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Annual Delivery Plan 2022 - 2023

North Highland

Plana Libhrigeadh Bliadhanail

Argyll & Bute

NHS Highland

Lead Author: Lorraine Cowie, Head of Strategy & Transformation
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Introduction from Pamela Dudek, Chief Executive of NHS Highland

I am delighted to introduce this Annual Delivery Plan (ADP) as Chief Executive of NHS Highland.

As we come out of the pandemic, we are facing some of the most challenging times that Health and Social Care services have ever seen. As an NHS Board who hold responsibilities for the delivery of Adult Social Care in the Highland council area alongside our NHS services across Highland and Argyll and Bute, we have much to consider in ensuring we have the right services in place looking ahead. There is much to do in reshaping our health and care services across our communities as well as ensuring good access to urgent and unplanned care alongside the requirement to reduce waiting times. We need to improve services by rethinking, alongside our staff and our communities, how to deliver the best we can with the resources we have available within our organisation. We also need to understand where we can do better by working with key partners in building our future across the vast geography that is Highland and Argyll and Bute council areas that cover 42% of Scotland's landmass including 36 Islands. We will work as a key partner in the integration space with our respective councils and the Integration Joint Board in Argyll and Bute.

This plan works hand in hand with our new Together We Care 5 year strategy to set out the priorities in each of our strategic outcomes, setting out our intended delivery plan over the next five years. Again, we have taken cognisance of the Argyll and Bute Integration Joint Board Strategic Plan ensuring we are supporting the delivery through our joint arrangements.

- Our mission - Anchor with our communities to support their health and wellbeing.
- Our vision - Outstanding care delivered by an outstanding team.

To deliver our mission and vision we have 3 strategic objectives:

- Population – deliver the best health and care outcomes for our population
- People – be a great place to work for our people
- Partnership – create value by working in partnership to transform the way we deliver health and care

The journey moving forward will be, I am sure, full of challenge and uncertainty however it is incumbent upon us as an organisation to have a clear direction of travel and those who work within it, to learn and develop working collaboratively with our key care partners and communities.

The best chances of success will come from this effort and our ability to work across different boundaries to deliver the best care and treatment possible with people. This is still relatively new in terms of how we work so there will be much learning along the way, the answers to the future lie beyond the NHS as an individual organisation and we must consider well how we achieve this. Transformation and change are easy words to say but much more difficult to realise, we know that there is much more opportunity in health and care through the use of digital means but again this requires exploration, debate and connection to communities, so we are all understanding and part of the change we seek to make.

This plan brings together an important part of the jigsaw but is by no means the end, we must check and recheck the possibilities as we go forward, developing and learning.

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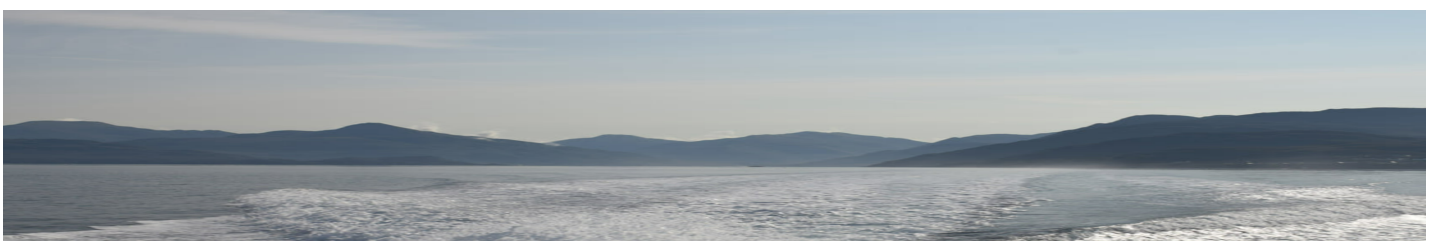
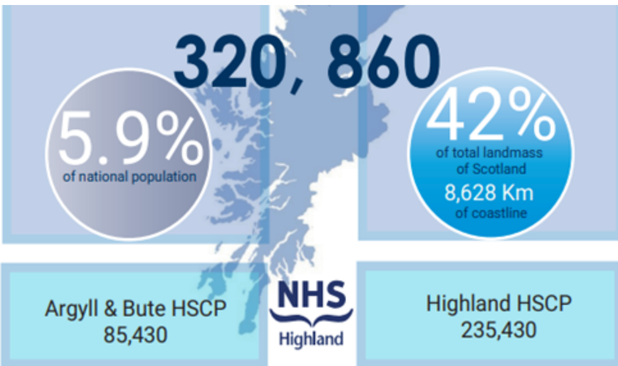
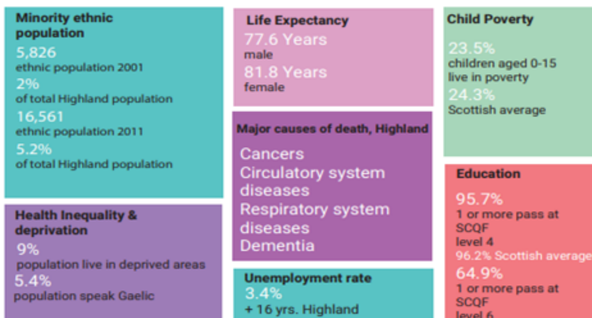


Overview of NHS Highland





When considered by geography, NHS Highland is both the largest and most sparsely populated health board in Scotland. NHS Highland spans a huge geographical area covering 32,566 square kilometres and accounting for 42% of Scotland's land mass.

NHS Highland is one of fourteen territorial boards and employs 10,745 people making it one of the largest employers in the Highlands. NHS Highland provides health and social care services to our resident population of approximately 320,000. The Health Board includes two local authority areas, Highland, and Argyll & Bute. The area is predominantly rural with many populated islands which provides challenges in relation to both the provision of, and access to, services. Our diverse area includes Inverness, one of the fastest growing cities in Western Europe and 36 populated islands - 23 in Argyll & Bute and 13 in Highland (excluding Skye which is connected to the mainland).

Integration of health and social care has developed in two differing strands across NHS Highland. The Highland Health and Social Care Partnership adopted a lead agency model where all staff engaged in Adult Social Work and Social Care transferred employer to NHS Highland. By contrast an Integrated Joint Board supports and oversees the provision of integrated care services in the Argyll and Bute Council area. Workforce planning is carried out at Integrated Joint Board level.

NHS Highland Acute services covers 4 Acute Hospitals, including Raigmore Hospital in Inverness and 1 Acute Mental Health Hospital. Highland Health and Social Care Partnership has 20 Community hospitals and 98 GP practices. There are 69 care homes across north Highland covering all client groups. 53 of these care homes are operated by the independent sector and 16 are operated in house. A significant proportion of independent sector care homes in north Highland (43%) are operated by small scale providers, who collectively deliver 581 beds and whose average size of care home is 27 beds. Whilst this smaller scale provision reflects Highland geography and population, it presents increased financial sustainability vulnerability risks.

There is a significant reliance in Highland on 3 providers (Meallmore, Crossreach and Parklands) who collectively operate 17 care homes and deliver a third of all care home beds in Highland.

Current Context

This final draft Annual Delivery Plan (ADP) and associated Delivery Planning Template is submitted to Scottish Government as supporting narrative setting out our integrated approach and current position on activity, quality, workforce, and financial planning. The plan has been developed in alignment with our new strategy "Together We Care, with you, for you" and through open, collaborative working with our population, people, and partners across our system. We have incorporated applicable Remobilisation Plan (RMP) deliverables into our ADP as appropriate, aligning with our new approach.

We have worked together to achieve shared priority setting and our plan reflects the following position in July 2022:

- Clarity and ownership of embedding quality priorities delivered through quality improvement frameworks will be essential as we emerge from the pandemic to improve outcomes for our population
- Creating full understanding of our strategic workforce challenges, the actions we need to take to address them, and in-year workforce plans aligned to finance, activity and quality with robust accountability for managing expenditure
- Commitment to continue to drive sustained or improved performance in core access aligned to proposed performance trajectories managed within our NHS Highland Performance Framework
- Financial targets being realised with ownership at all levels throughout the organization with clear accountability and responsibilities
- We will work in partnership with partners and other Boards and providers in the system to work up and deliver plans to increase value
- We have worked with our population, people, and partners to develop this ADP in collaboration so everyone can see their "service" in it and how they fit in to our overall objectives and outcomes as we emerge from the pandemic

Our strategic priorities are:

- **Our Population**: To deliver the best possible health and care outcomes
- **Our People**: Be a great place to work
- **In Partnership**: Create value by working collaboratively to transform the way we deliver health and care
- **Perform & Progress Well**: Core activities providing golden threads throughout our system that support the delivery, resilience and sustainability of our services supporting our strategy and our annual delivery plan
- **Enable Well:** Ensuring the organisation is transformational and with clear lines of governance and assurance processes to support delivery of high-quality health and care services for our population

We are committed to addressing the aspects of care that matter most to our population during 2022/23, we will ensure we remain dynamic to the changing needs of our patients and significant changes within both the national and local planning environment and will continue to review.

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Our new five-year strategy, with its associated governance and delivery framework will drive strategic decision-making, support implementation plans and ensure a proactive approach to influencing and assessing strategic reviews over 2022/23 and beyond. This approach will support progress towards the objectives set as well as the vision of the "anchor" and provide us with a significant opportunity to progress our strategic priorities at pace by working together with our partners to resolve some of the system-wide challenges we face.

National Treatment Centre, Highland (NTCH)

This Centre will be part of a network of nine regional treatment centres for planned elective procedures and diagnostic care across Scotland, over the next 5 years, announced by the Scottish Government to help meet capacity constraints in specific specialties. Opening of the NTC in NHS Highland will have a significantly positive impact on our orthopaedic and ophthalmology waiting times. The NTCH will provide a full range of Ophthalmology services and Primary Hip and Knee elective orthopaedic surgery and a dedicated range of Foot & Ankle and Hand procedures. The NTCH will have 24 beds and five operating theatres and is planned to open on 3 April 2023.

In 2023 the NTCH is planning to operate on 3,160 Cataracts, 1,340 Eye Procedures, 1,500 Primary Hip and Knee Joints, 160 Hand Procedures and 175 Foot & Ankle procedures and will contribute significantly to reducing waiting times in NHS Scotland. A full Operational Delivery Plan has been produced to describe the plans for the remainder of 2022/2023.

Integrated Service Planning

NHS Highland has developed an integrated service planning approach to align our workforce demand plans to our clinical outcomes, financial resources and availability of skills and experience. An organisation wide programme has been drafted to assure a whole system modelling approach in NHS Highland. Previous Annual Operational Plans and Remobilisation plans, workforce plans, and financial plans have been presented largely in isolation. In developing integrated service planning, we aim to ensure NHS Highland is delivering the right services, at the right time, with the appropriate workforce capacity and within its financial means. To do this, we will improve our understanding of what services are currently delivered, to inform what we need to deliver in the future.

Our integrated planning process aims to:

- Improve patient outcomes and safety, including increasing quality and the equality of service access
- Have a clear line of sight to national standards and recommendations from Royal Colleges and other professional advisory bodies
- Deliver the NHS Highland's Together We Care Strategy (which inclusive of our other strategies)
- Support NHS Scotland's Recovery Plan and associated Annual Delivery Plan

Initial engagement with two pilot services is underway as well as planning a phased roll out across all our health and social care services across 2022 and beyond.

In the next year NHS Highland will explore approaches to enable joint working with independent sector providers of social care to support them with workforce planning ensuring a coordinated approach to the provision of robust, safe, and reliable commissioned services.

Risks and Challenges

We have established a clear governance route through which to identify, assess and manage significant risks that may threaten the achievement of our strategic objectives, and this will continue to be evaluated and strengthened as part of the implementation of our new five-year strategy. This will include the development of a new Strategic Risk Register that the Board reviews on a bi-monthly basis.

There are several challenges and risks which this plan aims to reduce or mitigate the impact however it should be noted that some of these are not within our control and may impact negatively on our ability to achieve our outcomes:

Unscheduled Care Demand – We have ring fenced beds in our system for day case surgery to protect planned care in July 2022 however we are still experiencing a high demand for unscheduled care that is meaning many our population who are medical admissions are being placed in surgical areas. We continue to look at the prioritized areas through the urgent and unscheduled care collaborative and are taking a refreshed approach to redesign of the front door, reviewing our community and social care impact to prevent unnecessary admission or reduce delays in discharge. In order to deliver the standard that no one will wait over 2 years for planned care, we will require additional support from external sources to deliver this given our geography and infrastructure which is limited.

Social care / Care Homes – Care Home and Care at Home capacity and sustainability are significant challenges. We are also developing our social work services across Highland as part of our integrated service development. In relation to care homes, we have carried out a risk assessment of our current position which has identified a number of areas of vulnerability across all areas of Highland. Partnership working with the Highland Council will be key, given the instability of the sector and the high risk implications of this. Recruitment and retention of staff is a significant concern across all areas of social care.

Workforce sustainability – Recruitment and retention is becoming an increasing challenge due to the age profile of our workforce along with national shortages in key professions and the ability to find sufficient available housing across our Board area. These are detailed at a more individual level within our workforce plan however workforce supply for social care along with key clinical and professional posts is a significant concern locally and nationally, with NHSH in the unique position of directly employing adult social care colleagues rather than the Highland Council.

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Financial Balance - We have not been able to set a balanced revenue budget for 2022/23. Compounding this is the additional energy charges, uncertainty of pay awards, net zero carbon impact and continuing COVID costs. We have a cost improvement programme in place to partly mitigate these pressures, but it will not be significant enough for the Board to achieve financial balance in the coming year.

COVID (Impact on acute and COVID absence) – We have our system escalation framework that we put in place should we be facing pressure. Along with intelligence this provides a basis for managing this and developing a system wide response. Our vaccination programme is in place and is being rolled out across our population.

Pandemic (Burnout of our workforce) – Our colleagues have experienced high levels of pressure for many years and this has significantly increased since the beginning of the pandemic. Central to our ADP and Together We Care is supporting colleague health and wellbeing to stay both mentally and physically well and to support recovery when unwell, building on all of the good work done through our Recovery Plan.

Infrastructure (Maintenance) – We have considerable backlog maintenance issues, and our buildings are ageing. Over the next year we will develop our infrastructure strategy co-produced with our population to ensure we understand the impact on building and use of our community assets to help inform future development plans.

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Performance Framework

We have an NHS Highland Performance Framework which was adopted in July 2022. A Decision-Making Framework is being developed to complement this to allow decision making at the right level with appropriate escalation. Together We Care and this Annual Delivery Plan will bring together our strategic objectives, outcomes, and priorities. This will help structure our performance oversight through the Performance Oversight Board. Each Programme Board has dedicated support to enable this to be executed across our system.

Each programme board has a dashboard that is either in place or being developed and will encompass performance (finance/targets), workforce overview and quality standards. Corresponding key performance indicators will be reviewed by the governance committee and embedded in our Integrated Performance and Quality Report which gets submitted to the Board bi-monthly for assurance.

An overview of this is below and how it integrates into the organisation.

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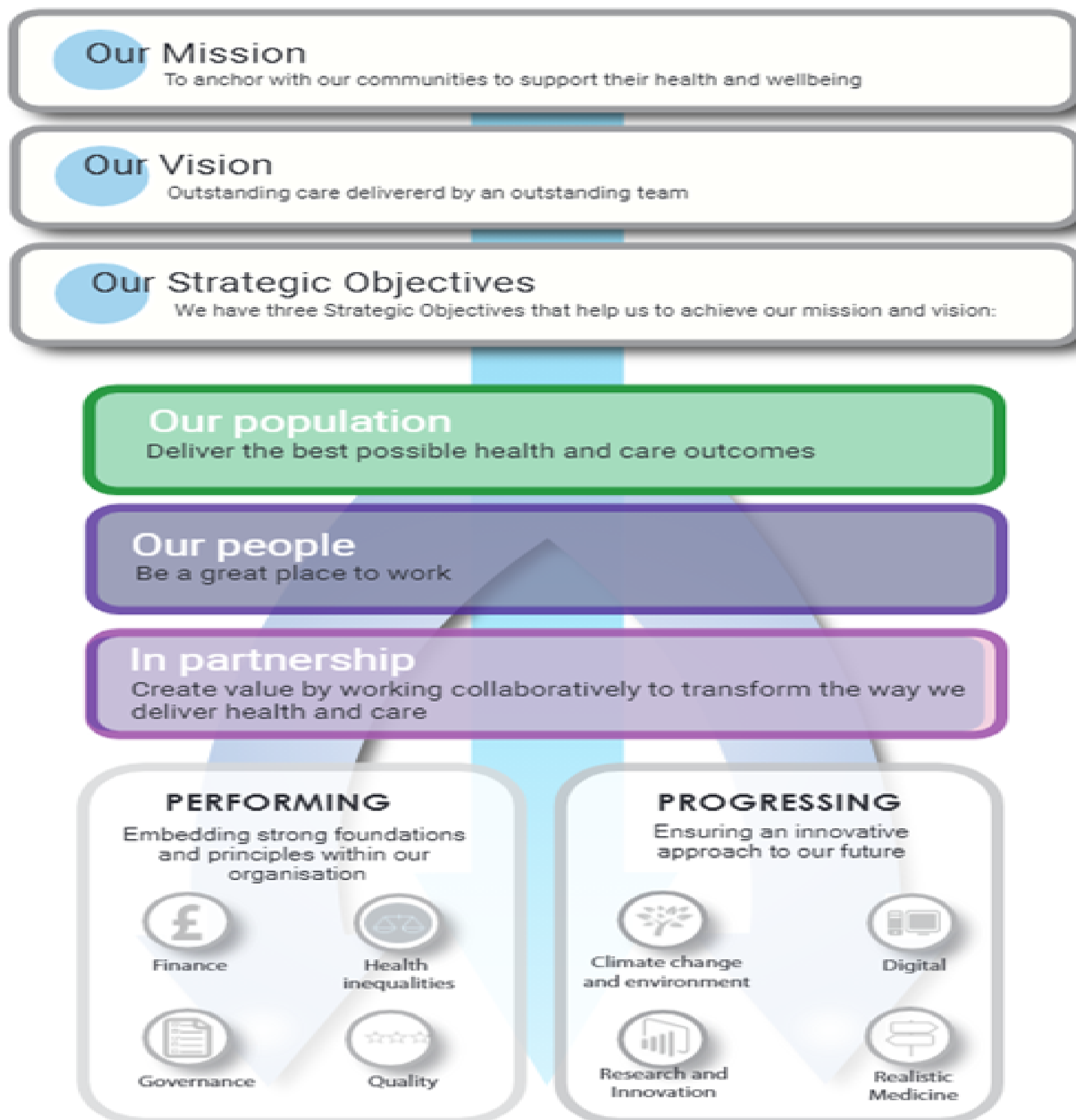
Together We Care, with you, for you

In order to adapt to our current and anticipated pressures we have widely collaborated and engaged across our colleagues, our partners and our communities, to develop our 5-year Strategy: Together We Care, with you, for you. Each strategic objective has a clear set of outcomes and priorities that form the basis of implementation of our strategy. Each outcome has 3 priorities, developed and refined during the consultation and engagement process. These make up key content of the Annual Delivery Plan. Through our lead agency model and our close working with Argyll & Bute Integration Joint Board, where applicable, we are working together to achieve the priority areas, and these are indicated by the logos throughout. The following pages give an overview of each strategic objective with the associated outcomes and priority areas.

The following is our strategy at a glance:



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Strategic Context - Our Strategic Outcomes

To deliver on each of our strategic objectives we have developed a set of 16 strategic outcomes and our perform, progress, and enable well areas. Each of these will be underpinned by the Annual Delivery Plan that will help us move towards achieving our vision and mission. These outcomes set out the direction for the next five years in relation to providing care closer to home, delivery of sustainable care, and putting our population, their families, and carers at the centre however this ADP focuses on year 1.

The outcomes follow the life cycle from cradle to end of life using holistic care provision and whole system working. As detailed in our Together We Care Strategy these outcomes were determined through consultation and engagement with our communities, partners and colleagues.

No	Outcome	Description	Main Service
1	**Start Well**	Give every child the opportunity to start well in life by empowering parents and families through information sharing, education, and support before and during pregnancy	Maternity & Neonatal Services / PNIMH
2	**Thrive Well**	Work together with our families, communities and partners by building joined up services that support our children and young people to thrive	CAMHS / NDAS / Corporate Parenting / Integrated Children's Services / Paediatrics
3	**Stay Well**	Work alongside our partners by developing sustainable and accessible health and care focused on prevention and early intervention	Public Health / Sexual Health / Gender Identity / Women's services
4	**Anchor Well**	Be an anchor and work as equal partners within our communities by designing and delivering health and care that has our population and where they live as the focus	Public Health / Comms & Engagement
5	**Grow Well**	Ensure that all colleagues are supported to be successful in their role and are valued and respected for the work they do. Everyone will be clear on their objectives, receive regular feedback and have a personal development plan.	People & Culture / All services
6	**Listen Well**	Work in partnership with colleagues to shape our future and make decisions. Our leaders will be visible and engage with the wider organisation, listening to, hearing, and learning from experiences and views shared	People & Culture / All services
7	**Nurture Well**	Support colleagues' physical and mental health and wellbeing through all the stages of their life and career with us. We foster an inclusive and kind culture where difference is valued and respected	People & Culture / All services
8	**Plan Well**	Create a sustainable pipeline of talent for all roles, and excel in our recruitment and onboarding, making us an employer of choice both locally and nationally	People & Culture / All services

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9	**Care Well**	Work together with health and social care partners by delivering care and support together that puts our population, families, and carers experience at the heart	Adult Social Care
10	**Live Well**	Ensure that both physical and mental health are on an equal footing, to reduce stigma by improving access and enabling all our staff in all services to speak about mental health and wellbeing	Mental Health Services
11	**Respond Well**	Ensure that our services are responsive to our population's needs, by adopting a "home is best" approach	Urgent and Unscheduled Care Services
12	**Treat Well**	Give our population the best possible experience by providing person centred planned care in a timely way as close to home as possible.	Planned care and support services
13	**Journey Well**	Support our population on their journey with and beyond cancer by having equitable and timely access to the most effective, evidence-based referral, diagnosis, treatment, and personal support	Cancer services
14	**Age Well**	Ensure people are supported as they age by promoting independence, choice, self-fulfillment, and dignity with personalised care planning at the heart	AHP services / Dementia / Long Term Conditions
15	**End Well**	Support and empower our population and families at the end of life by giving appropriate care and choice at this time and beyond	Palliative and End of Life Care Specialist and Community Services
16	**Value Well**	Improve experience by valuing the role that carers, partners in third sector and volunteers bring along with their individual skills and expertise	Carers / Third Sector / Volunteers
17	**Perform Well**	Ensure we perform well by embedding all of these areas in our day-to-day health and care delivery across our system	Quality / Health Inequalities / Financial Planning / Governance
18	**Progress Well**	Ensure we progress well by embedding all of these areas in our future plans for health and care delivery across our system	Digital / Research & Development / Climate / Realistic Medicine

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Implementation Timeline of Strategy through Annual Delivery Plans

A key priority for NHS Highland in 2022/23 is developing the "basics" or recovery plans to support our 16 strategic outcomes, to help meet our objective of delivering the best care and outcomes for our aging and growing population. This ADP is year one of the implementation of our strategy.

Outcomes & Priorities for the Annual Delivery Plan

The following describes how we have set out our Annual Delivery Plan, it is comprehensive and covers all aspects requested as well as incorporating our strategy, Together We Care.

The following sections give the following for each of our 16 outcomes:

- Section 1 - The overall outcome we want to achieve in 2027 aligned to our strategy
- Section 2 – Who worked together to create the ADP and who will work together to achieve it
- Section 3 - The impact implementing this outcome will have on reducing health inequalities
- Section 4 - The quality standards, policies and guidelines that will be reviewed mainly through clinical governance as an indicator of our quality and population experience
- Section 5 – Key priorities applicable to this outcome for workforce or financial planning considerations aligned to the financial plan and workforce plan
- Section 6 – Each of the priority areas (3 in each outcome) to move toward our overall outcomes with a specific table detailing what actions we will take over the next 12 months

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Outcome 1 – Start Well

Give every child the opportunity to start well in life by empowering parents and families through information sharing, education and support before and during pregnancy

Working Together to Achieve Outcomes and Priorities
Maternity & Neonatal Services Mental Health Services Pre-Conception Services including Primary Care, Gynae, Fertility, sexual health services Public Health - Health Improvement and Screening

Impact on Reducing Health Inequalities

- For those who are pregnant, especially from vulnerable groups, they are offered maternity care that is tailored to their individual circumstances. Continuity of carer is key which is a key focus of this ADP. Targeted support for smoking cessation is key.
- Improvements in the quality and accessibility of the information made available about choices during pregnancy and labour to enable people to self-advocate for the birth experience they want
- All birth workers are continuously educated about the signs and symptoms of perinatal mental health disorders across all birthing population with recognition of those who may be at greatest risk.
- Improving breastfeeding rates in lower socioeconomic groups and young parents can play an important role in reducing health inequalities. Increased physical activity in children focused on those in lower socioeconomic groups will reduce obesity in those most at risk.

Quality Standards, Guidance and Policies to Improve our Population Experience

- SPSP Maternity & Children Quality Improvement Collaborative
- Neonatal Care in Scotland: A Quality Framework
- The Best Start: Five Year Plan
- Pregnancy and newborn screening standards
- Child Poverty Act (Scotland) 2017

Workforce Planning - Specific Priority Areas Identified

Action	Outcome
Create a workforce plan that supports maternity & neonatal services	Sustainable and resilient service with appropriate staffing levels to support our population
Work collaboratively with National Education Scotland (NES)	Improve recruitment and retention to key clinical and professional posts

Financial Planning – Specific Priority Actions

Action	Outcome
Ensure we have financially planned for the additionality from the Moray networked model	Appropriate levels of funding received to implement workforce model and refurbish the infrastructure

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Outcome 1	Start Well
Priority 1a	Empower parents and families through support and information to see the benefits of choosing to eat well, being a healthy weight and being physically active from pre-pregnancy to later life

Action	Outcome	Measuring success or target
Pre-pregnancy support to help make informed decisions	Better information and universal approaches to women	More women on a green pathway
Increase breastfeeding training	All relevant professionals trained Breastfeeding attrition rate reduced	90% <32.4%
BFI accreditation	Gain stage 2 UNICEF BFI accreditation	Scope actions to meet criteria and assess position
Healthy weight interventions	Commissioned and piloted child healthy weight interventions with third sector partners and Local Authorities	No. completed increased from baseline
Supplementary feeding reviews and VitD rollout	Review feeding supplementation (incl. colostrum harvesting) at hospital maternity units	No. of feeds 95% Vit D
Increase levels of physical activity in children and young people	Working with our partners we will review our plans for increasing levels of physical activity in children (specifically with play) and young people	No. of people engaging No. of referrals made

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Outcome 1	Start Well
Priority 1b	Improve the access and quality of post pregnancy care, especially within vulnerable groups, to improve infant health outcomes and the development of strong parent-child relationships

Action	Outcome	Measuring success or target
Referral Pathways	Treatment commenced within 72hrs (Urgent) or 2 weeks (non-urgent) Develop referral pathways for women with Mental Health illness in the Perinatal period	Number of referrals Appointment types Treatment within 72hours (urgent) Treatment within 2 weeks (non-urgent) Lived experience surveys from Maternal Voices and team MNPI Number of referrals from maternity unit from PMS
Develop accessible parent and family material	Service users have immediate access into correct service & treatment commenced within 72 hours (urgent) and 2 weeks (non-urgent)	Treatment within 72hours (urgent) Treatment within 2 weeks (non-urgent)
Staff Supervision and Support	Woman & Partners will report positive experiences of the support and care they and their infant receive	Training % of staff up to date with required training from local source
Pre-conception services	Refreshed Pathways and referral criteria into services. Score Card developed to report to PNIMH Workstream	How many women have access to a pre-conception assessment service Preconception data in referral pathway measures
Assessment & facilitation of mother-infant relationships	Women will have access to assessment and facilitation of mother-infant relationship in context of maternal mental illness	How many women receive facilitation
Pregnancy and Newborn Screening Programme	Delivered to standards	Increased number of screenings performed

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Outcome 1	Start Well
Priority 1c	Ensure that we implement all recommendations of best start and ensure parents and families have the best care experience possible throughout pregnancy and birth

Action	Outcome	Measuring success or target
Implementation of Best Start	Best Start strategic ambitions /outcomes are fully embedded and expected as part of service delivery. Continuous improvements made when necessary	Best Start implementation level-50%
Data Improvements	Learn and improve from the building process to single out sources of failure	Standardise how data is input in Badgernet. Standard processes in place: Y/N
Continuity of Carer	Monitor adherence of SOPs through performing audit of service	Develop SOPs for standardisation of delivery of continuity of carer. Compliant to Best Start definition of Continuity of Care
Quality Measures	Funding allocated to support work and utilised methodically to advance implementation. Decisions are intelligence led	Ensure Best Start and all quality intelligence are included in Maternity & Neonatal Dashboard
Post-Natal Transitional Care	Develop post-natal transitional care in Raigmore by scoping potential sites for this	Ward occupancy LOS Foetal medicine prescribing Patient feedback - TBC % of babies going home early with plan for support at home
Skin to Skin	Raise awareness of skin to skin contact in NNU	Babies receiving skin to skin in NNU
Kangaroo Care	Introduce recording to identify extent of skin to skin/Kangaroo care in NNU	% of babies receiving kangaroo care

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Outcome 2 – Thrive Well

Work together with our families, communities and partners to build joined up services that support our children and young people to thrive

Working Together to Achieve Outcomes and Priorities	
Public Health Maternity & Neonatal Service Peri-Natal Infant Mental Health Service Child & Adolescent Mental Health Service Neuro-Developmental Assessment Service	Paediatric Acute Services Allied Health Professionals Sexual Health Services

Impact on Reducing Health Inequalities

- The Promise Implementation Plan sets out our actions and commitments to Keep the Promise for care experienced children, young people and their families. It contributes to our ambition / outcome for every child in Scotland to grow up loved, safe and respected so that they realise their full potential. With full implementation it is envisaged it will remove inequalities for this group of children
- COVID-19 pandemic has had a significant impact on children and young people, and a disproportionate impact on those who experience disadvantage. By implementing the Corporate Parenting Plan this will aim to reduce health inequalities as part of our statutory duties
- A range of services and organisations, including the NHS and public health services, local authorities, schools, adult education, youth justice, drug and alcohol services, and voluntary and community groups will work together to reduce inequalities and improve child and adolescent mental health through an agreed implementation plan targeted at those in greatest need
- Failure to implement national service specifications will result in an inequitable service for patients in NHSH

Quality Standards, Guidance and Policies to Improve our Population Experience

- Quality Standards for Paediatric Audiology
- Child & Adolescent Mental Health: Service Specification
- Emergency Care Framework for Children and Young People in Scotland
- Delivering a Healthy Future
- Ready to Act: A transformational plan for AHPs
- National neurodevelopmental specification: principles and standards of care
- HIS Bairns Hoose Standards
- Congenital Heart Disease Standards (forthcoming publication)
- Child Poverty Scotland Act (2017)
- Best Start, Bright Futures
- Transitions of Young People with Service and Care Needs Between Child and Adult Services in Scotland
- Intensive Family Support (Whole Family Support)
- Children and Young People (Scotland) Act (2014)
- Equalities Act
- Perinatal and Infant Mental Health MCN `Delivering Effective Services` Report Recommendation
- Getting It Right For Every Child (GIRFEC)
- National Guidance for Child Protection in Scotland 2021

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Workforce Planning – Specific Priority Actions

Action	Outcome
Create and support CAMHS to develop a workforce that supports different professionals	Fully embedded services that reduce waiting times with the right professionals in place
Public health	Ensure resilient support service
NDAS	To improve access times
Medical & Community Paediatrics services	Ensure sustainable and resilient service
Childrens AHPs	Work together with Highland Council to ensure access and transition
Sexual Health Services	Support choice with women who are vulnerable

Financial Planning – Specific Priority Actions

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings through Integrated Service Planning	Contributory to the organisation's ambition to achieve financial balance

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Outcome 2	Thrive Well
Priority 2a	We will work collaboratively to deliver #Keepthepromise to play our part in giving every child in Scotland the chance to grow up loved, safe and respected so that they realise their full potential

Actions and Outcomes

Action	Outcome	Measuring success or target
Develop Corporate Parenting Improvement Plan 2022 – 2025	Development of a NHS Highland Corporate Parenting Improvement Plan 2022 – 2025 whilst assuring alignment to The Promise and The Plan 2021-24	Improvement priorities, actions with achievable deadlines to ensure NHS Highland meets its corporate parenting responsibilities as detailed in the statutory guidance on Part 9 (Corporate Parenting) of the Children and Young People (Scotland) Act 2014
Child Poverty	Develop a plan to meet the 4 ambitions of the Child Poverty (Scotland) 2017 act	Improvement priorities, actions with achievable deadlines to ensure NHS Highland meets its areas of responsibility
Medical & Community Paediatrics services	Develop workforce skills plan for expected retirement of community paediatric workforce. Acute Paeds - following some recent success with recruitment - build on developing the resilience of services	Workforce plans are defined and implemented

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Outcome 2	Thrive Well
Priority 2b	We will work with together to deliver support to those children and young people who have health and care needs, to allow them to thrive

Actions and Outcomes

Action	Outcome	Measuring success or target
Plan for health and development following COVID-19	Understand, mitigate and respond to the unanticipated consequences of COVID-19 on the health and development of children who need health care support to allow them to thrive	Develop a design-led and improvement focussed approach to whole systems of care for vulnerable infants, young people from pre-birth to early twenties to ensure health gain and life opportunities are maximised. CHAS Service Level Agreement
Support the integrated children's service plan in partnership with The Highland Council	To develop the resilience of community based AHP and medical paediatric services, in order to reduce unwarranted pressures on acute services. To develop a test bed, to articulate and demonstrate the interface/joint working arrangements between NHSH and THC	Services enable patients to receive care in the right place at the right time
Community & Acute Paediatric Services	Develop workforce skills plan for expected retirement of community paediatric workforce. Acute Paeds - following some recent success with recruitment - build on developing the resilience of services	Services are sustainable and resilient

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Outcome 2	Thrive Well
Priority 2c	We will support our children and young people who have mental health or neurodiversity needs with timely, accessible care and a 'no wrong door approach'

Actions and Outcomes

Action	Outcome	Measuring success or target
Develop local IMH service model	Develop an evidence-based and innovative local model of service delivery for infant mental health service Refresh of the Highland Parent Support Framework for Families with Young Children Implementation and evaluation of the Planet Youth Model through the Caithness and Sutherland Pathfinder	NHSH Perinatal and Infant Mental Health Service Development Plan (as part of National PNIMH Commissioning Protocol) NHSH CAMHS Improvement Plan
Clinical Risk Assessment of CAMHS and NDAS Services	Prioritise and identify areas of clinical risk and finance in relation to access to CAMHS and NDAS (Neurodevelopmental Assessment Service) assessment and diagnostic services to align with National Service Specifications	Full alignment to national service specification
NDAS Service Development	NDAS - structure, leadership and governance. Develop data recording SOPs and develop reporting dashboard	Reduction in NDAS waiting times aligned to WTT
Delivery of CAMHS Improvement Plan	CAMHS - structure, data clarity and improved recording of such	Reduction in CAMHS waiting times, specifically first and second appointment and improved data quality to WTT
Improved Performance against waiting list targets, especially long waits	Tier 2 Services - early identification and prevention of mental wellbeing issues and concerns which may require Tier 3 intervention and support. Acute paediatrics have a supporting role related to CAMHS OOH/Unscheduled Care arrangements	Specific reduction relating to 2+ year waiting list. Reduce +2yr waiting list and to overall get a trajectory of reduced waiting lists

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NHS Highland

Outcome 3 – Stay Well

Work alongside our partners by developing sustainable and accessible health and care focused on prevention and early intervention

Working Together to Achieve Outcomes and Priorities	
✓ Public Health and Screening Programmes ✓ North Highland HSCP ✓ Argyll & Bute HSCP ✓ Drug & Alcohol Service	✓ Menopause Service ✓ Mental Health Services ✓ Sexual Health Services including gender identity services

Impact on Reducing Health Inequalities
• Many of the conditions for which screening and treatment are offered disproportionately affect individuals from socioeconomically deprived backgrounds or those with protected characteristics as described in the Equality Act and Fairer Scotland Duty. Targeted work to ensure availability and access to screening and vaccinations for these at-risk groups will reduce health inequalities • People with Protected Characteristics and from socioeconomically deprived backgrounds are at greater risk of poor mental health outcomes. Work to tackle stigma and discrimination and suicide prevention work aims to reduce health inequalities • Hearing the voices of Lived Experience will help us target services appropriate to need • Reducing smoking rates in lower socioeconomic groups can play an important role in reducing health inequalities • Improve health and social care of the Gypsy/Traveller community • Reduce inequalities for women

Quality Standards, Guidance and Policies to Improve our Population Experience	
• HIS Sexual Health Standards • Diabetic Retinopathy Standards • Bowel Screening Standards • MAT Standards • Women's Health Plan	• Breast Screening Standards • HIS AAA Screening Standards • Cervical Screening Standards • The Scottish Government Suicide Prevention National Action Plan 2018

Workforce Planning - Specific Priority Areas Identified

Action	Outcome
Public Health	Ensuring sustainability and resilience of service to support the ongoing challenges and impact of COVID

Financial Planning – Specific Priority Actions

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings through integrated service planning	Contribute to the organisation’s ambition to achieve financial balance
COVID costs	Mitigate the impact of ongoing service costs for vaccinations to ensure best value

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NHS Highland

Outcome 3	Stay Well
Priority 3a	We will deliver robust screening and vaccination programmes ensuring uptake is maximised and access is equitable across our population

Action	Outcome	Measuring success or target
Screening Inequalities Action Plan	NHSH can demonstrate reduced inequalities in screening	Action plan developed with measurable targets
A&B dissolution of screening services impact	Implementation of plan as part of NHSGG&C implementation plan and monitoring for unplanned impacts (timeline within this period to be confirmed)	Risk Register in place: Y/N Number of escalated risks with mitigation plans in place as required
Abdominal Aortic Aneurysm (AAA) screening performance against targets	Optimal delivery of the AAA screening programme for our population measured against national KPI's and local measures	Increased rates of screening (specific target to be defined)
Bowel screening performance against targets	Optimal delivery of the Bowel screening programme for our population measured against national KPI's and local measures	Increased rates of screening (specific target to be defined)
Breast Screening uptake	Improved performance against targets for breast screening	Increased rates of screening (specific target to be defined)
Cervical Screening uptake	Continuing improved performance against targets for cervical screening	Increased rates of screening (specific target to be defined)
Diabetic Eye Screening (DES) performance against targets	Optimal delivery of the DES screening programme for our population measured against national KPI's and local measures	Increased rates of screening (specific target to be defined)
Lung Cancer Screening	Delivery plan agreed nationally / locally (timelines TBC)	Delivery plan agreed with measurable targets and timelines
Vaccination Programme transition of provision of all vaccinations from Primary Care to Board-led delivery model	Optimal performance objectives met against national and local KPIs and metrics Optimisation of co-administration of flu and COVID-19 vaccinations. Transfer of travel vaccination service to community pharmacy. Optimal delivery of vaccinations in all groups from birth to Adults (18+)	Increased rates of vaccinations and comparable with national average across all age ranges

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Outcome 3	Stay Well
Priority 3b	Engage with individuals, families and communities to enable people to make healthier choices for their future and provide direct support when they are at risk

Action	Outcome	Measuring success or target
Suicide Prevention	Review progress and develop improvement plan to strengthen our programme of suicide prevention work	Suicide rate reduction Number of SIPP courses delivered and numbers of people trained
Alcohol Brief Interventions (ABI) Delivery	ABI delivery embedded within relevant services	ABIs delivered and performance improved
Smoking Cessation	Review progress of delivery and data improvement Improve attendance at first appointment for pregnant women in the community, by delivering training to community smoking cessation advisers Reduce smoking rates in pregnant women	Smoking rates and stops improved Improve 12 week quit rates in pregnant smokers
Smoke Free Hospital Legislation	Review adherence to smoke-free hospital legislation	Adherence plan
Tobacco Strategy	Review progress of NHSH Tobacco Strategy actions	Performance review through Population Board
Attitudes towards and use of alcohol, tobacco and other drugs	Embed Planet Youth model in prevention and education programmes across Highland - conduct lifestyle survey bi-annually and compare results - demonstrate reduction in risk factors - gather experiential data - secure additional resource to support roll out	Experiential data to assess impact
Drug & Alcohol Recovery Services Treatment Times	Achieve treatment waiting times standard and embed digital options - Delivered improvement plan and continuous monitoring and reflection on sustainment. Continuous risk assessment and performance review for future improvements	Improvement in waiting times
Alcohol Brief Interventions - Targeted Delivery	Sustain and improve targeting of ABI delivery in deprived communities - KPI - Risk assessment for continued sustainability Continuous performance review for future improvements	Improve targeting in deprived communities uptake rates
Medicated Assisted Treatment (MAT)	Sustain and improve MAT standards 1 - 10- Delivered Implementation Plan, continuous monitoring and reflection on success. KPI's - Experiential, numerical and process data gathered and analysed to demonstrate success/further improvements	Compliance to MAT standards
Drug Treatment Targets	Further sustain and improve OST treatment target - Experiential, numerical and process data gathered and analysed to demonstrate success/further improvements	OST treatment targets and improvement plan

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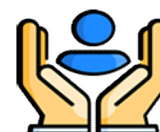
Outcome 3	Stay Well
Priority 3c	Ensure more people are empowered to take control of their own health and wellbeing



Action	Outcome	Measuring success or target
Improved menopause services	Have a comprehensive system wide menopause service in NHS Highland with appropriate referral pathways	Number referred, waiting times and access Population experience
Improved sexual health	Deliver a range of initiatives and services that improve the sexual health of people in Highland	Development of KPIs for sexual health services then measure success
Improved sexual health	Deliver a comprehensive programme of RSHP to young people across NHS Highland	Engagement numbers and population experience
Uptake in condom distribution	Deliver a comprehensive condom distribution scheme that meets the needs of a range of priority groups	Numbers distributed and communities
Gypsy/Travel health agreement delivered	Improved health and social care of the Gypsy/Traveller community	Protected characteristics engaged in services
Improve healthcare for women or those who identify as a woman	Improved healthcare for women or those who identify as a woman	Priorities from the 66 actions in the Women's Health Plan agreed, baseline data collected, and improvement plans created
Embed a gender identity service	Have a service that supports choice for our population	KPIs developed once service is developed
Type 2 diabetes prevention	Reduce occurrence of disease	As detailed in annual implementation plan
Childsmile & Flouride varnishing programmes for at risk children	Improved education and reduced occurrence of dental disease. Childsmile Practice is remobilised to direct children to access Oral Health Improvement within dental practices, supported by NHSH OHI staff. EDDN pilot in east/mid ross	Plans in line with national Dental Inspection Programme Monitor outcomes from EDDN pilot and advise on roll out

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Outcome 4 – Anchor Well

Be an anchor by working as equal partners within our communities to design and deliver health and care that has our population and where they live as the focus

Working Together to Achieve Outcomes and Priorities	
Public Health Communications & Engagement Primary Care Estates & Facilities People & Culture	Operational Units Procurement Clinical Governance Strategy & Transformation

Impact on Reducing Health Inequalities

- The standards below identify actions and duties required to be taken by NHS Highland to reduce inequalities
- The three main drivers to reduce poverty include:
- Increase income through Fair Work opportunities
- Increase income through income maximisation and
- Reduce cost of living
- Our actions below seek to deliver against these three main drivers.
- Anchor organisations play a key role in reducing health inequalities within the population they serve

Quality Standards, Guidance and Policies to Improve our Population Experience

- Fairer Scotland Duty
- Child Poverty Plan
- Equality Act (2010)
- Sustainable Procurement Duty
- Planning with People: community engagement and participation guidance
- Community Empowerment Act (2015)

Workforce Planning

Action	Outcome
Action from Board social mitigation plan	To reduce social barriers to receiving health and social care
Action from THC Employability Partnership / Local Community Partnership	To change the employability system in Scotland to make it more adaptable, responsive and person-centred

Financial Planning – Priority Areas

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings	Contribute to the organisation's ambition to achieve financial balance

Outcome 4	Anchor Well
Priority 4a	Support recovery from the pandemic for our population in the context of the impact on the wider determinants of health

Actions and Outcomes

Action	Outcome	Measuring success or target
NHS Highland Employability scheme in place	Build capacity of NHSH staff and organisation to respond to the needs of people recruited into posts and support for career development. Development of a raft of different entry level positions within NHS Highland and the opportunity for work placements; apprenticeships etc	No. of the population engaged in scheme
Progress Community Wealth Building	Development of action plan for the delivery of Community Wealth Building	Action plan in place Y/N
Delivery of Money Counts	Embed poverty sensitive practice within management development opportunities and ongoing CPD for managers	No. of training opportunities delivered
Community Link workers	Continue support for the ongoing delivery of the programme and UHI evaluation. Final year of funding for the programme	Assessment of programme and future
Procurement policies support the local economy	Promote the nationally developed community benefit portal for local community groups	No. engaged
Build community and organisational capacity to respond to mental health needs	Mental Health Reps supported within the organisation	No. of mental health reps within NHSH
Digital Inclusion	Support the development of a Highland Digital Inclusion network	Attendance at the network
Violence Against Women	Deliver on strategic 3 year plan April 2021 - 24	Performance led overview of implementation through Stay Well Programme Board
Community led hubs	Facilitate the development of Community led hubs. Starting with Hubs in three pathfinder areas, Caithness, Lochaber, Nairn. Hubs will be co-produced with all relevant stakeholders to provide asset-based conversations, signposting and advice in a holistic way making best use of technology to have strength-based conversations	Data from Outcome star tool and review of evaluation forms form both community and groups attending Hubs
Mapping and identification of available community assets	Mapping the available community assets and identifying any gaps. Working with the community and 3rd sector to support the development of areas where gaps exist	Increase in digital connectivity and other measures associated with gap analysis exercise
Revision of referral process	We will revise our referral process to deliver a culture of asset based conversations and introduce outcome star tool to support these productive conversations with people	Referral process revised: Y/N

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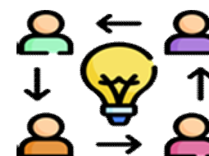
Outcome 4	Anchor Well
Priority 4b	Work with our population, communities and partners identifying priorities to co-produce and co-deliver health and care



Actions and Outcomes

Action	Outcome	Measuring success or target
Engagement Strategy	Best practice examples of engagement shared within and outwith Board	Engagement Strategy Developed: Y/N
Third sector interface	Standardise use of tool identified	Increased use of ALISS / tool by practitioners / communities / population / 3rd sector, etc.
NHSH's population response to Right Care Right Place	Carry out campaign with ongoing evaluation and iterative development. Start measuring. Share Findings	Social prescribing and community led initiatives KPIs to be developed following baseline data gathered in Yr1
Customer Relationship Management System	Assess CRM effectiveness of communication and engagement management. Reduction in error, increased efficiency in working, reduced response time, increased engagement across NHS Highland both internally and externally, effective management of communication programmes	Implement year 3 Outcomes TBC
NHS Highland website	Launch redeveloped user centred NHS Highland Website. Establish baselines of hits and dwell times and use to improve user experience	Hits / dwell times

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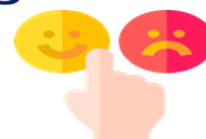
NHS Highland

Outcome 4	Anchor Well
Priority 4c	Embed population experience ensuring people are at the centre of all we do



Actions and Outcomes

Action	Outcome	Measuring success or target
Service User Experience embedded	Implement and monitor experience strategy	Implement strategy and positive population feedback
Carer strategy implemented	Strategy fully implemented	Strategy actions completed and positive carer feedback
Engagement Framework	Best practice examples of engagement shared within and outwith Board	Qualitative feedback
NHSH's population response to Right Care Right Place	Carry out campaign with ongoing evaluation and iterative development. Start measuring. Share findings	User feedback
Culture Programme Implementation	Staff report significant and last positive change in culture, more patient focus. Continued positive trajectory	iMatter statistics
Patient Experience Service Review Scheme	Collect data and provide feedback to services	Agreed intelligence established
NHS Highland website	Launch redeveloped user centred NHS Highland Website	Establish baselines of hits and dwell times and use to improve user experience
Customer Relationship Management System	Assess CRM effectiveness of communication and engagement management. Reduction in error, increased efficiency in working, reduced response time, increased engagement across NHS Highland both internally and externally, effective management of communication programmes	Care opinion engagement Utilisation of intelligence gathered

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Outcome 5 – Grow Well

Ensure that all colleagues are supported to be successful in their role and are valued and respected for the work they do. Everyone will be clear on their objectives, receive regular feedback and have a personal development plan.

Outcome 5	Grow Well
Priority 5a	Develop and implement a system to ensure all colleagues have clear objectives linked to our strategy, a development plan and regular performance conversations which feed into a robust talent and succession planning process

Actions and Outcomes

Action	Outcome	Measuring success or target
Implement strategy aligned objectives and appraisal for Senior Managers	All senior leaders (ESM C+, AFC 8C+) have their 2022/3 performance measured consistently on what and how they have delivered against the strategy and ADP	Completion of TURAS appraisal process for this cohort by 31 July 2023
Develop and pilot succession planning tools	A talent and succession plan will be in place for our exec posts, aligned to the national leadership success profile and our strategy and values	Exec succession plan reviewed and approved by Remuneration Committee by 31 March 2023
Develop standard strategy aligned objectives for core roles in each profession	Core objectives and support materials are in place, which make it easy for managers and colleagues to tailor and use to drive consistent performance conversations and appraisal in 2023/24	Core role objectives aligned to strategy and values and support materials are approved and ready for roll out on 1 April 2023
Guidance and Support in place for managers to deliver the appraisal and PDP process	A performance and development guide and online training is in place, including how to have good conversations, how to assess performance, how to identify development actions and how to record on the TURAS system	Guidance and training is launched by 28 February 2023, ready for performance year 2023/24

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Outcome 5	Grow Well
Priority 5b	Embed Promoting Professionalism and Civility Saves Lives within the organisation, to ensure colleagues and patients are valued and respected and issues can be quickly and effectively raised and resolved locally

Actions and Outcomes

Action	Outcome	Measuring success or target
Design our programme for promoting professionalism	Working in partnership with Vanderbilt University, we will have our programme approved, funded and underway to train key colleagues and to launch the first phase of our Promoting Professionalism Peer Support and Reporting	Funding approved, project team recruited and in place, project plan approved and first phase training complete by 31 March 2023
Embed the civility principles and offer training to support this,	Widespread adoption of the Civility principles across our clinical, care and support teams, through posters, social media engagement and uptake of training and awareness sessions	Increased volume of interactions with our social media channel, Good uptake of awareness and training sessions
Ongoing promotion of our Whistleblowing Standards and Guardian Speak Up service	All colleagues across NHS Highland understand and are confident to raise concerns via Speak Up Guardian service and via our Whistleblowing route and are supported to do so by local leaders	Engagement with ongoing Guardian / WB Champion visits Increased uptake of services Increased uptake of WB TURAS modules

Outcome 5	Grow Well
Priority 5c	Build a mature and resilient safety culture and systems to protect our colleagues and patients and enhance the quality of our services, whilst maintaining high levels of compliance and reducing risk

Actions and Outcomes

Action	Outcome	Measuring success or target
Deliver recommendations in Health and Safety Annual report reviewing our 2021 performance and compliance risks	Key recommendations from the 2021 H&S annual report have been progressed and progress is noted towards improving our safety culture maturity level	• Annual report for 2022 published in March 2023 showing improvement against 2021 recommendations • Health and Safety policy revisions approved and in place by Dec 2022
Deliver health and safety leadership and management training to all levels of leadership and management (Levels 5 to Level 1). Executive to Middle Managers will undertake accredited Safety Leadership training Frontline Managers and Supervisors will complete the Health and Safety Management within TURAS	All supervisors and managers are capable and confident in executing their duties in relation to Health and Safety in their teams and are proactive in identifying and resolving risks and issues that arise and have and contribute to effective systems of management in place locally.	• Completion of training by all identified senior managers by 31 December 2022 • Launch of Health and Safety module for NHS Highland programme and initial priority cohorts delivered by 31 March 2023
Address poor statutory and mandatory training compliance through structured improvement programme	Improvement is starting to be seen, through both local management and all colleagues taking action on and responsibility for their team compliance, supported through programme-led initiatives to deliver the agreed support, data and infrastructure requirements, as identified in the audit actions	• Compliance rates with online and face to face training show sustained improvement by 31 March 2023 • Improvement plan is in place and on track

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Outcome 6 – Listen Well

Work in partnership with colleagues to shape our future and make decisions. Our leaders will be visible and engaged with the wider organisation, listening to, hearing and learning from experiences and views shared.

Outcome 6	Listen Well
Priority 6a	Listen to and work in partnership with all colleagues to shape our future and support decision making and continuous improvement

Actions and Outcomes

Action	Outcome	Measuring success or target
Launched our listening and learning panels and undertaken a programme of engagement with them	An active panel of randomly selected colleagues from across our Board area have regular opportunities to contribute feedback and engage with development of our plans and priorities, giving us access to wider views and voices	Final recruitment to panels is completed - 31 August 2022 Programme of events is underway - 30 September 2022 Initial feedback and evaluation and plans for phase 2- 31 May 2023
Agree our sources of colleagues experience data and increase our insight and understanding in this area	We have a coherent plan to measure colleague experience, including scheduling our 2nd Listening and Learning survey, Imatter, Listening and Learning Panel and implementation of our Onboarding and Exit surveys, with clear organisational level actions agreed and progress monitored and a wider range of data available to measure our progress	Imatter action planning completed -by 31 October 2022 Listening and Learning Survey 2 launched - by 31 March 2023 Onboarding and Exit surveys launched - by 31 October 2022 Colleague experience data reviewed and updated - 31 December 2022
Development of our People Service Centre approach to support colleagues and managers	A full scoping exercise will have been caried out to agree how we will deliver our service centre, with detailed plans and requirements developed and approved for a Phase 1 rollout, which will focus on supporting the people processes.	Detailed plans for phase 1 signed off - by 31 December 2022 Implementation underway - by 31 March 2023

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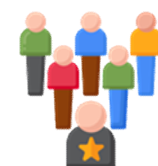
Outcome 6	Listen Well
Priority 6b	Have effective partnership working with all colleagues to maximise the value of collaboration to address opportunities, challenges, change and transformation

Actions and Outcomes

Action	Outcome	Measuring success or target
Review of facility time and partnership working completed	The required resource and funding to support partnership working across NHS Highland will be agreed and implemented and a process in place to monitor and track usage of time and funding.	Review completed and actions implemented - by 31 December 2022 Reporting on resource and funding in place - by 31 March 2023
Increase the numbers of concerns being resolved as part of early resolution	Management, HR and trade union colleagues are capable and confident in using early resolution and are working collaboratively and proactively to quickly identify and address concerns which are suitable for early resolution, reducing the numbers of formal cases and improving the experience of all involved	Participate in partnership development sessions to improve knowledge and skills of early resolution - 31 December 2022 Tracking of early resolution data shows sustained uptake of this and reduced numbers of formal processes, across all policies. - 30 June 2023
Introduction to partnership working and the staff governance standards to be core part of induction for all colleagues	Learning content developed, approved and rolled out for online and face to face induction programme which informs and equips both colleagues and managers to better work in partnership to achieve the Staff Governance Standards	Initial content for corporate induction for managers delivered and operational - 31 December 2022 Colleague content and e-learning module developed and launched - 31 March 2023
Local Partnership Forums re-established and working effectively and widespread management engagement in partnership working at all levels	Each area has a dedicated Local Partnership Forum in place and working well, engaging with local managers , staffside, HR and professional leads, led by a senior manager, who is then part of the Area Partnership Forum.	Local Partnership Forums in place, reporting progress to APF with the right level of attendance and working well - 31 December 2022

Outcome 6	Listen Well
Priority 6c	Have robust structures and develop skills in teams for listening, communication, engagement and team working



Actions and Outcomes

Action	Outcome	Measuring success or target
Team Conversations initiative has been rolled across a range of teams in NHS Highland	Teams who participate in this initiative will develop an action plan to enhance their team working with clear priorities, standards and behaviours they want to achieve, leading to improvements in colleague experience and the quality of service / care they deliver.	Intervention delivered to minimum 20 teams by 31 March 2023 Engagement increases as measured by Imatter and L&L survey and absences / processes are reduced within teams who participate. Service / Patient complaints reduced within teams who participate
Co-produced values and behaviours standards and guidance are available for colleagues and managers	Simple documents set out what colleagues and managers can expect and what we expect of them, in relation to the values and behaviours required at work. Examples will also support the performance management and development process.	Colleague and manager values and behaviours charters are agreed and communicated - 31 January 2023 Supporting examples of positive practice and development needs at different levels / roles are available for appraisals - 31 March 2023
NHS Highland leaders demonstrate effective and visible leadership across all levels of their organisations	Each leader has consistent and dedicated time ringfenced to support the leadership of their own team, with a defined schedule of 1:1's, team meetings, communications and information cascades, feedback loops and engagement visits.	Executive Directors to confirm the consistent adoption of these rhythms for their areas - 30 November 2022. Improved local engagement in Listening and Learning survey results.

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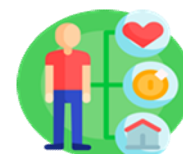
NHS Highland

Outcome 7 – Nurture Well

Support colleagues' physical and mental health and wellbeing through all the stages of their life and career with us. We foster an inclusive and kind culture where difference is valued and respected

Outcome 7	Nurture Well
Priority 7a	Create and deliver a health and wellbeing strategy and plan which ensures that colleagues can maintain good mental and physical health in delivering their roles, as well as being supported to recovery when unwell



Actions and Outcomes

Action	Outcome	Measuring success or target
Develop and implement health and wellbeing strategy and plan	NHS Highland has in place a co-produced, approved, funded and well promoted and understood wellbeing strategy and plan. It will set out and oversee delivery of priorities for the next 5 years and lead to improvements in the physical and mental health and wellbeing of our colleagues across NHSH.	Wellbeing strategy and plan approved by SGC / APF / Board and fully communicated by 30 November 2022. Initial improvements in absence rates and length of absence beginning to be seen by 31 July 2023 Achieve good take up of initiatives and support set out in the plan.
Roll out a consistent agile working framework for use across NHS Highland	NHS Highland colleagues and managers have a clear framework for making decisions about agile working, aligned to our business needs, data is captured and reported on and informs our property strategy.	Management actions from Agile working audit closed -31 October 2022 Guidance is in place and available to all colleagues - 31 October 2022 NHS Scotland terms and conditions for homeworking agreed and in place - TBC
Roll out of our NHS Mental Health First Aid training across initial priority areas	A programme of training has been delivered to identified priority areas, which supports colleagues and managers feeling capable and confident in their understanding and skills in supporting with mental health issues in their teams.	Initial roll out phase of training delivered - 31 March 2023 Evaluation carried out and further plan developed - 31 May 2023 Reduction in mental health related absences and duration - 31 July 2023
Develop a menopause at work toolbox	Colleagues and advisors work together to develop a toolbox for supporting colleagues experiencing the menopause	Toolbox launched - 31 March 2023

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Outcome 7	Nurture Well
Priority 7b	Strive to create an inclusive workplace where all colleagues can expect to be treated with compassion, dignity and respect and where difference of any kind is valued and celebrated

Actions and Outcomes

Action	Outcome	Measuring success or target
Develop our local networks to support inclusion and equality and ensure we are linked into national equalities agenda	We have clear understanding of and access to our diverse population across Highland and we know how they would like to engage with us and be supported and contributing towards driving our diversity agenda	Groups and forums in place with workplans and priorities set - 31 March 2023
Improving our data and insights on diversity	We have increased confidence that our colleague employment data reflects the diversity of our population and allows us to monitor and track their experience	Data validation exercise launched - 31 March 2023 Listening and Learning survey results analysed to understand impact of diversity on experience - 30 June 2023
Gaelic Language Plan approved and in delivery	Gaelic Language plan co-produced with key colleagues and approved at September board meeting and delivery of the core actions is on target	Gaelic Language plan approved - 30 September 2022 Gaelic Language plan aims delivered - 31 July 2023
Courageous Conversations e-learning launched	Online Courageous Conversations e-learning is available to all colleagues to improve their skills and knowledge in delivering difficult conversations	Module is finalized and launched by 31 October 2022 Access to module is monitored and feedback sought - 31 March 2023.
NHS Highland to work towards gaining or retaining relevant diversity accreditation	NHS Highland is actively progressing with achievement of Bronze Equally Safe at work accreditation, Exemplary Carer Positive accreditation and other priority diversity accreditation.	Agreement of priority accreditation activity - 31 October 2022 Award of Bronze Equally Safe at Work standard - 31 August 2023

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Outcome 7	Nurture Well
Priority 7c	Ensure all of our supervisors, managers and leaders are trained and developed in their roles and responsibilities and embedding the principles of systems leadership to harness all of our capacity and capability

Actions and Outcomes

Action	Outcome	Measuring success or target
Evaluation of impact of first phase of our leadership programme and agree priorities for future roll out and develop additional modules to support this	We fully understand how effective each 4 levels of our initial Leadership programme have been in achieving their aims, colleague experience and feedback and make recommendations for priorities for next phase of rollout out	Attendance levels and value added of the initial phase of activity Levels 1-2 - 31 October 2022 Levels 3-4 31 January 2023 Agreed rollout priorities and schedule in place for 2023 for Levels 1-2 - 30 November 2022 Levels 3-4 - 31 March 2023 Deliver additional modules for L&MD programme
Pilot Essentials in Management for new leaders in National Treatment centre	Content of Essentials course developed and approved for piloting with NTC and future rollout plan developed to ensure this can be made available before new managers take up post.	Delivery of NTC pilot completed and evaluation - 28 February 2023 2023/4 rollout plan agreed - 31 March 2023

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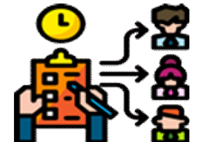
Outcome 8 – Plan Well

Create a sustainable pipeline of talent for all roles, and excel in our recruitment and onboarding, making us an employer of choice both locally and nationally.

Outcome 8	Plan Well
Priority 8a	We will develop and deliver against integrated workforce plans that enable sustainable service delivery and quality outcomes by using the best roles and skills to deliver health and care



Actions and Outcomes

Action	Outcome	Measuring success or target
Co-production, publication and delivery against a workforce plan aligned to TWC and the 5 pillars, for both NHSH and A&B HSCP, with quarterly milestones for each key action/priority	NHS Highland and A&B HSCP have a clear agreed workforce plan in place which is aligned to our strategy, finances and performance requirements and which forms the basis of our workforce activity across 2022/3 and beyond	Increased level of manager engagement in WFP planning training - 31 July 2023 Delivery against the agreed WFP actions - 31 July 2023
Embed integrated service planning for service areas identified within the actions in the ADP	Priority areas have worked collaboratively to agree an integrated service plan setting out workforce, performance and finance requirements, with a focus on outcomes and these are being delivered against.	Agreed number of integrated service plans in place - 31 July 2023
Develop data workflows with NES	Workflows in place that enable dashboard development for trend analysis and benchmarking	
Define key workforce metrics for performance monitoring at management and governance committees including the People & Culture Programme Board	Revised suite of metrics in place to allow us to effectively monitor our progress against all of the strategic People objectives as well as our Staff Governance standards.	Phase 1 metrics in place for IPQR / SGC - 31 August 2022 Phase 2 metrics for People and Culture programme board - 31 December 2022 Further development of metrics - 31 March 2023
Improve data quality accuracy and timescales through regular data cleansing and training on our workforce systems.	Ensure that information gathered and held about our workforce is up to date and accurate, through training of those who enter data and through regular validation with colleagues.	Improvement in data quality and accuracy on all systems - 31 July 2023 Reduction in failed EESS transactions - 31 July 2023 Carrying out a data cleanse exercise - 31 May 2023 Good attendance at training offered on workforce systems.

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Outcome 8	Plan Well
Priority 8b	Transform our attraction, recruitment and onboarding approach to position us as the Employer of Choice

Actions and Outcomes

Action	Outcome	Measuring success or target
Development and launch of a consistent, in person Corporate induction programme for every colleague	Every colleague joining NHS Highland is offered an in-person full day Corporate Induction, each Monday, on their first day of employment, which can be delivered virtually if required, to ensure they are set up for success.	First in person Corporate Induction event held by 31st October 2022 100% attendance for all new starts by 31 March 2023 95% compliance with stat man training for new starters by 31 March 2023
Delivered and evaluated high priority marketing campaigns – Aim High Aim Highland	Aim High, Aim Highland recruitment campaign delivers pan UK awareness and interest in our vacancies and leads to an increase in applications and appointments for key roles	Increased applications and appointments from our targeted recruitment and social media posts - by 31 December 2022 Increased brand engagement and awareness driven by our Tube and Central Scotland bus marketing campaign - 31 October 2022 NTC recruitment campaign delivers full establishment - by 31 March 2023
Deliver a programme of international recruitment of key professional roles in target locations	Evaluate and then build on our initial Zambian recruitment and expand our recruitment in particular to India and The Philippines for a small number of key hard to fill nursing posts working with trusted partners.	Evaluation of Phase 1 Zambia recruitments - 31 March 2023 Develop a limited approach to India and Phillipine's recruitment - 31 December 2022
Developed and commenced delivery of recruitment and onboarding training and support materials	Equipping key hiring managers with skills, knowledge and expertise to effectively deliver recruitment and onboarding in a fair consistent and timely way, that is candidate focused.	Initial training offering available - 31 October 2022 Supporting materials and guidance for onboarding - 31 October 2022

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Outcome 8	Plan Well
Priority 8c	Work in partnership with education and training providers, schools and communities to create wide ranging and well publicised career pathways and apprenticeships for our core roles

Actions and Outcomes

Action	Outcome	Measuring success or target
Develop and manage our NHS Highland apprenticeship strategy	Implement a single, consistent approach to apprenticeships across NHS Highland, to ensure we are maximizing use of these roles, have consistent roles and responsibilities to support them and centralise marketing, recruitment and onboarding to have the biggest impact.	Agreement of our strategy for apprenticeships and our plan for target recruitment for September 2023 intake - 31 December 2022 Launch our 2023 apprenticeship campaign - 31 March 2023 Successfully recruit target apprentice numbers - 31 August 2023
Identify develop and promote routes to work and careers with associated communication and engagement with schools, colleges and wider communities	Agree a single, consistent approach, plan and supporting materials for engagement with schools and offering volunteering and work placement opportunities across NHS Highland	Agreement of approach to schools - 31 December 2022 Piloting and review of approach and plan with some key schools 30 April 2023 Launch of our programme of engagement with all schools - 1 September 2023
Map out career pathway for Nursing and then utilise this template and approach for other professions and areas in future	Working with local and national professional leads, managers, education and training providers and develop a range of roles and career pathways and access points for nursing, both qualified and non qualified.	Set up a working group to take this forward - 31 October 2022 Working group to deliver initial proposals for review and agreement - 31 March 2023 Piloting and evaluation - 31 July 2023
Work collaboratively to increase access to training and engagement leading to potential employment for vulnerable and under-represented people within our communities	Alongside our work with schools, also review our approach to volunteering, work shadowing and access to employment opportunities with wider communities and groups who face barriers to their access to training and employment.	Develop a plan for engagement and activity for access to training and employment, working with public health and community and third sector partners - 31 March 2023

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NHS Highland

Outcome 9 – Care Well

Work together with health and social care partners by delivering care and support together that puts our population, families and carers experience at the heart

NHS Service Areas – Working Together
Primary Care including Pharmacy, GP services, Optometry and Dentistry Adult Social Care Community Services including AHPs, nursing and pharmacy Volunteer Services Highland Council

Reducing Health Inequalities Impact
• Our population receives the right care at the right time in the right place reducing barriers to access and providing the appropriate care needed. • Rapid access to crisis response team for vulnerable settings to support as required • Population who are not registered for NHS dental care will have the same access as those registered with a practice. These include more disadvantaged groups and vulnerable individuals. This will include those with complex special care needs who require general anaesthetic to access dental services
Quality Standards, Guidance and Policies to Improve our Population Experience
National Pharmacy Strategy Primary Care Modernisation Guidance Unscheduled & Urgent Care Collaborative Health & Social Care Integration Act GIRFEC standards

Workforce Planning - Priority Areas

Action	Outcome
Reviewing skill mix to identify the best professional to deliver care	Right level of support and care provided to our population
Social care support	Identify opportunities to increase care hours available
Pharmacy recruitment and retention	Sustainable and resilient service delivery (plan already developed)

Financial Planning – Priority Areas

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings through integrated service planning	Contributory to the organisation's ambition to achieve financial balance

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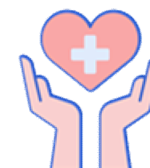
Outcome 9	Care Well
Action 9a	Support primary care to be resilient and sustainable to deliver the ambition of providing a range of local services, ensuring we work together across all parts of health and care



Actions and Outcomes

Action	Outcome	Measuring success or target
Implementation of Primary Care Improvement Plan	Embedding services developed in years 1-3 of the programme - pharmacotherapy, FCP, community link workers, mental health working toward full service coverage	Staffing status - red, amber green Increase in serial prescribing Increase in formulary compliance Numbers of individuals seen by each new service Performance against prescribing cost and quality targets GP and population feedback
Supporting GPs to address access challenges	Address access challenges across the area, embedding total triage	No. Face to face and virtual consultations
Implementation of MoU2 Priorities (VTM & CTAC services)	Implement service model ensuring IT support is in place (eHealth Order Comms project for CTAC), deliver transition of vaccination to Board service from March 2023	1. Vaccination transfer complete: Y/N; 2. CTAC - e.g., count of number of centres
Improved Local Enhanced Services	Develop consistent model of commissioning enhanced services	Review of local enhanced services and propose new commissioning framework
Board-managed (2C contract) GP Practices	Develop a transformation plan	Number of Board-managed GP Practices Cost efficiency of 2C Practices
Extend Pharmacy First Plus	Increased accessibility to Primary Care services through Community Pharmacies	Numbers of trained pharmacy prescribers Number and proportion of: - pharmacies with Pharmacy First Plus capabilities - vaccinations delivered through - Community Pharmacy consultations delivered virtually
Monitor PDS Dental capacity	Investment & recruitment plan to be developed to mitigate deregistration of NHS patients	Number of patients deregistered from independent NHS provision
Enhanced Optometry services	Enhanced local Optometry services available	Develop implementation plan for new enhanced services. Measure impact of new graduates
Dental access for vulnerable individuals inc general anaesthetic	Assisting in growing registrations with GDPs and providing emergency access for treatment for patients not registered with a GDP including vulnerable communities who need general anaesthetic	Waiting times No. of treatments No. Of new registrations

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Outcome 9	Care Well
Action 9b	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

Actions and Outcomes

Action	Outcome	Measuring success or target
Establish Programme Governance and appoint Programme Manager for Care at Home (CAH) and Care Homes	Stable, resilient and assured provision for Care at Home service Stable, resilient and assured provision for Care Home service	Specific measures to be developed in line with agreed workstreams: National Returns DHDs Management Information for Care Homes/Care-at-Home Occupancy, activity, flow, waits, bed occupancy, vacancies
Establish and implement a plan to ensure stable, resilient and assured provision for Care at Home service, within a wider integrated model	Those who need care at home services are able to receive them as part of an integrated service Services have a clear and positive identity and are regarded as important and valued by Highland communities Audit recommendations implemented across Highland Staff delivering care at home services are professionally and financially recognised as partners Staff are attracted to the sector, stay and are supported to develop and grow Models of care available embrace and maximise digital innovation and reflect the diversity and geography of Highland	Unmet need reduction with agreed parameters Embedded within districts as part of integrated provision Full implementation of audit recommendations Number of package return reduced CAH Audit Actions fully implemented
Establish and implement a plan to ensure stable, resilient and assured provision for Care Home Service	Target Operating Model in Place Objectives (Care Homes): • stable, resilient and assured care provision • short notice closures avoided/minimised • required capacity understood • locality profiled sustainable and affordable solutions Those who need care home services are able to receive them Services are of a high quality and are delivered in facilities fit for the future and are available in identified strategically important locations Care Home providers deliver responsive and person centred services and are supported by NHSH to avoid unnecessary hospital admissions Services are delivered in locations where they have access to sufficient staffing resources	Specific measures to be developed in line with agreed workstreams: National Returns DHDs Management Information for Care Homes Occupancy, activity, flow, waits, bed occupancy, vacancies Resident and family experience

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Outcome 9	Care Well
Action 9c	Develop fully integrated front line community health and social care teams across all areas of Highland

Actions and Outcomes

Action	Outcome	Measuring success or target
Fully integrate community services	Resilient and responsive care for people function. Fully understood role and function of integrated services over 24/7 period	Identify requirements of integrated services in providing a resilient response. Descriptor and map in place: Y/N Services aligned to people and place principles, developed to meet population need Average length of stay Unscheduled hospital admissions Patient and staff experience
Maximise use of technology to support integrated working	Maximised IT support to deliver information sharing and efficiency of integrated services	Status of IT project plan - red, amber, green
Establish appropriate facilities and working practices which promote integrated working	Teams and services supported to have access to appropriate facilities and resources to maximise the efficiency and effectiveness of integrated services	Status of facilities project plan - red, amber, green Clear resource plans for each integrated team
Build appropriate workforce capacity	Effective, sustainable and appropriate 24 hour response and service delivery	Have the capacity to deliver people and place services. Workforce plan based on 7 day working: Y/N Vacancies Waiting lists
Establish joined up clinical and operational leadership across Highland community	Leadership structure and ways of working to develop integrated services is fully understood, and services are supported to deliver effective and efficient person centred care	Define measurement and performance management system. Status of performance management system implementation - red, amber, green

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Outcome 10 – Live Well

Ensure that both physical and mental health are on an equal footing and reduce stigma by improving access and enabling all our staff in all services to speak about mental health and wellbeing

Working Together to Achieve Outcomes and Priorities	
Primary Care Mental Health Services including CAMHS Community Services	SARC services All other NHS services including regional and national services

Reducing Health Inequalities Impact
The likelihood of our developing a mental health problem is influenced by our biological makeup, and by the circumstances in which we are born, grow, live and age. Those who face the greatest disadvantages in life also face the greatest risks to their mental health. In order to support our population within NHS Highland the Mental Health & Wellbeing Framework that is being developed through co-production aims to support our population dealing with individual risk and support communities that are facing vulnerabilities within disadvantaged groups. It will focus on the wider determinants such as debt, employment etc but also on wider protected characteristics where mental health is more prevalent. This ADP will be year one of supporting this way forward.
Quality Standards, Guidance and Policies to Improve our Population Experience
Healthcare and SARC services for people who have experienced rape, sexual assault or child sexual abuse: children, young people and adults Quality Standards for Psychological Therapies Standards for integrated care pathways for mental health SPSP Mental Health HIS Personality Disorder Improvement Programme Learning/intellectual disability and autism: transformational plan

Workforce Planning - Priority Areas Identified

Action	Outcome
Reviewing skill mix to identify the best professional to deliver care	Right level of support and care provided to our population
Specialist mental health services	Right care by the right person
3rd sector partnership	Making best value of skills and expertise

Financial Planning – Priority Areas

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings which are	Contributory to the organisation's ambition to achieve financial balance
Ensure plans are in place when recovery and renewal funding is made available	Allow development of services according to population needs

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Outcome 10	Live Well
Action 10a	Deliver consistently excellent care that is quality focused, best practice and data driven, efficient, consistent and supported by the latest digital technologies

Actions and Outcomes

Action	Outcome	Measuring success or target
Data gathering including waiting list review	All people who are referred to our services will offer a therapeutic appointment within 12 weeks of referral. Full implementation of agreed PT plan.	Appointment within 12 weeks of referral. Trajectories defined for performance management
Process Mapping - Digital Therapies	Digital Psychological interventions are available before referral to specialist MH services.	Increased availability of range of resources in accessible formats Increase in access
Data review for dashboard development	Data is routinely gathered and used to inform all service developments and decisions. All staff are fully trained in understanding data and its use in day to day operational decisions.	Day to day operational decisions are made using intelligence
Implement Helicopter review	Electronic patient record in place.	All people who require one, will have a co-produced digital mental health risk assessment that is accessible to all who provide support to the person
HealthRoster	Workforce are positive, resilient, enjoying their roles and actively engaged in developments. The workforce is flexible to respond to both resource demand and supply availability.	iMatter
SPSP Gap Analysis	Full of implementation of SPSP Guidance and Best Practice.	Implementation plan with timelines and intelligence led
ADHD & Autism assessment pathway for adults	Implement ADHD & Autism Assessment Pathway & Service	Implementation plan with timelines and intelligence led
Development and Implementation of standards	Full implementation of Mental Health Standards	Full implementation with intelligence
Continuous learning culture	Develop service model to best meet the needs of patients	Co-production and co-delivery

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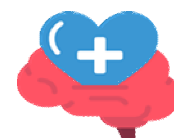
Outcome 10	Live Well
Action 10b	We will develop integrated local services by working together with local partners to enable people to stay well for longer, help meet growing demand and to coordinate care and prevention

Actions and Outcomes

Action	Outcome	Measuring success or target
Strengthen Third sector partnership working	Collaborative approach established to ensure partnership working to provide the right services at the right time for people	Working collaboratively with partner organisations Population experience
Delivery of prevention initiatives	Monitor outcomes from Mental Health & Wellbeing Fund through lead officer from NHSH	Agree, measure and improve outcomes
Mental Health & Wellbeing Primary Care Service	MHWPC Service fully operational and established	Fully operational with indicators being gathered
HIS Personality Disorder Improvement Programme	People with a personality disorder presenting to mental health services anywhere in Highland will have timely access to effective care and treatment	Agree access standards and measure against standard
MH & LD Review of structure – outcome implemented	The agreed integrated model will be established and ensure we manage growing demand by delivering a coordinated model that flexes available capacity to meet demand.	Single Highland structure in place Demand and capacity matched Staff and service user experience
Early Interventions in Psychosis service development	Population with a first episode of psychosis will have a named professional to teach self-management skills, signpost to support for social care issues such as housing or debt management, and provide relapse prevention work	Named professional for first episode of psychosis with appropriate interventions measured
Access to services	People with a mental health problem or learning disability will have equal access to healthcare	People with a mental health problem or learning disability will have equal access to healthcare
Learning Disability Services development plans	People with a learning disability are provided with the right support to enable them to lead meaningful lives in their local communities	Number of people in Out of Area Placements Learning Disability Register Developed – Y/N Population feedback
Drug Alcohol Recovery Service (DARS) development	Ensure a joined-up approach across the health and social care system to address underlying issues in adverse childhood experience, health inequalities and socio-economic inequalities Ensure appropriate access to DARS services across Highland	Reduction in admission and deaths related to drug /alcohol % of discharges New Craigs referred for follow up by CMHT – under development No. of referrals to Prison based D&A services

Person Centred and Flexible response	A strengthened community-focussed approach, which includes the third sector and community-based services and support for mental health and wellbeing, is supported by commissioning processes, partnership working and adequate, sustainable funding	Working collaboratively through partnership working People and place based community led support and partnership provision in districts
Programme of work on MH and wellbeing	Joined up approach across partners to improve the mental health and wellbeing of our population.	Evidence of collaborative working and improvement plans delivered

Outcome 10	**Live Well**
Action 10c	We will improve the quality of care delivered to patients receiving enhanced care to support their mental health and develop individualised care planning and the right level of care to those in crisis



Actions and Outcomes

Action	**Outcome**	**Measuring success or target**
7 Day Model	People with a severe and enduring mental health problem manage their condition or move towards individualised recovery on their own terms, surrounded by their families, carers and social networks, and supported in their local community	Accessibility to services by day of the week Co-produced recovery plans in place for individuals
Develop unscheduled care service	People can access mental health care where and when they need it, so that people who need intensive input receive it in the appropriate place, with appropriate follow up care and treatment	Clear route to access unscheduled care in all areas Reduction in avoidable admissions, re-admissions, complaints and Datix relating to unscheduled care
Quality of Inpatient Care New Craigs	Outcomes in Intention 11c achieved for mental health services	As in 11c
LD Crisis Response Team planning	Develop Learning Disability Crisis Response team, subject to funding	KPIs developed once service in place
Improve access to Mental Health Pharmacists	Ensure that every person with a severe and enduring mental health problem is offered a medication review by a specialist mental health pharmacist	Medication reviews completed
Psychiatric Emergency Plan developed and implemented	Comprehensive Psychiatric Emergency Plan established and implemented	Reduction in A&E attendance and unnecessary inpatient psychiatric admissions Appropriate emergency response Creation of crisis cafes / safe havens / crisis houses
Psychological Therapies Standards Implementation	Implement Psychological Therapies Standards as in Intention 10a	As in 10a

Outcome 11 – Respond Well

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

Working Together to Achieve Outcomes and Priorities	
Primary Care Scottish Ambulance Services Community Services	Acute services NHS24 NHS Inform

Reducing Health Inequalities Impact
Increased intelligence relating to performance across all socio-economic groups to allow prioritisation of actions Pathways for urgent and emergency care services provided at a more local level, increasing access to local communities
Quality Standards, Guidance and Policies to Improve our Population Experience
• National Urgent and Unscheduled Care Collaborative Priorities • HIS Value Management Approach • Accessing the Right Care from the Right Place • Scottish Trauma Audit Group (STAG) • Scottish Intensive Care Society Audit Group (SICSAG) • Scottish Hip Fracture Audit (SHFA) • HIS Excellence in Care

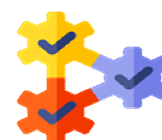
Workforce Planning - Priority Areas Identified

Action	Outcome
Reviewing skill mix to identify the best professional to deliver care	Right level of support and care provided to our population

Financial Planning – Priority Areas

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings through integrated service planning	Contributory to the organisation's ambition to achieve financial balance

Outcome 11	Respond Well
Action 11a	Respond to our population needs when they have an urgent health problem by treating them with right care, in the right place at the right time



Actions and Outcomes (N.B. Detailed plan in Urgent and USC Programme Plan: High Impact Change 2 – Redesign of Urgent Care and 3 – Virtual Capacity)

Action	Outcome	Measuring success or target
Public and patient messaging to support right care right place	Clear and sustained communications and engagement with the population regarding appropriate pathways and choices for urgent & unscheduled care access. Consistent application of Scottish Govt sign posting and redirection	Effect on service activity as a response to communications
Support people to access right care delivered at right time in right place through integration of OOH, FNC & Minor injuries unit	- Map current urgent & unscheduled care pathways: Identify requirements and scope resources; Develop vision for integration of FNC, OOH & MIU; Identify priority pathways and phasing of plans for integration; Build in standard work across integrated urgent care pathways - Implementation of Minor Injuries appointment scheduling in all MIUs and EDs in Highland - Dashboards developed for Quality Indicators for urgent care	ED attendances Flow Navigation Outcomes Dashboard Unplanned attendance % MIU appointment scheduled National Outcomes: Indicator 1 Response Times Indicator 2 - Appropriateness of triage for home visits Indicator 3 - Effective information exchange Indicator 4 - Implementing national clinical standards and guidelines Indicator 5 - Antimicrobial prescribing Indicator 6 - Patient Experience

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Outcome 11	Respond Well
Action 11b	Ensure that those people with serious or life-threatening emergency needs are treated quickly

Actions and Outcomes (N.B. Detailed plan in Urgent and USC Programme Plan: High Impact Change 2 – Redesign of Urgent Care; 3 – Virtual Capacity; 4 – Urgent & Emergency Assessment)

Action	Outcome	Measuring success or target
Improvement of ED performance Target	Optimise specialty in reach to Emergency Department (ED) for appropriate patient pathway Agree and implement streamlined pathways for ED admission into acute, including agreed fast track pathways Access pathways to Ambulatory Emergency Care (AEC) - develop and test criteria led pathways from ED to AEC. ED access RAC (AEC) within 48 hrs Defined pathway for referral and receipt of patients requiring non acute ongoing care e.g.: Community. Link to development of Flow and District Hubs Access to Occupational Therapy/Physiotherapy (OT/PT) input into ED dept 08:00 – 20:30. Prepare business case Develop system wide pathway for management of frail people	4 Hour Breach target 95% of People attending ED should be triaged within 15 minutes Conversion rate from admission from ED Time in ED: • Time to triage • Time to first assessment • The number of patients waiting longer than 12 hours • The number of 12-hour breaches as a proportion of total unplanned attends • ED admission rate • ED mean time: Admission to decision to admit • ED mean time: decision to admit to admission • ED breaches for diagnostic reasons
Reduce demand for ED through redirection	Promote public information and signposting to provide patients with a first point of contact which directs them to the most appropriate source of help via 111 and Flow Navigation Centre (FNC) Application of national redirection policy	ED attendances Unplanned attendances Number of patients redirected from ED Flow Navigation Centre outcomes Near Me usage in FNC National measurables below plus Acute Dashboard and USC Programme Dashboard
Continuous improvement of Quality and Safety	Enhance current Quality Assurance and Clinical Governance system in ED establishing connection with acute QPS forum. Value Management (VM) methodology introduced	Trend and type of Datix/Complaints % data flows established % teams with weekly VM huddle

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Continually identifying & reporting on risks	Identifying risks and inter-dependencies across ED Workforce expansion - lack of recruitment Service failures across wider Organisation e.g. FNC	No. of Vacancies in ED Impact vacancies in wider organisation has on ED Adding, recording and monitoring Risk Register for service failures Escalation route through ASLT and QPS

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Outcome 11	Respond Well
Action 11c	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

Actions and Outcomes (N.B. Detailed plan in Urgent and USC Programme Plan: High Impact Change 7 – Discharge without Delay and 8 – Community Focused Integrated Care)

Action	Outcome	Measuring success or target
Effective discharge planning	Embed culture of 'Why Not Home?' Communications with staff and public	Length of Stay (LoS) delayed patients from admission to ready for discharge - national reporting LoS from ready for discharge to discharge - national reporting Proportion of patients discharged without delay - national reporting Delayed days - acute dashboard Weekend discharge rate - national reporting Pre-noon discharge rate - national reporting Audit of patient status board - local reporting Audit of DDD embedded in acute / community - local reporting Audit capacity and demand through community teams - local reporting
	Implement early identification of patients using national pathways 1-4 as close to admission as possible Implement Frailty screening tool on admission	
	Embed Daily Dynamic Discharge (DDD) principles in all wards for all inpatients (acute, RGH & community hospitals) Acute & RGHs - 7 day consultant ward rounds in the morning Spread Criteria led discharge across acute & RGHs Timely completion of IDL to allow availability of discharge drugs at time of discharge	
	Introduce Planned Date of Discharge (PDD) join up planning from admission Communications to staff and public Implement PDD in all wards, all hospitals and all Districts	
	Electronic patient record - Work with eHealth to develop business case for Morse (Morse link 9c) Develop documentation supporting discharge to community Staff training and test in 5 wards and Districts Evaluate	
	Develop and test "Patient discharge status board" communication tool between acute and community services - test proof of concept Develop manual patient discharge status information board. Test with Raigmore and pathfinder Districts. Explore options for automation with eHealth	
	Aiming for assessment by right person in right place by identifying what assessment is required when. This includes: Joint working across acute and community AHPs to review existing practice and develop appropriate assessment process to get people to	

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NHS Highland

	the right place i.e. AHP screening assessment for home to assess Develop business case for frailty at front door Make social work referrals within 24 hrs (link to Flow Hub 9c)	
	Develop Flow Hub (see intention 9c) to support effective sharing of information and communication between acute & community staff and standard approach to DHD coding Recruitment of staffing resources to support implementation (Social Work & Administrative) Implement test of change with pathfinder wards and Districts Evaluate outcome of tests of change	
Effective management of patient flow in community setting	Develop District Flow Hubs (see intention 9c) building on Single Point of Contacts. District management of patient flow. Implement systems for understanding and managing capacity, demand and scheduling Recruitment of staff resources for pathfinder sites Implement tests of change with 3 pathfinder districts Evaluate outcome Embed Home first/discharge to assess across 3 District pathfinder sites Review requirements for rapid response Introduce step up/down intermediate care service in Inverness Evaluate service	Audit capacity and demand through community teams. - local reporting Proportion of patients discharged without delay - national reporting Delayed days - acute dashboard
Deliver seamless transition on day of discharge	Establish transport hub to ensure rapid access to discharge transport. Day before booking for transport Test concept for 6 bay collection point to facilitate discharge Evaluate	Time waiting for transport
Work with your family and carers	Development of Choice Guidance Provide training and support on use of Choice Guidance as part of development of Planned Date of Discharge processes Implement Choice Guidance usage alongside HHOME Bundle Introduce realistic care and 3 conversation model to support PD	Progress of implementation plan
Developing links with third sector to support patients returning home	Community Led Support (see intention 14b) Sign posting to self management tools embedded in all areas	Feedback from third sector
Reinvigorate and deploy process for "PJ Paralysis"	Reinvigorate PJ Paralysis and activity in hospitals	Progress of implementation plan

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Access to assisted technology and equipment	Identify requirements through test in Inverness	Number of people using tech to be supported to return home from hospital
Efficient use of adult social care resource	Develop criteria for prescribing proportionate care Consider implementation of single-handed care provision	Decreased unmet need Decreased LoS

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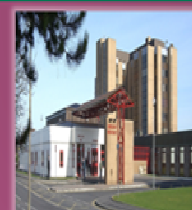
Outcome 12 – Treat Well

Give our population the best possible experience by providing person centred planned care in a timely way as close to home as possible.



Working Together to Achieve Outcomes and Priorities	
✓ Primary Care ✓ Community Services ✓ Acute Services ✓ Mental Health Services	✓ Social Care ✓ Scottish Ambulance Services ✓ NHS territorial Boards

Reducing Health Inequalities Impact	
People will be treated with dignity and respect in the most appropriate service Services will be accessible to our Highland population where it is needed Plans should take due regard of the need to reduce pre-pandemic and pandemic related health inequalities using related waiting list data that is embedded with the performance dashboards to measure outcome, access and experience from deprived	
Quality Standards, Guidance and Policies to Improve our Population Experience	
HIS Access QI Collaborative Scotland's Long COVID service Scottish Arthroplasty Project (SAP) Scottish Renal Registry (SRR)	Scottish ECT Accreditation Network (SEAN) Scottish Cardiac Audit Programme (SCAN) HIS Excellence in Care

Workforce Planning - Priority Areas

Action	Outcome
Reviewing skill mix to identify the best professional to deliver care	Right level of support and care provided to our population
Laboratory and Pathology services review	National direction set but ensure we realise impact within remote and rural context
Vascular services development	Sustainable and resilient service provision which may involve working across board boundaries
National Treatment Centre	Improved access for elective Orthopaedic and Ophthalmology patients across Scotland
Anaesthetic services	Right level of support and care provided considering recruitment challenges
Modernising the medical workforce	Ensure we adopt a non medicalised model and medical associated where appropriate using new roles available through agreed workstream

Financial Planning – Priority Areas

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings through integrated service planning	Contributory to the organisation's ambition to achieve financial balance

DRAFT

Outcome 12	Treat Well
Action 12a	Ensure our population have timely access to planned care through transforming the way we deliver this and making sure they have the best experience possible

Actions and Outcomes

Action	Outcome	Measuring success or target
Reducing waiting times for surgery	Meet waiting time targets set by Scottish Government according to clinical prioritisation of urgent and routine with the actions detailed below	Meeting all targets as set out in July 22 letter from SG
Increase day case surgery	Reduce the number of inpatient admissions	80% of elective procedures done as day case Benchmarking against key procedures - BADS 95% of pre-COVID elective activity achieved
Utilise Treatment room capacity	Reduce the number of inpatient admissions	Scope treatment room capacity in year 1 with Y2 target 10.5 lists a week (2750 patients) in treatment rooms
Utilisation of Rural General Hospitals and Community Hospitals	Reduce long waits over 104+weeks Review community hospital provision across Highland HSCP and develop a plan to provide consistent model of community hospital provision closely linked to integrated teams	3 day week theatre in Belford & Lorn and Isles 4 day week theatre in Caithness General Standardised wait times across all 4 sites Reduction in long waits over 104+ weeks Theatre utilisation % Increased flow with reduced LoS and primary care access to inpatient beds in the community
Developing sustainably staffed services	We have an efficient and sustainable workforce model in place	Vacancy % Age of Vacancies Unfilled bank/agency shifts Supplementary staffing use and cost
Bed requirements	We will understand our capacity and bed stock and will manage it efficiently	No measure in Year 1 as aim to reduce reliance on beds
Systems and process improvements	Performance reports provide correct information to enable planning and decision making	No measure in Year 1 as aim to reduce reliance on beds
Optimising External Acute resource	We will continue to utilise capacity outside of NHSH where appropriate in order to eliminate patient wait times or to eliminate a build up of longer waiting patients	Number of P2-P4 (routine) patients sent to Golden Jubilee against target of 350
Expand use of Robotic Assisted Surgery	Reduced surgery complications through use of Robotic Assisted Surgery	Post-surgery infection numbers & %

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Waiting list planning	Standard procedure times set	Benchmarking against standard procedures times NHSH capacity models against job plans and wait list to develop trajectories
Capacity Planning	Reduce non clinical hospital cancellations and ROTT rates	Non clinical hospital cancellations - number and % ROTT rate tracking
Patient Tracking Lists	Plans should ensure that patient tracking list management is undertaken at a system and specialty level and all capacity is being used	Good governance and safety net if reported at Scheduled Care Board
National Treatment Centre Opening	Support national treatment centre opening and develop a plan for handover and business as usual functions to be adopted	NTC opens and handover
Review of all services	Adopt NHSH integrated service planning through identified priority areas	Achieve best model of care and collaborative understanding
Quality and Population Experience	Service quality measures monitored to improve outcomes for patients	Datix, Near Misses & Harms

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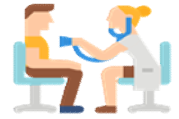
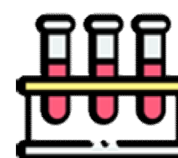
Outcome12	**Treat Well**
Action 12b	Deliver a hospital without walls system that transforms the way we deliver outpatient services that will rethink the boundaries between patient and clinician to make the most of our valuable resources



Actions and Outcomes

Action	**Outcome**	**Measuring success or target**
Reducing waiting times for outpatients	Maintain and develop workforce to deliver a safe, sustainable remote and rural service meeting NHSH waiting times target.	No one waiting more than 104weeks+ by March 2023
Implementation of CfSD priorities	We will ensure that all CfSD Programmes (including Heatmaps and supporting the specialty delivery groups) are implemented or on track to implement in all specialties. Assessment framework implemented to ensure progress	Submissions to CfSD Monitoring performance through dashboards
Outpatients Transformation Programme Board	Implement plans for all specialities	Self-assessment framework and monitoring through dashboards
Patient Initiated Follow Up	Plans should demonstrate rapid progress on PIFU that is clinically appropriate and safe	Increasing volume of PIFU at each specialty
Standard Booking Implementation	Implement plans for all specialities	Self-assessment framework and monitoring through dashboards
Monitoring Dashboards	Will allow performance monitoring and escalation routes	Dashboards implemented
Patient Hub roll out	Patient Hub fully rolled-out	Patient Hub fully rolled-out
Centralised Clinic Building	Increased capacity due to consistent application of model	Fully Rolled Out
Virtual Clinic Delivery	Improve on Virtual Appointment Target (New OPs)	Increasing trend
Improve on Virtual Appointment Target (New OPs)	More patients consulted virtually	Increasing trend
Build business case for improved aseptic dispensing	Improve flow and dispensing for our population and our system	Business case y/n

Outcome 12	Treat Well
Action 12c	Optimise diagnostic and support services capacity and improve efficiency with new service delivery models



Actions and Outcomes

Action	Outcome	Measuring success or target
Increase use of cytosponge and capsule endoscopy	Clinically appropriate use of current endoscopy types	Increasing trend, reported to CfSD
Endoscopy Service Improvements	Maintain JAG accreditation; Deliver 20 elective endoscopy sessions weekly.	Y/N; Count of elective weekly sessions
Radiology	Implement 5 year plan, along equipment and workforce plans	Submit 5 year plan: Y/N
Laboratory Services	Improved service resilience for RGHs	Continue to improve resilience of services, in particular in RGHs - electronic issue of blood, accreditation of POCT
Medical Physics & Equipment replacement Strategy	Resilient, sustainable equipment	Five to ten year phased plan for equipment replacement board-wide.
Clinical Physiology	1) Patients seen with minimal/zero waiting time including 7 day working 2) Service fully funded and recruited to a size and capacity to meet demand, with sufficient space and equipment within which to work and in locations to suit patients 3) Training programs fully operational to meet turnover and expansion	Waiting time activity
Nuclear Medicine	Achieve compliancy following MHRA inspection (Apr 22)	Compliancy achieved
Medical Physics / Radiation Protection	1) Expand capacity for Diagnostic Radiology and MR Physics support to maintain board compliance and patient flow in these services 2) Support for NTC & neighbouring boards (WI and Shetland) 3) Contribute to business case for third Raigmore MRI scanner 4) Complete actions from IRMER Inspector	1) introduction of MRI for radiotherapy treatment planning 3) Professional accreditation
Medical Illustration	Implement app for direct capture of patient images from clinician phones, for improved assurance/compliance for out of hours and community areas.	Implemented: Y/N
Assistive Tech Services	Establish optimal model of delivery for Assistive Technologies; At 2022/23 strategy is towards a clinic-centred approach with services moved off the main Raigmore acute site, to be sited alongside stock for use in diagnosis/treatment and increased productivity.	Implemented: Y/N

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Outcome 13 – Journey Well

Support our population on their journey with and beyond cancer by having equitable and timely access to the most effective, evidence-based referral, diagnosis, treatment and personal support

Working Together to Achieve Outcomes and Priorities	
Primary Care Acute Services including Cancer and Diagnostics Screening Services (Public Health)	Community Services including AHPs

Reducing Health Inequalities Impact
The most deprived populations have higher risk, worse experiences and poorer outcomes than the least deprived. Inequalities in cancer outcomes are likely to be compounded by the effects of the COVID-19 pandemic with vulnerable subgroups of the population more negatively affected. Health inequalities are associated with lower symptom awareness, later presentation and lower uptake of services including screening. The majority of cancer types have much higher incidence in more deprived areas. There is strong evidence linking risk factors, which are more common in areas of deprivation with higher incidence of cancer, including smoking, obesity and poor diet. Low levels of health literacy are associated with poorer access to health services, poorer communication with healthcare professionals, lower adherence to treatment and poorer self-management of health conditions. Better health literacy could therefore contribute to reducing health inequalities and improve healthcare efficiency. We need to learn from the COVID-19 experience and continue engagement with lesser heard communities, including ethnic minority groups, people with learning disabilities, communication difficulties and those for whom English is not their first language, to ensure equality of access to cancer services across the pathway and to information and support services.
Quality Standards, Guidance and Policies to Improve our Population Experience
Cancer Management Framework 31 and 62 day compliance National Cancer Network QPIs for Cancer across all main tumour types

Workforce Planning - Priority Areas

Action	Outcome
Cancer services and haematology reconfiguration and development	Resilient and sustainable services
Work with NES	To ensure NHSH can receive trainees and therefore allow increased recruitment from this pool

Financial Planning – Priority Areas

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings through integrated service planning	Contributory to the o62rganisation's ambition to achieve financial balance

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NHS Highland

Outcome 13	Journey Well
Action 13a	We will work together raise population awareness of the symptoms of cancer to facilitate earlier and faster diagnosis

Actions and Outcomes

Action	Outcome	Measuring success or target
Delivered a locally targeted cancer campaign focused on earlier detection	Targeted areas of inequalities locally directed to our population	Awareness raising
Identified any capacity gaps linked to screening programmes	Increased provision of screening programmes means increased throughput for acute diagnostic services therefore identify and mitigate	Access for our population within appropriate timescales
Reviewed and embedded changes to USC guidelines	Working in collaboration with primary care review and embed guidelines including continuous learning and intelligence being communicated	Shared learning event Improved referral process Shared intelligence
Direct access to CT	Improved access for primary care	Referral rate Detection rate
Business Case PET	Establish PET CT within Cancer Centre	Business case: Y/N
Early diagnostic centre	In line with pilots elsewhere in Scotland scope early diagnostic centre provision for remote and rural and understand impact	EDC plan y/n
Highland Cancer Centre	Development of business case for Highland Cancer Centre	Outline developed y/n
Framework for Effective Cancer Management	Implement consistent application of one stop clinics where possible.	CTW compliance, Review the current situation and assess opportunities for improvement
Access to diagnostic tests	Review tumour type demand and capacity in order to maximise access to diagnostic tests and reports within 14 days of referral	Diagnostics within 14 days
Workforce planning and recruitment	Work with colleagues to identify solutions for workforce planning and recruitment	Workforce data analysis

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Outcome 13	Journey Well
Action 13b	We will further develop multi professional teams to provide the most effective care during the active stages of treatment

Actions and Outcomes

Action	Outcome	Measuring success or target
NHSH Strategic plan for cancer care delivery	Cancer care plan that encompasses the whole journey aligned to national plan and incorporates business case for NHS Highland cancer centre	Developed: Y/N
Improve SACT services	Maximise access to SACT treatments in all Highland locations	Seek to appoint replacement & Additional SACT Nurses Workforce planning data / SACT Patient pathway data
Improve services	Seek to attract trainee medical posts in order to aid the recruitment of posts in the future	Benchmarking against national services. Trainees in place
Acute Oncology Service	Establish acute oncology service to provide our population with equitable access	Service established y/n
Haematology service	Embed an integrated service planning approach across Highland to ensure sustainability	Sustainable service and collaborative understanding
Improve SACT treatment options	Recruitment to vacant and additional posts within Pharmacy	Ensure that patients have equitable access to all new drug therapies, Workforce planning data / pharmacy data / CEPAS data
Develop technology solutions	Roll Out use of SABR Radiotherapy for additional tumour types Roll out of Patient Pathway Plus	Recruit to vacant Consultant Urologist post Improved patient pathway / outcome data / Cancer QPIs
Improve treatment options	Establish MRI Radiotherapy Planning service in Inverness Cancer Centre	Improved patient pathway/outcome data
Improve Comms solutions	Work with colleagues to make the Highland Cancer Centre an attractive place to work.	Improved public engagement/Early detection stats
Improve cancer staffing/skill mix	Work with Teams locally, regionally and nationally to improve the likelihood of appointment to posts	Ensure we utilise benchmarking to have full staff complement required and identify alternative staffing models where required
Improve cancer waiting times performance	Continue to implement and comply with all elements for the Framework for Effective Cancer Management in order to ensure compliance with National Cancer Wating Times Standards	Compliance with national Cancer Waiting Times Standards
Review of rehabilitation service	Participate in the review of the Prehabilitation Service being piloted by Maggie's Scotland in order to improve outcomes and quality of life post cancer treatment	Continue to explore opportunities to develop the Urology and other Workforces in line with recommendations of the Scottish Access Collaborative

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NHS Highland

Outcome 13	Journey Well
Action 13c	We will improve the experience of our population living with and beyond cancer

Actions and Outcomes

Action	Outcome	Measuring success or target
Build on learning from COVID-19 with increase the use of telehealth and technology	Increased use of telehealth	Baseline to improved position (target to be defined)
Offered all people a holistic needs assessment, an appropriate care plan and provide signposts to relevant sources of help and support	Improved patient experience and outcomes from date of referral	No. of HNAs in place increased since baseline
Assessed and risk stratified follow up pathways embedded	Improved patient experience and outcomes	No. of PIFU
Developed a model to promote good mental health and wellbeing for people affected by cancer	Improved access to mental health and wellbeing services for those with cancer	No. of people receiving signposting or intervention (target to be defined)
Embedded learning and improve our response to cancer quality performance indicators	Improved patient outcomes	Improved performance in key QPIs through appropriate reporting to Clinical Governance

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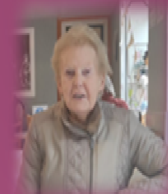
Outcome 14 – Age Well

Ensure people are supported as they age by promoting independence, choice, self-fulfilment and dignity with personalised care planning at the heart



Working Together to Achieve Outcomes and Priorities	
Primary Care Community Services including AHPs and nursing services	Acute care Adult Social Care

Reducing Health Inequalities Impact
Health inequalities in older age are mostly a result of the social patterning of chronic diseases such as heart disease, stroke and cancer. Supporting age well will support long terms conditions that are often diagnosed in older people and associated with obesity, which is linked with lower socio-economic status Along with anchor well and stay well working with our partners we aim to influence the lifelong exposure to the harmful effects of inequality and the significant proportion of older people who are affected by the damaging impact of living in poverty. We will target areas such as female pensioners who are more likely to live in poverty than male pensioners, largely a result of having fewer years of employment due to caring responsibilities. Given There is also a high prevalence of mental health problems among people with long-term health conditions and older adults who experience loneliness. Improving the detection and treatment of problems such as anxiety and depression among this group would be likely to reduce the prevalence of mental health problems as well as improve overall health status.

Quality Standards, Guidance and Policies to Improve our Population Experience	
SPSP Acute Adult Reducing falls and falls with harm Care of patients who experience a physiological deterioration Scotland's National Dementia Strategy 2017-2020 Realistic Medicine HIS Community Care HIS Excellence in Care Healthcare framework for adults living in care homes My Health – My Care – My Home General standards for neurological care and support Respiratory Care Action Plan 2021 – 2026 Diabetes Care: Diabetes Improvement Plan 2021 – 2026	Heart Disease: Action Plan Chronic Pain Framework Framework for Action on Neurological Conditions 2020 – 2025 Rare Disease Progress Report Scottish MS Register (SMSR) Scottish Renal Registry (SRR) Scottish Stroke Care Audit (SSCA) HIS Excellence in Care Illnesses and long-term conditions Coronavirus (COVID-19) Scotland's Long COVID service

Workforce Planning - Priority Areas

Action	Outcome
Reviewing skill mix to identify the best professional to deliver care	Right level of support and care provided to our population
Pharmacy recruitment and retention	Right level of support and care provided to our population (plan developed)

Financial Planning – Priority Areas

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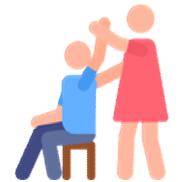
Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings through integrated service planning	Contributory to the organisation's ambition to achieve financial balance

Outcome 14	Age Well
Action 14a	We will support people to promote independence by targeting prevention and developing appropriate choices



Actions and Outcomes

Action	Outcome	Measuring success or target
Pharmacotherapy Service Response	Develop response to frail patients through the pharmacotherapy service	Formulary adherence
Frailty and Falls	Falls reduction- Strategic group has been formed for falls prevention, led by Evelyn Gray. SPSP- falls prevention, delirium prevention and deteriorating patient are all key focus areas	Reduction in falls
Frailty and Falls	Delirium reduction- Action for Strategic group to develop, implement and measure prevention and reduction in occurrences of delirium	Reduction in delirium
Reduced risk of falls	Identify target areas and have a member of staff trained at each setting in screening, e.g. Informant Questionnaire on cognitive decline in the elderly	Safe reduction of unnecessary conveyance relating to falls
Enhancement of leadership structure	We will establish a delivery structure and have submitted a consultant post for falls and frailty for the board.	In place: Y/N
Mapping of community falls pathway	Mapping community falls pathways through the flow navigation centre to reduce the incidence of second fall	Reduce the incidence of second falls for those who present to an emergency care setting
Team for care for at home falls	Team in all areas to deliver immediate care for any falls at home	Team in place: Y/N
Reduced attendances at A&E for falls	Procurement and training of new X-ray backpack allow people to be x-rayed in own homes/community location	Reduction in A&E attendances Count of number of people x-rayed at home/community
Frailty score in primary care	Implement Frailty score in primary care to improve prevention response	Count of frailty scores conducted in primary care
Dexa scanning	Identify the frequency of Dexa scanning in NHSH	Identify the frequency of dexa scanning currently and aim to measure over consecutive years
Geriatric assessment at hospital front door	Implementation of comprehensive geriatric assessment in Raigmore (front door- ED/GA)	Measure of how many assessments have been completed in Raigmore and then RGHS

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Outcome 14	Age Well
Action 14b	We will take a person-centred and flexible approach to providing support at all stages of the care journey for anyone who has dementia or depression

Actions and Outcomes

Action	Outcome	Measuring success or target
Improve Dementia Services	Completion of review and evaluation of the effectiveness of and accessibility to specialist dementia services, including post diagnostic support	Stress and Distress referrals Monitor post diagnosis support outcomes & measures through contracts
Improve Dementia services	Improved access to specialist practitioners and support services for dementia to support people to live at home (including Care Homes) for as long as possible	Completion of a review and evaluation of specialist services Stress and Distress referrals Monitor post diagnosis support outcomes & measures through contracts Integrated working with third sector

DRAFT

NHS Highland

Outcome 14	Age Well
Action 14c	We will develop a coordinated service model for long term conditions that is proactive, holistic, preventive and patient centred that enables patients and clinicians to work together

Actions and Outcomes

Action	Outcome	Measuring success or target
Long Terms Conditions Model	Identify outcomes measures in services, including those used with partners, and develop a standardised approach using validated tools	Start to develop long term condition models Reduction in key polypharmacy measures NHSH improvement against NTIs Outcomes measures – TBC e.g. reduction in admissions
Evidence Based Practice	Develop education approaches across Primary & Secondary care to support delivery of Long Terms Conditions Pathways across NHSH	Critical appraisal of health literature to identify evidence based practice Quality Assurance measures- TBC
Self Care & Third Sector Partners	Address gaps identified in Yr1, review any third sector contracts held by NHSH to ensure targets are met/amend to include self-management	Measures from SLAs / 3rd sector contracts Formulary compliance Social prescribing & Realistic Medicine links
Co-design of pathways	Ensure that the long term conditions model is developed with people with lived experience at the centre by establishing a co-design structure	Participation Measures TBC
Rare Diseases	Needs to be considered but not available at time of writing	TBC
Stroke Pathway	Full implementation of all standards of stroke care	Meeting all agreed indicators
Long COVID	Implementation of a service that will support people suffering with Long COVID holistically	Indicators measured
Other long term conditions, including chronic pain	Continued implementation of improvement strategy to increase access and capacity of service and new models of care	Reduced waiting times Improved self management Improved access to care
Mental Health Support for Long Term Conditions	Define a way forward using digital and direct support by working to co-produce a future model of care	Plan developed y/n

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Outcome 15 – End Well

Support and empower our population and families at the end of life by giving appropriate care and choice at this time and beyond

Working Together to Achieve Outcomes and Priorities	
Primary Care Community Services Adult Social Care	Acute Services Chaplain and bereavement services

Reducing Health Inequalities Impact
Dying well wherever you are and whatever your background or circumstances are fundamental aspects of human dignity. As part of a compassionate humane society, we need to do everything we can to make sure that people who are facing their last months, weeks and days of life receive the best possible palliative and end of life care. Those who care for them, including their families, others important to them and staff around them, equally deserve this consideration and support. More work is needed to understand access and barriers to palliative care in socially deprived areas and to understand the experiences that have affected people from socially deprived communities in order to build effective service responses and resources to maximise quality of life and death.
Quality Standards, Guidance and Policies to Improve our Population Experience
Carers (Scotland) Act 2016 Healthcare framework for adults living in care homes My Health – My Care – My Home

Workforce Planning - Priority Areas

Action	Outcome
Reviewing skill mix to identify the best professional to deliver care to allow choice for palliative and end of life care	Right level of support and care provided to our population
Pharmacy recruitment and retention	Right level of support and care provided to our population (plan developed)

Financial Planning – Priority Areas

Action	Outcome
Reviewing skill mix workforce plan to identify potential opportunities to effect cash releasing efficiency savings	Contributory to the organisation's ambition to achieve financial balance

DRAFT

NHS Highland

Outcome 15	End Well
Action 15a	In partnership, ensure our population has access to palliative and end of life services supportive round the clock care enabling people to live and die in the setting of their choice

Actions and Outcomes

Action	Outcome	Measuring success or target
End of Life Together (EOLT) Programme - Population Valuer Improvement Infrastructure	Completion of dashboard that shows prospective whole system service use and associated resource allocation. Production of an Annual Report on the current position of palliative & end of life care services across Highland	Status of EOLT Programme - red, amber, green
GP Partnership Agreement	Service measures will be in place to know if we are identifying all those in the population in their last year of life also ensuring that identification is equitable for individuals based on what primary disease they have, where they live, and what their deprivation status is	Status of GP Partnership Agreement - red, amber, green Number of practice signed up to partnership
Agree approach for 24/7 Palliative care support	Access to appropriate palliative care support for those in the last year of life	- % (No.) of people referred to coordination hub for care at home who are unable to receive this care - % (No.) of people who then go on to have a hospital admission within 7 days of this request - Individual / Family Carer Survey - Numbers of people on palliative care registers with anticipatory prescribing in place at end of life
Rapid Response Service	Provide outline service requirement plan for a pilot of rapid response social care service in pathfinder areas. EOLCT pilot across Inverness and surrounding area	Develop a plan for consideration within the partnership
Care & Residential Homes Palliative and End of Life Care	Identify and sign up care homes to EOLCT alongside GP Partnership agreements. Support education, identification and ACP, and monitoring tools to ensure integrated working with General practice	- No. of care / residential homes engaged in EOLCT - Care Home access to 24/7 advisory service year on year - Collective outcomes for residents based on the delivery of the outcomes based on preferences of care and ceilings of treatment from ACP plans

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Outcome 15	End Well
Action 15b	Proactively recognise people who may be in their last year of life, being respectful of what matters to them by co-developing anticipatory care plans with them and for them

Actions and Outcomes

Action	Outcome	Measuring success or target
Electronic / Anticipatory Care Plans (eACP)	Those in the last year of life will be recognised through addition to General Practice Palliative Care Registers / Key Information Summaries or through having an electronic ACP commenced in General Practice or other areas of care. With individuals and their family having access to these care plans. The quality and content of these care plans will be monitored through audit review and individual / family survey. Outcomes against these plans will be measured at an individual, service and population level to enable continuous cycles of quality improvement activity and to inform where to place future resource to improve population outcomes.	% of patients with a KIS with 4-6 criteria met % of KIS updated in the last 3 months
Professionals Access to Anticipatory Care Plans	Professionals will have access to single source of the truth up to date ACP that reflect what matters to the person and highlights the ceilings of care and treatment for the individual so that care can be provided in the most appropriate setting pertinent to their preference with a home first approach.	% of Care Homes with access to Highland eACP % of practices signed up to End of Life Care Together Number of organisations across health and social care with access to Highland eACP % of people with digital access to their own care plans % of carers with access to digital care plans of the individual with terminal illness and of their own individual care plan Number of times staff from different organisations access the eACP
Direct Enhanced Services - Palliative Care	Monitor and review if review and feedback of DES outcomes in PEoLC leads to QI activity based on benchmarking and annual review	% of people annually who report honest sensitive conversation with professionals regarding their prognosis % of practice populations on General Practice (pre) palliative care register N. people recorded as being palliative after death by GP practice who may have benefited from earlier identification

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		% of people at death with a Key Information Summary (KIS) with preferred place of care recorded % of people at death with a KIS stating preference for care that achieve this preference

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Outcome 15	End Well
Action 15c	Ensure we deliver timely, culturally sensitive and dignified care for our population in their last year of life and their families have a choice to access bereavement support

Actions and Outcomes

Action	Outcome	Measuring success or target
Education Palliative End of Life Care (PEoLC)	Have accessible education at induction and across career and occupational pathways consistent with the national educational framework in relation to PEoLC enabling up to date knowledge across the workforce.	- Numbers of Professionals accessing education - Feedback from evaluation of course delivery - Number of community groups/ individuals accessing 'Last Aid' course
Carers Support	Ensure that Adult Carers providing care for someone at home in their last 6 months of life have been offered or have Adult Support Plans in place in a timely manner from identification of this need	Did the family or carer feel that their loved one or person they were supporting were treated with dignity, compassion and empathy
Bereavement Support	Develop a coalition partnership to look at a population approach to bereavement support. Identifying what the need is across Highland based on the national bereavement charter with a view to support both individuals and professionals. Scope exemplars of bereavement service delivery nationally	Percentage of carers with an adult carers support plan for those caring for someone with a terminal illness (Carers Act 2016) Numbers of referrals to local bereavement services Quality of feedback from individuals receiving bereavement services Number with / Median length of time of Social care package in place Number with community Marie Curie / Rapid Response support Number with voluntary sector support
Spiritual Care	Recognising how our people and population access spiritual care services and how these are promoted alongside the provision of training / education to the workforce. Develop and update local policy and strategy while providing accessible resources on intranet and as public facing material in through our establishments and services	Referrals to Spiritual Care for people of Faith and none. Audit of resources available Access by staff to education and training

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Outcome 16 – Value Well

Improve experience by valuing the role that carers, partners in third sector and volunteers bring along with their individual skills and expertise

NHS Service Areas – Working Together
All NHS services

Reducing Health Inequalities Impact
Volunteering - Volunteering can make a positive contribution to individuals' health and wellbeing. We recognise its importance within our strategy in terms of population health – supporting the health of communities and the distribution of health within those communities. It is therefore crucial to recognise and understand how access to volunteering relates to significant inequalities across the life course. Many of those who could benefit the most are precisely those who are least likely to be involved. Although population health approaches to volunteering have the potential to reduce health inequalities, their potential will go un-realised unless inclusion is designed-in at local level which we are aiming to address through this ADP and our strategy. At time of writing we realise the impact health inequalities can have on carers and we will embed this here as we move forward with the ADP. We will also define this for our 3rd sector partners. **Third Sector** – it is important that we recognise the work that the third sector does in reducing health inequalities and to work alongside them as partners. They are often a gateway into specific help that our most vulnerable patients require. They can also be an onward destination for those who need additional help and support to maintain good health or for self-management. Social Prescribing is a holistic approach to overall health and wellbeing and the third sector is a key partner in providing different options for individuals, especially for those who need more ongoing support. **Carers –** The longer term impact that caring can have for individuals can often impact on their health overall. Being a carer may also impact on the social determinants that can lead to poorer health resulting in poverty as a result of having to stop working or reducing earning opportunities. Poverty is one of the root causes of health inequalities. It is important to consider the needs of carers alongside that of the cared for person to ensure that we reduce this impact and support people at the earliest opportunity so that not only can they care well, but that they are also to look after themselves.
Quality Standards, Guidance and Policies
Carers (Scotland) Act 2016 – updated July 21

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Workforce Planning - Priority Areas

Action	Outcome
Reviewing skill mix to identify the best professional, person or partner to deliver care and support of the carers	Right level of support and care provided to our population
Review SLAs to ensure we are making the best use of resources and expertise through 3rd sector partners	Closer integrated working with the right skills

Financial Planning – Priority Areas

Action	Outcome
Reviewing 3rd sector plan to identify potential opportunities to improve	Contributory to the organisation's ambition to achieve financial balance through agreed SLAs

NHS Highland

Outcome 16	Value Well
Priority 16a	Value the role of carers, acknowledging them as experts by experience, and ensure they are informed, supported and valued

Actions and Outcomes

Action	Outcome	Measuring success or target
Implemented the current Highland Carers Strategy (2020-23) and develop a new Carers Strategy	Improved personalised carer support and services in line with statutory requirements New strategy developed	Implemented: Y/N Carer feedback Carer strategy in place
Support the development of a 'carer-led' Carers' Union and restructured governance arrangements	Carer voice to support service redesign and development and to ensure carers views are heard, listened to and taken forward across all aspects of health and social care	Carers voice evident in service change and governance structures Carer feedback
Benchmark the number of carers looking after someone identified as being in their last 6 months of life who have Adult Carers Support Plan	Improved awareness of carers and carer support in line with statutory requirements	Benchmarking work complete Carer information collated KPIs in relation to statutory requirements
Work with Connecting Carers to ensure that there is equitable access and communication of plans to support carers	Good awareness of plans to support carers Equitable access to the right support in the right place and at the right time	Communication plan Carer feedback Audit of access to services

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Outcome 16	Value Well
Priority 16b	We will work in true partnership with the third sector to create collaborative opportunities to value the expertise they bring for our population

Actions and Outcomes

Action	Outcome	Measuring success or target
Agree strategic direction for partnership working with third sector	Effective approach to partnership working agreed with all partners to meet the needs of communities	Plan agreed with partners Feedback from partners and population Evidence of partnership working
Established positive working practices to ensure co-delivery	Co-production and co-delivery across all partners to meet the needs of communities	Plan agreed with partners Feedback from partners and population Evidence of co-production and co-delivery
Ensuring appropriate structures and processes are in place to ensure best use of expertise for the benefit of the population	Redesign of working practices across partner organization to best meet population need.	Plan agreed with partners Feedback from partners and population Evidence of co-production and co-delivery

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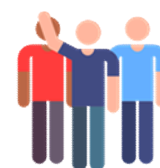
Outcome 16	Value Well
Priority 16c	We will enhance the experiences of patients and colleagues by recognising and valuing the role of volunteers in their unique contributions to our system



Actions and Outcomes

Action	Outcome	Measuring success or target
Develop a plan on how we will increase our current volunteer establishment	Improved patient experience and more efficient use of staff Better trained and supported volunteers would be that patients would receive enhanced person centered non-clinical care Reduced patient loneliness or isolation	Patient feedback Recruitment of 2 coordinator posts
Sustained and ideally increase the current 6,00 of hours p.a. that our volunteers support NHSH	Additional resource to support ward routines Meaningful interactions which can reduce the number of patient falls, alleviate patient anxiety and increase patient wellbeing outcomes Support general operational activity of Hospitals by improving flow of inpatient activity	Patient feedback
Encouraged growth within our mixed economy of volunteering	Extend the reach of the programme into areas and into services that have as yet not benefited from regular volunteer input	Patient feedback
Formally recognised and celebrate the positive impact that volunteers play in our system	Extend the reach and resilience of the programme	Patient, volunteer and staff feedback

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Argyll & Bute Integration Joint Board

Argyll & Bute Integration Joint Board (IJB) is the public body that has strategic oversight and direction of the integrated services across Argyll and Bute. Through the Health and Care Partnership NHS Highland ensures the safe and effective delivery of the healthcare services in partnership with the Council Social Care Services, this too is supported by a partnership integration scheme determining the partnership agreements. All NHS Services are delegated to the Argyll & Bute IJB The area is divided into four localities:

- Oban, Lorn and the Isles (including Lorn and Islands Rural General Hospital in Oban)
- Mid Argyll, Kintyre and Islay
- Cowal and Bute
- Helensburgh and Lomond

Argyll and Bute HSCP also manage their own corporate services. Argyll and Bute IJB has approved, in May 2022, their 3 year Joint Strategic Plan and Joint Strategic Commissioning Strategy which establishes the vision, strategic objectives and priorities setting out the strategic direction for how health and social care services will be shaped in the coming years. There are a number of areas where Argyll & Bute IJB work with NHS Highland collaboratively and these are detailed and planned each year as part of our Annual Delivery Plan.

In Argyll and Bute, the HSCP delivers and purchases a broad range of services covering all aspects of health and social care. Some of these services are provided by NHS Highland, NHS Greater Glasgow and Clyde via SLAs or other Regional services. Included in the remit of the HSCP are:

- NHS services (local, from NHSGGC and NHS Highland); Community hospitals; Acute Care; Primary Care (including GPs); Allied Health Professionals, Community Health Services, Maternity Services
- Public Health services including the Prevention agenda
- Adult social care services including services for older adults; people with learning disabilities; and people with mental health problems
- Children & Families social care services
- Alcohol and Drug Services
- Gender Based Violence
- Child and Adult Protection
- Criminal and Community Justice Services

In each of these areas we have identified our year 1 actions and objectives which align with National and NHS Highland Board targets and standards. These objectives and actions are captured in our operational plans and will be performance monitored by the IJB as part of its discrete governance arrangements via the Clinical and Care Governance committee, Strategic Planning Group and IJB meeting and are incorporated in the HSCP Annual Performance Report.

The HSCP through 2022 is implementing an Integrated Performance Management Framework for Health and Social Care taking account of the performance landscape informed from the Strategic Plan Objectives and which follows the agreed performance reporting cycle. More details can be provided should this be required.

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Enabling Outcomes – Perform Well and Progress Well

Underpinning these outcomes are our core areas which are golden threads that run through each of our outcomes and priorities. You will see each of these considered in turn through the main body of our ADP but there are specific priorities noted for each of these areas. These allow our system to function and perform and will be performance managed through our Executive Directors Group as these are aligned to their objectives for 22/23 in line with our strategy Together We Care, with you for you.

Perform Well

Quality & Population Experience
We will create a culture of continuous improvement to develop the safety, experience and our responsiveness to the population we serve by delivering outstanding care by an outstanding team everyday

Action	Outcome
Develop a shared approach with visual communications and a collaborative event	Better informed and ability to impact on quality as core role
Work in partnership across our system to embed the quality is everyone's business approach	Whole system is engaged aligned with our communications programme
Engage with national improvement programmes	Better engaged and best practice adoption
Create CG dashboards and embed governance processes	Whole system awareness and early warning system to allow ownership at local level
Develop system overview of quality standards for overview by the Clinical Governance Committee	Ensuring appropriate oversight of quality outcomes for our population
Working with primary care and clusters to improve pathways	Better pathways of care with our population with appropriate prescribing, diagnostics and referrals
Take a programme approach to reduce and improve HAI and TV performance	Reduction in HAI Improve TV
Improve our response to complaints by adopting more personal approaches and handling complaints within the specific timescales	Reduction in escalation of complaints More complaints being processed in timescales Performance management of complaints
Improve our response to FOIs by consistently meeting the timescales set by the Information Commissioner	Reduction of escalation

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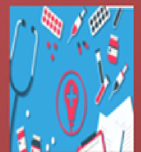
Health Inequalities

We will focus on reducing health inequalities with our partners across our system to reduce the gaps within our communities

Action	Outcome
Delivery of the actions from the screening inequalities plan with monitoring of effectiveness and screening uptake.	Aligned to stay well
Publication of equalities documents; delivery of actions and monitoring to increase vaccination among groups with low uptake	Aligned to stay well
Delivery of recommendations from DPH Annual Report	Aligned throughout
Delivering the social mitigation strategy and other plans based on experience to produce improved services and outcomes.	Aligned to Anchor Well

Realistic Medicine



We will have meaningful conversations with people to plan and agree care which will support all staff and patients to base care around what matters most to people, with a shared understanding of what healthcare might realistically contribute to this.

Action	Outcome
We will implement the action plan submitted to SG at end of July which is aligned to this ADP throughout	Establish pathways of care which promote person-centred care
Identify opportunities where Realistic Medicine can be further integrated into existing activities within NHSH in order to promote shared decision making and person-centred care	Increase uptake and use of ACPs and TEPs Increase community awareness of ACP and TEP resources and opportunities
We will develop a bank of educational resources & use innovative methods to deliver education	Provide clear signposting to resources and education around Realistic Medicine
We will empower our workforce to practice Realistic Medicine	Achieve greater engagement of workforce around Realistic Medicine principles Empower workforce with tools and skills necessary to practice and explain Realistic Medicine
We will continue to promote and embed the principles of Realistic Medicine working with our communities	Empower patients and our community to feel empowered to partner in their care
Provide a service which is environmentally, socially and financially sustainable while improving value, outcomes and experience	Improve RM related scores on National Sustainability Assessment Tool Improve patient feedback system

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NHS

Digital Delivery

We will provide digital systems that empower our communities to choose how they interact with us and enable our staff to work seamlessly.

Action	Outcome
Implement agreed digital delivery plan for 22/23, including:	Delivered to plan: Y/N
Deliver business as usual function to ensure continuity	Delivered to plan: Y/N
Continuation of existing programmes e.g. HEPMA, Order Comms	Delivered to plan: Y/N
Core infrastructure including wifi network, upgrade of core network, upgrade of Windows10 devices, GP merger server consolidation	Delivered to plan: Y/N
Replacement or upgrade of essential applications e.g. IDL, Chemotherapy system, Audiology system, Trakcare PMS, CareFirst (A&B)	Delivered to plan: Y/N
Support for national programmes – CHI and child health system replacement	Delivered to plan: Y/N
Support for new builds / redesigns e.g. NTCH, Caithness, Lochaber, maternity	Delivered to plan: Y/N
Additional delivery items e.g. develop plans for federation of Community digital platforms, linked access to systems, support for remote patient management (USC), contingency	Delivered to plan: Y/N
Develop and agree co-produced digital strategy and plan for 2023 onwards	Plan in place: Y/N

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Research, Development and Innovation
We will work in partnership to create opportunities for research, development and innovation to improve the health and care we deliver for our population

Action	Outcome
In development. Will be added to this ADP.	

Climate – Environmentally Proactive
We will work in a sustainable and efficient environment in line with carbon commitments to support delivery of health and care in the future

Action	Outcome
Complete our Net Zero Carbon audit to establish the financial impact on the board in achieving NZC	Establish funding to enable rollout
Continue with our various environmental and sustainability projects inc. green theatre, laundry waste, pharmacy waste project etc	We will have rolled out all green initiatives to the RGHs
Implement an environmental & sustainability policy in line with NHS Scotland strategy	Development of policy
Work with our external stakeholders in reducing our carbon commitments and contributing to a highland wide strategy	Work in partnership as a system to support our population, our people, in partnership

Corporate Services
We will develop, implement and review our governance frameworks to demonstrate and deliver accountable information to our Board and committees, Government and our population

Action	Outcome
Implement the long-term goals of the organisation and ensure delivery	Deliver on Together We Care in collaboration with our population, people and partners
Celebrate the successes and achievements of our organisation	Continuous feedback to the organisation and shared learning
Review policies and procedures that are a requirement to support our strategic objectives	Support our colleagues to deliver health and care for our population
Ensure we contribute effectively to the COVID public enquiry	NHS Highlands timely contribution to help inform the national outputs
Contribute to the development of the national recovery plan	Work in collaboration to deliver best outcomes for our population in a timely manner
Ensuring we learn and embed all internal audit outputs aligned to programme boards	Learn from internal audits to improve our health and care services
Work collaboratively to align to Scottish Government requirements such as reporting on this ADP, our annual review and other Committees	Give assurance to our Board and to Scottish Government on progress and challenges

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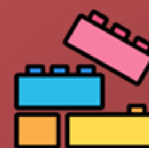
Estates and Infrastructure

We will work in collaboration with our communities and our workforce to provide safe, secure, high quality health and care buildings capable of supporting current and future health and care needs



Action	Outcome
Create an estates infrastructure strategy	Clear direction to support Together We Care and Co-Design principles
Implement our in year capital investment plan laid out in our 5 year capital plan	Future delivery of all aspects of health and care in suitable environments
Continue to invest capital funding in our backlog maintenance utilising a risk based approach	Future delivery of all aspects of health and care in suitable environments
Carry out organisation wide review of our primary care estate and future needs	Future delivery of all aspects of health and care in suitable environments
Continue in the SCIM process for service redesign in both Caithness and Lochaber	Working with communities to co-produce and co-deliver health and care in line with strategy
Carry out refurbishment of maternity infrastructure of Raigmore Hospital in line with Moray review and Best Start principles	In line with recommendations for modern maternity and neonatal units and to meet health and safety requirements

Living within our means – Financial Planning

We will become financially sustainable, work together to achieve efficiencies and create value by maximising our use of resources

Action	Outcome
Programme approach to financial savings embedded at all programme boards	Programme Boards with population outcomes at the centre ensuring quality, workforce, targets and best value are all considered during transformation.
Business partnering model to ensure support is provided across the organisation	Budget holders and decision makers fully conversant with the organisational funding and making informed decisions on spend
Specific workstreams to ensure sustainable savings are realised	Empowered and focused teams using successful project management/value management methodologies understanding all aspects of programmes of change
Definition of uncontrollable costs such as inflation; energy/fuel; NICE approval for drugs; cleaning standards; capital charges on investments etc are quantified	Strong financial governance over these areas with clarity for budget holders/decision makers about ownership/influence
COVID costs that remain will be carefully scrutinised and embedded in appropriate area	COVID will be managed as business as usual and built into every day processes and into baseline budgets

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REVENUE
NHS Highland started 2022/2023 with a baseline allocation of £725.117m. Additional anticipated funding of £232.942m from Scottish Government has been built into financial planning assumptions. Integrated Care funding of £138.305m, being the transfer of resource between Highland Council and NHS Highland in respect of Adult and Children's services, takes the NHS Highland planned funding for 2022/2023 to £1,096.364m.
At this point in the financial year, it has not been possible to prepare a breakeven financial plan. A gap of £42.272m has been identified. A Cost Improvement Programme of £26.000m is being developed but no funding source has been identified for the balance of £16.272m.

NHS Highland is working both at a local level and nationally to explore potential mechanisms to close this gap and deliver a breakeven financial position by 31 March 2023.

The position regarding supplementary allocations is currently unclear but it is assumed that investment in the following areas will continue into 2022/2023:

CAPITAL
NHS Highland is planning to invest £49.614m in capital schemes during 2022/2023. These schemes cover both the built and digital estate together with investment in new healthcare technology. The main areas of investment will be completion of the National Treatment Centre (Highland), increasing Maternity capacity at Raigmore Hospital.

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NHS Highland

COST IMPROVEMENT PROGRAMME

A Cost Improvement Programme of £26.000m is being developed with initiatives across the system as well as sitting within areas of specific operational focus.

We are focusing on all elements of good financial control to reduce our cost base with Cost Improvement Programmes to realize cost control, savings and cost avoidance activities. We will have a whole system approach with education, business partnering and dashboard reporting with KPIs and narrative to rapidly highlight areas of concern or focus.

We have drafted some **Quick Wins** which require further planning before implementation such as: -

- Building on our success with a programme to rationalize and standardize the provision of product in clinical areas which brings many more benefits than cost reduction.
- Full exit from COVID set-up including online COVID Pre-op testing, recycle and reuse mobile devices and laptops bought for COVID and closure of our COVID ward set-up.
- Develop Income Generation schemes with testing and services to 3rd sector and re-opening our Outpatient Café.

We have some **Key Actions** that we will progress quickly across the organisation which focus on: -

- Equity of access in our varied geographies, identifying fragile services with regard to workforce, developing admin bank as an alternative to agency use and developing an Internal Agency for Adult Social Care.
- Reviewing space utilization to ensure we get the best from our own facilities. Partnering with other organisations to share facilities where appropriate and finalizing our delivery model for vaccinations optimizing space to avoid spend on additional facilities.
- Rapid-fire service reviews challenging and supporting colleagues and teams into different ways of thinking/working and different staffing models using support from the Centre from Sustainable Delivery, involving GPs to deliver enhanced services, embedding International Recruitment to reduce reliance on agency spend.

We have an active **Ideas Generation** process which has produced a large list of schemes that still require planning and alignment to our Strategy and ADP the majority of which are enablers or foundational activities such as:-

- Use of technology for hospital monitoring
- Confirming rigor and benefits realization in our Business Case processes
- Review of centralized budgets and matching budgets to decision makers
- Development and Leadership training building confidence in transformation and conversance with organizational budgets / cost reduction targets as well as agile working.
- Challenging the culture of growing and adding to services, supporting colleagues and teams to transform and consider ways of getting more with existing funding
- Partnering with other agencies to deliver services where appropriate, for example – partnering with SAS to shape and deliver our Out of Hours Services.

There are further enabling initiatives which are required in order to ensure a longer-term sustainable organisation such as maximising the use of digital solutions to release time to care and to ensure that we have the correct mix of resources, allocated to the correct tasks at the correct time – across the organisation.

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Annual Delivery Plan 2022

Produced by Strategy & Transformation

NHS Highland July 2022.

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