NHS Highland

Service Model Report

Redesign of Health and Social Care Services in Caithness

Final Draft v4 – 23 March 2022

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SECTION 1 - INTRODUCTION

It is acknowledged that there is a need for change in the current provision of all adult health and social care provision in Caithness. This has been articulated in the Initial Agreement (IA) document which was approved by NHS Highland Board in November 2021 and the Scottish Government's Capital Investment Group in February 2022. As highlighted in the IA the current service model does not meet the changing requirements of health and social care in Caithness, with challenges across several areas including workforce, estates and shifting the balance of care to provide services closer to home and support the 2020 vision that "*everyone is able to live longer healthier lives at home or in a homely setting*". To facilitate this, we need to redefine and clearly articulate the Local Care Model. We need to listen and learn from the public that utilise the services and from the staff that deliver these. We need to build on good practice, identify the areas where we have gaps and look at what we can do differently.

To enable this key stakeholders and staff representing all the services in Caithness were brought together over three workshops to continue to refine the Local Care Model. The enthusiasm and commitment from all who attended the workshops proved invaluable and demonstrates the continual dedication to shape the future of services within the county.

The service model, the corner stone of the redesign, and a key element of the overarching Business Case will help define the workforce plan and the schedule of accommodation going forward.

It should be noted that the development of this service model forms an integral part of the current Place Based Review of Caithness, contributing to and dependent on a high degree of partnership working in meeting the wider priorities and outcomes of the people of Caithness.

During the course of the three workshops participants highlighted many of the infrastructure and enabling dependencies already articulated as part of the Place Based Review outputs – see Appendix E.

SECTION 2 - METHODOLOGY AND PROCESS

1. Background

The Caithness Service Model has been developed by NHS Highland (NHSH) with support from hub North Scotland Ltd. (hNSL) as a co-production with the community. The work undertaken develops the service model as articulated in the IA which has recently been approved by Scottish Government (SG) to a more mature state. The remit for hNSL was to provide 'challenge' to the current ways of working, to be 'provocative' to ensure that a new, fit-for-purpose, post-COVID Service Model emerged and to encompass all related health and social care services in Caithness.

The specialist resources that hNSL brought together to undertake the work were;

- Jill Pritchard – Specialist in change management within social care settings.
- Norman Sutherland – Healthcare Planner with in-depth knowledge of Caithness.
- Graham McCorkindale – hNSL Project Director with extensive experience of healthcare transformation projects.

The work was commissioned by NHSH utilising the hNSL 'Strategic Support Partnering Services' methodology. Activities and associated fees were set out and agreed prior to the commission commencing.

2. Initial Undertakings

At the commencement of the project, hNSL took time to understand the detail contained within the IA (which had recently been submitted to SG). Alongside this, we worked closely with NHSH colleagues to map out the stakeholder groups who were to be consulted and to develop a 'Three Workshop' approach to engagement.

3. Stakeholder Engagement Workshops

A series of three workshops were organised utilising Microsoft Teams. Each workshop followed a similar pattern whereby an objective was set, feedback from the previous workshop was illustrated and described, and then a series of questions were proposed which were analysed and discussed within 'Break Out Group Sessions'. Each workshop concluded with a reporting session where feedback was shared amongst all attendees and 'Next steps' were articulated by way of a preview to the subsequent workshop.

The title and objective of each workshop was as follows;

- **Workshop 1 (Initial Stakeholder Workshop) -** Objective: "To commence the process of reviewing and refining the local service model in support of Outline Business Case (OBC) Development". This workshop took place on 6th December 2021.
- **Workshop 2 (Proposed Service Model As Articulated in the IA) -** Objective: "To review our assessment of the developing service model before agreeing gaps, risks and actions required to address these" This workshop took place on 19th January 2022.
- **Workshop 3 (Refined Service Model In Support of the OBC) -** Objective: "To present, review and agree updated elements of the developing service model, as the basis for wider OBC development". This workshop took place on 9th February 2022.

Full details of the attendees, agendas, slide decks and the outcomes of each workshop are contained as appendices to this document.

4. Outcomes

Each workshop was well attended by a wide range of relevant stakeholders (>50 attendees per workshop) representing a full range of acute, community services including adult social care, public sector partners, community and third sector groups, patient and public representatives. It was gratifying that we received a significant level of continuity of input with many stakeholders attending all three workshops.

The discussions and points raised provided excellent input to the emerging Service Model. Valuable contributions were made by all attendees. The workshops were well organised by NHSH and the Breakout Group Sessions were facilitated by the hNSL team (noted above) supplemented by Diane Forsyth (Senior Project Manager for the Caithness project). For record purposes, each workshop was recorded.

5. Feedback

Excellent feedback was received by attendees both in relation to the content and the management of the process. Following a number of workshops, individual attendees supplemented their input by sharing further thoughts and information through follow-up emails.

SECTION 3 – MESSAGES AND THEMES

Diag. 1. The Initial Agreement "Rainbow Model"

The starting point for the work to consolidate and refine the model was the 'rainbow model' (above) plus the narrative in the IA, with its associated documents/appendices.

The discussion and engagement from the wide range of stakeholders over the three workshops and break out groups demonstrated robust general support for the model as first described and as it was further refined during this process.

Stakeholders consistently agreed with - the 'Local Care Model' approach and are clearly committed to delivering more preventative and early intervention services and support, increasing Anticipatory Care Planning and further developing the Multi-disciplinary Team (MDT)/ Single Point of Access (SPOA) approach with diagnostics, expert opinion, end of life and acute care being delivered as close to home as possible.

The resulting output from the workshops also enabled us to identify the critical infrastructure, enablers and dependencies that would need to be in place in order for this change to be delivered for the people of Caithness. Participants have also enabled us to articulate the key actions needed to progress the project to the OBC stage and to further identify the benefits that the redesign will bring.

The input from workshop participants allowed us to identify and fill gaps in the model and ensured that all partners were able to contribute to the key elements needed to make the model a reality going forward.

The main wider messages and themes from participants included:

- A clear commitment to partnership working across Health, Social Care, Community, Voluntary and Third Sector and Housing,
- The importance of staffing; recruitment and retention plus resourcing, supporting current staff, education and training, and workforce planning,
- The benefits of co-location (wider colleagues and partners included) and integrated teams
- The need for flexible responsive Commissioning,
- Data sharing, SPOA and single patient record, use of Near Me and digital approaches (robust IT)
- Communication and Education

SECTION 4 – ACTIONS

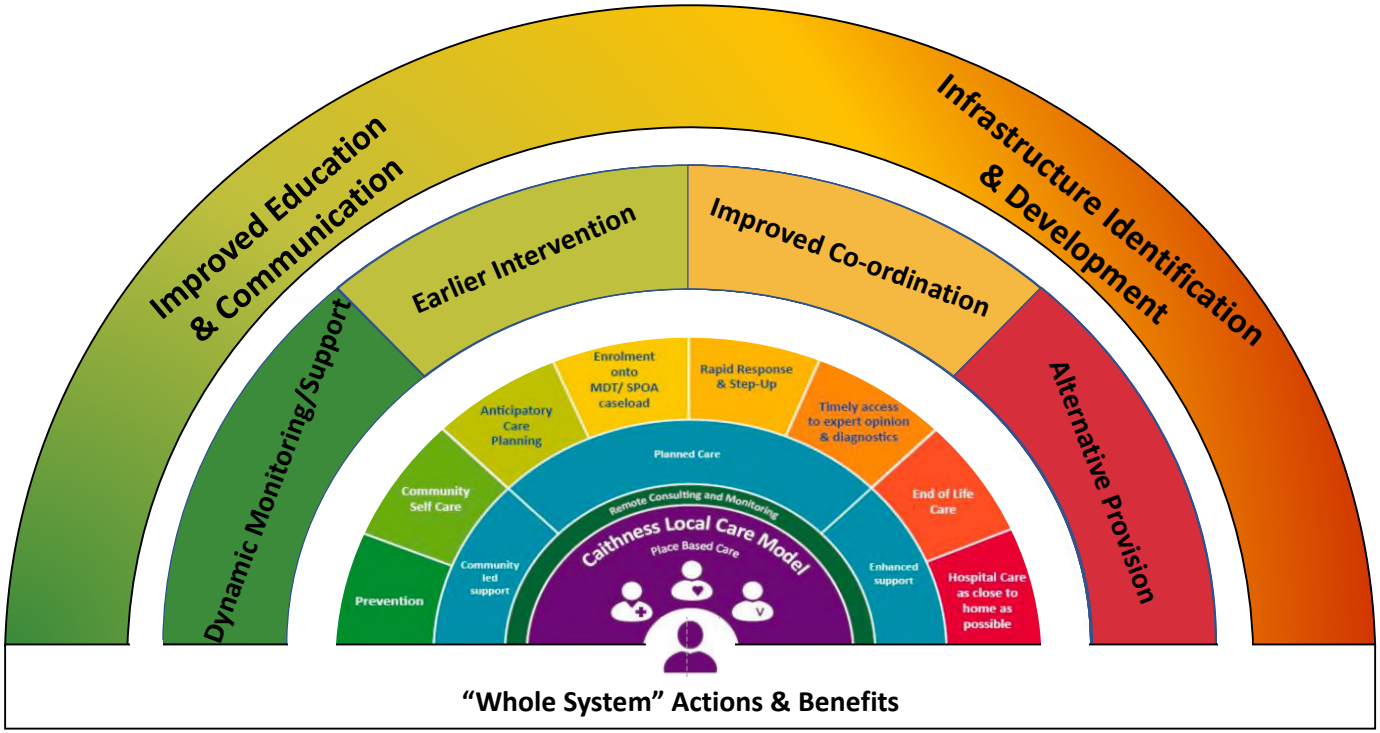
The workshop process identified a wide range of actions required to support the model, with relevant workshop outputs presented in Appendix D. These actions were also refined through extensive additional stakeholder workshop activity in an attempt to identify core actions required and ultimately the benefits they would give rise to. This refinement process also re-considered and re-defined the emerging "themes" associated with the model.

In practice this process involved continual review and refinement of the model, defined actions, and benefits as changes to any single component necessitated changes to all other elements. As with all elements of the work undertaken to date, the process was inclusive, interactive, and characterised by widespread enthusiasm and innovation.

Key themes agreed at the end of the workshop process were ultimately identified as:

- Dynamic support (The need to better understand and pro-actively respond to local needs)
- Earlier intervention (The need to act sooner to ensure better outcomes)
- Improved co-ordination (The need to make better use of all available resources)
- Alternative provision (The need to do many things differently)
- Improved education and communication (To ensure everyone is best able to recognise and support needs)
- Infrastructure identification and development (To ensure infrastructure is able to support delivery of the model)
- Whole system actions and benefits (System-wide actions and benefits that are essential to the global model for Caithness proposed)

These themes are summarised in the updated "Rainbow Model" presented in Diagram 2. (Below)



Diag. 2. The "Rainbow Model" Developed During Early OBC Workshop Activity

It is noted that all of these themes ultimately relate to the entire model but also that some themes, along with the activities and benefits they represent appear to have a "focus" in one or more sectors as represented in Diagram 2.

Diagram 3 (Overleaf) is aligned to the Rainbow Model and presents a summarised list of the key actions required by identified theme.

It is important to note that this is not all of the actions identified, but also that this summary has been agreed by the extensive range of stakeholders involved in the process as an appropriate overview of key actions required in support of practical implementation of the model. In use, these will be supplemented by a considerably more detailed action plan/benefits realisation plan that reflects all required actions.

Diag. 3. The "Rainbow Model": Key Actions By Theme

SECTION 5 – BENEFITS

The workshop process also sought to define specific benefits associated with implementation of the new model of care for Caithness and to relate these to the list of actions previously summarised. Outputs of this extensive discussion are summarised in Diagram 4. (Below)

Diag. 4. The "Rainbow Model": Key Benefits By Theme

Similar to the actions identified previously, it is again important to note that these are not all of the benefits identified, just those "core" benefits agreed by stakeholders as summarised through the workshop process. It is the intention of the process to ensure that these benefits are now used to update the developing project benefits register and support the completion of an appropriate benefits realisation plan that also includes those actions identified previously.

The more detailed understanding of the new model for health and social care services for Caithness developed through the workshop process will also:

- Allow alternative future scenarios to be developed in support of effective capacity modelling
- Identify alternative capacity requirements within different elements of the overall system and the impact these may have on the overall model
- Inform a preferred scenario for detailed planning purposes
- Support the identification of infrastructure and investment needs in all areas (and across the system)
- Ensure that all essential infrastructure components are included in the business case process (Not just CGH and the hubs in Wick and Thurso)
- Support the effective, evidence-based commissioning of all services (including through the third sector)
- Support the development of Schedules of Accommodation and briefing documentation for all required facility elements
- Support the development of appropriate workforce plans
- Support development and refinement of all the elements of the Outline Business Case

SECTION 6 – ENABLERS

As well as identifying actions and the benefits that may arise from these, during Workshop 2, participants were also asked to consider, by stakeholder-specific group, what else needed to happen in order for defined actions to occur. These elements were identified as "enablers" and characterised as statements that could be prefaced by the phrase: "to do this we need…".

A key objective of asking different groups of stakeholders to define "enablers" from their unique perspective was to understand the relative breadth and complexity of enablement required and the potential impact of empowering key groups. This also identified that many enablement actions required a very "light touch" from responsible public sector partners but could have potentially very significant positive outcomes for the process and new model of care. E.g. Whilst some required defined actions and/or investment, others simply required responsibility for something to be devolved or individuals/groups to be given "permission" to do something independently.

A summary of these enablers is presented in Appendix D 'Workshop 2 Feedback' in column E of the tab marked "Summary – Overarch Themes'. They will also be used to inform the developing project action plan, benefits realisation plan and risk register.

Key enablers identified include:

- NHS Highland and Highland Council to strengthening links between health and education
- NHSH to enhance commissioning and co-production of services between the public and third sector locally
- NHSH to provide technical/legal advice in support of the developing model as required
- NHSH to have an on-going role in co-ordinating and engaging with all stakeholders in support of the developing model
- NHSH to provide/commission specific additional training as required in support of the model

SECTION 7 – RISKS

During Workshop 3 participants were asked to think about and describe, as part of the breakout group sessions, what they thought were the three biggest risk to implementing the new model. Inevitably they listed more than three (see Appendix D) but there was unanimity on;

1. Recruitment and Retention being by far the biggest risk. This encompassed acknowledging the need to address the following;
    - Retaining existing population – young people and people of all ages in transition
    - Attracting people to Caithness – links to 'Making Caithness a great place to live, work, raise a family' etc
    - Working with schools, Further Education and wider partners to address skills gaps and create improved and sustainable career pathways
    - Do more 'Grow our own' staff, nurture and support existing staff, offer appropriate learning and development and training opportunities
    - Recruitment and Retention for third sector and voluntary groups
    - Contribute to wider opportunities to address the socio-economic challenges of the decommissioning of Dounreay and Vulcan.
    - Potentially link accommodation options to job opportunities

2. Followed closely by the need to have robust sustainable flexible digital, and IT infrastructure as well as more general support infrastructure, e.g. transport, buildings and connectivity. In particular the stakeholders highlighted;
    - The need for improved quality and resilience of Broadband cover for staff in work and at home/remotely
    - Broadband cover and Digital inclusion for the people of Caithness
    - Effective resilient platforms to share data across partners
    - Suitable transport/connectivity infrastructure options for patients/service users/the public
    - The need to use existing building assets in communities and ensure all buildings; new and existing are future proofed for future needs (as far as possible)

3. Capacity was also highlighted by all the groups in terms of;
    - The capacity within NHSH – do we have the necessary in-house resource to deal with such significant system change?
    - Workforce capacity and the need to upskill staff and the community
    - Training and development to meet increasing complexity of need
    - Transitional capacity – staff are already under pressure and we need to maintain momentum
    - Support Services - pharmacy, labs, soft FM, catering and cleaning, transport
    - Everyone's capacity to change!

The other top risks included Finance, Communication and Engagement, and Governance.

SECTION 8 – NEXT STEPS

Governance and Communication

This report will be shared with participants for comment and agreement, before being presented to the Project Team for ratification. Once ratified, the final report will be distributed to the full stakeholder group, Caithness Redesign Consultation group and published on the NHS Highland website. It will form the basis of OBC service redesign, workforce and accommodation development work.

Action plans

The outcomes and actions from this report will be incorporated into existing workstream action plans. The project workstreams are currently configured as follows:

- Workforce
- Multidisciplinary team (MDT)
- Single point of access (SPOA) / enhancing community services (ECS) / community led support (CLS)
- Supporting services
- Communications and engagement
- Estates
- eHealth

Further input from hub North Scotland Ltd

A scope of work is being agreed with hub North Scotland Ltd for further health and social care planner input to support the NHS Highland team and Service Leads with:

- Scenario planning and capacity modelling to quantify anticipated activity levels and fully detail the capacity required to deliver the agreed service model;
- Confirm service and activity groupings and location;
- Support service leads to produce service output specifications to include in the accommodation brief; and;
- Support the Estates workstream to develop schedules of accommodation, adjacency matrix and non-technical design briefing information.

Anticipated Deliverables

An outline of the anticipated project deliverables is provided below:

- Workforce and change management plans; delivering the service change process
- Accommodation briefs for the Community Hubs in Wick and Thurso and any associated satellite projects, and a reconfiguration of Caithness General
- Design development for the above facilities to planning permission stage, and then detailed design and construction drawings
- Design Quality Review and Verification process (at key business case decision points)
- Project benefits register, benefits realisation plan and risk registers
- Collation of Outline Business Case and Full Business Case, and subsequent governance process and approvals
- Construction - Community Hubs in Wick and Thurso and any associated satellite projects, and refurbishment of Caithness General Hospital

APPENDICES

The following appendices are contained within a separate document;

A – List of attendees from Workshops

B – Workshop Agendas

C – Slide Decks for Workshops

D – Outcomes from each Workshop

E – Dependencies with Place Based Review Work

NHS Highland

Service Model Report

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Appendices

A – List of attendees from Workshops

B – Workshop Agendas

C – Slide Decks for Workshops

D – Outcomes from each Workshop

E – Dependencies with Place Based Review Work

Appendix A Workshop Attendees

Forename	Surname	Designation	Organisation	Role / Representing	6th Dec. 2021	19th Jan. 2022	9th Feb. 2022
Alison	Brooks	General Practitioner / District Medical Lead / MDT Lead	Thurso & Halkirk Practices	MDT / General Practice	x		
Alison	Geddes	Senior Charge Nurse	NHSH	Outpatients			
Allan	Tait	Senior Development Officer	Caithness Voluntary Groups / Caithness Access Panel	Third Sector / Access Panel		x	x
Anna	Mackay	Occupational Therapist	NHSH	Occupational Therapy			
Bruce	Honeyman	Senior Charge Nurse	NHSH	Renal / Staff-side	x		
Catherine	Stokoe	Infection Control Manager	NHSH	Infection Control	x	x	x
Cathy	MacKay	Day Care Manager	Bayview	Day Care Services	x	x	x
Catriona	Naughton	Practice Manager	NHSH	Riverbank & Lybster Practices			
Chris	McKenzie	Manager	Caithness Mental Health Group	Day Services - Mental Health			
Christian	Nicolson	District Manager	NHSH	Community Services / Workforce Development	x	x	x
Christine	Tait	Practice Manager	Thurso & Halkirk Practices	Thurso & Halkirk Practices			
Claire	MacKay	Advanced Practitioner (West)	NHSH	Community Nursing		x	x
Claire	McIntosh	Care Home Manager - Bayview House	NHSH	Care Homes		x	x
Claire	Sutherland	Social Work Advanced Practitioner	NHSH	Adult Social Care	x	x	
Clare	Pottinger	Staff Nurse (Bignold)	NHSH	Standing in for Sam Lea			x
Clare	Rumgay	Clinical Services Manager	NHSH	Out of Hours			
Corrine	Mackay	Interim Chief Executive	Pentland Housing	Housing			
Craig	Loughhead	GP	Canisbay and Castletown Practice	Primary Care	x	x	x
Dan	Jenkins	Senior Health Improvement Specialist	NHSH	Health Improvement	x	x	x
Darren	Heppel	Estates Operations Manager	NHSH	Estates		x	
Dawn	MacDonald	Community Staff Nurse (Victoria Hospital, Rothesay)	NHSH	Staffside representative	x	x	
Diane	**Forsyth**	**Senior Project Manager**	**NHSH**	**Estates Projects / Group Facilitator**	x	x	x
Diane	Stark	Senior Infection Control Nurse	NHSH	Infection Control		x	x
Donna	Robertson	Assistant Support Manager	NHSH	Hotel Services			
Duncan	Scott	Consultant Physician	NHSH	Medical - Acute	x		x
Eileen	Reid-Richardson	Associate Lead Nurse North	NHSH	Nursing - Community Services	x		
Emma	Woolfenden	Rural Practitioner	NHSH	Clinical Lead Acute			
Eric	Green	Head of Estates	NHSH	Estates	x		x
Evelyn	Gray	Associate Director of Nursing (Acute)	NHSH	Nursing - Acute Services		x	
Ewen	Pearson	General Practitioner	Pearson Practice	Pearson Practice			
Fiona	Miller	H&S Manager	NHSH	Health & Safety	x	x	x
Fiona	Sinclair	Senior Charge Nurse	NHSH	Surgical suites			
Fiona	Watson	Specialist Primary Care Clinical Pharmacist	NHSH	Pharmacy	x		
Gail	Clark	Day Centre Manager	NHSH	Day Services - Learning Disabilities	x	x	x
Graham	Cormack	Area Service Manager	Scottish Ambulance Service	Scottish Ambulance Service	x	x	x
Graham	**McCorkindale**	**Project Director - hub North**	**hub North Scotland Ltd**	**Facilitator**	x	x	x
Heather	McLean	Patient rep	Member of public	Service user - West	x	x	x
Iain	McIvor	Director of Investment	Lochalsh and Skye Housing Association	Housing			x
Iain	Ross	Head of eHealth	NHSH	eHealth & Digital Technologies			
Isabel	Marr	Facilitator - hub North	hub North Scotland Ltd	Facilitator			-
Isabel	More	Medical Records Manager	NHSH	Medical Records	x		x
Jane	Ingleby	Oral Health Improvement Co-ordinator	NHSH	Public Dental Service		x	x
Jasmine	Oag	Employment Services Manager	NHSH	Human Resources			
Jenny	Peasley	Care at Home Manager	NHSH	Care at Home & Enablement	x		
Jill	**Pritchard**	**Change Management Practitioner**	**hub North Scotland Ltd**	**Facilitator**	x	x	x
Joanna	Groves	Practice Manager	NHSH	Riverview Practice	x		
Johan	Campbell	Laboratory Manager	NHSH	Laboratories		x	
John	MacLeod	Consultant Anaesthetist	NHSH	Pain Service			

Karl	Rosie	Local Councillor	The Highland Council	Community rep	x	x	
Kate	Dumigan	Staffside (RCN)	NHSH	Staffside representative			x
Kate	MacLennan	Community Engagement Officer	NHSH	Comms and Engagement		x	x
Kath	Gordon	Senior Business Support Officer	NHSH	Planning & Performance			
Kay	Allan	Area Support Manager / SS Project Manager	NHSH	Supporting Services	x	x	x
Kirstin	MacKay	Superintendent Radiographer	NHSH	Radiology	x	x	x
Kirsty	Morrison	Interim Chief Executive	Albyn Housing	Housing			
Laura	Bain	Clinical Nurse Manager	NHSH	Pain Service			
Laura	Menzies	Lead Midwife	NHSH	Community Midwifery	x		
Leonie	Cole	Professional Lead Dietician - North	NHSH	Dietetics	x	x	
Lesley	Martin	SPOA & Enhancing Community Services Lead	NHSH	SPOA / ECS	x	x	x
Lesley Anne	Bremner	Health Improvement Advisor	NHSH	Health Improvement	x	x	x
Linda	Bremner	Patient rep	Member of public	Service user - East			
Linda	MacDougall	Advanced Practitioner (East)	NHSH	Community Nursing	x		x
Lori	Pattinson	Workforce Planning Manager	NHSH	Workforce Development			
Lorien	Cameron-Ross	Clinical Director OOH	NHSH	Out of Hours			
Lorna	Whiteman	Professional Lead Physiotherapist	NHSH	Physiotherapy			x
Mairi	McIvor	TEC Services Manager	NHSH	TEC Services		x	
Marie	Cuthbert	Clinical Advisor	NHSH	Estates Projects		x	x
Marina	MacDonald	Patient rep	Patient Council	Service user - CGH			x
Margaret	Moss	Associate Director AHPs (North Highland)	NHSH	Allied Health			x
Margaret	Ross	Principal Housing Officer	The Highland Council	Housing		x	x
Mary	Richard	Cardiac Rehab Nurse	NHSH	Cardiac Rehab		x	x
Megan	Glass	HR Manager	NHSH	HR		x	x
Melanie	Sutherland	Advanced Practitioner, Diabetes Specialist Nurse	NHSH	Diabetes	x		x
Michelle	Johnstone	Area Manager	NHSH	Project Director	x	x	x
Mike	Hayward	Deputy Chief Officer	NHSH				x
Mike	Flavell	Lead Rural Support Team	NHSH	Rural Support Team		x	
Mike	Winter	Interim Clinical Leadership Advisor MH&LD service	NHSH	Mental Health	x	x	x
Morven	Shone	Project Manager (Workforce Development)	NHSH	Workforce Development	x	x	x
Muriel	Baroja-Rodriquez	Senior Charge Nurse	NHSH	Chemo & Medical Infusions		x	
Naomi	Watson	Project Manager	NHSH	Local Care Model MDT	x		x
Neil	Shepherd	Emergency Practitioner	NHSH	Clinical Lead Acute			
Nikki	MacKenzie	Integrated Team Manager (East)	NHSH	Integrated Health & Care Team / Community Mental Health	x		
Norman	**Sutherland**	**Healthcare Planner**	**hub North Scotland Ltd**	**Facilitator**	x	x	x
Nova	James	Clinical Nurse Manager	NHSH	Acute services	x	x	
Paddy	Farrell	Station Commander - North of Scotland	Scottish Fire & Rescue Service	Scottish Fire & Rescue Service			
Pam	Garbe	RGH Manager / SS Lead	NHSH	Supporting Services		x	x
Pat	McGee	Senior Charge Nurse	NHSH	Acute Assessment & HDU	x	x	
Pat	Niwa	Practice Manager	Pearson Practice	Pearson Practice			
Penny	Cormack	Care Home Manager - Pulteney House	NHSH	Care Homes	x	x	x
Penny	Gardner	Integrated Team Manager (West)	NHSH	Integrated Health & Care Team		x	x
Raymond	Bremner	Local Councillor	The Highland Council	Community rep		x	
Rebecca	Banks	Professional Lead - Podiatry	NHSH	Podiatry	x	x	x
Rob	Cargill	Deputy Medical Director - Acute	NHSH	Medical - Acute			x
Ron	Gunn	Community rep	CHAT	Service user	x	x	x
Ruth	Deplacido	Speech & Language Therapy Manager	The Highland Council	Speech & Language Therapy	x		
Sadat	Muzammil	Clinical Director, North	NHSH	Clinical Lead Community		x	x
Sam	Lea	Senior Charge Nurse	NHSH	Post-acute / Rehab		x	
Sandra	Jones	Senior Podiatrist	NHSH	Podiatry			
Sarah	Budge	Frailty Practitioner	NHSH	Community	x	x	x

Sarah	Pomfret	Staff Nurse (OPD)	NHSH	Outpatients (rep. as Alison Geddes is unable to attend)		x	x
Shirley	MacLeod	Macmillan Senior Cancer Nurse Specialist	Macmillan	Palliative & End of Life Care	x	x	x
Siobhan	Leen	Community Development Officer	NHSH	Public Health			
Stephen	Makin	Consultant Geriatrician	NHSH	Care of the Elderly	x	x	
Steven	Miller	Facilities Manager North Area	NHSH	Hotel Services	x	x	x
Susan	Shearer	Macmillan Advanced Nurse - Cancer Team Lead	Macmillan	Palliative & End of Life Care			
Tara	French	Head of Strategy and Transformation	NHSH			x	x
Teresa	Rayson	Planning & Performance Analyst	NHSH	Planning & Performance	x	x	
Tom	McWilliam	Assistant Clinical Dental Director	NHSH	Public Dental Service	x	x	
Tracy	MacKay	Manager	Laurandy Centre	Day Services - Older Adult	x		x
Tracey Ann	McGeachin	Senior Midwife	NHSH	Midwifery			
Urvi	Vora	Pharmacy Manager	NHSH	Pharmacy	x		
Vicky	Worrall	Senior Charge Nurse	NHSH	Emergency Department	x	x	x
Wendy	Edwards	Primary Care Manager	NHSH	Primary Care	x		x
Willie	MacKay	Local Councillor	The Highland Council	Community rep			
Zhen Ron	Tan	Project Manager	NHSH	Estates Projects	x	x	x

Appendix B – Workshop Agendas

Redesign of Adult Health and Social Care Services in Caithness

Development of the Detailed Service Model

Workshop 1 - Initial Stakeholder Workshop

Monday 6th December 2021 at 14:00 – 16:00

Via Microsoft Teams: Click here to join the meeting

Objective: ñTo commence the process of reviewing and refining the local service model in support of Outline Business Case (OBC) Development"

AGENDA

14:00	Welcome and introductions	MJ
14:10	Background, objectives and process	GM
14:15	Overarching Principles and Context	JP
14:25	Group Work Session: The current vs proposed service model	NS

Facilitators

1. Jill Pritchard
2. Norman Sutherland
3. Graham McCorkindale
4. Diane Forsyth
5. Isabel Marr

15:25	Plenary Feedback Session	Team
15:55	Any Other Competent Business	MJ

Redesign of Adult Health and Social Care Services in Caithness

Development of the Detailed Service Model

Workshop 2 – Developing the Service Model

Wednesday 19th January 2022 at 09:00 – 12:00

Via Microsoft Teams: Click here to join the meeting

Objective: ñTo review our assessment of the developing service model before agreeing gaps, risks and actions required to address these"

AGENDA

09:00	Welcome and introductions	MJ
	• Re(introductions) to hub North Team	GM
09:10	Summary of previous session and update on the developing service model	JP
09:30	Group Work Session: The developing service model	hub
10:30	*Comfort Break*	
10:40	Group Work continued: The developing service model	hub
11:10	Plenary Feedback Session	Team
11:55	Summary and Close	

Redesign of Adult Health and Social Care Services in Caithness

Development of the Detailed Service Model

Workshop 3 - Refined Service Model in Support of the Outline Business Case (OBC)

Wednesday 9th February 2022 at 09:00 – 12:00

Via Microsoft Teams: meeting link here

Objective: ñTo present, review and agree updated elements of the developing service model, as the basis for wider OBC development"

AGENDA

09:00	Welcome and introductions	MJ / GM
09:05	Summary of previous sessions; How will our service model change?	JP
09:15	The proposed OBC service model	NS
09:35	Group Work Session: The proposed service model	NS
10:30	*Comfort Break*	
10:40	Group Work continued: The proposed OBC service model	hub
11:15	Plenary Feedback Session	Team
11:45	Any Other Competent Business	GM
11:50	What happens next?	MJ

Appendix C – Workshop Slides

Development of Detailed Service Model for the Redesign of Adult Health and Care Services in Caithness

Workshop No. 1

6th December 2021

Welcome and Introductions – Michelle Johnson #1

The Caithness Redesign Journey

We've come so far already!

Protests

October 2017

Public Consultation

Aug — Nov 2018

105 meetings

2,017 responses, 9.4% response rate

70% support proposals for change

Integration, health and social care ☑

Clinical model, Caithness General ☑

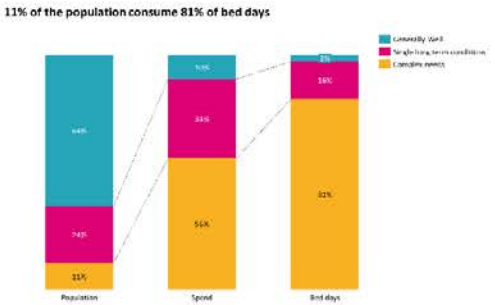
Workforce sustainability ?

Modernise estate and use of estate ?

Cabinet Secretary Approval May 2019

Pathfinder—Local Care Model

2019 to date



Service model development

Jan 2021 to date

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Risk Register workshop

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AEDET and Design Statement workshops

Submit IA business case

Summer 2021

Welcome and Introductions – Michelle Johnson #2

The Caithness Redesign Journey

The road ahead

OBC approval

FBC approval

Construction
New Hubs
Thurso
Wick

Construction
CGH refurb

Detailed Design—Hubs & CGH
. Room layouts
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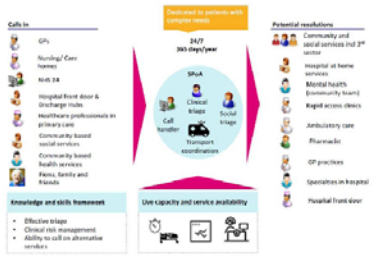

Accommodation Requirements
. Schedule of Accommodation
. Clinical Requirements
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Local Care Model
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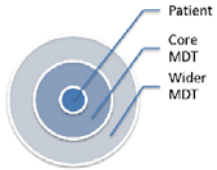


Detailed service model complete

Workforce plan

Outline Business Case
Autumn 2021 — Autumn / Winter 2022

Full Business Case
Autumn / Winter 2022—Autumn 2023

Implementation
Autumn 2023—Autumn 2025

Background, Objectives and Process – Graham McCorkindale #1

Background:

Hub North Scotland are the development partner for NHS Highland (community hubs)

- e.g. Skye + Aviemore, Lochaber & Dunoon.

Caithness

- Helping refine the Service Model + Project Brief
- Working with NHS Highland to deliver (design + procure)
- Hub North / SFT / SG Caithness Place Based Review = ongoing parallel activity

Graham – healthcare architect with over 25 years experience

Background, Objectives and Process – Graham McCorkindale #2

Hub North Introductions:

Jill Pritchard – social care transformation

Norman Sutherland – healthcare transformation

Graham McCorkindale – project director / project manager

Background, Objectives and Process – Graham McCorkindale #3

Objectives:

Preparation of a new, appropriate and innovative Service Model

- A continuation of the journey which has delivered the IA (positive feedback from SG)
- We are here to talk about services not buildings
- Its about opportunities to do things differently
- Once in a lifetime opportunity to provide real, person-focussed change (post COVID)
- Workshops are about listening and learning from each other

Background, Objectives and Process – Graham McCorkindale #4

Process:

3 workshops (this is No.1) to create a detailed Service Model

1st Workshop;

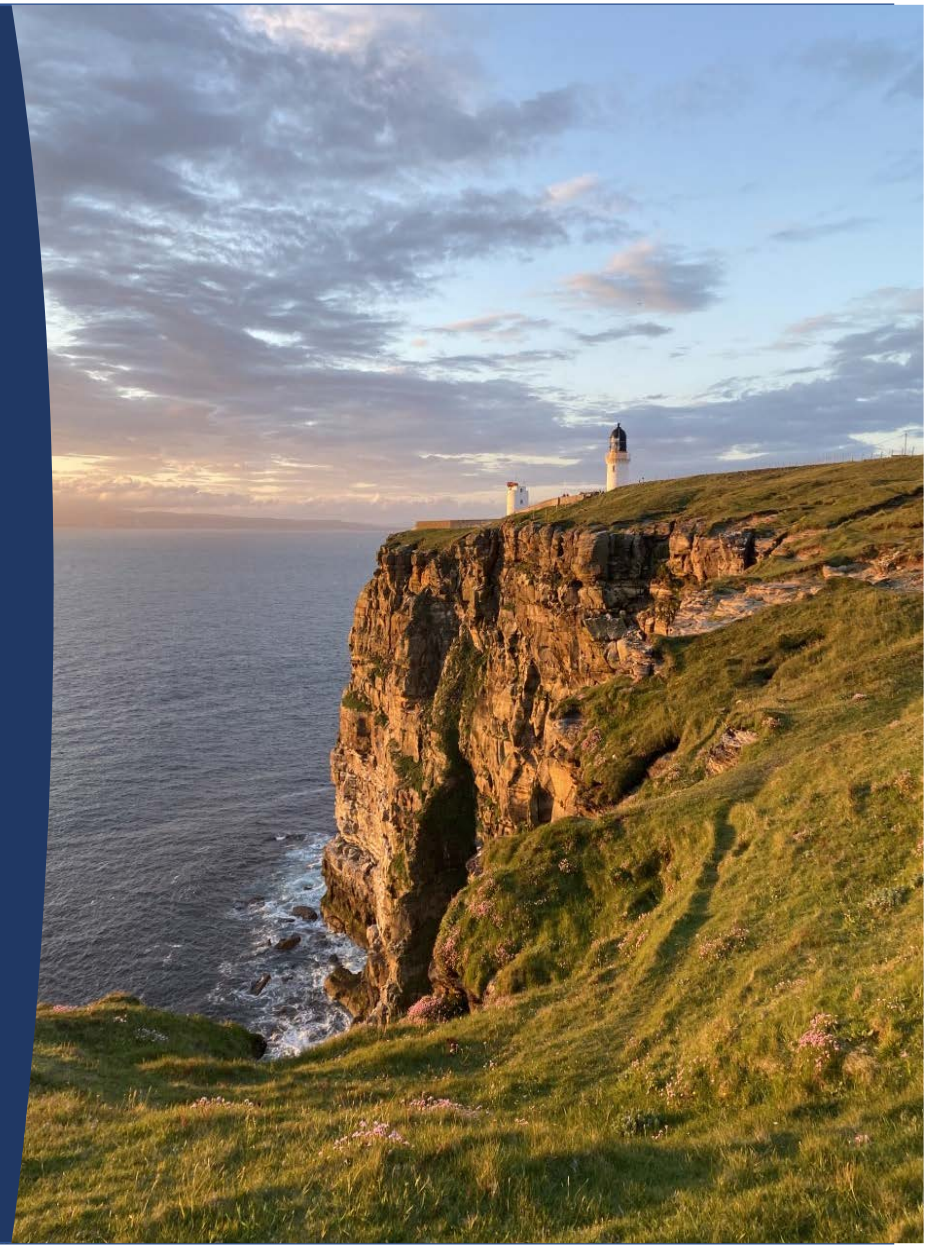
- Overarching Principles & Context – Jill Pritchard
- Group Work Sessions + Feedback – Norman Sutherland

Using Workshops 1, 2 + 3 we will develop;

- Service Brief
- Accommodation Requirements
- Workforce Planning

CAITHNESS HEALTH & SOCIAL CARE REDESIGN - BROADER LOCAL & NATIONAL CONTEXT

- Acknowledging impact (& opportunities) of/from Covid pandemic
- Remobilise, Recovery, Re-design Framework
- Part of a wider Caithness Place Based Approach
- Asset based approach with individuals & communities – ‘what’s strong’ not ‘what’s wrong’
- Digitally enabled self-management
- National Rehabilitation Framework
- Independent Review of Adult Social Care
- National Care Service Consultation
- Net Zero Carbon agenda, Just Transition



Our Caithness, Our Health
Delivering Healthcare & Health Improvement in Caithness - Overarching Principles

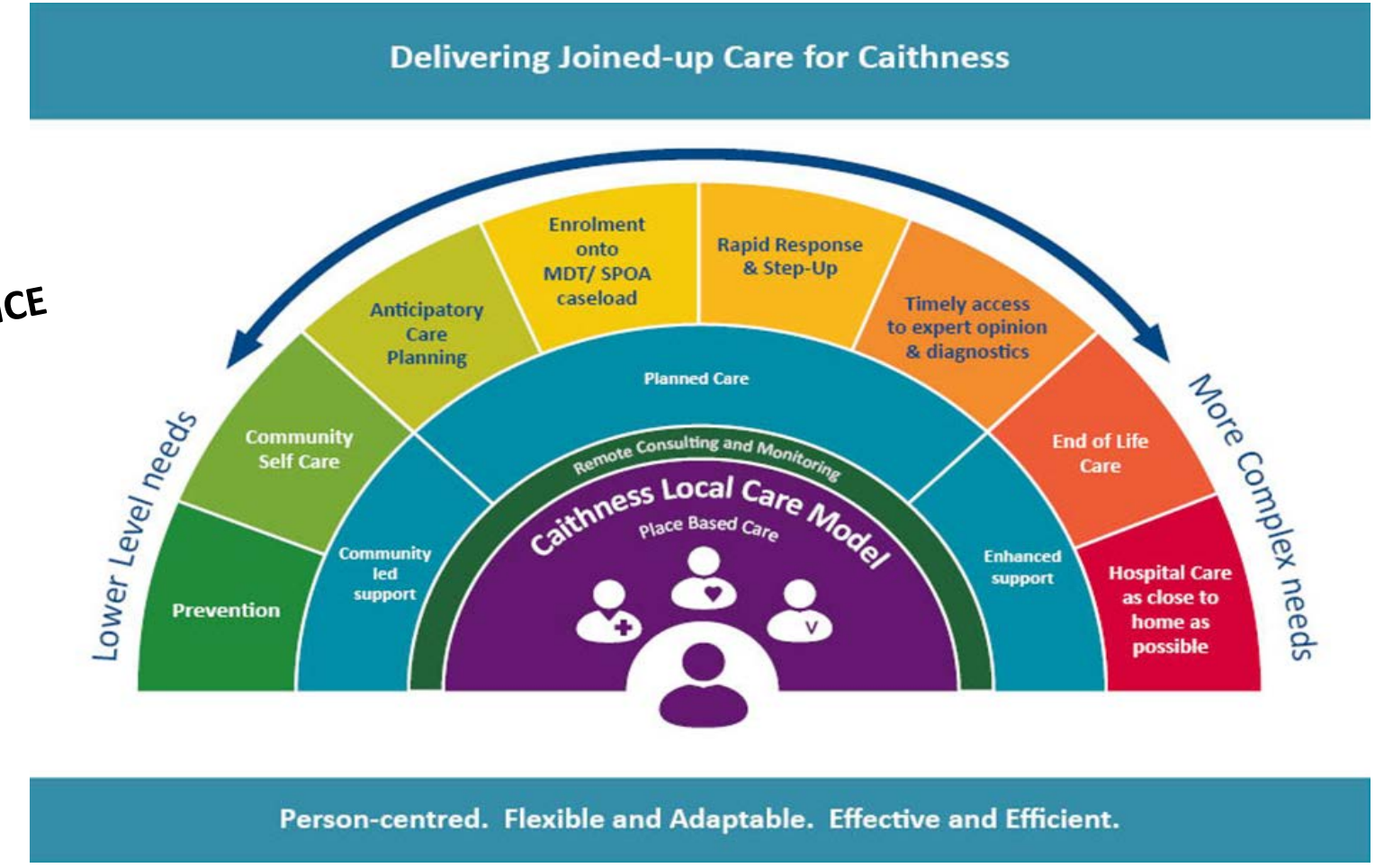
- **Utilising the 'Local care model'**
- **Supporting the workforce**
- **Focus on prevention & early intervention**
- **Person centred & outcome focussed**
- **'What matters to you' not 'what's the matter with you'**
- **Shifting the balance of care**
- **Right care, right place, right time**
- **Services closer to home**
- **Services provided in partnership with individuals & the community**
- **Population Segmentation / Targeted services**
- **Flexible, adaptable & sustainable**
- **Effective & efficient**
- **Utilising digital & technology developments in Health & Social Care**
- **Future proofing services**

Local Care Model

University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean

Our Caithness, Our Health
Delivering Healthcare & Health Improvement in Caithness

OUR CAITHNESS RAINBOW SERVICE MODEL



Developing the Rainbow Diagram

In Summary We Are:

BUILDING on the great work that has been supported by a lot of people already

REFLECTING on how the world around us has and will continue to change

DEVELOPING our local service model for Caithness

ADDING DETAIL to plans and beginning to inform design

Our Caithness, Our Health
Delivering Healthcare & Health Improvement in Caithness

Group Work uestions:

Thinking about the rainbo service model diagram from our business case that promotes support and care being delivered as close to home as possible:

1) **What do e already do that supports or underpins this model (What is good about the ay e currently deliver that e don t ant to lose)**

2) **Thinking ahead hat else do e need to do to ensure that people receive the support and care they need as close to home as possible**

BREAK OUT GROUP SESSIONS

Our Caithness, Our Health
Delivering Healthcare & Health Improvement in Caithness

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FEEDBACK FROM GROUPS

Next Steps – Graham McCorkindale

Workshop No.2

‘Proposed Service Model as Articulated in the IA’

Objective:

“To present an independent assessment of the proposed service model as documented in the IA before agreeing existing gaps, risks and actions required to address these"

- Summary of Workshop 1
- Independent overview of the proposed service model as presented in the IA
- Group Session on refining the service model as presented in the IA

CLOSE OF WORKSHOP No.1

Date and time for next workshop;

Wednesday 19th January 9am-12noon

NHS Highland

Development of Detailed Service Model for the Redesign of Adult Health and Care Services in Caithness

University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean

Workshop No. 2

19th January 2022

Welcome and Introductions – Michelle Johnson #1

The Caithness Redesign Journey

We've come so far already!

Protests

October 2017

Public Consultation

Aug — Nov 2018

105 meetings

2,017 responses, 9.4% response rate

70% support proposals for change

Integration, health and social care ☑

Clinical model, Caithness General ☑

Workforce sustainability ?

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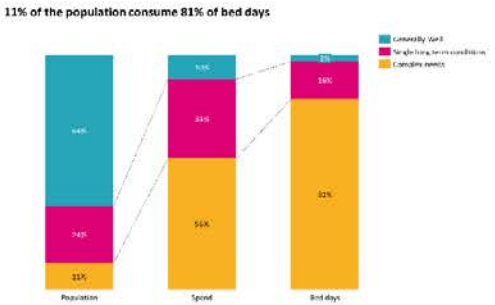
Cabinet Secretary Approval May 2019

Pathfinder—Local Care Model

2019 to date



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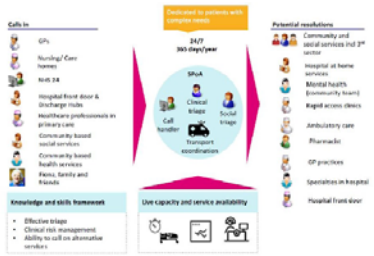

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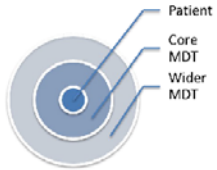

Detailed service model complete

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Full Business Case
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Implementation
Autumn 2023—Autumn 2025

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Hub North Introductions:

Jill Pritchard – social care transformation

Norman Sutherland – healthcare transformation

Graham McCorkindale – project director / project manager

Workshop No.2 Agenda – Graham McCorkindale #2

Workshop No.2

‘Developing the Service Model’

Objective:

“To review our assessment of the developing service model before agreeing gaps, risks and actions required to address these"

- Summary of Workshop 1 and update on the developing service model
- Group Work Session: Further Develop the Proposed Service Model

Workshop No.1 Discussion Questions

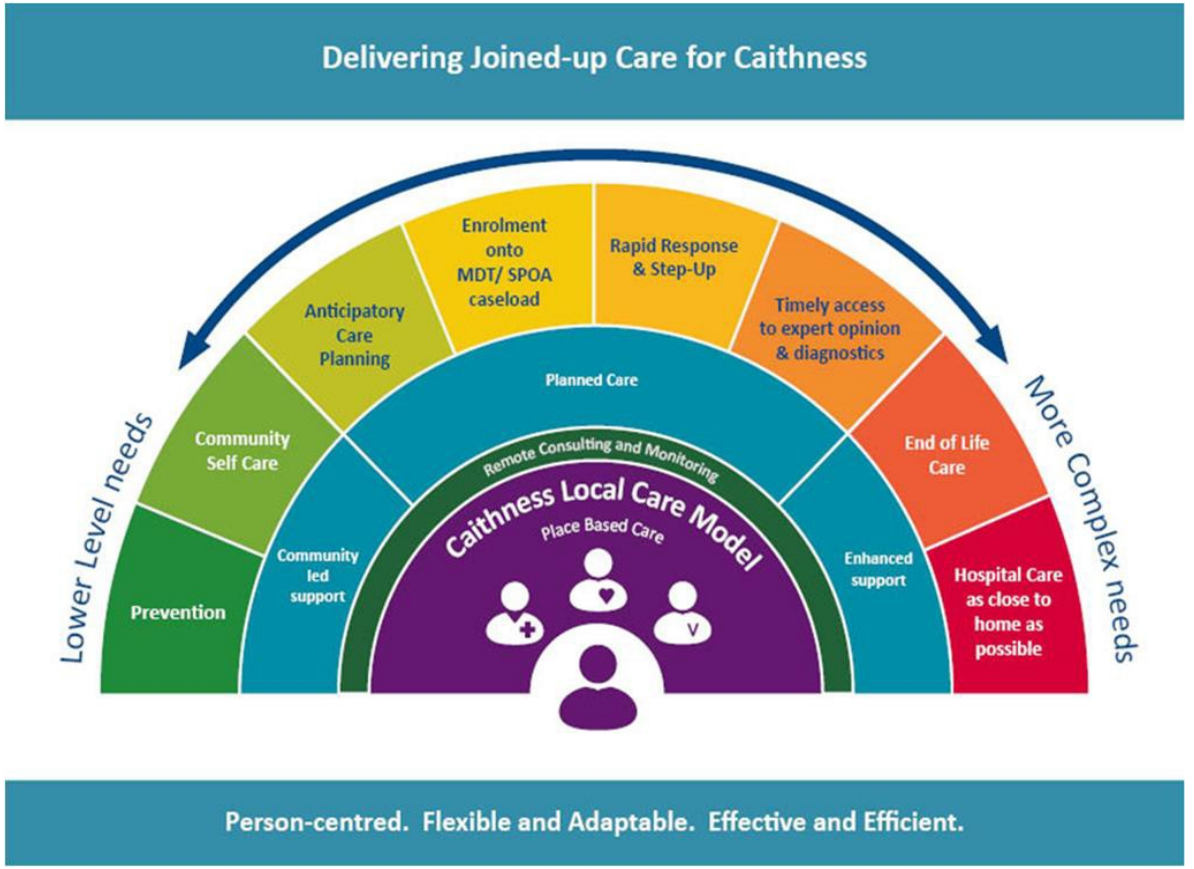
Caithness, Our Health Our Care:
Delivering Health & Social Care
Improvement in Caithness

Group Work Questions:

Thinking about the rainbow service model diagram from our business case that promotes support and care being delivered as close to home as possible:

1) What do we already do that supports or underpins this model? (What is good about the way we currently deliver that we don't want to lose?)

2) Thinking ahead, what else do we need to do to ensure that people receive the support and care they need as close to home as possible?



Initial Agreement: Summary of Baseline Local Care Model By Provision

Current Service Provision	Prevention	Community Self Care	Anticipatory Care Planning	Enrolment into MDT/SPOA	Rapid Response & Step up	Timely Access to Experts/ Diagnosis	End of life Care	Hospital Care as Close to Home as Possible
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Health Improvement Team								
Community/Vol/3rd Sector								
Podiatry								
Day Services-Older Adults								
Learning Disabilities								
Dental Services								
Community/District Nurses								
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MDTs								
Speech & Language Therapy								
General Practitioners								
Occupational Therapy								
Pharmacy								
SAS								
Drug & Alcohol Services								
Palliative Care								
Out of Hours								
Care Homes								
Acute Care – OP & Inpatient								
Accident & Emergency								
Facilities								

IA and Workshop No.1: Overarching Themes/Enablers

RECRUITMENT & ACCOMMODATION FOR STAFF

STAFFING/ RESOURCING/ WORKFORCE PLANNING/ROLE REVIEW

CONTINUE TO SUPPORT STAFF & EMPOWER THEM

CO-LOCATION OF INTEGRATED TEAMS

(& WIDER COLLEAGUES)

COMMISSIONING

PREVENTION & EARLY INTERVENTION

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& EDUCATION

IT

WIFI

BROADBAND

Workshop No.1: Participant Feedback on The Evolving Local Care Model

	Prevention	Community Self Care	Anticipatory Care Planning	Enrolment into MDT/SPOA	Rapid Response & Step up	Timely Access to Experts/ Diagnosis	End of life Care	Hospital Care as Close to Home as Possible
Community/Vol/3rd Sector								
GP/Primary Care Services								
Housing/Residential/Extra Care								
Acute/Hospital Services								
Whole System								

"Red boxes": Areas where previous discussions anticipate "us" doing more or doing things differently

Workshop No.2 How will we keep people at home or as close to home as possible?

Assumptions/Enablers
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Assumptions/Enablers
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Assumptions/Enablers
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Workshop No.2: Group Session Questions

Reflecting on the previous session, as a group of stakeholders with a particular focus:

1. What are the things (as a group) we could do differently that will keep people at home or as close to home as possible? (It may be helpful to concentrate on “red boxes”?)

2. What else needs to happen to enable you/us to do this? (What action and who by?)

3. What would the benefits be for the people of Caithness?

BREAK OUT GROUP SESSIONS

FEEDBACK FROM GROUPS

Workshop No.2: Group Session Questions

Reflecting on the previous session, as a group of stakeholders with a particular focus:

1. What are the things (as a group) we could do differently that will keep people at home or as close to home as possible? (It may be helpful to concentrate on “red boxes”?)

2. What else needs to happen to enable you/us to do this? (What action and who by?)

3. What would the benefits be for the people of Caithness?

AOCB

CLOSE OF WORKSHOP No.2

Date and time for next workshop:

Wednesday 9th February 9am-12noon

“To present, review and agree updated elements of the developing service model, as the basis for wider OBC development"

Workshop No.2 How will we keep people at home or as close to home as possible? (Community/Third Sector Feedback)

Assumptions/Enablers
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Assumptions/Enablers
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Assumptions/Enablers
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Assumptions/Enablers
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Assumptions/Enablers
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- Home visiting
- Structured activities
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Assumptions/Enablers
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NHS Highland

Development of Detailed Service Model for the Redesign of Adult Health and Care Services in Caithness

Workshop No. 3

9th February 2022

University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean

Welcome and Introductions – Michelle Johnstone #1

The Caithness Redesign Journey

We've come so far already!

Protests

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Integration, health and social care ☑

Clinical model, Caithness General ☑

Workforce sustainability ?

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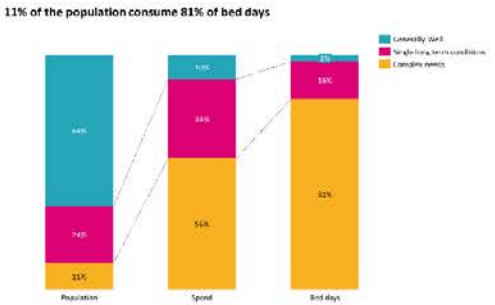

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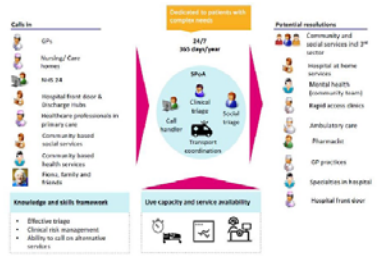

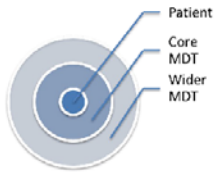

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Full Business Case
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Implementation
Autumn 2023—Autumn 2025

Background, Objectives and Process – Graham McCorkindale #1

Hub North Introductions:

Jill Pritchard – social care transformation

Norman Sutherland – healthcare transformation

Graham McCorkindale – project director / project manager

Workshop No.3 Agenda – Graham McCorkindale #2

Workshop No.3

‘The Proposed Service Model for the OBC’

Objective:

“To present, review and agree updated elements of the developing service model, as the basis for wider OBC development"

- Summary of Workshops 1 & 2 on the developing service model
- Group Work Session: Review & Agree the Proposed Service Model
- Prepare for wider OBC development

SUMMARY OF PREVIOUS SESSIONS

Workshop No.1 Discussion Questions – Jill Pritchard #1

Caithness, Our Health Our Care:
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Improvement in Caithness

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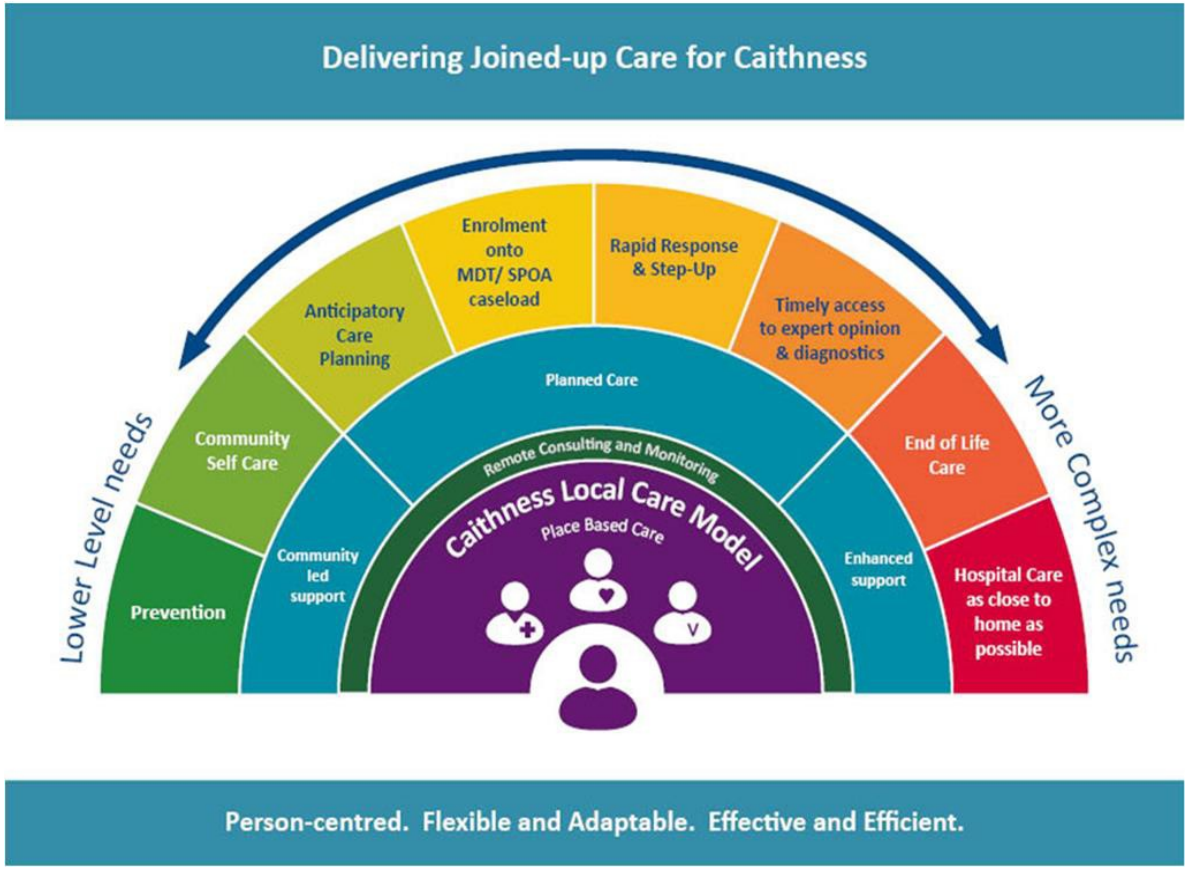

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IA and Workshop No.1: Overarching Themes/Enablers – Jill Pritchard #3

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& EDUCATION

IT

WIFI

BROADBAND

Workshop No.1: Participant Feedback on The Evolving Local Care Model – Jill Pritchard #4

	Prevention	Community Self Care	Anticipatory Care Planning	Enrolment into MDT/SPOA	Rapid Response & Step up	Timely Access to Experts/ Diagnosis	End of life Care	Hospital Care as Close to Home as Possible
Community/Vol/3rd Sector								
GP/Primary Care Services								
Housing/Residential/Extra Care								
Acute/Hospital Services								
Whole System								

"Red boxes": Areas where previous discussions anticipate "us" doing more or doing things differently

Workshop No.2 Discussion Question: How will <u>we</u> keep people at home or as close to home as possible? – Jill Pritchard #5

Assumptions/Enablers
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Workshop No.2 Provisional Analysis - Jill Pritchard #6

Enhanced Monitoring

We will:
- Expand monitoring & screening services
- Involve the third sector in assessment
- Identify client and carer needs
- Promote Power of Attorney
- Develop clear pathways for escalation

We will:
- Utilise a frailty assessment to identify potential people who may benefit from having an Anticipatory Care Plan (ACP)
- Identify a "lead person" to co-ordinate each individual's ACP
- Promote and enable POA's

We will:
- Identify those patients who may benefit from individual treatment plans
- Develop a data based schedule of services we can deliver locally
- Develop an action plan to minimise the impact of travelling for care/treatment

We will:
- Plan capacity needs in all areas based on available data and evidence-based assumptions
- Deliver screening services as appropriate

Earlier Intervention

We will:
- Provide/commission respite support
- Provide training for carers
- Develop a be-friending service
- Support pro-active prescribing
- Co-ordinate all ages pro-active activities

We will:
- Develop ACP's for all identified individuals
- Prioritise interventions as appropriate
- Involve the third sector in ACP's
- Co-ordinate with housing agencies

We will:
- Liaise with the MDT regarding specific ACP requirements
- Deliver more AHP services in community settings

We will:
- Work with the third sector to deliver financial and legal advice
- Support hospital based palliative care as required

Improved Co-ordination

We will:
- Commission the third sector when appropriate, E.g. Voluntary drivers
- Deliver peer to peer support
- Open doors locally to aid engagement
- Utilise TEC optimally

We will:
- Agree a shared vision for the MDT
- Better co-ordinate MDT meetings
- Agree what/who the SPOA will be
- Improve connections between Community Teams and GP Practices

We will:
- Standardise chronic disease management across Primary Care
- Involve carers in the MDT
- Support the Recovery College
- Develop individual treatment plans for those with complex treatment needs

We will:
- Normalise "Near Me" as the default consulting position
- Co-ordinate the delivery of individual treatment plans for those with particularly complex treatment needs

Alternative Provision

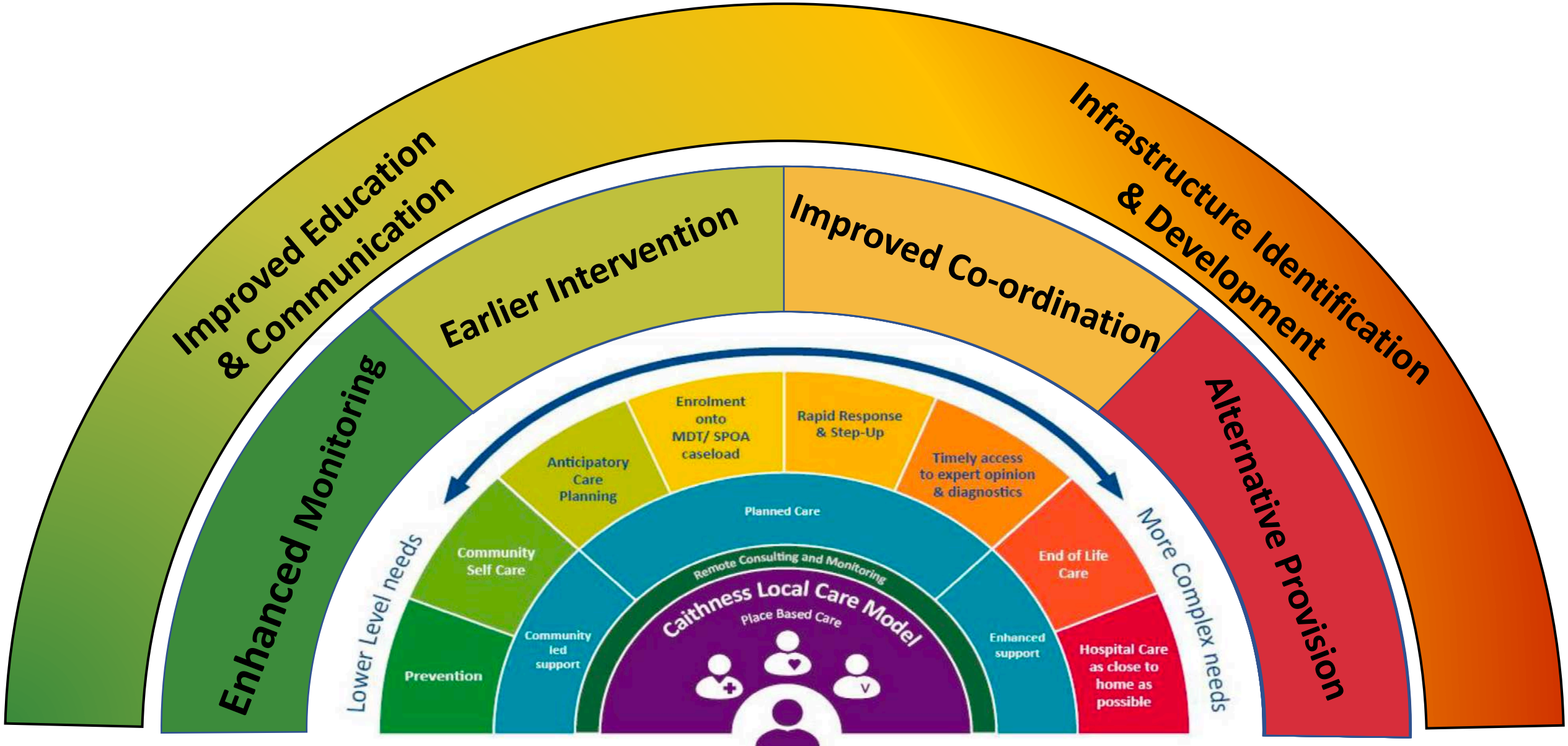
We will:
- Develop a schedule of prescribing alternatives (Social prescribing)
- Manage social prescribing activities
- Commission housing based support
- Develop a list of telecare responders

We will:
- Support direct professional to professional referral
- Utilise an effective Electronic Patient Record (EPR)

We will:
- Deliver a "hospital at home" service
- Enhance early access to investigations
- Support step-up bed and assessment capacity

We will:
- Support a "hospital at home" service
- Work with the third sector to improve/enhance palliative care provision (Services and facilities)
- Support enhanced rehabilitation

Workshop No.2 Provisional Analysis:
Mix of proposed actions and potential benefits across six "Key Themes" - Jill Pritchard #7



The New Model: Key Actions by Theme? - N Sutherland #1

Enhanced monitoring.

We will:

- Expand monitoring and screening activity
- Develop clear pathways for patient mgt. & escalation
- Provide respite support, day care & training for carers
- Support pro-active prescribing, E.g. Statins
- Develop and manage social prescribing
- Deliver peer to peer support
- Co-ordinate pro-active activities for all ages
- Commission housing support (Including faster adaptions)
- Develop a list of telecare responders

Early intervention.

We will:

- Agree a shared vision for the expanded MDT
- Better co-ordinate MDT meetings/activities
- Improve connections between Community Teams and GP Practices
- Utilise a frailty assessment to identify those requiring an Anticipatory Care Plan (ACP)
- Identify a "lead person" to develop and co-ordinate each individual's ACP
- Agree what, who and where the SPOA will be
- Support direct professional to professional referral

Improved co-ordination.

We will:

- Develop a data based schedule of services we can and should deliver locally
- Identify and manage those patients with complex needs who may benefit from individual treatment plans
- Standardise chronic disease management across PC
- Develop single person records & data sharing agreements
- Support the Recovery College
- Deliver "hospital at home"
- Enhance early access to investigations
- Support step-up/step down bed and assessment capacity

Alternative provision.

We will:

- Normalise "Near Me" as the default consulting position
- Work with the third sector to improve/enhance palliative care provision
- Support a "hospital at home" service
- Extend normal (scheduled) service operating hours
- Support enhanced rehabilitation
- Utilise Technlogy Enabled Care (TEC) optimally
- Undertake exception reporting for every episode where care deviates from agreed pathways

Education & Communication

We will:

- Promote self-management
- Promote Power of Attorney
- Embed enablement cross-system
- Improve "sign-posting"
- Support staff CPD
- "Grow our own" staff
- Manage expectations
- Underpin an effective media strategy promoting health in Caithness
- Work across agencies

Infrastructure

We will:

- Support effective consolidation
- Invest in digital infrastructure
- Identify existing resources to act as physical/satellite/virtual hubs
- Include transport considerations
- Make effective EPR's a reality
- Use data and agreed assumptions to model need
- Re-model our workforce
- Influence & inform change at CGH
- Develop new Community Hubs

The New Model: Key Benefits by Theme? - N Sutherland #2

Enhanced monitoring.

We will:

- Optimise local service delivery
- Reduce visits and travel distance for healthcare
- Reduce accidents at home
- Reduce unscheduled admissions to hospital
- Reduce length of stay in hospitals
- Reduce the number of hospital beds from that otherwise required
- Keep people in their own home for longer
- Reduce care home places from that otherwise required
- Strengthen the local community & economy

Early intervention.

We will:

- Keep people fitter and happier for longer
- Reduce the number of health appts/person
- Create capacity
- Reduce waiting times
- See the right person first time
- Avoid non-value adding interventions
- Enhance inter-professional relationships
- Improve health outcomes
- Optimise/re-align investment in services and facilities

Improved co-ordination.

We will:

- Better co-ordinate care for the most complex
- Reduce the number of patient journeys out with Caithness
- Reduce unplanned admissions and complications
- Free up professional time and resources to re-invest locally
- Improve recruitment & retention
- Improve chronic disease management
- Accelerate recovery
- Have an effective Recovery College with a positive impact on long-term condition mgt

Alternative provision.

We will:

- Reduce referral times
- Reduce acute hospital admissions (relatively)
- Reduce hospital bed days
- Reduce delayed discharges
- Reduce HAI and complications
- Enhance end of life care
- Reduce acute interventions/ admissions associated with end of life care
- Support continual improvement by learning from every mistake
- Modify and update systems and pathways accordingly

Education & Communication

We will:

- Better manage our own needs
- Increase POA use
- Focus on re-ablement
- Be aware of alternative services
- Have more motivated staff
- Have fewer recruitment issues
- Have fewer complaints
- Have an effective media strategy
- Benefit from optimal, cross-agency support

Infrastructure

We will:

- Have fewer but better buildings
- Have a good digital infrastructure
- Have a series of defined hubs across Caithness
- Improve transport for all
- Reduce duplication & error (EPR)
- Understand need and capacity
  Have clear plans for CGH
- Have clear plans for new Community Hubs
- Focus on NZC commitments

Workshop No.3: Group Session Questions – Norman Sutherland #3

Reflecting on our previous sessions and the feedback provided today, as a group of **mixed** stakeholders:

1. Do you agree with the key themes/messages emerging about the new model of care for Caithness?

2. How would you like to see the list of key actions currently presented being modified?

3. How would you like to see the list of key benefits currently presented being modified?

4. What are the three biggest risks you see to implementing the new model of care?

BREAK OUT GROUP SESSIONS

FEEDBACK FROM GROUPS

Workshop No.3: Group Session Questions – Norman Sutherland #3

Reflecting on our previous sessions and the feedback provided today, as a group of mixed stakeholders:

1. Do you agree with the key themes/messages emerging about the new model of care for Caithness?

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3. How would you like to see the list of key benefits currently presented being modified?

4. What are the three biggest risks you see to implementing the new model of care?

AOCB

What happens next? - Michelle Johnstone #3

- Refine the model in response to your feedback from today
- Use the model to inform:
  - Capacity requirements (Scenario modelling)
  - Workforce plans
  - Schedules of Accommodation (Actual spaces required)
  - Facility relationships (existing & new) and designs (Hubs and CGH)
  - Other infrastructure investments, SLA's, etc.
  - The Place Based Review
- Feedback to the wider community on progress
- Continue to develop the OBC
- We hope, with your involvement in all areas as an on-going "reference group"
- Thanks!

What happens next?– Michelle Johnstone #4

The Caithness Redesign Journey

The road ahead

OBC approval

Concept Design—Hubs & CGH
- Floor plans
- Planning application

Accommodation Requirements
- Schedule of Accommodation
- Clinical Requirements
- Technical Requirements

Detailed service model complete

Workforce plan

Detailed Design—Hubs & CGH
- Room layouts
- MEP design
- Building warrant

FBC approval

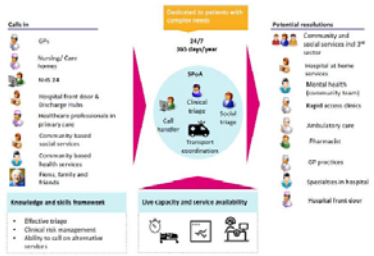
Transition plan

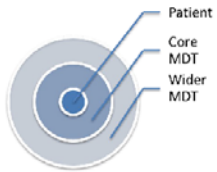
Local Care Model
- Test of Change
- Develop Model

Construction
New Hubs
Thurso
Wick

Construction
CGH refurb

Workforce Change
SPOA in place
MDT in place





Outline Business Case
Autumn 2021 — Autumn / Winter 2022

Full Business Case
Autumn / Winter 2022—Autumn 2023

Implementation
Autumn 2023—Autumn 2025

Early Option Appraisal Feedback - Michelle Johnstone #5

C	**C**aithness General Hospital should be re-furbished and maintained as a rural general hospital.
R	**R**e-patriation of patient episodes to Caithness should mean fewer people travelling longer distances for healthcare.
E	**E**xisting community beds delivering palliative (end of life) care and community access can be maintained in both Thurso and Wick.
A	**A**ppropriate co-location of key services, including hospital and care home beds, within new care hubs will enhance sustainability .
T	**T**eams – and wider stakeholders/services - will also be co-located within these hubs to enhance efficiency, effectiveness and further aid sustainability.
I	**I**nvestment in facilities, underpinned by robust business cases, will support delivery of the agreed model of care in the most effective way.
V	**V**oluntary sector and partnership working can be strengthened to provide optimal support for the overall service model and hubs as appropriate.
E	**E**nhanced community/stakeholder investment could mean care hubs become care villages and that Caithness could become Scotland's first "caring community".

Early Option Appraisal Feedback – Michelle Johnstone #6

Early Option Appraisal Feedback – Michelle Johnstone #7

Appendix D – Workshop Outcomes

Appendix D – Workshop Outcomes – Workshop 1

Workshop 1 – 06 12 21

Feedback from Group Work

Delivering Joined-up Care for Caithness

Person-centred. Flexible and Adaptable. Effective and Efficient.

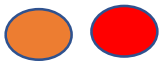
SERVICE	GOOD THINGS TO RETAIN	WHAT DO WE NEED TO DO
Public Health	Have increased public health promotion & prevention activity	Need more PH practitioners to do more promotion & early intervention
	We are working with 'here for Caithness' – community led support & intervention	Need to do more of this and not 'throw a statutory service at people'. Need to capitilise more on wealth of volunteers & community groups
		Need to educate everyone on early intervention & prevention – service users, patients & staff
Health Improvement Team	Focus on smoke cessation – well used service and linked to other service providers	Getting right balance of face-to-face and Near Me.
Community, Voluntary & 3rd Sector	Community support has been fantastic throughout COVID "We can't do everything the professionals do – but we can do a lot!" Covid experience has demonstrated how resilient the	Include the community/3rd sector in the developing Health & Care spec – 'we can do more' Important to sustain this and build on it going forward. Work with the community to jointly care for the population. Commission the 3rd sector organisations to deliver support/fill gaps where appropriate. (Great value!)

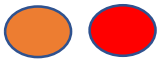
	people of Caithness are. They have shown an amazing community spirit.	
	Keep people out of hospital	Identify the people whose role is to scan for potential crisis.
		Encourage support networks to identify if/when someone needs help & Encourage those who need it to seek help earlier. Get better at recognising people who are heading towards a crisis.
		Better signpost the alternative services available
Podiatry 	Preventing infections and hospital admissions	Need to address work force issues , service is fragile
	Collaboration with GP's, community nurses + consultants	Need to do more activity around anticipatory care
	Avoiding patients travelling to hospital through Near Me, using photos and videos. Use of mobile WiFi hubs	Could use more tech for linkage to patients
Day Services – Older Adults 	Due to Covid the service has become 'one to one' and has been the 'crisis point' for many families	Resources - Staffing + funding issues
		Need to sort out referral service as can take up to 5 months to get in to system
		Need to address social isolation issues which still remain
		Need to improve transport issues (patients coming to day centres) due to restriction on patient numbers on a specific vehicle. Takes 2.5 hours to get 9 patients to the centre. (Covid). No local taxi service with wheelchair access
Learning Disabilities 	Provide an excellent service locally/support people with profound needs.	
	Give parents and carers a much needed break and support. (Aiding resilience)	Understand how/where this fits into the developing model
	Support people in their own homes as a result of COVID	Provide peer support to carers who are currently working much more independently than they were pre-COVID.
		Understand the longer-term impact of COVID on this (and other) service models.
Dental Services 	Good enhanced care/interventions for vulnerable people locally & in Care Homes in last 20 months	

Community & District Nurses 	'Can do' attitude in Caithness	Lack of resources, need more nurses- recruitment challenges
	Advancing skills for staff	Need to further develop the District Nurse model & role – promised a Review 2 years ago- Need to be more of an enabling, supporting role , shifting balance of care to home , health promotion & case management. Buurzorg Model
	Collaboration with other services – good use of MDT	Need to improve WiFi for staff and patients
	IV & chemo service at home	
	Good local orthodontist & secondary services to avoid traveling to Inverness	
Adult Social Care 	Focus on early intervention & prevention	Too much reactive stuff normally and therefore not getting to the preventative action We need systems to all talk to each other
	Good collocation with Care at Home teams, OT etc., allows continual (and happenchance) discussions + reviews	More physical collocation required
	Good links to housing	
		Need to address delays / bed blocks due to lack of POA
Care at Home/Integrated Care 		Tests of change being implemented as part of the redesign – rapid response • Overnight care service • Step up beds at Pulteney House New Frailty Practitioner post starting Jan 2022
	Re-ablement and Care at Home services. Care at Home is part of the NHS service, which is a real benefit to integrated team working.	Resourcing & recruitment issues - Need to 'grow our own' staff & have better career progression – Carers train as nurses at Raigmore then don't come back
		Need more flexible services – too rigid currently , don't meet peoples needs
	Single point of Contact is great	Need Single Point of Access !- one number – great triage
		Need SINGLE PATIENT RECORD, improve comms & patient records across whole of H & SC
		Need Discharge Coordinator/facilitator role
		Good reablement service – needs to be widened out & more people need to be made aware of the approach

	Good collaborative work with OTs and physios but could do more	Co-location at WSH has been great – huge benefit in being F2F. Enables being much more Person Centered
		Need to identify a Lead Person in the MDT for each service user/patient- one key contact
MDTs/Local Care Model 		Expand the capacity of all teams who will be involved (Care at home, AHPs, Community Geriatrician etc), to enable it to be more responsive. If at 100% all the time then there is no capacity to deal with emergencies.
	Holding regular MDT meetings	Need to agree process for co-ordination of service provision – is this through regular MDT meetings or some other way? IT systems to support once process is established
		Early identification is key in crisis response. Pre-referral discussions – preventative – think ahead and work with the third sector. Key role of MDT is to identify people heading towards crisis and intervening before this occurs. It is data driven.
		Need the right people in theMDTteam
		Ensure that we deliver optimal packages of care based on optimal inputs to MDT meetings.
		Get better at ensuring the available funding goes where it is needed and will buy us the most. (Benefit of third sector commissioning where/when appropriate)
Speech & Language Therapy 	Meets the needs at specialist level	Don't want to miss targeted group. Improve on universal awareness training for other teams so that they can provide general support, freeing up S&LT to provide more specialist input
General Practitioners 	Bulk of care delivered by General Practice, with community team support, they are the back-bone	Local care model will only work if primary care remains at the backbone. Bring this altogether and ensure the non-Hub practices are right up the middle of it.
	Covers a large area, don't need to go too far to access services	Keep access to services at the peripheral level – don't centralise in the Hubs. Ensure the redesign promotes GP across the county and that there is equitable access across Caithness.
	Multidisciplinary teams coming in to the practice to deliver services – works very well.	Ensure **all** Caithness practices have sufficient space to allow this
Occupational Therapy 	Good use of virtual assessments/interventions (recent splinting example!)	Under resourced – Recent establishment review based on whats essential – but should be based on evidenced based practice

		Need Single Patient Record to provide better service
		Need to do more to identify frailty early
		Huge benefits in co-location of MDT
		Good use of rotational approach , - helps spread experience. Re-ablement approach etc
		Partially contracted equipment service – need to learn from this (god waste reduction) . Need more integration of equipment services
Pharmacy 	Great relationships with primary & secondary care- know our patients & the staff really well (rapid development of services in the last 20 months)	Big challenge with recruitment of pharmacists, we need more – we don't have enough time for research, development, audits. Need more time for community led support
		Recruitment - Need to make Caithness more attractive for people – attract more diversity. Need to make our people happier at work . Majority of Comm Pharmacies are run by locums.. Plus some people nearing retirement
	Great use of transport to deliver drugs to support early discharge – really helps with Flow	Need to improve services & do more preventative work & facilitate discharge more - Provide more AHP led outpatient services (with nurse practitioners & other AHPs)to relieve pressure on Consultants
		IT & WIFi and Broadband connectivity need to be robust – frustrating – went down last week – colleagues lost work
		Challenge with new Pharmacy training – will locums be trained. Need supervision for 1st 2 years of new aspect of training
SAS 	SAS as an integrated part of the Team	Promote SAS co-location with other services.
	SAS treat patients in their own home using a broad range of alternative pathways. (Do not default to taking people to A&E)	Review opportunities for new/additional pathways that could be supported by the SAS
	SAS support post-discharge visits	Review additional opportunities associated with the advanced paramedic role, E.g. Anticipatory care/ assessment visits.
	SAS looking to further expand their role.	Review additional opportunities associated with the advanced paramedic role, E.g. Anticipatory care/ assessment visits.
Drug & Alcohol Services 	Provide third sector support	Commission services (including from the third sector) appropriately.

		Realise that Caithness has a negative international reputation relating to drug and alcohol problems and treat the issue accordingly.
		Increase our capacity and capability to deal with this huge problem in Caithness.
Facilities 	Shown we can be reactive as well as proactive	Hub services need to stay in Caithness
		Need to join up equipment & transport
		Need to break down Silos across schools, kitchens, council buildings – need to share facilities and join up more. Maybe look wider than Caithness – Sutherland
		Need improved IT services
		Need staff accommodation included in Workforce Planning
Palliative Care 		Fragile Service out of hours? Michelle/check
	Excellent MacMillan Service	Need to expand on this and offer/extend care at home
Out of Hours 	OOH services have a direct link to GP's (in some areas)	Ensure consistency across the area
		Agree the preferred model for co-location.
		Address gaps in the existing OOH service to ensure an optimal early response
Care Homes 	High quality end of life care – great joint work with Highland Hospice	Enthusiasm for rapid response care to prevent admission – some people in care homes who don't need to be
Acute Care – Outpatient & Inpatient 	Hospt setting day case service really good	Led by theatre time – could do more
	Really good end of life care in Town & County and Care homes. Everyone works together – including porters	
	Really good joint work with GPs – they can refer right in to hspt	
	Emergency Dept works really well even though environment is really poor	Team work really well in poor environment – a better environment is critical – its not fit for purpose
		Need more use of Near Me – need all Consultants at Raigmore to use Near Me as default – look at peoples post codes!

		Need to do more to identify frailty. Need to identify frailty early – hospital beds are full of frail people. Need to improve timely discharge
	Focus on safe discharge by working with MDT to avoid delays	Need more of a MDT approach & need to develop 'Hospital @Home service' Need more & enhanced District Nursing service
		GPs need to be in the Hubs – great relationships between primary & secondary care – need to support further
	COP nurse to reduce length of hospt stay	Need access to step down beds
		MORSE might be the way forward with single patient record- needs to include Care@ Home team
	Fundamental positive change in the service. From 1 to 8 physicians at CGH (over last 7 years). More junior docs and docs in training. Also now have surgeons and anaesthetists. Service now seen as an exemplar for Rural General Hospital	Ensure keep all staff at all levels
	Tight-knit team culture	
	Community of medical learning	
	Good communications	Need to improve the messaging to educate local population
A & E 	A&E can "flag" certain patient groups for f/u by specialists to generate additional support and prevent re-attendance. E.g. COPD, diabetes.	Add other "revolving door" client groups to this list for intervention, E.g. Those with drug and alcohol issues
	A&E discharge people quickly wherever/whenever possible	Increase our capacity/ capability to deliver "emergency support packages" to prevent admission.
	A&E support other services where they have the specific skills and capacity to do this	Ensure that the required capacity and clinical skills are maintained.
		Identify transport options – especially for those who arrive by ambulance, E.g. Volunteer drivers?
		Identify gaps in "emergency support packages" and who can best fill them. Is there a role for the third sector? Is there a role for the hubs?

Appendix D – Workshop Outcomes – Workshop 3

GROUP

1. **Community Vol & 3rd Sector**
2. **Housing/residential/extra care/care@home**
3. **GP/Primary Care**
4. **Acute/Hospital Care**

Appendix D – Workshop Outcomes – Workshop 3

CAITHNESS HEALTH & SOCIAL CARE
REDESIGN
WORKSHOP 2

	COLLATED FEEDBACK	GROUP	THEMES	ACTIONS	ENABLERS	BENEFITS
1	**Prevention, Self care & Community Care** 	3	Prevention	Awareness & education re healthy lifestyle habits in schools	Strengthen links between NHSH & THC/school nurses	More informed healthier population
2		3	Prevention	Other services/orgs/3rd sector getting involve in preventative work- eg local smoking prevention	Agreement with 3rd sector on what is required and who will deliver it	More informed healthier population
3		1	Prevention	Work with schools & local groups to deliver real world learning & experience - eg smoking cessation **NOTE SYNERGY WITH 2 ABOVE Group 3**	Agreement with NHSH & others on partnership approach	More informed healthier population
4		3	Prevention	Stregthen links with High Life Highland to encourage people to be more active AND Strengthen links with third sector activities eg walking groups	NSHS to work with partners to develop agreed approach . Raise awareness of what groups are out there/contact info. Ensure accomodation resources integrated with wider approach	Healthier more active community, reduction in health issues
5		3	Prevention	Cardiac Rehab /Heart Failure Deliver more prentative drugs	Need resources/staffing	Better managed conditiions , reduction in need for acute care
6		3	Prevention	Primary Care to re- establish proactive 'wellperson' clinics for general health check	Buy in and agreement from practices/community teams. Resources to deliver these	Early intervention & sign posting to right support at right time
7		4	Prevention	Continue/expand good **Dental Services** work done in Care Homes to expand preventative treatment	Changes to service models Liaison with care home providers	Care closer to home Less travel to the centre
8		4	Prevention	Continue/expand **orthodontic** services locally to avoid travel to Raigmore	Review service model	Care closer to home Less travel to the centre
9		1	Community & Self Care	**Assessment** - Primary care - Patients to self refer to some services - & services refer directly to each other without going through GP	Joint agreement on approach & processes	Reduce waiting times, people seen at the right time Reduced pressure on GP services

10	1	Prevention	**Assessment** - Voluntary & 3rd sector willing and able to be more involved in assessment, identifying those in danger of 'falling through the cracks' , playing a more formal role with vulnerable people in our	NHSH to recognise a more formal role & define the points we can play into	Earlier intervention & improved outcomes
11	2	Community Care	**Assessment** - Volunteer or nominated individual to do face to face visit in patients home with device allowing any other MDT member to link remotely for assessment	Agree roles Technology to support WiFi & Internet connectivity	Less duplication & better use of resources
12	1	Prevention	**Telecare** - Individuals in the community to become telecare responders	NHSH to support this proposal & someone to co-ordinate. Professional to help with technical & legal aspects. Local people to come on board & volunteer!	Everyone who needs telecare gets it. Supports early intervention & prevention
13	2	Prevention	**Telecare** - Recruit responders from the community **NOTE SYNERGY WITH 12 ABOVE Group 1**	NHSH to support this proposal – work together with the community to agree pathways. Also to provide support for any safeguarding requirements/processes. Need volunteers!	Everyone who needs telecare gets it. Supports early intervention & prevention
14	4	Prevention	More opportunity for tuning in to patients local requirements & immediate intervention by the community **NOTE SYNERGY WITH 12 & 13 ABOVE Group 1 & 2**	Links to 'Responders' theme from Group 1 Empowerment of community/3rd sector groups	Care closer to home Fewer hospital admissions
15	2	Prevention	**Telecare** - Utilise TEC monitoring systems to detect problems earlier- not just t osupport dischsrge butto support early intervention (National TEC programme hoping to identify provider across Scotland)	NHSH & partners to develop strategy to integrate TEC into early intervention approach	Supports early intervention & prevention. Potential problems picked up earlier
16	2	Prevention	Invest in/commission additional **housing support services** (none available since Nov 2021)	NHSH & partners to map out gaps in services to support the new model & address via flexible commissing approach	Early intervention low level preventative support will keep people at thome for longer & maintain tenancies
17	2	Community & Self Care	Provide more **training for informal carers.** Bayview staff already provide this but could be commissioned to do more - eg Moving & Handling, Medication	NHSH & partners to map out gaps in services to support the new model & address via flexible commissing approach	Carers able to support people at home for longer - builds their confidence
18	1	Community & Self Care	Help to identify carers & provide respite & support	NSHS to support & coordinate	Carers able to support people at home for longer
19	1	Prevention	Provide a **Befrienders Service** for older people who cannot get out and people who are lonely	NSHS to work with community/vol sector to set parameters and agree pathways. A person/local organisation to take the lead	People staying healthier and happier for longer, less loneliness
20	1	Community & Self Care	**Social Prescribing** - Define list of alternatives to traditional prescribing Agree process to agree how orgs/groups/activities become prescribable	Formal agreement on the process of getting on the prescribable list Someone (professionally) to develop & manage the local list Someone (locally) to coordinate - identify and support local groups to be included	Less prescription of drugs , more people prescribed alternatives People find a prescribed way into community life & increased sense of community Less pressure on professionals & more appointments available quickly for people who need them

21		3	Community & Self Care	**Social Prescribing** - Could be carried out by 3rd sector & commissioned services **NOTE SYNERGY WITH 20 ABOVE Group 1**	Training provided to allow people/orgs to do this	Less prescription of drugs , more people prescribed alternatives People find a prescribed way into community life & increased sense of community Less pressure on professionals & more appointments available quickly for people who need them
22		1	Community & Self Care	Provide a focus for community support eg- Dunbeath Day Care Centre Deliver drop in community hubs where a singe physical place is not appropriate or feasible Provide meals for vulnerable people/groups Support formal Community Education	Appropriate local hubs to be identified Someone to coordinate Engage with Community Education & education courses to be part of social prescribing	Deliver a 'safe space' people can go for help & support/easier for people to seek help Provide an early warning network Flagging up concerns to professionals Ensuring people get the help they need as soon as poss Identified hubs having a role in 'community focus' - eg defined space for this purpose
23		1	Community & Self Care	Deliver **peer to peer mentoring** - esp supporting hard to reach groups, eg Homestart, alcohol & drugs support etc Encourage & support tenant participation Provide local faces/experiences to make problems & fixes more real	Groups to support approach Coordination Appropriate relationships with professionals- for when advice, escalation required	Make it easier for people to seek help Reduce suffering & improve outcomes Improve/hasten access to professionals for those who need it most
24		2	Community & Self Care	**Highland Council Housing** already working in partnership with Cairn Housing Assc (2000 houses each) developing shared approach to the needs of their aging population of tenants . Very willing to work with health & social care to provide more early intervention & support for tenants	NSHS to work with partners to develop early intervention approach within the new model	Pick up potential problems earlier, provide support and/or signpost to appropriate community/NHSH resources
25		2	Community & Self Care	Invest in LD **day care & respite** - there is more demand than capacity. Could provide more including crisis care	NHSH & partners to develop joint commissioning strategy with flexibility built in	Providing breaks & support for families helps to keep their person at home for longer
26		2	Community & Self Care	**Facilitation** - Help to open doors by knowing/identifying & working with people locally who can really get things done (by contrast to those we believe 'should' get things done	To be asked!	Improve community engagement Improved outputs More local support
27		1	Community & Self Care	**Recovery College** - Support & participate in the developing Recovery College Act as the local face of new developments to encourage participation	To be involved in the planning & development of the Recovery College For the College to support enhance & strengthen local groups & structures- not replace them	A focus for many of the activities & improvements documented elsewhere in this groups feedback
28	Anticipatory Care Planning & Enrolment into MDT/SPOA caseload 	3	Anticipatory Care	Improve connections between community teams & GP practice Reinstate basing of District Nurses at GP practices More F2F / electonic contact between primary & community care services Identify someone to liase with each practice?	Primary care & community services to agree approach Tec to support communication & info sharing (where F2F not poss) Colocation of community & primary care teams Physical space to allow meetings & discussions to take place - in hubs and GP practices	Better communication, less duplication

29		1	Anticipatory Care	Have a formal role in the development, monitoring & management of anticipatory care plans Support physical home assessments, adaptations & equipment loans Deliver a local 'handyperson' service	NHSH to support/agree to any formal roles To understand & agree where legal & confidentiality issues may challenge feasibility & if/how we could/should overcome this Modest funding?	Fewer incidents/accidents Fewer emergency admissions Safer homes, less risk A more responsive/quicker adaptations service Quicker access to loan equipment Home risks being identified & responded to locally
30		3	Anticipatory Care	Standardise model of chronic disease management across primary care	Connect primary/secondary care/specialist services & agree approach Buy in from GPs & partners	Reduce variation & ensure consistency of approach
31		4	Anticipatory Care	Lack of POAs in place leads to bed blocking/decision making. Nees a major campaign to address	Major campaign to encourage pre planning of POAs	Swifter decision making & discharge
32		2	Anticipatory Care	Include the conversation about POAs in early interventions & AC Plans	NHSH & partners to develop a joint approach to early intervention model & conversations	Prevent long delays on hosptwhile guardianship is sought - often 10 months , sometimes longer
33		3	MDT/SPOA	Ensure health & care staff understand the vision for the MDT	Agree definition of a Local Care Model MDT, & communicate this to all	Consistent joined up intergated person-centred approach
34		3	MDT/SPOA	Lead person to coordinate each individuals care, & ensure all professionals providing that care are aware of what other teams are doing Regular updates to wider team on management of each individual	Establish Local Care Model MDT Lead professional identified for each individual, to liaise with colleagues/services & coordinate the care Electronic patient records Data sharing agreements	Reduction in duplication & multiple visits to the same person Joined up person centred care
35		3	MDT/SPOA	Patients screened for frailty & identified to MDT for ongoing management	GPs to code for frailty Data sharing agreements	Proactive targeted support to individuals - better management, reduction in episodes of crisis
36		2	MDT/SPOA	Prioritise low level early intervention prevention referrals to adult social care	Move resources/wider use of existing resources across partners Possible pump prime funding to support?	Early intervention - preventing people getting to crisi point before assessment/interventions
37		2	MDT/SPOA	Currently piloting use of E Frailty Index (Sarah Budge /Alison Brooks) potential to share data with partners	NHSH to evaluate pilot & develp/impement data sharing agreement & strategy with partners	Facilitate early intervention & prevention across partners/joined up approach
38		4	MDT/SPOA	More Physio and Occupational Therapy Services to be delivered in the community	Changes Service model Changes to staff working	Avoids visits to acute settings Avoids admissions and improves discharge Avoids bed blocking
39		2	MDT/SPOA	Enable formal carers to feed directly into MDT - they need to be able to share info directly, not just via the Home Care Coordinator	NSHS & partners to agree MDT wider tem & approach	Pick up potential problems/deterioration earlier & intervene
40	Rapid Response & Step-Up / Timely access to expert opinion & diagnostics 	2	Rapid Response & Step Up	Current pilot of overnight care & step up bed (Sarah Budge)	Evaluation of pilot & appropriate investment to take recommendations forward	Prevent unneccessary hospital admission Prevent consequent loss of function Keep people at home for longer
41		2	Rapid Response & Step Up	Develop Hospital@Home Service building on good practice elsewhere in the country	NHSH to agree to develop and fund the approach (NB should not be funded by Acute Services)	Eliminate or shorten hospital stay Interventions provided at home
42		2	Rapid Response & Step Up	Community Beds offer could be improved - need rehab facilities - ADL suites etc	Beds & Resources need to be built into Care Hub Model (beds currently filled with acute & long term patients)	Provide rehab/maintenance & supports enablement model

43		4	Rapid Response & Step Up	Discharge issues due to lack of beds out-with acute settings. We need to improve access to community beds & care at home	Review bed modelling across the H&SC landscape in Caithness as part of the new model Changes to discharge planning/service	Care closer to home less reliance on acute beds Potential to reduce 'return inpatients' if comm care can be more comprehensively provided (fractures & stroke patients a major issue
44		4	Timely access to expert opinion & diagnosis	Increase screening of patients at front door (or even better in the community or at home) by improved (holistic) Frailty & CDU services. Good work on CDU services could be expanded	Changes to service model Changes to configuration/allocation of space at front door of CGH Identification of appropriate space(s) for community activity	Reduces admissions Reduces length of stay
45		4	Timely access to expert opinion & diagnosis	Secondary Care Settings- Increase the amount of screening & investigations carried out out-with CGH	Changes to service model Channges to staff working Identification of app space(s) for community activity	Avoids admissions Reduces length of stay Care closer to home
46		4	Timely access to expert opinion & diagnosis	Secondary Care Settings - Increase the amount of care provision carried out out-with CGH	Changes to service model Channges to staff working Identification of app space(s) for community activity	Avoids admissions Reduces length of stay Care closer to home
47		4	Timely access to expert opinion & diagnosis	Normalise 'Near Me' as default for consultations - which has increased & become the norm during Covid- both within Caithness & linkage to Raigmore	Changes to 'Near Me' model Imporve IT at home and/or closer to home Provide empowered 'hubs' model in the community - aligned to Place Review Work with Place partners to develop	Reduce travel for patients Less activity in acute settings- reduced case load Care closer to home
48		4	Timely access to expert opinion & diagnosis	Radiography - extend the viable services (ultrasound & use of mobile imaging equipment) to the community & home settings	Changes to service model Changes to staff working Resource with mobile equipment & appropriate staff	Reduces need for patients to travel to CGH- potentially some involving overnight stays Reduces case load at CGH
49		4	Timely access to expert opinion & diagnosis	Aneurism Service - was previously done closer to home and brought back into the cnetre some time ago - need to revisit/reverse	Changes to service model Changes to staff working	Reduces need for patients to travel to CGH- potentially some involving overnight stays Reduces case load at CGH
50	End of life care/Hospital as close to home as possible	1	End of life care	Community could provide informal family support & provide a volunteer driver service Support the delivery of financial/benefits/legal advice	NSHS & partners to understand & agree where legal & confidentiality issues may hallenge feasibility and if/how we could and should overcome these	Improved & enhanced end of life care Easier access to sick relatives Less suffering for everyone affected
51		1	End of life care	Community could support the development of an appropriate environmen (fund raising, garden space etc). Provide additional equipment (fund raising) Help with visitor transport Help with loan equip, distribution & installation	Just need to be asked as part of the developing model Helped with legal issues if required	Improved environment for end of life care - better than the NHSH would be able to provide on its own
52		4	Hospital care closer to home	Chemo/renal infusions . Peripatetic service currently once a week. By improving staff training & re-planning , more could be done locally	Changes to service model Upskilling current staff Recruitment of additional specialist staff	Less reliance on visiting services More reactive care Increasing staff capabiities Fewer admissions to CGH
53		4	Hospital care closer to home	Chemo/renal infusions . Previously separate services have been grouped together - would benefit from being dissagregated with a focus on service specific development & specialised staff training	Changes to service model- return to prev model? Upskilling current staff Recruitment of additional specialist staff	More done locally in Caithness Less reliance on regional services Care provided more reliably & reactively closer to home

Appendix D – Workshop Outcomes – Workshop 3

OVERARCHING THEMES

COLLATED FEEDBACK	GROUP	THEMES	ACTIONS	ENABLERS	BENEFITS
	1	Recruitment	Community encouraged & encouraging of others to join the care @ home team	NHSH to listen & work with us A person/local org to take the lead	People discharged quicker Support for more people to remaim at home Fewer emergency admissions to hospital
	1	Recruitment	Do more to 'grow our own' carers & professionals Promote caring as a career Continue to challenge the 'ah buts' - make a positive case for change & find solutions to problems that come up rather than being overwhelmed by them Continue to push for & challenge on 'local service delivery	Good ongoing relations & constructive dialogue with NHSH & other partners	Aid recruitment to key roles
	2	Recruitment	Integrate recruitment strategies across agencies involved in providing care	All partners to agree to develop an integrated recruitment strategy to suuport the new model	Reduce pinching staff from one employer to another
	2	Recruitment	Expand 'Grow our own' staff and Provide career pathways/rotational experience/ education & training support/work placements with schools , colleges and universities. Build on Penny Gs work with Open University	NHSH to work with partners to consolidate current pathfinders and build on these as part of an integrated recruitment & retention strategy	Attract more people into care careers
	2	Recruitment	Better support the 'Befriender' scheme where high school pupils spend time in care homes/facilities – need to provide onward pathways with partners	As part of the above & including schools	Attract & support more people into care careers
	4	Recruitment	More education & training links for pupils to encourage students to consider a career in the NHS & Social Care	Work with schools & colleges & young people generally , further develop our joint Education/Training/Recruitment programme & career pathways	More potential local people entering the Health & SC professions. Maintain population locally
	2	Recruitment	Build on early work (Penny Gardner) to develop apprenticeships for Podiatry – other AHPs?	As per 'Grow your own' above	Grow our own schemes will help to fill posts & retain staff

2	Recruitment	Foundation Apprenticeships for care workers should be based in placements in the care homes (or other care facilities) with a day or 2 at College rather than the other way round	NHSH to work with Uni/College partners to agree best approach	Retain more care workers – apprentices more invested in the local care facilities and the people
2	Recruitment	Provide more flexibility in hours of work for carers	NHSH need to consider this as part of workforce planning, recruitment & retention strategy	Attract a broader range of people
3	Recruitment	Promote Caithness as a good place to live & work	Media awareness campaign	More sustainable services, improved local economy
3	Recruitment	Provide training more locally for trainee GPs	Physical space to do this in the Hubs & GP premises	Improved recruitment & retention
4	Workforce Planning	Radiography - Capacity & management of caseload could be better managed across 7 day working	Changes to service model linked to 7 day working Changes to the way staff work	Avoid need for patients to stay in hospt over the weekend pending imaging results
4	Workforce Planning	Occupational Therapy & Physiotherapy - 7 day working would support a more responsive service for those waiting to be discharged. Idea of more staff on-call provision provided for weekends etc	Changes to service model linked to 7 day working Changes to the way staff work	Reduction of overnight inpatient admissions & length of stay generally
4	Single Patient/person record	We could create a holistic & accessible on-line patient/person record	Build this into the new service model	Joined up person centred care Reduced duplication
2	Data Sharing	Ensure permission to share information/data is up front of the early intervention conversation/SPOA	Partners to develop & agreedata sharing strategy	Person centred integrated joined-up care & support
2	Data Sharing	Build on data sharing protocols already in place (Margaret Ross Housing)	Partners to tske learning into datasharing agreements & strategy	Person centred integrated joined-up care & support
2	Data Sharing	MORSE - develop better reporting capability	NHSH to take on board as part of data sharing strategy	Supports strategic planning
2	Data Sharing	Make better use of data sharing across partners - where are the people in need - what facilities & resources are needed where - eg cluster of frail elderly - do we need some extra care facilties with outreach	All partners to make best use of datain terms of strategic & operational planning, particularly across NHSH & Housing	Better informed & intergated response to needs and to keeping people at home or as close to home as possible
2	Communication & Education - Staff	REABLEMENT - Sarah Budge & colleagues have developed re-ablement training . They have an on-line version which they are rolling out to all Health & SC colleagues- they could further promote this and troll out to Housing colleagues plus wider 3rd sector	The go-ahead to do it! NHSH need to engage with wide rnge of partners to get their buy in to the trsining & approach Should feed into the development of the 'Early Intervention' model	Supports wider reablement approach within all interventions

2	Communication & Education - Staff	AUTISTIC SPECTRUM DISORDERS - Need to develop training & awareness in ASDs for Health & Social Care , Housing & wider 3rd sector partners (increasing numbers of people being diagnosed)	NHSH & partners to build this into a joint L&D strategy	Improved ability to support people with autism living at home
3	Communication & Education - Staff	Ensure that all Health & SC teams understand the range of in-house services & 3rd sector community groups available - and how to refer into them and work with them Education, training, pop up shops - continued awareness raising Promote 'Here for Caithness' website	Single collated list of services/groups that are available List of stakeholders & teams that need to be aware of these Incorporate awareness raising in the projects comms plan Keep NHSH website up to date with all this information	Beter signposting for everyone - directed clearly & immediately to the right supprt Better use of resources
4	Communication & Education - General public	Manage expectations better thro education. Anecdote of a family member wanting to be admitted to CGH over the weekend for a bit of a rest	Community education programme Comms/media strategy	Reduce reliance on acute services Clearer signposting for families & carers Greater knowledge & realistoc expectations
4	Communication & Education - General public	Need to provide better education/information to the local community on the locations of local services once re-modelled - and signposting	Community education programme Comms/media strategy	Greater understanding leads to better outcomes Swifter & approp access to (local) services
4	Communication & Education - General public	Could we have a publicity campaign to destigmatise PoA & encourage people to put them in place	NSHS & partners to consider publicity campaign	Prevent long deays in hosp while awaiting guardianship
3	Communication & Education - General public	Ensure that the public understand the range of heath, social care & 3rd sector/community services that are available & how to access them Encourage public to take responsibility for their own health as above	Update website & incorporate in comms plan Improved regular NHSH comms to public on range of services available & how to access	Reduced pressure on Health & Social care
4	IT	In order to provide services in local facilities (village halls, community centres etc) across Caithness we need better IT connectivity	Need to build this into the wider Place Based Review Approach with all partners	Facilitate wider coverage /access to services ocally for everyone
4	IT	We could avoid so many services tethered to CGH due to IT limitations .	Improve remote IT connectivity with partners support (place based approach?) generally & in newly planned community hubs	Care closer to home Less travel to the centre

1	New Model	Continue to challeng the 'ah buts' , make a positive case for change & find a way around problems that may arise - rather than being overwhelmed by them to the point that we give up Continue to push for & challenge on 'local service delivery'	Evidence based approach Access to data Data driven decision making Appropriate local spaces to deliver services A clinical body willing to travel as approp An understanding of the impact of having to travel from Caithness to Inverness for services/apptstreatment	We bring back a sense of community We create a positive outlook We aid recruitment to key roles We keep people independent for longer We better target efforts We move from being reactive to proactive We keep services, people & money local We make Caithness a place that people will choose to live & work in More outpatients appts, procedures being delivered locally, less travel to Inverness, incl virtual appts where approp More physical space being utilised in Caithness
4	New Model	PHARMACY & LABS - Some services are provided in community settings. Could be expanded with greater 'point of care' provision. Keen to see an additional 'hub' provided for services in Thurso	Consider resources required to provide Thurso hub as part of new model - or identificatio of approp space for community activity Changes to staff working	Swifetr results provided to speed up care plans Less travel to CGH
4	New Model	INFECTION CONTROL - Reduction in admission will likely lead to reduced HAI incidence	Changes to service model to reduce admissions Physical & environmental improvements to reduce HAI Single rooms as default	Less HAI Less need for additional clinical care
2	New Model	Many examples of inpatients being assessed as needing long term care , transferring to a care home, giving their house up and then improving to the point where they could be living more independently. Provide more options in intermediate beds (care hub? Assisted living? Extra care?	NHSH & partners to build this into the new model - involve housing providers as approp	People supported to live as independently as possible fror longer at home or as close to home as possible

Appendix D – Workshop Outcomes – Workshop 3

Caithness Service Model – Workshop 3 – Collated Feedback

Q1 – Do you agree with the key themes/messages emerging about the new model of care for Caithness

1	Area of the Model	Comment	Action
1.2	Rainbow Model	Broad agreement , some issues with missing key words & phrases from the Rainbow Model, Recruitment & retention, Sustainability, Funding, Flexibility, Health Literacy, Family, Safety.	Consider best way to integrate these into the model
1.3		Don't think that 'enhanced monitoring' captures the essence of the green section – also don't like the term used in this way	Consider alternative phrase – 'dynamic support' suggested
		We need enhanced monitoring to be happening but it goes across the whole model not just the green section	Noted
1.4		'Lower level needs' suggest they are unimportant- change language ?	Suggest Universal, Targeted, Specialist? Then that would also cover the fact that the left hand side of the rainbow diagram impacts on all patients/clients and the right hand side on the fewest - as per next comment – 1.5
1.5		Can we add the fact that the left hand side of the rainbow diagram impacts on all patients/clients and the right hand side on the fewest	See above 1.4

Q2. How would you like to see the list if key actions currently presented being modified

2	Area of the Model	Comment	Action
2.1	Enhanced Monitoring	Need to be more explicit about harnessing & nurturing community capacity. Investing in existing 3rd sector work, activities, groups etc – to expand & provide more	Capacity Building? Part of Education Strategy? Investment Noted
2.2		Seems very focussed on physical health – need to be more explicit about mental health needs, child & adolescent, suicide prevention etc	Noted
2.3		Need training strategy for informal carers – including training in dementia (previous training was very beneficial	Noted
2.4		Ensure social prescribing includes mental health as well as physical – whole person approach - holistic	Noted
2.5	Early Intervention	Need well – trained triage workers – invest in front end!	Noted
2.6		INTEGRATION of GPs & community teams important – also need clarity about GP locations/reassurance	Noted
2.7		Create more capacity in LD Day Care - could contribute much more at monitoring & early intervention end	Feeds into gap analysis – flexible commissioning – Commissioning/Procurement theme
2.8		Need to emphasise the importance of long-term commissioning of third sector services that may feel threatened. (The reality is that the strategy is an opportunity for them to be strengthened although some may see it as a risk to on-going funding!)	Feed into Commissioning /Procurement theme
2.9		Direct referrals not just professional to professional but across all agencies/sectors	Noted

2.10		Tying in to Early Intervention – and working across health and care, consider promoting 'Community Healthy Homes' concept which is in-play in Skye + Lochalsh. This strategy promotes long term community and individual's needs. Also involves 'Handy Person Services'; addressing practical support for patients in their homes	Noted
2.11		Consider concept of 'Smart housing' which helps support and monitor people in their homes e.g. impactful on dementia patients with sensor alarms at front door. Must not just focus on shiny new buildings but all assets including those living at home.	Noted
2.12		Need to refine wording around ACP – the core activity is providing support to the person, the ACP is a tool to support the care interventions	Noted
2.13		Good suggested wording -"right people, right skills, right place" – applies to staff and patient/client interface. Will also lead to greater patient satisfaction and cost benefits.	Noted
2.14	Improved Co-ordination	The MDT may sit better here as it is pivotal to improving coordination, Perhaps need to distinguish between the local care model core MDT that helps to co-ordinate care for those with frail and complex needs (improved co-ordination) and a more general MDT function for those who are less frail (early intervention?).	Noted
2.15	Alternative Provision	'Near Me' and 'default' are very definite terms. Perhaps this should be reworded to reflect the importance of options and patient choice/informed choice?	'Optimise? Near Me whilst preserving choice'
2.16		TEC & Near Me maybe not red area activities? Red provision may be more hands on/face to face. TEC & Near Me part of local care & avoiding unnecessary travel/time. Maybe add action re the transfer & movement of patients	Noted

2.17	Enhanced monitoring & early intervention	Procurement needs to be flexible & sustainable – 3rd sector/vol groups need to have security of funding. Some commissioning needs to be devolved, local & responsive	Noted

Q3 How would you like to see the list of key benefits currently presented being modified

3	Area of the Model	Comment	Action
3.1	Enhanced Monitoring	Benefits of professional to third sector and vice versa referring – relates to social prescribing too	Agreed
3.2	Improved Co-ordination	Benefits of near me include saving time, money and travel. It can be more relaxing to have the appointment in your own home, especially if people are fearful of health-related appointments. If F2F appts – travel time to be taken into account	Noted!
3.3		Need to educate colleagues re the contribution/benefit of virtual assessments by AHPs (expectation of F2F from other professionals/referrers)	Noted
3.4		Benefits of co-location & cross professional learning	Noted
3.5		Benefit of having one 'named person' /an experienced coordinator for more complex patients/clients	Noted
3.6	Alternative provision	Check wording around reducing bed capacity – acute & care homes – is that what we mean? Focus on 'care' rather than 'bed'	Clarified at plenary session - & refined wording
3.7		Key benefit is reducing length of stay in any 'care' bed . THE BEST BED IS YOUR OWN BED	Noted
3.8	Overall benefits	More flexible services, people being supported as health fluctuates – not labelling needs too early as we	Noted

		sometimes do now – long term care admissions before time!	
3.9		Saving time/improving scheduling, reducing travel expense claims, addressing health inequalities, making life easier for patients/clients	Noted
3.10		Benefits need to be SMART – some are too woolly	Benefits register to include hard and soft benefits – but still measurable
3.11		Additional benefit should include ' sustainable systems & buildings/facilities	Noted
3.12		Need to add wider community benefits, improved mental health & well-being, addressing inequalities, resilient communities (everyone needs training in addressing Health Inequalities as part of their approach)	Noted
3.13		Need to be careful not to portray hospt admission as a negative thing – sometimes required & very beneficial !	Noted
3.14	Infrastructure	2nd last bullet should read 'Have clear plans for new Community Hubs and existing facilities/satellites'	Noted

Q4. What are the THREE biggest risks to implementing the new model

	Area	**Comment**	**Action**
4.1	**Recruitment & Retention**	Recruitment & Retention – this is a big worry ! – shiny new buildings with no-one in them! Includes accommodation for new staff . Need to do more work in schools – work even more with UHI/Thurso College . Also develop more and improved career pathways.	Noted - an area for the Place based Review with Partners
4.2		Recruitment & retention of third sector workers and volunteers too	Noted
4.3		Is there a potential to lobby for Caithness to be eligible for an 'island allowance'?	Noted

4.4	**Infrastructure**	Ensuring we have robust sustainable flexible Digital & IT Infrastructure. Effective systems to share information. Plus connectivity & transport infrastructure	Noted – partly related to Place Based work
4.5		Future proofing our buildings – ensuring they are adaptable to meet future needs	Noted
4.6	**Finance**	Financial Stability	Noted
4.7	**Comms & Engagement**	Communication & engagement – public are well behind this approach but support is fragile, only as good as last message – need to keep the community motivated & engaged. Focussing on the changes being for the good of the community & population, not about saving money	Noted
4.8		Needs to be really good interface between 3rd sector, community & acute services – essential to 'flow'	Noted
4.9	**Depopulation**	Depopulation & de-investment (Dounereay)	Noted – partly related to Place Based work
4.10	**Capacity**	Do NHSH have the necessary in house resource & within the Team to deal with such significant system/service change?	Noted Michelle responded in the plenary?
4.11		Transitional Risks – staff are already under pressure & stressed as a result - there is a danger we lose momentum, might negatively impact on staff and patients/clients	Noted
4.12		Workforce capacity & need to upskill staff & community , including community responders. Training & Development to meet increasing complexity of need Everyone's willingness to change!	Noted
4.13		Support services need to be considered along side clinical & social care services – transport, soft FM – also pharmacy, labs, other clinical support services	Noted
4.14	**Unmet Need**	Capturing people who are off the radar plus isolation and loneliness leading to health issues and demonstrating health inequalities	Noted

4.15	**Focus**	Focussing too much on the patient – although this seems counter-intuitive there is a danger we might lose sight of the big picture- the wider family picture	Noted
4.16		Losing focus on rural issues – specifically forgetting about services outwith Wick & Thurso	Noted – relates to place based work & identifying 'satellite' hubs for services using existing community facilities & resources
4.17	**Governance**	Governance of the changes & alignment with individuals professionals registrations - doing things differently? – in different places & environments	Noted
4.18		Need to ensure we have a safe space for people to raise any concerns – patients, clients, public, staff, partners	Noted

5. ADDITIONAL OVERALL ISSUE – Staff & Culture – Staff need support and training/development opportunities, they need dedicated supervision time and for CPD activities. We need to have a continuous improvement culture with feedback loops for patients, staff and the whole system. Exception reporting needs to be built in to continuous improvement approach. We need to strengthen leadership structure

Appendix E

Caithness Health & Social Care Redesign - dependencies from workshop output

To note that the Critical infrastructure/enabling dependencies highlighted by Stakeholders across the 3 workshops (as below) all align with those already identified as part of the Place Based Review work with a wide range of Partners – lots of synergy!

- Recruitment, Retention, - expansion of 'Grow your own' staff (integrate accommodation)
- Recruitment, retention, support & nurturing for 3rd sector, voluntary sector, individuals - capacity building
- Further develop work in schools around placements in H&SC & developing more & improved career pathways, integrated through school, college, uni, H&SC & 3rd Sector workplaces
- Upskilling & training generally across 3rd & voluntary sector & community , as well as for H&SC staff
- Reducing depopulation, defunding, providing other sustainable job opportunities for partners/spouses/family of HSC/3rd sector workers
- Making Caithness a great place to live work & stay. Attract people into the area, widen inclusion & diversity
- All services taking an 'early intervention, enabling approach', all signed up to addressing health inequalities
- Engagement in 'social prescribing approach across partners
- Working with Housing partners to develop 'extra care/assisted living' type provision associated with the Thurso and Wick Hubs
- Utilising Technology Enabled Care & monitoring systems across Housing, Health & Social Care partners
- Ensuring we have robust, sustainable IT, digital & connectivity infrastructure
- Ensuring we have robust flexible transport infrastructure
- Maximising use of exiting assets in developing the Wick & Thurso Hubs
- Ensuring easy & equitable access to services- F2F and Virtual across rural Caithness as well as in Wick & Thurso Hubs –
  ie- utilising existing community/partner facilities as 'satellite' hubs & access points (including other services) ?investing in community assets?
- Providing additional co-location/touch down points for community staff & 3rd/vol sector