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 29 June 2022 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Ann Clark, Board Non-Executive Director - In the Chair
Tim Allison, Director of Public Health (2pm until 3pm)
Louise Bussell, Chief Officer
Cllr, Christopher Birt, Highland Council from (until 2.30pm)
Cllr, Muriel Cockburn, Board Non-Executive Director
Cllr, Ron Gunn, Highland Council
Joanne McCoy, Board Non-Executive Director
Gerry O'Brien, Board Non-Executive Director
Julie Petch, Nurse Lead
Michael Simpson, Public/Patient Representative
Wendy Smith, Carer Representative
Michelle Stevenson, Public/Patient Representative
Simon Steer, Director of Adult Social Care
Ian Thomson, Area Clinical Forum Representative
Elaine Ward, Deputy Director of Finance
Neil Wright, Lead Doctor (GP)
Mhairi Wylie, Third Sector Representative

In Attendance:
Stephen Chase, Committee Administrator
James Bain, Transaction and Income Manager
Sarah Bowyer, Psychological Services
Rhiannon Boydell, Head of Service - Community Directorate
Lorraine Cowie, Head of Strategy
Fiona Duncan, ECO Health and Social Care & Chief Social Work Officer
Tara French, Head of Strategy for Health and Social Care
Gillian Grant, Interim Head of Commissioning
Arlene Johnstone, Head of Service, Health and Social Care
Tracy Ligema, Deputy Director of Operations
Fiona Malcolm, Head of Integration Adult Social Care, Highland Council
Jo McBain, Deputy Director for Allied Health Professionals
Jacquline Paterson, Contracts Officer
Nathan Ware, Governance and Assurance Coordinator

Apologies:
Pam Cremin, Cllr David Fraser, Philip Macrae, Boyd Robertson, and Mhairi Wylie.

1 WELCOME AND DECLARATIONS OF INTEREST

The Chair opened the meeting at 1pm, welcomed the attendees and advised them that the meeting was being recorded and would be publicly available to view for 12 months on the NHSH website.

The meeting was quorate.

The Chair welcomed the new Highland Councillor representatives to the committee, and Muriel Cockburn as newly appointed Highland Council representative to the NHS Highland Board.

W Smith declared an interest as a member of the Carers Union and had decided to step out of the meeting during item 3.4 on the Carers Strategy.

2 FINANCE

2.1 Year to Date Financial Position 2022/2023 [PP.1-10]

E Ward noted that formal reporting for the financial year 2022-23 has not yet begun, and therefore the update would highlight how the 2021-22 position had been managed and the expected impact this would have on the new financial year.

- A one-year financial plan has been submitted to Scottish Government with the expectation that it will be revisited at the end of quarter 1.
- An initial budget gap of £42.3m was identified with a cost improvement program planned for £26m, which leaves an unidentified funding gap of £16.3m.
- At a national level, savings of £225m of savings had been identified with a gap of £230m
- At the time of submission, there had been an assumption that COVID costs would be fully funded by Scottish Government but it has now been confirmed that this will not be the case.Any COVID costs would have to be managed from the funding allocation received in quarter 4 of 2021-22. In terms of COVID cost relevant to the partnership, there are a number of areas where costs are anticipated to come through additional staff costs, infection protection, and control measures.
- The paper under item 3.5 addresses the impact of the introduction of non-charging for non-residential services.
- The biggest cost driver within the partnership is the social care providers sustainability payments which are in place in their current format until the end of June. From July the support available to providers will be reduced however there will still be a potential additional burden for the Board..
- The costs for the vaccination program and the responsibility for delivering are currently held centrally.
- Highland Council are managing on NHS Highland's behalf slippage from allocations in 21/22 of just under £16.4m. (shown in table 2), This will contribute to closing the adult social care funding gap for 22/23 and allow. 9.3 million to be built into the financial plan for 22/23
- Significant additional investment has been announced (see Appendix 1). Appendix 2 highlights investment plans.
- Overall the funding position is complex and uncertain.
- Recruitment challenges are likely to continue and will bring an impact. Given the national workforce shortages there is a requirement from Scottish Government to look at how the Board delivers services and whether there is the potential to deliver them differently.
- There are a number of known adult social care allocations which have yet to be confirmed for 2022-23 (see Appendix 3). These are allocations received last year which are expected to be recurring, but at this point in the year they remain unconfirmed.
- There are risks for 2022-23 associated with recurring costs of permanent appointments made in relation to unconfirmed allocations as well as cost increases above the previously used inflation assumptions such as utility costs and fuel costs.

- There are indications that the Agenda for Change Pay award will be higher than the Scottish public sector pay policy, but it is not clear what the funding implications associated with this could be at present.
- Subsequent papers to the committee will provide an update on the budget against the actual position, as well as including ongoing detail of incoming allocations and the plans against these allocations.

During discussion, the following points were addressed,

- Appointments have been made on a permanent basis as part of mental health recovery funding, however confirmation of the level of funding has not yet been received making this a small risk. L Bussell explained that this was set against the risk that if an effort to recruit was not made then recruitment to these specialist positions was unlikely to happen at all, especially because the board is in competition for specialist appointments with the other Scottish health boards.
- The savings challenge for the partnership for 2022-23 is currently £6.36m, from an overall £26m gap, but if no brokerage is obtained from SG then the partnership may have to find additional money to contribute to closing the overall 16.3m gap. . Technical accounting measures are being looked as are ways to drive down COVID-related costs along with ways of attracting additional funding and energy efficiency measures, but the position remains a significant challenge.
- £14.1m of non-recurrent funding has been identified for investment and decisions will be made about this, once recurrent costs are known. This includes the 9.3 being held by the Council. Should it be possible to invest any of these funds in the services for which the money was allocated in 21/22, that investment can be made recurrently and will form part of the baseline for 23/24. This is likely to be dependent on recruitment which will likely mean slippage, hence funding being made available non recurrently.
- Regarding COVID funding, it was asked that if the £7.1m that has been carried forward from 2021-22 to 2022-23 was not enough would this be funded through the partnership. E Ward confirmed this had not yet been discussed.
- S Steer commented that there was a high level of confidence of achieving the £3m ASC savings requirement. However inflationary pressures in the independent care home sector was unprecedented. This is a potential risk should the Board have to support care homes financially.
- The likelihood of long-term recurring costs for COVID was acknowledged and that this was in addition to the vaccination programme as a whole. Discussions are being had with Scottish Government about changes to policy decisions to address how these could mitigate the position.
- W Smith commented that the partnership's use of block contracts with private agencies had made it difficult for people to recruit Personal Assistants for their own care packages, and that the remobilisation of day centres would give more flexibility if pre 2018 arrangements were put in place, and a request was made that carers be involved in the discussions around these issues. L Bussell noted that ASC is still dealing with the effects of COVID and therefore safety was key in plans for ASC both locally and nationally which in addition to staff shortfall was a significant challenge. There is a recognition of a competitive situation in terms of recruitment across different care services. There are plans in progress to set up a programme board to explore the pressures on Care At Home and consider how the recruitment situation can be improved by attracting more people to work in the care sector. It was agreed that carers should be involved in any discussions about how to
- J McCoy asked if there was a timeline in place to address the unconfirmed but expected allocations referred to in appendix 3 of the paper. E Ward answered that that it is hoped there would be more information to provide after quarter 1 and updates will come to the committee.

The Chair concluded the discussion by noting the importance of investing the available funds wisely and in a way that would reduce demand and increase capacity on care services. It

was agreed that an assurance report be brought to a future Committee on use of the funds available for investment.

After discussion, the Committee:	
– **AGREED** to receive **moderate** assurance from the report.	
– **NOTED** The progress on the delivery and planning of ASC savings.	
– **AGREED that an assurance report be brought to the Committee on plans for and outcomes from investment of additional recurring and non recurring funds.**	

3 PERFORMANCE AND SERVICE DELIVERY

3.1 Assurance Report from Meeting held on 28 April 2022 [PP.11-21]

The draft Assurance Report from the meeting of the Committee held on 28 April 2022 was approved by the committee.

- The minutes would be corrected to show G O'Brien as in attendance, and year dates would be amended as appropriate.

The Chair noted that the Action Plan would be updated to reflect items which are now closed or where there have been further developments.

- L Bussell agreed to check closed items with S Chase for the next agenda planning meeting.
- The Chair noted, with reference to a future report on community planning and engagement a draft engagement framework will be coming to the Committee for consideration before going to the Board. This will be added to the workplan.
- Regarding development sessions, one has been agreed for 27 July on climate change and sustainability issues.
- S Steer noted the action to develop a Care Academy approach and offered to bring a paper to the committee that addresses the recruitment crisis and work with Scottish Care. S Steer will liaise with S Chase to establish a suitable committee date for a paper which may involve Scottish Care in the presentation.

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

3.2 Matters Arising From Last Meeting

- N Wright noted that issues of equity of access in relation to the vaccination strategy were to have been discussed at the present meeting. This will be addressed at the next planning meeting.
- M Simpson expressed thanks to the CO for arranging a meeting outwith the committee in regard to the current situation and future plans for the North Coast redesign.
- M Simpson also noted with respect to the matter of travel warrants raised in AOCB that this was to have been included in the Finance Update or the CO's report. In answer, L Bussell noted that there is a temporary increase arrangement from the Scottish Government for NHS staff and the Board are also looking at how to provide effective support for its independent providers. E Ward noted that this item is currently under review and details will come to the next meeting.
- The Chair requested that this be added to the Action Plan as a matter for the Finance Update or CO's report.
- The Chair asked if the mandate for the Fees Group (item 3.2) for decisions made outwith meetings of the committee was now agreed. L Bussell answered that discussions were being had with E Ward and others to determine the processes for the Fees Group. It was felt necessary to delay a final decision until the new Director of Finance is in post.

After discussion, the Committee:	
– Agreed that issues of equity of access in relation to the vaccination strategy will be discussed at the next planning meeting. – Agreed that further details about support with fuel costs will come to the next meeting and that this be added to the Action Plan as a matter for the Finance Update or CO's report. – Noted that the mandate for the Fees Group for decisions made outwith meetings of the committee remained under discussion.	

3.3 NHS Highland Strategy: Together We Care

L Cowie gave a presentation on the current stage of the NHS Highland Strategy and noted that the work has been developed through engagement with the population and workforce within Highland. The strategy will take the organisation through to 2027 and the slide presentation was offered to be shared with the committee.

- It has been developed against the backdrop of the pandemic and this has presented some delays to the work in order to give staff time to properly engage .
- There have been 1,700 responses and 45 engagement sessions. There have been a number of online questionnaires, and use of Facebook and radio to reach as wide a public as possible.
- Images in the documentation had been submitted either by NHS Highland staff or from existing archives.
- A Wordle was shown which emphasised the common themes which arose during engagement sessions, such as 'communities', 'reducing inequality', 'mental health', 'care and the community', 'compassionate' and 'locally available'.
- The quotes shown in the presentation had come from a wide group of people taking into account an inequalities perspective and a protected characteristics perspective to make sure that the people in these groups have a voice within the strategy.
- The mission and vision for the strategy had been drafted and featured three overall strategic objectives and 16 associated strategic ambitions. These are intended to cover the whole life course of the population and to deliver the best possible health and care outcomes within Highland's communities.
- Strategic ambition 1 concerns giving every child the opportunity to start well in life and support development and wellbeing before and during pregnancy
- Ambition 2, 'thrive well', has a focus on young people and building integrated early year services and resilient communities. This includes supporting children's mental health and learning development issues in conjunction with colleagues from Highland Council.
- Ambition 3, 'Stay well', has a focus on preventative health measures which include vaccines, screening and social prescribing.
- Ambition 4 is Anchor well and is about partnership working with communities. The embedding of community planning partnerships and coproduction has already commenced at Lochaber and Caithness, but the aim is to spread this community engagement work throughout Highland.
- Three ambitions relate to the NHS Highland workforce. These are based in part on the recently developed national workforce strategy but tailored to the needs of staff in Highland.
- The ambition 'Care Well' considers an integrated approach to care without boundaries with the aim of putting families and carers first.
- Mental Health was a theme frequently mentioned in feedback to the engagement team, wanting to place it on an equal footing with physical health and to reduce stigma.
- The ambition 'Respond Well' concerns efficiency of response and adopting a seven day approach.

- Providing person-centred acute care as close to home as possible is another ambition, as is supporting those with long term conditions and assisting self care and how an ageing population can better retain control of their own lives.
- The theme of ‘Age Well’ concerns our aging population, much of this ambition is roundabout frailty and falls, realistic medicine and how we support older people to take control of their own lives.
- The theme of ‘End Well’ concerns palliative and end of life care and giving support to families through bereavement care.
- The theme of ‘Value Well’ gives a focus to carers and volunteers, and the way in which the organisation works with third sector providers to better value their work in the community.
- Ambitions were also noted to embed financial balance, digital delivery, innovative thinking and practice contributing to delivery on climate change.
- A draft plan will be presented to the Board in July for consideration and an annual delivery plan is being formed.

L Bussell added that the strategy is a high-level plan with the aim of being an active and engaging piece of work at every level of the organisation but particularly for its engagement with communities.

During discussion, the following points and questions were raised,

- It was clarified for the attendees that Together We Care is the strategy for NHS Highland but that this involved joint working with partners at almost every level of the organisation. T French noted with regard to the development of a joint partnership strategy that a strategy working group has been established with multi-sector representation and this has mapped out previous engagement work onto the Together We Care strategy and the Highland Council strategy. The aim in this work is to avoid duplication of questions asked of participants.
- M Simpson asked how the work will be evaluated on an annual basis, over the course of the 5 years in order to identify trends and to measure how well ambitions are achieved.
- L Cowie noted that evaluation work is underway with key performance indicators for qualitative and quantitative data added to dashboards to measure the impact of the strategy on the population.
- J McCoy requested a breakdown of the level of engagement from staff, patients, carers and kind of the different groups that the strategy team have worked with.
- L Cowie offered to provide the information to S Chase for distribution.
- G O'Brien commented that all good strategies should be ambitious and challenging, and that this strategy work was starting to give a real context and a framework for discussions to happen to provide aims for delivery outcomes.
- N Wright asked how dashboards for strategy work will be monitored and how this information will feed into the work of frontline staff and communities.
- L Cowie answered that from intelligence perspective, the Integrated Performance and Quality Report (IPQR) is being redeveloped so that it aligns with each of the ambitions within the strategy and makes the dashboard reporting visible for all of the groups involved in the process. The Report is regularly discussed at the Board, within Committees and is being adapted for use by services and teams.
- L Bussell noted some of the key challenges and opportunities raised by the strategy for NHS Highland which include finding the time and the space to examine what it means for each of the districts of NHS Highland. Development sessions have been had with the senior team and this will move to incorporate conversations with each of the districts. Care Homes, Care At Home, and Mental Health services are other key issues within Highland and there has been a lot of consultation within Mental Health services which relates to the processes for Community and Primary Care engagement.

The Chair thanked L Cowie and her team for her work on the strategy.

The Committee:

- **NOTED** the report, and agreed that information would be circulated to the committee on the groups who were contacted for engagement.

At this point in the meeting the Director of Public Health addressed item 5 of the CO's Report due to the need to leave the meeting early for another commitment. The remainder of the CO Report follows in the proper sequence of papers.

3.7 CO Report (COVID & VTP update)

T Allison gave a short presentation which provided an overview of the current pandemic and the vaccinations programme.

- The lead time between the preparation of a report and its presentation was noted with regard to the fast moving circumstances of COVID, with details changing week on week.
- The present rate of infection was noted as one in twenty with a 5% infection rate in Scotland as a whole.
- Information on local infection rates is limited due to the lower levels of testing than was the case earlier in the pandemic. However, there is better information for hospitals and care homes due to regular testing requirements and both have seen a rise especially in cases among staff.
- It was noted that the new omicron variants, BA4 and BA5 were more infectious than previous variances.
- It is though the current wave may last a few weeks before another low and then another peak later in the year.
- It was noted that the current situation is less a case of 'living with COVID' than adapting to circumstances because it still presents a serious danger especially among vulnerable groups, however it was thought unlikely that there would be a return to previous government-enforced restrictions.
- Vaccination rates for the over 75s had been approaching 90% coverage and it was felt there was a need to continue to push on to ensure the population are protected as best can be against both COVID and flu, with an especial flu risk noted for later in the year.

In discussion, the committee raised the following points:

- T Allison noted that it was important to apologise on behalf of the Board for things that had gone wrong with vaccine programmes in the past, especially in terms of communications. Lessons have been learned however it could not be guaranteed that problems would not arise in the future due to the split between a national communication system and a local, Board-led delivery. However, it was thought that there was now broadly-speaking more confidence in terms of local delivery.
- It is currently envisioned that the flu vaccine will be delivered at the same time as a COVID booster.
- It was noted that people can be infected with COVID a second time and this is especially the case with the development of new variants. Precise numbers are not possible due to far lower numbers of PCR tests.
- At the time of meeting there had been no final decision from Scottish Government about the Autumn COVID vaccination programme. Interim advice from the Joint Committee for Vaccination and Immunisation was that the following groups would be offered vaccination:
  - residents in a care home for older adults and staff working in care homes for older adults
  - frontline health and social care workers
  - all those 65 years of age and over

- adults aged 16 to 64 years in a clinical risk group.

The Committee:

- **NOTED** the update and agreed that an item on the Committee's responsibilities regarding the Vaccination strategy and assurance on matters including equity of access would be included in the Workplan.

3.4 Carers Strategy Update [PP.22-44]

I Thomson gave a brief overview of the report which was produced with the aim of showing workings to explain what activity had been undertaken and the uses the funding for the Carers Program had been put to.

- Feedback was requested from the committee to help give some steer on the future direction of travel.
- An implementation plan had been developed from the current Carer Strategy. This has mostly been reactive in an effort to respond to pressing needs.
- It was felt that the short break scheme had been a successful use of the available extra monies and feedback from carers had been positive.
- The team have recently participated in a voluntary carers inspection by HIS. Results are awaited and these will feed into any improvement plans.
- Attention was drawn to the development of the Carers Union which has been viewed positively as a grassroots Highland development which the team are keen to support to help give a better voice for carers. It is hoped that in time a proposal for support will be received from the Carers Union.
- It is felt that support should be given to allow people to have flexibility and have resources at their own disposal to be able to devise good personalized solutions to meet their own needs.

In discussion the following matters were addressed,

- J McCoy noted that there was not much information in the report on inclusion with regard to those who may not, for whatever reason, access digital resources, and asked if there were plans to address this. I Thomson noted that a lot of information is presented in leaflet form but that he would come back with information after discussing this further with members of his team.
- It was asked if there was resource within existing budgets and capacity to support the development of the Carers Union. I Thomson commented that it was not the aim of the team to dictate the ways in which the Carers Union would be supported but that he would be keen to receive a proposal and see what could be done to support it and maintain its independence. The Chair added that the Carers Union had arisen from carers themselves. I Thomson commented that the Carers Improvement Group had not had much success with engaging carers and that the voices of providers had been more dominant, therefore the Carers Union was an encouraging development.
- L Bussell noted that the care inspection I Thomson had referred to had been voluntarily undertaken by NHS Highland in order to get a better view of what areas of support had been working and what could be improved, and for this to feed into both the larger strategy work but also consider issues of local delivery.
- The Chair suggested there may be some useful feedback from the work on Together We Care that could feed into the Carers Strategy.
- The importance of carers needs through the co-design of support was noted with regard to the shaping of budgeting.
- The importance of acknowledging the work of young carers was raised. This area is largely under the remit of the Highland Council and its Children's Services but the NHS Highland workforce needs to be alert to identifying issues when they are noticed and appropriately referred.

The Committee:

NOTED the update, and

AGREED

- 1. That the proposed carers' programme budget at Table 1 is deployed in its present form until work on the development of a new Carers Strategy is complete,
- 2. That work to develop a new Highland Carers Strategy (2023-26) incorporates the need to provide direction on the use of the resource available in the carers programme budget,
- 3. That work to develop a new Highland Carers Strategy (2023-26) incorporates the need to recommend/effect new arrangements to input the perspectives of carers into NHSH's governance arrangements,
- 4. That the CIG is discontinued and that the perspectives and needs of carers are incorporated as part of the strategy development process; and those of service providers are consolidated within existing network meeting arrangements,
- 5. That the Implementation Plan continues to structure current activity in this field; and is updated by our Carers Services Development Officer on a regular basis,
- 6. That officers seek to ensure they find an appropriate route to catalyse (support and fund) an independent Carers Union in Highland.

3.5 Commissioned Care At Home Services Report [PP.45-54]

G Grant gave a brief overview of the report and noted critical issues such as staffing availability and retention with 106 care at home vacancies at present which is in addition to over 180 vacancies in care homes.

A number of factors were given explaining the reasons for these pressures which included,

- High rates of absence due to sickness
- The difficulties of remaining punctual for visits over a wide geographical reach
- Increasing fuel costs

The report also sought to address service user experience in order to mitigate problems and improve dialogue in order to create agreed key objectives and attain a stable, resilient and assured provision.

During discussion, the following points were raised,

- It was asked if practical measures such as changing start times to allow greater staff flexibility had made any impact on delivery of services. Examples were given by M Stevenson of poor staff experience of working conditions and low pay..
  -It was answered that a number of initiatives are under consideration, including changes to contractually required start and finish times to allow staff more flexibility in their work, and proactive engagement with families and neighbours in a wider package of support, and always with an eye to avoiding additional burden where it is not sustainable.
  -G Grant expressed concern at the examples of poor staff experience and invited M Stevenson to contact her separately as the team is keen to reduce any barriers to staff who would like to work in the sector. Pay levels are set by Scottish Government at a minimum level of £10.50 an hour and this is an acknowledged challenge for recruitment and retention. Work is underway to consider what additional payments can be made to support staff such as to address increased fuel costs.

S Steer gave assurances that the team are doing everything to address the current system pressures on staff and patients and noted that NHS Highland was the first board in Scotland to apply a minimum rate of £10.50 an hour and that this is similar to supermarket minimum rates. He also noted that the independent sector of care providers is a symbiotic relationship and that workforce planning needs to reflect this, for example in acknowledging a net loss in the care staff pool if NHS staff are recruited from partner providers. S Steer referred to the

difficulties in changes to shift patterns where there is a tension between finding flexibility for the available staff and patient needs, through addressing difficult issues such as block contracts and considering salaries as opposed to hourly rates.

- M Stevenson raised concerns about a lack of training for supervisors especially when helping new employees. S Steer answered that all providers should have training in place and that they are inspected by the regulator against this, however the past two years of the pandemic have affected the ability to train staff and increase skills and therefore skills may have deteriorated during this period of isolation and indicates that more effort is needed to engage with in house and care providers and give greater levels of support especially considering the levels of exhaustion and burn out that have been experienced.
- W Smith questioned S Steer's statement that everything was being done to support unpaid carers and that not enough was being done to find out what carers need and address remobilisation of day centres. S Steer clarified that his point was about supporting independent care at home services rather than unpaid carers and that he is keen to have conversation about how best to provide support after a tough 2½ years. The Chair noted that there would be an opportunity to discuss day services at the August meeting.
- The Chair asked for clarification of the ask of moderate assurance from the paper. G Grant responded that work is underway to address the issues and that plans for further actions would be brought back to the committee. The Chair suggested that a substantive report come to the committee in 6 months. S Steer offered an interim update and it was decided that discussion would be had outwith the meeting with L Bussell to consider updates for the CO Report.

The Chair expressed an interest that an update should give some picture from available data of common themes across independent care providers, NHS Highland staff and the services of personal assistants, and whether or not there are any significant disparities across the geography of Highland in terms of care at home provision such as waiting times.

After discussion, the Committee:	
– **Agreed** to accept the recommendations in the report and to take **moderate** assurance.	

3.6 Adult Social Care Fees Group Report [PP.55-60]

James Bain gave an overview of the report which noted that charging for services such as support work, housing support and daycare had been impacted during the pandemic namely had been affected since April 2020 that charging processes work quickly aligned.

- All charging for non-residential chargeable services has resumed with the exception of supplier relief for items such as additional PPE.
- Scottish Government are expected to give their commitment to the ending of charging for non-residential services.
- Legislative and national guidance is highlighted in the appendices to the paper linked to care costs. The average 12-month consumer price index is currently very high with the real rate of inflation much higher for lower income households.
- With reference to the mention of Telecare during the meeting, this is a financially accessible service and the charge is only paid by those who are able to pay. There are currently over 2,800 people in receipt of a Telecare service, be that a basic or enhanced service. This has grown significantly over the last few years with the current charge at £635 per person per week, which is not subject to a financial assessment.
- There is a lot of work ongoing in the switch from analogue to digital which will require supporting a number of elderly people and others through that particular change process,

- Regarding recipients of support work and housing support the pandemic and current financial situation has impacted many in this area and a standstill position for non-residential charging is recommended.

During discussion, the following questions and points were raised,

- M Stevenson asked about the effects of the digital switchover particularly with respect to patients with no access to broadband and limited engagement with technology, and to seek assurance about issues if there was to be a power outage that call alarms would still function. L Bussell agreed to provide an update outwith the meeting on work to ensure no detriment from the switchover.
- M Simpson asked if the standstill or uplift figures would be viable or sustainable over the next 12 months give rising costs and inflation. J Bain answered that one of the reasons for a standstill position was to consider the unknowns of the current cost pressures, and that the terms of the uplift was in relation to discussion around the National Care home contract increase.

In summarising, the Chair drew attention to the recommendations of note, which were points 2, 3 and 4 in the paper.

After discussion, the Committee:	
NOTED: – the current data gathering exercise, the significant current and emerging inflationary cost pressures affecting many families and individuals, and the SG commitment to end non-residential charging – the charging report has been considered at meetings of the Adult Social Care Leadership Team, the ASC Fees, Commissioning, Briefing and Instruction Group, and the Joint Officer Group on 17 May 2002. **AGREED:** – a standstill charging position for all existing non-residential charges for 2022-23, noting that a short life working group is assessing day care charging as endorsed by the ASC Fees, Commissioning, Briefing and Instruction Group, – that for privately funded residents in NHS owned care homes, the maximum percentage uplift of 5.58% is applied from 1 August 2022 which equates to £1,054 per person per week, – that for maximum weekly respite charges that the organisation apply a maximum weekly charge of £506.65 per person per week subject to existing charging rules, effective from 1 August 2022.	

3.7 Chief Officer Assurance Report [PP.61-64]

In introducing the report the CO commented that it was a relatively short update in order to focus on key issues. Additionally, there has not been an update on the North Coast redesign because dialogue has been ongoing outwith the meeting.

L Bussell noted the vulnerabilities that have been recently experienced around care homes where significant challenges have been faced. Highland is not unique in this regard, but it does have a lot of private providers with small care homes which are becoming very challenging to run.

- In discussion, M Stevenson asked with reference to the Community Risk Register about delays to the maintenance backlog and fire compliance work proposed for the Ross Memorial Hospital. Assurance was sought that the nine patients have been moved to suitable accommodation and that the nine beds will be fully restored once work is completed.

- In answer, L Bussell gave assurance that patients will not be moved from the hospital but moved to another part of the building. There will be very limited disruption to patients and staff and the expectation is for a return to the same level of bed capacity prior to the work. She also noted that the fire compliance work is not a current risk but futureproofing work for the hospital. Liaison with Estates and the contractors is underway to determine the timescale.

After discussion, the Committee:	
• **NOTED** the report.	

4 HEALTH IMPROVEMENT

There were no matters discussed in relation to this Item.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Committee Annual Work Plan **[PP.65-68]**

The Chair noted that the workplan would be reviewed at the next agenda planning meeting in light of the fragility of the current situation, and would be presented for consideration at the next meeting.

The Committee APPROVED the Work Plan.	

6 AOCB

None.

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 31st August 2022** at **1pm** on a virtual basis.

The Meeting closed at 4.12 pm

Highland Health and Social Care Committee

ROLLING ACTION PLAN

	Item	Action/Progress	**Lead**	Outcome/Update
15/01/2019	**Care Academy Development**	Agreed progress report on development of a Care Academy be submitted to a future meeting	**S Steer/I Thomson**	Progress report to be brought to a future committee
04/09/2021	**Clinical Governance**	Agreed detailed report on ASC Clinical & Care Governance to be submitted to future meeting.	**S Steer**	Progress report to be brought to a future committee
03/03/2021	**Staff Experience Item**	SLT Team. (Team involved in savings on PMO workstreams.)	**R Boydell/L Bussell**	To be included in Development Sessions. Possible inclusion of SLT in Development Session.
08/07/2021 and 02/03/2022	**Enhanced Community Services**	Update report and assurance on progress and plans for redesign to provide enhanced community services including parity of opportunity across the region.	**R Boydell/L Bussell/T French**	Suitable date to be agreed.
12/01/2022	**Chief Officer's Report**	Request for report on all aspects of Adults with Incapacity work	**L Bussell**	Report proposed for April committee delayed due to service pressures. Short update in CO report
12/01/2022	**Mental Health Report**	Update in six months; to include further information on CAMHS position	**A Johnstone/L Bussell**	Paper to come to November committee.
12/01/2022	**SDS Strategy**	Consideration to be given to future report on Community Directorate implementation of NHSH Engagement Framework in redesign	**A Clark/L Bussell**	Timetabling to be discussed.
02/03/2022	**Finance Report**	Update on renaming of Police Custody Service to be provided	**L Bussell**	Completed. Details in CO Report.
02/03/2022	**COVID Update**	Chair/CO/D of PH to discuss how/when to bring information on service response to Long COVID to Committee	**A Clark/L Bussell/T Allison**	Updates in CO Report.
02/03/2022	**Children's Services Reporting**	Further discussions to be held taking into account Committee views, including with HC and update provided in CO report	**L Bussell/S Amor**	Provisionally at August committee.

Items addressed on an On-going basis

01/09/2021	**Chief Officer's Report**	To include North Coast Redesign update	**L Bussell**	On-going
01/09/2021	**Chief Officer's Report**	Regular update on the progress of the NCS and how the partnership is responding and considering changes at the local level.	**L Bussell**	On-going

Items to be Followed Up Outwith Meetings

12/01/2022	**SDS Strategy**	Chair, I Thomson and L Bussell to discuss and agree timetable for future reports to Committee on Implementation	**A Clark/I Thomson/L Bussell**	Arranged and postponed. When service pressures allow.
02/03/2022	**Children's Services**	Information on CAMHS referrals to be provided to N Wright	**L Bussell**	
02/03/2022	**Children's Services**	CO to hold discussions with Mhairi Whylie on inclusion of Third Sector in service redesign and decisions on additional allocations	**L Bussell/M Wylie**	

Development Sessions

	Item	Action/Progress	**Lead**	Outcome/Update
04/09/2019	**Chief Officer's Report**	Agreed consideration be given to inviting C Morrison to address a future meeting on Near Me.	**A Clark/L Bussell**	Development Session on **technology enabled care** during 2022/23
08/07/2021	**Workplan**	Climate Change: consideration to be given as to how to approach the subject, e.g what commitments have been made, how might the Mobilisation Plan be affected.	**A Clark/L Bussell/R Innes/J Burnside**	September development session (TBC)
02/08/2022	**Workplan**	**Public Sector Equality Duty**	**A Clark/L Bussell**	During 2022

Public Sector Equality Duty

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**31st August 2022**
Title:	**Learning Disability Services Assurance Report**
Responsible Executive/Non-Executive:	**Louise Bussell, Chief Officer**
Report Author:	**Arlene Johnstone, Head of Mental Health, Learning Disabilities and Drug & Alcohol Recovery Services**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

This report relates to the following Corporate Objective(s)

Clinical and Care Excellence • Improving health • Keeping you safe • Innovating our care		**Partners in Care** • Working in partnership • Listening and responding • Communicating well	
A Great Place to Work • Growing talent • Leading by example		**Safe and Sustainable** • Protecting our environment • In control	

• Being inclusive • Learning from experience • Improving wellbeing		• Well run	
Other (please explain below)			

2 Report summary

1. SITUATION

1.1. This paper provides an update and summary of the current provision of health and social care to individuals with a learning disability in North Highland.

The Committee is asked to:

- Note the ongoing strategy development work.
- Be aware of the risks associated with the provision of support to individuals with complex needs and the recruitment and retention difficulties being experienced by the support sector.
- Note the recommendations from the Coming Home Implementation Report (Feb 22) and support NHS Highland's involvement in the national work.

2. KEY DRIVERS (Background)

2.1 The Scottish Government published the ***Learning / Intellectual Disability and Autism: Transformation Plan*** in March 2021. This plan brings together the aspirations detailed in the Keys to Life (2013) and the Scottish Strategy for Autism (2011) and "*sets out to ensure that progress is made in transforming Scotland for autistic people and people with learning/intellectual disabilities."* **https://www.gov.scot/publications/learning-intellectual-disability-autism-towards-transformation/**

The purpose of the plan is to "*shape supports, services and attitudes to ensure that the human rights of autistic people and people with learning / intellectual disabilities are respected and protected and that they are empowered to live their lives, the same as everyone else*." The plan identifies 31 Actions, detailed in Appendix 1.

2.2 NHS Highland staff actively participate in Scottish Government led initiatives to action the plan:

Action 17: *"The Scottish Government is also working with Healthcare Improvement Scotland (iHub) and H&SCPs on a learning/intellectual disability collaborative to maximise partnership working on community led solutions to new models of day support for people with learning/intellectual disabilities."* NHS Highland successfully bid to participate in this work – Highland Resource Centre Managers, advocacy organisations and third sector partners participated in the working groups.

Action 5*:* "… *SLWG set up to improve delayed discharge and reduce inappropriate out of area placements for people with complex needs. The*

findings of this work will be reported on and published in the near future and mechanisms will be put in place to deliver on its recommendations." Arlene Johnstone, Head of Service represented Social Work Scotland on the SLWG and contributed to the contents of the report.

"Coming Home Implementation: A report from the working group on complex care and delayed discharge" was published by the Scottish Government on 21st Feb 2022. The full report can be read here: Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot (www.gov.scot). Further details relating to this report are discussed in section 6.

2.3 In 2018 the Health & Social Care Committee provided support to progress a Highland Learning Disability Strategy. This work has now been incorporated into the NHS Highland Strategy Development Work and will be included in the strategies as described in the table below:

NHS Highland Together We Care Strategy	
Responsible:	NHS Highland Board
Progress:	Final strategy imminent
North Highland Mental Health & Learning Disability Service Strategy	
Responsible:	Louise Bussell: Chief Officer NHSH,
Progress:	Engagement work led by Scottish Recovery Network underway. Ongoing discussions with People First and staff working within Learning Disability services to ensure people with a learning disability are included in engagement work. It is anticipated that the strategy will be in draft form, for further consultation, by the end of 2022.
Mental Health & Learning Disability Improvement & Transformation Plans	
Responsible:	Arlene Johnstone, Head of Mental Health, Learning Disability & Drug and Alcohol Recovery Services.
Progress:	Available for all Mental Health & Learning Disability services, however, currently transferring to the new workstream structure within the framework of the NHS Highland Annual Development Plan.

3. HIGHLAND DATA (Background)

3.1 The Scottish Learning Disability Observatory (**https://www.sldo.ac.uk**) identified from the Scottish Census in 2011 that 0.5% of people in Scotland have learning disabilities.

3.2 In 2020, to ensure regular contact with people with a learning disability throughout the pandemic an exercise was conducted by health and social care professionals to identify individuals known to NHS Highland specialist Learning Disability services or social work teams. This identified 1038 people with a learning disability known to services.

3.3 The Highland Learning Disability Service compromises support across both Health & Social Care:

- Team of 20 Community Learning Disability Nurses (based in localities)
- Epilepsy Specialist Nurse (pan-Highland)
- Specialist Allied Health Professional (AHP) team – Speech & Language Therapy, Occupational Therapy, Physiotherapy, Dietetics, Clinical Psychology (pan-Highland)
- 2 Consultant Psychiatrists (pan-Highland)
- Willows In-patient Nursing Staff Team – 6 Assessment & Treatment beds in New Craigs
- 4 in-house Building Based Day Services: Inverness, Invergordon, Fort William, Thurso
- 12 Commissioned or grant funded day services across Highland
- 2 in-house housing support services: Inverness & Portree
- Commissioned Social Care Support from Independent Support Providers in individuals own homes.
- Housing solutions in cluster arrangements, shared living, or isolated tenancies.
- Social Work Transition team

3.4 The budget is divided between the Mental Health and Community divisions and there is variation in the utilisation in "North & West" and "South & Mid". The current recording of spend is complicated and therefore it is not possible to provide an accurate performance report across the multiple divisions and health and social care services. Support is provided by a range of agencies including the third and independent sectors.

The Adult Social Care budget is spent on the provision of direct support to people with a learning disability, in either their own home or an alternative setting (usually referred to as day care).

Diagram 1 shows the projected spend for 2022-2023. Total spend £34,682,351.

- Option 3 refers to the cost of support that is commissioned from independent sector support providers to provide care and support to people with a learning disability.
- Option 1 refers to the cost of budgets that individuals or their families have been allocated to purchase their own support (usually the employment of Personal Assistants)
- Housing Support refers to the cost of support that is commissioned from independent sector support providers to provide care and support to people with a learning disability. (Recorded differently from Option 3 for historical reasons relating to Scottish Government budget allocations).
- Option 2 refers to the cost of Individual Service Funds that individuals or their families have been allocated to purchase their own support options
- Day Care refers to the cost of in-house buildings-based day services or independent sector commissioned day services

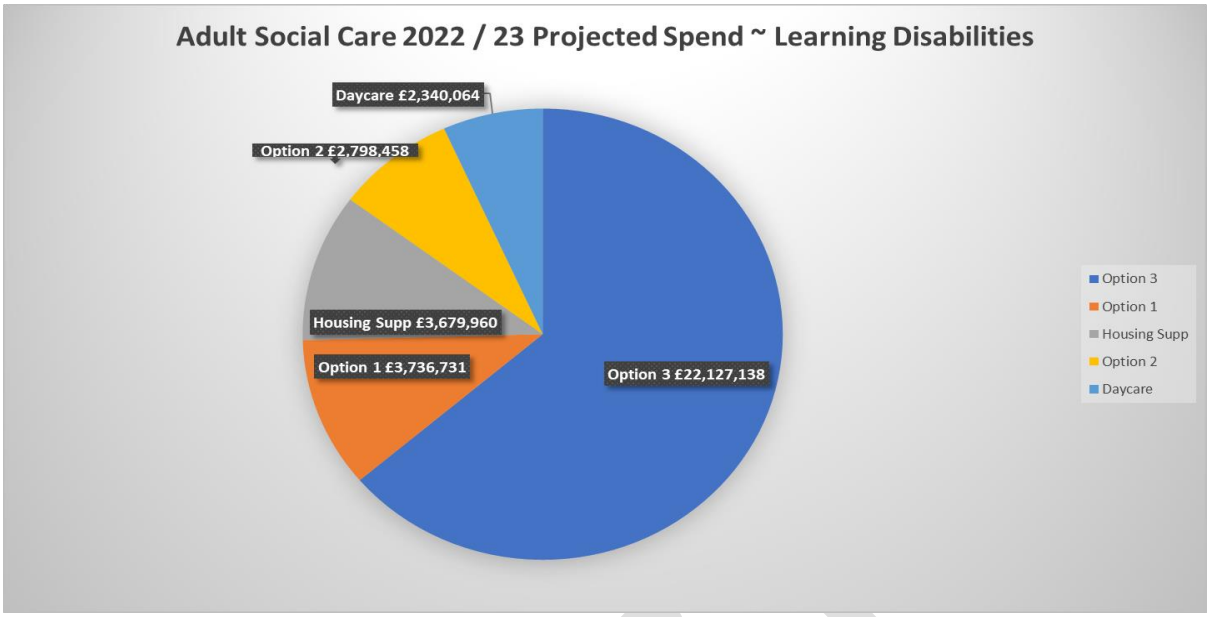


DIAGRAM 1. ADULT SOCIAL CARE PROJECTED SPEND 2022 / 2023

4. COVID RESPONSE (Background)

4.1 The Learning Disability Service responded quickly to the Covid pandemic and introduced a variety of different methods of attempting to ensure that health and social care professionals remained in contact with people with a learning disability throughout the pandemic. It was identified that some of these measures were very effective, and therefore continue to date:

- Contact a Learning Disability Professional Phone Line
- NHS Highland Learning Disabilities Facebook page updated regularly with Easy Read Information etc.
- Online activity sessions initiated.
- Highland LD Services You Tube channel
- RED meetings to provide advice to professionals or support providers as they identify people with a RED rag status. This has continued as a daily meeting and allows an immediate operational response to individuals in crisis.
- Daily Huddle for Support Providers & Specialist Care Homes (now weekly)

Day Centres significantly reduced provision (ie one / two people using building as a base to meet personal care needs or manage challenging behaviours). Staff were reassigned to deliver support in people's own homes or other roles.

4.2 The support to providers and changes to commissioning Learning Disability services in Highland were summarised in an I-hub insight piece, published on the national site in 2020. **PowerPoint Presentation (ihub.scot)**

4.3 The Community Learning Disability Nurse team provided vaccinations to individuals in an accessible clinic in the Corbett Centre and to those with complex needs in their own homes. They continue to work in partnership with the central vaccination team to ensure vaccines are accessible to all.

5. SUPPORT PROVISION (Assessment)

5.1 As shown in Diagram 1, most of the support provision received by people with a Learning Disability is commissioned via Option 3 and delivered by a support provider. NHS Highland has several specialist Learning Disability support providers on the framework:

Richmond Fellowship Scotland	Key
Thera Scotland	Gateway
Lifeways	Sense
Community Integrated Care	L'arche
Highland Home Carers	Gold

5.2 All support providers are inspected by the Care Inspectorate and the results are available online. Relationships with support providers are monitored via regular Contract Monitoring meetings. These meetings gather and discuss data regarding recruitment and retention, complaints and reportable incidents, quality of outcomes achieved and feedback from service users and their families. NHS Highland meet weekly with all providers to ensure timeous communication and escalation of concerns. ARC (Association of Real Change) facilitates a monthly providers meeting.

5.3.1 Agreement for the transformation of "traditional building based" day services was agreed by the Health & Social Care Committee in March and September 2018. Progress to new models was led slowly (to ensure alternative options were established and transitions were carefully planned, and person centred). The onset of the pandemic significantly impacted upon this work and the focus shifted to the provision of support to individuals in their own homes.

5.4 Further details of the day care provision is detailed in the previous papers. Provision is varied across Highland; a range of service models and commissioning arrangements are available:

IN House (NHSH) provision		
Thor House	Thurso	7 people with profound learning disabilities
Corbett Centre	Inverness	16 people in the building focusing on flexibility of model (outreach support in people's own homes now offered)
Isobel Rhind Centre	Invergordon	55 people focusing on employment activities and on-line support
Montrose Centre	Fort William	8 people focusing on employment activities
COMMISSIONED Support provision		
Kyleakin Connections	Skye	Block funded, focus on community participation
L'arche	Inverness	Block & spot funded, focus on employment activities
Nansen Highland	Muir of Ord	Block & spot funded, focus on young people and employment activities
Cantraybridge	Croy	Residential and day care. Focused on young people, rural & digital skills and employment
Clachbeg	Black Isle	Spot funded. Focus on rural skills.

Grigor House	Nairn	Spot funded, focused on day activities.
GROW Project	Inverness	Block funded, focus on gardening skills, qualifications, community participation and employment
Leonard Cheshire	Inverness	Residential and day service. Focused on individuals with physical and learning disabilities
Watermill	Croy	Spot / funded via individual's budgets. Cycle track, space for support.
Caberfeidh Horizons	Kingussie	Spot / funded via individual's budgets. Bookshop, Wombles, independent living.

5.5 In 2021 Highland participated in Healthcare Improvement Scotland Transformational Redesign Project: New Models for Learning Disability Support Collaborative. In-house resource centre managers, advocacy organisations, third sector providers and support providers all participated in the collaborative to support the design and redesign of models for the provision of support in Highland. The collaborative shared models of good practice and provided tools to review service delivery. Highland focused on the service provided in the in-house provision.

5.6 This work highlighted the NHS Highland assets:

- buildings (operated by NHSH) with specialist equipment eg sensory rooms, touch screen computers, safe space
- staff with additional training to meet the needs of individuals with profound and multiple learning disabilities, complex autism and behaviours perceived as challenging, with low turnover
- a range of support providers e.g., Richmond Fellowship Scotland, Key, L'arche currently providing high quality support to individuals at other times in their lives
- a varied range of opportunities developed by local people for local people with strong community links eg Kyleakin connections, Caberfeidh Horizons
- a commitment to following through the expressed desires of people with a learning disability to achieve employment (in its broadest sense)
- a commitment to supporting local opportunities

5.7 These assets have been maximised and space and / or support in in -house buildings-based resource centres is offered to individuals with profound and complex physical and / or behavioural difficulties in a very flexible model.

Activities offered are designed to meet the needs of clients with complex needs and aim to link with employment activities. For example: candle making in Isobel Rhind Centre, café in Fort William (that was recently celebrated for its work by Volunteer Scotland **Volunteer Friendly first for Fort cafe volunteers - The Oban Times)**

Many individuals are also now able to access the resources available in building based resource centres with support from their own familiar care team, eg Personal Assistants or support workers employed by a support provider (not NHSH).

NHS Highland resource centre staff are facilitating online group activities (open to a wider range of people than pre-pandemic), supporting people in community settings and teaching people skills in their own homes.

5.8 As Highland shifts to “living with Covid”, day services have evaluated the provision of support during Covid and are ensuring the most effective elements are included in the provision of support moving forward. There has been regular contact, both informally over the telephone and in the review process, with supported people and their carers throughout the pandemic and this feedback has informed the development of the virtual activity programme.

In December of 2021, people who received support from day services across Highland, and their carers, were invited to complete a short questionnaire asking them about their experiences since the onset of the current pandemic. It should be noted that there was limited response to questionnaires (29) and that additional engagement methods with stakeholders should be utilised to provide robust evaluation moving forward.

The following evaluation is based on the returned questionnaires:

- **Virtual and online groups** were generally viewed positively by supported persons. It was unclear from the returns, the views of carers. Staff delivering virtual groups, have noted that on the whole carers generally leave supported persons alone to participate in virtual activities, wherever possible. This may indicate these activities allow for some short-term respite from their caring responsibilities.
- **Provision of face-to-face support in own homes**. Although there was clear unhappiness regarding suspension of day services, questionnaires confirmed that day service staff had continued to provide support to individuals throughout the pandemic. Responses confirmed that supported persons were receiving support in a place they felt safe, primarily their own homes, and that this support had been positive for most individuals who had been in receipt of more 1:1 support, allowing them time to work on individual care and support needs such as bespoke physiotherapy routines, gaining skills such as cooking in their own homes etc.
- **Additional support**. From the twenty-nine responses available, twenty-one confirmed that they had received additional support from a range of paid providers and six recorded they had required additional support from families.

It is acknowledged that the service has only sought the views of those accessing in-house day provision. Further information about day activities is readily available and regularly shared from support providers but this has not been collated into one document.

To ensure the inclusion of people with a learning disability in the development of the strategy it is our intention to work in partnership with an independent third sector organisation with experience working with adults with a learning disability.

5.9 The ***Learning / Intellectual Disability and Autism: Transformation Plan*** clearly states that its purpose is to ensure the people with a learning disability are "*empowered to live their lives, the same as everyone else*." Actions 20 and 21 identify the aspirations to halve the employment gap and ensure progress. Previous consultation events in Highland have evidenced that people with a Learning Disability in Highland would like to be in employment and they require support to achieve this.

To further progress this work the NHS Highland Learning Disability Service intends to establish an Employment Transformation Programme that will work in partnership with key stakeholders and shift resource from "traditional" support provision to finding opportunities for jobs and supporting people with a learning disability in places of employment.

6 INDIVIDUALS WITH COMPLEX NEEDS that are DELAYED IN HOSPITAL or in OUT OF AREA PLACEMENTS (Assessment)

6.1. "Coming Home Implementation: A report from the working group on complex care and delayed discharge" was published by the Scottish Government on 21st Feb 2022. The full report can be read here: Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot (www.gov.scot)

Recommendations include:

- A dynamic support register should be developed into a tool for national use
- A national support panel should be established in order to provide support and oversight of the dynamic support register
- A national peer support network should be established to facilitate people coming together to learn and share best practice
- Further work should be undertaken to explore the issues in relation to people with enduring mental health conditions who are subject to delayed discharge from hospital

The report also clearly states "by March 2024 we expect to have seen out of area residential placements and inappropriate hospital stays greatly reduced, to the point that out of area residential placements are only made through individual or family choice and people are only in hospital for as long as they require assessment and treatment".

6.2 27 individuals with a Learning disability or Autism are placed in a range of residential settings out of our local authority area. 20 people are in Scotland, 6 in England and 1 in Northern Ireland.

6.3 There are 10 individuals with a Learning Disability and / or Autism diagnosis in hospitals out with Highland. 6 of these patients are receiving care at sites in Scotland and 4 further afield in England.

6.4 Highland has worked in partnership with Safe as Houses and Key (support provider) to develop a new cluster housing development for individuals with complex needs. Building work will, hopefully, be completed in the Autumn of 2022 and 6 tenants will move into their own homes in a phased manner in the winter of 2022. One individual is returning from a hospital in England, another is moving from New Craigs.

6.5 This is an area of risk within NHS Highland. The needs of each individual are highly complex and require staff teams that are highly committed, well trained and regularly

supported. Each individual requires high levels of care and support (for example 3:1 support provision 24 / 7), specific housing environments (for example two exits in each room, additional sound proofing) and regular contact with specialist health professionals.

6.6 Support providers are reporting increasing difficulties recruiting and retaining staff and are therefore less willing to agree to work together to create support packages for individuals with complex needs.

6.7 The difficulties in recruiting and retaining staff has led to providers being unable to create their own "staff bank", this means that they are unable to provide crisis or short notice support in ways that they have in previous years. It is likely that will lead to an increase in requests for out of area placements or inappropriate hospital admission due to the lack of appropriate care and support in community settings.

6.8 To ensure that NHS Highland meet the aim of reducing out of area placements we will establish a Short Life Working Group to establish how Highland will participate in the national work and agree the actions required. NHS Highland has agreed to be a pilot site for the national register work.

7. HEALTH INEQUALITIES

7.1 It is well documented that people with a learning disability experience poorer health outcomes than the general population and die on average twenty years earlier than the rest of the population. Last year, new evidence was published by the Scottish Learning Disabilities Observatory that adults with learning disabilities are twice as likely to die from preventable illnesses.

7.2 The Scottish Government wrote to all Health Boards on the 14th June 2022 with a direction: The Annual Health Check for People with Learning Disabilities (Scotland) Directions 2022 ("the Directions"), which provide a duty on Health Boards to provide Annual Health Checks to all people in Scotland aged 16 and over who have learning disabilities, using the Scottish Health Check for Adults with Learning Disabilities. Annual Health Check for People with Learning Disabilities

7.3 NHS Highland are awaiting confirmation of funding and are working on an options appraisal exploring options for delivery.

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

Support individuals to remain in their local communities and participate in meaningful activities.

3.2 Workforce

Current concerns regarding support providers ability to recruit and retain staff

3.3 Financial

Additional costs to provide support to individuals with complex needs is acknowledged. Scottish Government has provided funding to support model changes and fund double running costs etc.

3.4 Risk Assessment/Management

Risk of inability to provide support as required to individuals with complex needs. Management plan: to set up SLWG to increase partnership working and explore innovative options.

Risk of increased number of people placed out of area or inappropriately admitted to hospital. Management plan: as above

3.5 Data Protection

State whether the proposed piece of work or project involves personally identifiable information (including but not limited to patient, staff, service use, volunteer, NOK)?

If so, confirm whether advice has been sought from the Data Protection Team to ensure the correct risks have been considered and documentation completed.

Register work (for both health checks and individuals with complex needs) will involve liaison with Data Protection Teams.

3.6 Equality and Diversity, including health inequalities

Supports Board Equalities Outcomes by tackling health inequalities.

An impact assessment has not yet been completed.

3.7 Other impacts

Service changes have the potential to impact on carers.

3.8 Communication, involvement, engagement and consultation

Every person with a learning disability receiving support has a regular review (at least annually, often 6 monthly).
Participation in support providers monthly meetings.
Feedback is received from Advocacy organisations – People First and TAG

3.9 Route to the Meeting

Mental Health SMT 15.08.22

4 Recommendation

- Note the ongoing strategy development work.
- Be aware and discuss the risks associated with the provision of support to individuals with complex needs and the recruitment and retention difficulties being experienced by the support sector.
- Note the recommendations from the Coming Home Implementation Report (Feb 22) and support NHS Highland's involvement in the national work.
- Note the direction relating to the provision of annual health checks to all people with a learning disability in Highland.

4.1 List of appendices

The following appendices are included with this report:

- Appendix No 1: **Learning / Intellectual Disability and Autism: Transformation Plan: Summary of Actions**

APPENDIX NO 1.

Learning / Intellectual Disability and Autism: Transformation Plan: Summary of Actions

Action No:	HUMAN RIGHTS
1	The Scottish Government is clear that the needs of autistic people and people with learning/intellectual disabilities and their carers are to be actively considered as part of the ongoing independent review of the Mental Health Act. This legislative reform work will help inform the shape of our future legislation.
2	The Scottish Government will explore further the proposals for a commission or commissioner to help protect people's rights.
	BOTH LEARNING/INTELLECTUAL DISABILITY AND AUTISM
3	The delivery of the Mental Health Transition and Recovery Plan will support improvement in population–level mental health services. We will explore how these services can better meet the needs of autistic people and people with a learning/intellectual disability.
6	We will pilot a Nurse/AHP Consultant for Autism and learning/intellectual disabilities (learning from best practice from Alzheimer's Scotland Nurse Consultants) aimed at improving both mental health and hospital care of autistic people and people with learning/intellectual disabilities.
10	We and our partners have established a Gender Based Violence Steering Group and will develop an action plan to reduce incidence of violence and empower women with learning/intellectual disabilities and autistic women to have safe and loving relationships.
12	We will explore establishing: **A -** mandatory autism training for all NHS staff. **B -** mandatory learning/intellectual disability training for all NHS staff.
15	The Scottish Government will ensure that people with lived experience are listened to and better supported to initiate and influence programmes and initiatives which

	will impact on their lives. We want to ensure that those voices are part of discussions from the outset. This will include helping to support engagement with the issues set out in the review of adult social care, the Social Renewal Advisory Board and National Taskforce on Human Rights. This provides opportunities to ensure that social care reform and the transformation of social care services are focussed on reducing inequalities and better meet the needs of our population.
16	The Scottish Government continues to work with Inspiring Scotland 'Support in the Right Direction' and other partners to ensure that more autistic people and people with learning/intellectual disabilities access their rights under the Social Work (Self Directed Support) (Scotland) Act 2013 to direct their own support.
17	In May 2020, the Scottish Government, Social Work Scotland and COSLA produced COVID-19: Guidance on Self-Directed Support Option 1 and Option 2. The guidance is for Local Authority and Health and Social Care Partnership staff who assess, approve and administer social work and social care and support (including carer support), and approve Self-directed Support (SDS) budgets and is relevant only for the duration of the COVID-19 pandemic period.It aims to support local social care systems and services to continue to respond appropriately and flexibly, to enable service users to meet their outcomes during the pandemic.We will work with partners and individuals to understand the impact of this change. The Scottish Government is also working with Healthcare Improvement Scotland (iHub) and H&SCPs on a learning/intellectual disability collaborative to maximise partnership working on community led solutions to new models of day support for people with learning/intellectual disabilities.
18	The Scottish Government has launched a national carers marketing campaign to help more people recognise when they are in a caring role and to access the support available under the Carers (Scotland) Act 2016. We will help make sure that people know about this support.
19	The Scottish Government will explore asset based community development models to create better outcomes for autistic people and/or people who have learning/intellectual disabilities and their family carers.
20	The Scottish Government will continue to work towards our ambition to at least halve the disability employment gap as stated in A Fairer Scotland for Disabled People and **A Fairer Scotland for Disabled People: Employment Action Plan.**
21	The Scottish Government will ensure that the voices of autistic people and people with learning/intellectual disabilities are heard and a meaningful and important part of the decision making in the review of supported employment provision across Scotland. Supported Employment plays an important part in helping people into work who would otherwise struggle to gain employment in the open labour market. As such, it is a model that can make an important contribution to the ambition to at least halve the disability employment gap in Scotland, and will be more important than ever as part of our COVID-19 recovery efforts. The review is taking place in the first quarter of 2021 with the final report due in the summer of 2021.
22	The Scottish Government and COSLA will work with partners to support the implementation of the action plan on the recommendations of the Additional Support for Learning Review,**,** improving educational experiences and outcomes for all children and young people who need support with their learning.
24	We will build better learning/intellectual disability understanding by promoting the Talking about Learning Disability resources through the General Teaching Council and Association of Directors of Education in Scotland.
25	The Scottish Government will work to develop meaningful Additional Support for Learning outcome measures which capture indicators of the achievements and progress of autistic children and/or children who have learning/intellectual disabilities beyond solely academic and destination data.

26	The Scottish Government will produce new standalone guidance on the use of physical intervention and seclusion in Scotland's schools. This will provide a clear human rights based policy on physical intervention and seclusion and will be presented as part of the Included, Engaged and Involved suite of guidance. We will also introduce a standard data set and oversee subsequent implementation, including a review one year from publication of the revised guidance to ensure its effectiveness.
27	As part of our joint action plan in response to the Additional Support for Learning implementation review, we will explore how to support more parents to have access to the information, skills, support and advocacy they need to be active and equal participants in their child's education.
28	A - We will improve digital access for people with learning/intellectual disabilities so that they can stay connected to their friends, family, and communities. B - We will improve digital access for autistic people so that they can stay connected to their friends, family, and communities.
31	In partnership with Inspiring Scotland and the Scottish Commission for people with Learning Disabilities (SCLD), we will encourage people with lived experience to participate in a Future Leaders Programme to empower people to be active and involved in their own community. We also want to support self-advocacy initiatives like the National Involvement Network, autistic led charities and organisations, People First and the People's Assembly.
32	The Scottish Government will take specific action to engage with autistic people and also people with a learning/intellectual disability from Black, Asian and Minority Ethnic Communities to hear about their experiences and identify how we can best support and work with them.
	LEARNING/INTELLECTUAL DISABILITY
4	We will promote the Mental Health resources being developed by PAMIS to better support people with Profound and multiple learning disability (PMLD) to explore their emotions and a resource developed by Glasgow University to better support people with learning/intellectual disabilities to cope with anxiety.
5	We will ensure that the recommendations of the Coming Home Report are fully considered in the implementation of the work of the SLWG set up to improve delayed discharge and reduce inappropriate out of area placements for people with complex needs. The findings of this work will be reported on and published in the near future and mechanisms will be put in place to deliver on its recommendations.
7	We will work with the Scottish Learning Disability Observatory to further understand health inequalities and to identify specific predictors of mortality and actions that will improve health outcomes for people with learning/intellectual disabilities of all ages.
8	The Scottish Government, Aberdeenshire Health & Social Care Partnership and partners will take forward a pilot of health checks for people with learning/intellectual disabilities to address health inequalities and early deaths.
9	The Scottish Government and partners including NHS Boards, the Scottish Commission for people with Learning Disability and the Scottish Learning Disability Observatory will deliver improvements in data collection and access to data to improve the visibility of these populations and consider the development of a Key Performance Indicator to monitor improvements.
29	In partnership with the Scottish Commission for people with Learning Disabilities (SCLD) and People First we will build on the Covid-19 experience of providing access to accessible information. This will include using SCLD's website as an accessible information hub and linking into Disability Equality Scotland's Inclusive Communication Hub.
	AUTISM

11	We will continue to work with the National Autism Improvement Team (NAIT) to support autism and ADHD diagnostic services through improvement practice and explore with Healthcare Improvement Scotland (HIS) the development of a Key Performance Indicator to monitor diagnostic services across Scotland.
13	As committed to in the Programme for Government we will deliver a 6 month pilot national post diagnostic support service for autistic people from December 2020. We will work collaboratively with national autism charities, autistic led charities and organisations and evaluate the outcomes of the pilot post May 2021.
14	We will explore the barriers to autistic people living a healthier life.
23	We will action the Deputy First Minister's Working Group Implementation Plan following the**Not Included, Not Engaged, Not involved Report.**This will include building better autism understanding in Initial Teacher Education, working with the General Teaching Council Scotland and Universities to develop training resources and deliver training in autism to all trainee teachers.
30	We want to empower people to have their voices heard as active citizens. Our new autism campaign **– Different minds. One Scotland. –** is part of trying to change the way that autistic people are understood and was built on early and successful involvement from autistic people. We will continue our work on this.

Agenda Item XX

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**31st August 2022**
Title:	**PCIP Assurance Report**
Responsible Executive/Non-Executive:	**Jill Mitchell, Head of Primary Care**
Report Author:	**Catriona Naughton, Primary Care Project Manager**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

This report relates to the following Corporate Objective(s)

Clinical and Care Excellence • Improving health • Keeping you safe • Innovating our care	✓	**Partners in Care** • Working in partnership • Listening and responding • Communicating well	✓
A Great Place to Work • Growing talent • Leading by example • Being inclusive • Learning from experience		**Safe and Sustainable** • Protecting our environment • In control • Well run	

• Improving wellbeing			
Other (please explain below)			

2 Report summary

2.1 Situation

This Assurance Report has been prepared in relation to the implementation of the 2018 General Medical Services Contract in Scotland and provides a summary of progress achieved on the project to date and forecast for the coming period. The report covers the period to 31/07/2022.

2.2 Background

The Scottish Government and the SGPC (Scottish General Practitioners Committee) share a vision of the role of the GP as the expert medical generalist in the community. In line with commitments made in the Memorandum of Understandings (MOU) (1 & 2), HSCPs and NHS Boards will place additional primary care staff in GP practices and the community who will work alongside GPs and practice staff to reduce GP practice workload. Non-expert medical generalist

work load needs should be redistributed to the wider primary care multi-disciplinary team ensuring that patients have the benefit of the range of expert advice needed for high quality care.

Specific priority services to be reconfigured at scale are:

- Pharmacotherapy
- FCP MSK (First Contact Physiotherapy, Musculoskeletal)
- Community Link Workers
- Primary Care Mental Health
- Vaccinations
- CTAC (Community Treatment and Care)
- Urgent Care

2.3 Assessment

The programmes of **Pharmacotherapy** and **FCP MSK** are well established. **Community Link Worker** (CLW) services are progressing well demonstrated by increasing volume in patient referrals to the CLWs. **Primary Care Mental Health** have successfully recruited to the majority of posts. The Service Specification is being finalised and workers going live in practices in a phased approach from August 22. A Vaccination Service model for **VTP** (Vaccination Transformation Programme) was approved by SLT in July 22. There is a move away from a centralised service to an integrated team service. Understanding the skill mix and how that is developed over time is a key challenge. Close working is

required with Professional Leads to understand the best way to position that for each District. Community pharmacies will undertake travel vaccinations that were previously provided by GP practices. A SLA (Service-Level Agreement) has been shared with Community Pharmacy Highland and agreement reached in principle. An opportunity may exist to integrate **CTAC** and the VTP service model and an initial high level meeting is arranged for 15th August 22. **Urgent Care** working group are set to meet on 21 September 2022 with a revised membership to determine the best workable model for service delivery.

A total allocation of £7.9m is available and ring fenced to develop services associated with PCIP. The funding will not deliver all of the tasks and services across all work streams to practices. Clarity on service delivery against funding will become clearer as services develop. Tracking actual progress against budget/spend there is £3.6m already transferred to the work streams as at 31. 07.22. Budget management and monitoring arrangement are in place around the plan. Important that maximum benefit is achieved with the funding and some dedicated focus is applied on how to spend the non-recurrent funding and identified slippage (e.g. Appendix 5). Appendix 3, PCIF Annual Funding letter 2022-23 enables spend to be used for a wider range of costs (such as premises, training, digital, fixed term contracts, redesign and change management) as long as they support delivery of the MoU MDT (Multidisciplinary Team) and are agreed with the GP Sub Committee.

Recruitment difficulties and accommodation pressures are shared themes across the range of services and impact on equitable delivery of service across all GP Practices. PCIP Project Team and Work Stream groups aware, supporting alternative methods of service delivery where feasible, reviewing options and linking in with Community Accommodation and GP Premises Group.

See Appendix 1 – PCIP Assurance Report for the full detail.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	✓
Limited		None	

3 Impact Analysis

3.1 Quality/ Patient Care

General Practice is experiencing challenges, not least growing workload and increasing risk. The introduction of a broad range of PCIP services and

additional professional roles though an enhanced MDT within the Primary Care setting will positively impact the quality of care.

3.2 Workforce

PCIP offers new opportunities for clinical and non-clinical staff to positively impact patient care and outcomes. There are opportunities for personal development, training, up-skilling, collaboration and building relationships with the broader MDT both in a GP Practice and community based setting.

3.3 Financial

The Primary Care Improvement Fund is used to deliver priority services as set down in the MoU. To date the services are financially supported and resourced by the PCIF allocation. Robust financial planning supports the use of resources and PCIP trackers and financial reporting are completed and submitted to SG for monitoring of both slippage and funding pressures. PCIF allocation figures by Board and Integrated Authority are contained in Appendix 3 and the Board's PCIF funding position set down in detail in Appendix 6.

3.4 Risk Assessment/Management

The register was reviewed on 30.06.22 (quarterly) and details identified risks, controls, risk level and current mitigations and actions. There are currently six risks identified as HIGH and are scrutinised on a monthly basis by the Project Team and quarterly by the Project Board. See Appendix 2 – PCIP Risk Register.

3.5 Data Protection

The PCIP project, at its strategic level, does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

PCIP activity and services are focused on improving patient experience and care across all GP Practices, urban and rural and recognising and responding to locations experiencing higher levels of social deprivation. The changes to and development of services will contribute to achieving better health outcomes for the population. Primary Care outcomes are set down in the GMS 2018 contract and these include addressing health inequalities.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

State how his has been carried out and note any meetings that have taken place.

- GP sub and LMC representation on PCIP Project Team and Board.

- PCIP newsletter with updates issued three x yearly
- PCIP documents of interest shared on NHSH intranet under Projects
- Open communication channels with GP Practices

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.

- PCIP Project Board meeting, 25 May 2022
- PCIP Project Team meeting, 26 July 2022
- PCIP Project Group (Work stream) meetings, monthly and ad hoc as required

4 Recommendation

State the action being requested. Use one of the following directions for the meeting. No other terminology should be used.

- **Assurance** – To give confidence of compliance with legislation, policy and Board objectives.

4.1 List of appendices

The following appendices are included with this report:

- Appendix 1, PCIP Assurance Report July 22
- Appendix 2, PCIP Risk Register June 22
- Appendix 3, PCIF Annual Funding Letter 2022-23
- Appendix 4, GP sub PCIP progress report July 22
- Appendix 5, SBAR GP Record scanning June 22
- Appendix 6, PCIF Funding Position July 22

Appendix 1

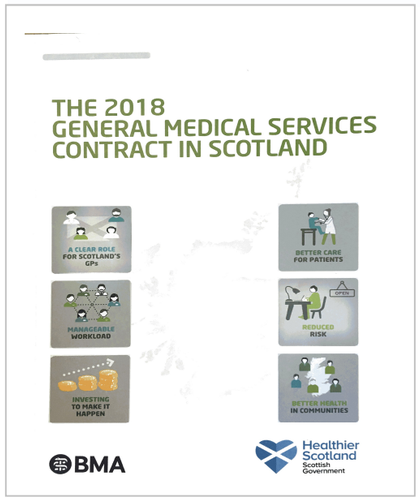
North Highland H&SCP – Primary Care Modernisation Programme

Project Manager's Assurance Report

Issued By Catriona Naughton, Project Manager

Employer NHS Highland
Address Assynt House
Beechwood Business Park,
Inverness, IV2 3BW

Report No 34
Date 31/07/2022



1. INTRODUCTION

This Assurance Report has been prepared in relation to the **implementation of the 2018 General Medical Services Contract in Scotland**. This strategic document is supported by a memorandum of Understanding and proposes a refocusing of the General Practitioner role as expert medical generalists. This refocusing of the GP role will require some tasks to be carried out by members of the wider primary care team where it is safe, appropriate and improves patient care. It is expected that these new arrangements will see a reduction in risk for GP partners and a substantial increase in practice sustainability.

Louise Bussell, Senior Responsible Officer has executive responsibility for the delivery of the programme and chairs the Programme Board.

Jill Mitchell is responsible for delivering the programme of work and is supported by a core project team of Catriona Naughton (Project Manager) and work stream leads. Highland GP Sub and LMC are key partners in the development of the programme.

This document provides a summary in relation to progress achieved on the project to date, activity in the previous period and forecast for the coming period. This progress report covers the period to **31/07/2022**.

2. Project Status - RAG

	Previous RAG	Current RAG	Comments
Timeline	Amber	Red	Year 1 programmes of Pharmacotherapy and MSK physiotherapy are well established. Strong progress is being made against year 2 programme CLW and steady progress in MH. RAG status remains at red due to the delay and progress in VTP, CTAC & Urgent Care.
Scope	Green	Amber	Workstream outputs continue to be developed and agreed broadly in line with the plan. There are ongoing discussions around VTP, there is no defined model for CTAC & Urgent Care, and so the RAG status remains as amber.
Budget (Aspirational)	Amber	Red	A total allocation of £7.5m available and ring fenced to develop services associated with the programme. The funding will not deliver all of the tasks and services across all workstreams to all practices. Clarity on service delivery against funding will become clearer as workstreams develop.
Budget (Actual)		Amber	Track actual workstream progress against budget/spend. £3.5m committed @ 30.06.22.Budget management and monitoring arrangement in place around the plan. Development of workstream models will better define actual financial requirements. Increasing pot of non-recurrent funding.

3. PROJECT PROGRAMME

Current Programme:	Rev Date: 31/07/2022	Rev: 31	**Current Status:**	Update	Amber

Milestone Activity	Due date	Estimated / actual date	RAG Status
Progress pharmacotherapy recruitment	August 2019	August 2019	Green
MSK physiotherapy recruitment in line with model	January 2019	August 2019	Green
Develop and agree MH delivery model	November 2019	June 2019	Complete
Progress sustainability loan scheme applications	February 2019	April 2019	Green
PCIP 2	May 2019	July 2019	Complete
Tracker Mar 19	May 2019	May 2019	Complete
Tracker Sep 19	Oct 2019	Oct 2019	Complete
Updated PCIP2	Jan 2020	Jan 2020	Complete
PCIP 3	Oct 2020	Oct 2020	Complete
Collaborative Working workstream established	Aug 2020	Aug 2020	Complete
CLW contract awarded	April 2021	April 2021	Complete
PCIP 4/PCIP 4.5	May/Nov 2021	May/Nov 2021	Complete
PCIP 5	May 2022	May 2022	Complete

4. KEY PROJECT DELIVERABLES COMPLETED THIS PERIOD (TO 31st July 2022)

Description	Status	Owner
A number of MH Band 6 & Band 3 posts recruited	Green – In Progress	Arlene Johnstone
A number of CLW posts recruited	Green – In Progress	Cathy Steer / (SIMS)
Vaccinations established within Community Directorate	Complete	Rhiannon Boydell
Progress Urgent Care	Green – In Progress	Jill Mitchell
Establish GP Premises Workstream	Complete	Jill Mitchell

5. KEY PROJECT DELIVERABLES TO BE COMPLETED IN NEXT PERIOD (TO 31st August 2022)

Description	Status	Owner
Workstream eHealth delivery plan developed	Amber – In Progress	Alister McNicoll
Further recruitment to remaining CLWs posts	Green – In Progress	Cathy Steer / (SIMS)
Recruitment and on boarding of MH Band 6 & 3 posts	Green – In Progress	Arlene Johnstone
Phased delivery of PCMH services to Practices across NH	Green – In Progress	Arlene Johnstone
Progress CTAC (VTP integration)	Amber – In Progress	Jill Mitchell

6. KEY PROJECT RISKS IN THE REPORTING PERIOD

Current Risks:	Rev Date: 31/07/2022	Rev: 18	**Current Status:**	Update	Amber

Key Risks in the period include:

Description	Risk level (current)	Current Mitigation/Action	Risk level (Target)	Next Review
Risk of destabilising established services due to new services being introduced within their specialty.	High	Close monitoring by project team and programme board	Medium	
Overall funding outlined by SG may not be sufficient to meet the aspirations of full contract delivery.	High	Workstreams to identify gaps or pressures Continue to report via PCIP submissions.	Low	Sep-22
Actual workstream progress against budget/spend	High	Develop workstream models to better define actual financial requirements.	Low	Sep-22
Failing to deliver workstreams in a timely manner.	High	Close monitoring by project team and programme board	Low	Sep-22
Lack of premises space to accommodate staff	High	Close monitoring by project team and programme board	Low	Sep-22
There is a risk to retention of pharmacy staff if they are not being integrated into practice teams and not being encouraged to continually develop professional skills.	High	Close monitoring by project team and programme board	Low	Sep-22
Geography of highland is challenging our ability to provide equitable service to all practices as outlined in the contract.	Medium	Development of workstreams will identify key challenges with delivery of both urban and rural services equitably.	Medium	Sep-22
Unable to recruit to new posts developed as part of the PCIP in an equitable way across North Highland.	Medium	Close monitoring by project team and programme board Skill mix	Medium	Sep-22
Funding available for services/posts may be impacted on increased employers superannuation costs (6%) and agreed Agenda for Change pay structure and pay awards.	Medium	Active monitoring within the governance structures. Focus on tangible operational progression of the outstanding workstreams Funding for existing posts unaffected.	Medium	Sep- 22
Workstreams are at different stages of development resulting in delivery based inequitable resource allocation.	Medium	Close monitoring by project team and programme board Gap Analysis	Low	Sep-22
Impact on ability to hold to timescales of end March 2022 and subsequent impact of transitional arrangements and the financial ability to support further development of workstreams.	Medium	SG/BMA Joint Statement and MOU2 issued. Further clarity around transitional arrangements required.	Low	Sep-22
Vaccination Strategy group in place out with this Programme's governance structure. Unknown impact on VTP and Collaborative Working.	Medium	Escalated to Programme Board to seek clarity for this Programme.	low	Sep-22

North Highland H&SCP – Primary Care Modernisation Programme

Project Manager's Assurance Report

Issued By Catriona Naughton, Project Manager

Employer NHS Highland
Address Assynt House
Beechwood Business Park,
Inverness, IV2 3BW

Report No 34
Date 31/07/2022

7. ADDITIONAL PROFESSIONAL ROLES – MSK PHYSIO

Current Programme:	Rev Date: 31/07/2022	Rev: 11	**Current Status:**	Update	GREEN

Current Plan	Progress	Due date	Est. / actual date
Submit Business case to Programme Board	Complete	October 2018	Complete
Develop implementation plan 1:13,000 patients	Complete	December 2018	Complete
Recruit Senior FCP posts	Complete	February 2019	Complete
Identify E-Health requirements	Complete	October 2018	Complete
Recruit to FCP posts across Highland	In progress	March 2019	Complete
Create Memorandum of Understanding	Complete	April 2019	Complete
Confirm access to clinic accommodation	Complete	April 2020	Complete
Meet eHealth requirements for access to Vision etc.	Complete	Feb 2020	Complete
Develop monitoring and evaluation reports	Complete	July 2021	Complete
Full evaluation of FCP service clinical activity	Requires data sharing agreement	March 2022	October 2022
Full FCP service evaluation awaited	Details awaited	October 2022	October 2022

8. PHARMACOTHERAPY

Current Programme:	Rev Date: 31/07/22	Rev: 12	**Current Status:**		GREEN

Current Plan	Progress	Due date	Est. / actual date
Develop equitable service model with all practices having access to level 1 services	Gap analysis undertaken and continually reviewed.	Ongoing	Ongoing
Recruit 4 WTE band 7 clinical pharmacists	Posts continually being advertised	March 2023	March 2023
Recruit 4 WTE band 5 pharmacy technicians	Posts continually being advertised	March 2023	March 2023
Recruit 6 WTE band 4 pre-registration trainee pharmacy technicians	Interviews schedules for 27.07.22	Sept 2022	Sept 2022
Recruit 6 WTE band 6 pharmacists	Job description being developed	Sept 2022	Sept 2022
Undertake survey of roles and tasks being undertaken in each practice SBAR submitted to Project Board	In development	Oct 2022 May 22	Oct 2022 May 22
Work with practices to optimise efficiency of prescribing processes – acute prescriptions and serial prescribing	Benchmark data reports to compare practices.	Ongoing	Ongoing
Develop monitoring and evaluation reports	Working with NSS via SP3A	Dec 2022	Dec 2022

9. ADDITIONAL PROFESSIONAL ROLES – MENTAL HEALTH

Current Programme:	Rev Date: 31/07/22	Rev: 13	**Current Status:**		AMBER

Current Plan	Progress	Due date	Est. / actual date
Recruit lead role	Complete	January 2021	Complete
Develop & Agree equitable service model	Plan to be agreed within Workstream	September 2018	Complete
Recruit Band 6 posts	Going through recruitment process	September 2021	September 2021
Recruit Band 3 posts	Going through recruitment process	December 2021	December 2021
Phased implementation	Ongoing	January 2021	October 2021
MoU – Operational Policy	Circulated to GP sub reps and workstream group 20.05.22	April 2022	June 2022
Mental Health And Wellbeing In Primary Care Services funding proposal submission	Complete	May 2022	May 2022

10. COMMUNITY LINK WORKERS

Current Programme:	Rev Date: 31/07/2022	Rev: 11	**Current Status:**	Update	AMBER

Current Plan	Progress	Due date	Est. /actual date
Develop & Agree equitable service model through options appraisal	Complete	December 2018	Complete
Identify E-Health requirements	Complete	June 2018	Complete
Create Communications and engagement plan	Complete	April 2019	Complete
Identify funding requirements and undertake Gap Analysis	Complete	February 2019	Complete
GP survey undertaken to establish interest in CLW and any current issues	Complete	July 2019	Complete
Stakeholders analysis undertaken as part of the communication plan	Complete	March 2020	Complete
Optional appraisal undertaken to identify delivery model	Complete	September 2019	Complete
Commissioning for one third sector organisation to commence	Complete	March 2020	Complete
Develop service specification and tendering documentation	Complete	June 2020	Complete
Develop remote and rural pilot proposal	Complete	April 2020	Complete
Elemental and ISAs returned	Complete	April 2022	Complete

11. VACCINATION TRANSFORMATION PROGRAMME

Current Programme:	Rev Date: 30/06/22	Rev: 2	**Current Status:**	Update	AMBER

Current Plan	Progress	Due date	Est. / actual date
Vaccinations established within Community Directorate	In progress	March 2022	March 2022
SBAR submitted for Travel Vax to transfer to Community Pharmacies.	In progress	May 2022	July 2022
Locality Plans (x 5) being devised for VTP delivery	In progress	June 2022	August 2022

12. COMMUNITY TREATMENT & CARE

Current Programme:	Rev Date: 31/07/22	Rev: 3	**Current Status:**	Update	RED

Current Plan	Progress	Due date	Est. / actual date
Re-establish CTAC activities	In progress	April 2022	June 2022
Exploration of alignment with VTP activities.	In progress	June 2022	August 2022

13. URGENT CARE

Current Programme:	Rev Date: 31/07/2022	Rev: 3	**Current Status:**	Update	RED

Current Plan	Progress	Due date	Est. / actual date
Re-establish Urgent Care activities	In progress	April 2022	June 2022
Refresh workstream group membership and set date	Complete	June 2022	June 2022

PRIMARY CARE MODERNISATION PROGRAMME - Risk Register

Updated 30/06/2022

Review Date for Risk Workshop **Sep-22**

ID	Description	Risk Type	Controls when risk identified	Risk level (current)	Risk level (Target)	Current Mitigation/Action	Next review
14	Risk of destabilising established services due to new services being introduced within their specialty.	Service delivery		High	Medium	Close monitoring by project team and programme board	Sep-22
3	Overall funding outlined by SG may not be sufficient to meet the aspirations of full contract delivery.	Financial	Budget management structure and monitoring arrangements in place around the plan. Formal project terms of reference and levels of delegation.	High	Low	Workstreams to identify gaps or pressures Continue to report via PCIP submissions.	Sep-22
23	Ability to deliver workstreams against budget/spend.	Financial	Budget management structure and monitoring arrangements in place around the plan. Formal project terms of reference and levels of delegation.	High	Low	Develop workstream models to better define actual financial requirements.	Sep-22
16	Failing to deliver workstreams in a timely manner.	Organisational	Project structure in place. PCIP agreed.	High	Low	Close monitoring by project team and programme board	Sep-22
21	Lack of premises space to accommodate staff	Organisational	Register of where there are accomodation constraints. Links to Inverness Premises Strategy Group. Premises Improvement Grants. Links to Community Accommodation Group. New Premises Group established.	High	Low	Close monitoring by project team and programme board. Membership on Community Accommodation Group (fortnightly meetings).	Sep-22
31	There is a risk to retention of pharmacy staff if they are not being integrated into practice teams and not being encouraged to continually develop professional skills.	Organisational	Share success stories. Continue to promote skill mix and clinical patient facing role, particularly for pharmacists. Focus on solution finding re lack of available accommodation. SBAR review of service delivery submitted.	High	Low	Close monitoring by project team and programme board. Associate Director of Pharmacy holds membership of the Community Accomodation Group.	Sep-22
4	Funding available for services/posts may be impacted on increased employers superannuation costs (6%) and agreed Agenda for Change pay structure and pay awards.	Financial	Financial oversight built into programme. Progress workstreams and associated recruitment in a timely manner.	Medium	Medium	Active monitoring within the governance structures. Focus on tangible opertional progression of the outstanding workstreams Funding for existing posts unaffected.	Sep-22
7	Geography of highland is challenging our ability to provide equitable service to all practices as outlined in the contract.	Service delivery	Recognising and factoring in the challenges of our geography to workstrem development and decision making.	Medium	Medium	Development of workstreams will identify key challenges with delivery of both urban and rural services equitably.	Sep-22
11	Unable to recruit to new posts developed as part of the PCIP in an equitable way across North Highland.	Service delivery	Controls are; different recruitment approaches, local and national. Mitigation plans in place.	Medium	Medium	Close monitoring by project team and programme board Skillmix	Sep-22
10	Workstreams are at different stages of development resulting in delivery based inequitable resource allocation.	Service delivery	Detailed financial plan for the 3 year period.	Medium	Low	Close monitoring by project team and programme board Gap Analysis	Sep-22
17	Loss of Project Director to support the plan.	Organisational	Temporary Project Director identified.	Medium	Low	Head of Primary Care Post, which includes this responsibility.	Sep-22
12	Differing views on how individual workstreams may be delivered effectively	Service delivery	Vaccination survey completed, community treatment & care and Urgent Care workstream survey completed. Locality plans (5) are under development via Vaccination Transformation. CTAC and Urgent Care workstreams are re-established.	Medium	Low	Development of workstreams will identify key challenges with delivery of models of care for further discussion with local managers and clinicians. Collaborative Working to aid delivery through joining of workstreams Options appraisals	Sep-22
15	Risk of workstreams not delivering the aspirations of the MOU for GPs and patients.	Organisational	Project Structure in place. PCIP iteration 1, 2, 3, 4,4.5 and 5 agreed	Medium	Low	Close monitoring by project team and programme board	Sep-22
18	Delay caused in waiting for banding for new Job Descriptions through Agenda for Change process	Organisational	Give details of posts to Project Directors. Workstream Leads can contact John Macdonald to try and speed up process.	Medium	Low	Close monitoring by project team and programme board	Sep-22
19	Loss of Workstream Lead for Urgent Care	Organisational	Continuing collaborative approach. Workstreams either to be joined together or lead will need to be identified	Medium	Low	Close monitoring by project team and programme board	Sep-22
22	Lack of IT equipment preventing appointed staff starting in post	Organisational	Identify costs and possible use of slippage	Medium	Low	Close monitoring by project team and programme board	Sep-22
26	Practices under additional pressure due to COVID / Flu, impact on prioritisation of Modernisation Programme	Organisational	Implementation of workstreams to alleviate pressures	Medium	Low	Develop workstream models to support General Practice	Sep-22
27	Impact on ability to hold to timescales of end March 2022 and subsequent impact of transitional arrangements and the financial ability to support further development of workstreams.	Organisational	Sustainability Funding in place and Transitional Arrangements to be published by SG	Medium	Low	SG/BMA Joint Statement and MOU2 issued. Further clarity around transitional arrangements required.	Sep-22
28	Practice responding to COVID pandemic waves might have impact on delivery of services.	Organisational		Medium	Low	Close monitoring by project team and programme board	Sep-22
30	There is a risk that practices do not see a benefit of the new contract because we cannot demonstrate that practice employed staff is the only feasible option, resulting in practices not accepting board employed staff as a delivery model.	Organisational	Project structure in place. PCIP agreed.	Medium	Low	Close monitoring by project team and programme board	Sep-22
32	Variation in practice ways of working and resistance to change e.g. To optimise repeat (as opposed to acute) prescribing and to implement serial prescribing	Service delivery	Benchmarking of rates of acute/repeat prescribing and serial prescribing	Medium	Low	Close monitoring by project team and programme board.	Sep-22
33	Priorities stated in the MOU2 do not align with progress and direction of travel in Highland	Organisational	VTP, CTAC to be considered as separate workstreams but further clarity pending.	Medium	Low	Close monitoring by project team and programme board. Further understanding required.	Sep-22
34	Vaccination Strategy group in place outwith this Programme's governance structure. Unknown impact on VTP and Collaborative Working.	Organisational	Board model in development and consideration of link between governance structures*	Medium	low	Escalated to Programme Board to seek clarity for this Programme.	Sep-22
35	Natural staff movement creating vacancies in FCP but challenged to re-recruit due to available workforce	Service delivery		Medium	low	Close monitoring by project team and programme board	Sep-22
2	Local engagement with Divisions/Districts in the development of the PCIP workstreams.	Organisational	Information sharing. Invitation to relevant workstream meetings. Primary Care Team participating in broader interrelated groups, e.g. Community Accommodation.	Medium	Low	Project Team attendance at relevant community forums and management forums.	Sep-22
13	Lack of synergy in the 6 workstreams resulting in missed opportunity for joined up services.	Service delivery	Professional leads on Project Team. Workstream updates to every Project Team meeting and workstream leads all on the Project Team. Project Leads to be identified for CTAC and Urgent Care workstreams.	Medium*	Low	Close monitoring by project team and programme board. Collaborative Working workstream created	Sep-22
1	Ehealth requirements and funding.	Organisational	Identification of e-health requirements when service models are not yet fully developed	Low	low	Develop workstream models to better define actual e-health requirements. Understanding other health board provision	Sep-22
9	Engagement with GPs	Communication	Newsletter after every project team. Intranet page developed and maintained. Regular updates to GP Sub Committee. NHSH Comms rep on Project Team.	Low	Low	Communication plan agreed by project Team. FAQ, Briefing To be updated post-COVID	Sep-22
8	Public engagement and involvement	Communication	Communication plan in place. Patient rep on Programme Board.	Low	Low	Communication plan agreed by project Team Feedback to SG about key national messages To be updated post-COVID	Sep-22
20	Pressure on NHS District budgets to accommodate staff	Organisational	Identify costs and monitor. Possible slippage for requirements	Low	Low	Close monitoring by project team and programme board.	Sep-22
29	There is a risk that a model for vaccinations in Highland cannot be identified because of a re-statement of the SGPC/Scottish Government position, resulting in Highland not meeting contractual requirements for transfer of immunisations to board delivery	Organisational	Continuing collaborative approach to development of the workstreams. Project structure in place. PCIP agreed. Clarification meeting held with SG.	Low	Low	Close monitoring by project team and programme board	Sep-22
6	Capacity within existing management to deliver the programme.	Organisational	Agreement to review capacity on an ad hoc basis and agree support required.	Low	Low	Current project management arrangements seem sufficent to deliver the programme.	Sep-22
24	Delay in mental health workstream	Organisational	New workstream lead. Agreement to progress phased implementation. Model agreed. Job Descriptions identified and progressing through recruitment	Low*	low	Significant progress with recruitment activities. Operation Policy circulated for comments. Meetings with Practices across the geography.	Sep-22
25	Change in consultation mode from Face to Face versus remote as a consequence of COVID	Organisational	GP Practices are offering a blended consultation approach with a real mix of F2F, telephone and near me.	Low*	Low	Close monitoring by project team and programme board. Insight and feedback from the Primary Care Managers.	Sep-22

Naureen Ahmad
General Practice Policy Division
Primary Care Directorate
Scottish Government
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

E: Naureen.Ahmad@gov.scot

Integration Authority Chief Officers
NHS Board Chief Executives
Integration Authority Chief Finance Officers
NHS Board Director of Finance

11 August 2022

Dear Colleagues

PRIMARY CARE IMPROVEMENT FUND: ANNUAL FUNDING LETTER 2022-23

I am writing to confirm the 2022-23 funding allocations for the Primary Care Improvement Fund (PCIF) element of the wider Primary Care Fund (PCF). As in previous years, funding will be allocated on an NRAC basis via Health Boards to Integration Authorities (IA's).

Background

The Scottish Government remains committed to the aims and principles which underpinned the 2018 GP Contract Offer. This letter relates to the PCIF component of the PCF, setting out our expectations as we continue to improve primary care. This should be read in conjunction with the Memorandum of Understanding 2 (MoU2) on GMS Contract Implementation for Primary Care Improvement[1] and the Amendment Regulations[2].

Primary Care Improvement Fund (PCIF)

Available Resources

Having assessed Primary Care Improvement and spending Plans, I can confirm that £170 million will be available for Integration Authorities in 2022-23 under the auspices of the Primary Care Improvement Fund (PCIF). In-year delivery and expenditure will be monitored by my team to account for both slippage and funding pressures.

[1] Memorandum of Understanding (MoU) 2: GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards
[2] The National Health Service (General Medical Services Contracts and Primary Medical Services Section 17C Agreements) (Scotland) Amendment Regulations 2022 (legislation.gov.uk)

Given the overall financial pressures across health and social care, and taking into account the Resource Spending Review, it is prudent and sensible to use existing reserves that have been built up over time. On this basis, we have agreed with the Cabinet Secretary for Health and Social Care that Integration Authorities should draw down existing reserve balances in the first instance, and therefore 2022-23 allocations will reflect reserves held. Please note, therefore, that the £170 million envelope takes account of the funds already held by Integration Authorities by means of these existing PCIF reserves.

Methodology for Tranche One Allocation

We will be making two in-year allocations on a 70:30 basis. The initial tranche of £119 million in August 2022 will take account of IA reserve balances at October 2021 as well as baselined pharmacy funding. Note that baselined pharmacy funding of £7.8m has been allocated separately and must also be treated as part of the Primary Care Improvement Fund.

Annex A shows the initial allocation of the fund, by Health Board and by IA. The funding must be delegated in its entirety to IAs.

Methodology for Tranche Two Allocation

Any locally held reserves should be invested in the implementation of PCIPs in 2022-23 before new funding is requested. Further funding will be made available to IAs later this year, subject to reporting confirming latest spend and forecasts required by Friday 4 November 2022.

Robust assessments of future resourcing requirements to support implementation of the PCIPs helps to inform central financial planning and policy development, enabling the Scottish Government to target funds as efficiently and effectively as possible, ensuring best value for the public purse. Reporting using national templates should detail how this initial 70% (comprising new funding plus utilisation of any local reserves) has been spent, providing a breakdown of spending by category (staff and non-staff costs) and detailing what benefits have been created.

Second tranche allocations will follow in Autumn 2022, subject to supporting data and evidence (in particular Primary Care Improvement Plans) regarding additional PCIF funding required in 2022-23. The approach to second tranche allocations will also be informed by updated financial data on the reserve positions as at 31 March 2022, which Scottish Government officials have separately requested from IAs. Second tranche allocations will be accompanied by any further guidance, as required.

Scope of PCIF

For 2022-23, PCIF should continue to be used to deliver the priority services set out in the Memorandum of Understanding:

- Pharmacotherapy
- Vaccination Transformation Programme
- Community Treatment and Care Services
- Community Links Workers
- Additional Professional Roles
- Urgent Care services

There should be a particular focus on Pharmacotherapy, CTAC and Urgent Care given existing or planned regulations for these services. Please also note the following changes in the scope of the fund:

- The Memorandum of Understanding 2 noted Pharmacotherapy, CTAC and the Vaccination Transformation Programme should be prioritised. The Vaccination Transformation Programme is now substantially delivered with GP practices only continuing to deliver vaccinations on a transitional or remote basis. We anticipate that Health Boards will have completed the remaining elements of the programme by the end of this financial year allowing Primary Care Improvement Plans to intensify their focus on other transformational activity. Where possible, Partnerships are advised to consider synergies between PCIF-funded VTP activity and wider Board governance and funding.

- With the introduction of the Mental Health and Wellbeing in Primary Care Services programme, partnerships are requested to use this additional funding to build on the existing investment from PCIF and other funding streams to create additional capacity. Partnerships are asked to use this year to consider whether there are any practical challenges in allocating and reporting on Mental Health Workers across different funding streams (PCIF, MHWPCS and other funding streams) and whether there would be benefits/opportunities to aligning reporting. We would ask partnerships to feedback as appropriate and we will write out with further guidance at financial year-end working alongside Mental Health and Wellbeing policy colleagues.

- We note that current investment projections from PCIP trackers assume the majority of the PCIF will be spent on MoU MDT staff. From 2022-23, new investment in the Primary Care Improvement Fund can be used for a wider range of costs (such as premises, training, digital, fixed-term contracts and redesign and change management) as long as they support delivery of the MoU MDT and are agreed with the GP Sub-Committee.

Future PCIF Funding

As previously noted, robust financial planning is critical to support effective and efficient use of resources and to enable continued investment in PCIF. To this end, the Scottish Government, in collaboration with other MoU Parties, will be reviewing and updating the PCIP trackers and financial reporting templates this year to ensure

they remain fit for purpose. Using this information, we will review the PCIF position mid-year, during the process of allocating tranche 2 of the funding.

Scottish Government will also work with Public Health Scotland and local evaluators to understand the current evaluation landscape, the work already underway at local level and any gaps that might exist. This work will inform further development of the monitoring and evaluation of PCIPs at the national level, in turn allowing us to better target investment in future years. **However, the Cabinet Secretary has agreed that £170 million will be the minimum budgeted position for future years. In future years, where Partnerships have used the full £170m minimum budgeted position, Scottish Government will ensure additional funding is available to apply agenda for change uplifts to staff recruited through the PCIF and ensure fulfilment of the terms of the MOU2 dated 30 July 2021. Any further investment will be subject to joint assessment and benefits case at each annual budget round.**

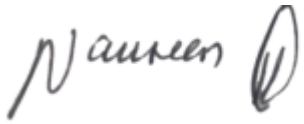
To help inform our ongoing review of the current monitoring and evaluation landscape, we also request sharing of Primary Care Improvement Plans this year. These can be sent to: PCImplementation@gov.scot

GP Sustainability Payment – 2022-23

The second tranche of the GP Sustainability Payments will be paid out later in the year.

I look forward to working with you as we continue to drive forward on delivering primary care reform.

Yours faithfully



Naureen Ahmad
Deputy Director - Primary Care Directorate

ANNEX A

PRIMARY CARE IMPROVEMENT FUND: ALLOCATION BY BOARD AND INTEGRATION AUTHORITY

Allocation By Territorial Health Board

NHS Board Name	NRAC Share 2022-23	PCIF NRAC Share 2022-23 (£)	PCIF tranche 1 2022-23 (£)	less PCIF baselined funds (£)	less PCIF IA reserves (£)	PCIF initial allocation 2022-23 (£)
Ayrshire & Arran	7.32%	12,440,274	8,708,191	-569,300	-4,050,213	4,088,679
Borders	2.15%	3,647,718	2,553,403	-161,300	-79,201	2,312,902
Dumfries & Galloway	2.97%	5,043,683	3,530,578	-229,100	0	3,301,478
Fife	6.86%	11,663,366	8,164,356	-521,800	-3,453,067	4,189,489
Forth Valley	5.46%	9,286,259	6,500,382	-415,000	0	6,085,382
Grampian	9.81%	16,672,511	11,670,758	-755,400	-10,567,097	348,261
Greater Glasgow & Clyde	22.18%	37,705,607	26,393,925	-1,718,200	-11,434,501	13,241,224
Highland	6.58%	11,188,302	7,831,812	-494,100	-2,785,450	5,239,790
Lanarkshire	12.28%	20,878,060	14,614,642	-947,700	-5,216,468	8,450,474
Lothian	14.97%	25,449,756	17,814,829	-1,132,000	-5,578,785	11,104,045
Orkney	0.49%	838,060	586,642	-75,000	-886,857	0
Shetland	0.48%	809,431	566,602	-76,200	-125,574	364,828
Tayside	7.80%	13,258,304	9,280,813	-601,900	-8,946,318	522,576
Western Isles	0.66%	1,118,667	783,067	-103,000	-318,806	361,261
Total		**170,000,000**	**119,000,000**	**-7,800,000**	**-53,442,336**	**59,610,387**

**Pharmacists in GP practice funding was baselined in 2018-19, this has been removed from the 2022-23 allocation in the above table.*

Allocation by Integration Authority

NHS Board Name	IA Name	IA NRAC Share 2022-23 (£)	PCIF NRAC Share 2022-23 (£)	PCIF tranche 1 2022-23 (£)	less PCIF baselined funds (£)	less PCIF local reserves (£)	PCIF initial allocation 2022-23 (£)
Ayrshire & Arran	East Ayrshire	2.37%	4,032,636	2,822,846	-186,694	-1,777,911	858,240
	North Ayrshire	2.70%	4,587,529	3,211,270	-209,033	-1,302,178	1,700,059
	South Ayrshire	2.25%	3,820,108	2,674,076	-173,573	-970,124	1,530,379
Borders	Scottish Borders	2.15%	3,647,718	2,553,403	-161,300	-79,201	2,312,902
Dumfries & Galloway	Dumfries and Galloway	2.97%	5,043,683	3,530,578	-229,100	0	3,301,478
Fife	Fife	6.86%	11,663,366	8,164,356	-521,800	-3,453,067	4,189,489
Forth Valley	Clackmannanshire and Stirling	2.57%	4,367,222	3,057,055	-195,164	0	2,861,891
	Falkirk	2.89%	4,919,037	3,443,326	-219,836	0	3,223,490
Grampian	Aberdeen City	3.81%	6,480,253	4,536,177	-298,317	-4,232,528	5,333
	Aberdeenshire	4.27%	7,251,701	5,076,191	-324,766	-4,714,534	36,891
	Moray	1.73%	2,940,557	2,058,390	-132,317	-1,620,035	306,037
Greater Glasgow & Clyde	East Dunbartonshire	1.85%	3,150,460	2,205,322	-140,141	-837,807	1,227,374
	East Renfrewshire	1.58%	2,685,569	1,879,898	-120,632	-1,233,315	525,951
	Glasgow City	11.99%	20,381,275	14,266,893	-928,315	-3,438,308	9,900,270
	Inverclyde	1.62%	2,747,032	1,922,922	-126,472	-1,223,070	573,380
	Renfrewshire	3.37%	5,721,487	4,005,041	-261,903	-3,161,668	581,470
	West Dunbartonshire	1.78%	3,019,783	2,113,848	-140,737	-1,540,333	432,778
Highland	Argyll and Bute	1.88%	3,199,436	2,239,605	-141,683	-2,785,450	0
	Highland	4.70%	7,988,867	5,592,207	-352,417	0	5,239,790
Lanarkshire	Lanarkshire combined	12.28%	20,878,060	14,614,642	-947,700	-5,216,468	8,450,474
Lothian	East Lothian	1.87%	3,173,726	2,221,608	-140,067	-75,922	2,005,619
	Edinburgh	8.35%	14,191,963	9,934,374	-634,173	-3,921,067	5,379,134
	Midlothian	1.63%	2,765,128	1,935,589	-120,660	-486,844	1,328,086
	West Lothian	3.13%	5,318,940	3,723,258	-237,100	-1,094,952	2,391,206
Orkney	Orkney Islands	0.49%	838,060	586,642	-75,000	-886,857	0
Shetland	Shetland Islands	0.48%	809,431	566,602	-76,200	-125,574	364,828
Tayside	Angus	2.16%	3,674,043	2,571,830	-165,208	-2,700,440	0
	Dundee City	2.86%	4,858,691	3,401,084	-226,196	-3,671,050	0
	Perth and Kinross	2.78%	4,725,571	3,307,899	-210,496	-2,574,828	522,576
Western Isles	Western Isles	0.66%	1,118,667	783,067	-103,000	-318,806	361,261
Total			**170,000,000**	**119,000,000**	**-7,800,000**	**-53,442,336**	**59,610,387**

GP Sub Committee – PCIP Update May 22

Pharmacotherapy
Pre-registration Trainee Pharmacy Technicians posts are out to advert, part of a Scottish wide NES programme and funded by NES for a two year training programme for Pharmacy Technicians. Space remains a challenge to place Pharmacotherapy resource on site to support Practices and access varies week to week. This is being picked up as part of the broader service review of current input to each practice and tasks being undertaken to ensure efficiency, effectiveness and quality of service delivery. The review will determine if practice priorities are being met in line with aiming to have a service that will attract and retain pharmacy staff. Pharmacy teams will work to optimise skill mix based on agreed practice priorities with a philosophy of right person, right job.

First Contact Physiotherapy
From 01.07.22 as per DWP announcement Physios (and other AHPs), are able to certify fit notes. NHSH are going to put out a holding statement and a plan to phase in the implementation. Recruitment has picked up with more interest showed for some FCP posts with recent success that will enable service provision to the Tain area practices. Progressing cross work stream working with CLW and PCMH to better maximise awareness of what those services do and how best to enhance patient care and flow through the practices. Fiona Ward has been successfully appointed to the role of Clinical Lead for First Contact Physiotherapists in General Practice.

Community Link Worker
There are currently 6 CLW vacancies - 3 in Inverness, 1 in Ross-shire, 1 in Wick and 1 in Nairn and Support in Mind Scotland have all of these posts out to advert. Elemental went live part way through May with 26 referrals made in May with 18 patients supported into community-based activities. Up to 24 June, 47 referrals were made with 12 patients supported into community-based activities. The main reasons for referral have been loneliness, mental health, physical activity and support for housing and income maximisation. There are some difficulties accessing space in some practices and accessing Wi-Fi with work on-going to improve and resolve where possible.

Mental Health
The MHWPC bid went to Scottish Government at the end of May there and the report for Phase- 2 money is expected in the second week of July. Recruitment continues and interviewing for the last Band 3 posts. The Band 5/6 adverts closed 29.06.22 with a number of applications received. MHPC practitioners are starting to provide services in the practices. Practice space for practitioner fluctuates and a scoping exercise is planned to better understand the hotspots. The MHPC operational document has been circulated and comments fed back to the MHPC team.

Vaccination Transformation Programme
Kim Corbett is the Programme Manager and locality plans are being developed with 5 x different locality teams or place based teams across Highland to oversee the vaccinations across the geography. Each of those team leads are preparing their Locality Plan which sets out the detail around geography, service provision, venues and locations, calendar and timeline. The details are to be provided to the PCM Project Team and Board detailing how the VTP would be conducted for North Highland with opportunities for comments, questions and approvals. The governance around VTP is quite complex and clarification is needed on the sequencing of the different groups. Travel vaccines are to be transferred over to community pharmacies this summer with a SLA.

Community Treatment and Care
Modelling work has started looking at what's needed in each area to deliver a service and combining with VTP activities. Primary Care order comms for ICE is being prioritised but there is a potential delay of two months. A CTAC Technical Task Team has been established to support the model and implementation. Initial scoping suggests a combined team in place near to patients' homes with some hub and spoke

method for the more challenging things to be done through the CTAC service. This is a priority area for implementation by March 2023.

Urgent Care
The Urgent Care workstream has been re-established with a refreshed membership of the workstream group and meeting date set for 21.09.22. UC is a PCIP priority for year 2023/24. There are a number of different models in place and/or being developed in other Board areas. An overview of what's happening nationally and the differing delivery models will be shared for discussion with the workstream group at the September meeting.

Catriona Naughton
Primary Care Project Manager
July 22

NHS Highland

Title:	**GP Record Scanning**
Report Author:	**Andy Ireland**
Version:	**1.0 June 2022**

1 Situation

General Practice room availability is an enduring challenge for many practices. This is in part due to the additional roles introduced to practice team in the 2018 GMS contract.

In some areas, practice list sizes continue to expand, and teams have been complemented by additional clinical and administrative staff to support the list and workload.

Practices have increased their outstanding input to medical education, which requires space for consulting, education and study.

Covid has created additional challenges, requiring practice teams to revise premises configuration and how space is utilised to reduce the risk of infection.

All practices in North Highland were requested to participate in a '*Highland GP Practice Record Scanning*' Forms survey in April and May 2022. The snapshot of the current position informs the development of a plan and prioritisation of any proposed scanning project.

All data quoted within this SBAR has been taken from practice responses unless otherwise stated.

Only 14% of North Highland practices have back scanned all their paper records. Of the practices which are yet to back scan, 58% confirmed that back scanning their paper records would release space for new clinical or administrative areas.

2 Background

In north Highland, 54 / 64 GP practices still hold large volumes of paper records; approximately 156,000 records for 197,000* of the Highland population (*ISD April 2022).

Paper records follow patients as they transfer practices. At point of registration / deregistration, practice teams coordinate paper record movements.

Information required from within the paper notes requires teams to physically locate and manual review content. Both aspects can be time consuming.

When patients request copies of their medical records by Subject Access Request (SAR) or Access to Medical Reports Act (AMRA), the practice teams will manually photocopy these to send to patients within 30 days.

Across Scotland, several boards including Forth Valley, Greater Glasgow and Clyde and Fife have back scanned all practice records, with Lanarkshire contracted to scan all in 2022/23. Ayrshire and Arran have a scan-on-demand contact in place. All other boards have pockets of practices which are fully back scanned, similar to north Highland.

NSS Practitioner services currently operates a 'paper lite' service for 652 practices which have fully back scanned their paper records. When a new patient registers with a paper light practice, the paper record is passed to the NSS contractor. Once scanned, the record is transferred to the new practice via eLinks import into the patients Docman.

As of March 2021, Highland GP practices had an additional 62.4 WTE PCIP staff embedded in practice teams from Pharmacotherapy and FCP Physio. Since March 2021, practices have additional staff from Community Link Workers, and more recently Mental Health. Vaccinations (VTP) also contacted practices regarding available space to co-locate vaccine clinics. All these 2018 GMS contract roles require space within practices to work alongside existing teams.

32 practices highlighted that back scanning would release space. Of these practices there is potential for creation of an additional:

- 11 clinical rooms
- 32 admin / remote consulting rooms
- Other general layout improvements resulting from scanning included dedicated spaces for medical students, expansion of dispensing areas and much needed storage.

Within the survey responses, several practices highlighted areas of risk (safety and environmental). These included:

- Unsafe storage solutions/locations including attic
- Work at height (ladders and steps)
- Fire risk
- Risk of water ingress and damp

- Poorly lit areas

Practices highlighted that paper notes are present in the administrative areas, and removal would result in these areas being more spacious, hygienic and IPC compliant.

Through global sum, practices are remunerated to summarise their records within 8 weeks of receipt. 34 practices confirmed they were not up to date with record summarising. This may result in practices requiring readily access to paper records to review patient history.

All practices have been prioritised based on responses to the *Highland GP Practice Record Scanning*' Forms survey.

In November 2021, Scottish government provided Highland with a premises improvement grant of £234,516. It was previously agreed by PCIP Project Board that this funding be prioritised for back scanning. Funding has been re-provided in FY 22/23 on the basis a scanning project couldn't be completed by April 2022 due to scope of the programme.

Programme of back scanning links with the NHS recovery plan and key themes within the Digital health and care strategy.

3 Assessment

Completion of a back scanning project would provide additional space for premises improvements, enabling other PCIP services to work alongside practice teams. Future premises funding allocations could be utilised for improvements, bringing the space into use.

Efficiencies

All scanned records would be available in Docman, stored as a multiple page pdf which can be reviewed immediately, using the 'F2' key to quickly search for specific terms.

When patients request copies of notes through Subject Access Request (SAR), the time taken to print is considerably less when compared to manually photocopying a set of paper records. Registration and deduction process will be further simplified and aligned with the NSS (PSD) digital strategy to remove paper processes.

Remote working

Throughout the pandemic, many staff have had to work differently. Fully digital records would be available to staff working remote from the practice. This would benefit practices with sustainability concerns where remote locums compliment practice based teams.

Environment

Removing paper records and avoiding the movement between practices will contribute to net-zero greenhouse gas.

Redesign

Many practices within Highland are involved in redesign projects which may lead to new premises. Back scanning would remove the requirement for record storage within new practice premises.

Compliance

Practice environments will be safer due to removal of Health & Safety, Environment and Infection Prevention Control concerns.

Compliance with GDPR will be less onerous with business-as-usual IT and system security taking the place of physical controls required for paper records.

Solutions

The Primary Care team have recently supported a practice with the tendering process for back scanning. Quotes were obtained from three suppliers. Each quote was reviewed to ensure it met the SCIMP advice for back scanning and aligned to the NSS paper light scanning process. Mandatory requirements included:

- Single PDF with Optical Character Recognition (OCR) for search functionality
- Upload direct to Docman (no manual *input* for practice teams)
- Indexing, boxing and uplift on day of collection to avoid disruption within practice

The contractor awarded the work was Ricoh. The contractor exceeded all the requirements whilst providing a favourable quote. On completion of the work, the practice confirmed they had a “very positive experience”. “Ricoh [were] excellent to deal with; all went smoothly with good communication”.

Ricoh had subcontracted the entire package of work to their scanning partner, On-Site Scanning (OSS). Partnering with OSS direct would avoid any mark-up in the price by Ricoh, and gain benefit of allowing NHSH to work closely with the team undertaking the work. Ricoh and OSS are aware of this proposed approach. OSS have completed scanning for:

- NHS Lanarkshire (in partnership with RICOH) completed phase 1 of scan and upload to Docman last year. Successful bid to complete phase 2 for all remaining GP Practices throughout 2022/23.
- NHS Dumfries & Galloway (direct OSS project as preferred supplier since Jan 2020) scan approximately 5 to 10 GP Practices via the Health Board.
- OSS have completed GP Practice level scanning for Practices across NHS Tayside, Lothian, & Greater Glasgow & Clyde and existing relationships with NHS Grampian, NHS Borders.
- OSS are/have also worked with NHS North East London CCG, Greater Manchester CCG, Wirral CCG and North Tyneside CCG for medical records scanning.

Given the confidence provided by OSS, a quote was requested for a full end-to-end back scanning project for all 54 practices in north Highland that require to be back scanned.

The quote includes:

- Boxing up, cataloguing and collection fees for all GP practices. 31 practices included collection. Remote practices are subject to an additional fee of £1,500.
- Uplifts will be consolidated for smaller practices where possible. The additional £1,500 charge may reduce further where trips can be combined. Final invoice will be based on actual return trips required to remote practices.
- OSS will catalogue all records to provide a fully managed service for every practice.
- Total patient list size is 197,291
- The contract fee is 2.5% of the total project cost for direct award via framework.

Savings can be achieved by remote practices boxing, cataloguing and NHS Highland organising the movement of records from rural practices to a central uplift location.

Pricing is based on contracting via the NHS Shared Business Services framework (Lot 3) with direct award available to NHS Highland.

Ricoh OSS Proposal	**Total Cost**
Boxing Up & Collection of Outlying Areas (15 overnight trips/1 van/2 staff)	£22,500.00
Supply Boxes & Labels	Included
Additional Record Cataloguing	£19,729.10
Scanning of 54 GP Practices & Upload to Docman based on estimated list size of 197,291	£655,006.12
NHS SBS Contract Management Fee (2.5%) with direct award option (Lot 3)	£17,430.88
Secure Destruction of Physical Records	Included
Total Estimated Project Cost excluding VAT	£714,666.10
Total Estimated Project Cost including VAT	£857,599.32

OSS would aim to complete all practice back scanning within 18 months of receiving all contractual paperwork. OSS will, where possible, look to improve on these timescales.

NHS Highland will provide as much notice as possible to practices prior to uplift. Indicative timescales would be available once the contractor drafts a project plan. This should enable practices not up to date with record summarising to address or improve the situation. OSS offer scan-on-demand where practices can request a record is prioritised for digitisation and return. Records would be returned to the practice clinical mailbox from the suppliers nhs.scot e-mail account.

Standard next day return is £6.50+VAT per record

Emergency return within 2 hours is £20.00+VAT per record

These scan on demand costs are out of scope for this proposal. The contractor will invoice NHS Highland monthly for scan on demand costs with these re-charged to the requesting practice.

Where practices have large volumes of notes which they may need to regularly refer to, NHS Highland will work with OSS to agree a bespoke plan to reduce the likelihood or frequency for scan-on-demand.

£234,516 has already been approved for back scanning. Based on practice prioritisation, this would progress back scanning for 10 of the 54 practices.

An additional £623k from PCIP would enable back scanning to progress for all north Highland practices.

Option1 – Practices already back scanned

Where practices have already engaged a contractor and back scanned all their paper records within the last 12 months, the project should seek to provide the equivalent reimbursement. The value reimbursed would be equivalent to the cost of back scanning their records as part of this programme, or the actual value if this is less than the re-imbursement proposed. This will be agreed on a case-by-case basis.

No payment would be made to practices that were already funded by NHS Highland, e.g., through redesign projects or where practice teams have scanned their records.

If approved this would require up to £84k from PCIP.

Option 2 – In-house scanning

An alternative option of working with NHS Highland Medical Records was considered. The timescales were prohibitive due to prioritisation of secondary care record scanning/other NHS Highland priorities yet to determined. Limited scanning of c25k notes could commence in 22/23. The work would approximately take three years to complete in full. There were shared concerns due to the lack of a solution to import of the PDF to Docman. Boxing and cataloguing may default to GP Practice teams and transport would be contracted out. The option can be explored further if deemed to be preferred.

4 Recommendation

Progressing with a back scanning project would release space, create efficiencies, and support digital/remote working. Secondary outcomes would include environmental benefits by reducing record transportation whilst also improving the security of the patient record for better compliance with GDPR and physical damage such as fire and flood.

I ask the Primary Care Modernisation Project Team to:

1. Approve the approach outlined in this SBAR to progress with an outsourced back scanning project.

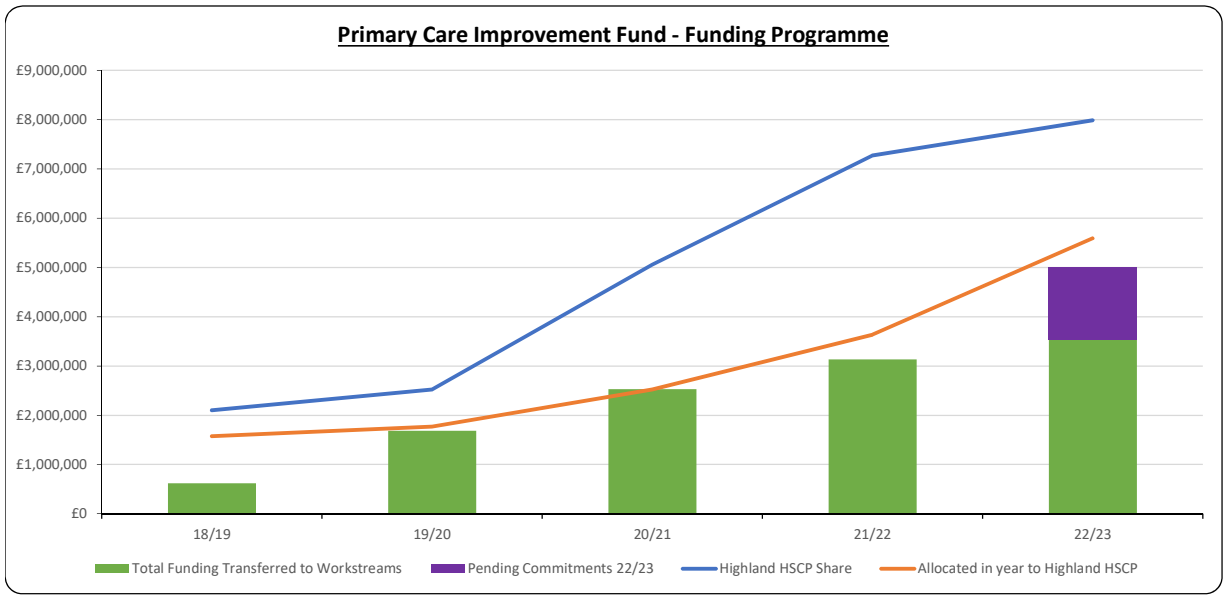
2. Endorse the use of the £234,516 funding to progress scanning for maximum number of practices as per prioritisation.

3. Approve the provision of an additional £623k of PCIP funding to facilitate scanning for all 54 practices.

4. Confirm if Option 1 should be in-scope and approve funding required – additional £84k.

NHS Highland - Highland HSCP

Primary Care Improvement Fund - Funding Programme **July 2022**



Funding Profile:	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	2022/23 (£000)	Recurring (£000)
NHS Scotland (year on year increase between 18/19 and 22/23)	45,750	55,000	110,000	155,000	170,000	**170,000**
NHS Highland (NRAC basis)	2,947	3,544	7,092	10,218	11,118	**11,118**
Highland HSCP Share	**2,099**	**2,526**	**5,058**	**7,270**	**7,989**	**7,989**
Allocated in year to Highland HSCP	1,575	1,768	2,523	7,270	5,592	**7,989**
Non-recurrent funding		957				**0**
Non-recurrent slippage	-957	-957		-4,000		**0**
Additional Allocation by SG			140			**0**
Funding returned to SG			-132			**0**
Total Funding Currently Allocated by SG	**618**	**1,768**	**2,531**	**3,270**	**5,592**	**7,989**
Balance of Recurring Funding Held by SG						

Funding Already Transferred to Workstreams (Recurring & Non-recurring)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	2022/23 (£000)	Recurring (£000)
Vaccination Transfer Programme	13	39	0	0	0	**0**
Pharmacotherapy	560	1,200	1,827	2,054	2,188	**2,188**
Community Treatment & Care	0	0	0	0	0	**0**
Urgent Care	0	0	0	0	0	**0**
First Contact Practitioners	6	340	619	629	753	**753**
Mental Health Service	0	0	0	0	182	**182**
Community Link Workers	0	0	1	351	481	**481**
eHealth	0	69	43	57	57	**57**
Management	39	39	41	44	49	**0**
Total Funding Transferred to Workstreams	**618**	**1,687**	**2,531**	**3,136**	**3,710**	**3,661**
Balance of Funding Available	**-0**	**81**	**-0**	**134**	**1,882**	**4,328**
Pending Commitments 22/23						
Board Vaccination Programme (FYE)					892	
Travel Vaccine SLA with Community Pharmacies (PYE)					50	
Mental Health Service (PYE)					226	
Pharmacotherapy (PYE)					155	
GP Patient Record Scanning (PYE)					150	
Community Treatment & Care				TBC		
Urgent Care				TBC		
Total Pending Commitments					**1473**	

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**31/08/2022**
Title:	**Vaccination Service**
Responsible Executive/Non-Executive:	**Louise Bussell**
Report Author:	**Christopher Arnold**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

This report relates to the following Corporate Objective(s)

Clinical and Care Excellence • Improving health • Keeping you safe • Innovating our care	X	**Partners in Care** • Working in partnership • Listening and responding • Communicating well	
A Great Place to Work • Growing talent • Leading by example • Being inclusive • Learning from experience • Improving wellbeing		**Safe and Sustainable** • Protecting our environment • In control • Well run	
Other (please explain below)			

2 Report summary

2.1 Situation

NHSH is required to

1. Plan and achieve the transition of all vaccination services from General Practice to health board provision by the 1st of April 2023
2. Plan and execute the Autumn / Winter influenza and covid-19 vaccination campaign as directed by SG

This report is to provide information on plans and progress for board assurance.

2.2 Background

Vaccination is one of the most important ways to prevent the spread of infectious diseases. Within NHS Highland vaccination has successfully been undertaken largely by general practice and the school nursing service to date.

1. Scottish Government policy is for vaccination to move from general practice to NHS Board led services as part of the Vaccination Transformation Programme (VTP)As part of the GP Modernisation Programme, Vaccination Transition is required to occur by the 1st of April 2023.

   Approved service model which sets out a transitional model for service delivery has now been approved and is being developed with operational teams.

2. Scottish Government policy is for an extended flu and covid-19 vaccination program during September to December 2022 following JCVI advice

2.3 Assessment

Vaccination Transformation Programme:

Approved service model which sets out a transitional model for service delivery has now been approved and is being developed with operational teams.

The North Highland Vaccination service has so far completed the following milestones

- Approved transitional model
- Funding gap resolved with model achievable within the financial model.
- Development of central data handling system for vaccination information
- Development of a central vaccination hub providing local information and scheduling resources
- Recruitment of 24.4 whole time equivalent (wte) vaccination staff (a further 4.2 wte to be recruited)

- Recruitment of 5 wte vaccination leads
- Development of training systems and resources
- Development of high level transitional and delivery plans
- Development of cold chain procedures for vaccination management

The following milestones are currently being completed

- Finalised transition plan
- Finalised locality delivery plans – including agreement of final vaccination locations to be provided in local communities across NH

Workshops are to be held with district management to develop and finalise plans and allow final transition to commence.

Autumn/Winter vaccinations -

Autumn and Winter plan has been developed and commenced following discussion with NHSH colleagues and Scottish Government personnel as part of the national Flu Vaccination / Covid Vaccination (FVCV) program.

The North Highland plan provides

- Co-administration of both influenza and covid-19 vaccines
- 154,000 vaccination slots in the community between September and December
- 60 different geographically placed clinical locations
- In-school vaccinations for Primary and secondary schools
- In-home vaccinations for all residential homes and house-bound citizens

The program commences on the 5th of September initially focussed on Care homes and Health and social care frontline staff.

The over 65 and at-risk cohort vaccinations commence from the end of September.

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

Delivery of vaccination within general practice has been successful and has been well regarded. It is important that quality of service delivery is maintained following transition and that there is a person-centred approach to the programme that is sympathetic to local needs. Experience of the recent COVID vaccinations has shown that a good quality patient focused service can be delivered. However, there have been occasions where issues such as poor communication and access have not delivered a service of sufficient quality.

This underlines the importance of administration activities such as booking and scheduling as crucial elements in the delivery of a high-quality vaccination service.

The service now offers an increased number of clinical locations and delivery times. Invitations are provided utilising an approach developed following national research and feedback and includes direct appointment letters and self-directed booking.

3.2 Workforce

Recruitment has continued well however challenges still exist in remote and rural areas with ongoing review of alternative models of delivery. A flexible, trained and experienced vaccination team is vital to the provision of a high quality service.

The autumn/winter workforce is dependant on bank services with over 600 bank shifts required during this period – so far approximately 50% of the shifts have been filled.

3.3 Financial

Funding gap for North Highland vaccination services has now been removed with operational models built to account for the 5.4m available funding. Discussion continues with SG regarding the NRAC funding model and the higher cost of providing vaccination services to rural and remote areas.

3.4 Risk Assessment/Management

Identification and availability of suitable vaccination locations – particularly in remote and rural areas remains a risk. We are working with estates colleagues and primary care colleagues to identify all potential options including community spaces and mobile units.

3.6 Equality and Diversity, including health inequalities

COVID vaccination addressed the needs of minority communities, and this approach needs to be continued and strengthened. Several vaccination locations have been developed in support of areas of deprivation

3.7 Other impacts

none

3.8 Communication, involvement, engagement and consultation

Implementation of VTP is a Scottish Government policy. During COVID vaccination programmes there has been considerable communication about the transition from general practice to board led clinics. Vaccination has been a major communication and engagement topic given both its priority and some communication failures.

A Communication plan has been developed for the autumn/winter campaign with local and national resources and is being rolled out across North Highland through the Communication Team.

3.9 Route to the Meeting

This paper was requested as an update by the Health and Social Care Committee

4 Recommendation

- **Assurance** – To give confidence of compliance with legislation, policy and Board objectives.

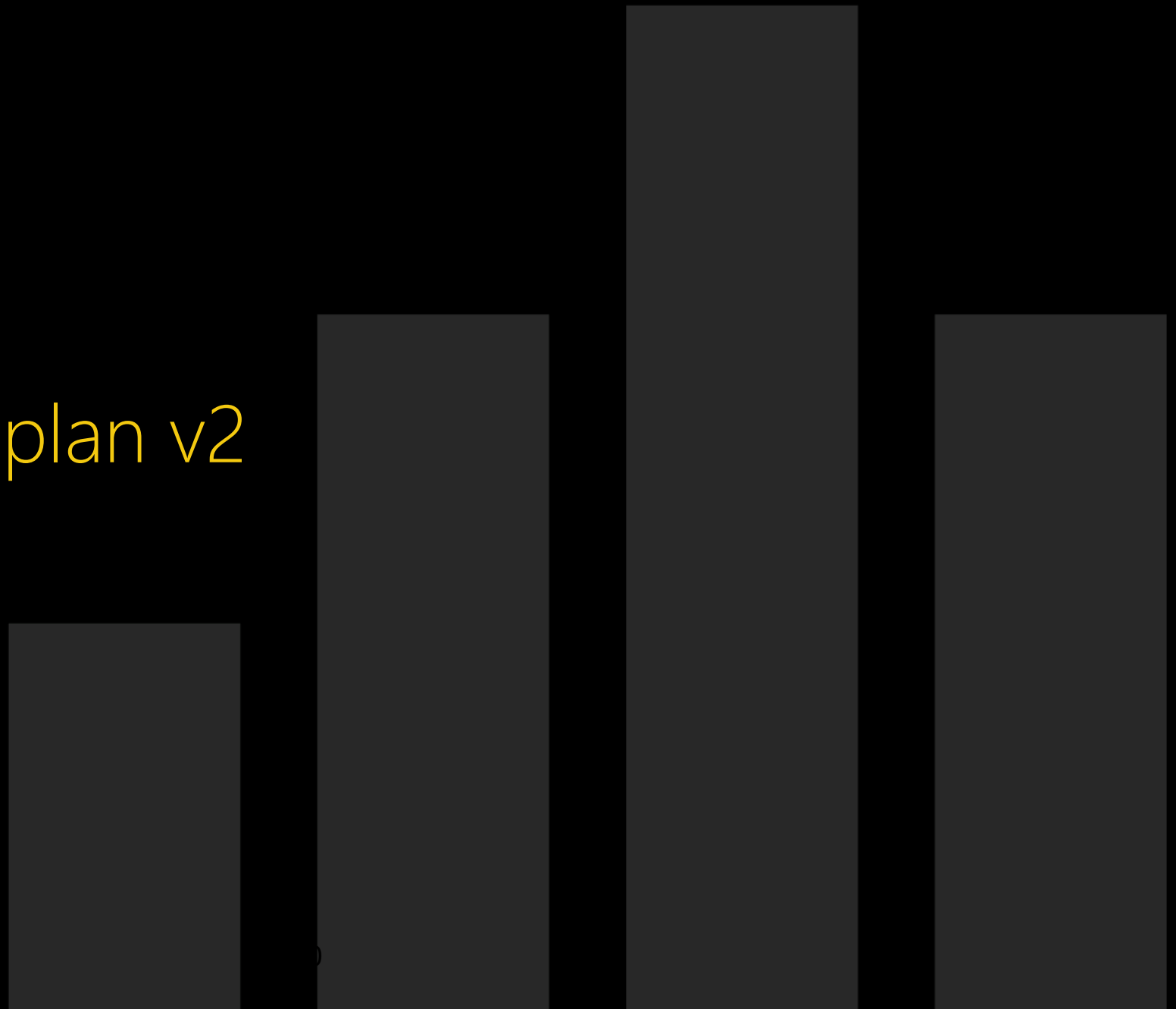
Microsoft | Power BI

Autumn winter plan v2

View in Power BI

Last data refresh:
29/07/2022 09:02:31 UTC

Downloaded at:
15/08/2022 08:06:31 UTC



Vaccine order	Count of Patient CHI	GP Practice Operational Unit
1	4815	Mid
1	3826	North
1	13858	South
1	4081	West
2	15466	Mid
2	12075	North
2	34938	South
2	13518	West
3	6059	Mid
3	5394	North
3	14487	South
3	6105	West
Total	**134622**	

135K

Count of Patient CHI

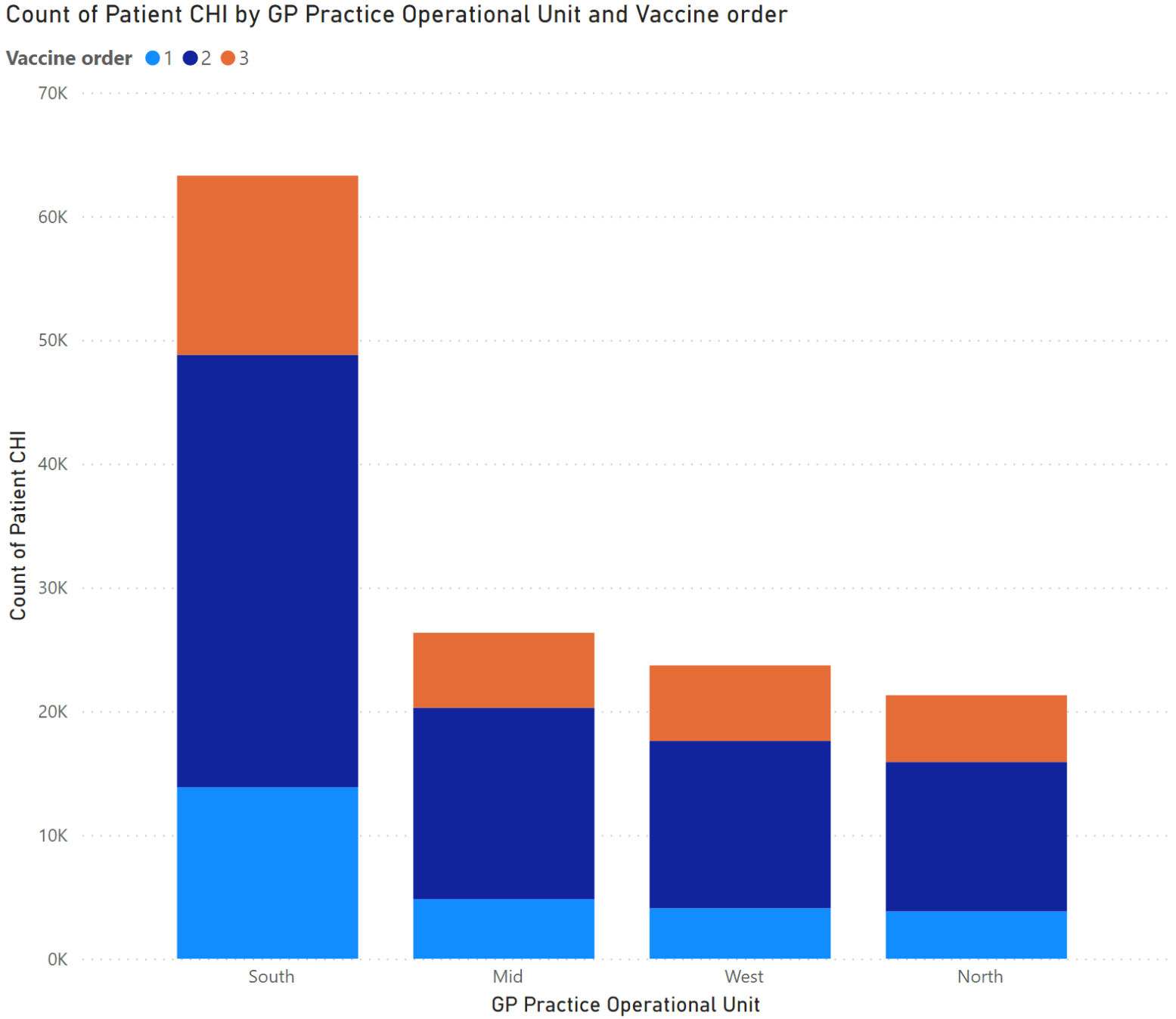
124K

Clinic Capacity

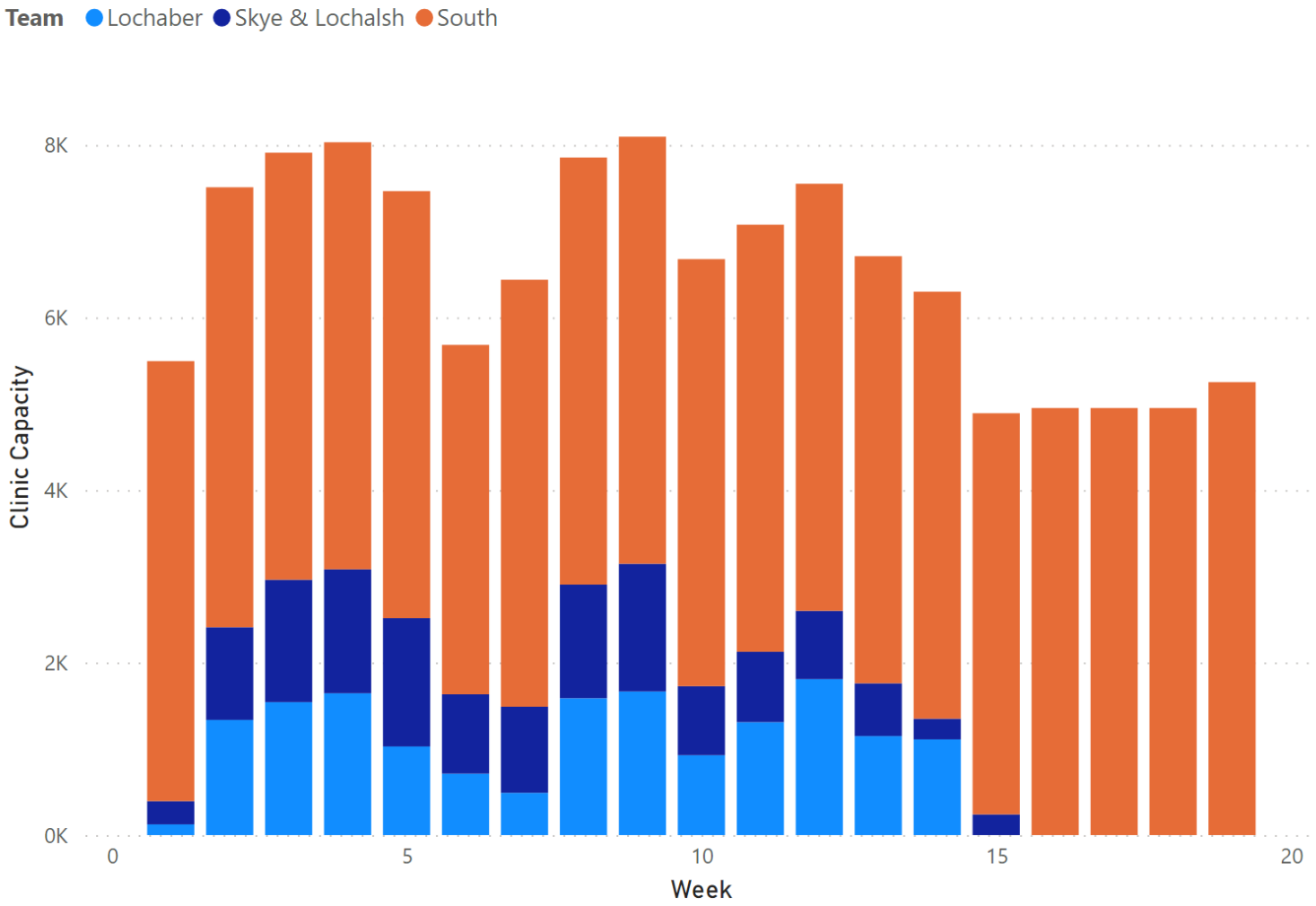
61

Count of LOCATION ...

28560 clinical spots for Caithness and Sutherland to be added with a further **20** clinical locations

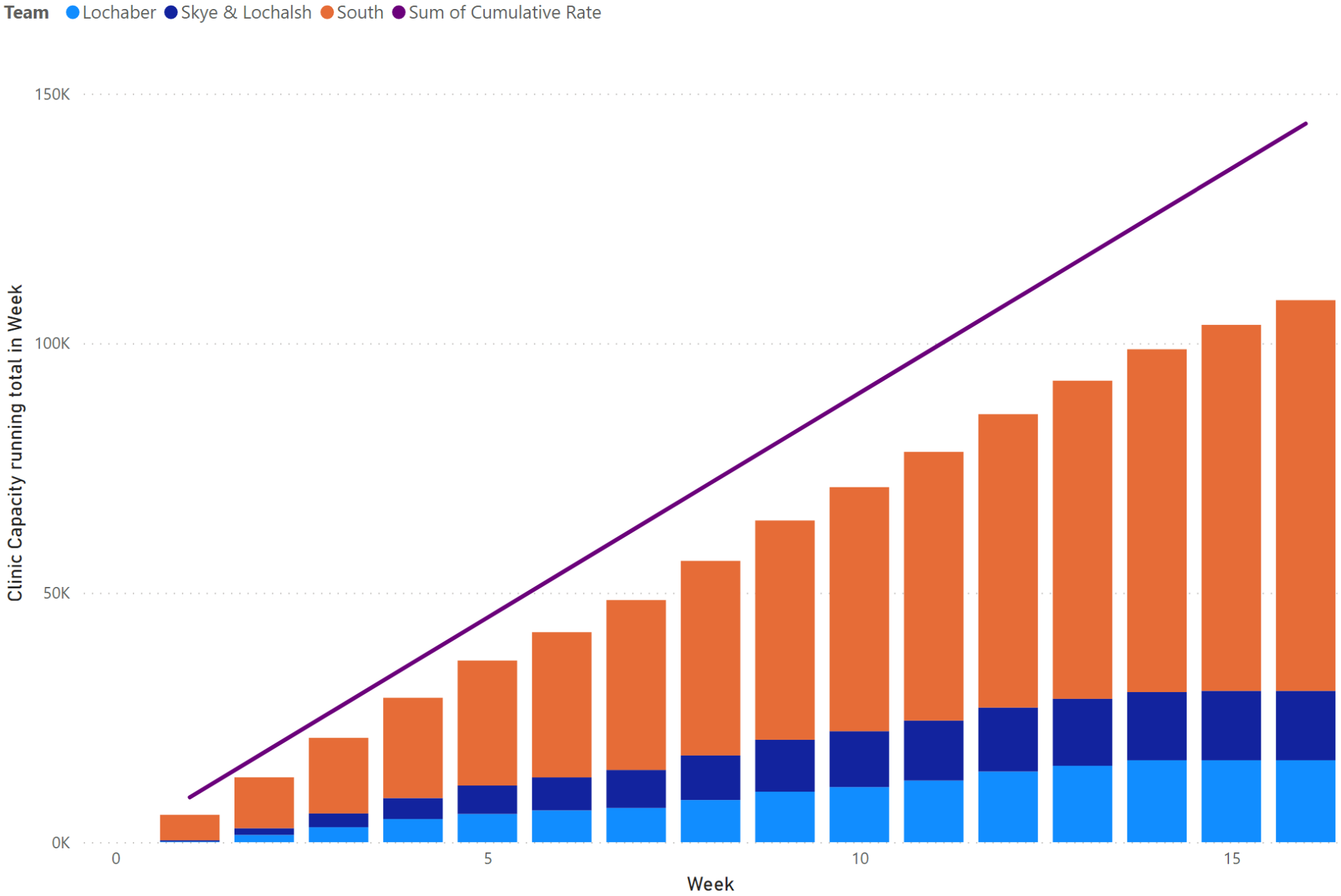


Clinic Capacity by Week and Team



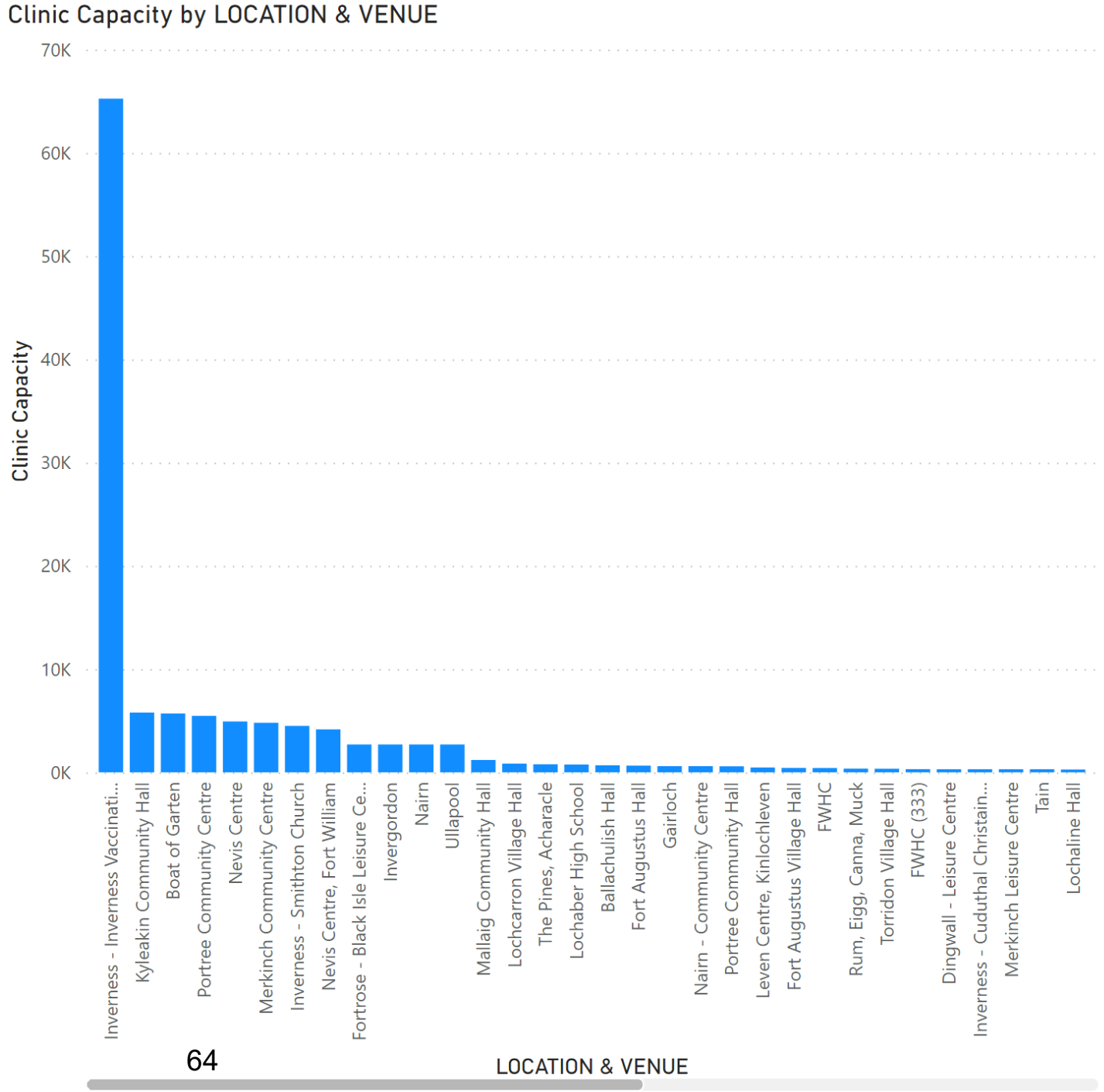
Week	Clinic Capacity	Month
1	5494	September
2	7509	September
3	7910	September
4	7222	September
4	809	October
5	7464	October
6	5682	October
7	6438	October
8	7854	October
9	1540	October
9	6555	November
10	6676	November
11	7075	November
12	7550	November
13	4042	November
13	2668	December
14	6299	December
15	4890	December
16	4950	December
17	4950	December
18	4950	January
19	5250	January
Total	**123777**	

Clinic Capacity running total in Week and Sum of Cumulative Rate by Week and Team



Week	Clinic Capacity running total in Week
1	5494
2	7509
3	7910
4	8031
5	7464
6	5682
7	6438
8	7854
9	8095
10	6676
11	7075
12	7550
13	6710
14	6299
15	4890
16	4950
17	4950
18	4950
19	5250
Total	**123777**

LOCATION & VENUE	Clinic Capacity
Abbeyfield Care Home Ballachulish	36
An Ach Acarsaid	60
Applecross Village Hall	213
Arnamurchan High School	115
Ballachulish Hall	685
Ballachulish Medical Practice (45)	51
Ballachulish Village Hall	235
Boat of Garten	5700
Carbost Medical Practice	9
Cill Chuimein Medical Practice (20)	25
Dail Mor Care Home Strontian	6
Dingwall - Leisure Centre	300
Dunveggon Medical Practice	30
Fort Augustus Hall	650
Fort Augustus Village Hall	428
Fortrose - Black Isle Leisure Centre	2700
FWHC	420
FWHC (333)	308
Gairloch	600
Home Farm	30
Howard Doris	30
Invergordon	2700
Inverness - Cuduthal Christain Centre	300
Inverness - Inverness Vaccination Centre	65250
Inverness - Smithton Church	4500
Invernevis House Fort William	28
Kilchoan Community Hall	167
Kilchuimein Academy	62
Kinlochleven High School	135
Kinlochleven Medical Practice (22)	25
Knoydart Village Hall	70
Total	**123777**



Team

Multiple selections

Week

1 19

61
Count of LOCATION & VENUE

124K
Clinic Capacity running total in Week

1964
No of Vaccinators Required

17
No of Vaccinators Required average per DATE(s)

COHORT	Clinic Capacity
	71100
>65	9600
16-64 at risk	460
2-5 year olds	1800
50-64s	2976
50-64s & mops ups	120
5-11s at risk	216
All Cohorts	1118
All cohorts (69)	70
All Cohorts mop ups	480
At risk 16-64s	1317
At risk 16-64s & Over 50s (151)	154
At Risk 16-64s (158)	165
At risk 16-64s (163)	171
At Risk 16-64s (227)	222
At risk 16-64s (2396)	2400
At Risk 16-64s (245)	300
At Risk 16-64s (254)	257
At risk 16-64s, Healthcare Mop ups	127
Care Home Residents and Staff	214
Flu only Cohorts (?)	216
Healthcare Staff	80
Healthcare Staff (486)	928
Total	**123777**

North Highland Vaccination Service Model – as part of the Vaccination Transformation Programme

Background

As part of the GP Modernisation Programme, Vaccination Transition is required to occur by the 1st of April 2023. Over the preceding years, due to the pandemic, NHS Highland began and has complete the transition of covid -19 and influenzas' vaccinations, but general adult and pre-school vaccinations are still required to transition.

This plan sets out a transitional model for service delivery allowing for further operational development and professional review as we gain a greater understanding of the best value possibilities associated with localised integration of vaccination services, which will allow us to build toward a best value model of delivery in the years to come.

Summary

- Transitional model (model 3) is recommended for approval
- Model 3 utilises:
    - centralised scheduling procedures
    - Integrated team based general adult nurses providing vaccination administration
    - Centralised pan Highland team for pre-school vaccination administration
    - Centralised portfolio operational planning
    - Best value principles to maximise service performance, enabling potential for 3rd party administration of vaccinations
- Model has been proposed by Professional leadership, planned by Operational Management and reviewed by the vaccination project team, including public health consultants and pharmacy representatives.

Service Scope

The North Highland Community Vaccination Service is to oversee the provision of all community-based adult and child vaccination procedures, either through direct administration or by sub-contracting appropriate 3rd party organisations to undertake administration on its behalf.

The service is also required to provide community wide plans and reports to demonstrate uptake of vaccinations to the require populations taking in to account geography and equality factors on its approach.

The service will provide appropriate community communication, supported by internal and external agents, to inform the public and professionals regarding the plans and intentions of the service.

Service Principles

The Service Plan is based on the following key principles:

- The service will operate to enable the highest possible uptake in all vaccination cohorts to ensure that the risk of vaccine preventable diseases and outbreaks is minimised
- A safe, effective and high-quality service will be delivered with vaccinations provided to the populous in a timely manner as close to home as reasonably practicable
- The service will be planned to operate with financial boundaries

- The service is provided to a best value model aiming for flexibility and adaptability to achieve this
- The service will review provision model against a need for inclusivity and ensure the operational delivery incorporates equality in access to services
- The service is supported by accurate and timely data collection to enable effective monitoring

Service Aim

Is to achieve the highest level of possible public vaccination in acceptance of the overwhelmingly positive public health benefits associated with vaccinations.

Current service delivery

Influenza and Covid-19 vaccinations under the national FVCV program are administered by NHS Highland from the Spring of 2022.

Adult and pre-school vaccinations are currently provided by General Practices across North Highland and transition of these services are part of the GP Modernisation Programme, this transition must be concluded by the 1st of April 2023.

School age vaccinations, as part of the lead agency model, are delivered by Highland Council. A program of work is to be undertaken to transition these services to NHS Highland upon agreeing required workforce and financial recompense.

Service Demand

Demand is model using Public Health data taken from a variety of sources, demand is highly variable and these figures represent eligible individuals as approximated from 2022 data sources

	Cohort population sizes				
	South	North	Lochaber	Skye	Ross-shire
Covid/Flu	114997	36013	20296	15000	50843
Pneumococcal	6188	2766	1155	880	2614
Shingles	10076	4754	1814	1280	4127
Pre school	4199	1302	748	346	1166
School boosters	1121	388	243	97	355
HPV	2233	795	472	194	666

Service Model

During the ongoing exploration phase of vaccination management and provision the organisation has reviewed, considered, and tested a range of operating models, these have informed our prevailing model option going forward.

A place-based locality boundary model with a hub and spoke operation was previously considered the prevailing model of provision. This model has been utilised to good effect during the pandemic vaccination roll out and remains a preferred model for mass vaccination requirements. The locality-based model provides good coverage given the wide variation in geographical/political/medical

boundaries across the Highlands created by variations in communities, Highland Council boundaries, NHS Highland boundaries and GP cluster boundaries.

However, this model when transferred to support a wider Vaccination Transformation Program (VTP) requirement fails in several regards. Mainly the model requires a significant vaccination workforce to be in place with a subsequently high financial pressure, due to the resource duplication created at a management line, the model also has not demonstrated the ability to recruit the required number of vaccinators consistently and, pivotally, it does not take full account of the paediatric requirements presented in the wider VTP as opposed to the heavily weighted adult provision required during the pandemic vaccination programs.

In consideration of these limitations Medical and Nursing professionals considered a variation in our approach which would enable a greater focus on the specific professional requirements of paediatric vaccinations and reduce the financial requirements of the workforce model, whilst providing time to determine how the service be delivered through an integrated model at the district level.

'The recommendation at this point is that the Band 7 operational leads take a portfolio based operational and oversight role, which would enable them to develop an in depth understanding of the different aspects of the programme, the challenges in delivery as well as understand the local pressures and to use that to inform future modelling. This may not be the final position as part of their role would be to better understand how the leadership skills at this level can be best used to the benefit of the service across Highland. They would also support the band 6s in local planning and delivery, training, and governance. They would take a lead role in developing what could become a network of vaccinators across north highland, such as peer vaccinators for staff clinics and key baby/childhood vaccinators in remote and rural areas and ensuring that they maintain their competencies and confidence, which may prove challenging in some cases where case numbers are low. In terms of their portfolios there are systems and processes to be developed and they would lead on this. Examples include the consenting processes for school aged children, or AWI safeguards – both areas in which we have had incidents. It should be noted that these roles have already been recruited into.' (Professional Leadership)

Operationally this will see Band 7 staff undertaking portfolio(s) of strategic North Highland wide vaccination work, working with integrated teams across the Highland Health and Social Care Partnership (HHSCP) to manage specific cohort level delivery.

In the initial phase, the vision would include, but not be limited to:

- Band 6 clinical leads, locality based. They would sit within the integrated team structure of that locality but their focus would be the VTP. They would be trained to deliver vaccinations from cradle to grave, act as clinic lead (for all clinics), deliver/coordinate local training, and with admin, Hub, and band 7 support, plan and schedule cohort clinics.
- a core group of vaccinators (band 3/5) who have been trained to deliver:
    - paediatric vaccinations – initially they may need to be mobile and cover a wider geographical area. The key to this would be the development of a network of competent vaccinators in different localities, which the band 7s will need to take a lead on.
    - School aged vaccinations (HPV and winter flu campaigns) should also include DTP/MenACWY campaign and MMR catchup.
    - Adult vaccinations (predominantly shingles and pneumonia vaccinations throughout the year and winter delivery of flu and covid vaccinations).

- A band 8a/b lead nurse to provide professional leadership, develop systems of clinical and professional governance, improvement, and service development.

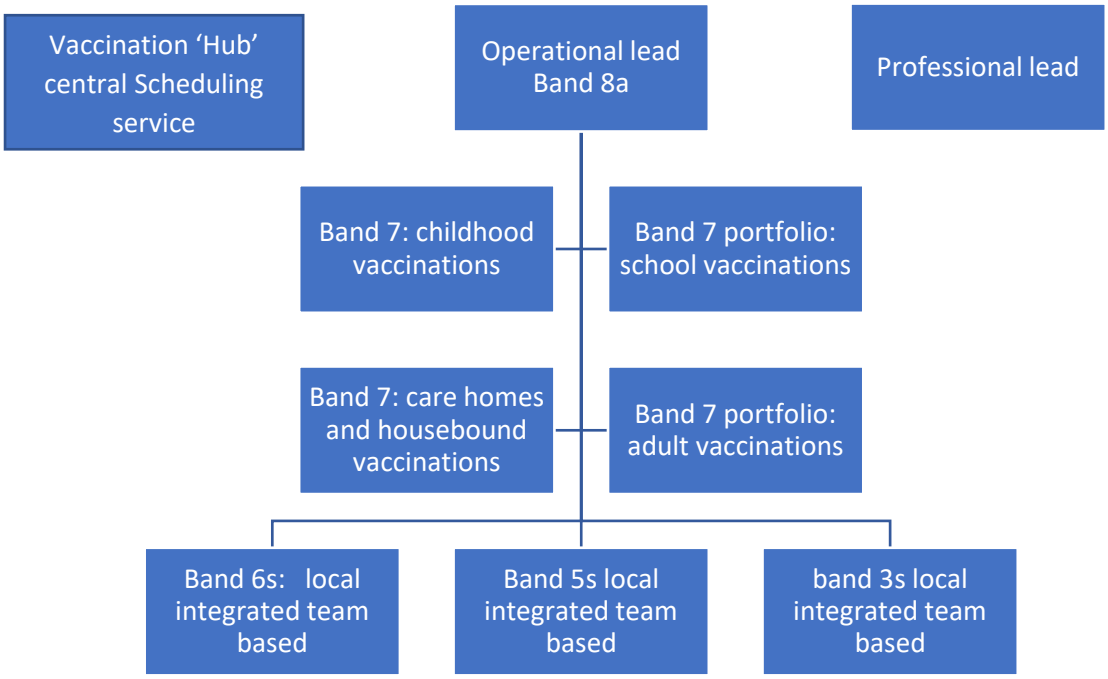
The model would aim to sit within the wider integrated team in the different localities. Community nursing teams already undertake housebound and residential care home vaccinations in some localities, and this should be standardised across north Highland.

With a focus on 'placed based care' and community health provision, the aim is to build on the relationship within the integrated teams and to identify opportunities where, by basing the vaccination workforce in the integrated teams (hence increasing the overall WTE of the combined team), this creates opportunities for cross skilling and flexible working across the integrated workforce to the benefit of both aspects of service provision. This is something that needs to be explored more fully in the coming months.

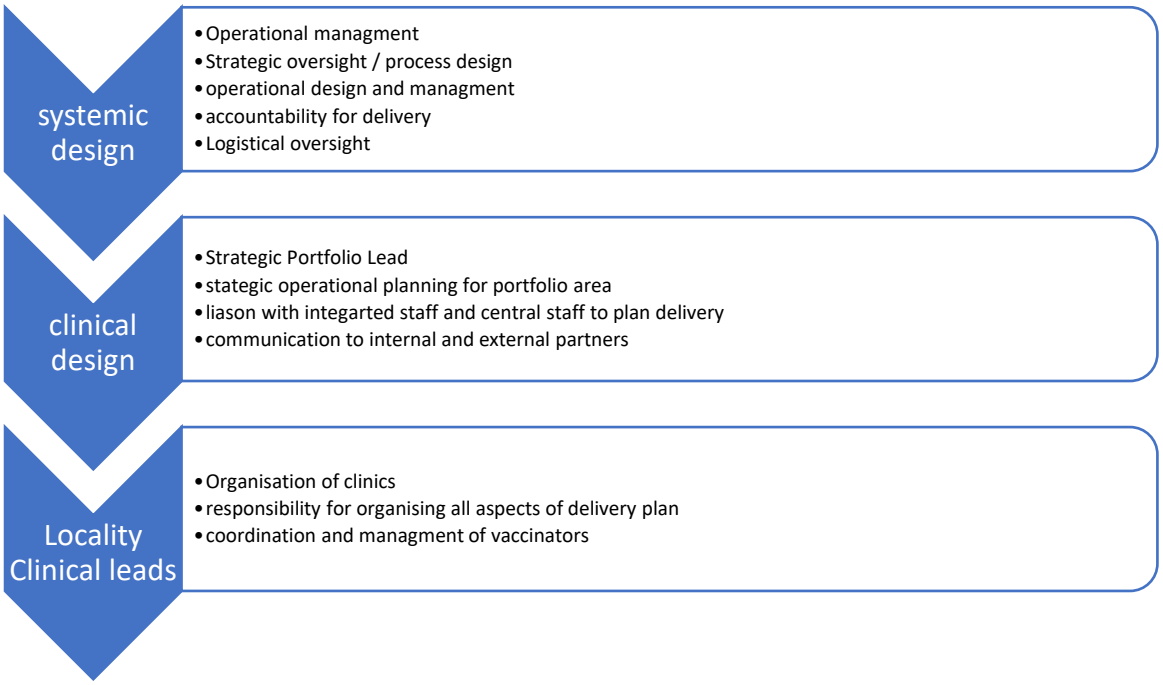
There is a further opportunity to explore how CTAC service delivery can be supported through this model. **However, this is only enabled if the recruitment to vaccination roles focused on general nursing trained individuals, as opposed to wider professional or nonprofessional qualifications.**

For peak (surge) times and in remote areas the aim is to look at the wider workforce to deliver vaccination services. This may include the RST, AHPs and practice nurse staff in the 2C practices.

This would be required during the annual influenza and covid-19 vaccination roll outs, where significant increase to vaccination workforce will be required temporarily to meet the organisations requirements regarding winter vaccination. A clear process will need to be designed and agreed so that appropriate staff can be released to the vaccination service to support population delivery during the autumn and winter months.



The diagram above shows an example of the model hierarchy, below is a role oversight of the service provision.



Staffing complement

The new model focuses vaccination service staffing on specialist core areas – such as portfolios of work and paediatric vaccination provision. This model will require some flexibility in our delivery options, such as, integrated team and specialist nursing teams providing vaccinations at specific times or in specific locations.

The model envisages that a core preschool and school vaccination team will be established, managed, and operated centrally initially with review of the longer-term approach. Adult vaccination provision will be provided by vaccinators who are embedded into the existing integrated team such as district nursing team and reviewed further to determine the long-term approach.

Vaccinator requirement is a complicated and debatable calculation. This estimate is produced by looking at current known vaccine uptake by geographical area, using GP clusters as a baseline. Uptake is then multiplied by a determined time taken for each vaccine, weighted by cohort size and averaged out over all cohorts. The required weekly hours of work are then divided to calculate WTE numbers based on an average across North Highland district teams – a weighting was required as, for example, inverness will need more vaccinator time than other districts, also a weighting is applied for rurality with rural and remote districts requiring twice the average time requirement per vaccination to account for travel distances etc. The current calculation of wte staff for recruitment is

(Assumptions: 15 min and 30 min per vaccine timings applied to urban and rural areas respectively for adults and 30 and 60 minutes respectively for preschool and school aged)

Area	District WTE	Pre School team wte	School age team wte
south	2.1	2.2	1.7
north	1.9	1.3	1.2
lochaber	0.8	0.8	0.7
skye	0.6	0.4	0.3
rossshire	1.7	1.2	1.0

This totals 17.9 wte vaccination band 5 staff – further discussion with professional colleagues is required to review potential skill mix for these groups. **The school age group vaccinations are currently provided by the Highland Council team and transition is not part of VTP or influenza/covid-19 finance, the additional finance to enable recruitment of 5 wte band staff must be discussed and agreed with HC to achieve school age vaccination transition.** From an operational perspective the pre-school and school teams will operate as a single pan highland unit in the transitionary phase.

Further operational level discussion, with integrated teams, is required to determine if band 6 staff will align within existing integrated team structures or if they should be centralised – with a constraint of a maximum number of available band 6 staff.

The model also includes budgeting for 12 wte band 5 bank staff to enable a flexible budget to support in year or mass vaccination demand levels. It will be vital in each year to maintain a high bank staff capacity especially for winter periods, a further option would be to use some of these funds to support annualised hours contracts for individuals to work specifically during the winter months.

Finance

3 models have been considered over the 6 months; Model 1 underwent estimated costing and this was put forward to Scottish Government (SG) in terms of a funding request, this is summarised as

Estimated Costs Model 1	
Pay	6,719
Estimated Pay Award	134
Non Pay	1,030
FHS Payments	20
Total Costs	**7,903**
Funding Deficit	**-2,465**

Based on the subsequent funding provision allocated by SG a funding deficit of £2.465 million existed.

Subsequently teams were asked to review model 1 funding and workforce requirements and model 2 was developed and funding is summarised as :

Estimated Costs	
Pay	5,573
Estimated Pay Award	162
Non Pay	1,030
FHS Payments	20
Total Costs	**6,784**
Funding Deficit	**-1,346**

Model 2 reduced the deficit to £1.346 million

This paper presents Model 3, which achieves a financial balance

Estimated Costs	
Pay	4,249
Estimated Pay Award	123
Non Pay	1,030
FHS Payments	20
Total Costs	**5,422**
Funding Deficit	**15**

By reducing the number of previously planned band 7, band 6, band 3 and band 2 roles we can achieve a potential financial saving of approximately £1.4 million.

Models 1 And 2 were based upon a new single central vaccination service, there was assumed economies of scale associated with a single central service, however it has become clear across the iterations of the model that less financial pressure is produced through a more integrated model. Pay costs for Pharmacy, Ehealth, Facilities, Planning & Performance, Public Health, Nursing leadership and communications have remained relatively fixed through all models.

Cost per vaccine per operational service

It is assumed that there are 350,000[1] vaccination events required in any year, which is comprised of 150,000 influenza and covid 19 vaccinations co-administered (300,000 individual vaccines) and 50,000 adult, pre-school and school age vaccinations (preschool vaccinations are multiple per individual and so are counted up for totality). *School age vaccinations are currently undertaken by the Highland Council and so their administration is not accounted for in the funding presented in this paper – meaning that further resource, growth will need to occur to absorb this additional workload.*

Removing school age vaccinations means across a year NHS highland will need to undertake, approximately, 343,500 vaccination events due to influenza, covid and the vaccination transformation program.

Model 3 can be subsequently broken down as a cost per vaccination – £15.78 per vaccination. All models can be summarised as

Model	**Total cost**	**Cost per vaccine**
Model 1	7903000	23.01
Model 2	6784000	19.75
Model 3	5422000	15.78

Target cost can be summarised as £15.83

These costs can be further broken down

[1] This number is a calculated estimate using accepted uptake rates the range is from 287,128 up to 539,799 vaccinations per year

Model	Model 1	Model 2	Model 3	Target
Total cost	£ 7,903,000.00	£ 6,784,000.00	£ 5,422,000.00	£ 5,438,000.00
Cost per vaccine	£ 23.01	£ 19.75	£ 15.78	£ 15.83
cost non-pay per vaccine	£ 3.04	£ 3.16	£ 3.16	£ 3.01
Cost Vaccination Pay / vaccine	£ 14.90	£ 11.45	£ 7.58	£ 7.65
Cost Pharmacy services pay / Vaccine	£ 1.34	£ 1.34	£ 1.34	£ 1.34
Cost facilities pay / vaccine	£ 1.69	£ 1.69	£ 1.68	£ 1.69
Cost Ehealth Pay / vaccine	£ 0.40	£ 0.40	£ 0.40	£ 0.40
Cost P&P Pay / vaccine	£ 0.54	£ 0.54	£ 0.54	£ 0.54
Cost Public Health Pay / vaccine	£ 0.48	£ 0.48	£ 0.48	£ 0.48
Cost Nursing leadership Pay / vaccine	£ 0.21	£ 0.21	£ 0.21	£ 0.21
Cost Comms Pay / vaccine	£ 0.10	£ 0.10	£ 0.10	£ 0.10

Non Pay costs

Non Pay costs are summarised as

	NH	
Sundries	80,000	Estimate for all vaccinations, ledger info for 21/22 incomplete
Travel	111,000	1 pool car per locality and 2000 miles per annum for registered nursing WTE
Subsistence & Staff Accommodation	24,000	Accommodation in Skye
Vaccine Clinic Venues	369,000	Long term some leasing of premises is anticipated & not fully estimated as costs unknown. Estimate includes utilities
Vaccine Transport		estimated costs associated with HMRA compliant transport from GGC & supply from Belford of Covid vaccine
Digital Technology	228,000	NH based on original costing includes IT & mobile phones and MS365 Licences
Pharmacy Supplies	50,525	Excludes costs of new cool room planned for Raigmore, 2 exisitng portacabins and designated parking area (these costs TBC
Travel Vaccinations	102,240	Plus 12k non rec costs
Comms	60,000	
Estates Costs		
Stationery	5,000	will include other misc small value expenditure
	1,029,765	

These costs have not been altered between models based on an assumption that, relatively, non-pay costs, although spent differently, would remain the same.

Administration roles

The service requires a high degree of administration from direct clinic provision through to national liaison for population level appointment letter generation. Also, a significant degree of large complex data set analysis and planning is required to support portfolio leads in service planning. Clinical administrative support we envisage will be at local level embedded in in the locality-based teams, however wider planning and scheduling administration is seen as a central function undertaken by the vaccination service central hub and in cooperation with the portfolio leads as required.

IT roles

The service requires a high degree of dependency on national clinical vaccination systems and data reporting systems supported by eHealth roles. NVSS, VMT, NSS GP Backfill Tool, SEER and NCDS are mission critical systems hosted nationally with local technical support and user administration requirements. IT roles within the eHealth department are responsible for providing the large complex data sets to administration and management roles and data quality. These requirements exist regardless of the operational model and are a relatively fixed requirement of the services provision.

External contractors

The provision of such a service to a geographical area as vast as the Highlands, against a backdrop of complicated public transport and appropriate venue identification, means that there is a high

relative financial cost to the provision of some vaccination service to specific geographical areas due to the volume of patients and fixed costs of staff transportation, facility appropriation etc. A best value approach is to be always considered by the service. It is therefore evident that there will be locations and opportunities to provide better value to the community by contracting external agents to administer vaccinations at certain times. This will require contractual discussion and negotiation with potential providers for comparison to direct service provision costs. An example may be pharmacies providing direct vaccinations or General Practice providing prescriptions for nursing home residents so nursing home can provide direct delivery of required vaccinations.

Facilities

The service will require a wide geographical spread of bookable clinical spaces to be utilised for clinical administration of vaccines, it is envisaged that this would be possible in existing NHS Highland facilities.

Storage and office space would also be required for each locality team to operate services, which is assumed to be shared with other services.

Venues will need to be acquired, through short term rental, to support mass vaccination services during the autumn and winter.

Further work with NHS Highland facilities and estates teams is required to identify all possible locations and venues that are available to the teams.

Cold-Chain

The cold-chain requirements of vaccinations are a specifically complicated area of operational requirement. 4 potential options have been identified; however, all have specific advantages and disadvantages that must be considered, this mainly has an affect during the autumn and winter when vaccination delivery requirements will be extremely high for covid-19 and influenza immunisation programs being active and the potential for over 200,000 doses being delivered.

1. Direct delivery to vaccination locations via National Procurement (NP) and/or local VHCs (Vaccine Holding Centres in Raigmore, Belford and Caithness)– this would require vaccine fridges checked twice daily for temperature adherence and monitored during the year. As an example, the service utilised over 40 vaccination locations during the spring campaign. Locality based delivery in the form of a central locality hub would mean a location that is potentially staffed 5 days a week by vaccination service staff which would increase financial staffing costs. Locked locations with remote monitoring of fridges are an option that could be explored with staff available for receipt of stock as required.
2. Direct Delivery to NHSH community hospitals (forming de facto hubs) via NP and/or local VHCs. Like vaccination locations - this could mean once weekly non specialist vaccination staff, most likely ward staff receiving and signing for vaccine delivery, ensuring its appropriate storage and daily temp. recording. Considering the high pressure on community wards during the autumn and winter months this may add a significant burden on wards with low staffing. It is possible that non nursing staff such as receptionists or porters could accept delivery and a process to scope and define this would be required. The risk of poor record keeping or mishandling of deliveries could result in thousands of doses being unusable.
3. Delivery to centralised pharmacy services only via the VHCs with transportation out to teams – this option would place a significant addition volume-based burden specifically during autumn/winter on the central pharmacy teams impacting on workload and space, incurring

additional cost. Also, transportation services are unavailable during the weekends and during the winter plan when multiple weekly weekend clinics are planned.

4. Direct Delivery via NP and/or via the VHCs to locality based external agents– contracting with specific General practices or pharmacies with access agreements would provide a wider geographical range of delivery options although would incur an additional financial implication. Monitoring of the fridges and cold chain processes would need to be included in this agreement, regular audit by the Board would also need to be built in. Additional fridge capacity for vaccine and cool packs would be required and space for vaccine porters would also be required in these sites.

At this time the service would recommend a further exploration of option 4 as the best value approach; with subsequent specific discussion and agreement on autumn/winter vaccination delivery models undertaken to determine the best value approach.

Governance

This document is now to be reviewed for approval by:

- Vaccination Transformation Project Team - 11 July 2022
- Senior Leadership Team – 13 July 2022
- NHS Highland Board – 13 July 2022

This document is also to be reviewed and noted by

- General Practice Modernisation Board

Next Steps

Was the document has been finalised and approved a project work breakdown schedule and network diagram will be devised and actions allocated as appropriate within the Vaccination Transformation Project Team.

Further operational discussion at the North Highland Senior Management Team meeting will also be required.

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.

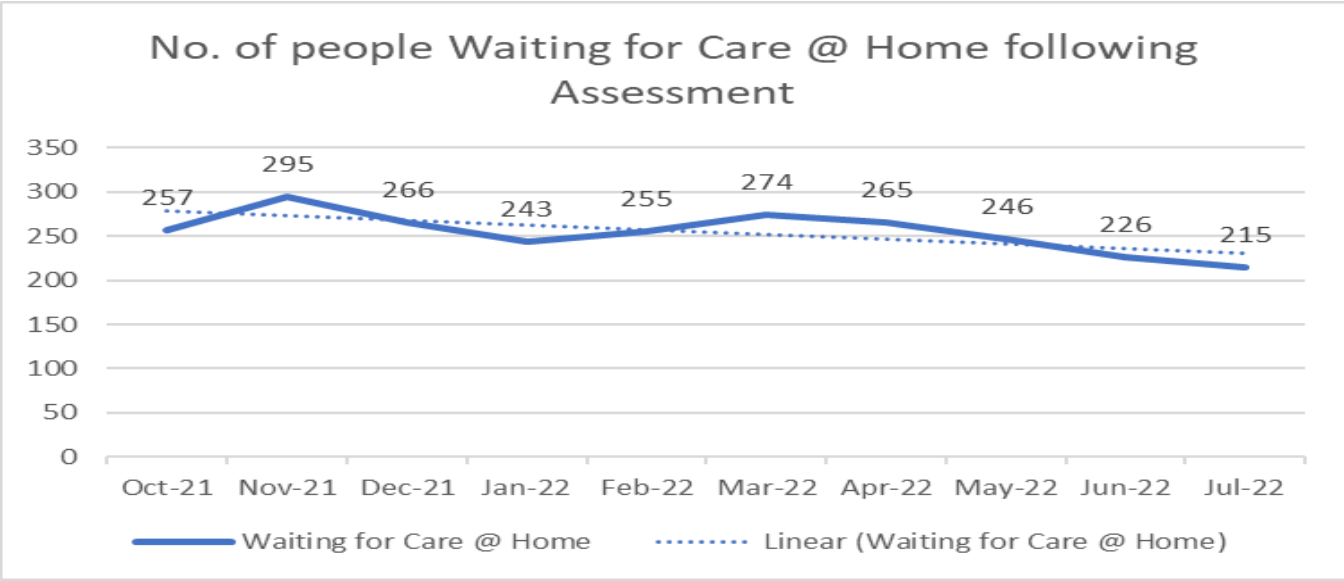
It is **recommended** that:

- 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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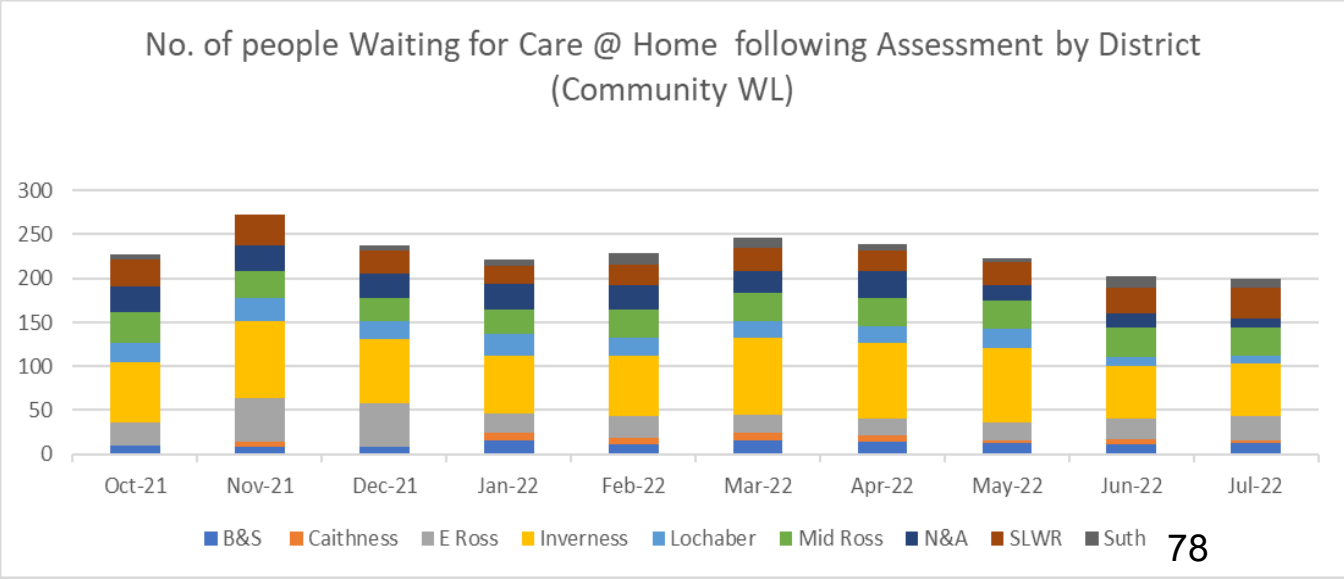

Currently provided weekly as part of the PHS weekly return on unmet need. This return commenced in September 2021 and is provided by each district team weekly. The hospital DHD's are added to the community data.

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

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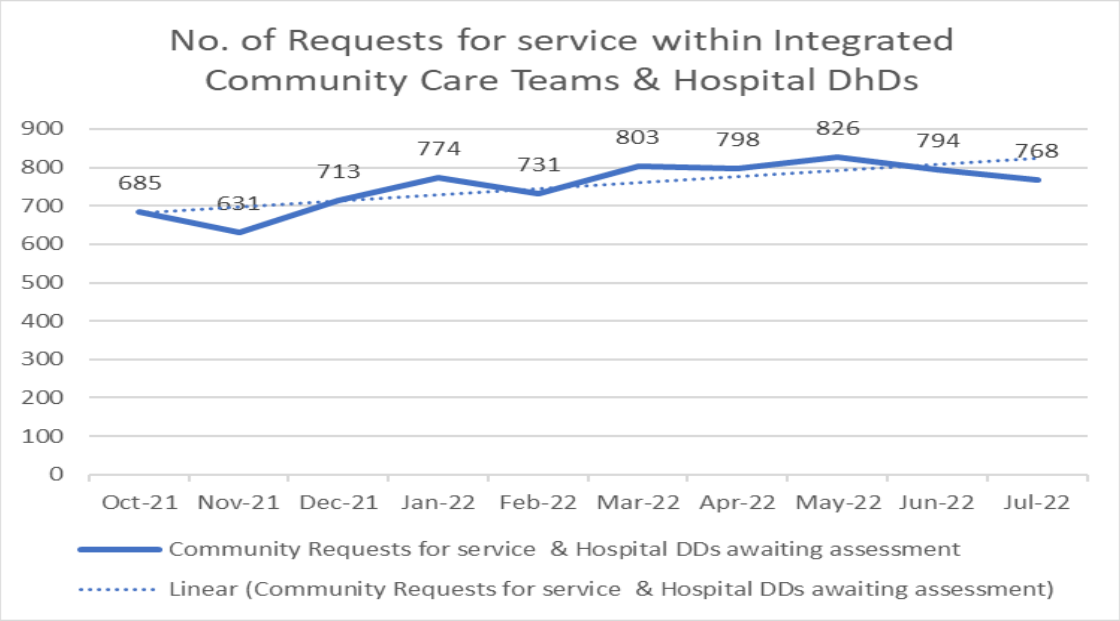

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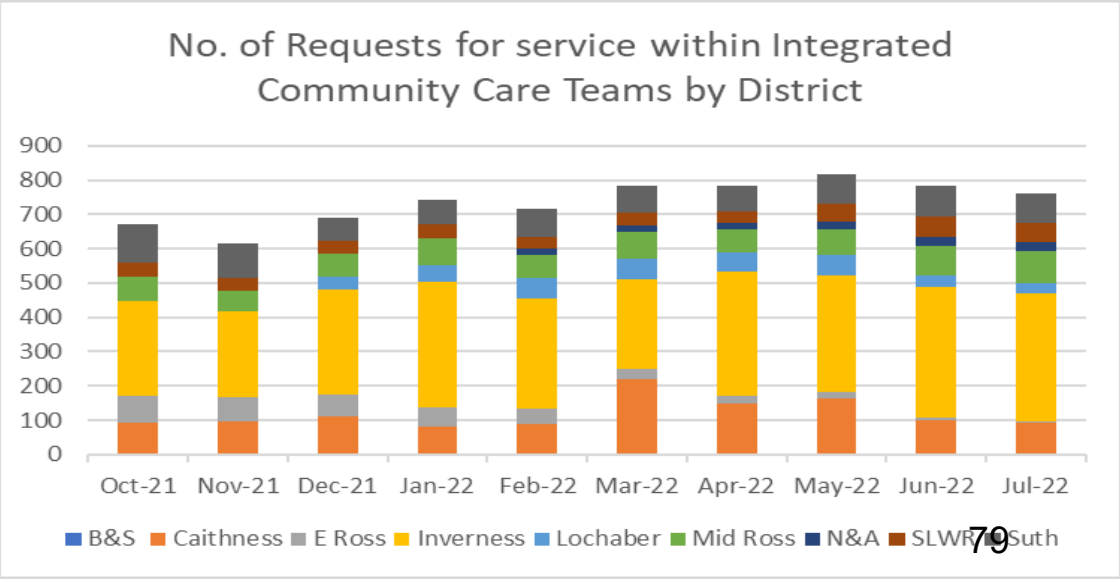

Currently provided weekly as part of the PHS return as a proxy for people waiting for a service. This return commenced in September 2021 and is provided by each district team. These are provided from individual team desktops based on referrals (often referred to as requests for service), however there 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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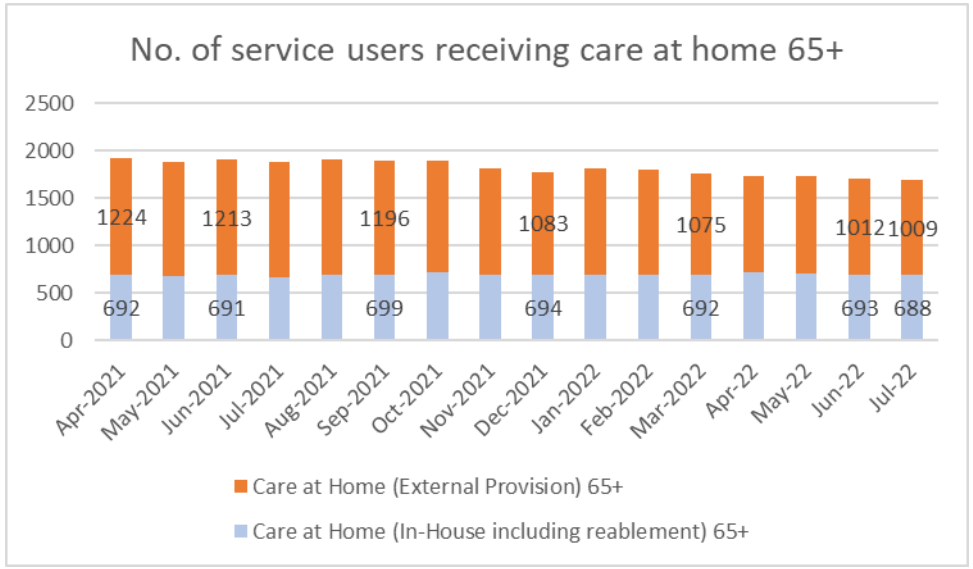

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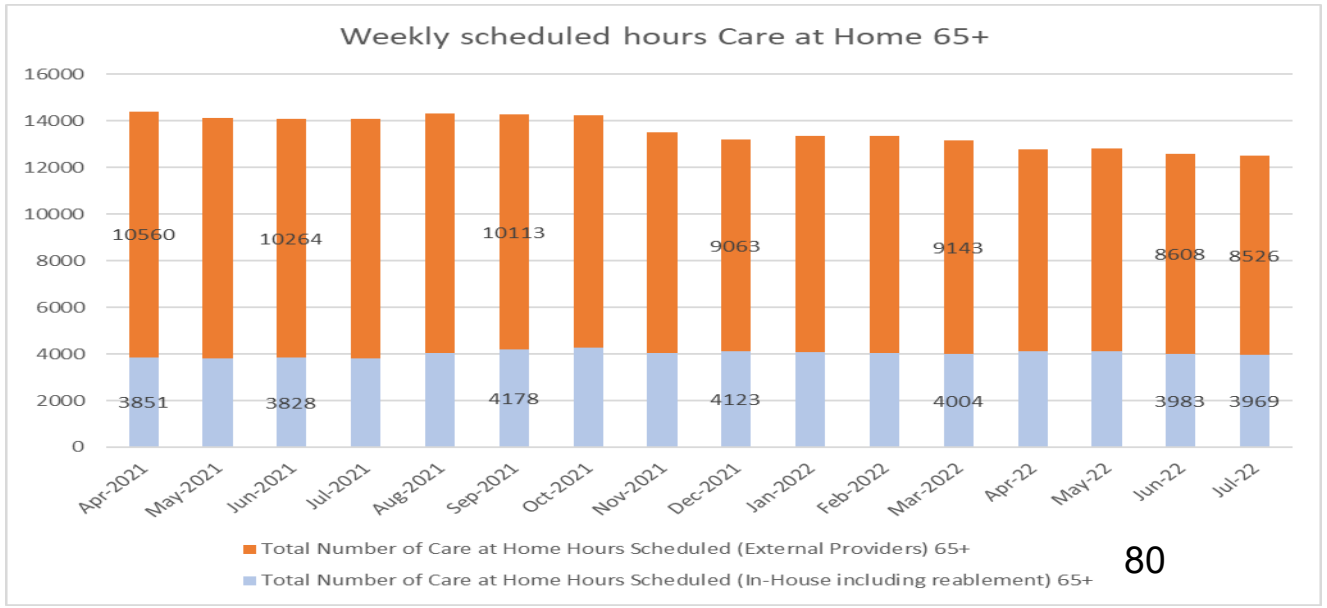


Adult Social Care, NHS Highland

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:

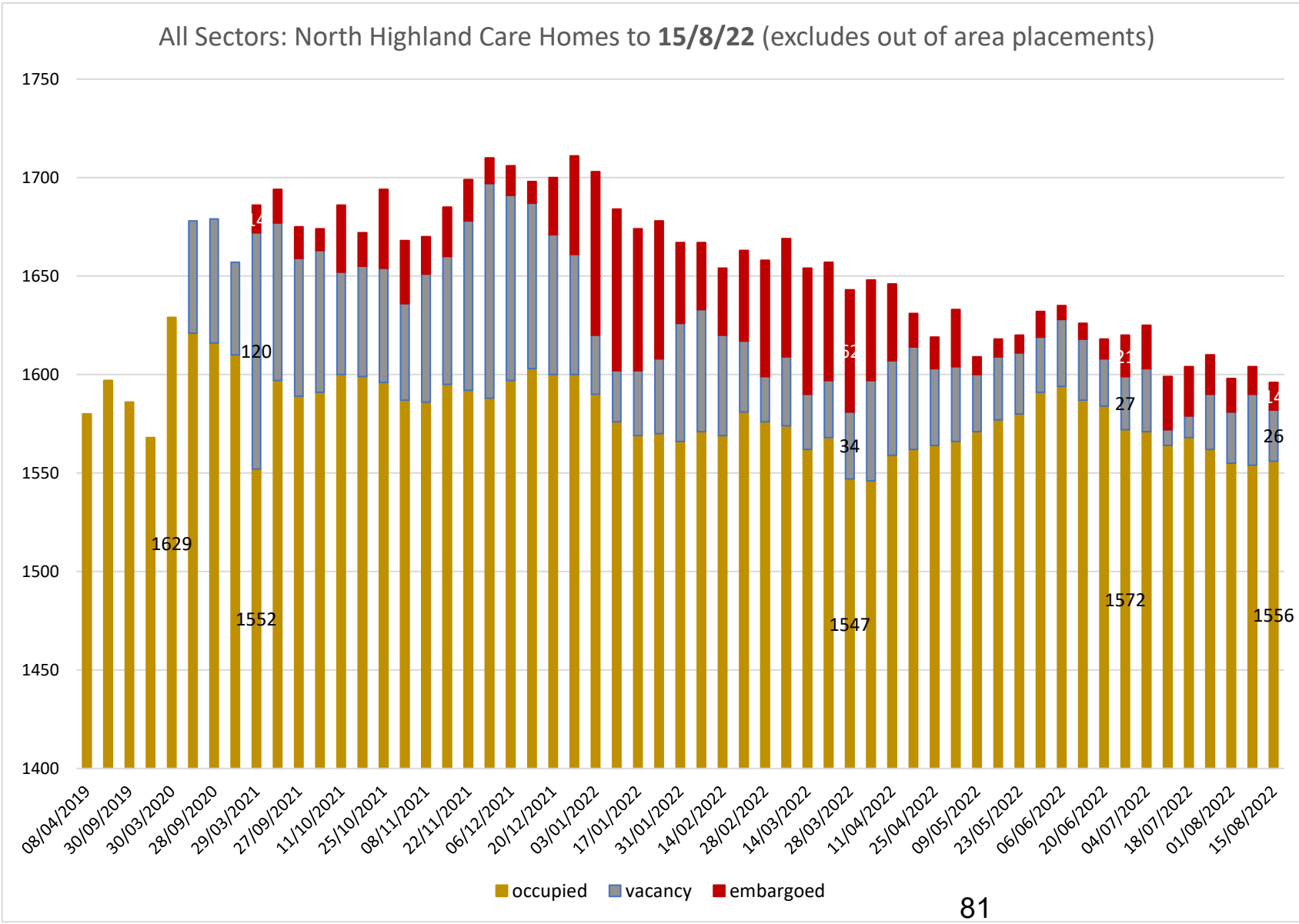
- **Immediate:** to seek to stabilise, support the ongoing provision of safe care and to facilitate additional capacity.
- Where services are commissioned from the independent sector, there is regular and close dialogue about obstacles, issues and barriers to delivery, and to seek to urgently unblock / 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

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



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

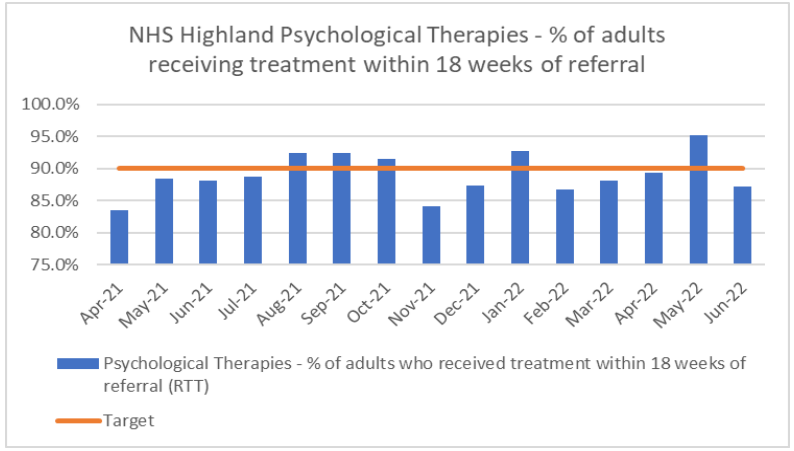
Update as at 15/08/2022

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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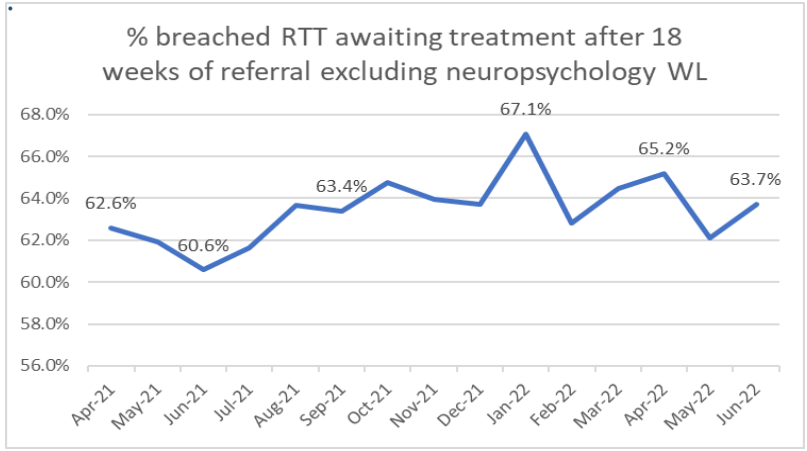
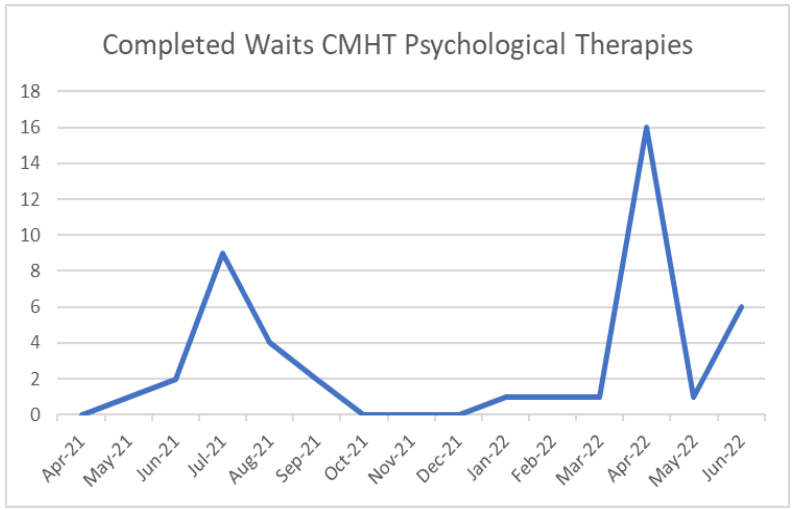


Community Mental Health Teams

1.



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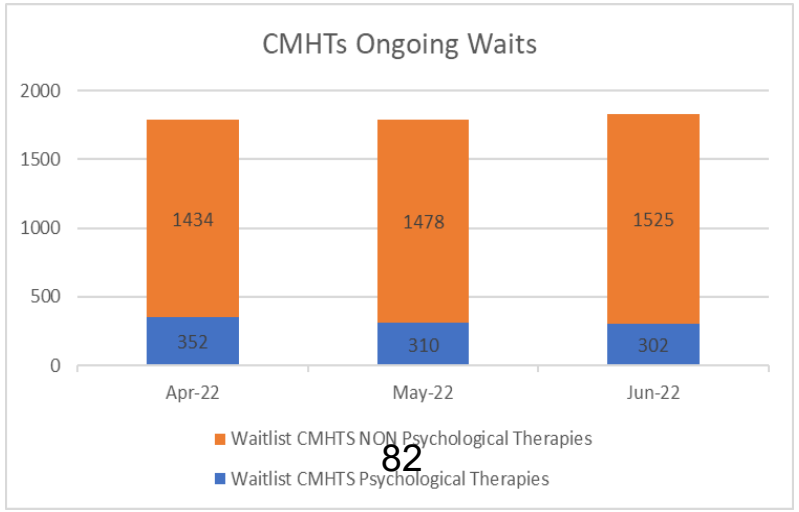


Adult Psychological Therapies has an RTT of 90% of patients to receive treatment within 18 weeks of referral.
Graph 1 – shows the performance against target for NHS North Highland
Graph 2 – shows the percentage of existing referrals who have already breached the target of 18 weeks (excluding neuropsychology)
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.

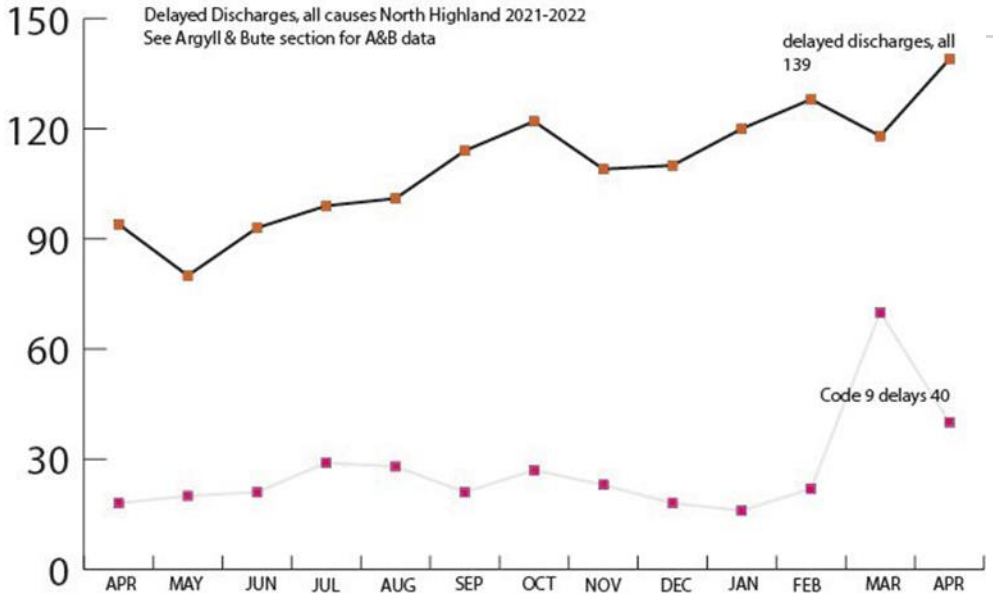
15/08/2022

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					

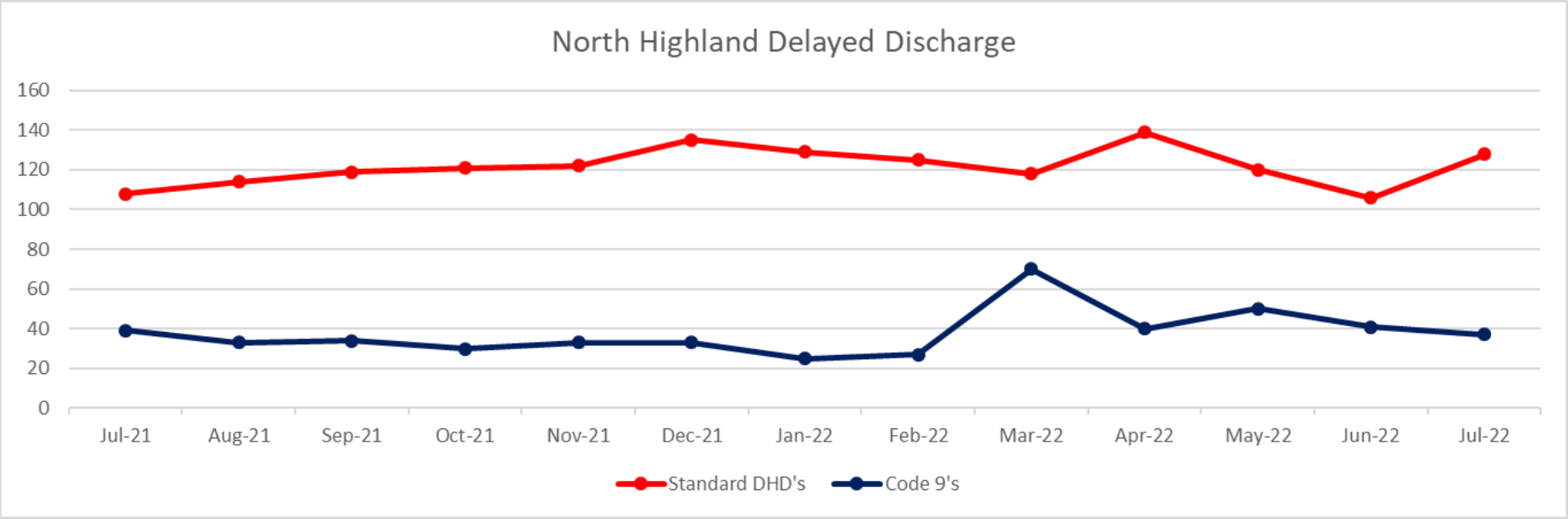


This table provides a position on delayed discharges in Community Hospitals at 2 comparison dates of 14th July and 11th August and the waits in Raigmore on 11th August for available beds.

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.

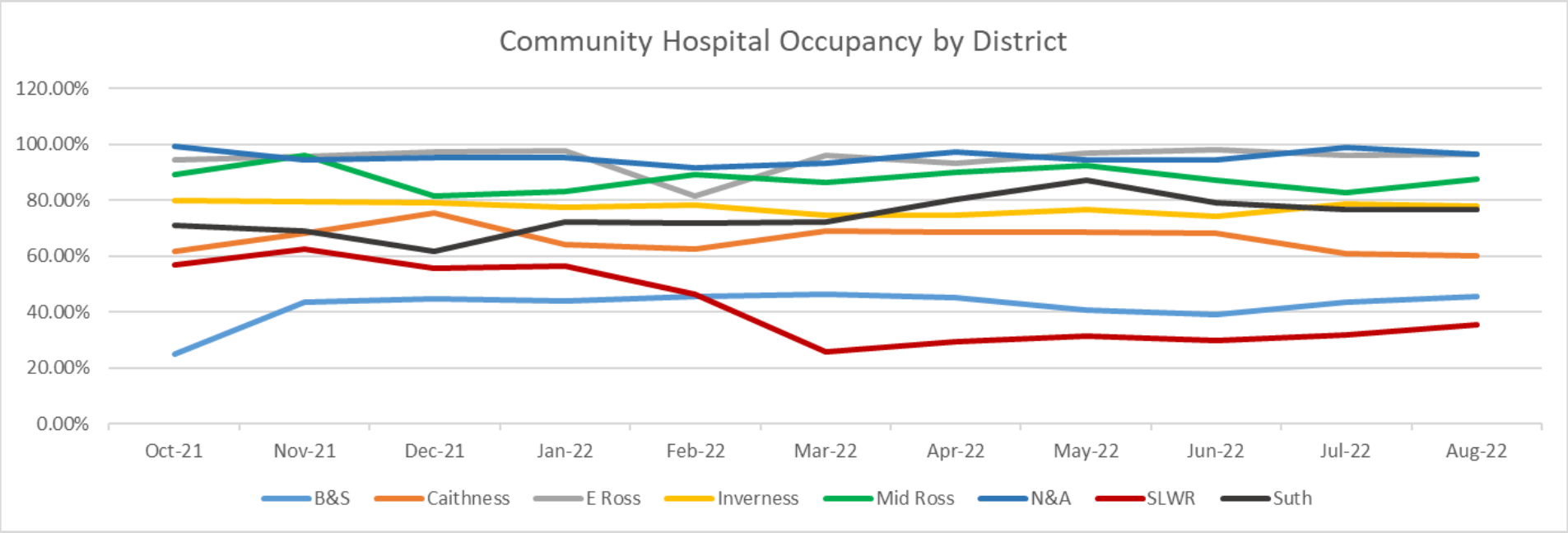
Nevertheless it is recognised that the fragility and retraction of care home and care at home services are resulting in people waiting longer than we would wish in hospital.

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

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



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	37	8		
recruited using winter pressures funding in the quarter	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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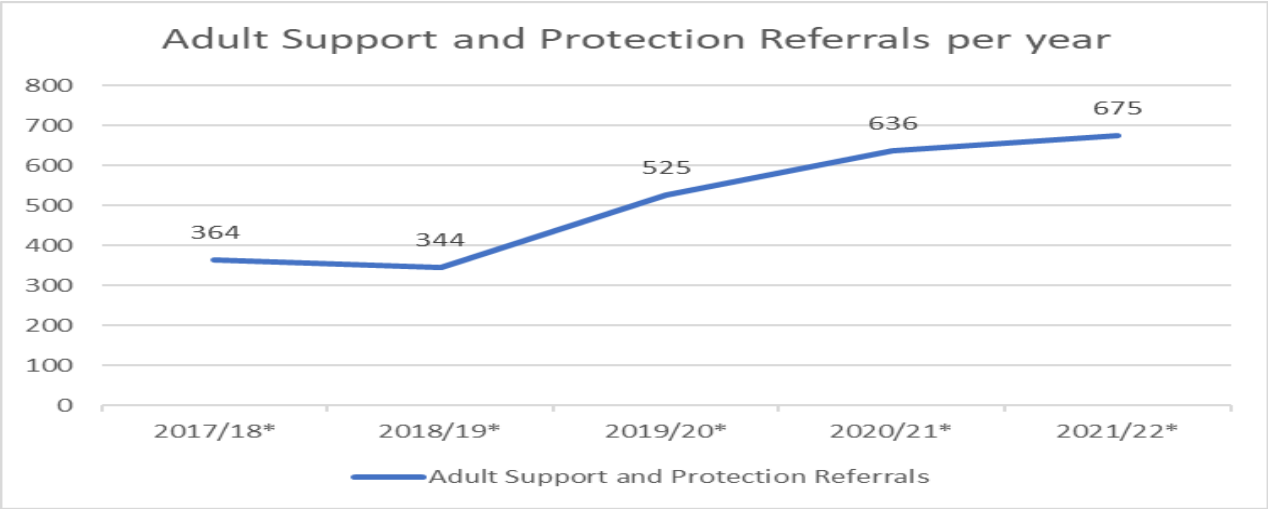

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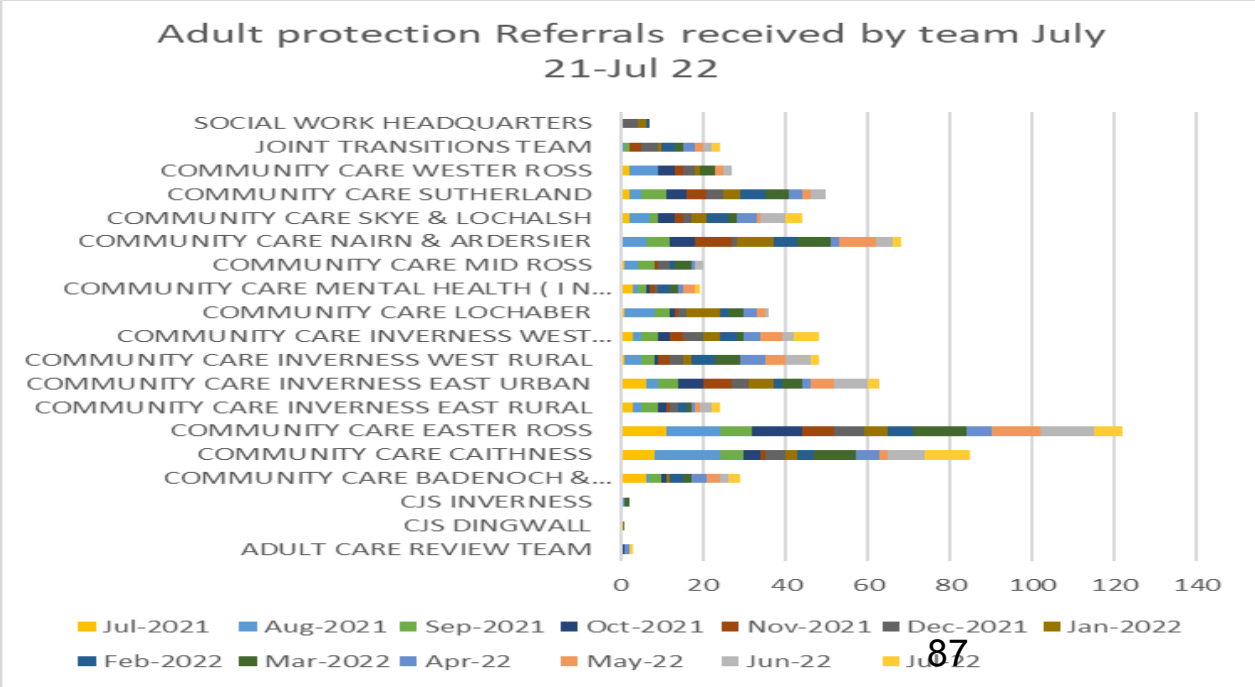


The indicators provided within this report represent the current reporting requirements for ASC. Previously, development sessions took place to discuss the requirements for a performance framework that would both provide indicators for the Adult Protection Committee and be useful to ASC leadership to 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

SBAR

HEARING AND SIGHT CARE

To seek approval from the Third Sector Project Board to award an uplift in funding to Hearing and Sight Care for the interim period 1 April 2022 to 30 September 2023, whilst the Health Board undertakes a tender exercise for adult sensory services beyond September 2023.	
Situation	Hearing and Sight Care (HSC) wrote as part of a collective with 2 other sensory providers to the Health Board on 18 January 2022 asking the Health Board to undertake a tender exercise for adult sensory services, after having exhausted negotiations. On 1 March 2022 the collective wrote to the Health Board advising that any further offer of a contract extension would require further discussion/negotiations. The Health Board wrote to each individual provider including HSC on 9 March 2022 offering to extend the provider's current contract by 18 months from 1 April 2022 to 30 September 2023, to allow the tender process to be undertaken. The Health Board further noted the provider's financial concerns during the interim period and agreed to meet with the provider to discuss any possible uplift to their existing arrangement. Following several recent meetings with the provider the Health Board is seeking agreement in principle from the Third Sector Project Board to uplift the provider's funding from £15,184.85 to £50,000.00pa (pro-rata'd for the half year) for the period 01/04/22 – 30/09/23 to allow the tender to be undertaken and ensure service continuity meantime.
Background	NHSH currently commissions sensory services under contract from the following 3 providers: Sight Action, Hearing and Sight Care and Lochaber Sensory Care. During 2019, NHSH worked in partnership with the 3 providers, along with other key partners to develop the Highland SEE HEAR Strategy, in line with the National SEE HEAR Strategy. The Scottish Government confirmed that the strategy is to be used as guidance; and that there is no specific delivery model, recognising that local partnerships will adopt different approaches and the level of pace and progress will accord with local priorities. The providers were advised at the time that the Highland Strategy would underpin/inform future commissioning and procurement of community based sensory services in Highland. During 2019 NHSH notified the providers of its intention to undertake a procurement exercise for services beyond June 2020. At that time Sight Action served notice on NHSH, and proceeded to commence a pro-active media/MSP campaign. During 2020 NHSH Senior Management met with representatives of Sight Action and proposed by way of compromise that the provider draft/submit a proposal with costings for delivery of future services, for consideration. In light of this, Sight Action rescinded their notice on NHSH and a "collective" proposal from all 3 providers was received by

	NHSH. The providers' proposal further included estimated budgets for the next few years, which are significantly greater than current funding levels. All parties met during late 2020 to discuss the proposal, at which point the collective asked for more clarity on NHSH's requirements, to enable them to refine their proposal and costings. During early 2021 NHSH provided the collective with its service delivery requirements, with the further intention of discussing them in more detail at a meeting with the collective, planned for mid 2021. The meeting was cancelled by the collective and since then NHSH's operational staff have on a number of occasions sought to hold meetings with the collective to progress matters. The collective have on each occasion opted instead to write to/meet with NHSH's Chief Officer (HHSCP)/Deputy Chief Executive, where more recently they stated they are unable to work with the Operational Team members progressing matters. In an attempt to move matters forward constructively, all parties agreed to attend a workshop during December 2021, facilitated by NHSH's Head of Strategy and Transformation (HHSCP). The workshop provided the opportunity for all parties to openly discuss working in collaboration; NHSH's future service delivery requirements, including areas in/out of scope and to hear the reasons for this; and provide clarity, where required. It was hoped that this clarity would then allow the 3 collective providers to refine their collective proposal and associated costings accordingly and continue with negotiations. Unfortunately, following the workshop and the provision of further information requested during the workshop regarding integrated locality teams and confirmation of flexible service delivery models for sensory services from Scottish Government the 3 providers (as a collective) wrote to NHSH on 18 January 2022 stating that they had exhausted the negotiating process and collectively feel that there is no merit to further debate; and as a collective requested that NHSH create a tender document on which they can tender and price. NHSH wrote to the providers individually (due to current contractual arrangements) on 9 March 2022 offering to extend the provider's current contract by 18 months from 1 April 2022 to 30 September 2023, at current funding levels to allow the tender process to be undertaken. The Health Board further noted the provider's financial concerns during the interim period and agreed to meet with the provider to discuss any possible uplift to their existing arrangement. The Health Board's Chief Officer along with Operational and Contract Team staff met with the provider on 31 March 2022 to clarify that the Health Board's expectation was for current service continuity to be maintained meantime i.e. not an expansion of service; and any request for an uplift should be based on current contractual requirements. The Health Board sought clarification of the provider's financial position; requested information (financial and service delivery) from the provider around the level of uplift funding sought, with evidence of need.

	Further follow-up meetings were held on 13th April and 3rd May 2022 to discuss the position/information received. It is further highlighted that a similar meeting is due to be held with the remaining sensory provider Sight Action. It is likely that a similar request for a short term uplift may be presented for approval in the near future.
Assessment	Over the years, and other than a reduction in funding of 5% over 18 months during 2011-2013, the provider has continually received annual standstill funding; whilst their service delivery costs have continued to rise. It is also worth noting that the provider is a non-registered service and as such does not currently qualify for any of the Scottish Government uplifts awarded to registered services. The Provider is contracted to deliver a drop in service with outreach providing sensory information, advice and sensory aid maintenance and repair, including providing batteries for hearing aids supplied by the Health Board. The provider is also required to undertake hearing assessments. Service delivery area is Caithness. The Provider further receives a small amount of funding (less than £5kpa) from Sight Action towards rent and a member of staff for delivery of sight services on behalf of Sight Action. The member of staff is currently funded by funding from The Robertson Trust (due to end August 2022) topped up by the monies from Sight Action. As well as the NHSH contracted service, the Provider also delivers charitable services e.g. Lip Reading funded from other sources and which account for approximately 15% of services delivered. The provider has estimated expenditure of approximately £78k for the period 1 April 2022 – 31 March 2023. The provider's costings include significant increased salary costs (by approximately 7%) to align with COSLA salary scale, plus a 6.2% inflationary uplift across all other areas of their costs. In line with the Procurement legislation and the Health Board's Standing Financial Instructions, funding of this level would require the Health Board to give further consideration to undertaking a procurement exercise due to the value being over the £50kpa threshold. Financial submissions by the provider to OSCR/Companies House over the last few years shows an average expenditure for their whole service of approximately £60kpa. To maintain current service continuity whilst the tender process is undertaken the Health Board has offered to uplift the providers funding from £15,184.85 to £50,000.00 (pro-rata'd for the half year) for the period 1 April 2022 to 30 September 2023. This provides funding for salaries, travel and overheads. The Health Board has further advised the provider that it intends to resume quarterly monitoring of the contract during the interim period, to provide reassurance in light of the significant uplift being offered.

	The provider confirmed acceptance of the offer on 10 May 2022, subject to support from the Third Sector Project Board and approval by the Health and Social Care Committee.
Recommendation	It is recommended that: a) Support is given for an interim uplift in funding from £15,184.85 to £50,000.00pa (pro-rata'd for the half year) for the period 1 April 2022 to 30 September 2023, to allow the tender to take place; and b) Support is given to seek agreement from the Health and Social Care Committee for the uplift stated in a).
Author	Jacqueline Paterson
Designation	Senior Contracts Officer
Date	19 May 2022

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**31st August 2022**
Title:	**Chief Officer Assurance Report**
Responsible Executive/Non-Executive:	**Louise Bussell, Chief Officer**
Report Author:	**Louise Bussell, Chief Officer**

1. Purpose

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

1. Joint Monitoring Committee

The Joint Monitoring Committee (JMC) was held on 3rd August 2022. A joint presentation was shared to provide the background and purpose of the JMC in order to support the welcoming of the new members of the committee. This was followed by assurance reports for children's and adult services and a commitment to have a single assurance report for the next committee in line with the integration agreement. Updates were also provided on Finance, the Integration Scheme Implementation and Strategic Plan.

A further presentation was given by Louise Bussell, Chief Officer on the new NHS Highland Board strategy and annual delivery plan with a specific focus on adult social care. The meeting was telecast with a subsequent members only meeting held in relation to the care home position. A further follow up committee members only meeting of the JMC is due to take place on 22nd August 2022.

2. Sexual Assault Referral Centre (SARC)

The service formally referred to as Forensic Medical Examination service is now confirmed as the Sexual Assault Referral Centre (SARC) in line with the national campaign #Turn to SARC. The Shores is the building name within Raigmore Hospital where the central SARC team are based.

The SARC building at Raigmore is now open and is being used for all examinations including paediatric cases within the Inverness and surrounding areas, all modifications to the building are completed e.g. CCTV etc and other systems to ensure chain of custody for evidence is maintained for those cases that proceed to court. The environment is 'trauma informed' for any age group. The service launched self-referral for anyone over 18 in April 2022 and have a 24-hour phone contact available for this purpose. There is one national phone number for anyone to call who has been a victim of a sexual assault for support, the details are then passed to the closest SARC to respond. There is a satellite building in Caithness which is

called 'The Northern Shores' for examinations to be carried out in our more rural areas, negating the need for every person to travel to Inverness. We are planning to develop a peripatetic service where a small team would travel out to nearer where the person lives rather than expecting them to travel large distances for examinations. Rooms in local areas will be identified for this use due to environmental monitoring and the requirement around preserving forensic evidence.

3. Highland Alcohol & Drug Partnership (HADP)

Annual Report (2021/22)

The HADP annual report submitted to Scottish Government on 5th August 2022 pending sign off from the Strategy Group on 23rd August 2022 and in-turn the Community Planning Partnership. The report will also be shared with the NHSH Board and HSCP for scrutiny and feedback purposes. The report is focused on progress with; Education and Prevention, Treatment and Recovery, Children, Young People and Families, Public Health Approach to Justice. Progress and improvement in most areas has been reported. However, HADP recognises the need for further improvement. Greater involvement of people and families with lived experience in service and policy development is a key area for improvement. The lived experience panel is developing, albeit wider and ongoing recruitment is challenging. Slippage of £110,676 is reported. Request to Scottish Government via NHSH for permission to carry slippage forward and currently awaiting a response from government.

MAT Standards National Benchmarking Report

The national report was published in June with recommendations for improvement in local ADP areas. 18/07/22 meeting with MIST (national implementation team), shadowing arranged for 29/08/22 and Quality Improvement Workshop for 30/08/22. Progress on implementation includes; Priority initial contact tool for all services (MAT Standard 3), Additional record sheet for notes to ensure easier identification of when Naloxone was offered to individuals family and friends and repeated on a regular basis, Job pack for Salaried GP/Associate lead approved for advert, Re advertise Consultant 0.6 post, Test of Change at Osprey House to focus on same day prescribing where clinically appropriate, individuals choice, Plan to provide further leadership into the prison to support MAT Standards, Housing First project in Caithness. Adverts out for health post and support worker post, Ness Engagement team (NFOD response), 2 posts to advert (Health post and support worker). Accommodation identified at New Craigs. Additional monies via MIST, albeit well below what was requested will be used to support implementation. Plans include increasing capacity in local teams (4xband 6 nurses), development of Advanced Nurse Practitioner (ANP) roles, development of GP post, Service Manager (HMP Inverness), and potentially a specialist pharmacist post if monies allocated late 2021/22 can be carried forward to 2022/23. £210,000 MIST monies allocated to NHSH in March 2022. In the absence of an integration authority, representation by made to Scottish Government NHSH for special permission to carry monies forward into 2022/23 to fund a specialist pharmacist Highland is required to report monthly on progress with embedding the MAT Standards starting Sept 2022. An Improvement Plan that includes recommendations from MIST has to be signed off by Chief Officer for end of Sept.

Drug Related Deaths (2021)

There were 35 drug related deaths in Highland, an increase of 2 deaths (33) in 2020. It is the second highest annual total on record for Highland, with 36 deaths recorded in 2018. The annual average number of deaths in Highland for the five-year period 2017-2021 is 31, an increase of 17 (126 per cent) on the 2007-2011 average of 14 deaths. The non-fatal overdose immediate response team (collaboration between Drug and Alcohol Recovery Service and Criminal Justice Social Work) will be established in the near future. The nursing and support worker post is currently advertised with plans in place to advertise the social work post.

Additional funding may be required for administrative support and management costs for the social work post located with criminal justice social work. The MAT Standards are focused on reducing drug deaths, particularly MAT 3. The priority initial contact tool introduced for all services as a test of change and an additional record sheet for notes to ensure routine identification and review of Naloxone offered to individuals, family and friends will support improvement. Work ongoing to increase downloads of HOPE App. The Drug Death Review and The Drug Death Prevention Group continue to identify and implement improvements.

New OST Treatment Target

Projections for achieving an increase of 9% in the number of people with problem opiate drug use engaged in community-based OST treatment by 2024 have been submitted to Scottish Government with planning underway to monitor and report progress.

Treatment Waiting Times Standard (Jan to Mar 2022)

76% of people accessed treatment within 3 weeks from referral against the standard of 90%. Highland has one of the highest vacancy rates (13.2%) as evidenced in the Alcohol and Drugs Workforce Survey (31/03/22). Improvements include services have recruited to vacant posts including Mid Ross and Caithness. This will provide increased capacity in more remote and rural areas where many of the challenges are in meeting the waiting time standard. Recruitment is on-going for remaining vacancies and the Drug and Alcohol Recovery Service are positive about recruitment. Some of the MIST resource will also be used to increase capacity in areas where, even at full establishment, it can be challenging to meet/maintain the standard. To increase recruitment and retention of staff, development of a wider career structure is being progressed as described in the MAT Standards update. Some Third Sector funding challenges appear have impacted on the standard. NHSH and HADP have provided resource to aid sustainability until March 2023. However, there is a need to increase the reach and range of Third Sector provision in line with national priorities and the national mission. NHSH (Contracts and Drug and Alcohol Recovery Service) in collaboration with HADP; plan to commission Highland wide alcohol and drug Third Sector service(s) to increase access and choice in local communities.

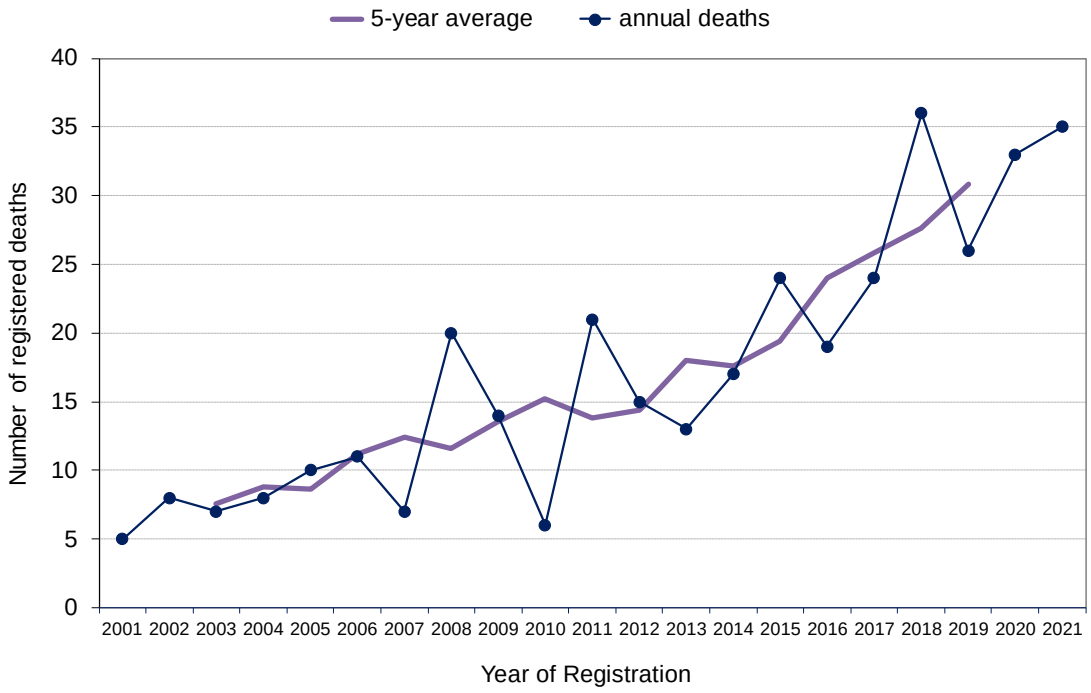
Improving Holistic Family Support

Scottish Government half day online learning event planned for 22nd September on behalf of the Children, Young People (Drug and Alcohol) Committee. The purpose of the event is to raise awareness of the policy framework and discuss implementation in Highland. Dairy date flyer distributed, but given workload related to the inspection the date may have to be rescheduled.

Performance Data Relevant to Public Protection

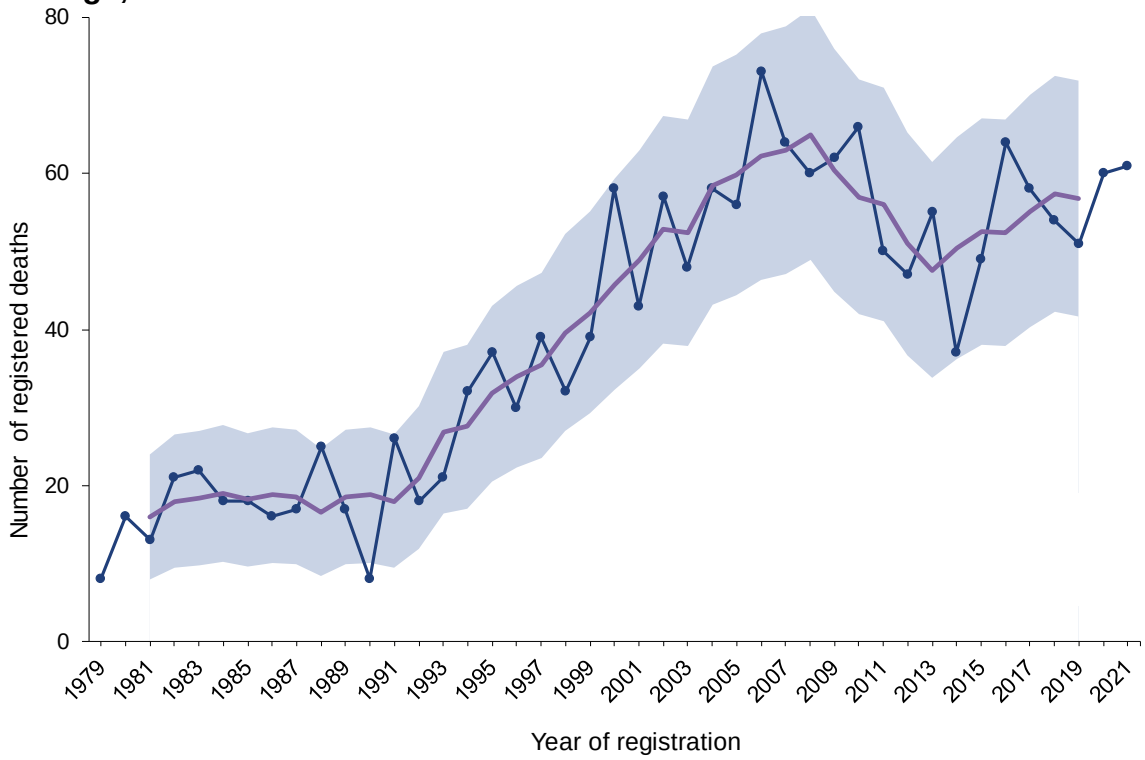
1) Drug Deaths

Number of Drug misuse deaths for Highland Council area, annual values and five-year annual moving averages; 2001 to 2021



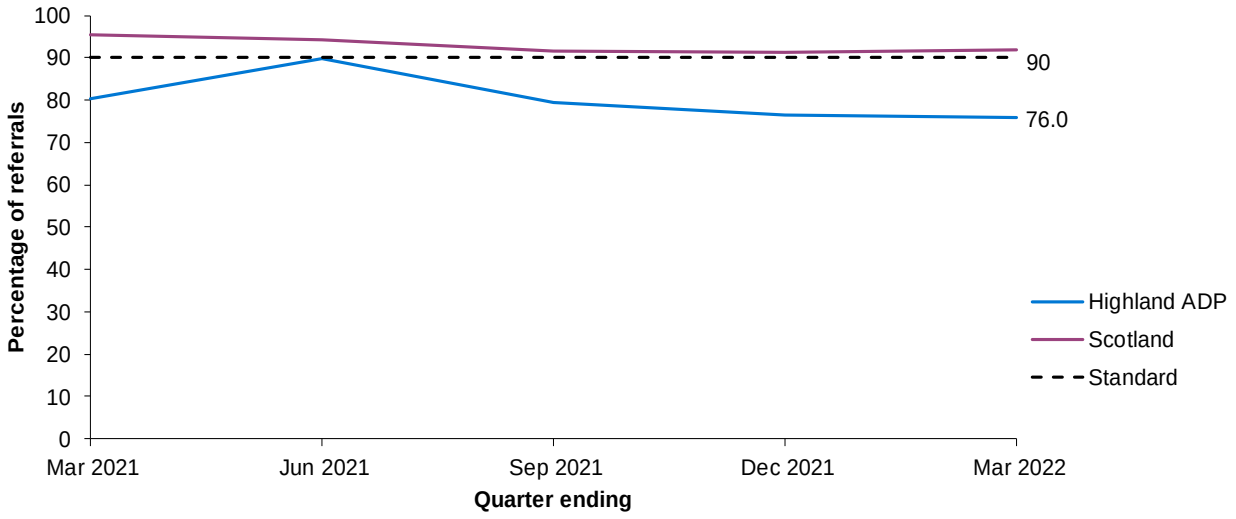
2) Alcohol Specific Deaths

Number of Alcohol-specific deaths registered in Highland Council area, annual values, five-year moving annual averages and the likely range of values around the average; 1979 to 2021



3) Waiting Times for Drug and/or Alcohol Treatment

Waiting times from referral to first treatment: performance against the standard (90%) for previous five quarters
Percentage of referrals waiting 3 weeks or less for Completed Waits; Jan 2021 – Mar 2022



4. Long Covid

NHS Highland is working closely with the Scottish Government Long Covid team and are in the final stages of planning to launch a board wide Long Covid service in the next few weeks. We are currently recruiting OT & Physiotherapy staff to support rehabilitation and are the first board in Scotland to adopt the C19-York Rehab Scale App which will assist triage and self-management. An OT is currently supporting staff with Long Covid with good outcomes.

5. Adult Social Care, NHS Highland

Key Issues, Challenges and Improvement Work
29 July 2022

- There are significant staffing pressures and fragility across commissioned 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; Covid absence (12 outbreaks across the 67 homes); and summer annual leave. Accordingly there are unmet mutual aid requests, and unmet in house service demands.

- In addition, there are significant sustainability and financial fragility issues across commissioned care home services. These pressures are considered due to:

  - the higher number of smaller size and scale of operator in Highland;
  - the National Care Home Contract fee being based on an average size of 50 beds (only 8 of 67 care homes in Highland are >50 beds);
  - the age, condition and lack of provider investment in care home stock; and
  - the trend of larger providers divesting from Highland.

- The above have been contributing factors to the two care home closures since January 2022: Shoremill (Cromarty) and Grandview (Grantown). Where there have been closures (recent and in previous years), these have been well managed to date.

- A third care home closure (Budhmor, Portree), is in progress. Due to circumstances, NHSH will be taking on temporary (6 week) responsibility for this service to safely transfer residents to Home Farm.

- Further (two) care home closures are potentially imminent and more are expected. These developments have potentially significant operational, financial risks and implications for NHSH. The Joint Monitoring Committee is considering a private item on this on 22 August 2022.

- The Care Inspectorate's approach to inspecting care homes already closing and their focus on infection prevention and control is proving a challenge. These issues / impacts are to be raised with the CI asap.

- Significant staffing pressures and fragility is also affecting in house care home and care at home services, which are experiencing similar staffing challenges. Short and longer term plans are in place to seek to release and grow capacity.

- These two priority areas of service provision (care home and care at home) are now a key focus area under a newly established programme structure, to ensure visibility and oversight.

Whilst work is being taken forward to develop longer term strategic solutions, members of the committee are advised that there are several planning horizons that need to be met at present, namely:

1. Urgent operational plans – to mitigate shortages and service failures over next days and weeks
2. Tactical operational plans – to address the foreseeable medium-term challenges, e.g. Winter
3. Strategic plans – for the next three to five years to address the significant future challenges

In terms of the latter area (point 3) significant national work is being undertaken to address the status, pay, recruitment & qualification pathways etc. This includes innovative work on new apprenticeship routes in Highland, however this work is not addressing the current immediate pressures and challenges.

In terms of activity to address current challenges, the following actions are being explored and progressed as quickly as possible, it being recognised that this activity is being actioned within a climate of extreme staff pressures to react to unrelenting requirements to support and bolster key services.

1. A Programme Board has been established for Adult Social Care. This area of work is now a formally established and managed work stream.
2. Work is being undertaken to standardise, support and better communicate recruitment opportunities within the NHS. This includes identifying a "Recruitment Champion" from within Adult Social Care. This will allow better support of recruitment fayres, links with schools etc.
3. Work is being undertaken to smooth and hasten induction processes and to develop a (mobile) Recruitment, Assessment and Induction Centre that could operate in various locations. This links with 5. Below.
4. Work is being progressed with Scottish Care to re-establish the Care at Home Development Worker post with a focus on sustainability, resilience and recruitment.

The Scottish Care will provide members with a verbal update on further developments towards a “Care Academy” at the committee.

6. Service Redesign

Caithness Redesign

The Scottish Government formally approved the Initial Agreement for the redesign of adult health and care services in Caithness in February 2022 and invited the Board to submit an Outline Business Case (OBC). This is an ambitious redesign of acute, community and primary care services, working in partnership with our third sector and public planning partners to deliver care as close to home as possible. It includes three major building projects; Community Hub and Care Villages in Wick and Thurso, and a reconfiguration of Caithness General Hospital.

The service model is now being developed in sufficient detail to inform workforce and accommodation requirements, and a technical analysis is underway to determine the recommended site for the Wick Community Hub. All of this will culminate in an operational and technical brief for the three building projects and appointment of design and build partner(s) to develop the designs up to planning permission stage.

Elements of the redesigned service are being tested in advance of our OBC submission, e.g. an overnight care service in East Caithness. Early indications show this is facilitating discharge, reducing hospital admissions, and providing increased choice to patients in where they receive their end-of-life care. Two step-up beds will be established in Pulteney House Care Home later this year, and we are collaborating with partner organisations through the Caithness place-based approach to develop a series of demonstrator projects.

Lochaber Redesign

The redesign of services in Lochaber has a particular focus on the acute element; the replacement of Belford Hospital. Following resubmission of our Initial Agreement in April 2022, formal approval from Scottish Government was received in July 2022. This advised that the project is not within the current financial planning cycle (to 2026) however this is under review. Preparation of the OBC is continuing so that NHS Highland are in a position to proceed should this change.

Key areas of work include the development of a core Rural General Hospital (RGH) service model and operational brief, which will inform requirements for Lochaber and Caithness General projects. A good understanding is required of the full patient pathway, including community-based services, and Lochaber is at an earlier stage in this regard. The RGH service model will be developed through an intensive series of workshops to be undertaken between now and the end of the calendar year, following which we’ll be in a position to move forward with the acute infrastructure design.

The development of the technical accommodation brief is underway jointly for the two redesigns.

7. 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.

Executive Directors Group – 22nd August 2022 Confirmation received from EDG – 22nd August 2022
8. Recommendation • **Awareness** – For Members' information only.

HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE WORKPLAN TO 31 March 2023

Standing Items for every HHSCC meeting

- Apologies
- Declarations of interest
- Minutes of last meeting
- Finance
- Performance and Delivery
- Health Improvement
- Committee Function and Administration
- Date of next meeting

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

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

• Committee Terms of Reference	
[Development Session: 29 September *Climate Change and Health & Social Care*]	
NOVEMBER	
• Adult Social Care Fees Arrangements	Provisional
• Community Health Services/AHP	
• Redesign of Unscheduled Care	
• Highland Council Commissioned Services Assurance Report	Postponed
• Mental Health Services Strategy	
• Public Bodies Annual Report	
• Assurance Report on Integration Planning	
• Engagement Framework	
[Development Session, tba: *Annual Delivery Plan / Integration Work between Acute Services and Health & Social Care*]	
JANUARY	
•	
•	
•	
•	

Added

HIGHLAND HEALTH & SOCIAL CARE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: January 2022

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.