North Highland Health and Social Care Partnership Performance and Quality Report

August 2022

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

North Highland Health & Social Care Partnership

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

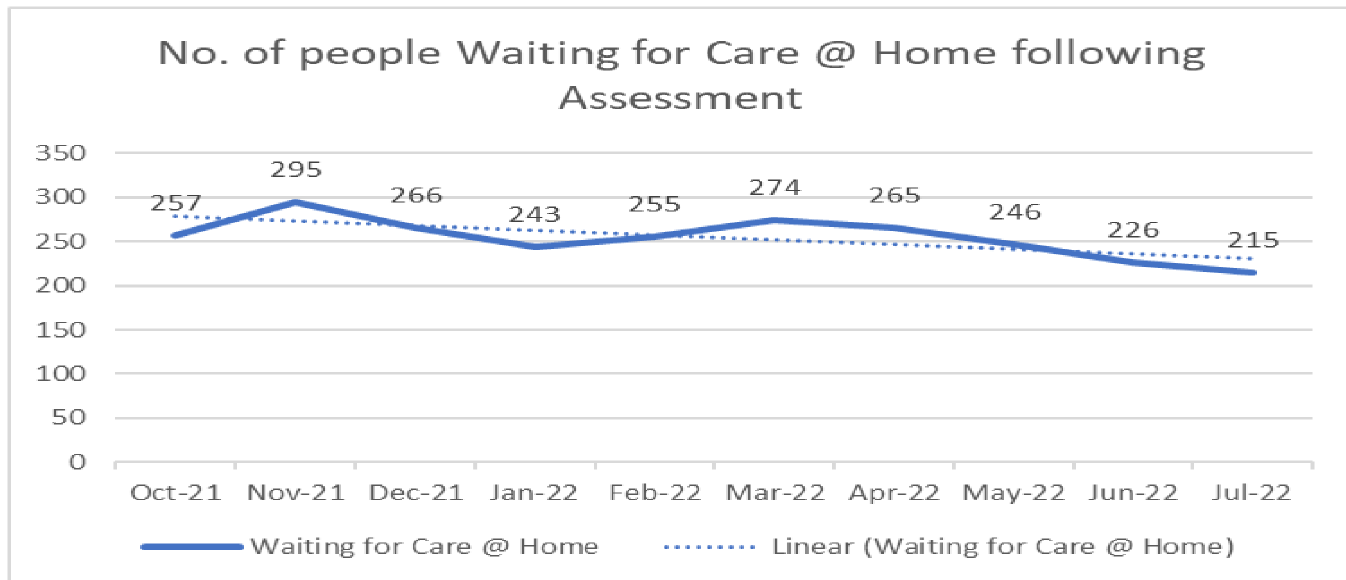
It is **recommended** that:

- Committee consider and review the initial Performance Framework identifying any areas requiring further information or inclusion in future reports.
- Further development work is undertaken with ASC SLT to agree additional requirements for future inclusion within the overall partnership's performance framework.
- Committee to note that the initial focus is on Adult Social Care and that the development of this performance framework will include relevant Community Service indicators, delayed hospital discharge's and other yet to be agreed indicators.

Strategic Objective 3 Outcome 9 – Care Well

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

1.



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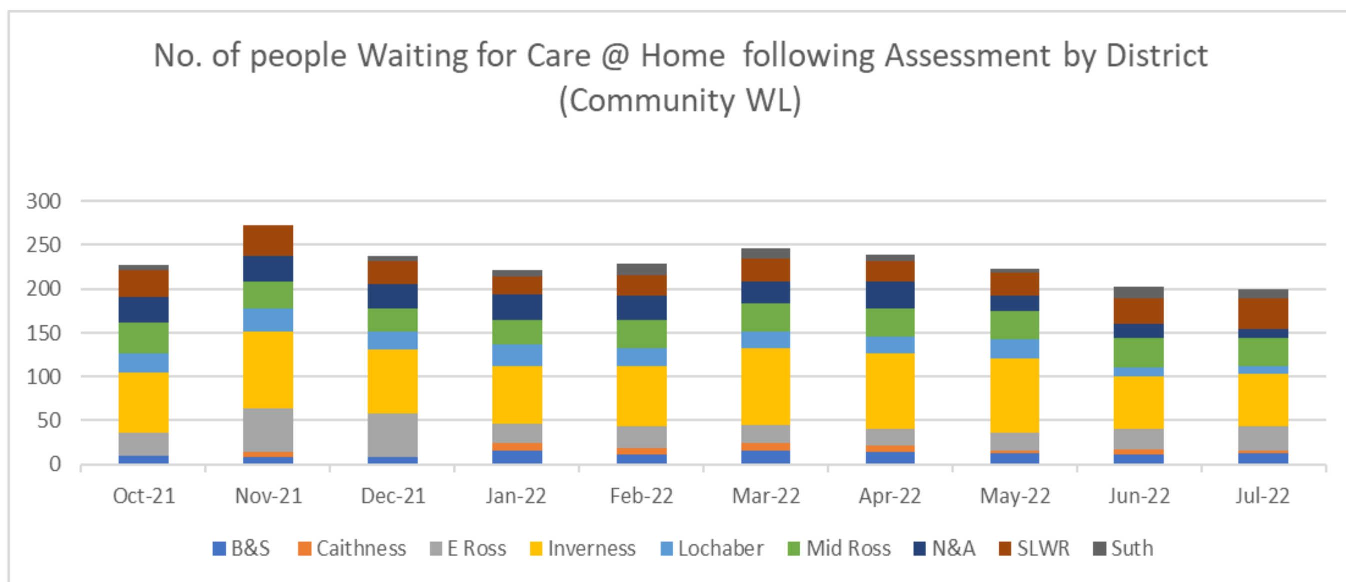


Currently provided weekly as part of the PHS weekly return on unmet need. This return commenced in September 2021 and is provided by each district team weekly. The hospital DHD's are added to the community data.

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

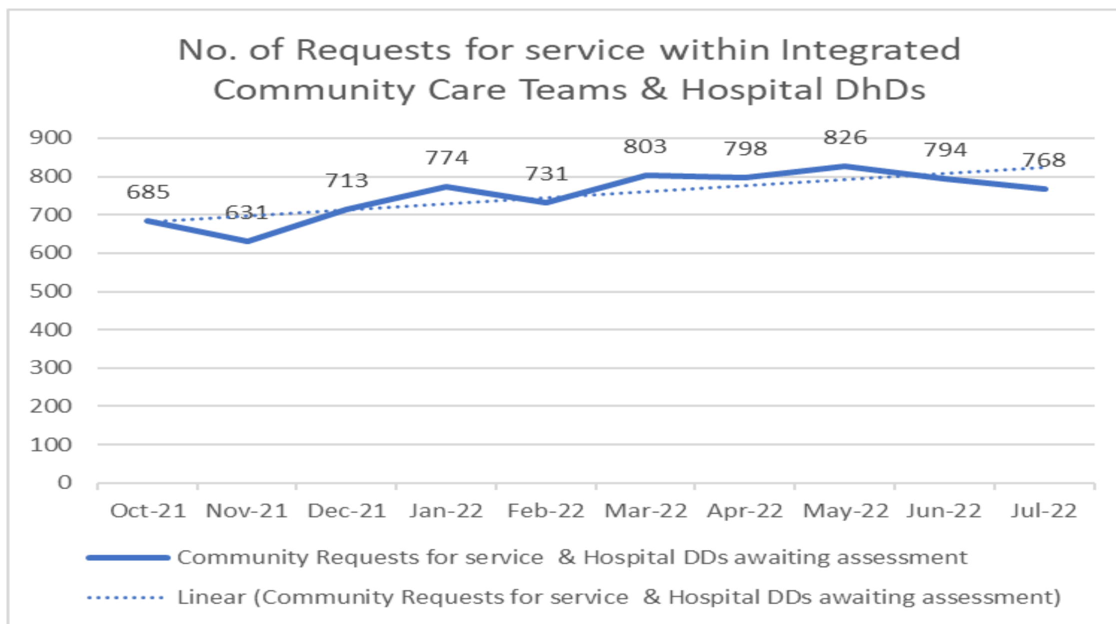
Graph 2 – Care at Home unmet need (District level) - the number of people waiting on a care at home service to commence following completion of a social care assessment, community only

Update as at 15/08/2022

Strategic Objective 3 Outcome 9 – Care Well

Priority 3 - Develop fully integrated front line community health and social care teams across all areas of Highland

1.



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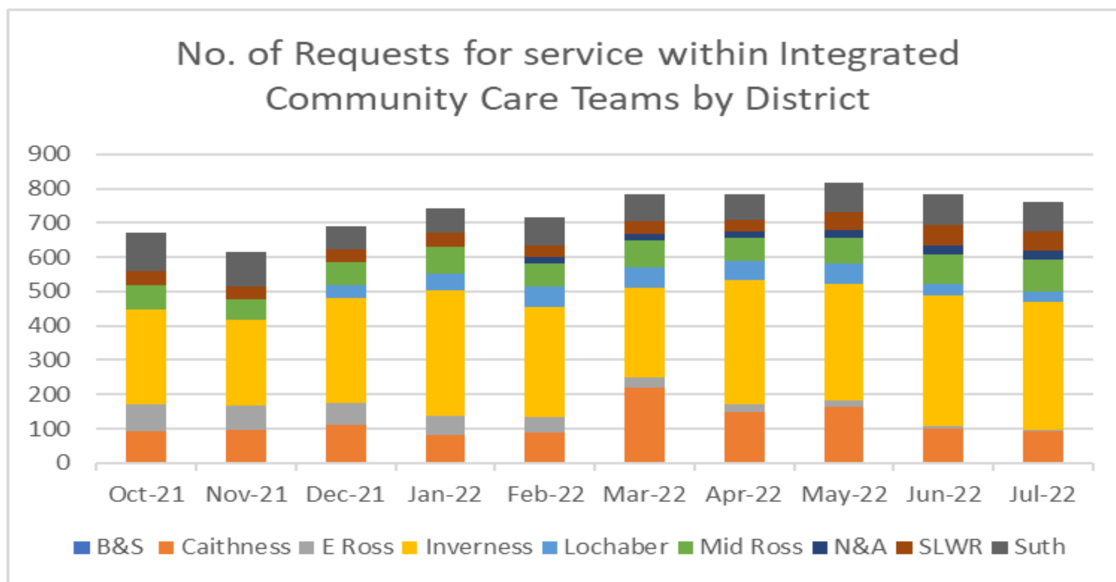

Currently provided weekly as part of the PHS return as a proxy for people waiting for a service. This return commenced in September 2021 and is provided by each district team. These are provided from individual team desktops based on referrals (often referred to as requests for service), however there is no breakdown available in terms of actual assessed care needs at this early referral stage. It is not possible to accurately determine at this stage if a care at home service or OT assessment is required, further signposting, or a mobility request i.e. a grab rail is requested.

Graph 1 - This is the number of accepted referrals received (requests for service) for people waiting on a request for service received by the Integrated Community Care Team.

Graph 2 – Provides a breakdown by district of the number of people referred to adult social care teams who **may** require further support as per above.

Update as at 15/08/2022

Strategic Objective 3 Outcome 9 – Care Well

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

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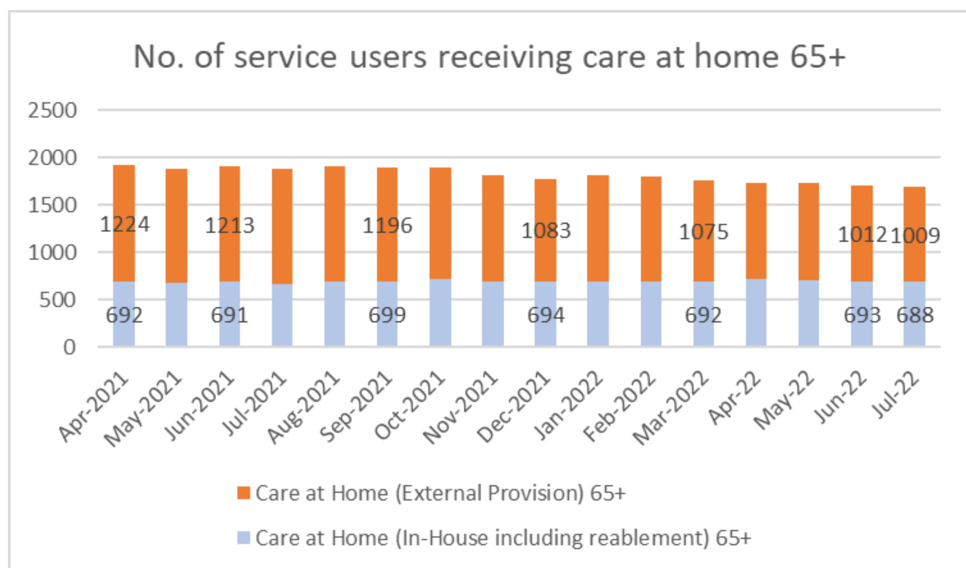

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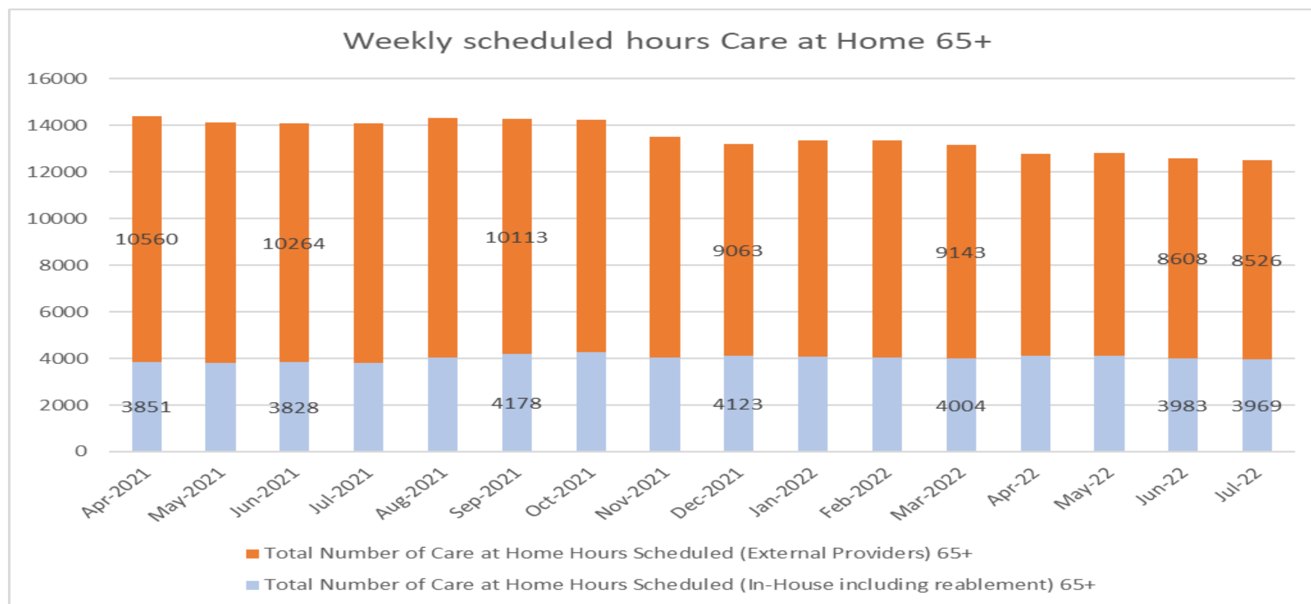

Adult Social Care, NHS Highland
Key Issues, Challenges and Improvement Work for Care-at-Home

- There are significant staffing pressures and fragility across commissioned and in-house care home, care at home and support services in north Highland, which continues to compromise service capacity and whole system flow.
- These pressures are due to ongoing recruitment and retention challenges; staff stress, wellbeing and turnover; recruitment by NHSH (although NHSH itself is struggling to recruit); competing seasonal and tourism employment; pandemic absence and summer annual leave.
- Accordingly, there is therefore unmet need within commissioned and in house services.

The challenges and issues are numerous and the landscape fast paced and changing. The key focus of NHSH therefore at this time in respect to **care at home provision** is:

- **Immediate:** to seek to stabilise, support the ongoing provision of safe care and to facilitate additional capacity.
- Where services are commissioned from the independent sector, there is regular and close dialogue about obstacles, issues and barriers to delivery, and to seek to urgently unblock / address.
- These actions include whole system mutual awareness, so there is an improved understanding of the actions on one part of the system impacting on another.

- **Medium and long term** horizon: current pace is moving faster than we can currently improve and transform and the current focus very much remains on immediate issues.

Update as at 15/08/2022

Strategic Objective 3 Outcome 9 – Care Well

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All Sectors: North Highland Care Homes to **15/8/22** (excludes out of area placements)

Care Homes Bed Vacancy Update - 15/08/2022

Independent Sector

Total number of empty Independent Sector Care Home beds - **66**
Vacant beds are in **25 out of 50** Independent Sector Care Homes - **50%** of Independent Sector Care Homes have empty beds
3 care homes currently closed to admissions
1 is impacted by Covid-19
2 are under embargo by NHS Highland
Of the 66 vacant beds a total of beds 37 are unavailable, 29 available (please note, this is all beds, including those that are privately funded).

In-House Sector

Total number of empty In-House Care Home beds **- 33**
Vacant beds are in 6 out of 16 In-House Care Homes - **44%** of In-House Care Homes have empty beds

0 care homes currently closed to admissions due to impact from Covid-19
Of the 33 vacant beds a total of 31 are unavailable

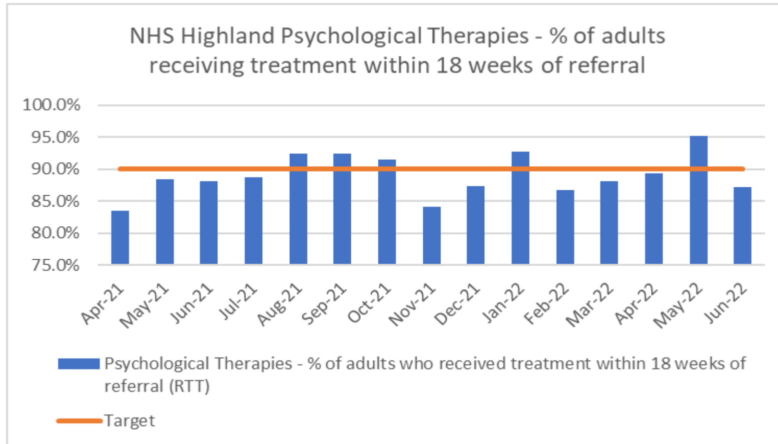
Update as at 15/08/2022

Strategic Objective 3 Outcome 10 – Live Well

Priority 1 - Deliver consistently excellent care that is quality focused, best practice and data driven, efficient, consistent and supported by the latest digital technologies

Psychological Therapies

1.



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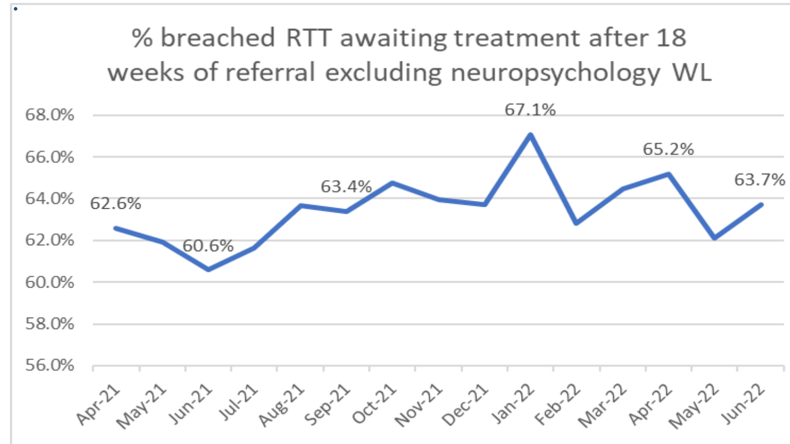

Community Mental Health Teams

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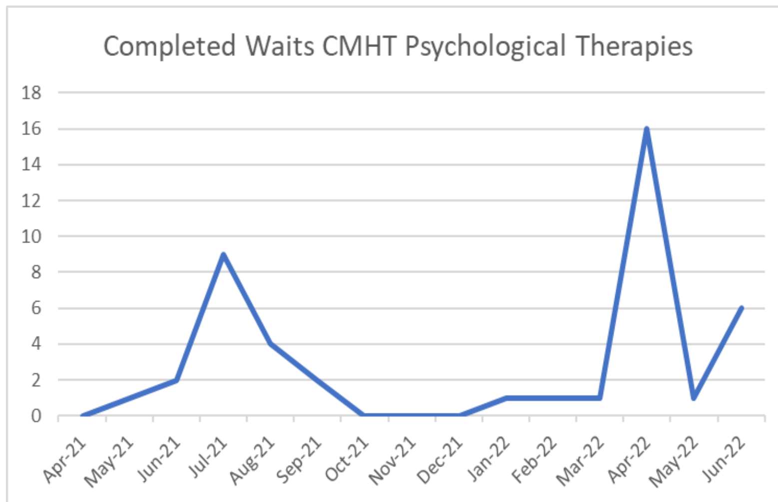

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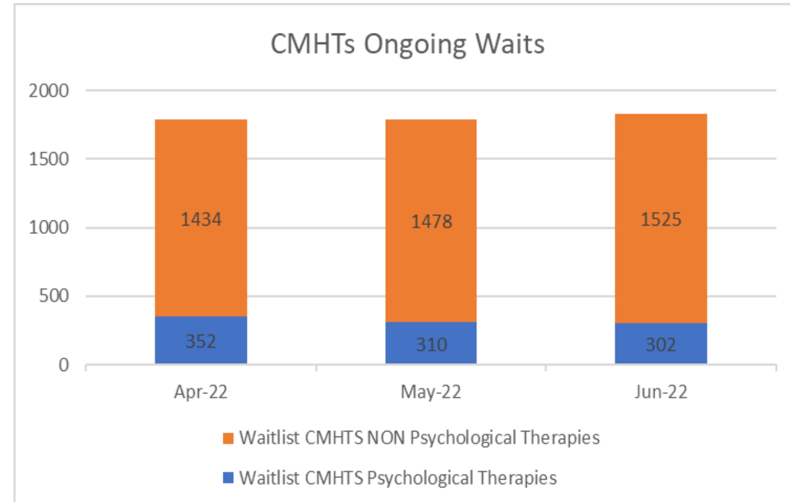


Adult Psychological Therapies has an RTT of 90% of patients to receive treatment within 18 weeks of referral.
Graph 1 – shows the performance against target for NHS North Highland
Graph 2 – shows the percentage of existing referrals who have already breached the target of 18 weeks (excluding neuropsychology)
Ongoing waits are reported based on time bands and Improvement Plans within the ADP. They have set targets against the longest waits based on clearing these within set timescales. However, within Adult Clinical Psychology they have been working with a 34% deficit of staff due to vacancies/recruitment.
Neuropsychology is a large part of these longest waits these are being reported separately to clearly identify plans within different parts of the service.

Community Mental Health Teams
The ongoing waits for CMHTs are not currently reported unless they fit the criteria for psychological therapies such as STEPPS group therapies. The delivery of these group therapies was halted during COVID and the availability of an online method was slow to progress. This has resulted in a significant backlog in this area. There is a shortage in STEPPS trainers within the UK so we are therefore exploring a range of options for increasing NHS Highland STEPPS practitioner capacity.
Graph 1 – shows the number of completed waits within the CMHT PT patients waiting on group therapies.
Graph 2 – shows the ongoing waits as recorded on PMS for the last 3 months, split between PT group therapies and other patients.

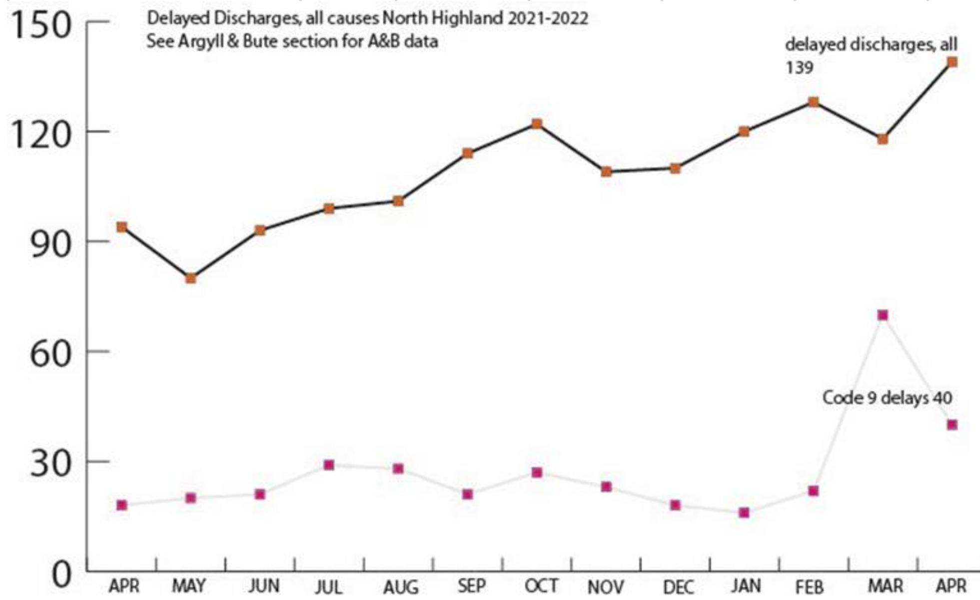
15/08/2022

Strategic Objective 3 Outcome 11 – Respond Well

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

Delayed Discharges – Community Hospitals

	DDs community hospitals	bed compliment in community hosps	occupied beds	available beds	bed occupancy %	waits in Raigmore for community hosp bed	DDs community hospitals	bed compliment in community hosps	occupied beds	available beds	bed occupancy %	waits in Raigmore for community hosp bed
Caithness	3	15	9	6	60.0%	0	4	15	9	6	60.0%	2
Sutherland	12	36	27	9	75.0%	0	16	36	28	8	77.8%	0
SLWR	0	35	18	17	51.4%	5	1	35	35	14	60.0%	6
B&S	4	20	18	2	90.0%	2	4	20	20	2	90.0%	3
N&A	8	16	16	0	100.0%	6	6	16	16	2	87.5%	3
Inverness	4	27	24	3	100.0%	9	6	27	27	3	88.9%	6
Mid Ross	2	9	9	0	100.0%	5	1	9	9	0	100.0%	4
East Ross	15	28	25	3	89.4%	1	15	28	28	0	100.0%	4
	14.07						11.08					

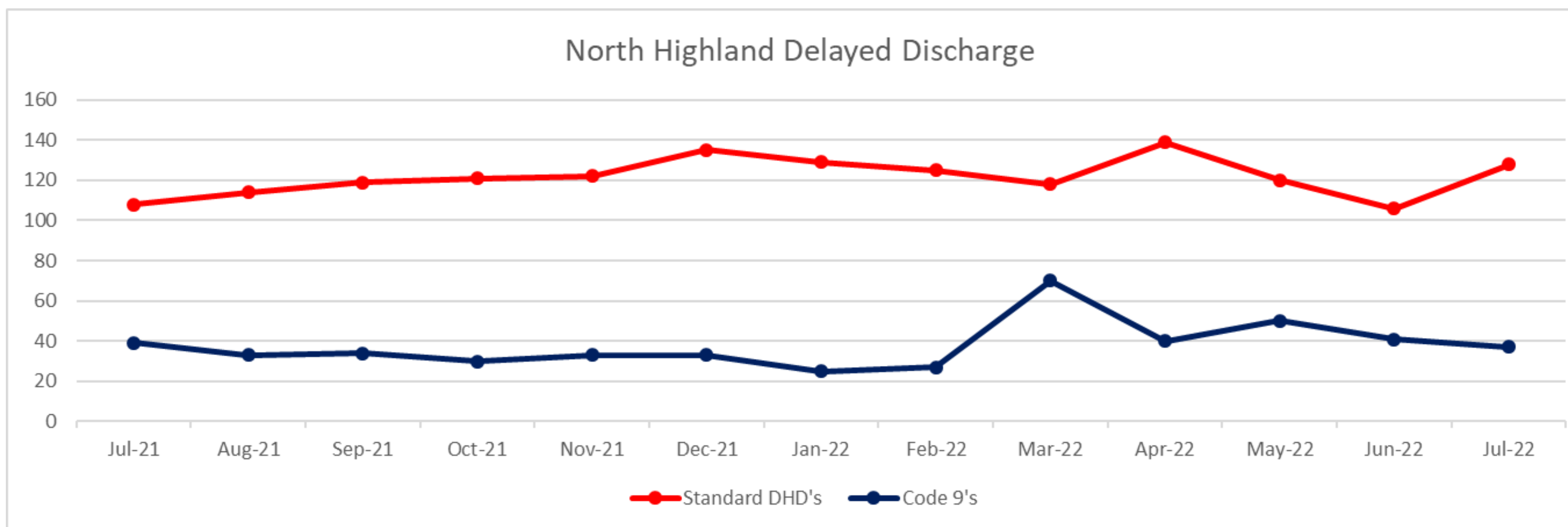


This table provides a position on delayed discharges in Community Hospitals at 2 comparison dates of 14th July and 11th August and the waits in Raigmore on 11th August for available beds.

Strategic Objective 3 Outcome 11 – Respond Well

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

Delayed Discharges – All Delays



There remain significant issues with data accuracy of DHD.

Nevertheless it is recognised that the fragility and retraction of care home and care at home services are resulting in people waiting longer than we would wish in hospital.

The impact of service shortages is exacerbated by the need to improve our discharge planning activity and tolerance of increasingly unrealistic choice.

Reduction of delayed discharges is a key focus of a number of aspects of our annual delivery plan.

Strategic Objective 3 Outcome 11 – Respond Well

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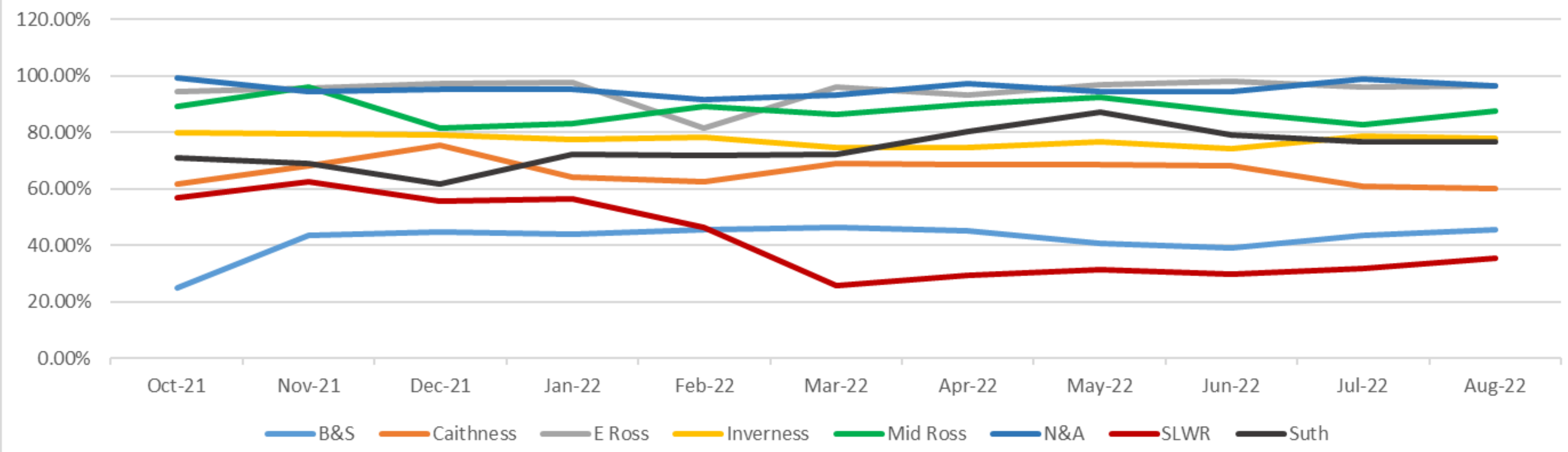

New slide demonstrating community hospital bed occupancy by district.

This data needs further work to ensure all beds that are shown on the system as available are in use at any given time and then to understand what the data is telling us.

Strategic Objective 3 Outcome 11 – Respond Well

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

Winter Pressures Funding Indicators

Metric	Jan-March 2022	Apr-Jun 2022	Jul-Sept 2022	Oct-Dec 2022
Number of people who have been discharged to an interim care home placement in the quarter	1	7		
Number of people in an interim care home placement at time of reporting	0	2		
Sum of the number of days spent in interim care home placements, which have completed in the quarter, by all individuals	42	145		
Number of people that have completed an interim care home placement in the quarter	1	5		
Output: Average length of interim care home placements completed in the quarter (days)	42	29		
Number of Whole Time Equivalent (WTE) additional internal adult social care staff recruited using winter pressures funding in the quarter	37	8		
	1	0.5		

- Funding of £9.4m (£8.54m is recurring) in 2022-23 was provided by SG for the purpose of:
- standing up interim care provision to support significant reductions in the number of people delayed in their discharge from hospital;
- enhancing multi-disciplinary working, including strengthening Multi-Disciplinary Teams and recruiting additional band 3s and 4s; and,
- expanding Care at Home capacity.

Various enabling projects have been agreed by NHS Highland which are funded. Many of these projects are in the early stages of recruitment. For example, in the 1st quarter 38 staff were permanently recruited to the Care Response Team to create a multi skilled team that can be mobilised at short notice to a variety of settings to support adult social care services during periods of extreme pressure with further recruitment in 2nd quarter.

During the period from January to June 2022, there was a significant number of care home beds unavailable due to the continued staffing pressures and residents affected by pandemic related absences and positive testing.

It is important to highlight that the current SG definition for interim care placements specifically refers to discharges from an acute hospital setting to an interim care placement (where there was an assessed need for care-at-home) and although not included within the winter pressures return, there are also interim care placements direct from community hospitals, and from the community due to the lack of current capacity in both care at home and care homes.

Section 4 – **Development** of Future Management Indicators, an example - Adult Protection

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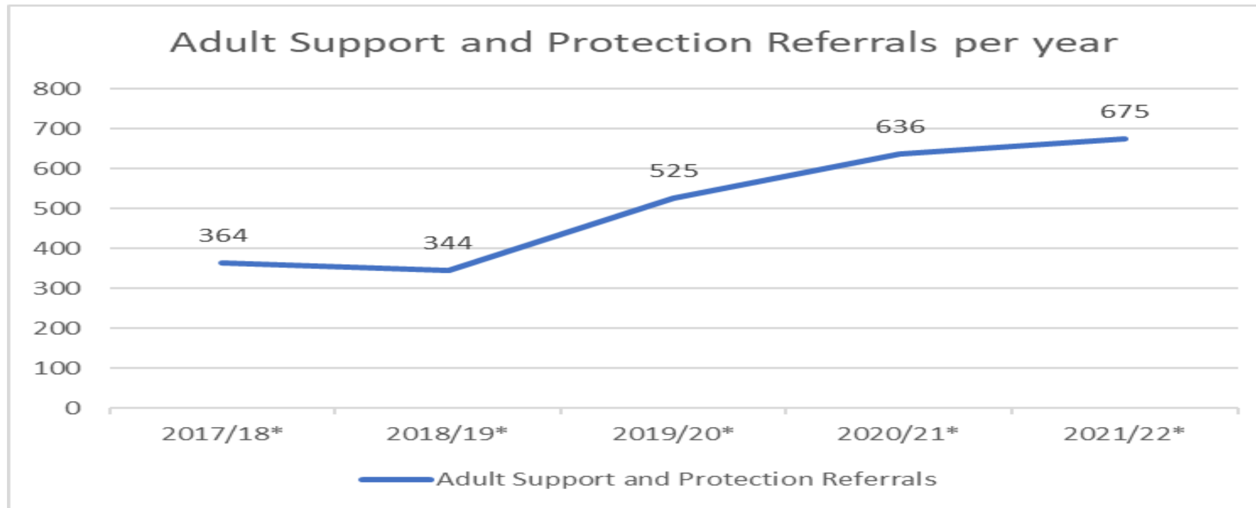

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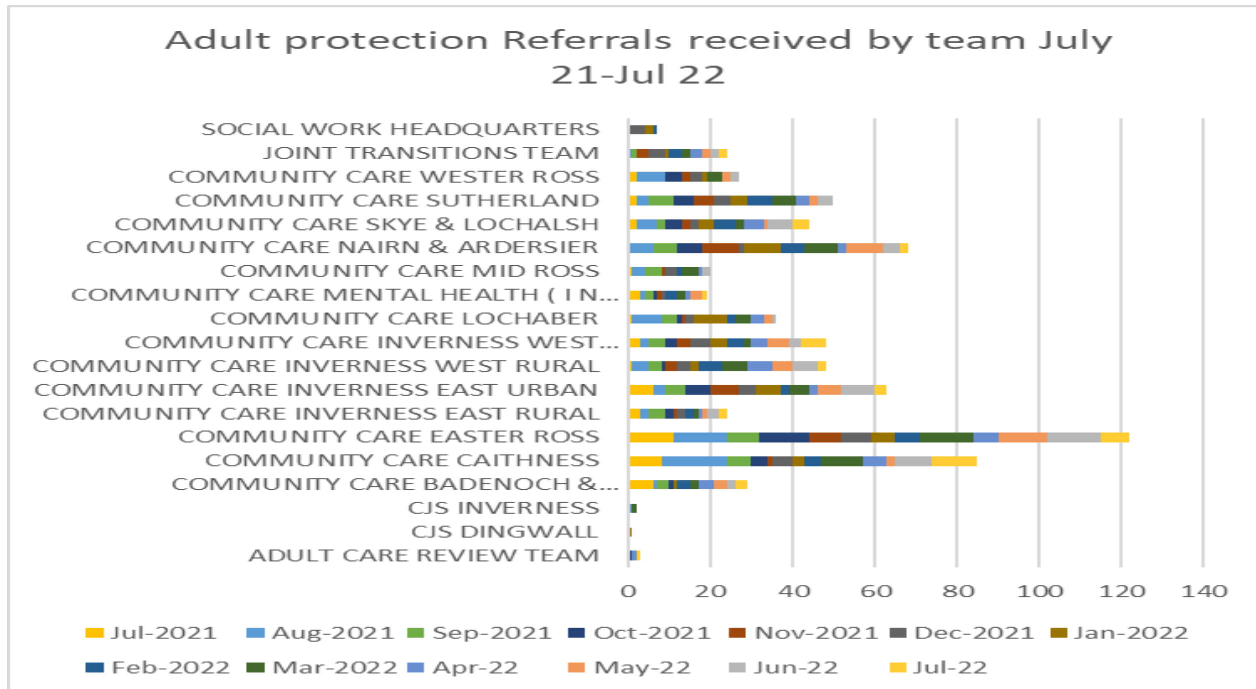

The indicators provided within this report represent the current reporting requirements for ASC. Previously, development sessions took place to discuss the requirements for a performance framework that would both provide indicators for the Adult Protection Committee and be useful to ASC leadership to show accurate data positions. Further development work is required to agree the indicators still required

Example:

Currently provided as part of an Annual Adult Protection return and shows the number of initial referrals and inquiries received and assessed by teams as to whether or not they meet the 3 point test and should progress to an investigation.

Graph 1 - This is the number of people referred as an adult protection concern annually. The numbers have been steadily increasing over the last few years as reported to committee.

Graph 2 – Provides a breakdown of the numbers of adult protection referrals received by community care teams monthly over a rolling year period.

15/08/2022

Section 4 – **Development** of Future Service Management Indicators

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

Development sessions were held with committee previously where the following suggestions were made as to possible indicators with associated actions by professional leads taken to further improve services.

Development Session:

- Self Directed Support – all Options
- Telecare
- Care Homes and Care-at-Home
- National Integration and relevant Ministerial indicators

Adult Social Care:

- Flow/Pressure
- Capacity and Resource Utilisation
- Compliance - (AWI, ASP, Complaints, Absence Management, FOI, Data Protection etc)
- Experience/Quality/Carers Agenda
- Care Homes and Care-at-Home Programme