeing, reduction in criminal behaviour and less health emergencies including overdose”. The learning will be incorporated in to mainstream services.
- Delivery of a webinar by Caithness Drug and Alcohol Recovery Service In partnership with Health Improvement Scotland, in order to share learning on delivery of assertive outreach in remote and rural communities to reduce drug deaths.
- Expansion of the residential rehabilitation capacity in Inverness within the grounds of Beechwood House. The expansion will allow a 46% increase in annual service capacity and provide benefit to the Highlands

as well as the surrounding areas of Moray and the Western and Northern Isles. Supported by the Drug and Alcohol Recovery Service, CrossReach were able to secure funding of £2.4million from the Scottish Government to achieve this.

- Progress toward delivering the national Medication Assisted treatment Standards (MATS) across NHS Highland. There are no longer lengthy waits and individuals requiring medication assisted treatment will be able to access this on the same day of presentation. There has been an increase in non-medical prescribers who can prescribe treatments previously only available from a GP or specialist doctor.
- Progress in relation to proactively seeking and offering support to all individuals identified as being at risk of harm.
- Caithness and Inverness have both developed specific outreach models with the objective of reducing
- drug related deaths.
- Joined up working arrangements with Scottish Ambulance Service and Police Scotland have strengthened enabling local services to proactively and urgently respond where concerns have been identified i.e. non-fatal overdose pathway
- Waiting times have reduced across Drug and Alcohol Recovery Services.
- Improvements in access to harm reduction interventions.
- Individuals are now routinely offered a range of harm reduction interventions wherever they present for treatment. This is evidenced by an increase in Naloxone distributed across Highland.

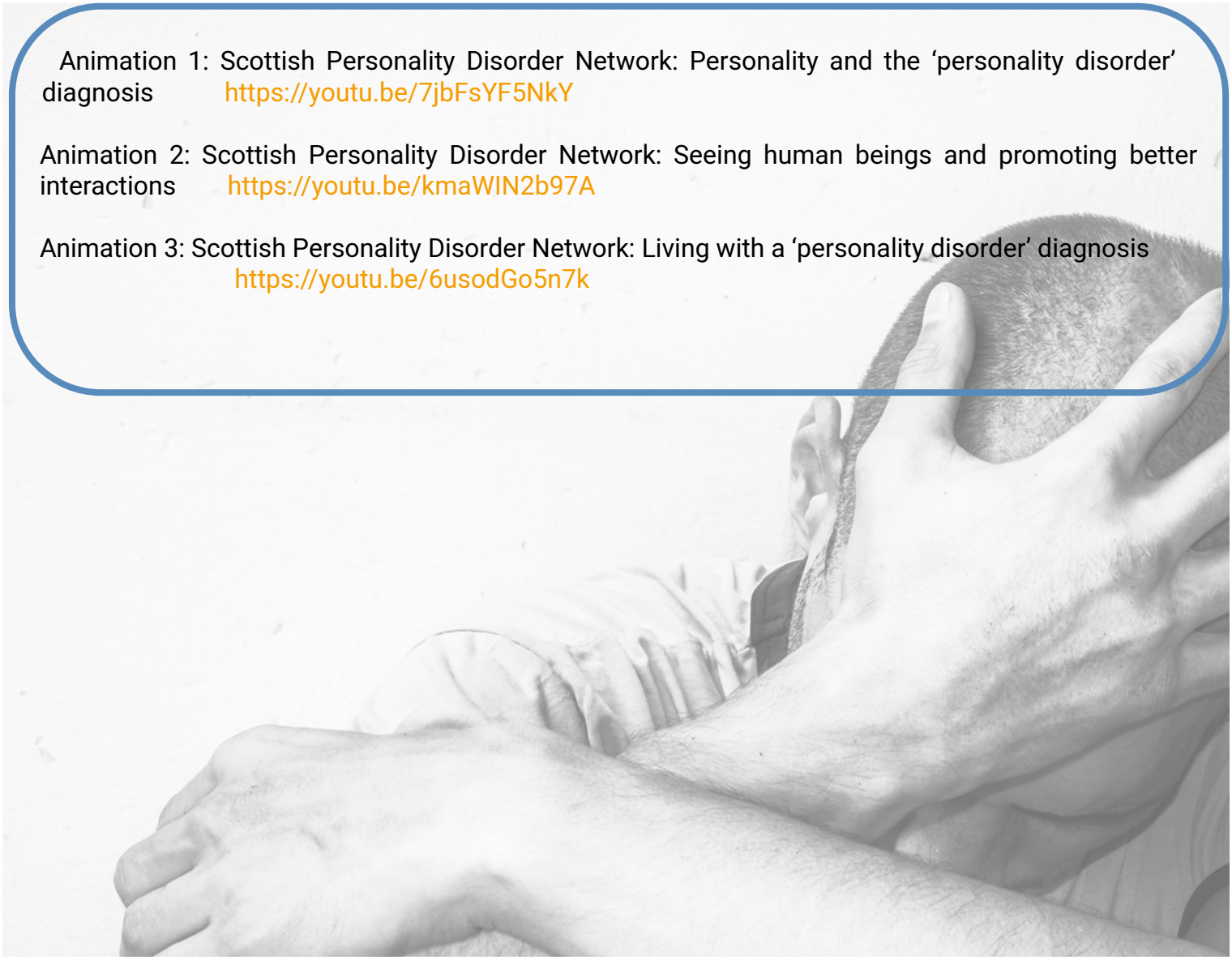
MENTAL HEALTH

- Establishment of a Mental Health & Wellbeing Primary Care Service (MHWPC). The service provides easily accessible psychological interventions to individuals with mild to moderate mental health concerns
- Revision and improvement of the Psychiatric Emergency Plan including the provision of a new Escort Team to support people transferring into New Craigs Hospital in Inverness from across Highland.
- Establishment of The Highland Peri-natal and Infant Mental Health service. The service provides care and treatment from a wide range of disciplines including midwifes, psychology and mental health nurses.
- Involvement of the Highland Mental Health Assessment Unit in the joint Operation Respect initiative over the festive period. This initiative aimed to improve relationships between agencies and the unit continues to proactively develop relationships with other agencies.
- The development of strategies and interventions to enable people to stay at home longer by the Older Adults Stress & Distress Team working with care homes and community health and social care teams.
- Participation in a pilot project to design Attention Deficit Hyperactivity Disorder (ADHD) assessment
- pathways which will be evaluate later this year.
- Creation of a Mental Health and Learning Disability Services Strategy that we will be available in draft format in July this year. To co-produce this we have worked in partnership with the Scottish Recovery Network to arrange a series of Conversation Cafes to hear from people and created a Stakeholder Group to draft the strategy.
- The NHS Highland Personality Disorder Service has worked closely with the Personality Disorder Network and the Scottish Government to create 3 short animations: “There is Hope Beyond Diagnosis- A Series of Short Animations”.

Animation 1: Scottish Personality Disorder Network: Personality and the ‘personality disorder’ diagnosis https://youtu.be/7jbFsYF5NkY

Animation 2: Scottish Personality Disorder Network: Seeing human beings and promoting better interactions https://youtu.be/kmaWIN2b97A

Animation 3: Scottish Personality Disorder Network: Living with a ‘personality disorder’ diagnosis https://youtu.be/6usodGo5n7k



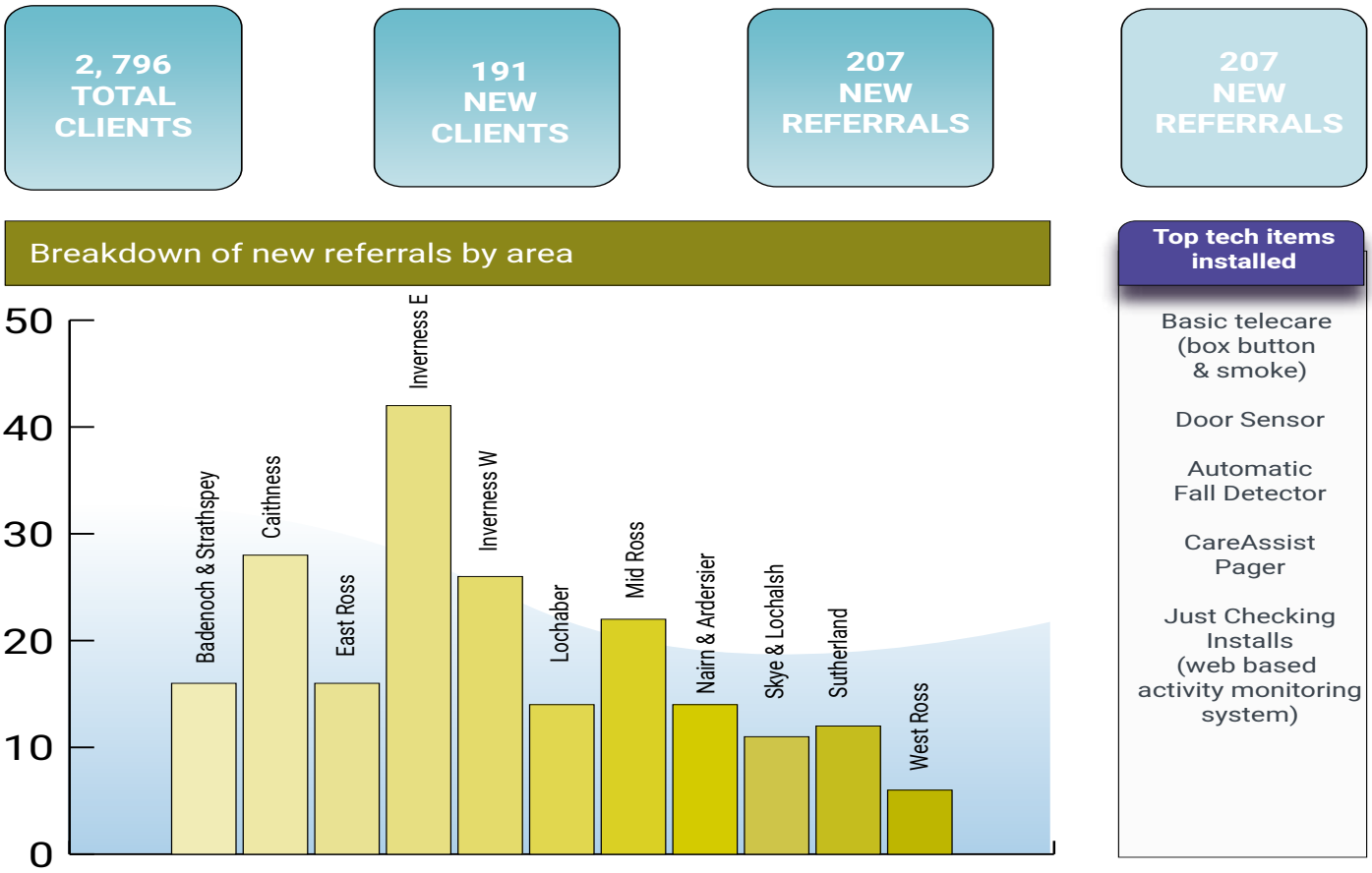
LEARNING DISABILITIES

- Creation of a plan to enable all people with a learning disability to receive a health check from a registered professional.
- Review of our housing models. Following the review we will develop further cluster housing models and work with people living in isolated tenancies to live nearer their peers to receive support.
- Development of a new cluster housing project for people with complex needs. We have worked with partners to design and build the project and people will move into their new homes in the forthcoming months.

KEY ACHIEVEMENTS IN DIGITAL HEALTH AND TECHNOLOGY ENABLED CARE

The following data identifies a that there are 2,796 people in Highland currently receiveing telecare support services.

Between January 2023 and March 2023 there an additional 191 people of 207 people referred, received the service, of which the top service was a basic call and response service. This totalled 923 items which were installed during this period.



TECHNOLOGY ENABLED CARE

- Continued uptake of the use of technology enabled care by clients and patients. Over the year there were 191 new clients and 923 items installed in people's homes.
- Continued use of Near Me video consultation appointments. Psychology Services was our top provider of NHS Near Me, with approximately 44% of people accessing Psychological Services through the platform.
- Completion of a trial in Inverness of Komp, which supports the safe self administration of insulin. The results of the trial were positive and continued funding has been secured for a further 12 months.

KEY ACHIEVEMENTS IN PRIMARY CARE

- The integration of Pharmacotherapy teams of clinical pharmacists and pharmacy technicians across all GP practices. Remote hub models are also in development in Lochaber, Caithness, Invergordon and Inverness.
- First Contact Physiotherapists are in place across all practices working closely with GPs providing improved access for musculoskeletal conditions. With a team of 30 advanced physiotherapy practitioners, the First Contact Physiotherapy service now works in every general practice in NHS North Highland and provides around 50,000 appointments annually.
- The service enables direct, fast access to assess, diagnose and manage musculo-skeletal conditions and supports GP workload, with the ability to prescribe, inject and refer onward. Patient feedback continues to be positive, highlighting ease of access, expert opinion and supported self-management.
- Provision of a community link worker service by Change Mental Health to 29 GP practices. Between February-April 2023, 306 referrals were received. Community link workers can co-ordinate and refer people to access local support services within their area. A service evaluation has been commissioned from the University of the Highlands and Islands.
- Planning for the provision of Community treatment services. These services are due to be implemented during 2023/24 from a range of local venues including community hospitals or GP practices. This service will provide access to a range of nursing services including phlebotomy, wound management and support vaccination transformation.
- Completed merger of three Caithness GP practices creating a greater skill mix of staff, supporting the GP as expert medical generalist. A further merger, of two GP practices is planned, providing greater stability for the Ardnamurchan peninsula.
- Review of GP services on North Coast of Sutherland aligned with the North Coast Redesign and new care facility to be built in Tongue.
- Implementation and progression of an Out-of-hours service review to ensure appropriate workforce model across local areas.
- Increased Public Dental Service (PDS) capacity for in-hours routine and urgent dental care for unregistered and deregistered dental patients. Increasing capacity has been limited by failure to recruit to Dentist posts, mitigated partially by recruitment of Dental Therapists. Recruitment to Dentists posts is unlikely to improve in the short-term. Clinical time has been taken from PDS Dentist appointment books to provide care of unregistered and deregistered dental patients, with the impact of reducing capacity to provide routine care for registered PDS patients and increased waiting times to assess/ treat referrals. Currently, extension of the weekend OOH Emergency Dental Service into weekday evenings is being considered, to alleviate some pressure on in-hours PDS Emergency Dental Service. Also, in specific geographic locations such as Ullapool, where the General dental Practice has closed permanently. The PDS is planning to provide part-time Emergency Dental Service provision in Ullapool, from the vacant Dental Surgery in the Ullapool Health Centre.
- Recruitment to dentist vacancies and introduction of skill mix ensuring dental access for vulnerable individuals, including general anaesthetic. Successful recruitment to Dentist posts has been very limited and unlikely to improve in the short-term, therefore impacting directly on service delivery. Dental Therapists have been recruited where Dentist posts remain unfilled. Recruitment to Dental Therapist posts has proved to be more successful at this time , compared with dentist recruitment, although still challenging.
- New enhanced service glaucoma pathway implemented across 7 Community Optometrists. The new enhanced service 'Community Glaucoma Service (CGS) is a national service and so far, only some HSCP areas in NHS Greater Glasgow and Clyde have implemented the service. The roll out of the service is being directed by SG Community Eyecare Team. NHS Highland requires more optometrists to obtained NESGAT (NES Glaucoma Accreditation Training) before Scottish Government will support the Health Board implementation of the service (this is a similar position in the majority of health Boards). The next NES training cohort for NESGAT will start in July and so it is anticipated the service will be rolled out across NHS Highland next financial year.

- Development of the Pharmacy First scheme now in place across 59 Community Pharmacies, offering

- advice and treatment for range of minor ailments. Twelve pharmacies provide an enhanced Pharmacy plus scheme. The Pharmacy First Service provided by Community Pharmacies is a National service that was established in 2020 as part of the Core Pharmacy contract. The activity over the last year has seen a significant increase. The number of Pharmacy First items prescribed have increased by 27% to 105216 items for full year 2022 - 2023 which is representative of the awareness and confidence in the service by the public. The number of recorded consultations to provide advice has also significantly increased with the biggest increase seen over the busy winter period in comparison to the previous year. Overall activity which includes items, consultations and referrals recorded has seen a full year rise by 28%, slightly higher than the national 24% increase year on year.

KEY ACHIEVEMENTS IN ENGAGEMENT

- Completion of a significant participation and engagement exercise on our Self Directed Support (SDS) strategy by NHS Highland, The Highland Council and a range of partners receiving responses from around 200 people. The exercise gathered the views of people who need support and of those involved in its provision, about how we should deliver self-directed support into the future.
- Completion of a significant consultation exercise on our Mental Health and Learning Disabilities Strategy.
- Completion of a significant participation and engagement exercise included people with lived experience and 74 Partner / Community groups and 18 NHSH service areas. Various methods of engagement were utilised, including virtual and face to face sessions, conversation cafes and event tagging. Over 1000 feedback entries were received from across all areas and the information is stored and available for future use.

KEY ACHIEVEMENTS IN CHILDREN'S SERVICES

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

A clear service model has been agreed, maintaining our unscheduled care model, a plan to establish a separate function for intensive home treatment, and realign our core capacity into a locality-based model, which has become centralised in response to staff shortages and covid response. Locality alignment allows for greater integration with early intervention locality-based provision across NHSH and THC, improving service user experience and allowing for greater flexibility and maximisation of workforce capacity across the entire system.

In March 2023, the North Highland CAMHS service carried out an experience of service survey. Outcomes are presented below for parents/carers, adolescent, and children's experience of accessing the CAMHS Service currently. Overall high levels of satisfaction were recorded, and an action improvement plan is being developed for 2024.

Some comments and feedback received:

- I was treated well by the people who saw me.
- My views and worries were taken seriously.
- I feel that the people who have seen me are working together to help me.
- My appointments were usually at a convenient time.
- Overall, the help I have received here was good.

TRANSFORMING THE ROLE OF THE SCHOOL NURSE

As part of Highland's integrated Children's Services Whole Family Approach to Mental Health and Wellbeing, the partnership have made significant progress to transforming the role of School Nursing. Highland's Advanced Nurse Training Programme has raised the qualification, skill, competence, and confidence of the school nursing workforce to address the impacts of inequalities and address family poverty, with a particular focus on mental health for all of school nursing.

PERINATAL INFANT MENTAL HEALTH

The Perinatal and Infant Mental Health Team is a tri-pathway service covering Perinatal Mental Health, Maternity and Neonatal Psychological Intervention, and Infant Mental Health. The PNIMHT has a particular focus on psychosocial support for the Maternity and the Neonatal Unit, CAMHSs sessions, Perinatal Advice Meetings / Professional Reflection (PAMPR) sessions which offer support to staff across the partnership including Midwifery and Health Visiting.

HIGHLAND SOLIHULL IMPLEMENTATION

The Solihull Approach focuses on developing nurturing and supportive relationships between children and their carer by promoting reflective, sensitive and effective parenting. The Scottish Government have refreshed the Solihull approach as part of the whole system approach to mental health. The partnership have progressed with implementing the national approach over the past 6 months. The partnership are on track to have a cohort of Solihull trainers by Summer 2023. This will enable local implementation of the approach across the partnership and 3rd sector.

CHILD HEALTHY WEIGHT

Working closely with NHS Highland and the third sector The Highland Council dietetic service is helping deliver the tiered programme for child healthy weight which aims to meet the Scottish Government standards for Child Healthy Weight (Tier 2&3) as well as focusing on improving health outcomes for the whole family. To increase uptake, the programmes have been advertised throughout the Highland Council area along with the development of a dedicated webpage on the NHS Highland internet detailing the programmes.

CHILD PROTECTION

There have been a number of key achievements in child protection. These have included:

- Implementation of the new National Child Protection Guidance
- The delivery of interagency and single discipline learning and staff development opportunities
- Quality Assurance of practice and supervision
- Dissemination of learning from case reviews and the sharing of good practice
- Pilot project using Virtual Reality Headsets to obtain the views of children and young people
- Improve opportunities for supporting children, young people and families affected by drug or alcohol issues by implementing a whole family approach
- Implementation of the Safe and Together Model

LEARNING FROM CASE REVIEWS

In Children and families Social Work it was recognised that undertaking reviews during the pandemic has been extremely challenging and not conducive to a safe learning environment. Highland have adapted the National Learning Review Guidance (Scotland) 2021 and held a Learning Review workshop to explore best practice in progressing learning reviews and disseminating learning effectively. A mentoring scheme is currently underway through Barbara Firth, author of the national guidance, to support 12 members of staff from across Health, Social Work, Education and High Life Highland to undertake Learning Reviews and disseminate key messages and learning across agencies

CARE AND RISK MANAGEMENT PROCESSES

Care and Risk Management processes have been reviewed and updated with an increased focus on Care elements. Previously, the focus has been primarily on risk management from a Police perspective. However, the new procedures enable a multi-agency approach to ensuring the wellbeing needs of young people are met whilst minimising risk to the wider community. Procedures have been developed in line with national FRAME guidance

HOME TO HIGHLAND PROGRAMME

The 'Home to Highland' Programme vision is to return care experienced young people to the Highlands from Out of Area (OOA) residential placements, whilst also building services in-area to help children avoid OOA residential placements. The Programme aims to reduce spot-purchased residential placements, retain more

young people in the Highland area and increase the number of children placed in foster care and family alternatives.

Since 2018, over 70 children have returned to Highland and over 400 have worked with the 'Home to Highland' team with demonstrably improved educational and emotional wellbeing outcomes. A combination of new services and the creative use of existing provisions are enabling children to remain in the communities they know and that care for them. This also reduces the need for additional out of area placements.

UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC)

During the past year the Home Office have created a rota system for transferring UASC to local authorities across the country. This process was mandated towards the end of 2021. Our alliance with our 3rd sector partners enabled us to provide a service to these young people and have s.uccessfully adopted a model to ensure ongoing sustainability in meeting our mandated responsibility.

Finance

Summary

Note HHSCP financial position at month 12 which shows a year end overspend of £6.800m
ASC breaking even due to funding drawn down which was held by Highland Council

Final position to March 2023

For the 12 months to March, HHSCP have overspent against budget by £6.800m, components of this overspend can be viewed in Table 1 below.

Current Plan	Detail	Plan to Date	Actual to Date	Variance to Date
£000		£000	£000	£000
	HHSCP			
234,002	NH Communities	234,002	240,518	(6,516)
49,592	Mental Health Services	49,592	50,617	(1,025)
146,698	Primary Care	146,698	147,451	(753)
(287)	ASC Other & Income	(287)	(1,781)	1,494
430,004	**Total HHSCP**	**430,004**	**436,805**	**(6,800)**
	HHSCP			
262,299	Health	262,299	269,077	(6,778)
167,706	Social Work	167,706	167,728	(22)
430,004	**Total HHSCP**	**430,004**	**436,805**	**(6,800)**

Within the NH Communities year end out-turn of £6.516m, an overspend of £2.633m relates to Adult Social Care expenditure – see appendix 1 for further detail on Social Care. Adult Social Care for 22/23 saw an increase in Independent Sector Care costs, with Learning Disability younger adult packages being the main attribute. Health ended with a year-end overspend of £3.882m, with unfunded services in Chronic Pain and Enhanced Community Service and slippage on the CIP contributing to this variance. Recruitment issues across the districts have resulted in a high number of vacancies which helped to mitigate the pressures within the service.

Mental Health Services ended the year with a £1.025m overspend; with locum and agency usage the main outliers. National recruitment difficulties within the Psychiatry service meant a greater reliance on the use of medical locums with £2.334m agency expenditure in the financial year. Increase in clinical observations in both the Dementia and LD units have resulted in nursing agency costs of £1.526m. However, ongoing vacancies across both inpatient and community services have mitigated this pressure.

Primary Care's year end out-turn showed an overspend of £0.753m. Within 22/23 the Board increased its number of managed practices (2cs) and as such there was an increase in locum costs due to recruitment issues. Within Prescribing, short supply drugs increased costs nationally with the HHSCP overspending by £1.200m in 22/23. Mitigating this position, Dental reported an underspend of £1.418m which reflects the ongoing recruitment difficulties within the service.

ASC Central are reporting a £1.494m underspend. This position reflects the drawdown of funding held by the Highland Council and the full Adult Social Care position can be viewed on appendix 1.

Savings
NHS Highland identified a savings challenge of £26.000m to deliver a balanced position at the start of the year. Whilst there was delivery of savings of £3.165m from the Division, additional support from the SG at the end of the year was required to deliver a breakeven position.

Conclusion
HHSCP financial position completed the year end with an overspend of £6.800m. This position reflects the challenge of the service pressures and slippage on the CIP.

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

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

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

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

	Annual	YTD			YE	
Services Category	**Budget**	**Budget**	**Actual**	**Variance**	**Outturn**	**Variance**
	£000's	£000's	£000's	£000's	£000's	£000's
Older People - Residential/Non Residential Care						
Older People - Care Homes (In House)	16,670	16,670	15,965	705	15,965	705
Older People - Care Homes - (ISC/SDS)	32,270	32,270	33,995	(1,725)	33,995	(1,725)
Older People - Other non-residential Care (in House)	1,288	1,288	1,227	61	1,227	61
Older People - Other non-residential Care (ISC)	1,590	1,590	1,640	(50)	1,640	(50)
Total Older People - Residential/Non Residential Care	**51,818**	**51,818**	**52,827**	**(1,009)**	**52,827**	**(1,009)**
Older People - Care at Home						
Older People - Care at Home (in House)	16,672	16,672	15,860	812	15,746	926
Older People - Care at home (ISC/SDS)	16,586	16,586	18,183	(1,596)	18,296	(1,710)
Total Older People - Care at Home	**33,258**	**33,258**	**34,043**	**(784)**	**34,043**	**(784)**
People with a Learning Disability						
People with a Learning Disability (In House)	4,643	4,643	3,483	1,160	3,483	1,160
People with a Learning Disability (ISC/SDS)	34,737	34,737	35,656	(919)	35,656	(919)
Total People with a Learning Disability	**39,380**	**39,380**	**39,139**	**242**	**39,139**	**242**
People with a Mental Illness						
People with a Mental Illness (In House)	561	561	332	228	332	228
People with a Mental Illness (ISC/SDS)	7,914	7,914	7,738	176	7,738	176
Total People with a Mental Illness	**8,475**	**8,475**	**8,071**	**404**	**8,071**	**404**
People with a Physical Disability						
People with a Physical Disability (In House)	932	932	646	286	646	286
People with a Physical Disability (ISC/SDS)	6,951	6,951	7,185	(234)	7,185	(234)
Total People with a Physical Disability	**7,883**	**7,883**	**7,831**	**52**	**7,831**	**52**
Other Community Care						
Community Care Teams	8,546	8,546	7,420	1,126	7,420	1,126
People Misusing Drugs and Alcohol (ISC)	16	16	10	6	10	6
Housing Support	6,091	6,091	5,908	183	5,908	183
Telecare	985	985	929	56	929	56
Carers Support	1,485	1,485	1,485	(0)	1,485	(0)

	Annual	YTD			YE	
Services Category	**Budget**	**Budget**	**Actual**	**Variance**	**Outturn**	**Variance**
Total Other Community Care	**17,122**	**17,122**	**15,752**	**1,371**	**15,752**	**1,371**
Support Services						
Business Support	1,860	1,860	1,658	201	1,658	201
Management and Planning	7,686	7,686	8,161	(475)	8,161	(475)
Total Support Services	**9,546**	**9,546**	**9,820**	**(274)**	**9,820**	**(274)**
Care Home Support	836	836	836	(0)	836	(0)
Total Adult Social Care Services	**168,318**	**168,318**	**168,318**	**0**	**168,318**	**0**

RISKS TO PERFORMANCE

There are several key risks to delivering our strategic objectives and overall performance. These are:

Service sustainability and increasing demand
Regionally and nationally, the demand on our health and care services is increasing. In Highland, our aging population and the difficulty to recruit is putting additional pressure on services. The Aim High, Aim Highland programme is working to tackle this, along with working with partner agencies to secure housing for staff, collaboration with the NES and UHI oncareer pathways and also strategic workforce planning within each of our programme board to review current and future issues.

Infrastructure
Many of our facilities are now dated and no longer fit for purpose. These are addressed in priority through our Estates services and utilising risk registers. Achievemtns in this area, improving staff and patient experience, have been investment in and the completion of two new builds, Broadford Hospital and the National Treatment Centre. Two hospitals, in Aviemore and Broadford, won the Healthcare Building of the Year award in 2022 and 2023. Further investment has been agreed in Lochaber and Caithness.

Rural Delivery
There is an increased cost of care associated with delivery across our remote and rural region. In addition to this, we must ensure that the geography of our Board area does not increase inequalities to accessing care. ADD STRATEGY

Workforce capacity and resilience
Recruitment to NHS Highland is challenging due to our geography and demographics. The lack of a complete workforce results in additional pressure on existing staff and results in reduced staff resilience. The Highland Health and Social Care Partnership and NHS Highland are working to proactively address the situation. In addition to the work being done to improve recruitment and career pathways, NHS Highland has in place an independent Guardian Speak Up service and a 24/7 employee assistance programme staff can directly access.

Finance
As demand increases, the finance available is decreasing. We must attempt to deliver more with less and thus work in new and adaptive ways. With regards to this, all programme boards are working with finance, strategy and transformation, service leads and workforce planning to identify more efficient ways of working.

NHS Highland

The Highland Council
Comhairle na Gàidhealtachd

NHS Highland Data Reports

National Integration Indicators

Together We Care Outcomes

Minesterial Strategic Indicator Summary

North Highland Health & Social Care Partnership Performance and Quality Report Indicators

National Outcomes	National Standard	National Integration Indicators	Target 2022/23	Reporting Period	Reporting Periods							NHS Highland	Benchmarking	Scotland 2022
1	NA	1. Percentage of adults able to look after their health very well or quite well	NA	Biennial	15/16	95%	17/18	94%	19/20	94%	21/22	92.4%		90.9%
2	NA	2. Percentage of adults supported at home who agreed that they are supported to live as independently as possible	NA	Biennial	15/16	83%	17/18	86%	19/20	82%	21/22	86.5%		79%
2 & 3	NA	3. Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	NA	Biennial	15/16	77%	17/18	79%	19/20	75%	21/22	72.1%		70.6%
3 & 9	NA	4. Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	NA	Biennial	15/16	73%	17/18	76%	19/20	69%	21/22	71.9%		66.4%
3	NA	5. Percentage of adults receiving any care or support who rated it as excellent or good	NA	Biennial	15/16	83%	17/18	83%	19/20	79%	21/22	83%		75.3%
3	NA	6. Percentage of people with positive experience of the care provided by their GP practice	NA	Biennial	15/16	89%	17/18	87%	19/20	85%	21/22	77.2%		66.5%
4	NA	7. Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaing their quality of life	NA	Biennial	15/16	85%	17/18	86%	19/20	78%	21/22	84.3%		78.1%
6	NA	8. Percentage of carers who feel supported to continue in their caring role	NA	Biennial	15/16	37%	17/18	38%	19/20	33%	21/22	28.7%		29.7%
7	NA	9. Percentage of adults supported at home who agreed they felt safe	NA	Biennial	15/16	84%	17/18	84%	19/20	82%	21/22	86%		79.7%
1& 5	NA	11. Premature mortality rate for people under 75 (per 100,000 population)	NA	Year Ending	19/20	390	20/21	397	21/22	407	22/23			466
1, 2, 4, 5 & 7	NA	12. Emergency admission rate for adults (per 100,000 population)	NA	Year Ending	19/20	10,677	20/21	9,836	21/22	9,828	22/23			11,155
2, 4, & 7	NA	13. Emergency bed day rate for adults (per 100,000 population)	NA	Year Ending	19/20	117,078	20/21	99,861	21/22	108,743	22/23			113,134
2, 3, 7 & 9	NA	14. Emergency re-admissions to hospital within 28 days of discharge (per 1,000 discharges)	NA	Year Ending	19/20	113	20/21	118	21/22	110	22/23			102
2, 3 & 9	NA	15. Proportion of last 6 months of life spent at home or in a community setting	NA	Year Ending	19/20	89%	20/21	91%	21/22	90.4%	22/23			89.3%

National Outcomes	National Standard	National Integration Indicators	Target 2022/23	Reporting Period	Reporting Periods							NHS Highland	Benchmarking	Scotland 2022
2, 4, 7 & 9	NA	16. Falls rate per 1,000 population aged 65+	NA	Year Ending	19/20	15	20/21	15	21/22	14.2%	22/23			22.2%
3, 4, & 7	NA	17. Percentage of care services graded "good" (4) or better in Care Inspectorate inspections	NA	Year Ending	19/20	83%	20/21	84%	21/22	83%	22/23			75.2%
2	NA	18. Percentage of adults with long term care needs receiving care at home	NA	Year Ending	19/20	55%	20/21	54%	21/22	52.2%	22/23			63.5%
2, 3, 4 & 9	NA	19. No. of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	NA	Year Ending	19/20	1,278	20/21	817	21/22	1,249	22/23			919
2, 4, 7 & 9	NA	20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	NA	Year Ending	19/20	23%	20/21		21/22	23%	NI. 20 presents the cost of emergency admissions as a proportion of total health and social care expenditure. PHS have recommended that integration authorities do not report information with their APR beyond 2019/20. Due to changes in service delivery during COVID-19 pandemic, NHS Boards were not able to provide information at this level for financiall year 2020/21. As a result, PHS are not able to produce cost information for that year.			
8	NA	**10. Percentage of staff who recommend their workplace as good	NA								Under development by PHS			
2	NA	**21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home (under development)	NA											
2, 3 & 9	NA	**22. Percentage of people who are discharged from hospital with-in 72 hours of being ready (under development)	NA											
2, 3 & 9	NA	**23. Expenditure on end of life care (under development)	NA											

KEY TO TABLES

performance status		benchmarking	
improving performance			better than average
static			average +/- 5%
declining performance			worse than average
pending publication			PHS data

Calendar year 2022 is used here as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance issued by Public Health Scotland which was communicated to all Health and Social Care Partnerships. Using more complete calendar year data for 2022 should improve the consistency of reporting between Health and Social Care Partnerships. Biennial survey data is next updated in 2024.

Section	MSG No.	Standard/Indicator	Target 2021/22	Reporting Periods								NHS Highland	Comments
Ministerial Strategic Indicators	MSG 1	Number of emergency admissions - North Highland		18/19	"23,072 (10.9)"	19/20	"23,008 (8.6)"	20/21	"19,783 (9.2)"	21/22	"20,717 (8.8)"	22/23	not yet published	(rolling 12 months & rate per 1,000 population)
	MSG 2a	Unplanned bed days -acute		18/19	"179,741 (84.3)"	19/20	"184,712 (72.9)"	20/21	"158,248 (77.2)"	21/22	"180,136 (82.4)"	22/23	not yet published	(rolling 12 months & rate per 1,000 population)
	MSG 2c	Unplanned bed days -mental health		18/19	"39,519 (18.3)"	19/20	"38,641 (16.0)"	20/21	"33,214 (14.2)"	21/22	"32,636 (15.7)"	22/23	not yet published	(rolling 12 months & rate per 1,000 population)
	MSG 3	A&E Attendances		18/19	"39,450 (17.3)"	19/20	"40,451 (13.2)"	20/21	"31,598 (14.2)"	21/22	"38,185 (17.0)"	22/23	not yet published	(rolling 12 months & rate per 1,000 population)
	MSG 4a	Delayed Discharges - bed days All Reasons		18/19	"37,824 (16.8)"	19/20	"42,611 (18.0)"	20/21	"28,223 (14.6)"	21/22	"34,673 (17.0)"	22/23	not yet published	(rolling 12 months & rate per 1,000 population)
	MSG 4c	Delayed Discharges - bed days H&SC Reasons		18/19	"27,769 (11.3)"	19/20	"31,830 (12.4)"	20/21	"19,819 (10.2)"	21/22	"24,482 (9.2)"	22/23	not yet published	(rolling 12 months & rate per 1,000 population)
	MSG 5	End of life care -Percentage of last 6 months in the community		18/19	89.7%	19/20	89.6%	20/21	91.6%	21/22	91.4%	22/23	not yet published	21/22 provisional from PHS
	MSG 5	End of Life - Percentage of last six months in hospital / hospice		18/19	103.0%	19/20	10.4%	20/21	8.4%	21/22	8.6%	22/23	not yet published	21/22 provisional from PHS
	MSG 6	Balance of Care - Percentage of Population in Community Settings		18/19	99.6%	19/20	99.7%	20/21	99.7%	21/22		22/23		latest PHS published data is for 2020/21

Strategic Objective/ Outcome	Priority	Measure	National Outcome	Reporting Period	Reporting Periods					Comments
					Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	
SO 3 Outcome 9 Care Well	2 (9a,9b, 9c)	Care at Home - Unmet Need - No. of clients assessed and awaiting a service (waiting list includes DHD patients)		Year-End	143	155	163	241	321	number of clients per week
SO 3 Outcome 9 Care Well	2 (9a,9b, 9c)	Care at Home - Unmet Need - No. of hours required - assessed and awaiting a service (in-cludes DHD patients)		Year-End	397	593	911	1455	2383	number of scheduled hours per week requried including new clients and those already in receipt of a service requiring additional hours
SO Outcome 9 Care Well	2 (9a,9b, 9c)	Care at Home - current clients in receipt of a service		Year-End	1,889	1,871	2,020	1,904	1,784	number of clients per week, including internal and external provision
SO Outcome 9 Care Well	2 (9a,9b, 9c)	Care at Home - hours per week (current clients in receipt of a service)		Year-End	14,970	14,440	15,921	14,949	13,458	number of hours per week, including internal and exter-nal provision
SO Outcome 9 Care Well	2 (9a,9b, 9c)	Care at Home - new cli-ents in receipt of a service		Yearly	1,032	1,091	1,256	1,052	1,034	number of new clients during year, including internal and external provision
SO Outcome 9 Care Well	2 (9a,9b, 9c)	Care at Home - closed clients		Yearly	1,150	1,111	1,095	1,193	1,189	number of closed clients during year, including internal and external provision
SO Outcome 9 Care Well	2 (9a,9b, 9c)	Care Homes - long-stay residential & nursing placements (current)		Year-End			1,723	1,758	1,733	number of residential placements for March of each year
SO 3 Outcome 9 Care Well	2 (9a,9b, 9c)	Care Homes - long-stay residential & nursing placements (new)					59	53	52	number of new residential placements for March of each year
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	Care Homes - long-stay residential & nursing placements (closed)					54	73	81	number of closed residential placements for March of each year
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	Carer Breaks - Number of people who were ap-proved funding	6	Annual				171	213	Only commenced in 21/22, total number of people whose application for funding was approved (respite, holiday or treatments for wellbeing)
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	Carer Breaks - Total fund-ing approved	6	Annual				£399,458	£532,286	Only commenced in 21/22, total funding for people whose application for funding was approved (respite, holiday or treatments for wellbeing)
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	SDS Option 1 - Current number of clients in re-ceipt of a direct payment		Year-End	355	373	403	451	585	
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	SDS Option 2 - Current number of clients in receipt of an ISF		Year-End	261	266	241	235	207	

Strategic Objective/ Outcome	Priority	Measure	National Outcome	Reporting Period	Reporting Periods					Comments
SO 3/Outcome 10 - Live Well	10a, 10b, 10c	Psychological Therapies - Current number of People on Waiting List within North Highland		Year-End						
SO 3/Outcome 10 - Live Well	10a, 10b, 10c	Psychological Therapies - % of People within North Highland in receipt of treatment within 18 weeks		Year-End						National Target 90% of people will receive treatment within 18 weeks
SO 3/Outcome 10 - Live Well	10a, 10b, 10c	CMHT		Year-End						
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	Adult Protection - Number of referrals received	7	Annual	344	525	636	675	740	Total number of referrals received within the financial year
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	Adult Protection - Percentage of referrals received that progressed to an investigation	7	Annual	30.2%	26.9%	36.9%	31.4%	25.8%	Completed referrals with an outcome of further AP action
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)	Adult Protection - Number of investigations	7	Annual	97	127	211	206	183	Total number of investigations commenced within the financial year
SO 3/Outcome 9 Care Well	2 (9a,9b, 9c)									
SO 3/Outcome 11 - Respond Well	3 (11c)	DHD		Year-End						

No	Together We Care Outcome	Description	Main Service	Linked to National & Ministerial Outcomes and Indicators
1	Start Well	Give every child the opportunity to start well in life by empowering parents and families through information sharing, education, and support before and during pregnancy	Maternity & Neonatal Services / PNIMH	
2	Thrive Well	Work together with our families, communities and partners by building joined up services that support our children and young people to thrive	CAMHS / NDAS / Corporate Parenting / Integrated Children's Services / Paediatrics	
3	Stay Well	Work alongside our partners by developing sustainable and accessible health and care focused on prevention and early intervention	Public Health / Sexual Health / Gender Identity / Women's services	National Outcome 1
4	Anchor Well	Be an anchor and work as equal partners within our communities by designing and delivering health and care that has our population and where they live as the focus	Public Health / Comms & Engagement	
5	Grow Well	Ensure that all colleagues are supported to be successful in their role and are valued and respected for the work they do. Everyone will be clear on their objectives, receive regular feedback and have a personal development plan.	People & Culture / All services	
6	Listen Well	Work in partnership with colleagues to shape our future and make decisions. Our leaders will be visible and engage with the wider organisation, listening to, hearing, and learning from experiences and views shared	People & Culture / All services	National Outcome 8
7	Nurture Well	Support colleagues' physical and mental health and wellbeing through all the stages of their life and career with us. We foster an inclusive and kind culture where difference is valued and respected	People & Culture / All services	
8	Plan Well	Create a sustainable pipeline of talent for all roles, and excel in our recruitment and onboarding, making us an employer of choice both locally and nationally	People & Culture / All services	
9	Care Well	Work together with health and social care partners by delivering care and support together that puts our population, families, and carers experience at the heart	Adult Social Care	"National Outcome 2, 3, 4, 6, 7, 9 Ministerial Strategic Indicator 6"
10	Live Well	Ensure that both physical and mental health are on an equal footing, to reduce stigma by improving access and enabling all our staff in all services to speak about mental health and wellbeing	Mental Health Services	"National Outcome 2, 3, 4, 7, 9 Ministerial Strategic Indicator 2c"

No	Together We Care Outcome	Description	Main Service	Linked to National & Ministerial Outcomes and Indicators
11	Respond Well	Ensure that our services are responsive to our population's needs, by adopting a “home is best” approach	Urgent and Unscheduled Care Services	"National Outcome 1, 2, 3, 4, 5, 7, 9 Ministerial Strategic Indicator 1, 2a, 2c, 3, 4a, 4c"
12	Treat Well	Give our population the best possible experience by providing person centred planned care in a timely way as close to home as possible.	Planned care and support services	National Outcome 2, 3, 4, 7, 9
13	Journey Well	Support our population on their journey with and beyond cancer by having equitable and timely access to the most effective, evidence-based referral, diagnosis, treatment, and personal support	Cancer services	National Outcome 2, 3, 4, 7, 9
14	Age Well	Ensure people are supported as they age by promoting independence, choice, self-fulfillment, and dignity with personalised care planning at the heart	AHP services / Dementia / Long Term Conditions	"National Outcome 2, 4, 7, 9 Ministerial Strategic Indicator 5"
15	End Well	Support and empower our population and families at the end of life by giving appropriate care and choice at this time and beyond	Palliative and End of Life Care Specialist and Community Services	National Outcome 1, 2, 3, 4, 5, 9
16	Value Well	Improve experience by valuing the role that carers, partners in third sector and volunteers bring along with their individual skills and expertise	Carers / Third Sector / Volunteers	National Outcome 6, 8
17	Perform Well	Ensure we perform well by embedding all of these areas in our day-to-day health and care delivery across our system	Quality / Realistic Medicine / Health Inequalities / Financial Planning	This ambition facilitates delivery of the strategic ambitions
18	Progress Well	Ensure we progress well by embedding all of these areas in our future plans for health and care delivery across our system	Digital / Research & Development / Climate	This ambition facilitates delivery of the strategic ambitions
19	Enable Well	Ensure we enable well by embedding all these areas at a whole system level that create the conditions for change and support governance to ensure high quality health and care services are delivered to our population	Strategy & Transformation / Resilience / Risk / Infrastructure / Corporate / Procurement / Regional / National	This ambition facilitates delivery of the strategic ambitions

Performance Management Framework

Integrated Childrens Services Planning Board Performance Management Framework

OUTCOME 1 Highland's Children will be safe, healthy, achieving, loved, nurtured, active, included, respected and responsible				
indicator 1	target	baseline	current	data source
the number of young carers identified on SEEMiS will increase	improve from baseline	68		Education & Learning
analysis				
indicator 2	target	baseline	current	data source
the number of households with children in temporary accommodation will reduce	95	100		Education & Learning
analysis				
indicator 3	target	baseline	current	data source
Percentage of children reaching their developmentalmilestones at their 27 – 30 month health review will increase	85%	75%	82%	Child Health
analysis				
Data from NHS, last updated Jan - Mar 23. Note in the data file that this is incomplete. Data shows a slightly deceasing number of children achieving their developmental milestones at the 27-30 month Child Health Surveillance review. This is correlated to the number of assessments being undertaken and the targeted approach which is part of the mitigation plan to improve outcomes. (note Indicator #6) GRAPH				
indicator 4	target	baseline	current	data source
Percentage of children in P1 with their body mass index measured	95%	85%	94%	Child Health
analysis				
data last updated in 2021-22 by NHS Highland				
indicator 5	target	baseline	current	data source
The rate of LBW babies born to the most deprived compared to those born in the least deprived parts of Highland.	improve fgrom baseline	1%		Public Health
analysis				
Note from NHS H: "Monitoring metric still unclear - change to singletons only? - to discuss at next data meeting"				

indicator 6	target	baseline	current	data source
Improve the uptake of 27-30 month surveillance contact	95%	52%	77%	Child Health

analysis

There has been a slight decrease in the uptake of this core contact. A contributory factor has been the availability of suitability qualified Health Visitors.Highland's Advanced Nurse Training programme has been highly successful across the past 2 years in supporting the recruitment and training to advanced level health visitors.

Highland currently have allow vacancy rate (around 8%) in Health Visiting however 20% of the HV workforce are undertaking the one year post graduate masters level health visitor training programme. Training requirements mean that trainee health visitors are not available or qualified to undertake this review. This has impacted on the ability to undertake the developmental assessment within the allotted timescale.

Mitigating actions are in place which include prioritisation for families in need, at risk, where there are concerns, care experienced, suffering the impacts of inequalities or trauma. Bank Staff are also used where necessary to support the review. There is likely to be a significant improvement in performance with the 22/23 and 23/24 cohort of health visitors achieve their advanced qualification and are supported through the preceptorship course GRAPH

indicator 7	target	baseline	current	data source
% of children with 1 or more developmental concerns recorded at the 27 – 30 month review	95%	85%	82%	Child Health

analysis

Not updated in NHSH file.

indicator 8	target	baseline	current	data source
Percentage uptake of 6-8 week Child Health Surveillance contact	95%	85%	82%	Child Health

analysis

Data updated by NHSH - last update Dec 22. Note saying incomplete data for Mar 23.Data from Quarter 3 (incomplete) reports only 82% of children have had a 6-8 week child health surveillance contact. This contact is part of the universal Health Visiting pathway. This contact remained a priority through the pandemic as determined by the Chief Nursing Officer. Health visitors complete the infant assessment, and the paperwork is forwarded to the GP who submits the completed documentation only after the GP 6-week infant check is complete. This GP check historically included the 6–8 week infant immunisation. A number of GPs have reported a reduction in presentation to the 6 week check since infant immunisations are no longer delivered at this time. Mitigating action to include

1. Ongoing scrutiny of the data is required to measure risk
2. The Highland Council Health visitors to promote attendance at GP practice for completion of review
3. NHSH Child Health Dept reminder to all GPs re submission of completed data forms.

indicator 9	target	baseline	current	data source
Achieve 36% of new born babies exclusively breastfed at 6-8 week review	36%	30%	32%	Child Health

analysis
Data updated by NHSH - last update Mar 23. A number of key professionals, including midwives, health visitors, Community Early Years Practitioners (CEYP) and specialist breast feeding support workers support women to exclusively breastfeed their baby in Highland. Breastfeeding rates have been consistently good in Highland. The performance has dipped slightly in the past quarter, however an improvement plan has been put in place to address this, particularly to a partnership approach, between NHSH and THC, is being tested to improve support for breast feeding in remote and rural Highland. This involves better use of core support worker roles (CEYP) through enhanced additional infant feeding support. It is hoped this approach will provide a more effective and equitable service for families across Highland. This will be evaluated to support the scale and spread of a more universal approach to infant feeding support across other rural locations in Highland.

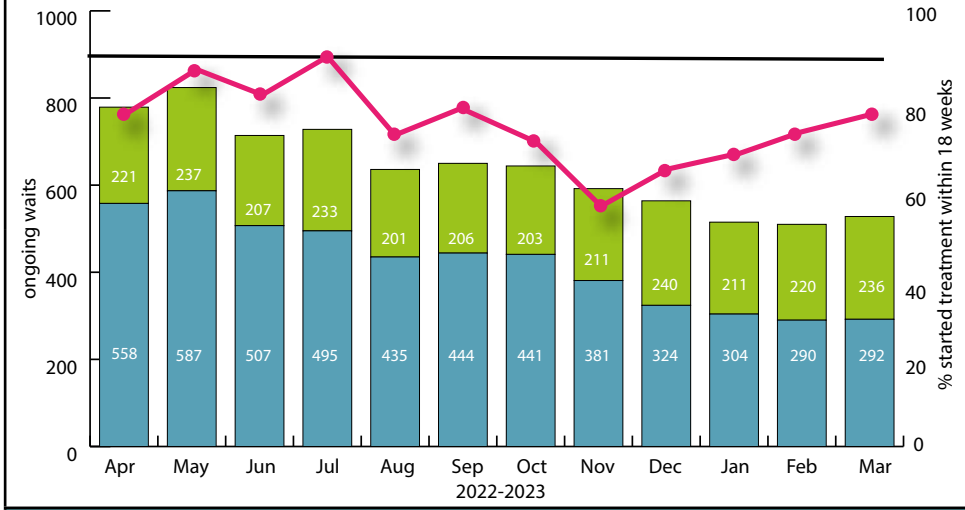
indicator 10	target	baseline	current	data source
Maintain 95% Allocation of Health Plan indicator at 6-8 weeks from birth (annual cumulative)	95%	97%	NK	Child Health

analysis
not updated in NHSH file

indicator 11	target	baseline	current	data source
Maintain 95% uptake rate of MMR1 (% of 5 year olds)	95%	95%	95%	Child Health

analysis
latest data from NHSH to Dec 22

Indicator 12	target	baseline	current	data source
90% CAMHS referrals are seen within 18 weeks	90%	80%		CAMHS, Education & Learning



analysis
considerable progress has been made in clinical modelling, performance and governance. Progress has been made despite despite a lack of appropriate supports and improvements in e – health with much of the work of business analyst colleagues having to be completed manually due to limitations of current systems. The service has halved the number of patients waiting since the peak of May 2022 and reduced longest waits from over 4 years just over 2 years projected clearing of cases over 2 years by April 2023. This progress has been achieved with a workforce funded establishment at the second lowest of mainland boards with a current vacancy rate of 48% with ongoing national workforce shortages and additional recruitment challenges of remote and ruralservices. We are diversifying our staff profile and adopting a grow our ownstrategy which is showing promise but will be a medium term approach to increasing capacity.

indicator 13	target	baseline	current	data source
Percentage of statutory health assessments completed within 4 weeks of becoming LAC will increase to 95%	95%	70%	72%	Health & Social Care

analysis

Statutory health assessments in Highland for Care Experience infants children and young people are carried out by health visitors and school nurses in accordance with the Scottish Government Guidance for Health Assessments 2015. A number of NHS Boards have recently adopted a proportionate approach to assessing health need for care experienced children and young people. This approach recognises the need for a relationship based approach to assessing health needs of children and young people who may have suffered extreme trauma. The approach enables an assessment which has the views, voice and choice of children and young people at the heart and supports a more meaningful and considered holistic assessments and analysis of need. It is proposed that across 23/24 Highland move to this model of assessment of health need for CE CYP.

In order to drive forward this approach additional training is being rolled and existing documentation has been reviewed. It is projected that the change will have a positive impact on the performance data, quality of the assessment and skill of the workforce. The advanced qualified school nursing workforce has been increased in Highland through the advanced training programme, from 6 FTE in 2018, to 22 FTE in 2023. The vacancy rate in School Nursing is currently 5%. Pressures in teams centre on supporting the advanced nurse training programme. It is anticipated performance will improve as the advanced nurses currently in training qualify and are supported through the preceptorship year

indicator 14	target	baseline	current	data source
Percentage of young people in RCC with an up to date Routine Childhood Immunisation Schedule (RCIS)	improve from baseline	67%	57%	Health & Social Care

analysis

Data updated quarterly in PRMS. 57.4% represents a decrease from the baseline but an increase compared to recent quarters. There has been a small increase in this indicator although it remains down from baseline. Recent developments within School Nursing and Transforming roles has allowed a greater health resource for Children and Young People in Residential Childcare. Developing relationships, taking time to explore barriers and supporting attendance at health appointments should support an increased uptake of immunisations. The centralisation of immunisation services with more open clinics may have a positive impact on the immunisation uptake for CYP in residential child care.

indicator 15	target	baseline	current	data source
Percentage of children and young people referred to AHP Service PHYSIOTHERAPY, waiting less than 18 weeks from date referral received to census date (Interim Measure) - NOT 18RTT METHODOLOGY	90%	85%	89%	Health & Social Care

There are a number of contributory factors to the slight increase in the waiting times for paediatric physiotherapy, these centre on staffing availability thought acting up arrangement/retiral/staff sickness and the loss of the ASN support within schools as “therapy partners” which place pressure on the resilience of such a small Highland wide team and affect performance. The number of requests for assistance have continued to rise. A mitigation plan was put in place which included temporary pause of some assessments (now restarted), prioritisation of urgent cases and hospital discharges, and introduced clinics where feasible to reduce travel and create capacity to cover outlying geographical areas. Staff have worked flexibly across geographical boundaries. Virtual appointments have continued where this is possible. Building capacity through reduction to Just Ask enquiry line, use of staff bank where possible and data cleansing exercise. The workforce continues to be under pressure however not withstanding this, there are early signs the mitigations are helping. There is continued risk to staff morale, sickness levels and service user complaint particularly as an increasing number of families are electing to use private therapists. The small service requires to be futureproofed as a result of potential retiral of staff in the incoming years.

indicator 16	target	baseline	current	data source
Percentage of children and young people referred to AHP Service OCCUPATIONAL THERAPY, waiting less than 18 weeks from date referral received to census date (Interim Measure) - NOT 18RTT METHODOLOGY	90%	85%	51%	Health & Social Care

analysis

There are a number of contributory factors to the increase in waiting times for OT over the last year, including an increase in need/number of request, limited resilience due to staff sickness/availability of staffing within the small paediatric OT service in Highland, increase in the urgent area of work, hospital discharges from out of authority and acute complex cases in more rural areas and increased surgeries for CYP post covid. A particular pressure has arisen since 2020 since the removal of a number significant portion of ASN support in schools. A mitigation plan is in place which includes: A Central approach to managing waiting times for cross team overview and prioritisation, revisiting geographical boundaries to enable longer waits to be actioned, consideration of alternative ways of interventions (telephone, telehealth, face to face), pre request discussions are being carried out and increasing to manage where possible advice / support and intervention and building capacity through reduction of time on Just Ask helpline. Clinic-based services have been tried with limited success as many CYP need school / home visits as well. Some aspects of the service have been redesigned to ensure upfront intervention and support and reduce the need for Requests in some areas (e.g. Sensory , Post diagnostic support). Further data cleansing is planned to ensure figures are correct. OT have recently redesigned some aspects of their service to ensure upfront intervention and support, aiming to reduce the need for Requests in some areas. A steady staffing flow over the coming months is required to begin to improve the 18 week RTT target. GRAPH

indicator 17	target	baseline	current	data source
Percentage of children and young people referred to AHP Service DIETETICS, waiting less than 18 weeks from date referral received to census date (Interim Measure) - NOT 18RTT METHODOLOGY	90%	88%	66%	Health & Social Care

Paediatric dietetics consists, in the main of a small specialist team. The increase in waiting times has been a direct result of an increase in need/referrals (from 71 requests in 2022 to 86 per month in 2023) to the service and a decrease in staffing availability, with an average of 28% reduction across dieticians and support staff as a result of long term sickness, carers leave etc. A review of the service was undertaken in 2022 with mitigating action plan which included further prioritisation. This includes a greater focus on early prevention and intervention and working with schools and families, addressing emerging issues at an earlier stage working and through the implementation of new focussed pathways around particular areas of increased need. (eg: selective eating). The plan also is driving forward change to the approach addressing infant allergy which aims to provide early support for parents of infants with feeding difficulties and a reduction in the misdiagnosis of cow’s milk protein allergy as well as contributing to service development for the increased number of CYP who have diabetes including supporting access to technology for more vulnerable CYPs, to support self management A period of full staffing may be possible in coming months, and this should improve waiting times to within target by the autumn as long as demand does not continue to significantly increase. The mitigation plan will be adapted according to presenting need with risks escalated as necessary.
GRAPH

indicator 18	target	baseline	current	data source
Percentage of children and young people referred to AHP Service SPEECH & LANGUAGE THERAPY, waiting less than 18 weeks from date referral received to census date (Interim Measure) - NOT 18RTT METHODOLOGY	90%		46%	Health & Social Care

analysis
There are a number of contributory factors to the increase in waiting times for SLT over the last year, including an increase in need/number of request and the decrease in availability of staff with long term sick leave, phased returns, secondments without backfill, a career break and maternity leave and the loss of ASN therapy partner support. There is consistently a difficulty in recruitment to paediatric SLT as a result of a national shortage. These factors have a direct impact on the length of waits for SLT assessment and intervention. It is clear from caseload evaluation that there is increasing complexity of requests for SLT post pandemic creating a widening gap between new requests and discharges. It is also clear that the SLT capacity is significantly impacted by the increased need to support early assessment into neurodiversity. The central SLT team has supported the building of capacity of a core NDAS team for Highland through the diversion of resource for this specific activity. A mitigation plan is in place which include pre-request conversations, whole setting approaches, NDAS Early Conclusion assessment work, online and face to face parent groups for the early intervention around complex cases. An extensive team action plan has been put in place with a number of potential routes to address waiting times Risks centre on supporting developmental outcomes, particularly for infants and non-verbal children and on the health and wellbeing of the workforce. With the mitigations it is hoped that by end of 2023, overall service waits will be reduced to 75% being seen within 18 weeks. GRAPH

indicator 19	target	baseline	current	data source
Percentage of children and young people referred to AHP Services (ALL above), waiting less than 18 weeks from date referral received to census date (Interim Measure) - NOT 18RTT METHODOLOGY	90%	80%	56%	Health & Social Care

analysis
The AHP teams collectively have had an increase in the numbers of requests for assistance being made in the post covid period. This is beginning to settle for Occupational Therapy (OT) but continued to increase over the past year for Speech and Language Therapy (SLT) , Dietetics and Physiotherapy. Numbers of children/ young people (CYP) waiting has increased for all services over the past year with only Physiotherapy being within the 18 weeks target in the last few months. This is mainly due to difficulties with staffing. Vacant posts can be difficult to fill quickly and there is often no cover for staff who are on long term leave. Staffing has fluctuated for all teams, however staff availability (as a result of absence/maternity leave etc) is a broad theme across all teams creating a lack of resilience. Systems changes, including the loss of ASN support in schools working alongside AHP disciplines as “therapy partners” has had a direct impact on capacity with all AHP teams GRAPH

indicator 20	target	baseline	current	data source
The health needs of children are considered within risk identification and safety planning, through specialist child health protection advisors	100%	100%		Health & Social Care

analysis

indicator 21	target	baseline	current	data source
Numbers of children and young people waiting less than 18 weeks from date of request received by NDAS (Neuro Developmental Assessment Service) to census date(monthly	90%	24%	24%	NHS Highland

analysis
Waiting list data March 2023 .The 2017 National Neurodevelopmental guidance determined the need for a MDT approach to assessment and differential diagnosis of potential neurodevelopmental disorders. This was a significant change from the previous approach which enabled single or dual clinical diagnosis dealt with in a locality approach by members of the CAMHS, paediatric and/or SLT teams. This guidance was consolidated in 2021 with the release of The National ND Specification. The waiting list has steadily grown since 2017, to a current wait of 36 month (2023). Requests for NDAS have risen by 300% post pandemic, (from 30/month to 90/month in April 2023). An improvement plan is in place to address the current service pressures, with scrutiny via the CAMHS Oversight Board, NHS Performance Oversight Board and the Integrated CS Planning Board. Early conclusion pathway has been developed for young infants with initial positive results. NDAS is recorded as a risk on both NSH Highland and H&SC Risk Register.

indicator 22	target	baseline	current	data source
Percentage of referrals that lead to recruitment to the Family Nurse Partnership programme	85%	65%	85%	Health & Social Care

analysis
The Family Nurse Partnership provides intensive family support to new and first time parents under the age of 20. (under the age of 15 if care experienced) The programme is voluntary and reliant on referrals from midwives. This is a national programme, with rigorous fidelity regulations, scrutiny and reporting. Highland are working with the Scottish Government Programme Team to consider the provision in remote and rural areas. This has historically proved problematic as a result of recruitment difficulties.

indicator 23	target	baseline	current	data source
Increase the uptake of specialist child protection advice and guidance to health staff supporting children and families at risk	improve from baseline	59%	100%	Health & Social Care

analysis
IRDs are the interagency tripartite (health, social work and police Scotland) discussions which form part of the risk assessment and planning for children at risk of harm. Child Protection Advisors, are accountable for co-ordinating, representing and analysing all information from across the health systems as part of the IRD process. There has been a 48% increase in the Interagency Referral Discussions (IRDs) between 20/21 and 22/23. This created significant pressure to the service including risks to the delivery of stat/man Child Protection training across the partnership and for providing supervision to staff to universal and targeted health services. An action plan was implemented to ensure the tripartite process was secured. These actions included upskilling from the general workforce to be trained in being the agency decision maker at IRD. Notwithstanding this, the service, and ability to retain the national tripartite approach to child protection risk management, continues to be at risk. The risk is likely to increase in the incoming months as a result of implementation of the new Child Protection Guidance and an increase in the number of IRDs

Outcome 2 The voice and rights of Highland's children will be central to the improvment of services and support				
indicator 24	target	baseline	current	data source
The number of children reporting that they feel safe in their community increases	improve from baseline	85%	88%	Education and Learning

analysis
Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils. Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools Large improvement in the value for the most recent survey, with an increase from 55.41% in 2019 and 58.98% in 2017.

indicator 25	target	baseline	current	data source
Self-reported incidence of smoking will decrease	improve from baseline	13%	3%	Education and Learning

analysis
Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools Mean of 3.28% (P7: 0.44%, S2: 2.71% and S4: 6.70%) is a decrease from 5.32% in 2019. This downward trend has been seen for a number of years.

indicator 26	target	baseline	current	data source
The number of children who report that they drink alcoholat least once per week	improve from baseline	20%	6%	Education and Learning

analysis
Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools Mean of 5.56% (P7: 0.43%, S2: 1.37% and S4: 14.90%) is a decrease from 8.79% in 2019. This downward trend has been seen for a number of years.

indicator 27	target	baseline	current	data source
The number of children in P7 who report that they use drugs at least once per week	improve from baseline	1.8%	0.26%	Education and Learning
analysis				
Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools. There has been a decrease over time, with 2017 reporting at 2.60%, 2019: 1.14% and 2021: 0.26%.				
indicator 28	target	baseline	current	data source
The number of children in S2 who report that they use drugs at least once per week	improve from baseline	5.3%	0.65%	Education and Learning
analysis				
Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools. There has been a decrease over time, with 2017 reporting at 7.20%, 2019: 5.07% and 2021: 2.38%.				
indicator 29	target	baseline	current	data source
The number of children in S4 who report that they use drugs at least once per week	improve from baseline	19.2%	2.38%	Education and Learning
analysis				
Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools There has been a decrease over time, with 2017 reporting at 7.20%, 2019: 5.07% and 2021: 2.38%.				
indicator 30	target	baseline	current	data source
Maintain high levels of positive destinations for pupils in Highland vs national averages	93%	91%		Education and Learning
analysis				
indicator 31	target	baseline	current	data source
The number of offence based referrals to SCRA reduces	improve from baseline	528	314	Education and Learning
analysis				
Latest data from FY21/22. Offence based referrals have decreased since the baseline was established, but have increased slightly in the last year. GRAPH				
indicator 32	target	baseline	current	data source
The reduction in multiple exclusions is maintained	36	55		Education and Learning
analysis				

indicator 33	target	baseline	current	data source
The number of children entering P1 who demonstrate anability to develop positive relationships increases	improve from baseline	91%		Education and Learning
analysis				

indicator 34	target	baseline	current	data source
The delay in the time taken between a child being accommodated and permanency decision will decrease (Target in Months)	9	12	9.4	Health & Social Care
analysis				
This data is reported quarterly on PRMS under the title “Average months between child accommodated to permanence decision at CPM Qtr”. The latest update was for Q4 21/22 and the baseline was established in 2016.				

indicator 35	target	baseline	current	data source
The number of care experienced children or young people placed out with Highland will decrease (spot purchase placements)	15	55	21	Health & Social Care
analysis				
This data is reported monthly. The baseline was established in 2016.				

indicator 36	target	baseline	current	data source
The number of care experienced children or young people in secure care will decrease	3	8	3	Health & Social Care
analysis				
This data is collected monthly. The baseline was established in 2021.				

indicator 37	target	baseline	current	data source
There will be a shift in the balance of spend from out of area placement to local intensive support, to reduce the number of children being placed out with Highland through the Home to Highland programme	50%	10%	38%	Health & Social Care
analysis				
This data is collected monthly. The baseline was established in 2018.				

indicator 38	target	baseline	current	data source
All children returning “Home to Highland” will have a bespoke education/positive destination plan in place	100%	22	15	Health & Social Care
analysis				
This data is collected annually. The baseline was established in academic year 2018/19				

indicator 39	target	baseline	current	data source
Number of children subject to initial and pre-birth child protection case conferences		26	38	HSC-CP minimum dataset

analysis
This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23. GRAPH

indicator 40	target	baseline	current	data source
Number of initial and pre-birth child protection case conferences		19	51	HSC-CP minimum dataset

analysis
This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23. Overall number of initial and pre-birth CPCCs decreasing but the number of overall children subject to CPCCs are increasing - suggesting an increase in family sizes being subject.GRAPH

indicator 41	target	baseline	current	data source
Conversion rate (%) of children subject to initial and pre-birth child protection case conferences registered on child protection register	95%	78%	87%	HSC-CP minimum dataset

analysis
This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23. Conversion rate dropped below 90% in latest update, however of the 5 children that were not registered in the quarter, 4 of these decisions have been deferred pending further investigation. GRAPH

Indicator 42	target	baseline	current	data source
Number of children on the child protection register as at end of reporting period		112	96	HSC-CP minimum dataset

analysis
This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23.There has been an overall reduction in the number of children registered on the CP Register, however there has been a noticable increase in the last quarter. This is due to a lower number of de-registrations in the period. GRAPH

Indicator 43	target	baseline	current	data source
Number of children de-registered from the child protection register in period	35	34	23	HSC-CP minimum dataset

analysis
This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23.Q3 2022/23 has seen the greatest variation in the number of registrations and de-registrations for some time – with 10 more registrations. This is the largest variance since Q3 2020/21. It should be noted that large sibling groups being registered or de-registered in any quarter can impact on the overall figures significantly

indicator 44	target	baseline	current	data source
Number of concerns recorded for children placed on the child protection register in period at a pre-birth or initial conference		58	90	HSC-CP minimum dataset

analysis

This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23.In Q3 2022/23, there were 90 concerns recorded and showed an increase from the low value in the prior quarter. Emotional Abuse was the most common concern recorded across Highland in the Quarter, but there was also a notable increase in Physical Abuse in the quarter.
GRAPH

Indicator 45	target	baseline	current	data source
Number of children and young people referred to the Children's Reporter		213	317	HSC-CP minimum dataset

analysis

This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23. There tended to be little variation in the figures until last quarter, where the number of children referred on Non-Offence Grounds has increased significantly and remained at this high level. In particular, there have been sharp rises in the reason for referral being: "Child's Conduct Harmful to Self or Others", rising from 49 in Q1 2022/23 to 94 in Q2 and 130 in Q3, and "Lack of Parental Care", rising from 93 in Q1 to 125 in Q2 and 180 in Q3.The current figure is much higher than the baseline figure.
GRAPH

indicator 46	target	baseline	current	data source
Number of children and young people referred to the Children's Reporter	reduction from baseline	8	1	HSC-CP minimum dataset

analysis

This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23.
GRAPH

indicator 47	target	baseline	current	data source
The number of non-offence referrals taken to a hearing by the Reporter	reduction from baseline	218	417	HSC SCRA quarterly

analysis

Data reported quarterly from SCRA, last update for Q3 22/23 (April 23).There has been a sharp and significant increase in recent updates in the total number of non-offence referrals.
GRAPH

indicator 48	target	baseline	current	data source
Number of Children's Hearings held		263	202	HSC SCRA quarterly

analysis

Data reported quarterly from SCRA, last update for Q3 22/23 (April 23). The number of Children's Hearings has remained relatively steady in recent quarters, with the most recent update being the lowest level since Q4 21/22.
GRAPH

indicator 49	target	baseline	current	data source
Number of Pre Hearing Panels held		4	20	HSC SCRA quarterly

analysis

Data reported quarterly from SCRA, last update for Q3 22/23 (April 23)

indicator 50	target	baseline	current	data source
Number of children with a Compulsory Supervision Order in place at the quarter end		54	62	HSC SCRA quarterly

analysis

Data reported quarterly from SCRA, last update for Q3 22/23 (April 23). There has been some variation quarter-to-quarter in the number of children with a CSO in place. The current figure of 61 is higher than recent quarters. GRAPH

indicator 51	target	baseline	current	data source
Number of looked after children and young people at home with parents	increase from baseline	112	82	HSC SG annual return

analysis

This data is collected and quality-assured annually as part of the statutory returns to Scottish Government. The snapshot for the data is 31 July. The number of LAC and young people at home with parents has dropped from 114 in 2021 to a provisional figure of 82 in the 2022 submission. This is in part explained by the overall trend in number of looked after children in Highland (-28% decrease at home v -17% decrease overall).

indicator 52	target	baseline	current	data source
Number of looked after children and young people with friends and families	increase from baseline	100	79	HSC SG annual return

analysis

This data is collected and quality-assured annually as part of the statutory returns to Scottish Government. The snapshot for the data is 31 July. The number of looked after children and young people with friends and family has decreased in a similar manner to that at home with parents from 117 (-32% decrease with friends and family v -17% overall LAC).

indicator 53	target	baseline	current	data source
Number of looked after children and young people with foster parents provided by local authority	increase from baseline	121	172	HSC SG annual return

analysis

This data is collected and quality-assured annually as part of the statutory returns to Scottish Government. The snapshot for the data is 31 July. Number of looked after children and young people with foster parents provided by local authority has increased from 156 to a provisional figure of 172. This explains themovement in indicators #50 & #51 above; while the overall number of LAC decreased by -17%, LAC with foster parents provided by the local authority has increased by 10% in the year.

indicator 54	target	baseline	current	data source
Number of looked after children and young people with prospective adopters	increase from baseline	12	16	HSC SG annual return

analysis

This data is collected and quality-assured annually as part of the statutory returns to Scottish Government. The snapshot for the data is 31 July. Number of looked after children and young people with prospective adopters has decreased in the year from 22 to 16. This decrease is in line with the decreases seen above (-28%). It is, however, above the baseline figure.

indicator 55	target	baseline	current	data source
Number of looked after children and young people within a local authority provided house	reduction from baseline	81	65	HSC SG annual return

analysis

This data is collected and quality-assured annually as part of the statutory returns to Scottish Government. The snapshot for the data is 31 July. While the number of looked after children within a local authority provided house has decreased from 70 in 2021 to a provisional figure of 65, this represents a greater %age of overall LAC. The number of LAC has reduced by -17% but those LAC within a local authority provided house has only decreased 7%.

indicator 56	target	baseline	current	data source
The number of LAC accommodated outwith Highland will decrease	30	44	17	Health and Social Care

analysis

This data is reported quarterly on PRMS, with the baseline being established in 2016. The last update was in April 2023. The indicator on PRMS is titled: The average no. of LAC accommodated outwith Highland - Quarterly. The current value of 17 is a continued decrease since Q3 22/23, and represents the lowest value since the baseline was established.

indicator 57	target	baseline	current	data source
The percentage of children needing to live away from the family home but supported in kinship care increases	20%	19%	18%	Health and Social Care

analysis

This data is reported monthly on PRMS, with the baseline being established in 2016. The last update was in April 2023. There has been a slight decrease in the monthly figure for the last three months, with the current figure sitting below both the target and baseline figure GRAPH

indicator 58	target	baseline	current	data source
The number of children where permanence is achieved via a Residence order increases	82	72	120	Health and Social Care

analysis

This data is reported monthly on PRMS, with the baseline being established in 2016.The last update was in April 2023.There has been an overall steady increase in the value in recent months, and a significant increase in both the target and baseline figure.

Highland Health and Social Care Committee Work Plan 2023/2024

Date	30 August 2023	[Development Session 20 Sep]	1 November 2023	[Development Session 29 Nov]	17 January 2024	6 March 2024
Agenda Planning	July		13 September		22 November	29 January
Check-in meeting	15 August		18 October		5 January	21 February
Paper Deadline	18 August		20 October		12 January	23 February
Standing Items	Apologies & Declarations of Interest		Apologies & Declarations of Interest		Apologies & Declarations of Interest	Apologies & Declarations of Interest
	Matters Arising		Matters Arising		Matters Arising	Matters Arising
	Minutes of Last meeting		Minutes of Last meeting		Minutes of Last meeting	Minutes of Last meeting
	Finance		Finance		Finance	Finance
	Risk (Level 1 Risks)		Risk (Level 1 Risks)		Risk (Level 1 Risks)	Risk (Level 1 Risks)
	Performance & Delivery: IPQR Dashboard		Performance & Delivery: IPQR Dashboard		Performance & Delivery: IPQR Dashboard	Performance & Delivery: IPQR Dashboard
	Performance & Delivery: Chief Officer's Report		Performance & Delivery: Chief Officer's Report		Performance & Delivery: Chief Officer's Report	Performance & Delivery: Chief Officer's Report
	Health Improvement: District Reports		Health Improvement: District Reports		Health Improvement: District Reports	Health Improvement: District Reports
	Date of next meeting		Date of next meeting		Date of next meeting	Date of next meeting
Core Business	Primary Care Overview (DCO)	***IPQR review***	Engagement Framework Assurance Report (R Fry)	***Sustainability Issues***	SDS Strategy Assurance Report	Children and Young People Services Performance Report
	Community Services Overview/District Reports (B Green)		Together We Care Implementation		Community Services Risk Register Assurance Report	Mental Health Services Assurance Report
	Winter Planning (CO)		Preparation for Winter (CO)		Carers Strategy Update	Adult Social Care Fees and Charges 24/25
	Mental Health Strategy (Head of Service)		Chief Social Worker/Adult Protection (S Steer/F Duncan)			
	Highland Alcohol and Drug Recovery Services Delivery (Head of Service)		Technology Enhanced Care Overview (I Ross)			
			Children and Young People Services mid-year review			
Governance matters	Workplan for 2023-24		Final Committee Annual report			Committee Annual Assurance Report 23/24
	Draft Committee Annual Report		Committee Terms of Reference Revision			Committee Workplan 24/25
	Committee Terms of Reference review					

Agenda Item 5.2

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**30 August 2023**
Title:	**Review of Committee Terms of Reference**
Responsible Executive/Non-Executive:	**Gerry O'Brien, Chair**
Report Author:	**Gerry O'Brien, Chair**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

2 Report summary

2.1 Situation

As part of the Board's annual review of governance, all Governance Committees are required to review Terms of Reference and recommend any changes for consideration by the Audit Committee before going to the Board for approval.

4 Recommendation

- **Discussion** – Examine and consider the implications of a matter ahead of agreement of the Terms of Reference at the November meeting of the Committee. The Terms of Reference will then go to the Audit Committee for recommendation to the Board.

HIGHLAND HEALTH & SOCIAL CARE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: January 2023

1. PURPOSE

1.1 The purpose of the Highland Health and Social Care Committee is to provide assurance to NHS Highland Board that the planning, resourcing and delivery of those community health and social care services that are its statutory or commissioned responsibility are functioning efficiently and effectively, ensuring that services are integrated so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care.

2. COMPOSITION

2.1 The membership of the Committee is agreed by the full NHS Board and has a Non-Executive Chair.

Voting Committee members as follows

5 x Non-Executives, one of whom chairs the Committee and one of whom is the Council nominee on the Health Board
5 x Executive Directors as follows - Chief Officer, Director of Adult Social Care, Finance Lead, Medical Lead and Nurse Lead
3 Representatives of Highland Council

The wider stakeholder and advisory membership (non-voting) will be as follows:

Staff Side Representative (2)
Public/Patient Member representative (2)
Carer Representative (1)
3rd Sector Representative (1)
Lead Doctor (GP)
Medical Practitioner (not a GP)
2 representatives from the Area Clinical Forum
Public Health representative
Highland Council Executive Chief Officer for Health and Social Care
Highland Council Chief Social Worker

The Committee shall have flexibility to call on additional advice as it sees fit to enable it to reach informed decisions.

2.2 **Ex Officio**

Board Chair

2.3 **In Attendance:**

Head of Personnel
Head of Health & Safety

The Committee Chair is appointed by the full Board.

3. QUORUM

No business shall be transacted at a meeting of the Committee unless at least one Non-Executive Director being present (in addition to the Chair) and comprising a minimum of one third of Committee members.

4. MEETINGS

4.1 The Committee shall meet at least five times per year. The Chair, at the request of any three Members of the Committee, may convene ad hoc meetings to consider business requiring urgent attention. The Committee may meet informally for training and development purposes, as necessary.

4.2 The Committee will be serviced within the NHS Highland Committee Administration Team and minutes will be included within the formal agenda of the NHS Board.

4.3 The agenda and supporting papers will be sent out at least five clear working days before the meeting.

4.4 All Board members will receive copies of the agendas and reports for the meetings and be entitled to attend meetings.

4.5 Any amendments to the Terms of Reference of Highland Health and Social Care Governance Committee will be submitted to NHS Highland Board for approval following discussion within the Governance Committee.

4.6 The Agenda format for meetings will be as follows:

- Apologies
- Declaration of Interests
- Minutes
    - Last Meeting
    - Formal Sub Committees
    - Formal Working Groups
- Strategic Planning and Commissioning
- Finance
- Performance Management
- Community Planning and Engagement
- Operational Unit Exception Reports

5. REMIT

5.1 The remit of the Highland Health and Social Care Committee is to:

- Provide assurance on fulfilment of NHS Highland's statutory responsibilities under the Public Bodies (Joint Working) Act 2014 and other relevant legislative provisions relating to integration of health and social care services
- Provide assurance on fulfilment of NHS Highland's responsibilities under the Community Empowerment Act in relation to Community Planning
- Contribute to protecting and improving the health of the Highland population and ensure that health and social care services reduce inequalities in health
- Develop the Strategic Commissioning Plan for integrated health and social care services and approve arrangements for the commissioning of services to deliver the agreed outcomes of the plan, ensuring the involvement of stakeholders and local communities
- Develop policies and service improvement proposals to deliver the agreed outcomes of the plan, within the available resources as agreed by the Joint Monitoring Committee
- Monitor budgets for services within its remit and provide assurance regarding achievement of financial targets
- Scrutinise performance of services within its remit in relation to relevant national and locally agreed performance frameworks, including the NHS Highland Annual Operating Plan and the Strategic Commissioning Plan for integrated health and social care services.
- Through the annual performance report of the Integration Authority provide an overview of North Highland Adult Services performance, in line with the 9 national outcomes for health and wellbeing to Highland Council as partners via the Joint Monitoring Committee
- Receive and scrutinise assurance from the Highland Council as to performance services delegated by NHS Highland under the Lead Agency arrangements

5.2 The Committee will undertake an annual self-assessment of its work and effectiveness in accordance with NHS Highland and Good Governance values. This will inform the Annual Report to the Board.

5.3 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit Committee in June.

5.4 The Committee shall draw up and approve, before the start of each financial year, an Annual Work Plan for the Committee's planned work during the forthcoming year.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Highland Health and Social Care Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Highland Health and Social Care Governance Committee is a Governance Committee of NHS Highland and is accountable directly to the Board.

7.2 The Committee will report to the Board through the issue of Minutes/Assurance Reports and an assessment of the performance of the Committee will be undertaken annually and presented by way of an Annual Report to the Audit Committee, then the Board.

7.3 As a committee of the Board and as indicated in the Standing Orders, the HH&SCC will escalate any risks or concerns that require a Board decision to the Health Board.

7.4 Establish a Strategic Planning and Commissioning sub-committee to fulfil the obligations set out in the legislation.