HIGHLAND HEALTH & SOCIAL CARE GOVERNANCE COMMITTEE
Report by Committee Chair

The Board is asked to:

- **Note** that the Highland Health & Social Care Governance Committee met on Wednesday 17 January 2024 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Gerry O'Brien, Committee Chair, Non-Executive Director
Philip Macrae, Non-Executive Director, Committee Vice Chair
Tim Allison, Director of Public Health (until 2.30pm)
Ann Clark, Board Non-Executive Director and Vice Chair of NHSH
Cllr, Muriel Cockburn, Board Non-Executive Director
Pam Cremin, Chief Officer
Cllr, Ron Gunn, Highland Council (until 2pm)
Joanne McCoy, Board Non-Executive Director
Kara McNaught, Area Clinical Forum Representative (until 3pm)
Kaye Oliver, Staffside Representative
Sara Sears, Nurse Lead (shared role)
Simon Steer, Director of Adult Social Care
Michelle Stevenson, Public/Patient Member Representative
Diane Van Ruitenbeek, Public/Patient Representative
Neil Wright, Lead Doctor (GP)

In Attendance:
Rhiannon Boydell, Head of Service, Community Directorate
Louise Bussell, Nurse Director
Sarah Compton Bishop, Chair, NHS Highland Board
Ruth Daly, Board Secretary
Fiona Duncan, Chief Executive Officer and Chief Social Work Officer, Highland Council
Frances Gordon, Interim Finance Manager (on behalf of Elaine Ward)
Arlene Johnstone, Head of Service, Health and Social Care
Fiona Malcolm, Head of Integration, Highland Council (until 3pm)
Stephen Chase, Committee Administrator

Apologies:
Kate Dumigan, Claire Copeland, Cllr Chris Birt, Cllr David Fraser.

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1 WELCOME AND DECLARATIONS OF INTEREST

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

The meeting was quorate and no declarations of interest were made.

The Chair welcomed new member, D Van Ruitenbeek as Public Patient Representative who gave a brief introduction to her background to the Committee.

The Chair informed the Committee that item 3.1 would be taken ahead of item 2.1 after which the meeting ran as set out in the agenda.

1.2 Assurance Report from Meeting held on 1 November 2023 and Action Plan

The draft minute from the meeting of the Committee held on 1 November 2023 was approved by the Committee as an accurate record.

Regarding the Rolling Actions, the committee agreed to close the Staff Experience item, the Terms of Reference item due to its inclusion at the present meeting, and the TEC item would be incorporated into the Chief Officer's overview with particular reference to the analogue switch off. All other items were to be closed as they would be considered in the 2024-25 Work Plan discussions between the Chair and the Chief Officer.

The Committee
- **APPROVED** the Assurance Report
- **NOTED** the Action Plan.

1.3 Matters Arising From Last Meeting

There were none.

The Committee:
- **NOTED** the updates.

2 FINANCE

2.1 Year to Date Financial Position 2023/2024

The report which had been circulated in advance of the meeting noted that NHS Highland had submitted a financial plan to Scottish Government for the 2023/2024 financial year in March 2023. An initial budget gap of £98.172m was presented with a Cost Improvement Programme of £29.500m proposed, leaving a residual gap of £68.672m. Work had been ongoing within the Board and nationally to consider options and schemes to close the gap. Scottish Government had provided additional funding and the Board was looking to deliver a financial deficit of no more than £55.800m. The report summarised the position at Month 8, and provided a forecast through to the end of the financial year highlighting the current and ongoing service pressures.

For the period to end November 2023 (Month 8) an overspend of £11.149m was reported within the Health & Social Care Partnership. This overspend was forecast to increase to £14.984m by the end of the financial year.

The report offered limited assurance due to work to progress savings delivery and address the ongoing utilisation of locums and agency staff. A robust recovery plan was in development in order to increase the level of assurance with oversight and support from Scottish Government in line with their "tailored support".

F Gordon spoke to the report and noted that there were a number of drivers

During discussion that followed focus was given to the following areas,
1. The level of confidence of the partnership's ability to take transformational action was addressed and it was noted that at month 9 there had been no increase in the position and that in fact there had been observed a decrease and that measures had been having an effect.
2. The Chief Officer noted a number of the challenges to transformation plans, which included the difficulty of achieving Adult Social Care savings due to the impact there could be on quality and patient safety, however there had been areas identified in the

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move to Horizon 2 around financial efficiency plans and service redesign which include a reduction in the reliance on locums, reductions in prescribing costs, and opportunities to take schemes forward with the 22 Board-run GP practices.

3. The Chief Officer also noted that the Joint Strategic Plan between NHS Highland and the Highland Council, provided an opportunity to address community engagement and links in, with Community Planning Partnerships regarding the impact of large-scale redesign of services and to consider better use of Technology Enabled Care and strategic commissioning.
4. It was confirmed that funding for independent GP contractors was covered under GMs. N Wright commented that in numerical terms independent contractors were value for money when compared with the pressures of Board-managed practices.
5. It was noted regarding the Adult Social Care position, that there had been a conscious decision following dialogue with the Highland Council not to take forward some proposals in order to avoid severe impact on the system, which meant that instead of slippage there had been unachieved savings which would be carried forward into the next year. It was noted that discussion was ongoing with regard to an acceptance by Highland Council of the ASC position. The Chief Officer commented that she had been in regular dialogue with Highland Council's Corporate Management Team.
6. The Director of ASC provided assurance to the Committee that pressures for the next year had been identified to a reasonable level of accuracy and the extent to which those were funded or not funded, and that possibilities for a range of transformational schemes and clarity around the potential impact were also under examination with Highland Council colleagues.

The Committee:
- **NOTED** the report and accepted **limited** assurance.

3 PERFORMANCE AND SERVICE DELIVERY

3.1 Quality Review Framework

The Nurse Director presented an overview of the approach taken to review quality within NHS Highland. The Chief Nursing Officer for Scotland had been appointed to assist with the quality review. It was noted that forty-three leaders across NHS Highland from different professional backgrounds had been interviewed. Professions had included those from Clinical, Operational, Social Care and Executive Directors. The interview had highlighted the key question: what can I do to make patient quality and safety better in NHS Highland? A report had been provided to the Board with suggested recommendations to help guide the Board to make necessary improvements to quality.

The key themes that the report emphasised had included Approach to quality; Leadership and Direction; Experience and Engagement; Data; Systems and Processes; People; Language; Learning Organisation; Culture. Suggested recommendations include acknowledging good practices and positive attitudes expressed; ensuring there is a clear definition of quality to be used in the context of health and social care; agree a definition for Clinical Governance. Explore local, unit and organisation wide – sharing of learning and good practice.

The Quality Commissioning report was presented to professional advisories for feedback with it going to the Social Work Advisory Committee on 1 February 2024. Feedback received had included the correct language to ensure it was adapted to health and social care. Importance of a learning culture was emphasised and how leaders need to influence this. There would be a plan completed taking into consideration the recommendations and comments received. The plan would be presented to the Area Clinical Forum and a review undertaken on the whole pathway by linking in with Primary Care.

In discussion,

- Challenges around implementing consistency of quality were acknowledged regarding training with a large workforce, and around supporting staff expected to work alone in remote locations.
- The importance of clear Care Governance was noted in terms of evidencing suitable processes and safety systems were in place, and communicating appropriate escalation routes, especially with regard to Care Home Collaboratives, and independent and Third Sector colleagues.
- Management of public assurance was raised in terms of emphasising that agency staff have suitable access to training and support. The Nurse Director noted the challenges for agency staff when having to move location between shifts but noted that there was generally a good level of consistency of staffing and locations.
- Consideration towards gathering independent staff experience was raised and access to the staff survey was mooted.

The Committee:
– **NOTED** the report and the current position in terms of compliance with legislation policy and the Board's objectives.

3.2 HSCP IQPR

R Boydell spoke to the circulated report and noted that the position had remained relatively static across the year. There had been no improvement in Care at Home, Care Homes, Adult Support and Protection, or delayed discharges this month due to ongoing sustained challenges. However, carer breaks had been accessed and utilised and would continue into Q4, which would be reported next time. There was continued growth in SDS direct payments and great improvement in waiting times for psychological therapies over the year. Performance of Drug and Alcohol Recovery service had also improved greatly over the year and was better than national average. Strategy and Transformation team's non-reportable data would be brought to the next meeting.

During discussion, the following issues were raised:

1. M Cockburn noted the significant collaboration with third sector partners in relation to Drug and Alcohol services and asked whether this was sustainable as there were concerns about the level of challenges in Highland.
2. The Chief Officer commented that the position was more positive and sustainable than graph showed and there had been improvement, particularly around implementing some of the Medical Assisted Treatment (MAT) Standards which had enabled access for people across the service, not just the MAT part of it.
3. The Head of Service (Health and Social Care) gave assurance that the service was moving in the right direction from a health and social care perspective. The service was doing particularly well around MAT standards; work within the custody suite had been Nationally and possibly Internationally recognised; and a national campaign regarding the uptake of naloxone was being discussed, which would see all staff across all services carrying the drug and would be relatively easy to implement within our services.
4. It was noted that the Drug and Alcohol Recovery service was one small piece of the fuller Alcohol and Drugs Partnership whose governance route was through the Community Planning Partnership and the full picture would be seen later in the year through the ADP annual report.
5. M Stevenson cited an example of delayed discharge from her recent stay in hospital, where a patient had been in since April and was showing clear signs of distress which was in turn distressing other patients, and asked why this was happening and how those affected were being supported.

6. The Chief Officer recognised that several patients were in the wrong places whilst awaiting care and that the effects of this reached further than the patients whose discharges were delayed. While work was being done to remedy this and staff were passionate about promoting a good care experience, different factors affected discharge delays such as capacity, staffing and legislative procedures.
7. The Nurse Director suggested that it might be helpful to differentiate the reasons behind different delayed discharges in future reports and highlighted that while there was an issue with lack of availability of services, for some it was a case of there being nowhere appropriate for them to go due to complex needs, particularly those with mental health care requirements and solutions were being sought.
8. A Clark suggested a future discussion around the relationship between the Quality agenda and the IPQR data that was brought to the committee.
9. Several challenges were raised around the provision of Care at Home Services and these had been addressed as follows:
   - Work had been done with partners to look at block contracting and bringing people more into the multi-disciplinary team. While there were some financial challenges around that, these shouldn't be a barrier.
   - A specific board had been set up to measure and better understand the vast amount of work that had been done on Care at Home.
   - The cost of agency staff and issues with staffing outside of Inverness were being addressed through a joint strategic plan, project charter and several workstreams. However, increasing oncosts on top of our financial settlement made this increasingly challenging, particularly as there was overspending as a board on agency staff and an increased demand from the population.
   - The Director of Adult Social Care advised that the current Care at Home position was largely unchanged with 2600 hours short and the work being done was to stem the flow as opposed to expanding the service.
   - The hope was to build a Care at Home Collaborative with the Third Sector with the ability to be flexible within contracts without the need for bureaucratic processes.
   - A review had been initiated to look at flexibility and a joint staff member was in post to promote recruitment.
   - The reserves programme had been successful in recruiting over 70 people.
   - The way runs as opposed to zones were structured was being considered in partnership with the sector.
   - The biggest issue was where services were handed back due to providers inability to continue. It was important to look at support as well as care at home.
   - There were significant concerns around the financial position for next year, which was yet to be confirmed but would likely mean having to operate within a smaller financial envelope when there was an already depressed level of care provision across Care at Home, Care Homes and Support Work. Work was being done on increasing alliance on digital solutions and reducing the use of inefficient systems, such as double handling.
10. A Clark suggested that the delivery of mental health support to young people and young adults through more remote means might be explored given the increased acceptance and familiarity with information technology and it was agreed this would be picked up at a future meeting.

The Committee:
- **NOTED** the report,
- **ACCEPTED moderate** assurance from the report, noting that there would be a fuller discussion at a forthcoming development session.

[The Committee took a rest break from 2.30pm to 2.40pm]

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3.3 Joint Strategy

The report circulated ahead of the meeting provided an update on the development of the HHSCP Joint Strategic Plan which had been developed and overseen by the Strategic Planning Group, had been subject to extensive engagement to its conclusion. The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Partnership to have in place a Strategic Plan which sets out the arrangements for the carrying out of the integration functions for the Partnership area over the period of the plan and which also sets out how these arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes. The same Act also directs that a Strategic Planning Group is required to be established to support the development of a Joint Strategic Plan. That group had been established and had supported the Partnership to prepare a draft joint strategic plan which was approved by the Joint Monitoring Committee as an outline document for the process of wide and inclusive engagement over a 3-month period up to 30th September 2023. The plan was updated following the engagement process and reviewed further by the Strategic Planning Group on 6th November and 4th December 2023. The finalised Joint Strategic Plan was presented and agreed at the Joint Monitoring Committee on 15th December 2023.

The Chief Officer spoke to the report and noted that there had been good feedback on issues such as affordability and equitable service provision from stakeholders, and noted that the plan covered both health and social care. The Chief Officer also noted that the Joint Monitoring Committee would meet in March to articulate the engagement work and determine the role as a partner within Community Planning.

In discussion, the following areas were considered,

- The level of work to get to the current stage was acknowledged by the members.
- It was suggested that it may be useful for the committee to receive a paper on locality and community planning in relation to the responsibilities the Committee had in relation to the Community Empowerment Act and the Joint Strategy, and that it could be useful for the Committee to hear the thoughts of the Collaborative Care Home Programme Board on the next steps in relation to care home planning.
- With regard to the implementation of district planning groups it was noted that there was a need to take account of the complexity involved especially concerning support given to small organisations, and to have good engagement with district managers to best communicate the role and remit of the strategic planning group.
- It was noted that engagement was underway with a number of providers around collaborative commissioning with a view to finding sustainability in the Third Sector.
- The need to engage differently on the consultation with different groups was commented upon, for example using digital methods or via the Handy Person network or Fire Service dependent on age group and available local arrangements. However, the need for consistency of messaging was emphasised.
- The Chair noted that he would consider in conversation with the Chief Officer, where in the Committee work plan issues such as community empowerment and the further implementation of the Joint Strategy could be reviewed.
- It was noted that the Joint Strategy was available via the HHSCP section of the NHSH website but that consideration would be given in collaboration with the Comms Team about an official launch.

The Committee: – **NOTED** the report and – **ACCEPTED substantial** assurance.	

3.4 Community Services Risk Register

The Chief Officer explained that the report had been submitted to provide a summary of Community Services Risks across adult health and care services and was brought to the committee for assurance of action and to note the mitigations put in place. The report notes that the Community Directorate holds risk registers in operational areas of Community Services, Primary Care Services, Out of Hours, and Mental Health and Learning Disability services. A monthly Community Risk Register Monitoring Meeting was held to monitor all risks and ensure mitigation action was recorded and to review and update risks.

Two very high risks relating to workforce including access to NHS dental care. There are nine high risks relating to, workforce; information technology; compliance; protection; engagement; reputational; and service delivery. NHS Highland had been able to recruit to a specialist workforce that are keen to move to the area, but availability of suitable housing had been highlighted as a risk. Work had been done in partnership with the Highland Council to mitigate against those risks. The Statutory and Mandatory short life working group had been focused on achieving required levels of compliance with statutory and mandatory training.

Five medium risks were highlighted and had included; Engagement, risk to service redesign due to lack of standardised engagement; Service Delivery, risk to achieving service redesign within financial parameters; Service Delivery, risk of not being sufficiently able to respond to the outcome of the National Care Service consultation; Compliance, risk of low morale in health due to perceived inequalities in pay banding between health and social work professions; and Reputational, risk of vulnerability/harm to staff, services and public due to lack of clear governance arrangements in Social Work.

Chief Officer HSCP noted that moderate assurance was being provided with the report as all risks were being mitigated and were regularly reviewed through governance process.

During discussion,

- N Wright highlighted that independent GP contractors had received an email on 29 December 2023 regarding changes to be made to Enhanced Services effective from 1 April 2024 with responses required by 1 February 2024. A number of independent contractors had expressed concern as the proposed changes indicated that some service contracts would be removed with an adverse impact on certain communities. The delay in adding these risks to the Risk Register via DATIX was commented upon. N Wright explained that there would be risk to population health with a reduction of health services though the risk to Secondary Care, with further pressures added by increased referrals from Primary Care. In addition there were financial, reputational and a relationship risk between the Health Board and independent GP contractors.
- The Committee Chair thanked N Wright for raising the concern at the committee and asked the Chief Officer to take away the concern to engage through the correct process. The Chief Officer advised that an update on the matter would be given through the Chief Officer Report at the next meeting of the committee. It was commented that concern had been raised at the recent meeting of the Area Clinical Forum. A briefing was recommended from the Chief Officer to the Chair to provide assurance on behalf of the committee that appropriate action had been taken prior to the February deadline date.

- Discussion had been had around the progress of the development of a Social Care Governance framework using principles from the Vincent Framework guidance. Work would continue to develop the framework with the input from social care practitioners and professionals.
- DATIX had been used to highlight and monitor issues and the Quality and Patient Safety Committee has seen improvements that enable large quantities of data to be accessed. Proposals had been submitted to the Chief Social Work Officer and Chief Executives of the Board and Council about Clinical and Care Governance. Governance and escalation issues were still to be resolved but noted progress would be made over the upcoming months. A higher number of DATIX reports had been submitted due to increased awareness of the tool and assurance was given that reports were followed up appropriately

by management. The Nurse Director highlighted the importance of all staff being able to submit DATIX reports.
- The Director of Adult Social Care noted that appropriate Social Work and Social Care governance was in place for the next financial year to allow questions in term of equity and allocation of resource efficiency.

Action: Chief Officer to engage with the concerns raised regarding the Enhanced Services and to provide an actions taken update at the 6 March 2024 meeting.

Action: Chief Officer to provide assurance briefing to HHSCC Chair noting actions taken to address the Enhanced Service concerns prior to the deadline 1 February 2024.

The Committee: - **NOTED** the report and - **ACCEPTED moderate** assurance.

3.5 Chief Officer's Report

The Chief Officer spoke to the circulated report and included a summarised progress update of the major redesign projects which included Caithness Hospital and Lochaber Community Hospital. The report noted the impact of Storm Gerrit over the Christmas and New Year period and that community, operational teams, and multi-agency partners had responded well to the challenges. Appreciation was expressed for staff who had worked very hard and at times over their standard hours to ensure services and systems were safe and operational.

The Chair advised in response to a question that the proposed changes to the vaccinations programme would feature on a future agenda. The Chief Officer advised she would be attending the Vaccination Programme Board after the committee meeting.

Action: Chief Officer to provide Committee with a report detailing implications on services due to the proposed changes to the vaccinations programme.

The Committee: – **NOTED** the report.

4 COMMITTEE FUNCTION AND ADMINISTRATION

4.1 Annual Review of Committee Terms of Reference

The Board Secretary noted that following the proposed changes to the committee's Terms of Reference (ToR) to incorporate reference to the Joint Management Committee and its role, that this had been completed.

An amendment to the numbering was noted by the Board Secretary for completion following the meeting.

In discussion, it was suggested that.
- Clarification be made in the ToR regarding Adult Social Care governance arrangements and that this would also need to be carried out for the Clinical Governance Committee's ToR.
- The Chair noted that he would discuss the continued relevance of reference in the ToR to a Commissioning Subgroup outwith the meeting with the Chief Officer.

- The Nurse Director noted that she would discuss with the Chief Officer and Board Secretary how best to agree the naming conventions of lead executives in the document.

The Committee
– **Agreed** the Terms of Reference in its current form for the purpose of approving governance processes with the Board.

4.2 Committee Work Plan

The Chair noted that the draft work plan for 2024-25 would be presented to the committee at the next meeting with the Annual Assurance Statement.

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

5 AOCB

There was none.

6 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 6 March 2024** at **1pm** on a virtual basis.

The Meeting closed at 4 pm

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Agenda Item 2.1

NHS Highland	

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**6 March 2024**
Title:	**Finance Report – Month 10 2023/2024**
Responsible Executive/Non-Executive:	**Pam Cremin, Chief Officer**
Report Author:	**Elaine Ward, Deputy Director of Finance**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to a:

- Annual Operation Plan

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

Effective

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This report is presented to enable discussion on the NHS Highland financial position at Month 10 2023/2024 (January 2024).

2.2 Background

NHS Highland submitted a financial plan to Scottish Government for the 2023/2024 financial year in March 2023. An initial budget gap of £98.172m was presented with a Cost Improvement Programme of £29.500m proposed, leaving a residual gap of

£68.672m; work is ongoing, within the Board and nationally to look at options and schemes to close this gap. Scottish Government provided additional funding and the Board is now looking to deliver a financial deficit of no more than £55.800m - further additional funding is anticipated and reflected in the forecast position at financial year end. This report summarises the position at Month 10, provides a forecast through to the end of the financial year and highlights the current and ongoing service pressures.

2.3 Assessment

For the period to end January 2024 (Month10) an overspend of £13.210m is reported within the Health & Social Care Partnership. This overspend is forecast to increase to £14.963m by the end of the financial year..

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	X	None	

It is only possible to give limited assurance at this time due to current progress on savings delivery and the ongoing utilisation of locums and agency staff. During this ongoing period of financial challenge the development of a robust recovery plan is required to increase the level of assurance – this is currently being developed at pace with oversight and support from Scottish Government in line with their “tailored support”.

3 Impact Analysis

3.1 Quality/ Patient Care

The impact of quality of care and delivery of services is assessed at an individual scheme level using a Quality Impact Assessment tool. All savings are assessed using a Quality Impact Assessment (QIA).

3.2 Workforce

There is both a direct and indirect link between the financial position and staff resourcing and health and wellbeing. Through utilisation of the QIA tool, where appropriate, the impact of savings on these areas is assessed.

3.3 Financial

Scottish Government has recognised the financial challenge on all Boards for 2023/2024 and beyond and are providing additional support to develop initiatives to reduce the cost base both nationally and within individual Boards. NHS Highland is receiving dedicated tailored support to assist in response to the size of the financial challenge.

3.4 Risk Assessment/Management

There is a risk that NHS Highland will overspend on its 2023/2024 revenue budget by more than the current forecast of £39.055m with this risk replicated within the HHSCP. The forecast assumes slippage against the CIP of £15.855 – there is a risk associated with CIP delivery at this level. The forecast is also dependent on assumptions around funding and expenditure. The Board continues to look for opportunities both locally and nationally to bring the recurrent cost base down.

3.5 Equality and Diversity, including health inequalities

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

3.6 Other impacts

None

3.7 Communication, involvement, engagement and consultation

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

- Executive Directors Group – via monthly updates and exception reporting
- Efficiency Transformation Group
- Monthly financial reporting to Scottish Government

3.8 Route to the Meeting

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

- EDG
- FRPC

4 Recommendation

Discussion – Examine and consider the implications of the matter.

4.1 List of appendices

The following appendices are included with this report:
Associate Presentation

NHS Highland

HHSCC Finance Report – Month 10 (January 2024)

MONTH 10 2023/2024 – JANUARY 2024

Actual v Planned Financial Performance

	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Planned Deficit	12.0	16.5	21.0	25.5	30.0	36.0	42.0	48.0	55.0	62.0	68.7
Revised Plan	12.0	16.5	21.0	25.4	29.8	34.1	38.5	42.9	47.3	51.6	56.0
Actual	15.6	20.7	25.5	32.6	38.1	43.5	46.9	48.8	50.7		39.1

Target	YTD £m	Forecast £m
Delivery against Revenue Resource Limit (RRL) DEFICIT/ SURPLUS	50.7	39.1
Delivery against Financial Plan DEFICIT/ SURPLUS	4.3	29.6
Deliver against Cost Improvement target DEFICIT/ SURPLUS	14.3	15.9

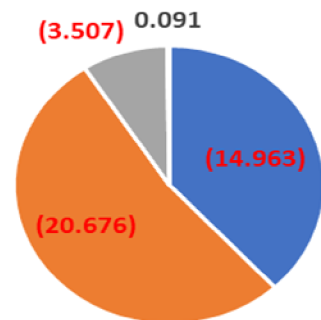
Forecast year end deficit of £39.055m
Forecast slippage against CIP £15.855m

MONTH 10 2023/2024 – JANUARY 2024

NHS Highland

Current Plan £m	Current Budget £m	Summary Funding & Expenditure	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
1,163.211	1,163.211	**Total Funding**	951.713	951.713	-	1,163.211	-
		Expenditure					
450.867	452.760	HHSCP	374.695	387.906	(13.210)	467.723	**(14.963)**
310.154	296.997	Acute Services	246.380	264.383	(18.004)	317.673	**(20.676)**
207.487	149.145	Support Services	113.980	133.685	(19.705)	152.652	**(3.507)**
968.508	**898.902**	**Sub Total**	**735.055**	**785.974**	**(50.919)**	**938.047**	**(39.146)**
263.375	**264.309**	Argyll & Bute	**216.658**	**216.442**	**0.216**	264.218	**0.091**
1,231.883	**1,163.211**	**Total Expenditure**	**951.713**	**1,002.416**	**(50.704)**	**1,202.265**	**(39.055)**
(68.672)	-	**Planned Deficit**	-	-	-	-	
1,163.211		**Total Expenditure**					

Forecast Deficit by Operational Area



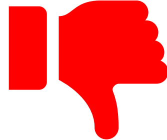
MONTH 10 2023/2024 SUMMARY

- YTD overspend of £50.704m reported
- Forecast to reduce to £39.055m at end of the 2023/2024 FY – due to application of anticipated additional SG funding
- YTD position includes slippage against the CIP of £14.288m
- Cost improvements of £13.645m included within operational year end forecasts – slippage of £15.855m against the £29.500m plan
- Forecast is £29.617m better than that presented within the financial plan
- Forecast continues to assume support to balance the ASC forecast overspend

MONTH 10 2023/2024 – JANUARY 2024

NHS Highland

KEY RISKS



- Supplementary staffing – reduction in spend not as anticipated. Still at a static level
- Prescribing & drugs costs – information now up to date but still a pressure area
- Adult Social Care pressures – accelerating in a number of areas
- Continuing impact of high inflation rate
- Mental Health Out of Area placements
- Delivery of savings
- Support with ASC overspend

MITIGATIONS

- Reduced support/ sustainability packages
- Reduction in planned spend (review of business cases/ pressures)
- Non-recurrent VAT rebates
- Additional SG Funding – Sustainability & NRAC Parity and New Medicines Funding. Plus further benefit from UK consequential funding
- Financial Recovery Plan

MONTH 10 2023/2024 – JANUARY 2024

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
253.466	NH Communities	210.846	216.828	(5.982)	261.252	(7.785)
51.297	Mental Health Services	42.527	48.357	(5.830)	57.373	(6.076)
152.492	Primary Care	126.806	128.782	(1.975)	154.849	(2.357)
(4.496)	ASC Other includes ASC Income	(5.484)	(6.061)	0.577	(5.751)	1.255
452.760	**Total HHSCP**	**374.695**	**387.906**	**(13.210)**	**467.723**	**(14.963)**
	HHSCP					
278.283	Health	231.065	241.241	(10.176)	289.799	(11.516)
174.477	Social Care	143.630	146.665	(3.035)	177.924	(3.446)
452.760	**Total HHSCP**	**374.695**	**387.906**	**(13.210)**	**467.723**	**(14.963)**

	In Month £'000	YTD £'000
Locum	638	7,056
Agency	577	5,687
Bank	703	7,629
Total	**1,918**	**20,373**

HHSCP

- YTD overspend of £13.210m reported
- Forecast that this will increase to £14.963m by financial year end – deterioration of £0.288m from Month 9
- Slippage of £6.127mm against the CIP reported in the YTD position with £7.051m of slippage built into the year end forecast
- Continuing pressure with agency nursing and locum usage within Mental Health, in-house Care Homes and 2C practices - £20.373m incurred YTD
- A £2.300m prescribing pressure is forecast due to an increase in both the cost of drugs and volume of scripts being issued.

MONTH 10 2023/2024 – JANUARY 2024

Current Plan £000	Detail	Plan to Date £000	Actual to Date £000	Variance to Date £000	Forecast Outturn £000	Var from Curr Plan £000
74.116	Inverness & Nairn	61.825	62.938	(1.113)	76.226	(2.110)
53.660	Ross-shire & B&S	44.794	46.259	(1.465)	55.607	(1.946)
46.755	Caithness & Sutherland	39.015	40.550	(1.535)	48.790	(2.035)
55.016	Lochaber, SL & WR	45.824	46.552	(0.728)	55.498	(0.482)
10.935	Management	8.487	9.621	(1.134)	12.117	(1.182)
7.170	Community Other AHP	5.988	5.580	0.408	6.672	0.498
5.814	Hosted Services	4.912	5.327	(0.415)	6.343	(0.529)
253.466	**Total NH Communities**	**210.846**	**216.828**	**(5.982)**	**261.252**	**(7.785)**

NORTH HIGHLAND COMMUNITIES

- £7.758m overspend forecast at FYE
- £0.615m pressure from unfunded services within Chronic Pain and Enhanced Community Services continue to drive the forecast overspend
- As in all other areas supplementary staffing is creating a pressure – particularly in in-house care homes (£1.503m)
- Forecast position includes slippage of £1.813m against the health element of the North Highland Communities CIP target

MONTH 10 2023/2024 – JANUARY 2024

Current Plan £m's	Summary Funding & Expenditure	Plan to Date £m's	Actual to Date £m's	Variance to Date £m's	Forecast Outturn £m's	Var from Curr Plan £m's
	Mental Health Services					
23.756	Adult Mental Health	19.751	23.110	(3.359)	27.441	(3.684)
14.095	CMHT	11.580	11.530	0.050	13.705	0.390
7.076	LD	5.882	7.654	(1.772)	9.066	(1.990)
6.370	D&A	5.314	6.064	(0.750)	7.161	(0.791)
51.297	**Total Mental Health Services**	**42.527**	**48.357**	**(5.830)**	**57.373**	**(6.076)**

MENTAL HEALTH SERVICES

- Overspend of £6.076m forecast at FYE
- Locum costs and agency nursing continue to be the main drivers behind the forecasts overspend
- This has impacted on the operational position and the delivery of the savings target
- Forecast position includes slippage of £1.257m against the CIP target

MONTH 10 2023/2024 – JANUARY 2024

Current Plan £m's	Detail	Plan to Date £m's	Actual to Date £m's	Variance to Date £m's	Forecast Outturn £m's	Var from Curr Plan £m's
	Primary Care					
56.527	GMS	46.892	47.779	(0.887)	57.402	(0.874)
64.573	GPS	53.822	55.777	(1.955)	66.879	(2.306)
22.049	GDS	18.713	17.936	0.777	21.335	0.714
5.237	GOS	4.518	4.522	(0.005)	5.244	(0.007)
4.105	PC Management	2.863	2.768	0.094	3.989	0.116
152.492	**Total Primary Care**	**126.806**	**128.782**	**(1.975)**	**154.849**	**(2.357)**

PRIMARY CARE

- £2.357m overspend at FYE forecast
- Prescribing continues to present a challenging position with a £2.300m overspend built into the year end forecast
- Locum costs within 2C practices continue to be the other main driver for the forecast overspend position
- £1.264m slippage against CIP within the year end forecast

MONTH 10 2023/2024 – JANUARY 2024

Services Category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Outturn £000's	YE Variance £000's
Total Older People - Residential/Non Residential Care	58.647	48.531	47.777	0.755	57.277	1.370
Total Older People - Care at Home	34.330	28.640	30.342	(1.702)	36.257	(1.927)
Total People with a Learning Disability	41.636	34.709	36.542	(1.833)	44.361	(2.725)
Total People with a Mental Illness	8.276	6.881	6.911	(0.030)	8.226	0.051
Total People with a Physical Disability	8.334	6.953	7.147	(0.194)	9.199	(0.864)
Total Other Community Care	19.398	15.381	15.081	0.300	18.949	0.449
Total Support Services	4.379	2.970	3.830	(0.861)	4.779	(0.400)
Care Home Support/Sustainability Payments	-	-	(0.371)	0.371	(0.366)	0.366
Total Adult Social Care Services	175.001	144.067	147.260	(3.193)	178.682	(3.681)
Total ASC less Estates	174.477	143.630	146.665	(3.035)	177.924	(3.446)

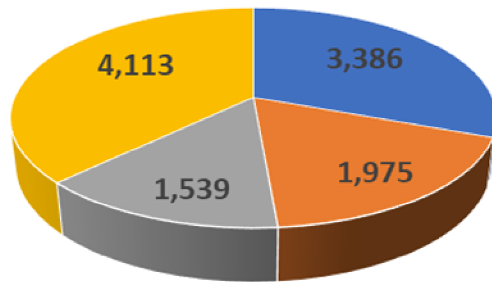
Care Home	YTD Actual
Ach-an-eas	23
Bayview House	30
Caladh Sona	13
Grant House	71
Home Farm Portree	746
Invernevis House	32
Lochbroom House	25
Mackintosh Centre	3
Mains House Care Home	404
Melvich Centre	4
Pulteney House	12
Strathburn House	46
Telford Centre	17
Wade Centre	75
Grand Total	**1,503**

ADULT SOCIAL CARE

- Slippage of £2.718m on the CIP has been built into the year end forecast
- £1.503m expenditure on agency nursing incurred to date within NHS Highland care homes
- £1.501m forecast full year spend on sustainability packages to ensure continuity of service provision
- Position assumes funding held by Highland Council from the 2021/2022 financial year will be drawn down in full – £9.734m
- Overall NHS Highland year end forecast continues to assume financial support in respect of the forecast overspend within ASC

MONTH 10 2023/2024 – JANUARY 2023

NHS Highland



HHSCP	Target £000	Forecast £000	Variance £000
NH Communities	3,386	1,573	(1,813)
Mental Health	1,975	718	(1,257)
Primary Care	1,539	275	(1,264)
ASC	4,113	1,395	(2,718)
Total	**11,012**	**3,961**	**(7,051)**

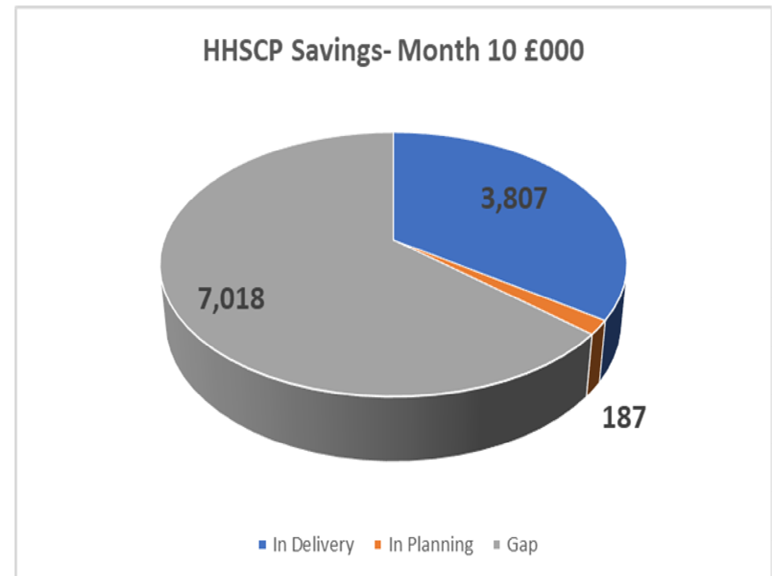
HHSCP COST IMPROVEMENT

- £11.012m target set for HHSCP CIP
- At the end of Month 10 slippage of £6.127m against the CIP is reported
- Slippage of £7.051m is built into the year end forecast
- There is an ongoing risk around non delivery of cost improvements/ reductions
- The CIP was built in the main with an anticipation that medical locum and agency nursing costs would be reduced significantly – progress in this area has been limited
- Ongoing service pressures within ASC has limited progress on delivery of savings

ASSURANCE OF PROGRESS 23 FEBRUARY 2024

HORIZON 1	Target	Value of Schemes In Delivery (YTD + Forecast)	% of Target Achieved (YTD Forecast)	Value of Schemes In Planning Stage (In Year Estimate)	Total	Gap (Target) - (In Delivery + In Planning)	% of Target Achieved (In Delivery + In Planning)	Count of Schemes with No Value	Total Count of Schemes	% of Schemes With No Value
HHSCP										
Mental Health	930	450	48%	50	500	-430	54%	0	4	0%
N. Highland Community Services & Primary Care	5,617	1,962	35%	137	2,099	-3,518	37%	0	22	0%
HHSCP-Health Unallocated	352	0	0%	0	0	-352	0%	0	0	
Adult social care	4,113	1,395	34%	0	1,395	-2,718	34%	0	3	0%
Unit-wide										
HHSCP Sub-Total	**11,012**	**3,807**	**35%**	**187**	**3,994**	**-7,018**	**36%**	**0**	**29**	**0%**

Workstream	No of Schemes	Value of Schemes in Delivery £000	Value of Schemes in Planning £000
ASC	1	400	
Estates - Energy	1	5	
Other Non-Pay	5	566	6
Prescribing	1	175	
Procurement	1	6	
Service Redesign & Reform	1	-	37
Unidentified	3	141	
Workforce - Medical Locums	2	327	50
Workforce - Nursing Agency	2	80	
Workforce - Permanent Staff	12	2,106	94
Total	**29**	**3,807**	**187**



Agenda Item 3.1

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**6 March 2024**
Title:	**Director of Public Health Annual Report:** Medication and Public Health – Do the Right Thing
Responsible Executive/Non-Executive:	**Tim Allison, Director of Public Health & Policy**
Report Author:	**Tim Allison, Director of Public Health & Policy**

1 Purpose

This is presented to the Board for:

- Awareness and Discussion

This report relates to a:

- Legal requirement

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

The Annual Report of the Director of Public Health for 2023 is presented.

2.2 Background

Directors of Public Health are required to produce an annual report concerning the state of health of their local population. There is no set format for the report and in recent years the reports have tended to focus on individual themes rather than acting as a repository for population health intelligence.

2.3 Assessment

The report for 2023 is brought to the Committee along with a presentation. A link is provided for the full report.

The theme for the report is medication and public health and there is a sub-title of Do the Right Thing. Public Health challenges cannot be solved simply by prescribing medication. There are areas of public health where medication plays a huge role in improving health but conversely it is important to be aware and take action where medication causes harm such as impacts on the environment.

The report presents information about the health of the population of NHS Highland then gives examples of how medication affects public health. The areas selected for this report are not intended to provide a comprehensive picture of the relationship between medication and public health but rather serve as examples of wider themes. The report contains six chapters as follows with key points, it also sets out recommendations:

Demography and health inequalities

- Information on NHS Highland's population is essential for planning health and care services across the life course.
- An ageing population is increasing the demand on health and care services as more people are living with one or more long-term health conditions and with increasingly complex needs.
- Population data from Scotland's Census 2022 will provide a detailed picture of the characteristics of our people and communities, including information on: ethnic group, armed forces veterans, sexual orientation and trans status or history; health, disability and unpaid care.
- Improving the health of our population requires a fundamental shift towards prevention and mitigating the underlying issues that can impact on health, such as poverty and deprivation.

The Environment: How medication can make our environment sicker

- There is growing evidence of the negative effects of medicines on our environment. When medicines are excreted from our body or flushed down toilets or sinks, they can end up in our water environment and soils. They can have negative effects on aquatic organisms and end up in the crops we eat.
- NHS Highland is at the forefront of research and action to reduce the impact of the medicines we use on the environment and is a co-founder of the One Health Breakthrough Partnership (www.https://ohbp.org).
- There is something that everyone can do to help reduce pollution of our environment with medicines.

Hepatitis C: How medication is transforming treatment and prevention

- Hepatitis C (HCV) is a blood borne virus (BBV) which can lead to cirrhosis of the liver and hepatocellular carcinoma.
- The management of HCV has been revolutionised in recent years by the introduction of new therapies. This development has played a significant role in the increase in treatment initiatives and the potential across Scotland to achieve HCV elimination.
- The availability of effective treatment that can be taken over a short period of time with few side effects should encourage more people to come forward for testing for Hepatitis C and provide a major step towards elimination of the virus.

Social Prescribing: How an alternative to medication can work

- It is estimated that 20% of people visit their GP with non-medical needs and up to one fifth of GPs' time is spent on issues related to social needs.
- Social prescribing provides an evidence-based potential to complement management of a wide range of health conditions through providing a holistic person-centred model of care to improve health and wellbeing and reduce reliance on medication and health services.
- The social determinants of health play an important role in the development of risk factors for a range of diseases and the health outcomes that people experience throughout life. Supporting people with wider social and environmental issues is important for improving health and wellbeing and reducing demand on health and care services.
- There is promising evidence that social prescribing provides a positive return on investment from between £2.30 and £7.08 for every £1 invested.

Analgesics and Opioids: How medication can have long lasting effects on public health

- There is little doubt that analgesics and opioid use can bring great benefits to individual but there are serious disadvantages as well.
- There are negative impacts of opioid prescribing, particularly the management of chronic pain. Alternatives are available such as social prescribing programmes, psychologically based interventions and physical therapies.
- Leadership and support for the continued implementation of the Medicines Assisted Treatment Standards, and in particular the use of Opioid Substitution Therapy, is vital in assisting individuals with problematic drug use to turn their lives around.

Recommendations for action for both NHS Highland and for partners.

NHS Highland and its partners should ensure that planning addresses the change in demography and ageing population.

NHS Highland and it partners should prioritise tackling health inequalities and the causes of those inequalities.

NHS Highland and those prescribing medicines should prioritise actions which will reduce the impact of medicines on the environment.

Citizens should take up actions which will reduce the impact of medicines on the environment.

NHS Highland work to eliminate Hepatitis C should promote the effectiveness of new medication and so encourage more people to be tested and successfully treated.

NHS Highland should increase the number of health and social care staff who are aware of social prescribing by developing and promoting a social prescribing network and a Directory of Services and by creating targeted messaging through staff and service newsletters, bulletins and social media.

NHS Highland and partners should improve the knowledge and skills of health and social care staff in relation to social prescribing by providing learning and development opportunities.

NHS Highland and partners should improve the infrastructure and availability of social prescribing by embedding link workers in a range of health and social care services and increasing use of the community benefits gateway through public sector procurement and commissioning processes.

Alcohol and Drug Partnership members should support further work relating to opioid and analgesic prescriptions, including needs assessment and development of alternative programmes for chronic pain.

Alcohol and Drug Partnership members should continue to support the delivery of the Medicines Assisted Treatment standards and the increased choices offered to individuals through the Opioid Substitution Therapy programme.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	✓	Moderate	
Limited		None	

Comment on the level of assurance

There is substantial assurance that the requirement for the publication of the report is met. Other elements of public health reporting will continue to need further work as will implementation of the recommendations from the report.

3 Impact Analysis

3.1 Quality/ Patient Care

Medication is an important part of both quality and patient care. NHS systems and processes are all affected by this complex topic of medication and board members will want to consider how to “do the Right Thing”.

3.2 Workforce

From a preventative perspective the main workforce recommendation is about increasing awareness of the number of health and social care staff who are aware of social prescribing and to promote a social prescribing network and a Directory of Services. This also has the potential to improve the health of the workforce through job satisfaction and staff being recipients of interventions. NHS Highland should continue delivering and supporting all staff in adhering to the principles of realistic medicine and safe and effective prescribing.

3.3 Financial

There are no direct financial implications from the paper. A focus on prevention, for example, social prescribing, would incur costs, but net savings are possible from NHS budgets for many prevention initiatives. Some could also be cash releasing.

3.4 Risk Assessment/Management

Risks are managed in line with NHS Highland's policy.

3.5 Data Protection

No personally identifiable information is involved.

3.6 Equality and Diversity, including health inequalities

The report addresses equality issues. The chapter on demography clearly outlines, for the Highland and Argyle and Bute populations, trends in health inequalities for selected health outcomes. This chapter also discusses the need for a fundamental shift towards prevention and mitigating the underlying issues that can impact on health such as poverty and deprivation.

3.7 Other impacts

No other impacts to note.

3.8 Communication, involvement, engagement and consultation

The principles of public and user involvement and engagement are embedded in public health actions.

This is an independent report from the Director of Public Health.

3.9 Route to the Meeting

This is an independent report from the Director of Public Health. Considerable work has been undertaken within the Public Health Directorate to produce the report. The report has been presented to NHS Highland Board.

4 Recommendation

The Highland Health and Social Care Committee is asked to note and discuss the 2023 Director of Public Health Annual Report.

4.1 List of appendices

The full report can be found at: The Annual Report of the Director of Public Health 2023 - Medication and Public Health - Do the Right Thing - Dr Tim Allison (scot.nhs.uk)

NHS
Highland
na Gàidhealtachd

The Annual Report of the Director of Public Health

2023

Medication and Public Health – Do the Right Thing

Acknowledgements and list of contributors

Thanks are due to the following colleagues for their contributions to this year's report:

Alison McGrory
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Contents

Introduction 4

Summary and Key Findings 6

Recommendations 8

Progress on recommendations from the 2022 report 9

Chapter 1: Demography and health inequalities 10

Chapter 2: The Environment: How medication can make our environment sicker 19

Chapter 3: Hepatitis C: How medication is transforming treatment and prevention 27

Chapter 4: Social prescribing: How an alternative to medication can work 31

Chapter 5: Prescriptions for Pain: How medication can have long-lasting effects on public health 41

Chapter 6: Case study – How medication and other measures can work together to improve health 48

References 55

Introduction

"Medication and Public Health" is the subject that I chose for the Public Health Report this year. We cannot solve public health challenges simply by prescribing medication for them. However, there are areas of public health where medication is a crucial if we want to deliver the most effective overall approach. Medication has transformed how we deal with infections, and it is hard to imagine the time before antibiotics. Yet we are now faced with the spectre of antibiotic resistance and the environmental impact of medication.

Our overall health is affected both in good ways and in bad ways by medication. I did originally think of tying this into an overall theme for the report of the good, the bad and the ugly. The idea was to pick up on the title of the 1966 spaghetti Western and look at different aspects of medication and public health, some good, some bad and some ugly. However, I was reluctantly persuaded that this was style over substance. I have though chosen the title of another film, one I saw when I was spending a couple of months as a student in Chicago – Do the Right Thing. The film focuses on varying perceptions from different groups of people; audiences sometimes had different responses depending on their background and experiences. When we look at medication and its different effects on public health we come from different backgrounds and experiences.

We will have varying perceptions about the power of medication to change lives or the influence of powerful pharmaceutical companies. We will also all want to do the right thing and I hope that this report will help to give further information and insight to help us judge what are the right things to do for the people of Highland and Argyll and Bute.

Dr Tim Allison MD MRCP FFPH
Director of Public Health and Health Policy, NHS Highland
Stiùriche na Slàinte Phoblach, Bòrd Slàinte na Gàidhealtachd

Structure of this Report

The report presents information about the health of the population of NHS Highland then gives examples of how medication affects public health. There are many ways in which medication affects public health. Some of these effects, such as antibiotic resistance, are of great significant and have received considerable attention.

The areas selected for this report are not intended to provide a comprehensive picture of the relationship between medication and public health but rather serve as examples of wider themes.

The Environment: How medication can make our environment sicker

Hepatitis C: How medication is transforming treatment and prevention

Social Prescribing: How an alternative to medication can work

Prescriptions for Pain: How medication can have long-lasting effects on public health

Case Study: How medication and other measures can work together to improve health

Summary and Key Findings

Demography and health inequalities

Information on NHS Highland's population is essential for planning health and care services across the life course.

An ageing population is increasing the demand on health and care services as more people are living with one or more long-term health conditions and with increasingly complex needs.

Population data from Scotland's Census 2022 will provide a detailed picture of the characteristics of our people and communities, including information on: ethnic group, armed forces veterans, sexual orientation and trans status or history; health, disability and unpaid care.

Improving the health of our population requires a fundamental shift towards prevention and mitigating the underlying issues that can impact on health, such as poverty and deprivation.

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There is little doubt that analgesics and opioid use can bring great benefits to individual but there are serious disadvantages as well.

There are negative impacts of opioid prescribing, particularly the management of chronic pain. Alternatives are available such as social prescribing programmes, psychologically based interventions and physical therapies.

Leadership and support for the continued implementation of the Medicines Assisted Treatment Standards, and in particular the use of Opioid Substitution Therapy, is vital in assisting individuals with problematic drug use to turn their lives around.

Recommendations

NHS Highland and its partners should ensure that planning addresses the change in demography and ageing population.

NHS Highland and its partners should prioritise tackling health inequalities and the causes of those inequalities.

NHS Highland and those prescribing medicines should prioritise actions which will reduce the impact of medicines on the environment.

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Alcohol and Drug Partnership members should continue to support the delivery of the Medicines Assisted Treatment standards and the increased choices offered to individuals through the Opioid Substitution Therapy programme.

Progress on recommendations from the 2022 report

Last year's report focused on the importance of prevention and the need to give more attention to activities that promote good health in addition to those that tackle poor health. Since the publication of the report there have been the following developments:

- The overall approach to prevention has been reviewed within NHS Highland and new arrangements are being put in place designed to increase preventative activity and links in patient pathways.
- The Highland Community Planning Partnership Board has highlighted prevention and health inequalities work and how to build on existing work.
- The new Living Well programme has been launched in Argyll and Bute, supporting people to improve their physical mental emotional and social wellbeing.
- NHS Highland has developed its plan as an anchor institution, helping to address the wider determinants of health.
- Infant feeding activity in Highland and Argyll and Bute has developed well and received positive external assessment.
- Work to address the harmful effects of tobacco and alcohol has progressed steadily, but plans are in place for significant development.
- Immunisation rates have been largely in line with past trends, but the steady slow decline in uptake needs to be tackled and uptake increased.

Chapter 1:

Demography and health inequalities

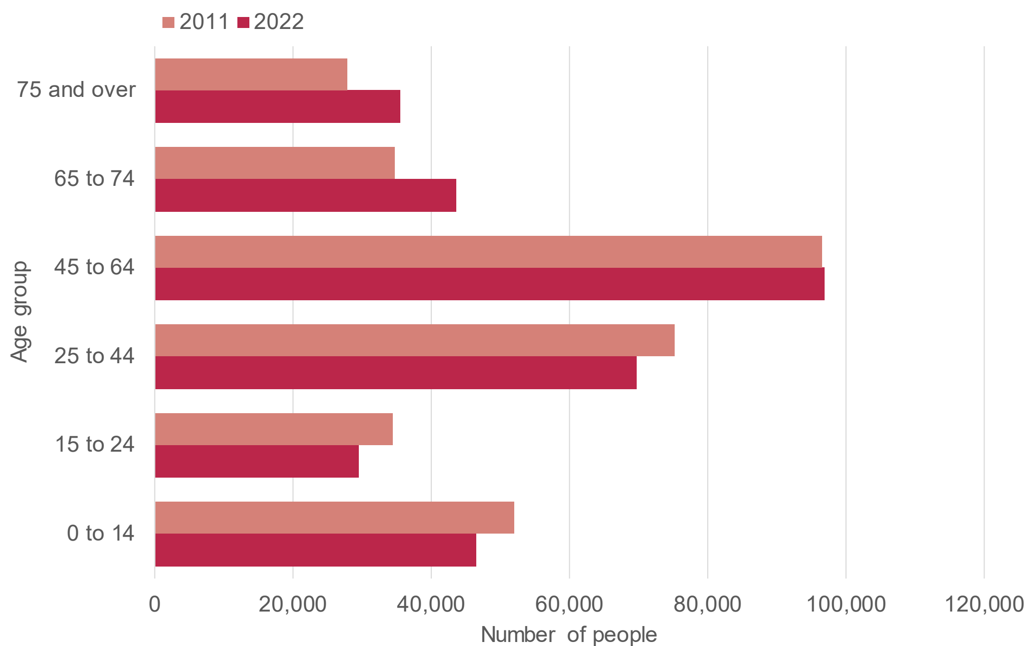
Chapter 1: Demography and health inequalities

Demographic trends

Demographic changes in the population of NHS Highland are having a significant and increasing impact on the provision of health and care services in the region. At the recent Scotland's Census 2022, the population of NHS Highland was estimated to be 321,500 people. This was an increase of 1,200 people (0.4%) since the previous census in 2011. Population growth was seen in the Highland council area (up 1.4%) but Argyll and Bute council area saw a decrease (down 2.4%).

The population is continuing to age, with many more people in the older age groups than previously recorded. Figure 1.1 shows the changing number of people living in NHS Highland by age group between 2011 and 2022. There are now over 79,000 people aged 65 and over (24.6%) compared with 46,400 people under 15 (14.4%). Increasingly the population structure includes a smaller and older workforce and fewer children and young people. The proportion of people in older age groups varies across council areas. Argyll and Bute council area had a higher proportion of people aged 65 and over (27.2%) compared with the Highland council area (23.7%).

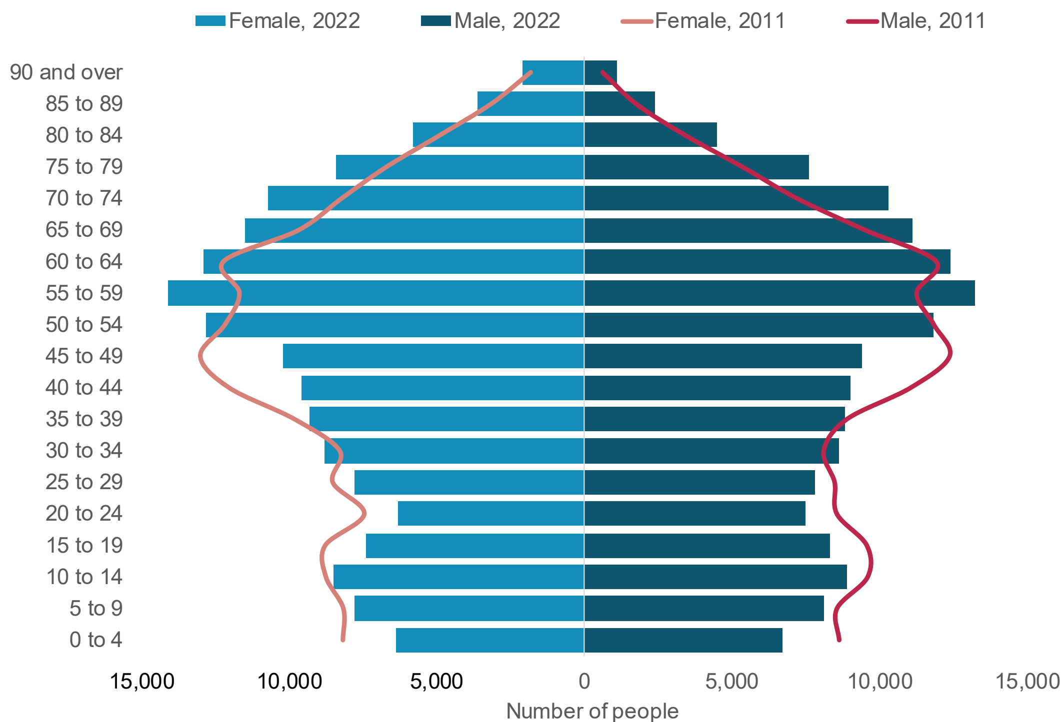
Figure 1.1 - Number of people resident in NHS Highland by age group, 2011 and 2022



Source: National Records of Scotland, Scotland's Census [1,2]

This is also seen in the changing shape of the population pyramid shown in Figure 1.2. The bars show the population of NHS Highland by five-year age groups and sex from the 2022 census and the lines show population data from the 2011 census.

Figure 1.2 - The structure of NHS Highland's population by age group and sex in 2011 and 2022



Source: National Records of Scotland, Scotland's Census [1,2]

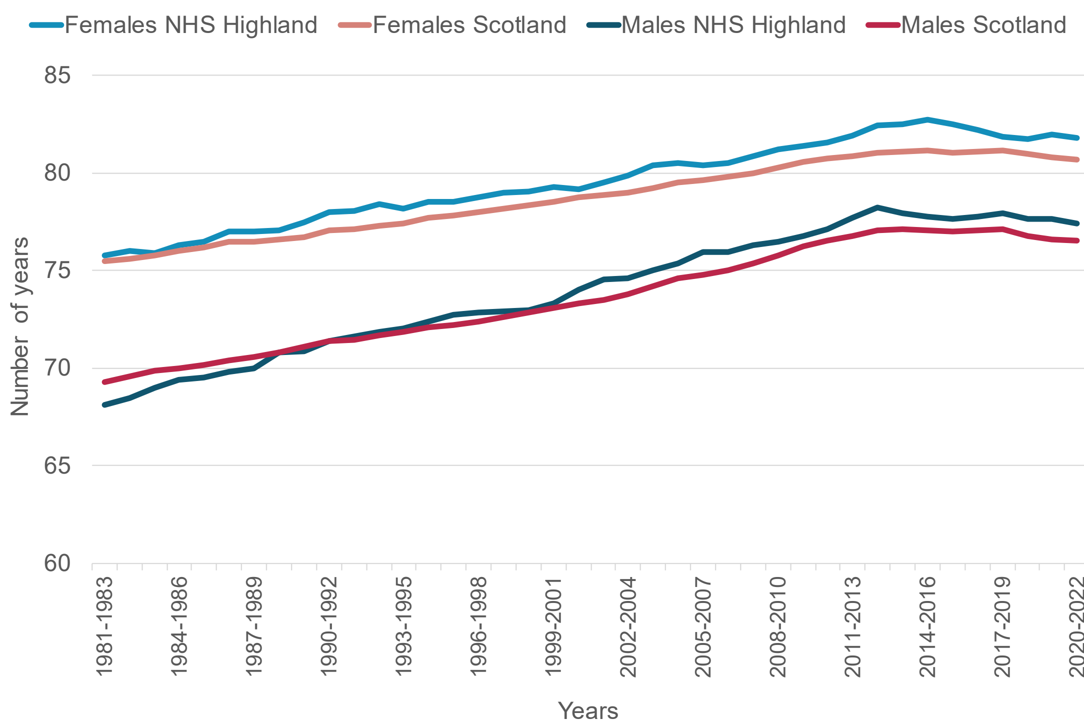
Information showing the rise in the population of older people in NHS Highland is not new and has been set out in previous years[3]. However, the extent of the increase is still considerable.

Information on NHS Highland's population is essential for planning health and care services across the life course. Population data from Scotland's Census 2022 will provide a detailed picture of the characteristics of our people and communities, including information on: ethnic group, armed forces veterans, sexual orientation and trans status or history; health, disability and unpaid care.

Life expectancy

People are living longer lives than in previous generations. Life expectancy in NHS Highland has increased over time for both males and females, with only minor variation from year to year. However, following the pattern in Scotland, average life expectancy has stopped improving. Recent trends show life expectancy in NHS Highland has decreased for both males and females as shown in Figure 1.3.

Figure 1.3 - Life expectancy at birth, NHS Highland and Scotland, from 1981-1983 to 2020-2023

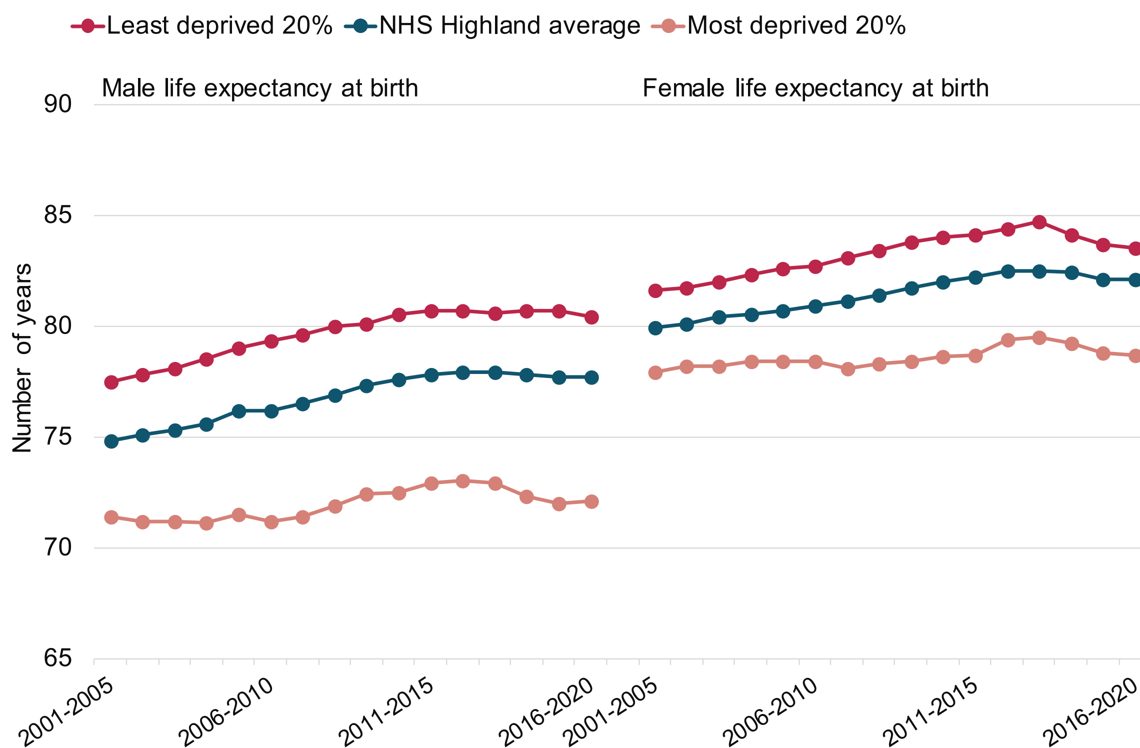


Source: National Records of Scotland, Life expectancy in Scotland[4], Scottish Public Health Observatory, Online Profiles Tool[5]

Notes: y-axis scale does not start at zero

Gaps in life expectancy between the most and least deprived areas of NHS Highland highlight significant health inequalities. People in our poorest neighbourhoods are dying younger than their peers. In 2016-2020, the gap in life expectancy between the most deprived and least deprived areas of NHS Highland was 8.3 years for males and 4.8 years for females. Gaps in life expectancy have increased over time for both sexes and highlight widening inequalities in society (Figure 1.4).

Figure 1.4 - Life expectancy at birth by deprivation quintile in NHS Highland between 2001-2005 and 2016-2020

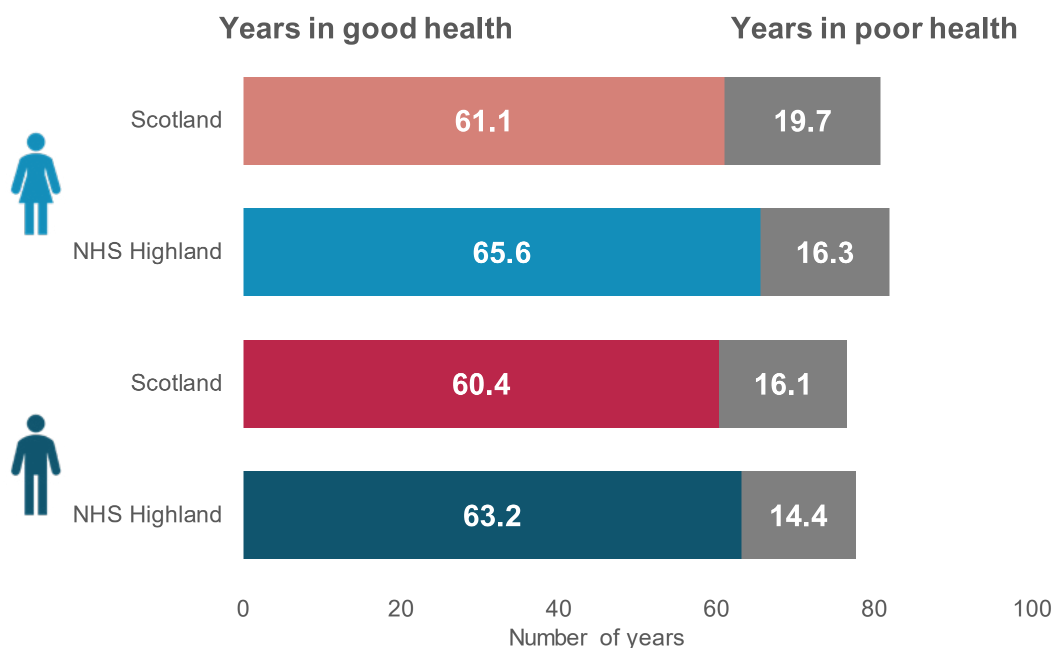


Source: National Records of Scotland, Life expectancy in Scotland[4], Scottish Public Health Observatory, Online Profiles Tool[5]

Health status

Despite overall improvements in life expectancy, healthy life expectancy has been decreasing in Scotland in the last decade[6]. Figure 1.5 shows the difference in the average number of years lived in good health compared to the average number of years lived in poor for the NHS Highland and Scotland population. It is now estimated that in NHS Highland the average proportion of life spent in poor health is 18.6% (14.4 years) for males and 19.9% (16.3 years) for females. Inequalities in healthy life expectancy between more wealthy and poorer areas are also particularly stark.

Figure 1.5 - Estimated number of years spent in good health and poor health in NHS Highland and Scotland in 2019-2021

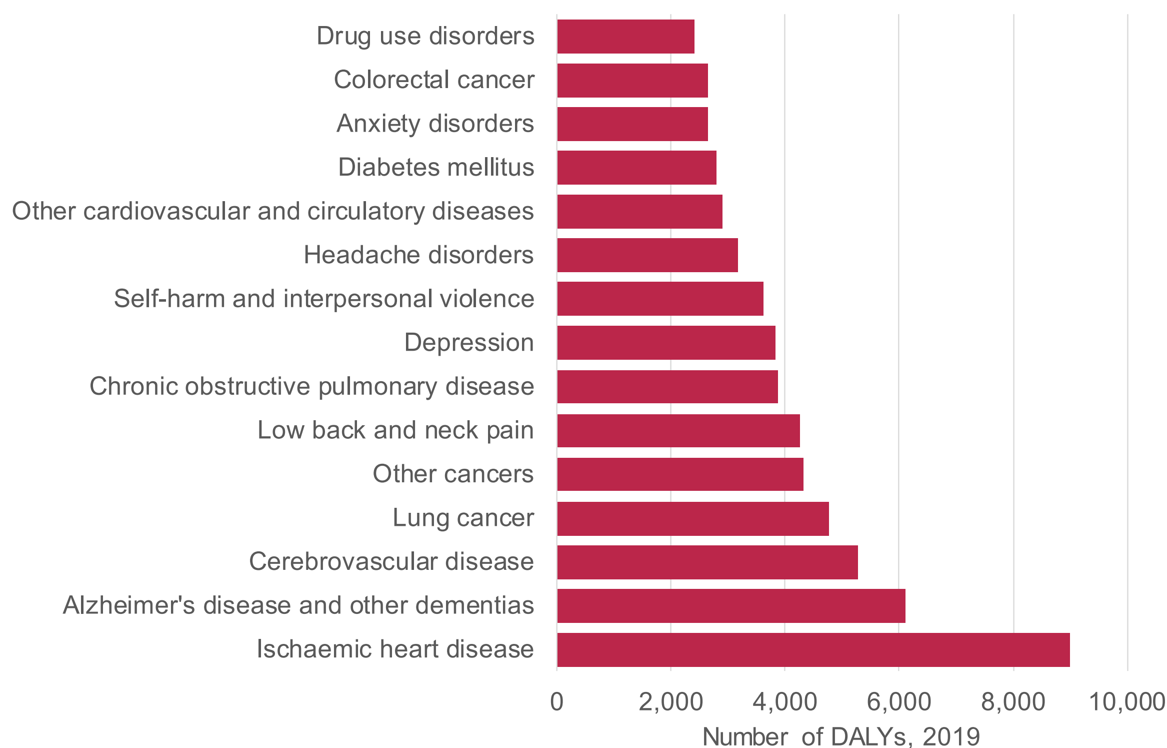


Source: National Records of Scotland, Healthy Life Expectancy (HLE) in Scotland 2019-20216

The leading causes of poor health in NHS Highland are summarised in Figure 1.6. Disability adjusted life years (DALYs) are a measure of the number of years of healthy life lost to physical and mental ill-health, disability and early death[7]. These estimates show the proportionate impact of different causes of ill health and mortality on population health. This can help inform priorities for disease prevention and planning for health and care services.

Cardiovascular diseases (such as ischaemic heart disease and cerebrovascular disease) make the biggest contribution to health loss, followed by Alzheimer's disease and other dementias. Cancer is also an important cause of ill health and mortality. These conditions are linked to risk factors including smoking, poor diet, and physical inactivity. In addition, mental health conditions such as anxiety and depression and injuries associated with self-harm and interpersonal violence substantially contribute to poor health in the NHS Highland population.

Figure 1.6 - Leading 15 causes of population health loss in NHS Highland in 2019



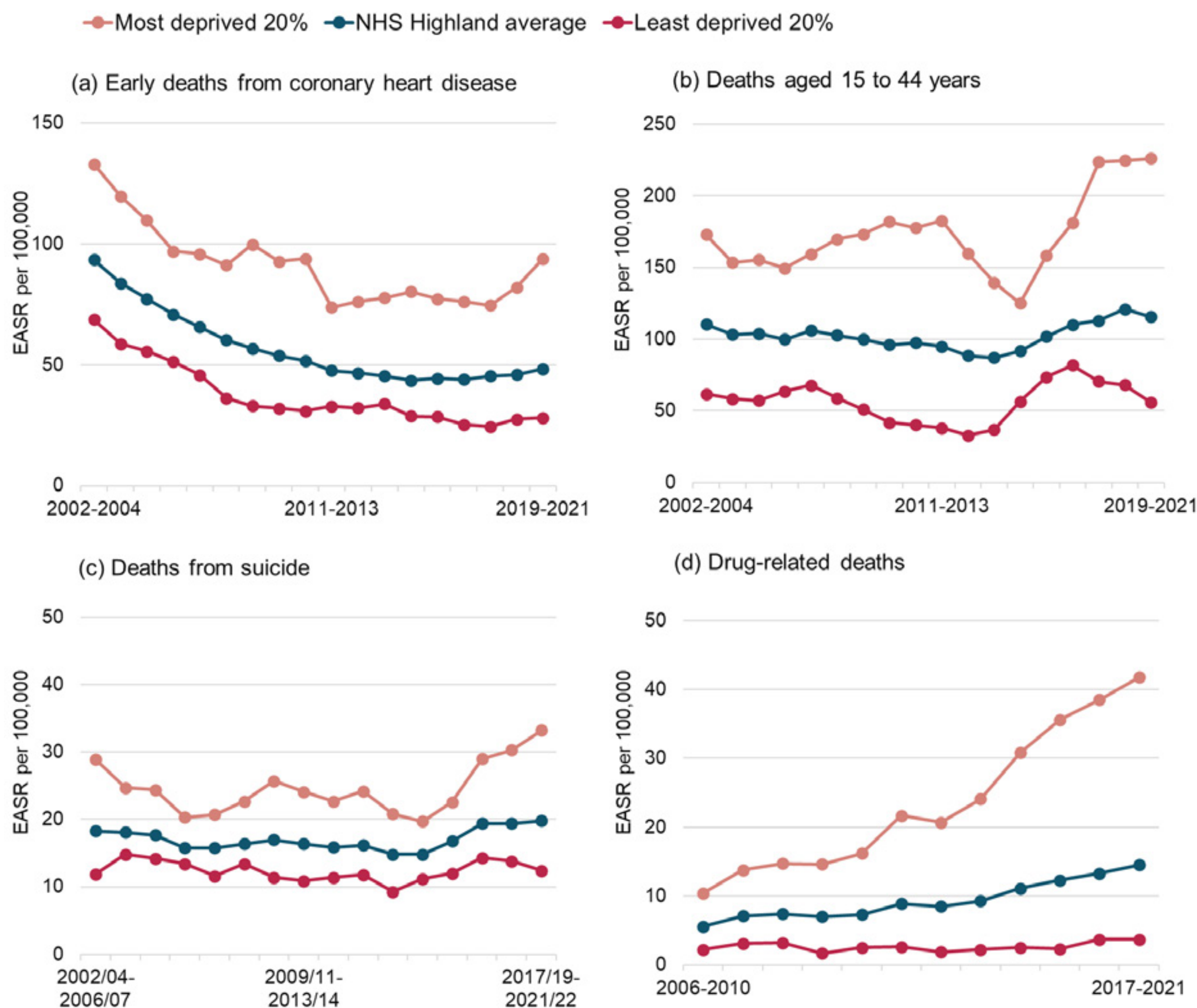
Source: Scottish Burden of Disease Study, Public Health Scotland[8]
Notes: Number of Disability adjusted life years (DALYs), all ages, both sexes

Health inequalities

Health inequalities are the "systematic, avoidable and unfair differences in health outcomes that can be observed between populations, between social groups within the same population or as a gradient across a population ranked by social position"[9]. In NHS Highland, as in other areas, the levels of health experienced by different groups of people are not equal.

The level of health inequalities across NHS Highland can be calculated and shown by summarising health outcomes in five groups based on levels of area deprivation. Figure 1.7 highlights the difference between the 20% most deprived and 20% least deprived areas of NHS Highland for four health outcomes: early deaths from coronary heart disease, deaths in people aged 15 to 44 years, deaths from suicide and drug related deaths. The gap in death rates between the most deprived and least deprived neighbourhoods has widened, highlighting the extent of growing health inequalities in NHS Highland.

Figure 1.7 - Trends in health inequalities for selected health outcomes in NHS Highland



Source: Scottish Public Health Observatory, Public Health Scotland
Notes: Based on Scottish Index of Multiple Deprivation (SIMD) 2020 local quintiles
EASR: European age-sex standardised rate, directly standardised to the 2013 European Standard Population

Health inequalities are largely a consequence of differences in people's living conditions and experiences through life. Inequalities in power, money and resources at a local and national level can make people's daily lives more challenging and more vulnerable to poor health[10].

Evidence shows factors driving these health outcomes include long-term health implications of economic recession, austerity policies, a stagnation of living standards and people experiencing multiple disadvantage[11,12]. The rising cost-of-living will disproportionately affect low-income populations, disabled people, older people, minority ethnic people and rural populations with long term effects on children[11].

Summary

The health concerns facing our region are common in Scotland and in other countries. An ageing population is increasing demand on health and care services as more people are living with one or more long-term health conditions and with increasingly complex needs. Research has shown that by 2043, the level of illness in Scotland is expected to increase by over 20%, with cancers, cardiovascular disease and neurological conditions contributing the most to poor health[13].

The causes of ill-health are complex and longstanding economic and social inequalities are impacting on the health of individuals and communities in NHS Highland. As previously reported, improving the health of our population requires a fundamental shift towards prevention and mitigating the underlying issues that can impact on health, such as poverty and deprivation[14].

Chapter 2:

The Environment: How medication can make our environment sicker

Chapter 2: The Environment: How medication can make our environment sicker

Medicines are used extensively in everyday life, whether prescribed or bought over-the-counter. This is mainly due to an ageing population, new technological advances and a "pill for every ill" culture where people tend to turn to a medicine first to make them better.

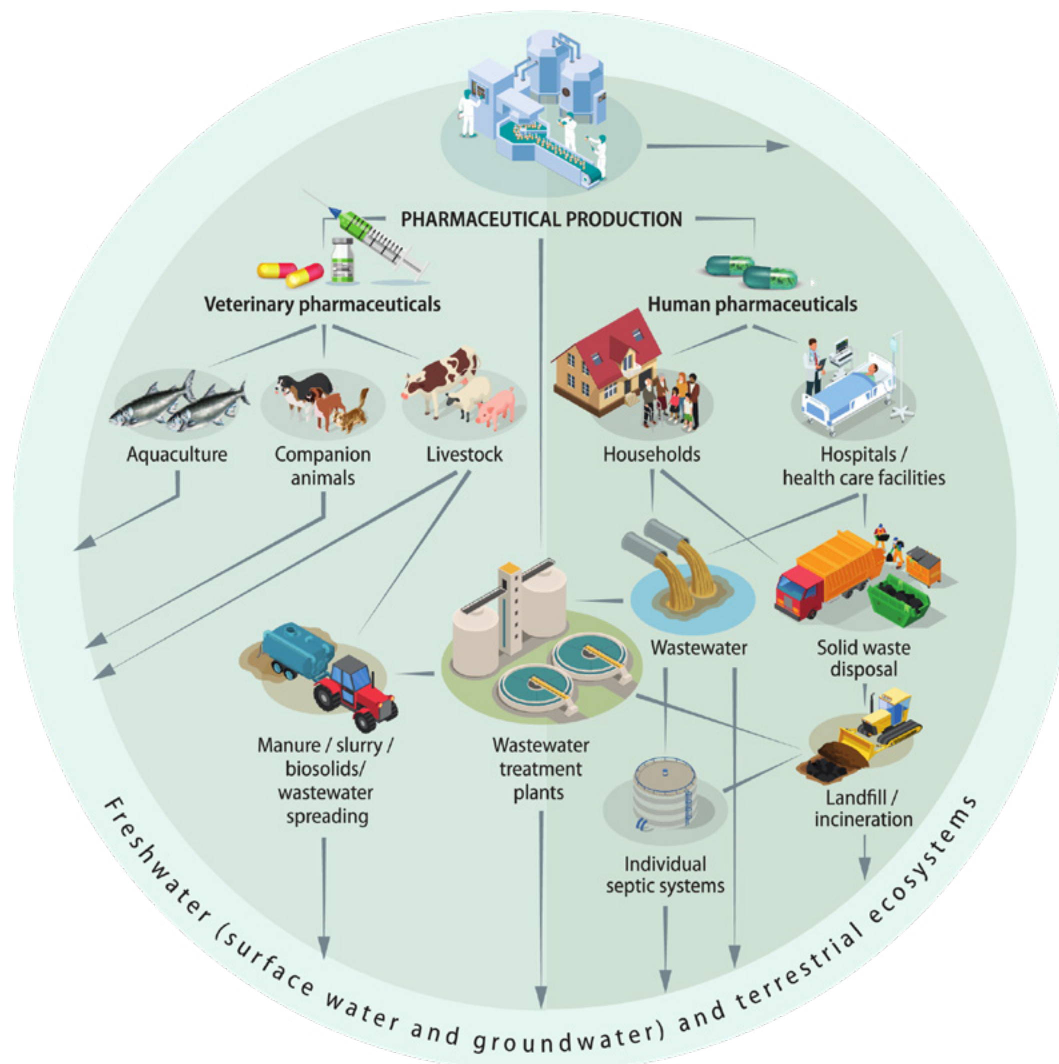
However, medicines can have negative effects on the environment. They account for 25% of the NHS total carbon footprint and contribute to pollution of the environment and are now classed as emerging environmental contaminants[15]. This section of the report focuses on pharmaceuticals in the environment (PiE) and groundbreaking work taking place in NHS Highland.

How do medicines enter the environment?

There are three ways in which human medicines can enter the environment.

1. **Pharmaceutical manufacturing processes** including industrial wastewater discharge and solid waste disposal.
2. **Incorrect disposal by users** - many people flush medicines down the toilet or pour them down the sink thinking this is the safest thing to do but this means that unmetabolised, active medicines are directly entering the wastewater system[16]. Putting them in household waste means they enter landfill and can leach into the soil eventually ending up in groundwater, surface water bodies and in crops.
3. **Excretion by users** - between 30 to 100% of an oral dose of medicine will be excreted as the parent pharmaceutical or a metabolite in urine or faeces into toilets and enter wastewater treatment plants or septic tanks. Pharmaceuticals are present in hospital and domestic wastewater. Excretion by patients via discharge of treated or untreated wastewater from domestic households is the main route for human pharmaceuticals entering the aquatic environment.

Figure 2.1 - Major pathways of release of human and veterinary medicines into the environment



Source: OECD (2019) [17]

Why is PiE an issue?

Wastewater treatment plants (WWTPs) were never designed to remove small, complex chemical molecules[18]. They were designed to remove biological solids, pathogens, organic and inorganic material rather than removal of modern chemicals at low concentrations[19].

Therefore, depending on several variables such as the pharmaceutical or the amount of rain, pharmaceuticals will be present in the effluent (the treated wastewater coming out of the WWTP) in unchanged form or as transformation products and be pumped into rivers and oceans. WWTPs are thought to be the main source of human pharmaceuticals entering the environment, although landfill sites, septic tanks and manufacturing sites also contribute[20].

Figure 2.2 - How do pharmaceuticals get into the environment

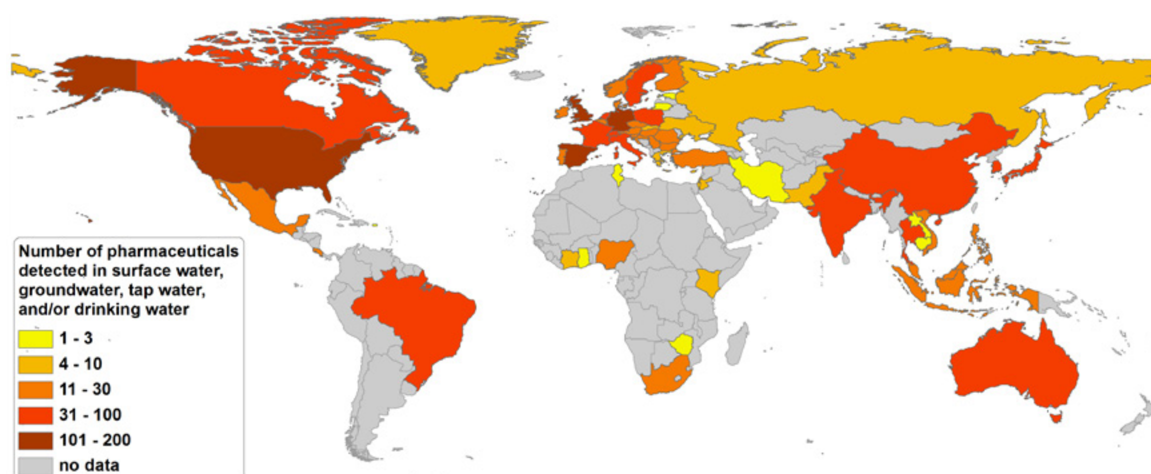
Source: Niemi (2020)[15]

1. Active pharmaceutical ingredients (APIs) are designed to interact with a living system and have a biological effect at extremely low doses. They can do this across a range of organisms[20] such as fish, frogs, duckweed, for example, and then unintentional harmful effects may occur.
2. Pharmaceuticals are designed to be stable (persistent) to reach and interact with their target molecules[21]. Persistent substances which can withstand natural degradation increase the potential for long-term effects in the environment[22]. Even if a pharmaceutical is degradable, a high volume of use means that it is "pseudo persistent" as it is continuously entering the environment. Examples of such pharmaceuticals include paracetamol and ibuprofen because the rate at which they are used and enter the environment is greater than the environmental degradation rate[23].
3. Pharmaceuticals can be bioaccumulative which means that they are incorporated into living tissue without being properly excreted or degraded, remaining within the organism. This has implications for the human food chain.
4. Pharmaceuticals can be toxic to humans or ecosystems and their transformation products can be more toxic than the parent compound[24].

Why should we care about pharmaceuticals in the environment?

Pharmaceuticals have a direct pathway into the environment via wastewater processes. More than 630 pharmaceuticals have been found in rivers, lochs, seas and estuaries across the world with antibiotics, anti-inflammatories and painkillers topping the list[25].

Figure 2.3 - The number of pharmaceuticals detected in surface water, groundwater or drinking water globally



Source: aus der Beek et al. (2016)[25]

The most recent and largest study of pharmaceutical pollution of the world's rivers across all continents found that over 25% of rivers tested pose a threat to environmental and/or human health. The river Clyde in Glasgow rated 26th highest out of 137 river catchments for concentration of pharmaceuticals.

There is growing evidence of the negative effects on ecological and human health. Behavioural changes in aquatic species have been reported such as: altered salmon migration in the presence of anti-anxiety medicines[26]; impaired development of frogs exposed to anti-depressants[27]; population collapse in fish exposed to estrogen hormones[28]; near extinction of vulture populations in India resulting in 47,000 human deaths from rabies, since vulture loss led to an in increase in feral dogs and their bites[29].

Future projections on pharmaceuticals in the environment

Pharmaceutical consumption has grown rapidly over the last decade due to aging populations, epidemiological changes, technological advances and changes in clinical practice[30]. This trend is expected to continue.

In addition, climate change is likely to affect the amounts and types of medicines used and released to water bodies. Non-communicable diseases such as cardiovascular disease and mental illness, respiratory, water-borne and vector-borne disease are expected to become more common[31,32]. This will lead to an increase in associated medicine usage and increased pollution of the environment.

Many other aspects of climate change will also affect the fate and transport of medicines in the environment, for example heavy rainfall will trigger storm overflows bypassing WWTPs, while lower rainfall and increased water scarcity will reduce the dilution of pharmaceuticals.

It is therefore essential that public health interventions such as health improvement and social prescribing are employed to ensure as healthy and resilient a population as possible as climate change begins to increase its impact on human health. Healthy humans depend on a healthy planet.

What is NHS Highland doing to reduce the impact of PiE?

NHS Highland is a founding member of the One Health Breakthrough Partnership (https://ohbp.org), a collaboration between the Scottish Environment Protection Agency (SEPA), Scottish Water, Scotland's Centre of Expertise for Waters (CREW) and the Environmental Research Institute (part of UHI). Formed in 2017, the OHBP has brought together key regional and national stakeholders across the environment, healthcare, and water sectors with a commitment to generate positive One Health outcomes and create a 'non-toxic' environment. The OHBP mission is closely aligned with the Scottish Government's Hydro Nation agenda, recognising that Scotland has internationally significant and high-quality water resources, which are of vital importance to its economy and the health of its population.

OHBP recognises One Health to be an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems. It works across organisational and disciplinary boundaries, collectively and collaboratively, to ensure optimal outcomes for the health of humans, domestic and wild animals, plants, and the wider environment (including ecosystems).

To date, the focus of work has been on sustainable medicines and addressing anti-microbial resistance. Impacts and achievements so far include:

- achieving a world first in Water Stewardship at Caithness General Hospital (https://a4ws.org/download/aws-case-study-caithness-general-hospital/)
- developing an action plan to substitute environmentally harmful medicines with less toxic ones
- engaging >6000 clinicians across the world on the environmental impact of pharmaceuticals
- developing a database of pharmaceuticals in the water environment (2021) and visualisation tool to compare environmental data with prescribing data in Scotland – the first of its kind in the world (https://ohbp.org/2022/06/13/pharmaceuticals-in-the-water-environment-new-data-tool-launched-by-sepa/)
- publications in international, peer-reviewed scientific journals e.g. First, do no harm: time for a systems approach to address the problem of health-care-derived pharmaceutical pollution - The Lancet Planetary Health (https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(22)00309-6/fulltext)

- launching a website in Aug 2021, viewed in >30 countries (https://ohbp.org), Twitter/ X @ OneHealthBP and a Twitter conference #OHBP2023
- developing and evaluating a free to use public education video on antibiotics and the environment: https://www.youtube.com/watch?v=VBJztG31jRs
- promoting public awareness e.g. BBC Radio Brainwaves programme, BBC Alba television programme
- contributing to an international online course 'Water, Soil, and Health" with experts from Grenada, Jamaica, Kenya, and Scotland on sustainable environmental change
- promotion at national and international conferences (e.g., COP26, Planetary Health Alliance and NHS Scotland sustainability conference)
- helped developed a Policy Brief for the House of Lords (https://ohbp.org/2023/07/28/new-policy-recommendations-launched-for-eco-directed-and-sustainable-prescribing-of-pharmaceuticals-at-uk-parliament/)
- won several awards including VIBES (https://vibes.org.uk/)

Summary and potential for action

The presence of pharmaceuticals in the environment has been gaining recognition over the past decade. Whilst evidence on human and environmental health is still being developed, drinking water regulators and providers, governments, healthcare professionals and the public are raising concerns. The German Environment Agency (UBA) estimate that 10% of pharmaceutical products indicate potential environmental risk with hormones, antibiotics, painkillers, antidepressants and anti-cancer medicines being of greatest concern[33].

Scotland has a vested interest in the Hydro Nation and One Health agendas, which are multi-sector strategies to effectively manage the water environment and improve public health (respectively). These concepts recognise that human health and environmental health are closely interconnected, and that water quality is a central and significant factor to the wellbeing of both.

Many parts of the private and public sectors across Scotland and the UK may be affected by pharmaceutical pollution and have an interest in addressing this issue. This includes pharmaceutical manufacturers and the healthcare sector, the food and drink sector (including agriculture and fisheries), and public organisations including water regulators, environmental protection bodies, healthcare, researchers/academics, and policymakers. The OHBP is providing leadership in this area driving research, innovation and policy change.

Whilst more evidence is developed there are many things that healthcare professionals and the public can do to reduce the impact of pharmaceuticals on the environment.

How the public can help

- Stay healthy with exercise and a balanced diet.
- Accept invitations for screening and vaccinations to prevent ill health.
- Use good respiratory hygiene to prevent spread of viruses such as coughs, colds and flu.
- Ask your prescriber about the risks and benefits of medicines and whether there is any alternative.
- Only order what you need for repeat medicines and do not stockpile.
- Ask your prescriber or community pharmacist how to get the best out of your medicine.
- If you use an inhaler ask your pharmacist to check your technique.
- Return any unused, unwanted or out of date medicines to your community pharmacy or GP practice for safe disposal.

How healthcare professionals can help

- Ask the patient what matters most to them. It may not be getting a medicine.
- Explain the risks and benefits of a medicine, whether there is an alternative and why it might be best to do nothing.
- Consider social prescribing rather than a pharmacological intervention.
- Always prescribe the lowest dose and smallest quantity when starting a new medicine to avoid waste should side effects occur.
- Plan in a medicines review to check whether the expected clinical outcomes are being achieved.
- Advise patients to return unwanted medicines to their community pharmacy or GP practice for safe disposal.
- Learn more about PiE.

Chapter 3:

Hepatitis C: How medication is transforming treatment and prevention

Chapter 3: Hepatitis C: How medication is transforming treatment and prevention

Background

Hepatitis C virus (HCV) is a blood borne virus (BBV), spread through contact with blood or body fluids from an infected individual, which can lead to cirrhosis of the liver and hepatocellular carcinoma. HCV is a significant issue across the world with around 1.5 million new infections and 290,000 deaths each year globally according to data for 2019[34].

The Scottish Government's Hepatitis C Action Plan and the subsequent Sexual Health and Blood Borne Virus (SHBBV) Strategic Framework provided a world leading structure for the prevention, diagnosis, treatment and care of HCV. The management of HCV has progressed enormously over recent years with current treatment options providing the potential to cure more than 90% of those infected with HCV. This has led to the global ambition to eliminate viral hepatitis as a public health threat through effective treatment and prevention of transmission by 2030. Within Scotland, the Scottish Government has made a commitment to treat more people with hepatitis C with the aim of eliminating HCV infection and HCV related severe disease and death as a major public health concern in Scotland by 2024. This is an ambitious target which seeks to achieve elimination six years ahead of the target set by the World Health Organization.

The latest surveillance data has identified that there are just over 4,000 individuals who are estimated to be diagnosed and living with chronic HCV infection in Scotland. A breakdown by NHS Board of residence is shown in the table below[35].

NHS Board data on the prevalent number of people diagnosed with hepatitis C virus (HCV) in Scotland and last known to have chronic infection, up to August 2023

NHS Board of Residence	Estimated number diagnosed and living with chronic HCV	Distribution by NHS Board
NHS Ayrshire & Arran	376	9.3%
NHS Borders	69	1.7%
NHS Dumfries & Galloway	73	1.8%
NHS Fife	279	6.9%
NHS Forth Valley	257	6.4%
NHS Grampian	460	11.4%
NHS Greater Glasgow & Clyde	1055	26.1%
NHS Highland	102	2.5%
NHS Lanarkshire	495	12.3%
NHS Lothian	641	15.9%
Island health boards (Orkney, Shetland and Western Isles)	20	0.5%
NHS Tayside	209	5.2%
Total	**4036**	**100%**

Development of new Direct Acting Antiviral (DAA) therapies

One aspect which has revolutionised the management of HCV has been the development of Direct Acting Antiviral (DAA) therapies. These pharmaceutical developments have significantly increased the efficacy of antiviral treatments which eradicate HCV infection as detailed in the table.

The efficacy of antiviral treatments over time[36]

Year	Treatment	Sustained Viral Response % (Genotype 1)*
1994	Interferon	7-11
1998	Interferon + Ribavirin	28-31
2001	Pegylated Interferon + Ribavirin	42-46 (note 70-80% for G3)
2011	Pegylated Interferon + Ribavirin + First Generation Direct Acting Antivirals (DAAs)	67-75
2014/15	Interferon-free Direct Acting Antiviral Therapy (especially for genotype 1 but increasingly for other genotypes)	93-100

*Clinical trial data

Whilst the early Direct Acting Antivirals (DAAs) were particularly focussed on one type of the virus, genotype 1, these treatments are now increasingly covering all types. In addition to the increased efficacy, the new all-oral DAA regimes provided a safe treatment with far fewer side-effects and of relatively short duration compared with the interferon-based therapies. This development has played a significant role in the increase in treatment initiatives and also the ability across Scotland to achieve HCV elimination.

Despite the ever-expanding treatment options, a significant proportion of HCV cases remain undiagnosed. The high proportion of undiagnosed cases, combined with the increasing range of HCV therapeutics underlies the need for effective approaches to awareness raising, HCV case-finding, re-engagement and scale-up of treatment and care. A national Short-Life Working Group (SLWG) was convened in 2018 to review approaches to each of these aspects of HCV prevention and treatment. As a result of this, 18 recommendations were developed in order to support the aim of eliminating HCV-related disease as a major public health concern.

The COVID-19 pandemic had a significant impact on the ability of boards to progress action towards elimination as planned. This arose due to a number of factors including more limited capacity for professionals to support this agenda due to the need to respond to the pandemic but also a change in the way that some services were provided. However, there has been a renewed emphasis on this elimination commitment in addition to refreshed HCV treatment targets for NHS Boards.

NHS Highland's Blood Borne Virus Managed Clinical Network (BBV MCN) is committed towards the ambition of eliminating HCV in Scotland. A local elimination strategy details the range of activities pertaining to case-finding, testing, awareness raising and access to care that are being undertaken in support of this aim.

Effective detection of those who have been infected with HCV combined with the provision of accessible treatment options enables more of our patients to be treated as early as possible and prior to progression to advanced liver disease which improves health outcomes. In addition to the health benefits for the patients, eliminating HCV will also result in cost-savings to the NHS in the longer term. Effective treatment also has wider public health benefits due to the reduction in onward transmission of hepatitis C. Scotland's commitment to eliminate HCV is an exciting opportunity and one to which NHS Highland's BBV MCN is fully committed.

This is an excellent example of where new medication has the potential to improve public health. The availability of effective treatment that can be taken over a short period of time with few side effects should encourage more people to come forward for testing for Hepatitis C and provide a major step towards elimination of the virus.

Chapter 4:

Social prescribing: How an alternative to medication can work

Chapter 4: Social prescribing: How an alternative to medication can work

Introduction

Social determinants such as poverty, isolation, employment and housing have a substantial effect on people's health[38,39]. It is estimated that 20% of people visit a GP with non-medical needs[40] and up to one fifth of GPs' time is spent on issues related to social needs rather than issues best solved by medical interventions such as medication. In areas of high deprivation, many GPs report that they spend significant amounts of time dealing with the consequences of poor housing, debt, relationships, and loneliness[41].

Supporting people with wider social and environmental challenges is therefore important to improve their health and reduce demand on health services. Furthermore, it has been shown that the effectiveness of some medication can be reduced if people are facing adversity in their everyday lives, for example depression medication has been shown to be less effective if a person has employment or housing issues[42].

Inappropriate pharmaceutical prescribing, particularly for older people and those experiencing inequality was highlighted as a contributory factor for increased drug reactions and hospitalisation in up to 1 in 5 people in the over 65-year age group[43]. Social prescribing is increasingly being recognised as one potential solution for a proportion of people who attend health care services with non-medical needs.

What is social prescribing?

There are many definitions of social prescribing currently used but the core common principles of Social Prescribing are to support person-centred care and shared decision making, and to encourage a non-clinical approach to address aspects of health and wellbeing[37].

In 2022, the Scottish Social Prescribing Network was invited by the Global Social Prescribing Alliance to take part in a research study to find an internationally accepted definition of social prescribing. This definition was agreed on by 48 experts from 26 different countries, including Scotland, and has recently been accepted by the BMJ.

Social prescribing is "a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections."

Source: Muhl et al. (2023)[44]

Social prescribing can take place within clinical and community settings but will have a focus on the social determinants of health. The overall aim of social prescribing is to improve health and wellbeing and can be more than just signposting. For maximum impact, it is likely to involve a link worker who will work with people to co-create a social prescription based on individual need. The link worker will help to remove barriers to individuals accessing support.

Use of medicines and social prescribing

Realistic Medicine advocates a shared decision-making approach which supports people and families using healthcare services to discuss their treatment through a personalised approach to care. This approach provides opportunities to develop social prescribing through focusing on non-clinical, non-pharmacological interventions which can improve health and wellbeing through reducing medication use and environmental harms[45].

Social prescribing effective medication in a number of areas of mental health[45]

More research is needed to demonstrate that social prescribing is effective at reducing medicine prescribing but there is a growing recognition that a social prescription can be as effective as medication in several areas including managing mental health and wellbeing[45]. The Royal College of Psychiatrists and the Royal College of Occupational Therapists have published a joint position statement advocating for social prescribing.

Figure 4.1 – Spectrum of definitions of social prescribing

Source: Adapted with permission from Lejac (2021)[37]

Example of broad, medium, and specific social prescribing approaches are described below

Broad social prescribing can be where a conversation identifies the need for non-medical support and an individual is told about support services or where an individual recognises, they need help and is able to access it for themselves.

Medium social prescribing can be where a health professional or a support worker recognises an individual needs support and actively directs them or signposts them to services or an organisation that could help. For example, a referral to an exercise programme where there is a single issue and support is targeted primarily to that issue. This may also involve additional signposting if appropriate but is not part of the planned intervention.

Specific - involves a referral to a dedicated link worker who will work with individuals to identify what is important to them, co-produce a social prescription and support them to access the right non-medical services or community support. The link worker will also help remove barriers to accessing services or support and is likely to work with an individual over an extended period of time.

Evidence

Evidence suggests that on an individual level social prescribing can have a positive impact on health and wellbeing and complement medication prescribing to manage a wide range of health conditions. The following table outlines some of the impacts that social prescribing can have on individuals and health services:

Impact of social prescribing approaches on the individual
Increased confidence and reduced social isolation[43,46]
Physical activity referrals from a link worker can result in the following: • Improvements in physical health such as the lowering of BMI and blood pressure[47] • Improvements in mental health such as a reduction in anxiety and depression and increased sense of wellbeing[47]. Reduction in use of health services[47].
Improvement in quality of life and mental well-being through addressing practical issues such as housing, care and finances[48,49].
Improved glycaemic control for certain age groups with type 2 diabetes[50].
Referral to activities such as the Arts, cultural activities including attending museums and music related activities has demonstrated: • Increased social interaction and decreased stress[51]. • Improvements in employment and enhancement of skills, and economic development[51].
Nature-based interventions can positively impact health and wellbeing through: • reducing social isolation and fostering a connection to nature[52]. • reducing postoperative complications and has been shown to reduce cardiovascular risk[53].

Impact of social prescribing approaches on health and care services
A 14% decrease in admissions to emergency inpatient services[54].
Reduction in the number of hospital admissions and outpatient appointments. One study found a 75% decrease in non-elective inpatient episodes among those who had accessed support through Social Prescribing[55].
Reduced demand for GP appointments by an average of 28% (range 2% to 70%) and A&E referrals by an average of 24%[56].
A 40% reduction in GP appointments for participants at a 3-month follow-up, compared to those who did not use a Social Prescribing service[57].

Opportunities and Challenges

There are opportunities to develop and embed social prescribing approaches in health and care services as an alternative to or alongside medicines prescriptions.

Two recent events to explore how social prescribing could be developed in Highland identified a number of local enablers and barriers to embedding this approach in health and social care services. These included:

Key Enablers	Enablers identified from the Highland events 2023
Capacity of primary healthcare services and a shift in ethos towards person-centred care[43]	Social prescribing to be recognised across Highland as an integral part of Health and Social Care where clinicians are encouraged and supported to move away from a 'medicalised' model of health.
Link worker practice and developing trust through co-produced services[47,58]	Local multi-agency working in Highland with a shared understanding of Social Prescribing best practice to promote more consistent and coordinated practice across all sectors.
Peer training and providing support to use new technologies[58]	Standardised training to upskill staff and consider the remote and rural nature of Highland, especially when developing digital and technological solutions.

Key Barriers	Barriers identified from the Highland events 2023
Resources[43]	For statutory and community organisations there is a lack of long-term, consistent funding and link worker capacity' across Highland.
Awareness[43]	Lack of awareness of what social prescribing is amongst those delivering, supporting, and accessing it. Particularly in smaller communities. Issues such as stigma relating to financial problems, particularly in smaller communities.
Knowledge[43]	Shared knowledge of local assets, organisations and connections across Highland requiring development of a Directory of Community Services.

Social Return on Investment

Social return on investment (SROI) is a method of assigning monetary values to social value as well as traditional assets and offers one way of evaluating social prescribing initiatives. It is recognised that this is an area that would benefit from more research but a range of studies that explored SROI for Social Prescribing initiatives found positive financial returns on investment:

- **For every £1 invested the social return on investment ranged from £2.30 to £7.08[59]**

Currently, the University of the Highland's and Islands is undertaking an evaluation of the Highland Community Link Worker Programme including exploring SROI in the context of delivering a Community Link Worker service in remote and rural areas. This will provide valuable information to inform future development of Link Worker services across Highland and Argyll and Bute.

A study exploring the economic benefits following a social prescribing intervention for patients who were frequent attenders and frequent non-attenders at primary care found a cost saving for frequent attenders of £78.37 and a reduction in health care usage suggesting that social prescribing interventions be targeted at this group for maximum cost benefit[60].

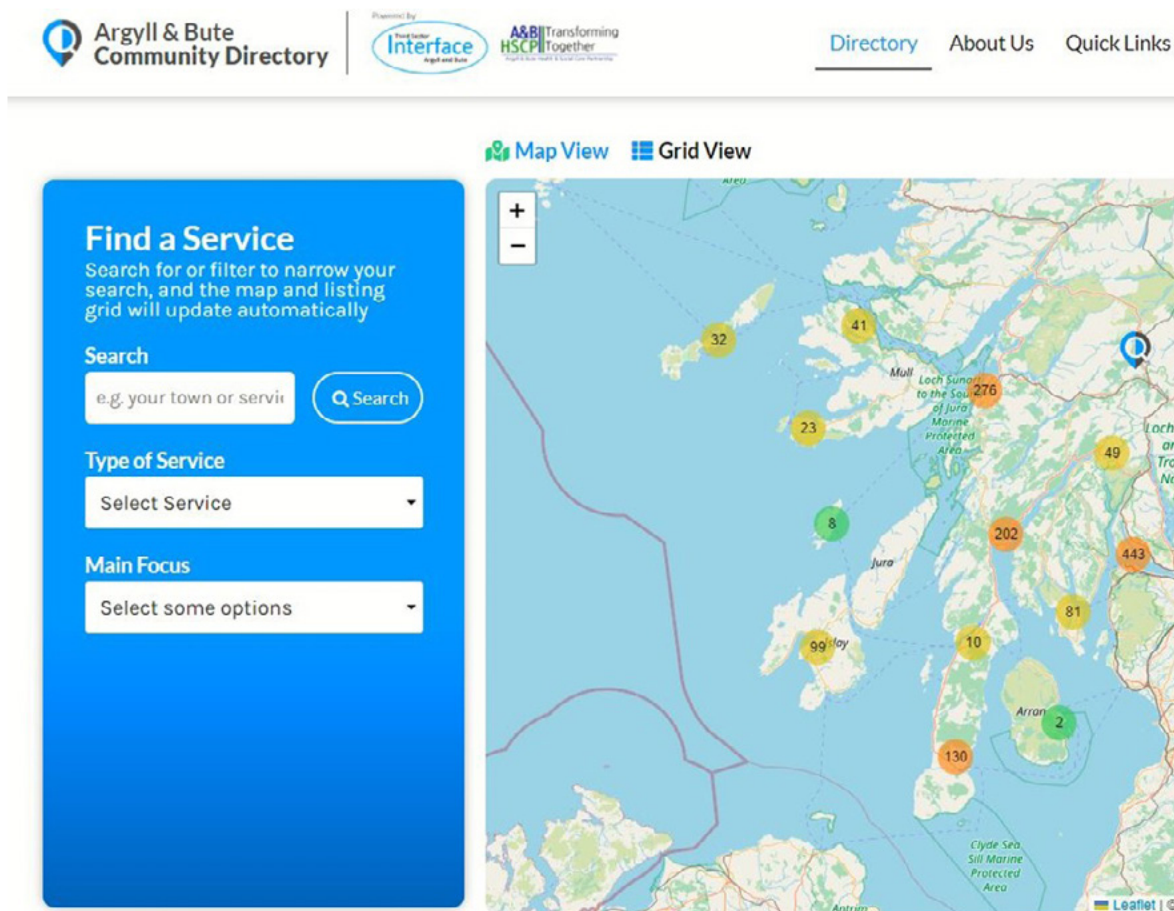
Examples of social prescribing initiatives in NHS Highland

Third Sector Interface (TSI) Community Directory

Argyll and Bute Health and Social Care Partnership (HSCP) supported development of the Third Sector Interface (TSI) Community Directory. The directory is a website which provides details of many of the third sector organisations that provide community-based support throughout Argyll and Bute – available at www.abcd.scot. The directory is a single source of regularly updated service information for referring agencies, or those making a self-referral.

The Public Health Team have collaborated with the TSI to develop the content of the site. The directory is widely promoted to HSCP staff, particularly allied health professionals, to support active signposting to community resources that can support individuals with their health and wellbeing.

Figure 4.2 – Argyll & Bute Third Sector Interface (TSI) Community Directory



Active Health Project

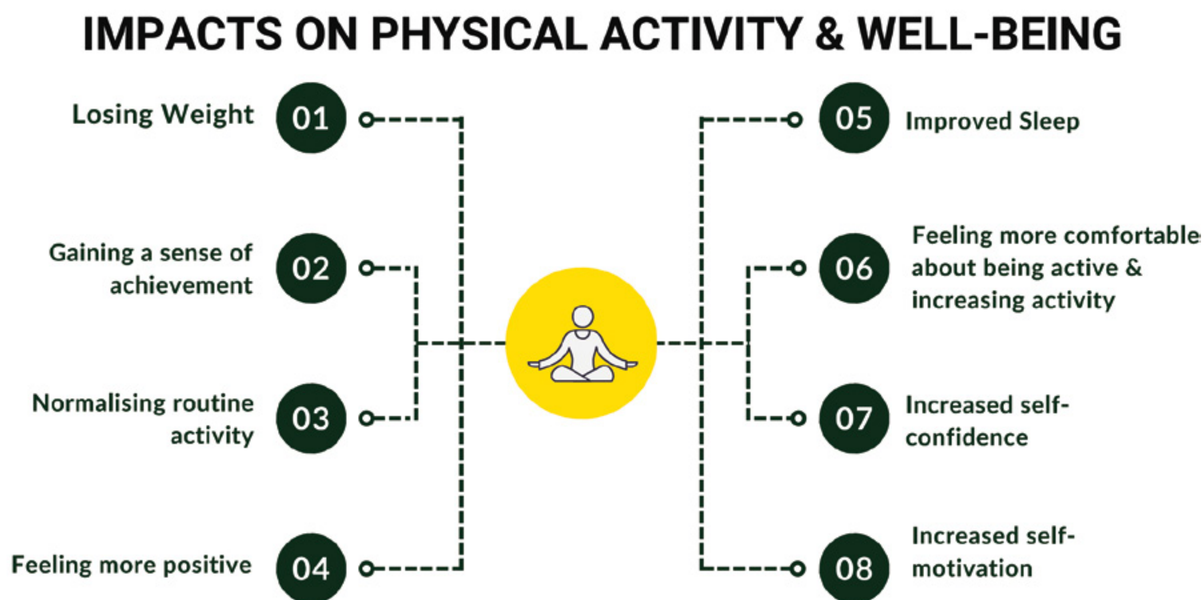
The Active Health project was set up in April 2019, funded by NHS Highland and Paths for All.

Active Health is a free and confidential service for people (aged 16+) living in the Highland area who would like to become more active to help their physical and/or mental health.

The project engages individuals in one-on-one conversations and additional follow-up discussions to assist them in developing a healthier and more active lifestyle. The service offers support to anyone registered with a GP practice in Highland who would benefit from being more physically active. Individuals can be referred by their GP, other health professional or self-refer.

From March 2019 to Sept 2023 there were 1042 people referred to the project with 772 people engaging (74%) with the service.

Figure 4.3 – Impacts of the Active Health Project on physical activity and well-being



Source: Active Health Link Workers Study, UHI Research Team, UHI

Prescribe Heritage Highland

Building on the Prescribe Culture initiative developed by Edinburgh University Museums, Prescribe Heritage Highland is a pilot project that aims to support health and wellbeing through heritage-based activities offered by local museums and heritage facilities.

A partnership between High Life Highland, University of Highland and Islands, Edinburgh University, NHS Highland and Museums Heritage Highland, Prescribe Heritage Highland aimed to explore whether, and how, the approach developed in Edinburgh could be scaled up in rural areas. Five local museums devised a programme of hands-on activities delivered over six weeks for participants to attend. Referrals came from a range of sources including health care professionals and 3rd sector support workers. Currently the project is seeking funds to expand and develop the initiative.

For more information on the pilot project, click the following link https://vimeo.com/868658211/02bd10c902?share=copy

Community Link Workers

NHS Highland has commissioned third sector organisations in Highland and Argyll and Bute to deliver inequalities focussed Community Link Worker Services in Primary Care as part of the national programme of work on Primary Care modernisation.

The aim of the service is to support people to live well through strengthening connections between community resources and primary care and developing pathways to community and third sector services and activities. Community Link Workers provide a person-centred service that is responsive to the needs and interests of patients registered with GP Practices in socio-economically deprived areas of NHS Highland. They work with people who face multiple and complex challenges: mental health, social isolation, loneliness, poor housing conditions, unhealthy relationships, poor physical health, financial worries, long term conditions, bereavement and more.

Community Link Worker's follow a social prescribing model and are embedded in the work of GP practices. They aim to address socio-economic and personal circumstances that affect health and wellbeing to improve the outcomes for patients and reduce pressure on GPs time.

Watch Video

Scan QR Code for video about Highland Community Link Workers or click 'Watch Video' button **https://vimeo.com/863137735/191292a64c?share=copy%20**

Chapter 5:

Prescriptions for Pain:
How medication can have long-lasting effects on public health

Chapter 5: Prescriptions for Pain: How medication can have long-lasting effects on public health

Be analgesic and opioid aware

This section is about the use of medication for pain - analgesics and opioids. There is little doubt that analgesics and opioid use can bring great benefits to individual but there are serious disadvantages as well. Analgesics are widely available, for example paracetamol, by prescription or over the counter. Opioids and synthetic opioids are regulated and available by prescription or lower strength through a pharmacy. The latter has an illegal market. Tackling drug related deaths is a Scottish national mission[61], so this chapter will also describe analgesics and opioids within the context of drug related deaths.

What are analgesics and opioids?[62]

An analgesic is a medicine that relieves pain. Analgesics are widely available through pharmacy over the counter and by prescription. There are three main types of analgesic: non-opioid analgesics, opioid analgesics and compound analgesics that combine the previous two forms. Most non-opioid analgesics work by reducing inflammation at the site of pain and opioid analgesics work by stimulating opioid receptors on neurons, which inhibit the release of chemicals (neurotransmitters) that transmit pain signals.

Opioids have analgesic and sedative effects, and medicines such as morphine, codeine and fentanyl are commonly used for the management of pain. The term 'opioids' includes compounds that are extracted from the poppy plant as well as semi-synthetic and synthetic compounds with similar properties. In the UK opioids are controlled and available on prescription because of the possible side effects including physical and psychological dependence. Opioids can be obtained illegally and increasingly from internet suppliers.

Prescribing and use of illegal drugs

There is a large body of evidence, including randomised controlled trials and systematic reviews, that concluded opioids may reduce pain for some patients in the short and medium term (less than 12 weeks). Opioid use in acute pain and for pain at the end of life is well established. There is, however, a lack of consistent good quality evidence to support a strong clinical recommendation for the long-term use of opioids for patients with chronic pain[63]. Opioid dependence is one of a number of side effects although estimates of prevalence vary. Sign guideline 13: Management of Chronic Pain[64], cites from a systematic review opioid dependence ranged from 3% to 26% who were using opioids for chronic pain. The guideline also includes alternatives such as supported self-management, psychological based interventions and physical therapies. This is an area where social prescribing can play a significant role.

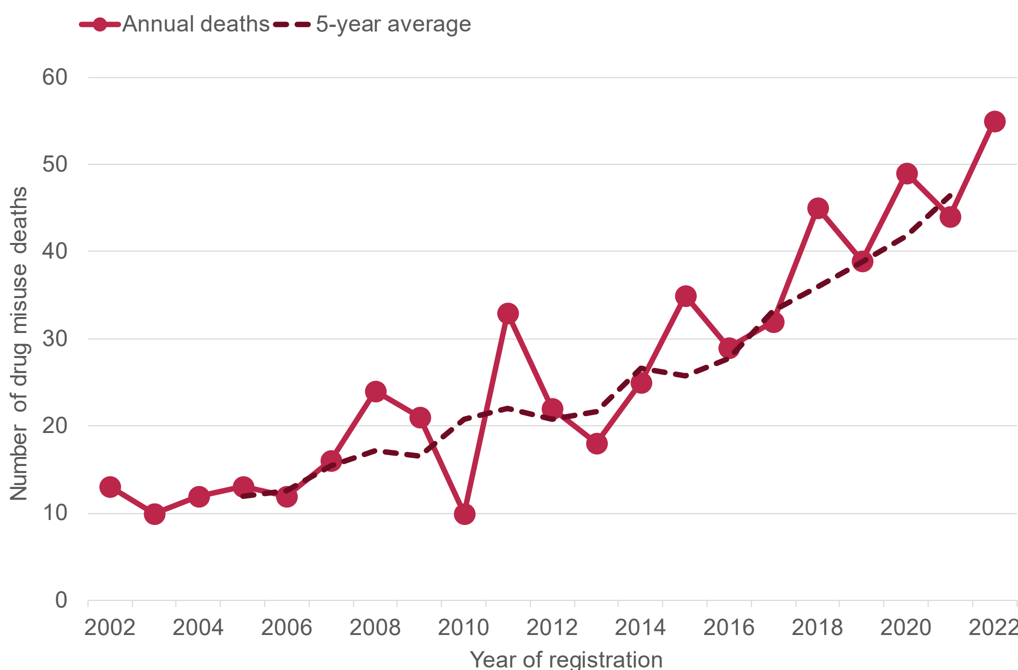
It is difficult to estimate how many people take opioids and analgesics that are not prescribed by a doctor. Estimates of prevalence can be derived from surveys, police seizure records or drug testing in prisons. Intelligence gathered from surveys suggests that most people obtain prescribed drugs from a friend or relative, from drug dealers and buy online.

All of these sources carry risks and include not knowing the strength of the substance or what the chemicals ingredients are. In 2018-20, 9.7% of respondents to the Scottish Crime and Justice Survey (aged 16 years and over) had used illicit drugs compared with 7.4% in 2017-18[65]. The report does not separate out opioids and analgesics. The Scottish Drug Misuse Database (SDMB) recorded for NHS Highland in 2020/21, 230 individuals and of these 82% reported illicit drug use[66]. The Scottish percentage for the same time period was 75%.

Drug Deaths in Highland

Across Scotland, reducing drug related deaths was declared as a national mission in 2018. There were 55 drug-related deaths registered in NHS Highland in 2022[67]. This was the highest number ever recorded and an increase of 11 deaths from 2021. Of these deaths, 42 were recorded in the Highland council area and 13 in the Argyll and Bute council area. The five-year average number of deaths shows an increasing trend and has more than doubled over the last ten years.

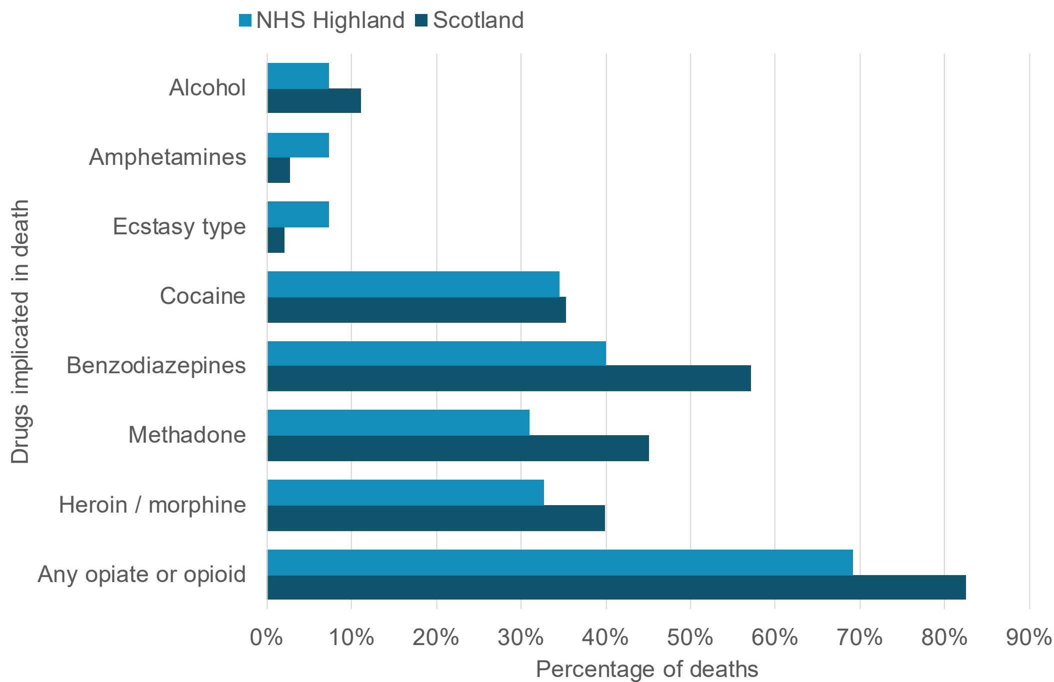
Figure 5.1 - Number of drug related deaths registered in NHS Highland between 2002 and 2022



Source: National Records of Scotland, Drug related deaths in Scotland 2022; Scottish Public Health Observatory

Information from the drug death review process is available and toxicology reports show what drugs had been taken at the time of death.

Figure 5.2 - Drugs implicated in drug related deaths registered in NHS Highland and Scotland in 2018 – 2022



Source: National Records of Scotland, Drug related deaths in Scotland 2022

The drugs implicated in drug related deaths in NHS Highland and Scotland between 2018 and 2022 are shown in Figure 5.2. Opioids or opiates were recorded in 69% of deaths in NHS Highland, followed by benzodiazepines in 40% of deaths and cocaine in 35% of deaths. Most drug related deaths are of people who took more than one substance.

The benefits of prescribing – Opioid Substitution Therapy

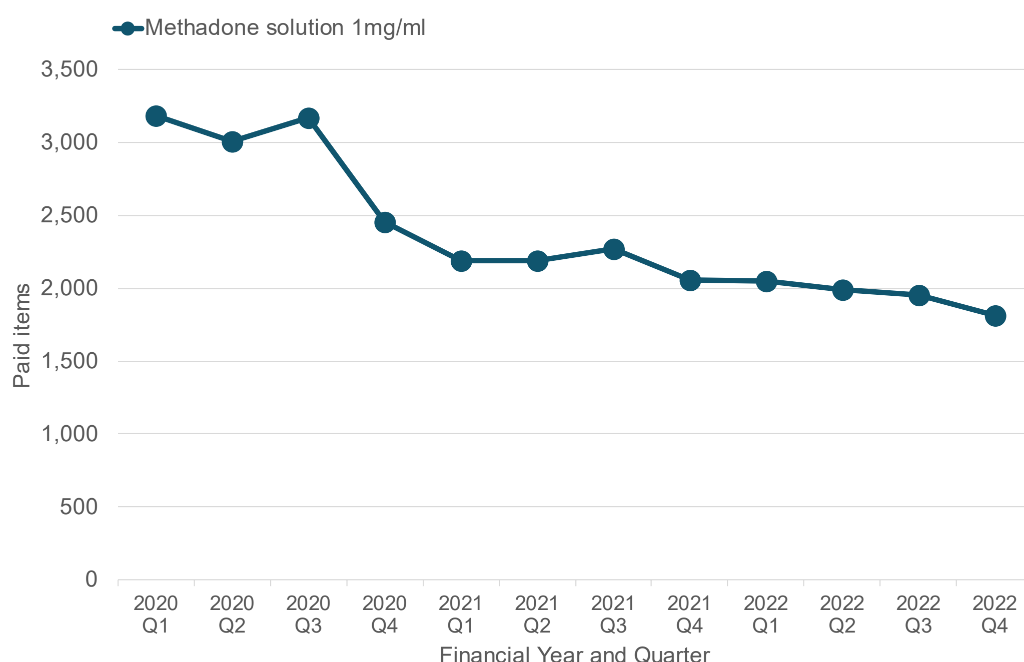
People who experience problematic opioid use may benefit from being prescribed Opioid Substitution Therapy (OST). The aims of OST are to decrease or stop the use of illicit opioids, as well as reduce the risk of other serious consequences of drug use. As mentioned earlier, drug related deaths became a national mission and the Scottish Government's key policy was the implementation of the Medicines Assisted Treatment (MAT)[68] Standards. These standards include the increased choice of treatments such as opioid substitution therapy, earlier access and increased support.

Data on OST prescriptions dispensed in the community are recorded in the Prescribing Information System (PIS)[69]. Current OST prescribed in Scotland include:

- methadone hydrochloride,
- buprenorphine,
- buprenorphine,
- naloxone and
- long-acting buprenorphine (including Buvidal© slow-release formulations)

Opioid Substitution Therapy (OST) can be a lifeline for individuals who have problematic drug use (such as heroin). Methadone has been commonly prescribed and is a synthetic opioid agonist; it is taken daily and comes as a powder, liquid or tablet. The treatment focuses on maintenance and harm reduction and enables individuals to manage and stabilise their lives, for example, successfully engage in work. The impact of OST can extend to families and children who often experience the negative impacts of someone with problematic drug use in the family. Figure 5.3 shows the number of paid methadone items dispensed within NHS Highland between 2020 and 2022 and shows a downward trend.

Figure 5.3 - Number of methadone paid items dispensed in NHS Highland between 2020 and 2022



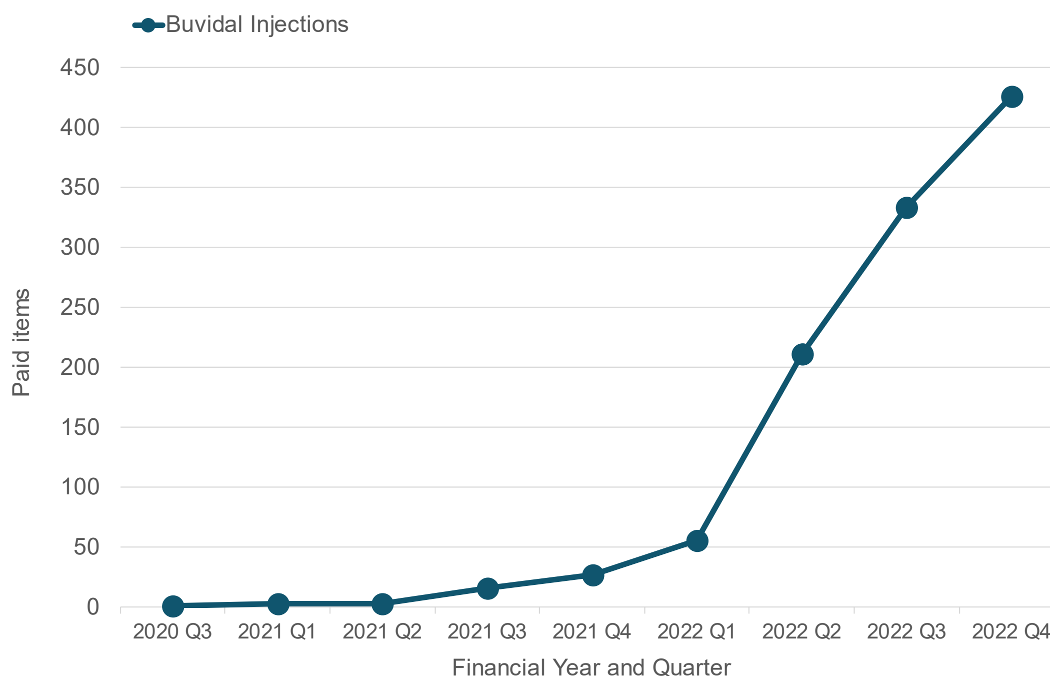
Source: Prescribing Information System

In contrast the number of prescriptions of Buvidal has increased. Buvidal, an OST, is a medicine used to treat dependence on opioid drugs such as hereon or morphine. It is long-acting buprenorphine and isn't suitable for all individuals with problematic drug use but for those who meet the prescribing criteria it can be transformational. Buvidal, is a subcutaneous injection administered weekly or monthly by a health care worker.

The benefits include reduced visits to a pharmacy and anecdotally individuals describe the process as liberating. Figure 5.4 shows the number of Buvidal injections paid items dispensed within NHS Highland between 2020 and 2022. The sharp rise in paid items dispensed in 2021 and 2022 is due to the implementation of the Medicines Assisted Treatment[68] programme because it includes a wider choice of medication. Within a prison setting the change from prescribing methadone to Buvidal cuts down on daily visits to the dispensing pharmacy and avoids the need for prisoner escorts. This potentially saves prison officer time as well as being of value to the person in the care of the prison.

A recent budget[70] analysis of the introduction of buprenorphine over a year in a defined population concluded a decrease in costs for care of those with an opioid use disorder. Cost savings were attributed to the indirect costs of lower crime rate, reduced supervision, avoidance of other infections and reduced hospital admissions.

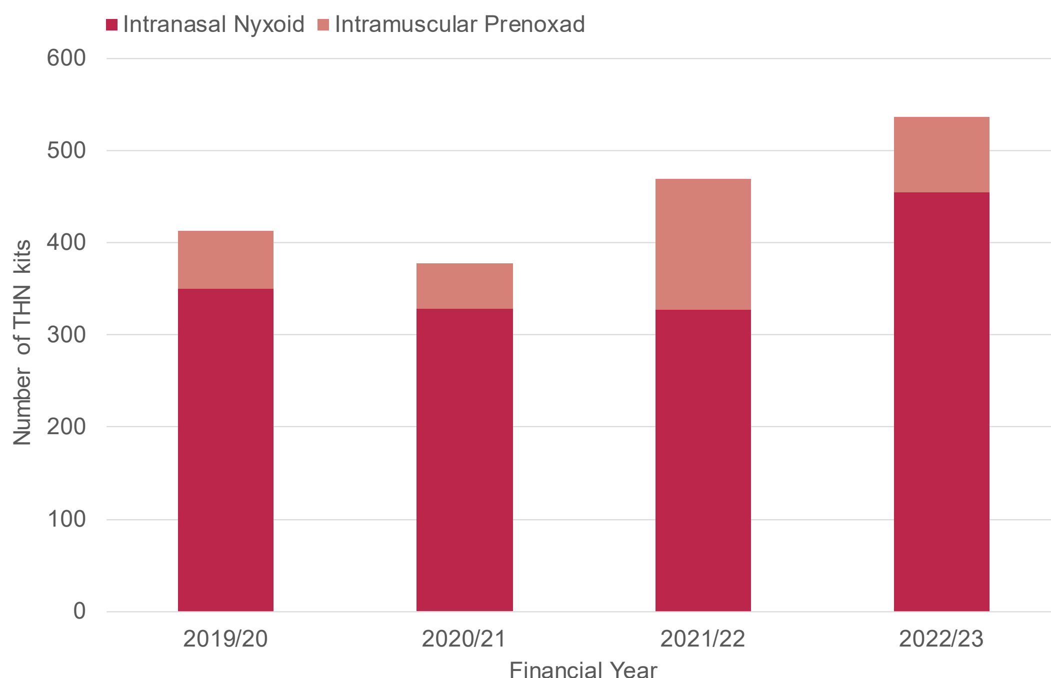
Figure 5.4 - Number of buvidal injection paid items dispensed in NHS Highland between 2020 and 2022



Source: Prescribing Information System

Naloxone is another opioid antagonist. It is a medication used to reverse or reduce the effects of opioids and used to counter decreased breathing in opioid overdose. Effects begin within two minutes when given intravenously, five minutes when injected into a muscle, and ten minutes as a nasal spray. Throughout Highland, naloxone kits along with training, have been made available to individuals, friends and family where a risk harm has been identified. Figure 5.5 shows the numbers of kits have increased each year since 2019[71]. In the calendar year 2022, 518 kits were issued by services based in the community and 11 kits were issued by HMP Inverness.

Figure 5.5 - Number of Take Home Naloxone (THN) kits issued by type of kit in Highland between 2019-2020 and 2022-2023



Source: National Naloxone Programme Scotland, Public Health Scotland

From a population-based approach the interface of substance use (both legal and illegal) and medication presents a complex picture There is analgesic and opioid medication that is prescribed for pain, which can result in dependence and where long-term use may have limited benefit. This medication also has the potential to be used illicitly. Drug related deaths is a significant challenge across Scotland. However, medication in the form of opiate substitution therapy may offer great help in reducing the serious consequences of illicit drug use.

Chapter 6:

Case study –
How medication and other measures can work together to improve health

Chapter 6: Case study – How medication and other measures can work together to improve health

Introduction to case study

Risk factors leading to heart disease (more technically cardiovascular disease) are often lifestyle based, such as eating unhealthy food and lacking physical activity. There is also consistent evidence that the social determinants of health including economic, social, environmental and psychosocial factors play a significant role in the development of cardiovascular disease risk factors[72]. It is recognised that people with established heart disease are very likely to require medication to manage their condition. However, there are other approaches that might be beneficial to an individual's health and wellbeing that can be used alongside medication prescribing and that has potential to reduce the use of medication and health care services. In this chapter, we explore how a pharmacological (traditional) approach to managing such conditions can work alongside a social prescribing approach.

What is cardiovascular disease?

Cardiovascular diseases (CVDs) are a group of conditions affecting the heart or circulatory system. They include coronary heart disease, cerebrovascular disease (stroke), atrial fibrillation and peripheral arterial disease. Cardiovascular risk factors include high blood cholesterol, high blood pressure, diabetes and psychosocial factors such as anxiety, depression and social isolation. Other known risk factors include smoking, physical inactivity, alcohol consumption and poor diet[73]. Research indicates a strong relationship between social deprivation and cardiovascular disease risks[74]. The risk of CVD is greater in men and in people aged over 50 years. Risk increases with age, with those aged 85 years and over at particularly high risk. Treatment of CVD involves reducing modifiable risk factors and drug management.

Cardiovascular diseases are among the most common causes of health loss in NHS Highland, contributing to ill health and early deaths[75]. The scale of cardiovascular disease in NHS Highland is summarised below.

The scale of cardiovascular disease in NHS Highland

- Cardiovascular disease in one of the leading causes of death and disability, accounting for 1,070 deaths (26%) in 2022[76].
- Overall, it is estimated that around 18% of men and 16% of women are living with a cardiovascular condition[77].
- In the past ten years, more than 12,000 people have been newly diagnosed with coronary heart disease[78] and around 8,500 people have been newly diagnosed with cerebrovascular disease[79].
- There were around 5,700 hospital admissions related to coronary heart disease or cerebrovascular disease in 2021-2022.
- More than 32,000 people in NHS Highland are recorded on general practice disease registers with atrial fibrillation, coronary heart disease, heart failure and stroke or transient ischaemic attack (TIA)[80].
- The number of patients prescribed drugs for the cardiovascular system, and cost of prescribing, has increased over the last ten years. Common medications include statins and antihypertensive drug treatment.

Description of example case studies

Case study 1 - Bill

Bill is a 59-year-old man with a family history of cardiovascular disease as his father had died from a heart attack aged 65 and his brother had suffered a heart attack aged 55. Bill was diagnosed with type 2 diabetes when he was 46 years old, high cholesterol when he was 49 years old and high blood pressure when he was 52 years old. He has been on oral glucose lowering medicines since he was diagnosed with diabetes. Bill smokes 30 cigarettes per day and has smoked since he was 15 years old. Bill is overweight and takes little exercise. He reports suffering regularly from breathlessness and fatigue.

He lives with his wife who has multiple health conditions and he is her main carer. He is currently unemployed, finding it difficult to get work that he can do given his various health conditions and his caring responsibilities. He meets up with friends once a week at the local social club and drinks alcohol socially but admits that he worries about money and thinks it will be difficult to keep this going given rising costs of energy and everyday essential items.

Case study 2 - Isobel

Isobel is a 58-year-old woman who was diagnosed with angina when she was aged 56. She has a history of anxiety and depression that was diagnosed in early adulthood and has been on medication to deal with this since she was in her early 20's. Isobel works part time as a secretary in a local builder's firm.

She lives alone and does not venture out much apart from going to work. Isobel admits to a lonely lifestyle and regularly uses alcohol to cope with her low mood. Isobel is overweight and takes little exercise outside of her short walk to work. She regularly attends her GP for support with her anxiety and depression which has worsened in recent months as well as regularly having her angina medication reviewed. Isobel has been struggling to stay at work recently, feeling overwhelmed by her circumstances. She is sometimes not sure if the physical symptoms she experiences relate to her angina or anxiety and she is finding that she has started taking her angina medication more regularly but is not sure if it is making a difference.

A medicinal approach to supporting people like Bill or Isobel

Medication prescribed could include the following:

- aspirin 75mg daily,
- atorvastatin 40mg daily,
- ramipril 10mg daily,
- bisoprolol 2.5mg daily,
- metformin 500mg twice a day,
- omeprazole 20mg daily.

This is a large number of drugs, that need to be taken more than once every day. They are aimed at controlling high blood pressure, elevated blood glucose (leading to type 2 diabetes), raised blood lipids (like cholesterol), as well as a drug to protect the stomach lining from being harmed by these drugs. Like other licensed medication, these have been rigorously tested and evaluated for evidence of effectiveness in tackling the symptoms of heart disease and helping to prevent worsening disease.

If for either person angina is the main clinical feature, the following could be prescribed:

- aspirin 75mg daily,
- bisoprolol 5mg daily,
- clopidogrel 50mg daily,
- ramipril 10mg daily,
- atorvastatin 40mg daily,
- nicorandil 10mg daily,
- Glyceryl trinitrate (GTN) spray (Isosorbide mononitrate 20mg twice a day for an acute attack).

This approach with medication has been shown to improve health and lengthen life, so it is important that people take the medication when it is prescribed for them. However, it cannot reverse changes that have already happened to the body. It also has a major impact on an individual's life, for example, repeat monitoring visits to the GP and the need for regular medicine reviews.

Use of a social prescribing approach alongside medication management to support people with cardiovascular disease

Social prescribing is a means of enabling health and care professionals to refer people to a range of local, non-clinical services. Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

Case study 1 – Bill

During a recent visit to his GP practice, Bill's GP noticed that he was more down than usual and that his physical health although relatively stable, was not improving despite being given lifestyle advise about healthy eating, physical activity and stopping smoking. Bill's GP noted that he had gained additional weight and that his diabetes medication needed to be increased to control his blood glucose levels. Bill's GP offered to refer him to the practice Community Link Worker.

The Link Worker arranged to meet Bill, discussed how he had been feeling and helped him to identify what was important to him and what changes he would like to make to improve his wellbeing. The Link Worker helped Bill to identify how he could improve his health and wellbeing, what barriers there might be and how he could overcome these. Bill identified that he was struggling with his caring responsibilities, feeling increasingly that he was unable to leave his wife on her own and was becoming more and more concerned about money as he was unable to get work that would allow him to still look after his wife. Bill stated that he would like to stop smoking but wasn't ready to. He felt that he would benefit from being more active but was concerned about how that would affect his caring commitments.

The Link Worker was able to identify a carers organisation, an online carer peer support group and a disability activities group in the area. The Link Worker was able to link Bill with the carers' organisation, complete a carer's assessment and get a carer support plan in place. They were able to identify some befriending volunteers to help free up some of Bill's time to leave the house. The Link Worker also arranged for the local disabilities' activity group leader to contact Bill and talk about activities that were available at the local community centre.

The Link Worker identified the Money Advice service that was offered by Bill's GP practice, the local authority benefits advice service and the local Citizens Advice Bureau as options to support Bill explore his financial worries. Bill was a regular attendee at his GP practice and identified the practice-based service as the best option for him. The Link Worker made an appointment for Bill with the service and at Bill's request attended the appointment to support him. The Money Advice adviser was able to complete a financial assessment and identify several benefits that Bill was entitled to that he had not claimed. As a result, Bill was able to claim benefits to boost the household income and help him reduce his anxiety about his financial situation.

Bill had identified improving his levels of physical activity as important. The Link Worker was able to identify a range of community-based options for physical activity including a local walking group, a conservation group at the local nature reserve and a walking football team at the local football club. The Link Worker spent time going over the options with Bill and worked with him to create a social prescription. Bill identified the walking football club as a good option. The Link Worker contacted the coach and arranged for Bill to attend a session and accompanied him to his first session to help him overcome his anxiety about being in a new social situation.

One year on and Bill's life looks very different. Bill regularly attends the walking football club, and the weekly wheelchair bowling club with his wife where he has also taken on a volunteering role to support the running of the club. He is feeling more connected to his community and befriending volunteers allow Bill time to attend activities and have time to himself without worrying about leaving his wife alone. Bill has managed to lose around 10% of his body weight because of being more active and having more energy to prepare meals with fresh ingredients for himself and his wife. He has been able to reduce the dose of his diabetes medication and his blood pressure is more stable allowing him to reduce the medication required to control this.

Bill reports that he feels better able to manage his health conditions and as a result has reduced the frequency of visits to his GP practice. He praises social prescribing as an approach to improving health and wellbeing by helping people like him to identify the issues that are affecting their health and wellbeing and supporting them to make positive changes.

Case study 2 – Isobel

During a visit to her GP practice for a routine review of medication, Isobel spoke to the practice nurse about her low mood and opened up about her use of alcohol as a means of coping with feeling anxious. Recognising that Isobel needed more than just medication to help her maintain or improve her health, the practice nurse referred her to the Community Link Worker.

The Link Worker contacted Isobel and spent time with her to unpick her situation and identify the things that were important to her. The Link Worker was able to help Isobel systematically look at the issues that were affecting her health and wellbeing and make a holistic assessment of her situation. This meant looking beyond the initial condition that Isobel was referred for and helping her to identify things that she could do for her wellbeing.

The Link Worker encouraged Isobel to think about what was affecting her wellbeing starting from where Isobel felt she was at the time and helped her to identify options for things that could support her to improve her health and wellbeing. The Link Worker was able to identify a range of community-based options including an art group in the local community centre, a local health walks group, a gardening club, a singing group, a book club and a beginners yoga class.

The Link Worker gave information about the options to Isobel and spent time with her to create the social prescription by helping Isobel to identify the options that best fitted her circumstances. The Link Worker supported Isobel to identify what might get in the way of making any changes to her circumstances and helped her to identify how she could move forward.
In Isobel's case, she was keen to have opportunities that would get her out of the house regularly to do something that she had an interest in. Isobel had enjoyed art at school but had not put brush to canvas since leaving school.

Isobel was also keen to increase her levels of physical activity but was concerned that her low levels of fitness would get in the way. The local art group and health walks group were identified as a good fit for Isabel. The Link Worker and Isobel had identified lack of confidence as something that might get in the way of Isobel being able to make changes to her circumstances and the Link Worker arranged to accompany Isobel to her first art session and introduced her to the tutor. The Link Worker also arranged for the local health walk leader to meet Isobel to go over the options that would best suit Isabel's level of fitness. The Link Worker met with Isobel several times to review progress and continued to help Isobel identify any barriers to change and supported her to overcome them. One year on and Isobel still regularly attends the local art group. She met some like-minded people at the art group and regularly meets up with them for coffee and outings to the cinema. Isobel was also able to identify a weekly walking group that suited her level of fitness and has gradually built up her confidence and fitness to a point where she is now able to walk longer distances and has been successful in reducing her weight. Isobel has reported that she feels less lonely, and the art and walking groups have helped her to focus on something other than her health conditions. As a result, she has felt less anxious, her mood has improved, and she no longer feels like she is struggling to attend work. She has managed to reduce the use of her angina medication as her symptoms have improved and she now recognises that her symptoms were probably related to her anxiety.

Isobel now reports that she feels like a functioning member of her community with improved connections and is better able to cope with the stresses of everyday life. She has reduced her use of alcohol and is getting a better quality of sleep. She reports that she does not feel the need to visit her GP as often as she did and the medication she was prescribed for anxiety and depression has reduced as Isobel feels that improved social connections, regular exercise and getting outdoors has helped her to better manage her condition rather than allowing it to manage her.

Final Remarks

Personalised care using socially prescribed interventions can be used to support the health of people with cardiovascular disease[81]. Medication remains an essential part of heart disease management, but additional approaches can work in combination to give considerable synergy and benefits.

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Notes:

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Any feedback on the report would be welcome.
To provide this please use the link:
https://www.smartsurvey.co.uk/s/NHSHDPHAR2023/

Medical illustration NC24-00004

Agenda Item 3.2

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**6 March 2024**
Title:	**Vaccination Transformation Plan Update**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer Highland Health & Social Care Partnership**
Report Author:	**Christopher Arnold, Senior Operations Manager, Specialist Services & Divisional Performance**

1 Purpose

This is presented to the Board for:

- Awareness and Discussion

This report relates to a:

- Legal requirement

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This document provides an overview of our continued commitment and ongoing actions being taken to provide and improve the Vaccination services across

Highland Health and Social Care Partnership area of the Board, to meet the National programme expectations.

This summary follows submission of NHSH Vaccination Service Delivery Plan, Summary and KPI dashboard in November 2023.

2.2 Background

Currently, our teams are doing Shingles and Pneumococcal vaccinations, together with Covid and Flu mop-ups. All Covid and Flu mop-ups are being done in drop-in sessions. For Shingles and Pneumococcal, all eligible patients have been contacted to come forward and book a vaccination appointment. We are also offering drop ins for this as we are currently seeing low uptake.

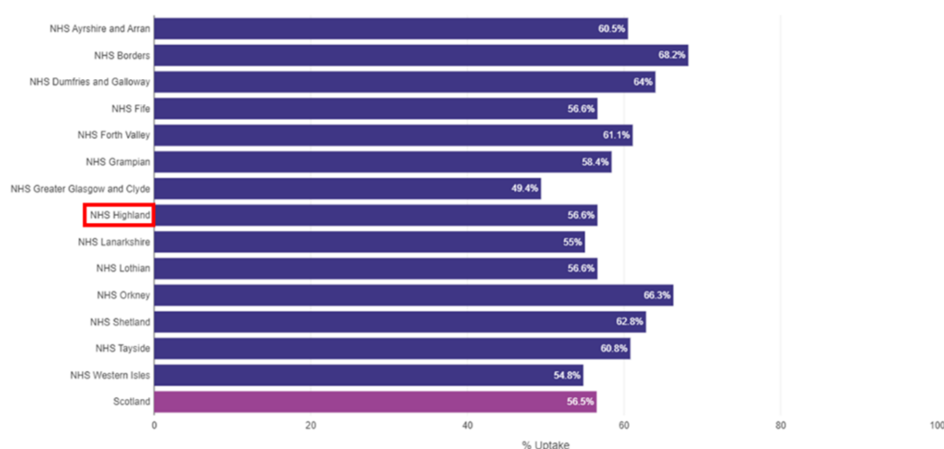
Since January, most of our clinics have seen very low uptake. We are currently using all communication methods at our disposal, including advertising on social medial and opening our clinics for drop ins.

2.3 Assessment

Adult Programmes

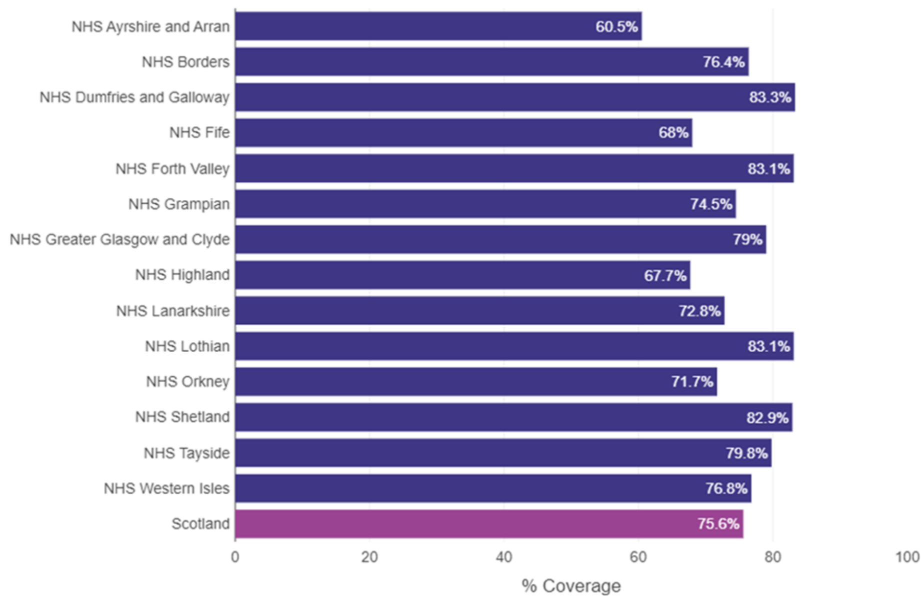
Covid and Flu

Mop up programme with drop ins across the Highlands for all eligible citizens. We achieved 56.6% uptake of Covid vaccinations in Winter 2023, against a Scottish average of 56.5%

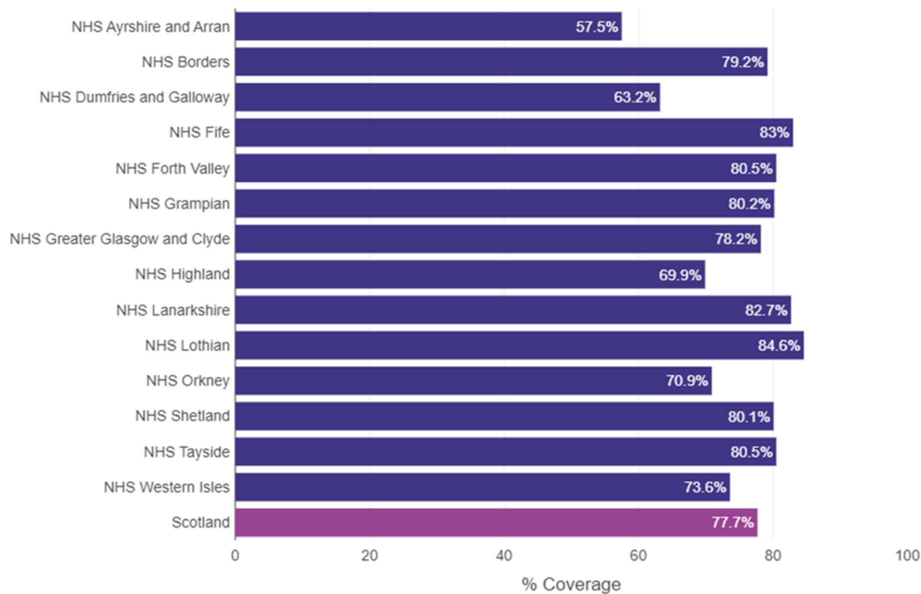


Shingles

All eligible citizens have been contacted. All immunocompromised citizens were given the earliest opportunity with timed appointments to achieve full immunisation before April. All other cohorts received prompts to make an appointment or use a drop in opportunity. Current achievement is 67.7% against a 75.6% Scottish average.



Pneumococcal
All eligible citizens have been contacted. All cohorts received prompts to make an appointment or use a drop in opportunity, unless they were for co-admin of shingles and pneumococcal. Current achievement is 69.9% against a Scottish average of 77.7%



For Shingles and Pneumococcal we are seeing very low uptake currently in the program and we are assessing options for improvement in the program.

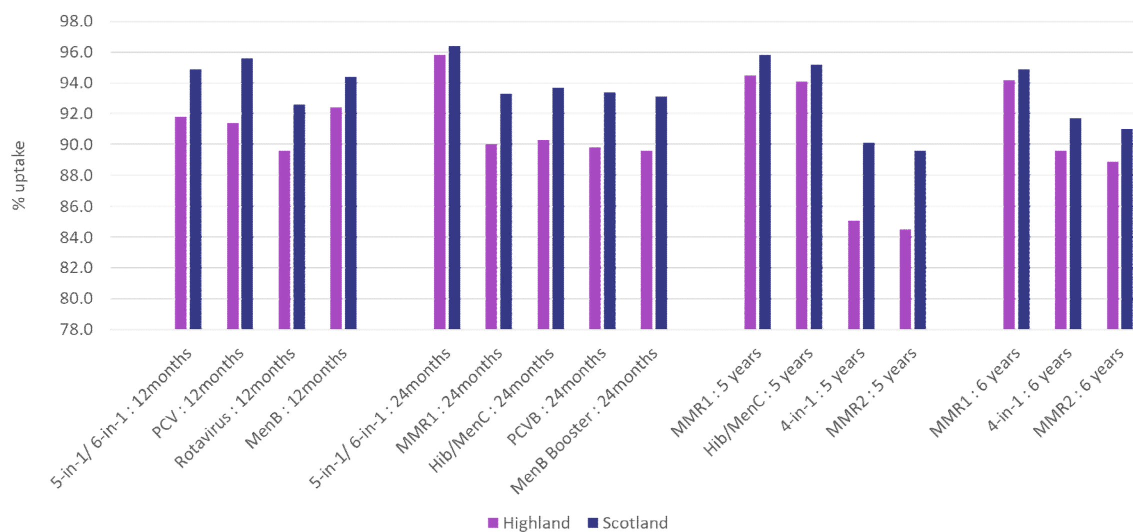
Ongoing complexity due to a lack of electronic scheduling system, which is creating risks and delays in delivery. Awaiting eHealth support to be available to access TRAKcare for scheduling, this would also create potential financial savings.

MMR

Through a referral and appointing system. Appointing is required to allow medical review of records to ensure eligibility. This is in line with all ad-hoc vaccinations. We are looking at a project of work with PHS to increase uptake of the offer given the current concerns regarding measles outbreaks in the UK.

Travel vaccinations
Provided by local community pharmacies across the region, we now have improved coverage with increasing number of pharmacies joining the program.

Childhood Programmes & MMR



Overall rates are below national target and average, review of the delivery model is underway to consider how an improvement can be achieved, alongside a range of associated actions considered through the HIghland Immunisation Coordination Group supported by a consortium of subject matter experts.

Preschool
Vaccinations offered through times appointments in line with national guidance. Uptake sitting just below target level looking at locations of delivery and information provision to families regarding the importance of vaccinations. Additional issue is the inability to transfer data back to primary care systems from SIRS without manual entry requirements, so GPs have a lack data on current immunisation status of patients in their care.

School age
Vaccinations continue to be provided in schools during term times as per pre-VTP. All schools now vaccinated by the community vaccination service following transfer of work from the Council School nursing teams.

HPV
Ongoing due for completion at the end of February.

MMR

Decision to complete S1 – S3 catch up in schools with additional community clinic capacity for all other years through an appointing system. Appointing is required to allow medical review of records to ensure eligibility.

Approach to Post Exposure Prophylaxis (PEP)

The protocol for tetanus and other PEPs remains unchanged. Out of hours this follows the longstanding need to access emergency or injury facilities open out of hours. In hours there is also the option to use these facilities. If, however, someone is seen within primary care an appointment is arranged through the Health Protection Team for them to have a vaccination through community services vaccination or at another facility. Plans are in place for practices to be able to offer vaccination in hours, but these still require final discussion with LMC prior to consideration by individual practices regarding provision.

Distance Travelled Data for COVID and Influenza

Highland only

Distance Category	Total	Percentage
Less than 1 mile	11433	27%
Less than 5 miles	16120	38%
Less than 10 miles	6758	16%
Less than 20 miles	6087	14%
Over 20 miles	1168	3%
Over 30 Miles	832	2%
Unknown	166	0%
Total	42564	100%

For the 832 people who travelled over 30 Miles (Highland only)

Distance Category	Total	Percentage
30 to 34 Miles	269	32%
35 to 39 Miles	175	21%
40 to 44 Miles	49	6%
45 to 49 Miles	42	5%
50 to 59 Miles	85	10%
60 to 69 Miles	55	7%
70 to 79 Miles	47	6%
80 to 89 Miles	27	3%
90 to 99 Miles	33	4%
100 Miles Plus	50	6%
Total	832	100%

Long distance travellers are associated with citizen choice.

We continue to review travel information where this is available to assess for clinical location improvements but are restricted by the availability of suitable clinically capable venues across North HIghland.

Locality Breakdowns

Overall Vaccination rates at 16/02/24

Area	COVID Vacc %	Flu Vacc %	Pneumo Vacc %	Shingles Vacc %
HHSCP	60.48%	54.37%	65.13%	58.72%
Badenoch and Strathspey	**62.43%**	**55.54%**	**66.51%**	**59.55%**
Caithness	**60.03%**	**54.42%**	**54.75%**	**55.50%**
East Ross	**54.62%**	**49.38%**	**65.01%**	**52.44%**
Inverness	**58.92%**	**54.18%**	**68.17%**	**63.45%**
Lochaber	**58.02%**	**50.61%**	**57.65%**	**52.04%**
Mid Ross	**62.59%**	**57.83%**	**71.06%**	**60.79%**
Nairn	**65.40%**	**57.53%**	**60.99%**	**58.96%**
SLWR	**61.05%**	**53.92%**	**68.13%**	**60.34%**
Sutherland	**61.62%**	**55.46%**	**65.53%**	**55.09%**

Complaints

Overview of themes and numbers for recent complaints received and comparison to last year.

Count of ID	Column Labels		
Row Labels	2022	2023	Grand Total
HHSCP	97	72	169
Compliment	1		1
Concern	36	23	59
Concern - Covid-19	28	1	29
Covid Vaccination Team - Appointment	1		1
Covid Vaccination Team - MSP Enquiry	1		1
MP/MSP Enquiry	12	15	27
Stage 1	15	25	40
Stage 2	3	7	10
Stage 2 (MPMSP)		1	1
Grand Total	97	72	169

2023 Stage 1 complaints were a variety of issues but with themes around booking processes and portal access, as well as available facilities at clinics.
2023 concerns were theme around information regarding vaccines and eligibility.
So far during 2024 there have been 2 stage 1 complaints, both relating to Shingles vaccination letters.

Improvements Update

Delivery model

Review of the current operational model is underway to ascertain the options for more localised delivery and District alignment. Opportunities to benefit from localised

knowledge, lost in the current centralised operational model, may provide improvement in uptake and reduced barriers to administration.

Staffing
Stabilised staffing across teams with a reduced number of vacancies for vaccinators. This is particularly apparent in Skye with significant reductions in locum usage.

Childrens vaccinations
we have completed the transfer of schools-based vaccinations to the NHSH teams with ongoing assessment.

Peripatetic Team
developed for the winter program provided school-based program and stabilised geographical support requirements.
Approaching 1 year anniversary of VTP transfer and seeing a much more stable provision of geographical clinical capabilities which is allowing us to consider further improvements.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	x
Limited		None	

Comment on the level of assurance

Overall, we are providing most vaccination programs in line with national average uptake rates. However, we had expected to see reductions in pre-school uptake associated with the vaccination transition program, this was seen across all boards at the time of transition. Other boards have recovered uptake rates in the years following the transition and operationally we are looking to achieve the same through review of the operational model and focusing on the barriers to uptake in the Highland region. Significant changes continue to occur in the national delivery plans and the financial support for vaccination services, these present significant risks to teh program as they provide uncertainty as to future delivery requirements as we look toward more organisational change.

3 Impact Analysis

3.1 Quality/ Patient Care

Vaccination is an important part of both quality and patient care. NHS systems and processes are all affected by the complex topic of Vaccination and members will want to consider how to “do the Right Thing”.

3.2 Workforce

From a preventative perspective the main workforce recommendation is about increasing awareness of Vaccination

3.3 Financial

There are no direct financial implications from the paper. A focus on prevention, for example, would incur costs, but net savings are possible from NHS budgets for many prevention initiatives. Some could also be cash releasing.

3.4 Risk Assessment/Management

Risks are managed in line with NHS Highland's policy.

3.5 Data Protection

No personally identifiable information is involved.

3.6 Equality and Diversity, including health inequalities

3.7 Other impacts

No other impacts to note.

3.8 Communication, involvement, engagement and consultation

None

3.9 Route to the Meeting

This report will be reviewed at the Health and Social Care Committee.

4 Recommendation

The Highland Health and Social Care Committee is asked to note and discuss the content of the report

4.1 List of appendices

Vaccination Communication Strategy

VTP KPIs

2024 vaccination capacity plan

Vaccination Transformation Programme Key Performance Indicators

- **Lived Experience**
- **Finance**
- **Capacity Planning**
- **Vaccination Coverage**
- **Workforce**
- **Vaccine Stock**
- **Systems & Infrastructure**

Lived Experience

Metric	Current Performance	Baseline	Target	Status/Comment	RAG
Delivery location	Monthly & Annual: X% vaccinations administered in OWN HOME X% vaccinations administered in CARE HOME X% vaccinations administered in GP Practice X% vaccinations administered in HB clinic X% vaccinations administered in Hospital (in-patient) X% vaccinations administered in 'other'	Data available from BI	Publish to address citizen concerns	New	
Communications and Engagement Plan in place					
Vaccination citizen mileage	Monthly & Annual: For Highland registered addresses 65% vaccination administered <5 miles from home address (Highland) 81% vaccination administered <10 miles from home address (Highland) 0% vaccination administered out with Highland	Data available from BI	Address public concerns that travel barriers are an access issue to uptake	81% within 10 miles of hoem and 95% within 20 miles of home. We do still citizens making a choice to travel further to fit with personal circumstances. No new complaints received in the past quarter align to this issue.	
Town data		Data from BI	Population awareness raising	New Data is available on the reporting catalogue by district and by GP - - achieving this by town would be very difficult as we would need to assign every possible post code to a town	
Citizen Survey	New	Spring/Summer campaign 2023 Autumn/winter campaign 2023/24 Spring/summer campaign 2024	Improve public engagement and communication	To be developed Proposal to use Care opinion for an ongoing process of feedback	
Complaints/Compliments			Thematic analysis to Improve citizen satisfaction		

Finance

Metric	Current Performance	Baseline	Target	Status/Comment	RAG
Pay spend		Scottish Government funding PCIF funding	Programme to remain within financial constraints	Within financial envelope mainly due to recruitment challenges	
Non-pay spend		Scottish Government funding PCIF funding	Programme to remain within financial constrains	Within financial envelope	

Workforce

Metric	Current Performance	Baseline	Target	Status/Comment	RAG
Vaccinators high level resource spread based on employer status	Employment status of vaccinator – of monthly/annual cumulative % Vaccinators contracted in via NHSH Staff Bank % Vaccinators employed as NHS Highland Staff 0% Vaccinators employed in GP Practices % Vaccinators employed in Community Pharmacy 0% Vaccinators employed by Local Authority % Vaccinators employed by SAS	Monthly and cumulative % from BI	Aim to show diminishing number of GP vaccinators.	Business view to display % of vaccination activity broken down by staff cost allocations. Operationally vaccine data for all vaccines is not held in one place. There is variation by cohorts and vaccine this measure would not capture. No vaccines are now provided by GP or LA. The other groups will vary by which vaccine and cohort we refer to.	
VMT joiners/leavers	Monthly and Annual cumulative Vaccinator Role Joiners/Leavers for VMT system: % by Board employed VMT Users % by Staff Bank VMT Users % by GP employed VMT Users % by CP employed VMT Users % by SAS employed VMT Users % by Local Authority employed VMT Users			VMT turnover rates to predict training demand.	
Staff Satisfaction	Bi-annual staff survey to include; Job factors – workload, routine, variety Organisational factors – empowerment, conditions, teamwork, training & development, communication ,leadership Cultural factors Individual factors		Aim to develop job satisfaction and identify areas of concern ; improve recruitment and retention	To be developed would this not be covered by the organisationally led iMatters process? What is used for any other specific staff group?	
Vacancy Rate	No of vacancies No. Days/week post vacant Turnover rate	Workforce date /eESS		Job families for vaccinators is currently mixed up with pandemic response, data would be available in future following integration of services.	
Absence Rates	No of days absence Reason for absence	Workforce data/eESS			

Capacity Planning

Metric	Current Performance	Baseline	Target	Status/Comment	RAG
Independent Contractor Capacity (GP and CP)	Available clinic slots +1mth GP Available clinic slots +2mth GP Available clinic slots +3mth GP Available clinic slots +1mth CP Available clinic slots +2mth CP Available clinic slots +3mth CP				
DNA rate					

Vaccination Coverage

<table>
<tr><th>Metric</th><th>Current Performance</th><th>Baseline</th><th>Target</th><th>Status/Comment</th><th>RAG</th></tr>
<tr><td>Covid 19 Vaccination programme

Autumn/Winter 2023/24</td><td>Uptake 45.4% (all cohorts) against national average of 45.1%</td><td>Meeting schedule for first cohort doses
Discovery Level 1 Seasonal Vaccination Programme data</td><td>To meet Scottish Government schedule for completion of vaccination cohort by 12 December 23</td><td>Estimated position at end of Dec:
<table>
<tr><th>Primary Cohort</th><th>Estimated Final %</th></tr>
<tr><td>AGE_12_TO_64_COVID_AT_RISK</td><td>34.72%</td></tr>
<tr><td>AGE_6_MONTHS_TO_74_WEAKENED_IMMUNE_SYSTEM</td><td>74.22%</td></tr>
<tr><td>AGE_65_TO_74</td><td>70.04%</td></tr>
<tr><td>AGE_75_AND_OVER</td><td>82.44%</td></tr>
<tr><td>All Cohorts</td><td>60.65%</td></tr>
</table></td><td>Amber</td></tr>
<tr><td>Flu Vaccination Programme

Autumn/Winter 2023/24</td><td>Adults 18+ = 42.6% uptake against national average of 43.4%

All Healthcare Workers = 27.5% uptake against national average of 25.9%

All Social Care Workers = 9.8$ against national average of 8.8%</td><td>Discovery Level 1 Seasonal Vaccination Programme data -</td><td></td><td>Estimated position at end of Dec:
<table>
<tr><td>AGE_18_TO_49_FLU_AT_RISK</td><td>27.78%</td></tr>
<tr><td>AGE_50_TO_64</td><td>37.80%</td></tr>
<tr><td>AGE_6_MONTHS_TO_74_WEAKENED_IMMUNE_SYSTEM</td><td>70.77%</td></tr>
<tr><td>AGE_65_TO_74</td><td>70.59%</td></tr>
<tr><td>AGE_75_AND_OVER</td><td>81.99%</td></tr>
</table></td><td>Amber</td></tr>
<tr><td>Performance against other Boards</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Vaccine Stock

Metric	Current Performance	Baseline	Target	Status/Comment	RAG
Stock delivery times/distances					
Available stock levels					
No. Of vaccines required by seasonal variation					
No of vaccines required by useage					

Systems & Infrastructure

Metric	Current Performance	Baseline	Target	Status/Comment	RAG
DQ Errors VMT	Monthly and Annual cululative DQ errors % by Board employed VMT Users % by Staff Bank VMT Users % by GP employed VMT Users % by CP employed VMT Users % by SAS employed VMT Users % by Local Authority employed VMT Users			On going problem with DQ errors – much needed metric to target staff training and any bottlenecks for vaccination upstream systems and recalls	
Recall invites	Monthly and Annual cumulative Invitation Letters by Highland Town			Dashboard metric to track invites and also for comms to show coverage hotspots for invites	
Vaccination Venues with WIFI access					

NHS Highland

OASIS Plan
Vaccination Transformation Programme

Campaign objectives

- to ensure consistent and clear messaging on the changes in the Vaccination Programme from GPs to Health Board
- to ensure everyone is clear on who delivers vaccination
- to avoid calls to GPs about vaccination

Audience insight

- **NHS Highland population – to ensure all know how any vaccinations they, or their children, will be delivered from now on**
- **GPs – for info as, while at a minimum, they may get calls**

Strategy

- Consistent information
  - Online on NHSH website
  - Via patient communication – letters
  - Newspaper advertising
  - Local radio advertising – MFR, Skye, Lochaber, Caithness
  - Vehicle advertising
  - Social Media
  - Email to key groups
  - GPs

Implementation

- Press releases – general information about the change from GP to Board vaccination. To be shared with the press and on our social media.
- Website – Update the website with the relevant changes and keep this updated as and when appropriate
- HN Media column– Director of Public Health column advising of the changes and what people should expect and when
- NHSH Social Media – locally produced assets shared periodically advising of the change from GP to Board vaccination and where to get more information. This can also be shared to local community groups
- Vehicle imagery – using NHS Highland vehicle (proposed one to begin with) that travels across Highland to advertise the change and direct people to the website for more information
- GPs – keep practices up-to-date on info for when members of the public contact them
- Local community groups – share clinic info with our contacts
- Paid advertising – advertising in HN Media (covers a wide area and range of titles, Lochaber and Skye papers about the change for those who don't access social media – Can also use local radio (Inverness, Skye, Lochaber and Caithness, B&S)

Evaluation

Inputs	Outputs	Outtakes	Outcomes	Organisational Impact
Develop press and social media messaging	Assets produced	Increase awareness of programme and timetable	Patients aware of changes	Maintain / increase vaccination
Develop content for website	Website updated – clinic info, FAQs	Increase awareness of programme and timetable	Patients aware of changes	Maintain / increase vaccination
Develop vehicle livery	NHSH van has VTP design	Increase awareness and where to go for more information	Patients aware of changes	Maintain / increase vaccination
Develop advertising with local papers	Adverts across the local area	Increase awareness and where to go for more information	Patients aware of changes	Maintain / increase vaccination

Timeline of activity

Timing	
February	Initial article about the changes (WRU, press release, GP newsletter – will also be shared on social media) Website updated – detail on the changes on vaccination for the population Stakeholder update
March	HN Media column from Tim Allison explaining the changes Mini social media column reminding of the changes and directing people to website / press release Radio Advertising Print Advertising
April	Vehicle livery – advertise on an NHS Highland van that vaccination delivery has changed – direct to website for more information Social media reminders – in case you missed it reminder Radio Advertising
May	Release / social media reminders – photos from pharmacies / clinics to help highlight changes

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**6 March 2024**
Title:	**Highland Health and Social Care Partnership - Integrated Performance and Quality Report (IPQR)**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer, HHSCP**
Report Author:	**Lorraine Cowie, Head of Strategy & Transformation**

1 Purpose

This is presented to the Committee for:
Assurance

This report relates to a:
Annual Delivery Plan

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

The HHSCP Integrated Performance & Quality Report (IPQR) is a set of performance indicators used to monitor progress and evidence the effectiveness of the services that HHSCP provides aligned to the Annual Delivery Plan.

A subset of these indicators will then be incorporated in the Board IPQR.

2.1 Situation

In order to standardise the production and interpretation, a common format is presented to committee which provides narrative on the specific outcome areas and aims to provide assurance.

It is intended for this developing report to be more inclusive of the wider Health and Social Care Partnership requirements and to further develop indicators with the Community Services Directorate, Adult Social Care Leadership Team and members that align to the current strategy and delivery objectives.

It is proposed we refresh the HHSCP IPQR approach in line with data that has been developed at district level and to understand performance of health teams in more detail in line with the non MMI waiting lists.

2.2 Background

The IPQR for HHSCP has been discussed at previous development sessions where the format of the report and the Adult Social Care indicators were agreed**.**

2.3 Assessment

As per **Appendix 1**.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	X	None	

Given the ongoing challenges with the access to social care, funding and delayed discharges limited assurance is offered today.

3 Impact Analysis

3.1 Quality / Patient Care

IPQR provides a summary of agree performance indicators across the Health and Social Care system primarily across Adult Social Care.

3.2 Workforce

IPQR gives a summary of our related performance indicators affecting staff employed by NHS Highland and our external care providers.

3.3 Financial

The financial summary is not included in this report.

3.4 Risk Assessment/Management

The information contained in this IPQR is managed operationally and overseen through the appropriate groups and Governance Committees

3.5 Data Protection

This report does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document.

3.9 Route to the Meeting

This report has been previously considered by the following stakeholders as part of its continued development:

- Health and Social Care Committee Development Session
- Adult Social Care Leadership Team
- Management feedback and narrative from respective operational leads

4 Recommendation

The Health and Social Care Committee and committee are asked to:

- Consider and review the agreed performance framework identifying any areas requiring further information or inclusion in future reports.

- To accept limited assurance and to note the continued and sustained stressors facing both NHS and commissioned care services.#
- The approach is refreshed in line with newly developed data

4.1 List of appendices

The following appendices are included with this report:

- **HHSCP IPQR Performance Report, March 2024**

Highland Health and Social Care Partnership Integrated Performance and Quality Report

North Highland

6 March 2024

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

Highland Health & Social Care Partnership

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

It is **recommended** that:

- Committee consider and review the agreed Performance Framework **identifying any areas requiring further information or inclusion** in future reports.
- Committee to note that although the continued focus is on Adult Social Care data, additional data on DHDs and Mental Health is included.

Development

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

A Development sessions was held with committee in September 2022 where the format of the report and ASC indicators were discussed in detail with discussion on possible indicators to be included in future reports.

Content:

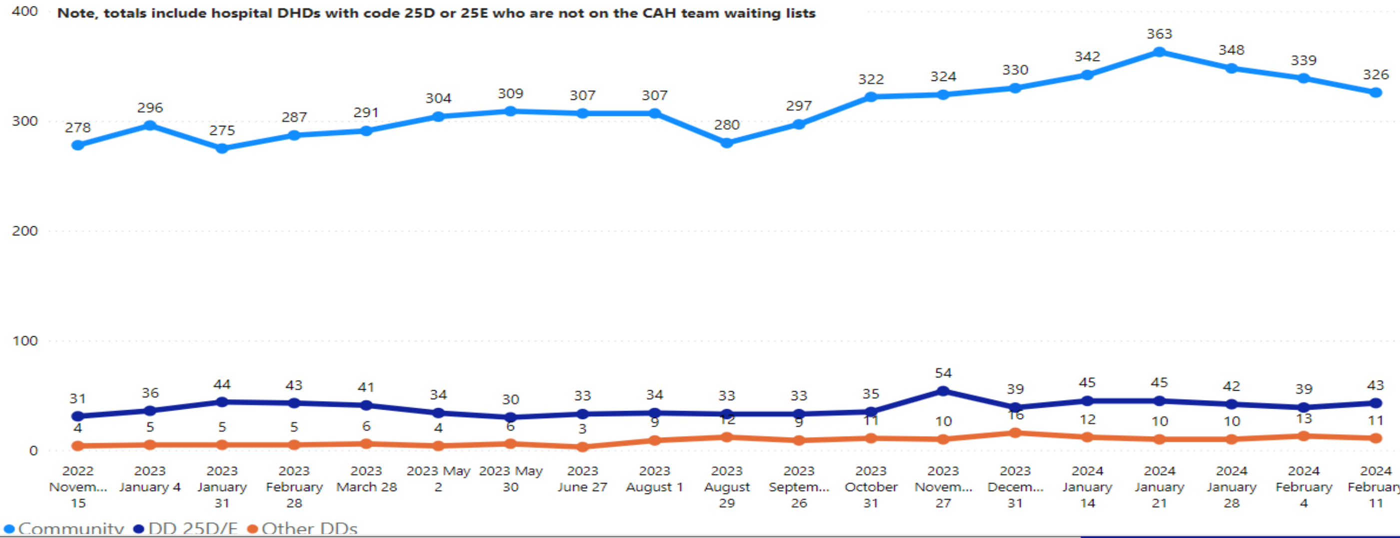
- Care-at-Home and Care Homes – slides, 4-7 & 8-9
- Delayed Discharge – slides 10-11
- Self Directed Support/Carer Short Breaks – slides 12-14
- Adult Protection included – slide 15
- Mental Health Psychological Therapies and Community Mental Health Services – slides 16-17
- HHSCP Drug & Alcohol Recovery Services – slide 18
- Non MMI Non Reportable Specialties Waitlists – slides 19 & 20
- National Integration and relevant Ministerial indicators – to be reported as an annual inclusion

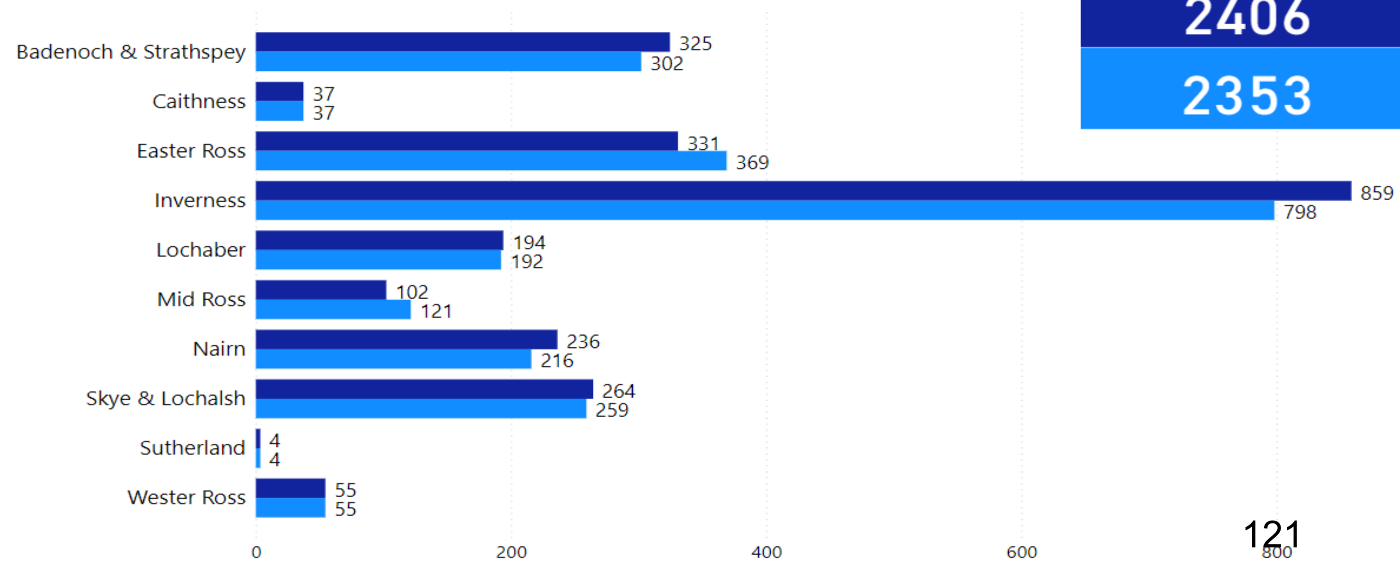
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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

Priority 9A, 9B, 9C – Work together with H & SC partners by delivering care and support together that puts our population, families and carers experience at the heart

HHSCP Care at Home – Unmet need





Currently provided weekly as part of the Public Health Scotland (PHS) weekly return.

Graph 1 - All HHSCP delayed hospital discharges (DHD's) are included which show those assessed as requiring CAH in either a hospital, or at home.

- Community - 326 awaiting a care at home service
- DHDs – 43 awaiting a care at home service
- DHDs – 11 awaiting a service for other coded DHDs (complexity)

This data is published by PHS and weekly returns from CAH officers are provided to allow for validation and analysis.

Graph 2 – Care at Home (District level) - the total number of weekly hours of unmet need for those above and includes hours required for people in receipt of a service with required additional hours.

Despite significant ongoing organisational and provider effort to improve flow, the overall unmet need for CAH is 2406 planned hours per week.

Update 16/02/2024

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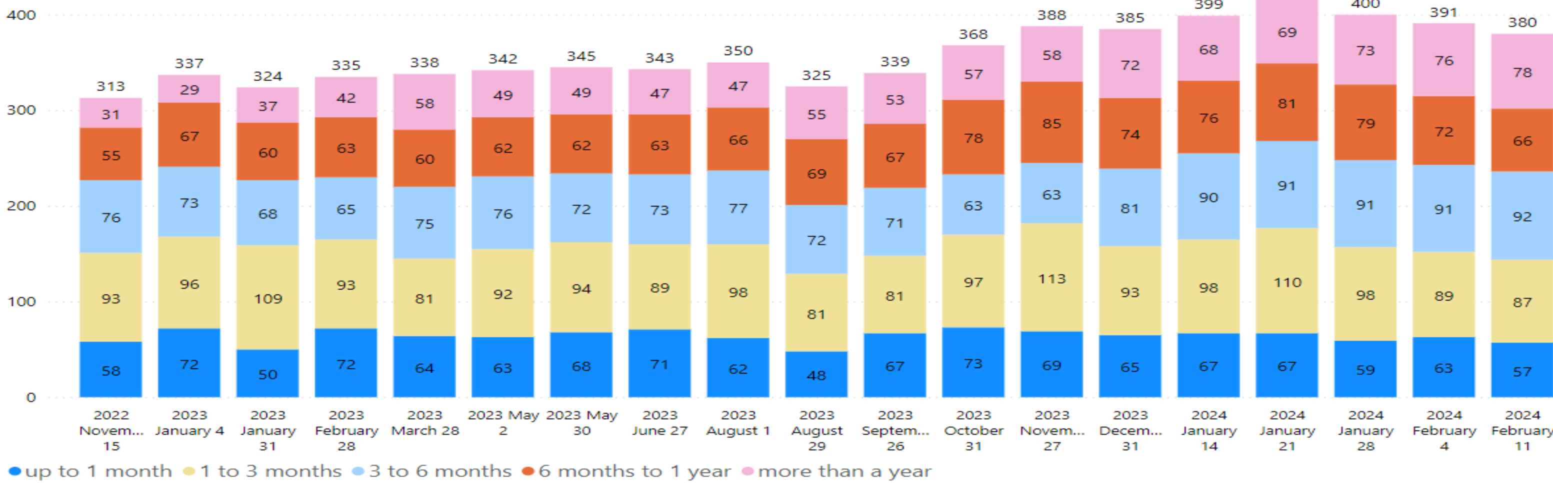

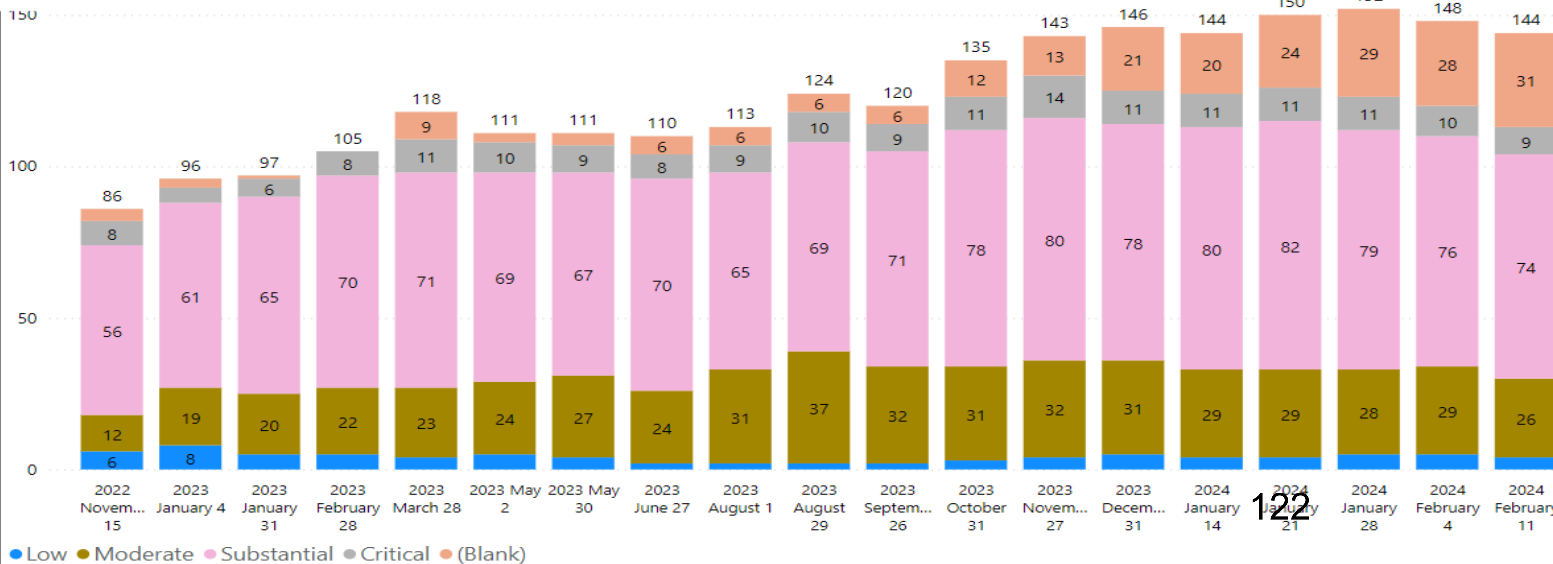

Graph 1 - HHSCP unmet need for care at home, including waiting list. Total number waiting for a care at home service is 380 as at last available data point.

The number has reduced by 38 from the last reported period to committee.

Up to 1 month – 57
1 to 3 months – 87
3 to 6 months – 92
6 to 12 months – 66
More than a year - 78

This data is published by PHS and weekly returns from CAH officers.

Graph 2 – Further breakdown of those waiting longer than 6 months for a service by level of need.

Update 16/2/2024

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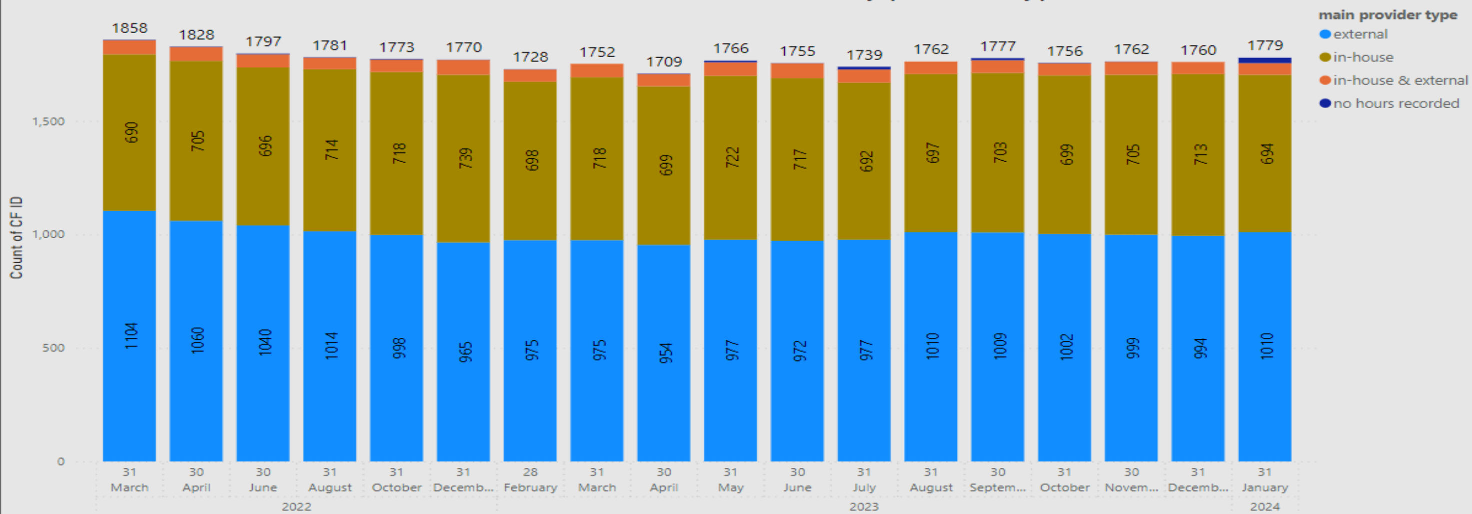
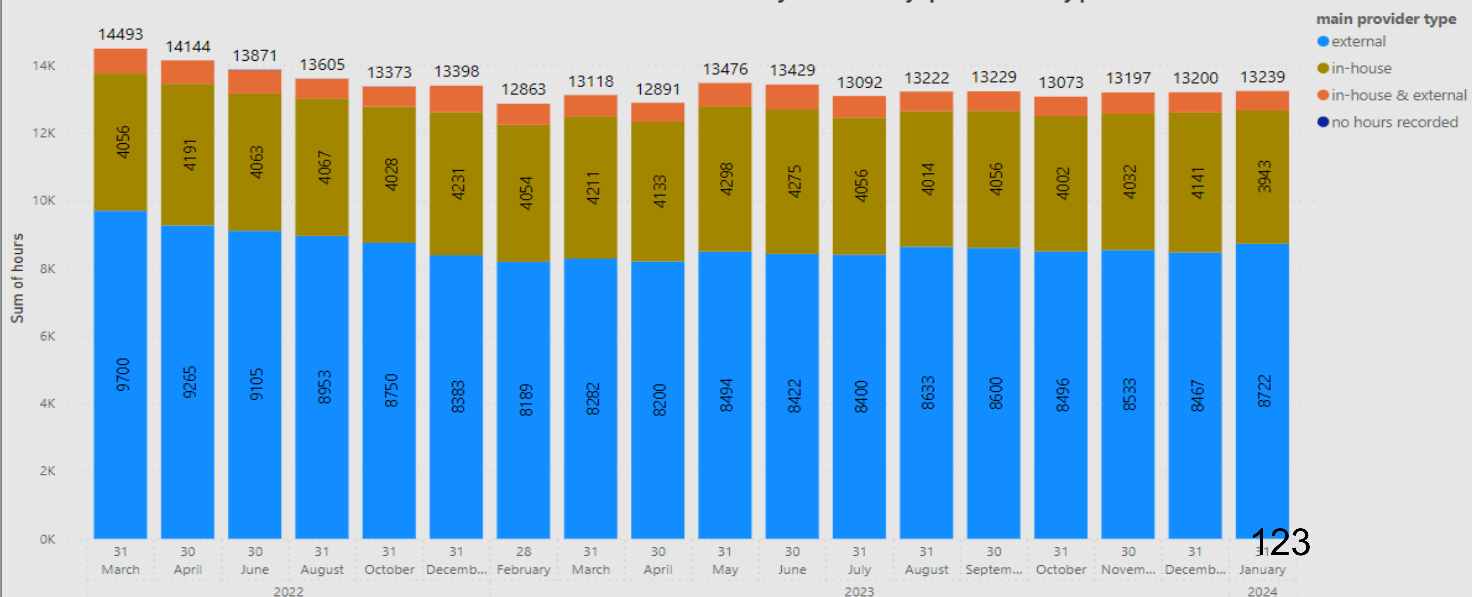
HHSCP Care at Home





HHSCP Care at Home

During Aug and Sept 2023, we have seen some small signs of growth although service delivery is down overall after a period of sustained reductions.
NHS Highland (NHSH) and care providers continue to operate in a pressured environment

We have not seen the expected growth in external care at home and low levels of recruitment and the loss of experienced care staff continue to be the primary concern expressed by providers in our frequent and open discussions.

NHSH and care providers still await the specific details on the proposed £12ph minimum wage increase due April 24 with modelling rate options in progress.

The impact of lower levels of service provision on flow within the wider health and social care system is significant, and this needs to be recognised as part of the approach to, and solutions around, addressing care at home capacity.

A short life working group (SLWG) has co created and co-developed proposals to try and address capacity and flow issues. The SLWG has co-produced and agreed eight commissioning proposals, and these have been endorsed by NHSH at the Care Programme Board and by Joint Officers Group.

In identifying and developing proposals, the SLWG considered it necessary to establish a **clear vision** for service provision with commissioning principles set.

- Person directed and outcome focussed
- Individual, holistic, functional and accurate assessments informed by good conversations
- Realistic achievable and sustainable
- Professional recognition and value
- Sector wide flexible workforce

Progress around this area is dependent on available resourcing to take forward.

Update 19/02/2024

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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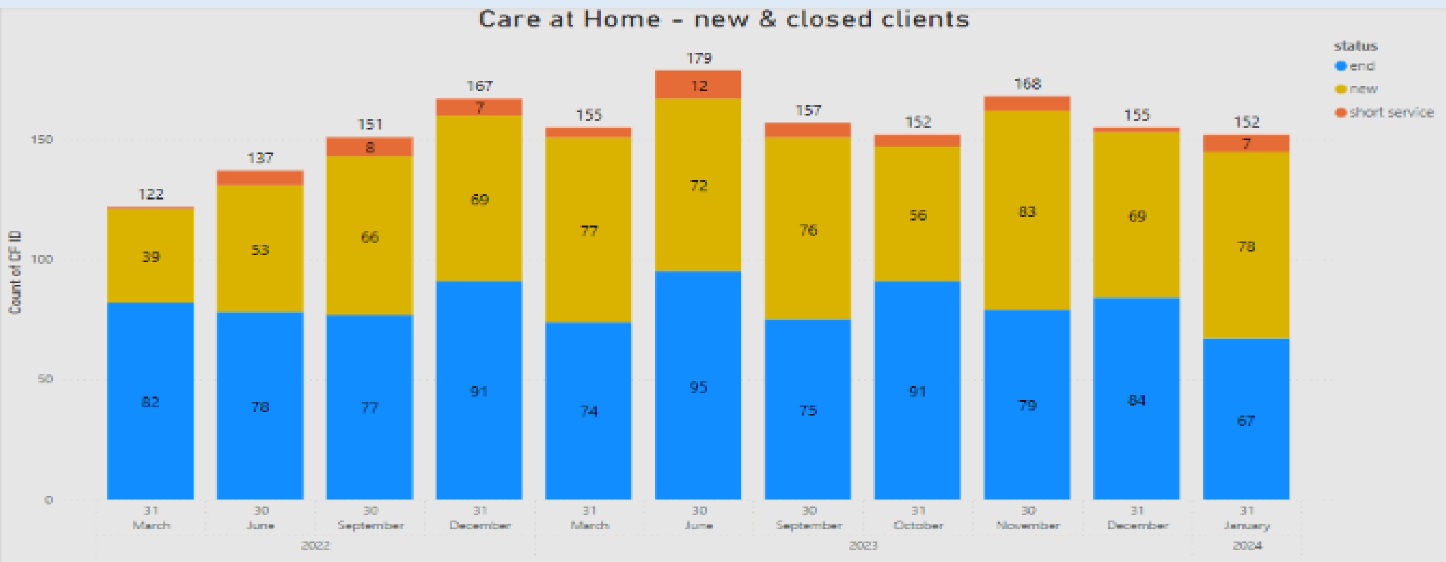
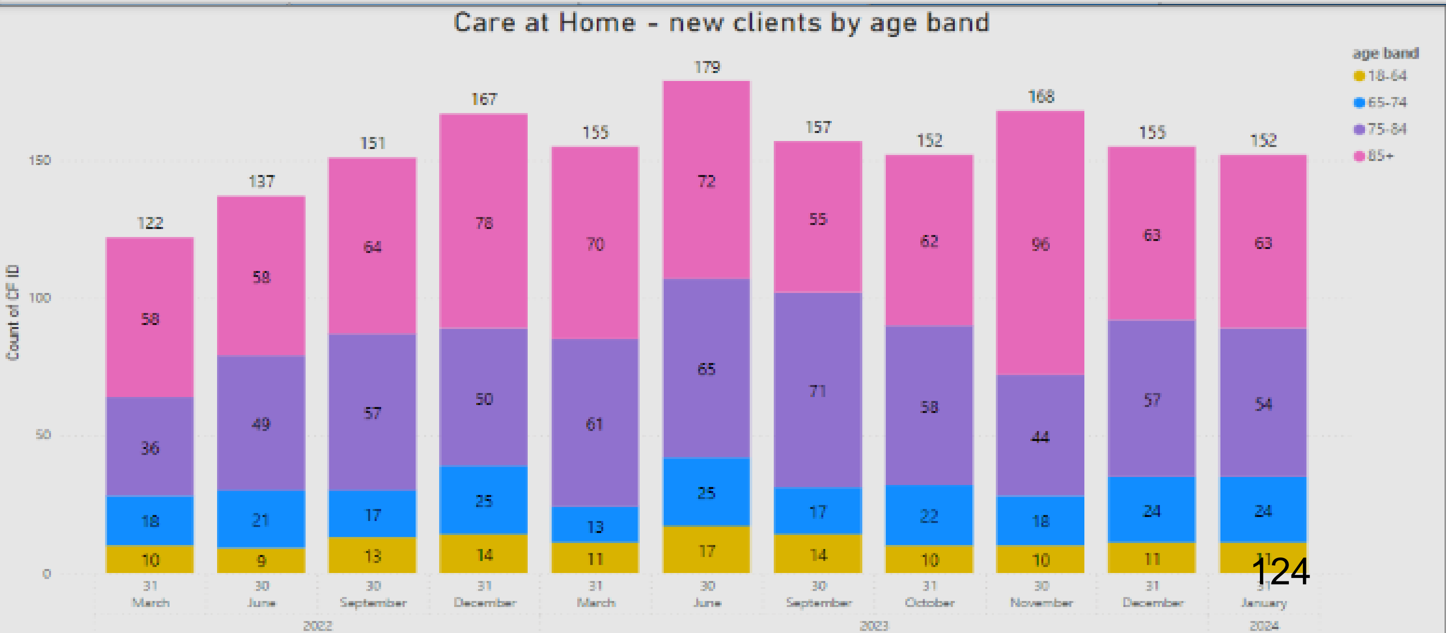
HHSCP Care at Home





Care at Home – New & Closed Packages

Graph 1 – Shows the number of new and closed packages per month.

Please note that available capacity to provide care-at-home to new service users is particularly challenging during the winter months due to staffing related pressures in our in house and commissioned external services.

Graph 2 – Shows the number of **new** care at home service users split by age band over the same period.

The number of new clients receiving care at home has been reducing from the peak of March 2023. Flow is particularly challenging for care at home due to staffing related pressures across the care sector.

Update 16/02/2024

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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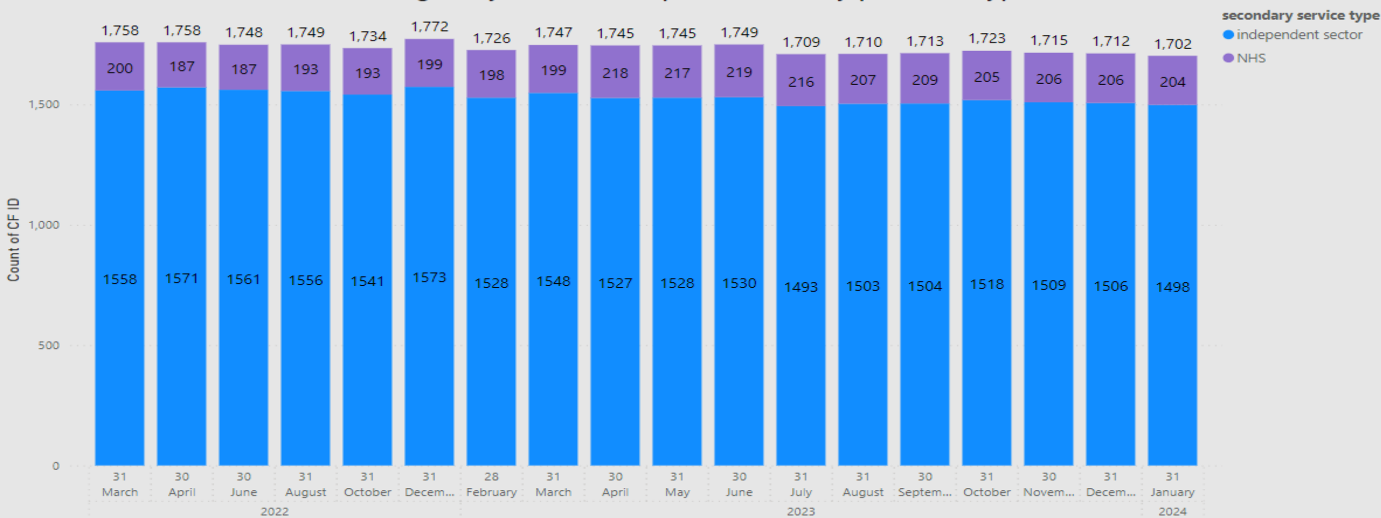
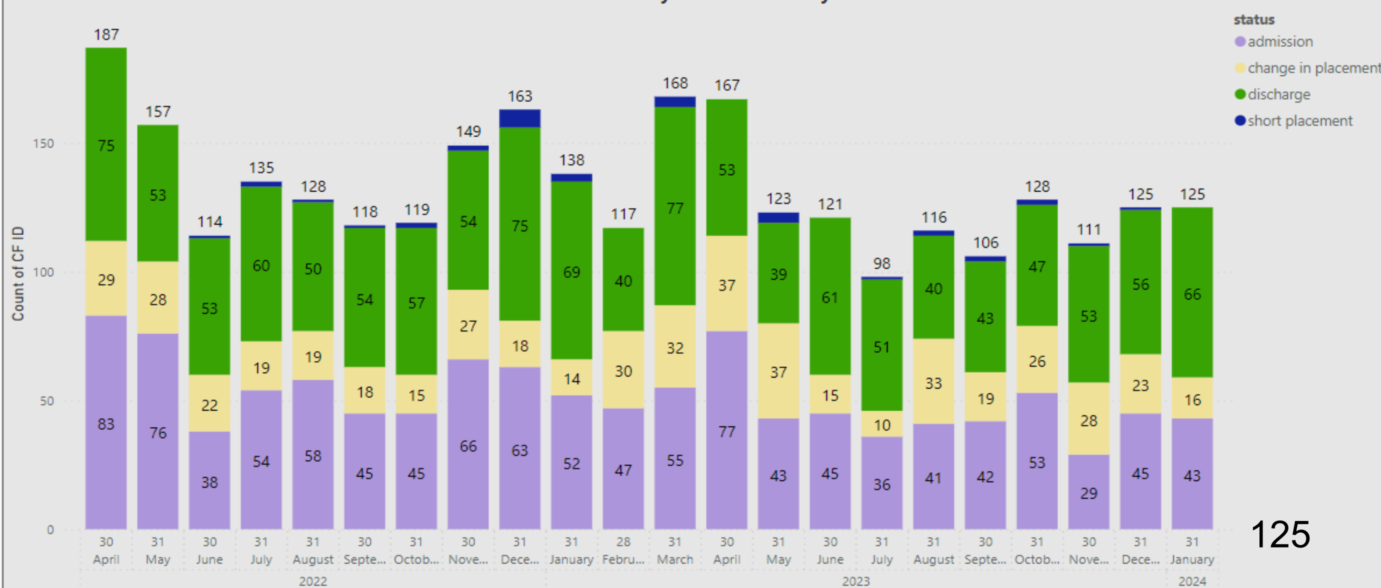
HHSCP Care Homes





HHSCP Care Homes

From March 2022 to date, there has been significant turbulence within independent sector care home market related to operating on a smaller scale, and the challenges associated with rural operation - recruiting and retaining staff in these localities, securing and relying on agency use, and the lack of available accommodation which compounds the challenges.

A further compounding factor of this turbulence relates to the current National Care Home Contract (NCHC) – this is insufficient to cover their costs and particularly disadvantages Highland as the NCHC rate is predicated on a fully occupied 50 bed care home – in Highland only 8 of the 47 independent sector care homes are over this size.

In-house care homes and some care home providers are still experiencing staffing resource shortages. As at 12/2/24, 19 care home beds are unavailable in 3 in-house care homes due to low staffing levels.

Since March 2022, 5 independent sector care homes have closed. During this period, the partnership also acquired a care home in administration to prevent the closure of this facility and a further loss of bed provision.

This year, 3 in house care homes have also closed although two are closed on a temporary basis and the closures are in small rural and remote communities with closure due to acute staffing shortages.

This reduced care home bed availability is having an impact on the wider health and social care system, and in particular the ability to discharge patients timely from hospital. There is a need for a Care Home strategy to be developed in 2024-25.

A **Care Programme Board** is established to oversee:

- Acquisitions, closures and sustainability
- Forward Planning and Strategy

Update 19/02/2024

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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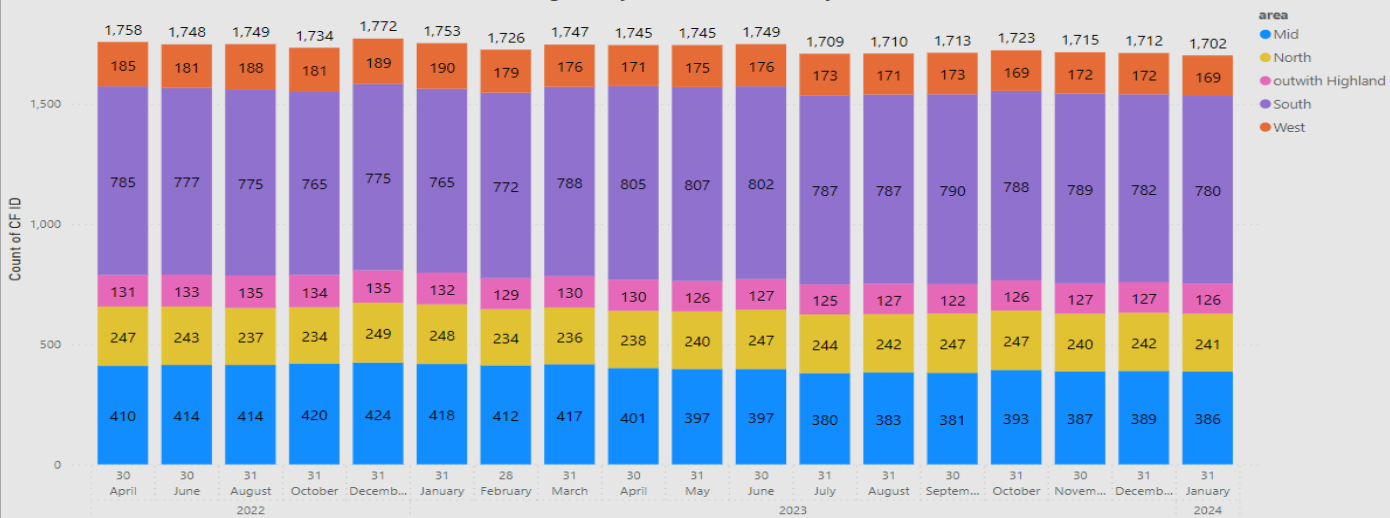
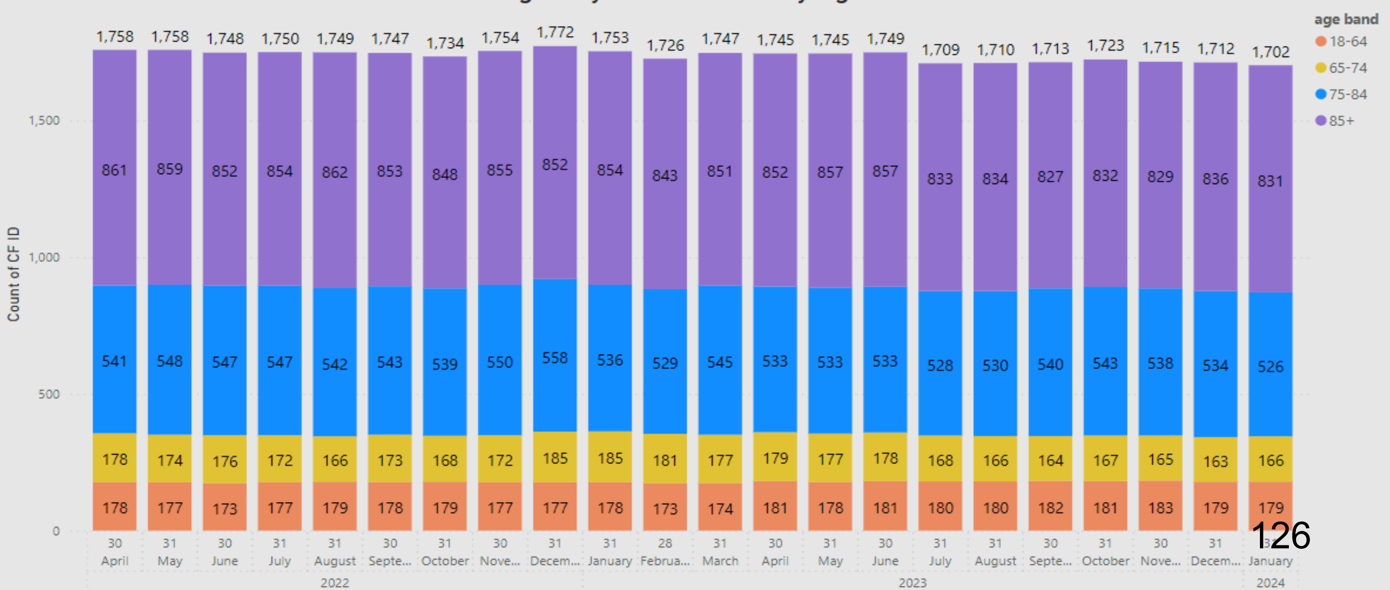
HHSCP Care Homes





HHSCP Care Homes

These graphs provide an overview of the **occupied** long term care beds during the month for both external and NHS managed care homes by providing a breakdown by area and those placed out of area but funded by HHSCP.

South: 780 occupied beds
Mid: 386 occupied beds
North: 241 occupied beds
West: 169 occupied beds
Out of Area: 126 occupied beds

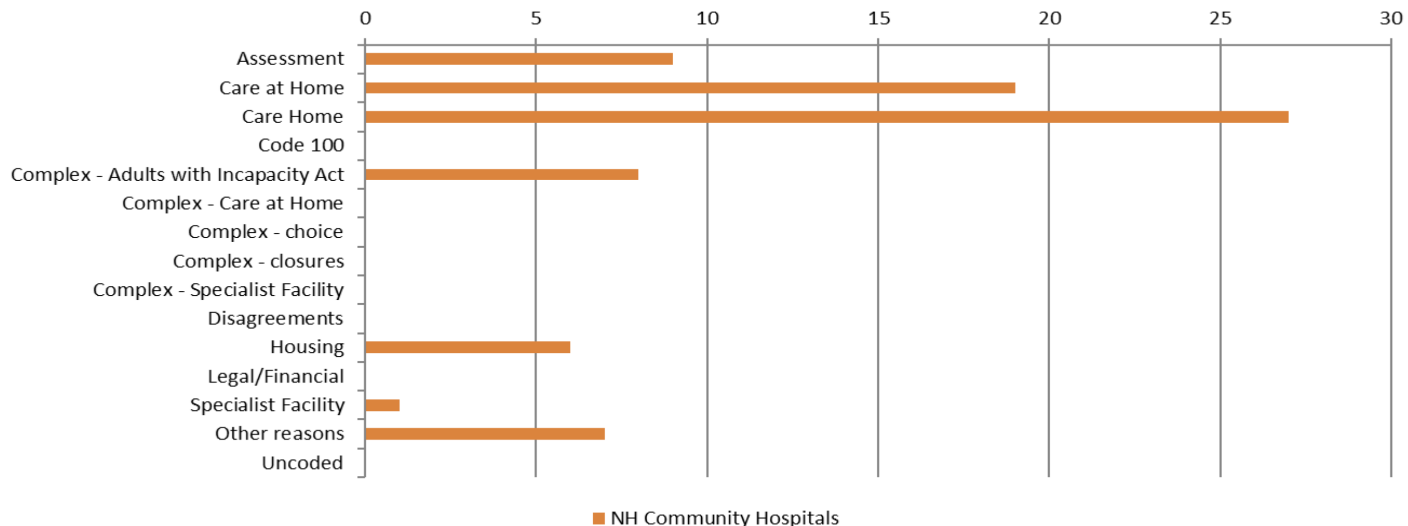
In addition, a further breakdown is provided by the current age of those service users for HHSCP only, **showing 49%** currently over the age of 85 in both residential and nursing care settings.

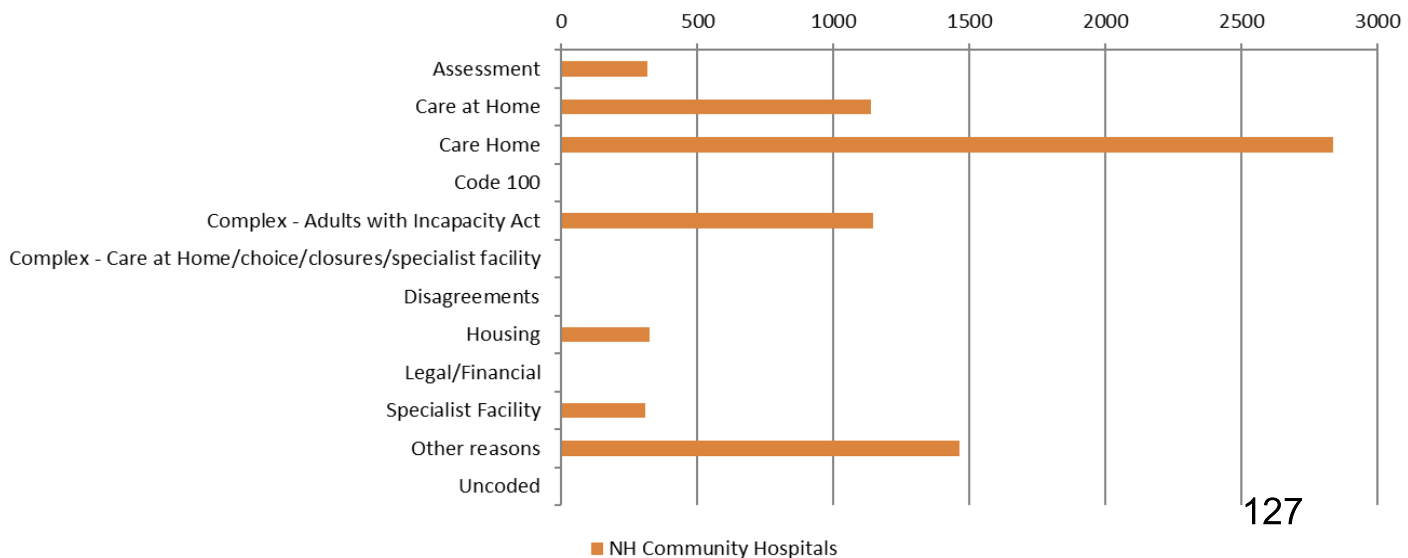
Update 16/02/2024

Strategic Objective 3 Outcome 11 – Respond Well & Care Well (Delayed Discharges)

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

Priority 11C – Ensure that our services are responsive to our population's needs by adopting a "home is best" approach.





HHSCP Community Hospital DHD's

There is no national target for delayed discharge, but we aim to ensure we get our population cared for in the right place at the right time.

Of the 189 delayed discharges at 07/02/2024, 77 are in HHSCP Community Hospitals, 15 are in New Craigs hospital and the remaining 97 are delayed in acute hospitals.

Work continues on the implementation of standard work, including daily huddles and the setting of accurate PDDs for all inpatients across all hospital sites. Early notification to community DMTs of people on pathways 2, 3 and 4 is recognised as crucial in terms of timely discharge planning and facilitating community pull. Communication between acute and community remains a challenge with capacity issues within the Discharge Support Team and significant delay in introduction of the discharge app.

Daily oversight and collective problem-solving remains a key feature of DMT meetings in each of the Districts.

Focused work ongoing in CAH to ensure maximisation and most efficient targeting of limited resources. Work also ongoing with teams in relation to the maximisation of digital/technological aids.

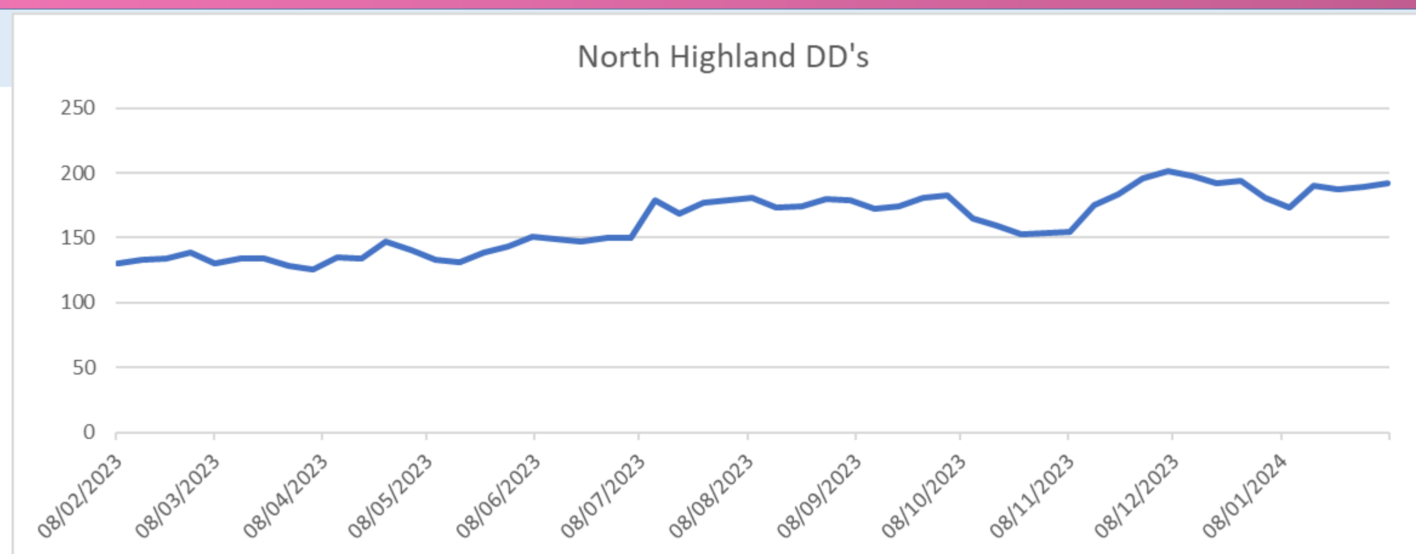
Work ongoing across acute and community regarding the importance of realistic conversations with service users and their families. Distribution and implementation of refreshed Choice Guidance week beginning 19/02/24.

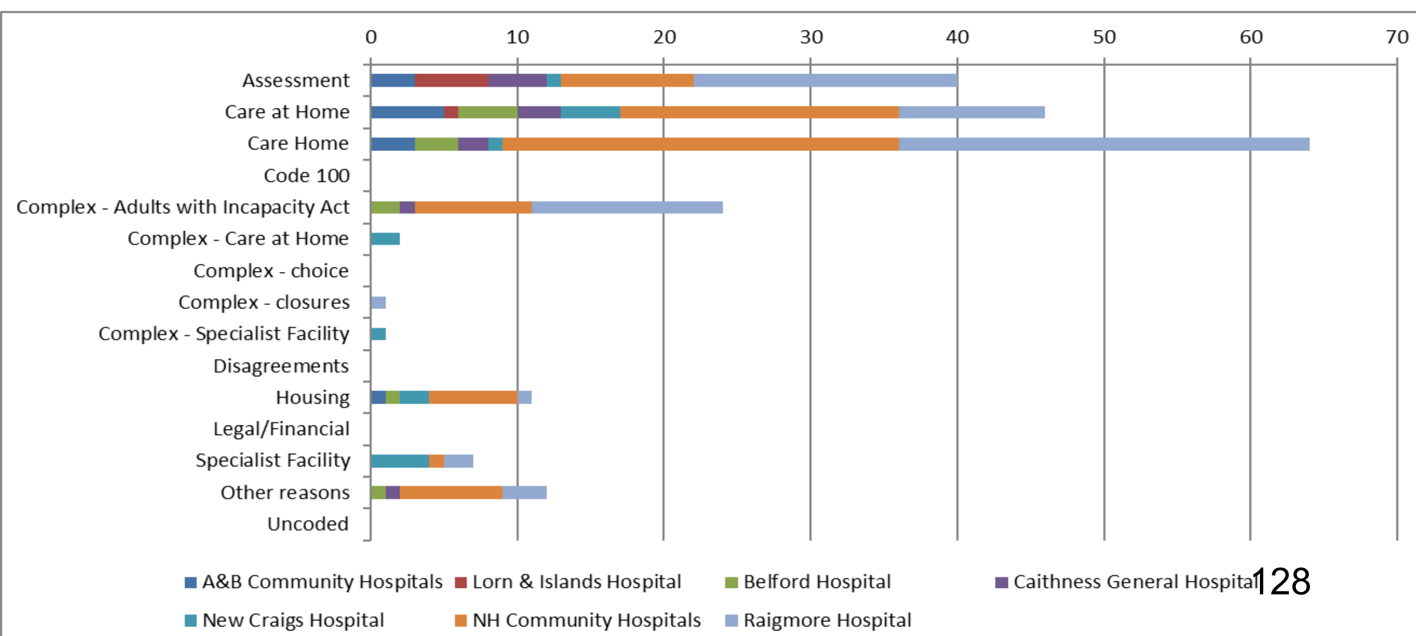
Update 21/02/2024

Strategic Objective 3 Outcome 11 – Respond Well

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

Priority 11C – Ensure that our services are responsive to our population's needs by adopting a "home is best" approach





HHSCP DHD's

Update: *189 delayed discharges @ 07/02/2024 of which 26 of those are code 9 (complex-AWI), 43 are awaiting social care arrangements to return home (care at home/adaptations), 10 are awaiting housing; 29 awaiting outcome of assessment and 65 awaiting care home placement. Additional delay reasons include complexity, patient exercising choice, family/other reasons and ward closure.*

The graphs show the trend for total delayed discharges for HHSCP and the reason for those awaiting discharge shown at a hospital level.

•Delayed discharges remain a significant concern.

•Discharge without Delay and Optimising Flow Groups continue to have a focus of working across acute and community services to establish more efficient systems and processes to facilitate community pull, respective operational and management units now need to ensure these are embedded and sustained. This remains the key challenge.

•Ongoing work includes review of care at home provision to ensure most efficient and effective use of limited resources and the development of wrap-around models of care.

•Cross system working and adopting a whole system approach remains key to ensuring the success of this work. If one or more arms of the service do not work to agreed process it has an overall impact on flow and delivery of desired outcomes.

•On a journey of cultural change - still some way to go in some areas regarding pace of discharge planning and adopting a daily mantra of **why not home today?**

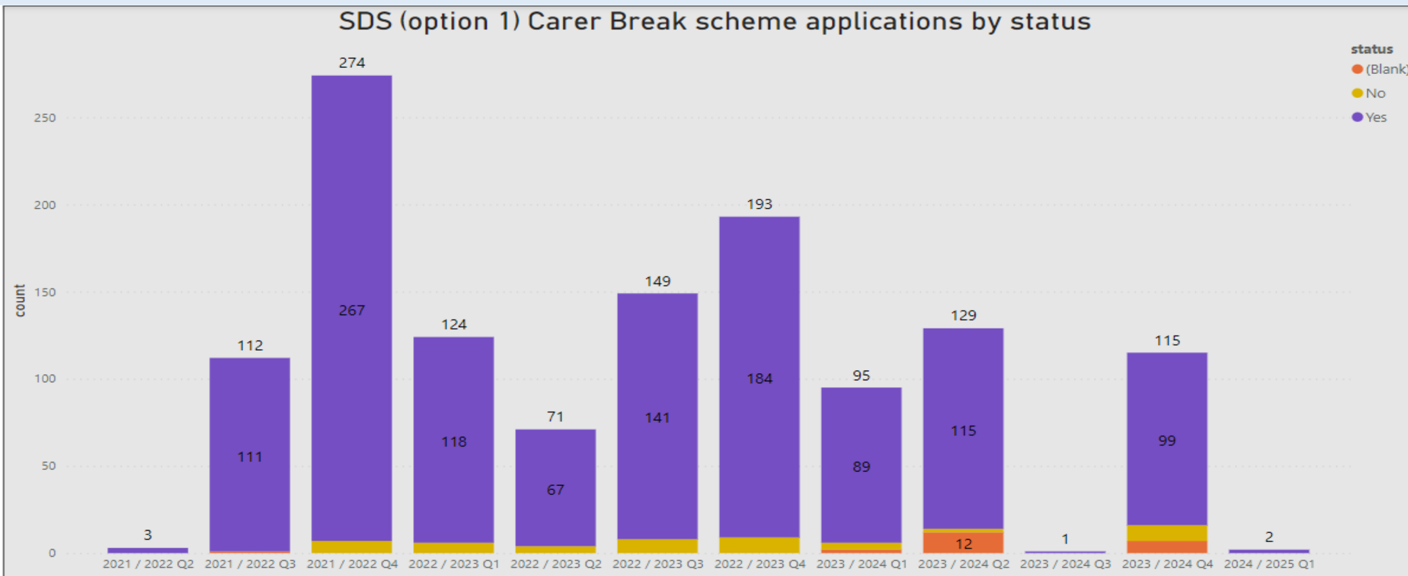
Update 21/02/2024

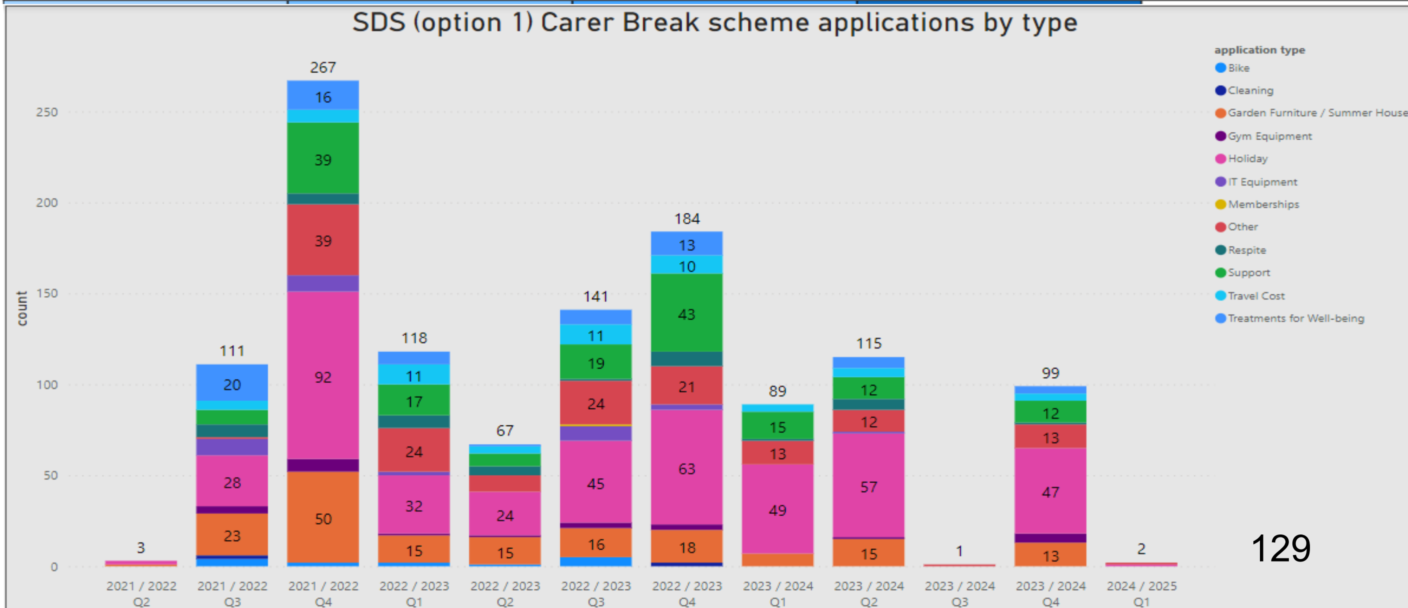
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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

Priority 9A, 9B, 9C – Work together with H & SC partners by delivering care and support together that puts our population, families and carers experience at the heart

Carer Breaks – Option 1 (DP)





SDS Option 1 (Carer Well-being fund)

We are continuing to use powers within the Carers Act to provide an Option 1 Well-being fund for unpaid carers. It seeks to make resources available to carers via a simple application process supported by a social worker or a carers link worker etc. The scheme is largely free from resource allocation decision-making processes and seeks to rely on professionals and carers coming together to identify the kind of help that would be right for them. Help is targeted to support unpaid carers to be willing and able to maintain their caring role.

This is consistent with our aims to:

•Ensure that resources and supports are used effectively and efficiently to meet people's needs and outcomes: and are complementary to other sources of support

•Maximise people's choice, control and flexibility over the resources available to them

Work has recently concluded national colleagues - via the award of "Promoting Variety" funding - to provide our local workers with "outcomes-focused" good conversations training to ensure that resources are used to their best effect.

We have also been liaising with our unpaid carers reps to ensure the scheme reflects their priorities. Currently the scheme works to a finite budget of around £1m per annum (£0.25m made available in quarterly tranches). Their suggestion is that there are financial ceilings set for different types of purchases used for a short break: i.e. limits of contributions for holidays, summer houses and e-bikes etc.

A new Carers Development Officer has just been appointed after the retirement of the previous post-holder.

Quarter 1 for 2024 has now reopened to new applicants this month so the data will be updated for the next committee when available.

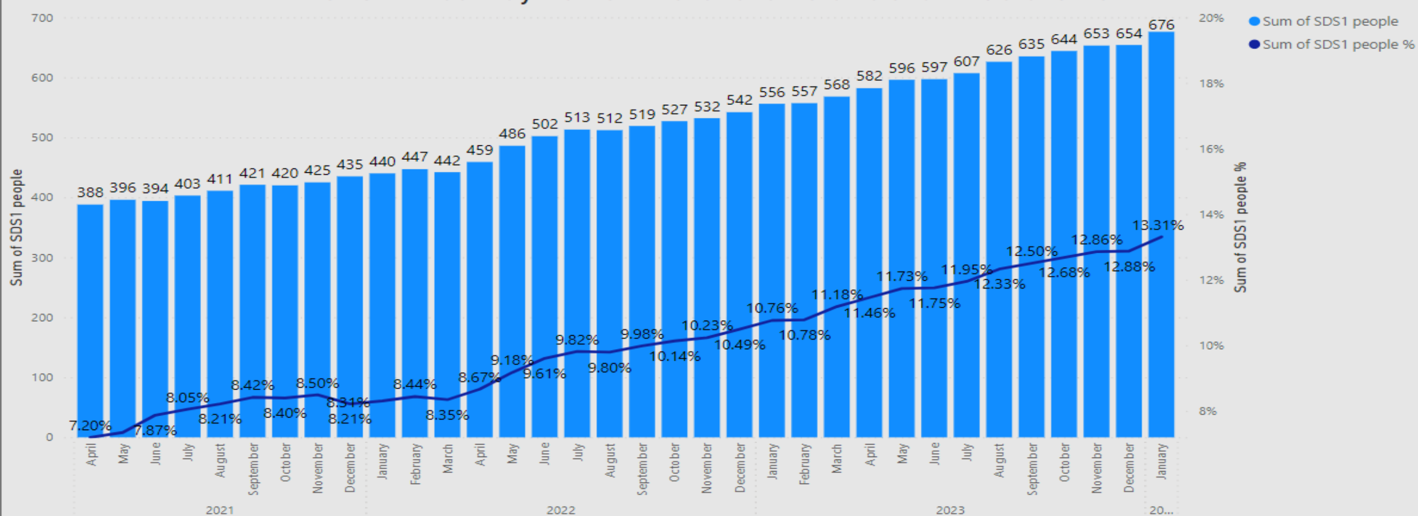
Update 16/02/24

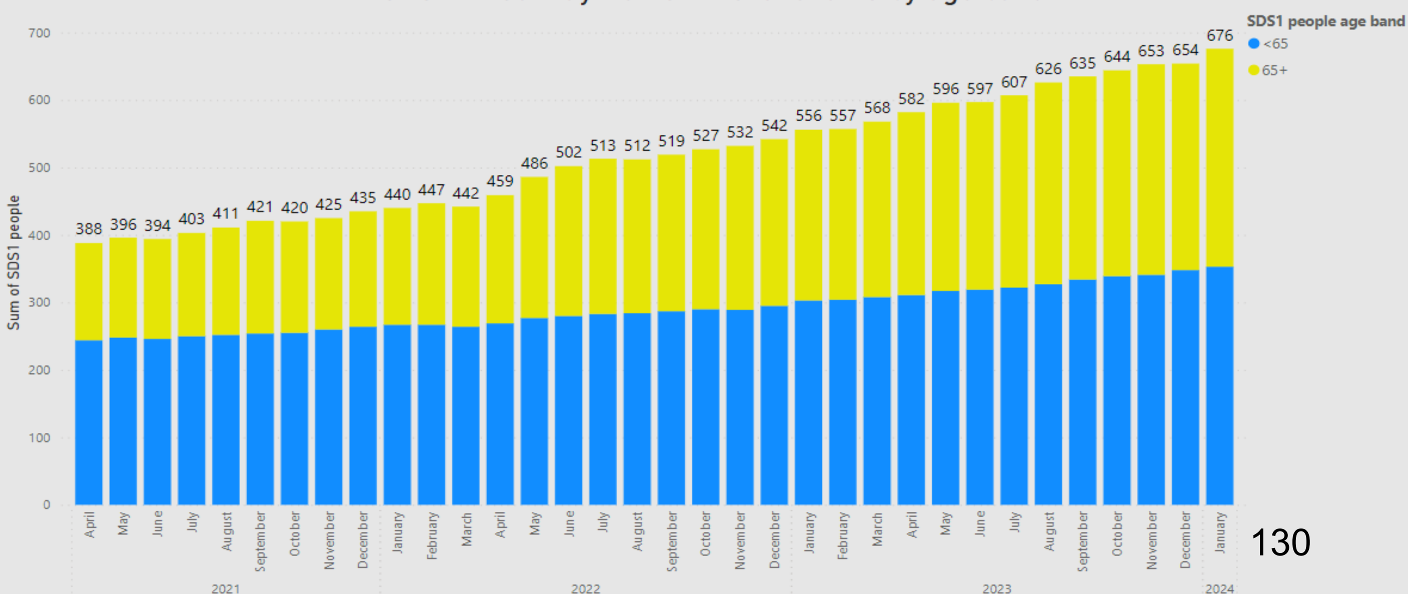
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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

Priority 9A, 9B, 9C – Work together with H & SC partners by delivering care and support together that puts our population, families and carers experience at the heart

Self Directed Support – Option1 (DP)





SDS Option 1 (Direct Payments)

We have seen sustained levels of growth for both younger and older adults in our more remote and rural areas. There has been a steady increase in numbers since March 2022 with further growth expected to continue this financial year.

These increases do however highlight the unavailability of other care options, and our increasing difficulties in our ability to commission a range of other care services, strongly suggest a market shift in Adult Social Care service provision.

We are also aware of increasing numbers of Option 1 recipients who are struggling to retain and recruit personal assistants. This demonstrates the resource pressure affecting all aspects of care delivery. Work is underway to promote the opportunities that taking on Personal Assistant role can offer people.

NHS Highland has implemented in Oct 23, a co-produced urban, rural and remote hourly rate by establishing a transparent personal assistant hourly rate for Option 1s. This increase and new model has been very well received by users and families and will help to retain and recruit valued personal assistants. NHSH and Option 1 recipients await the specific details on the proposed £12ph minimum wage increase due April 24 with modelling hourly rate options in progress.

This internal cost investment was required to ensure the sustainability of our Option 1 packages which are still the most cost effective and efficient delivery models which have significantly grown, primarily due to the absence of any other traditional delivery and more expensive care models.

Finally, NSH is committed to increasing the level of independent support across all service delivery options but due to the current financial constraints, officers are exploring any remaining funding available to procure independent sources of advice, information and support.

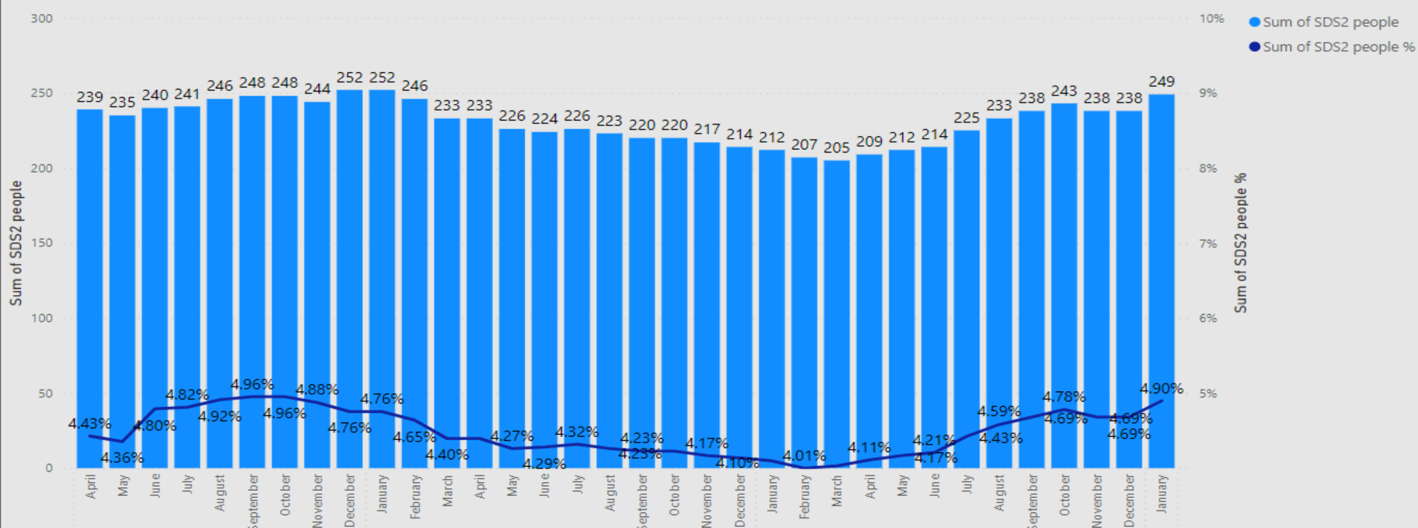
Update 19/2/24

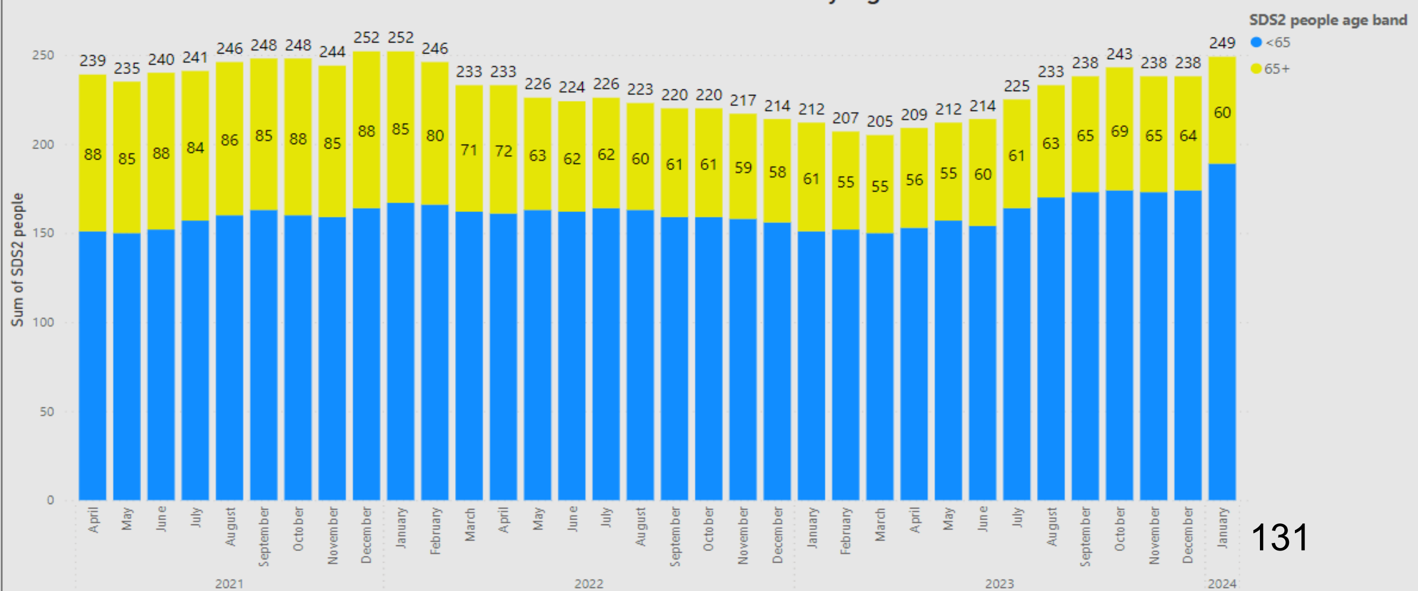
Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)

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

Priority 9A, 9B, 9C – Work together with H & SC partners by delivering care and support together that puts our population, families and carers experience at the heart

Self Directed Support – Option2 (ISF)





SDS Option 2 (Individual Service Funds)

ISFs steadily reduced during 2022 although we have seen a stabilising of the position in 2023 and note a welcome increase in commissioned service provision during the last 3 quarters.

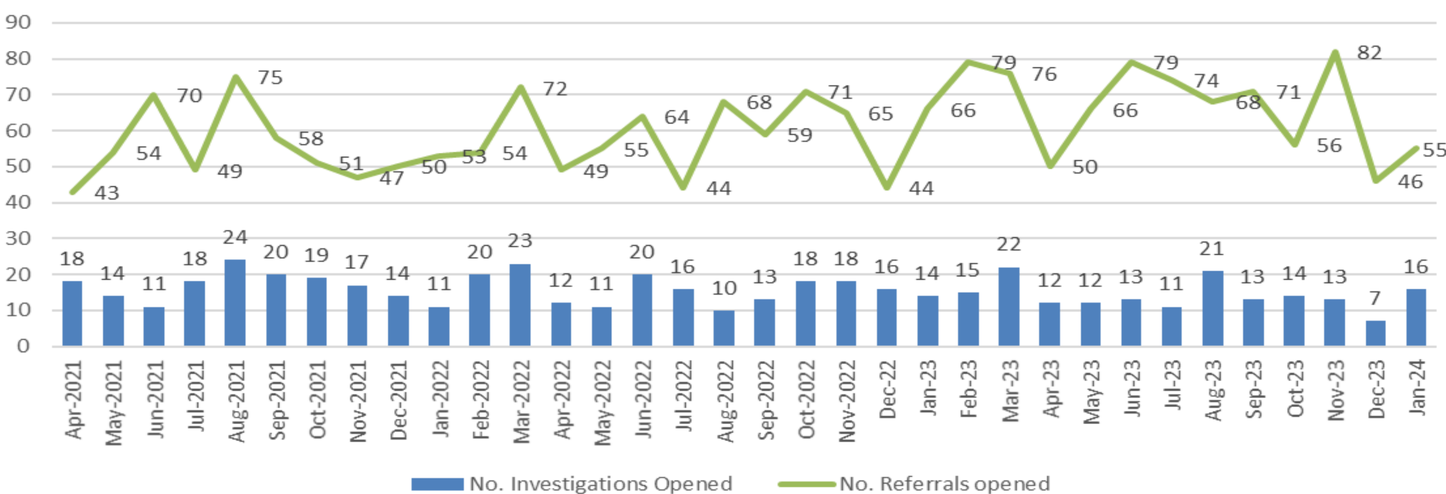
Our current number of active service users is 249 with a projected annual cost of £5.37m.

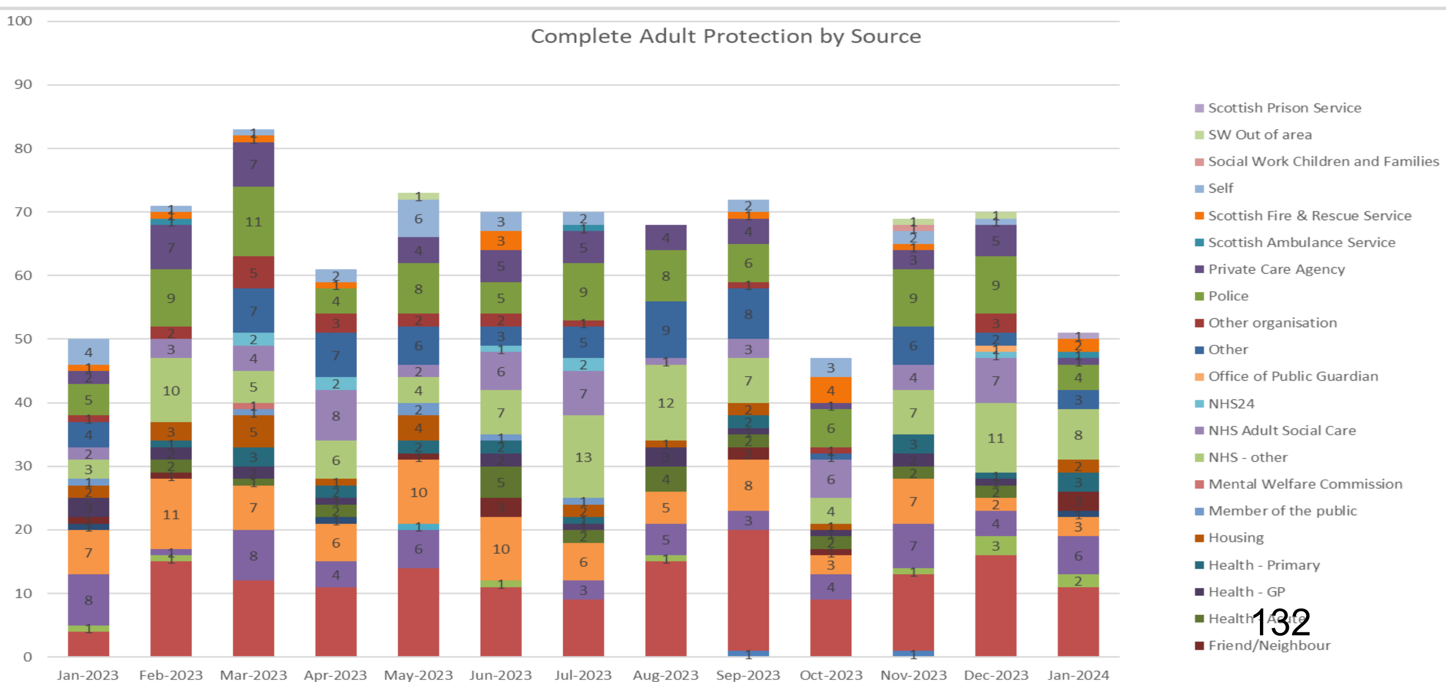
Graph 2 - Overall number of ISFs split by age band, noting over 76% of our current service provision is provided under this commissioning option to younger adults.

After an inclusive inquiry into the operation of our Option 2 offer in Highland plans are now in place to increase the range and number of 'providers' who can offer an ISF within an overall programme for Promoting choice, flexibility and control.

Update 16/02/24

Strategic Objective 3 Outcome 9 – Care Well (Adult Social care)





Adult Protection

The annual Adult Protection data return was made to Scottish Government on 31st May 2023. This will be the final annual data report return.

The definitions of Referrals, Inquiries (with or without the use of Investigatory powers), Case Conferences and Protection Plans have been consolidated and agreed across Scotland. Benchmarked data (across the 32 Local Authorities) is expected from Q3 or Q4.

There have been changes made to the ASP forms on CareFirst to ensure system alignment with the Minimum Dataset requirements from mid-May 2023.

The ability to greater analyse referrals in respect of type and location of harm is already being utilised to give a clear picture of harm in our communities.

Ongoing and increasing demand on Adult Protection Services is shown in the adjacent chart.

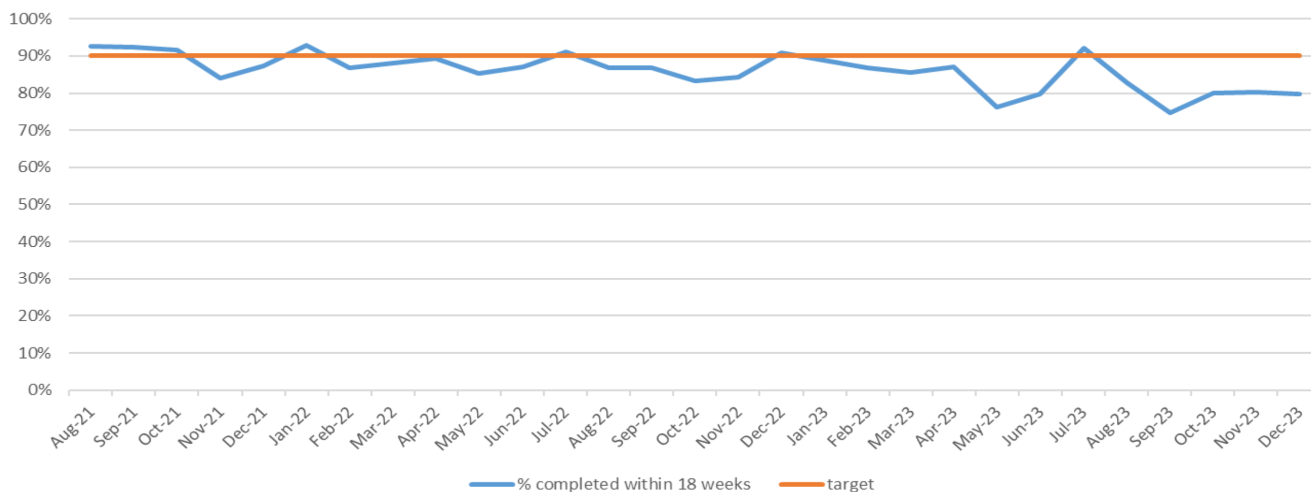
Highland’s Adult Protection arrangements across Health, Social Work and Police are currently the subject of a Joint Inspection

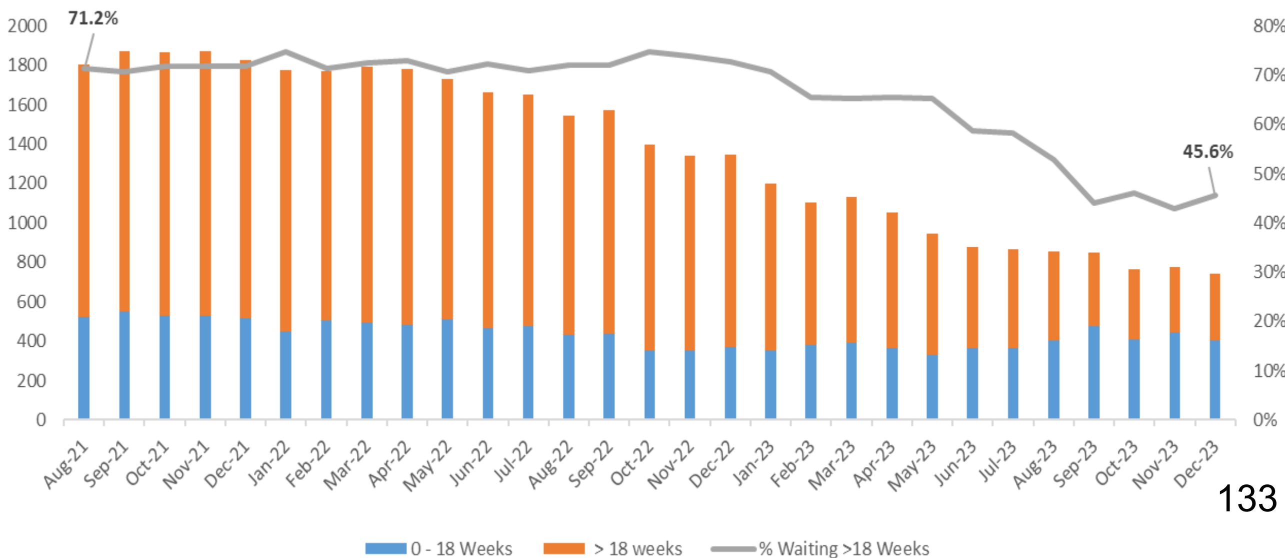
Update 16/02/2024

Strategic Objective 3 Outcome 10 – Live Well (Psychological Therapies)

Priority 10A,10B,10C - *Ensure that both physical and mental health are on an equal footing and reduce stigma by improving access and enabling all our staff in all services to speak about mental health and wellbeing"*

Psychological Therapies HHSCP Performance





Psychological Therapies Performance Overview - HHSCP

The national target:

90% of people commence psychological therapy based treatment within 18 weeks of referral.

December 2023 performance: 79.8%

As at December 2023:

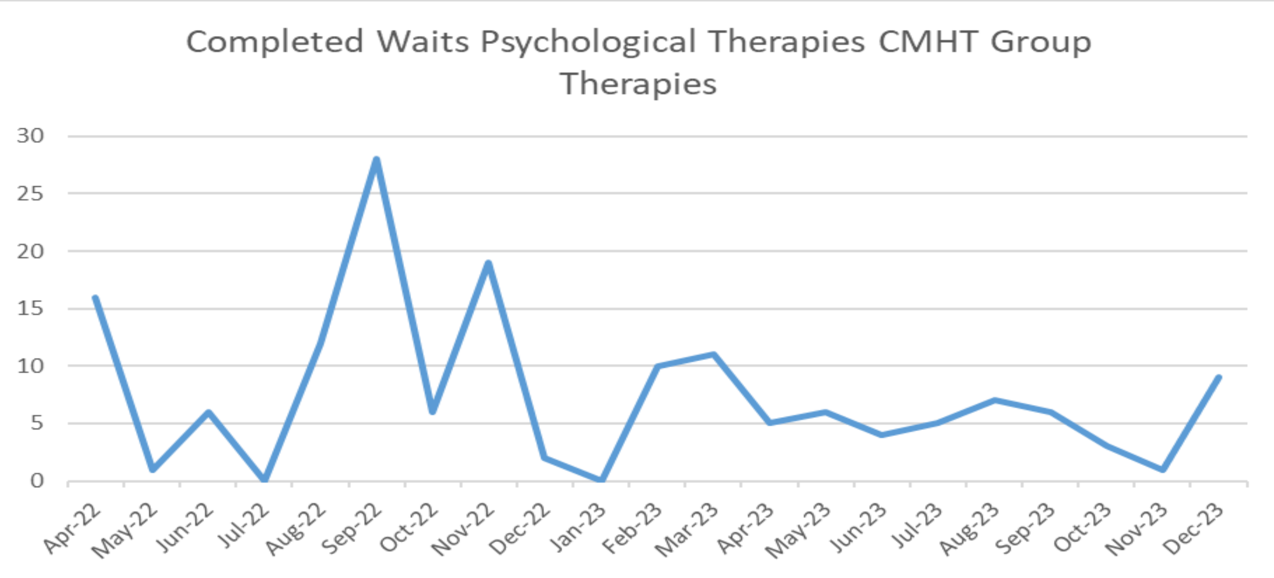
- 742 of our population waiting to access PT services in HHSCP.
- 338 patients are waiting >18 weeks (48% breached) of which 113 have been waiting >1year.
- Of the 113 waiting >1 year, 49 are awaiting group therapies and 30 are awaiting AMH, making up the majority of these waits.

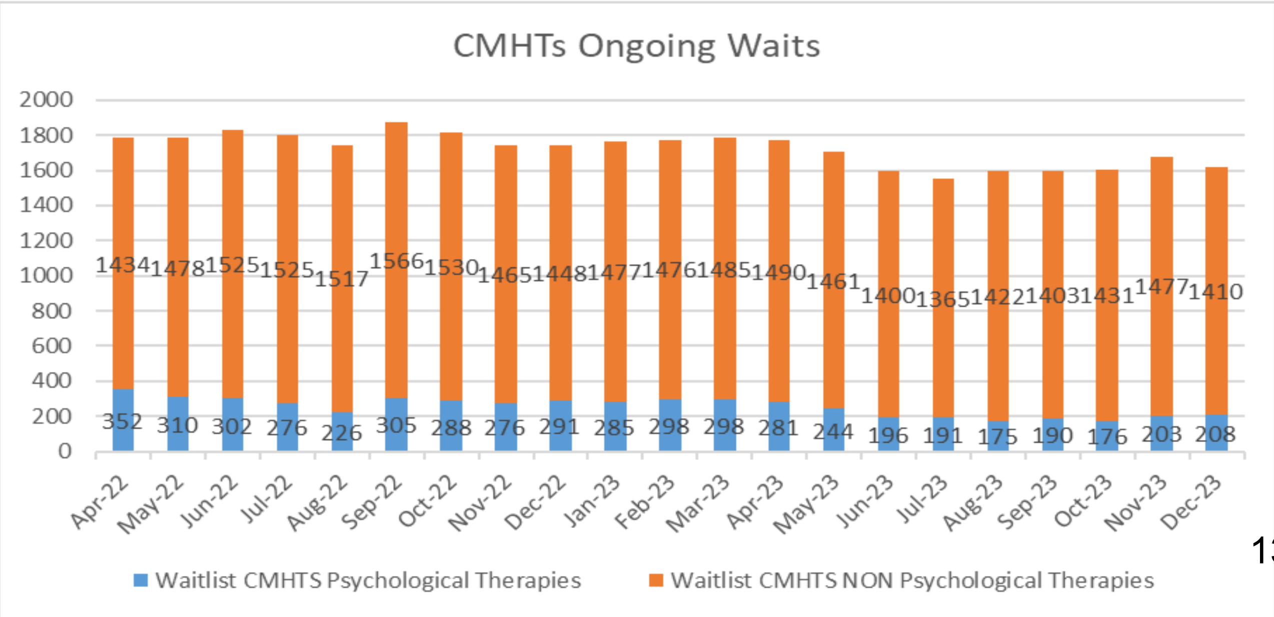
Psychological therapies services have had longstanding challenges with significant waiting times. There are a number of factors that have led to this including a lack of any other route for psychological interventions at an earlier stage. The development of Primary Care Mental Health services will help to fill this gap in provision along with the targeted use of community resources and the development of CMHT colleagues to work with their Psychological Therapy colleagues. It has also been identified that there is a gap in the provision of Clinical Health Psychology this is currently being addressed by the Board and Director of Psychology.

There will though always be a need for specialist services and the team are working to build a resilient model. The Director of Psychology is working closely with her team to reduce the current backlog and to build for the future. Recruitment and retention is difficult when national recruitment is taking place, however, there has been some success to date with the development of our Clinical Neuropsychology service which has proved effective in reducing a large number of our extended waits. The data provided here is already showing improvement overall with clear trajectories agreed with SG as we progress with our implementation plan.

Updated 13/02/2024

Community Mental Health Teams





Community Mental Health Teams

The ongoing waits for CMHTs are not currently reported unless they fit the criteria for psychological therapies such as STEPPS group therapies. The delivery of these group therapies was halted during COVID and the availability of an online method was slow to progress. This has resulted in a significant backlog in this area. There is a shortage in STEPPS trainers within the UK so we are therefore exploring a range of options for increasing NHS Highland STEPPS practitioner capacity.

Also, in addition the PD Service are going to lead by example with an on-line STEPPS for patients across NHS Highland. Three people have been identified for the impending training.

Graph 1 – shows the number of completed waits within the CMHT PT patients waiting on group therapies.

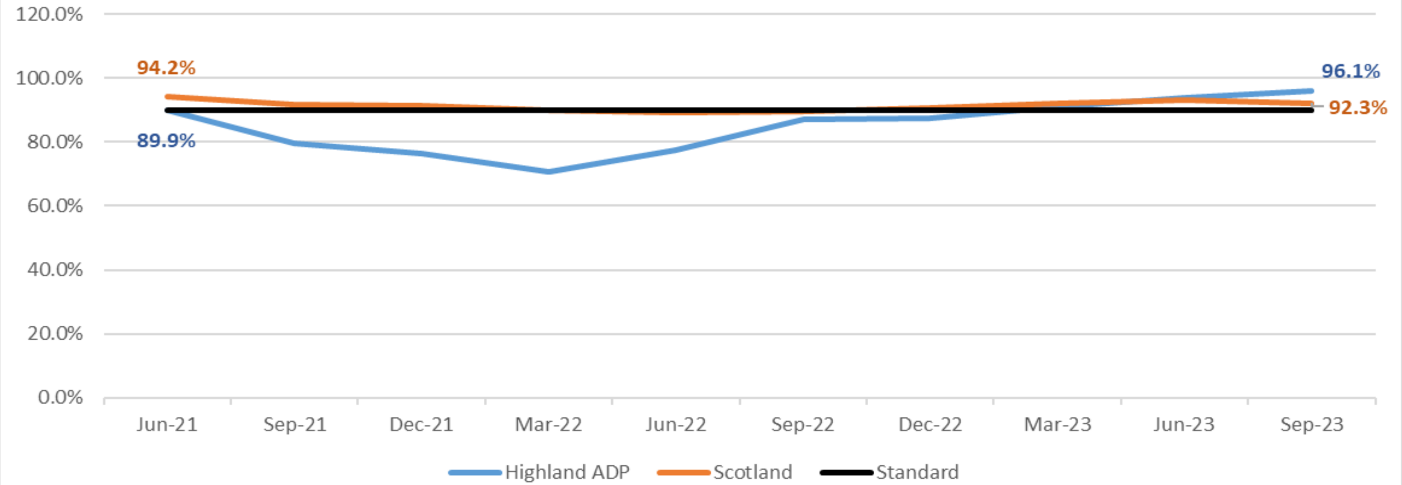
Graph 2 – shows the ongoing waits as recorded on PMS for the CMHTs, split between PT group therapies and other patients. Validation work is ongoing around this waitlist as has happened within PT.

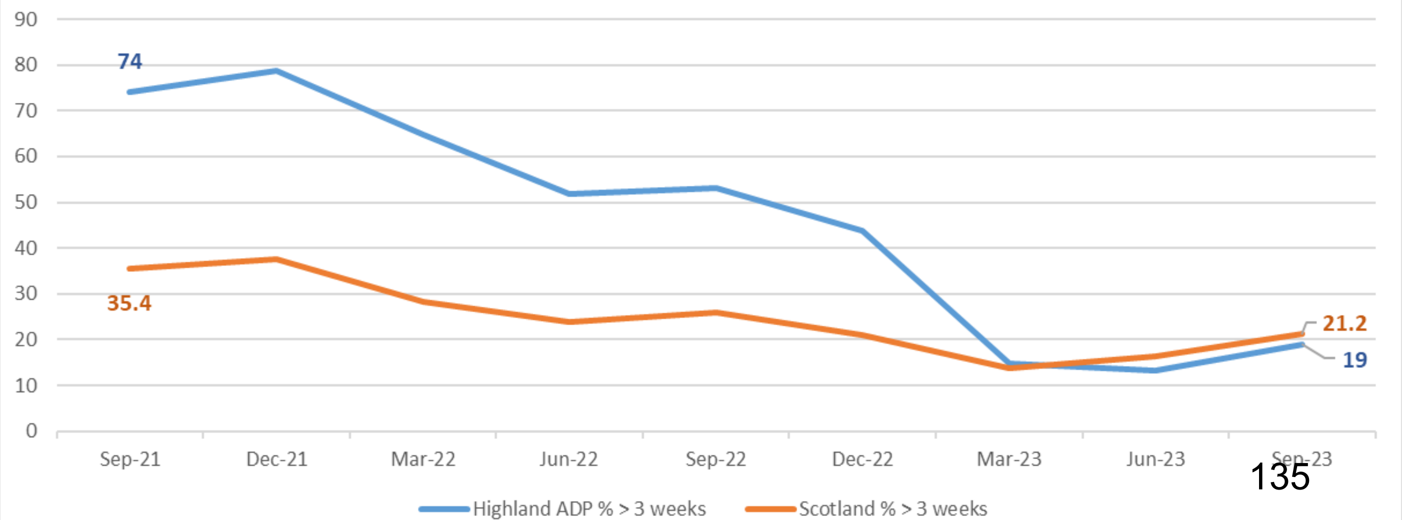
Updated 13/02/2024

Strategic Objective 1 Outcome 3 – Our Population

Priority 3b – No patient will wait longer than 3 weeks for commencement of treatment

Highland Drug & Alcohol Recovery Services





HHSCP Drug & Alcohol Recovery Services Update PHS Publication September 2023

HHSCP Drug & Alcohol Recovery Service performance against standard 96.1%, Scotland 92.3%

<u>**NH IPQR - Highland only**</u>		
No. of referrals to community based services completed in quarter end 30/09/2023	**Highland ADP**	
Alcohol	*187*	
Drug	*156*	
Co-dependency	*37*	
Total completed	*380*	
% of referrals to community based services completed within target in quarter end	**Highland ADP**	**Scotland**
% completed <= 3 weeks - Alcohol	*96.8%*	*91.2%*
% completed <= 3 weeks - Drug	*95.7%*	*94.0%*
% completed <= 3 weeks - Co-dependency	*91.7%*	*92.4%*
% completed <= 3 weeks - All	**96.1%**	**92.3%**
TARGET	**90%**	**90%**
> 3 weeks	3.9%	7.7%

Ongoing referrals to community based services at quarter end 30/09/2023	**Highland ADP**	
Alcohol	25	
Drug	9	
Co-dependency	8	
Total ongoing	42	
<= 3 weeks	34	
> 3 weeks	8	
% breached ongoing waits as at quarter end 30/09/2023	**Highland ADP**	**Scotland**
% ongoing > 3 weeks - Alcohol	32.0%	23.7%
% ongoing > 3 weeks - Drug	0.0%	19.9%
% ongoing > 3 weeks - Co-dependency	0.0%	13.8%
% ongoing > 3 weeks - All	19.0%	21.2%

Priority areas include identifying areas for improvement using lean methodology and the method for improvement to release capacity in teams to further meet this standard. This work has started in some teams.

Non Reportable Specialties – Ongoing Waits 14/02/2023

NHS Highland Non Reportable Specialties - Outpatient Ongoing aits 14/02/2024 (Excludes Raigmore)

Total Waiting List – 13,734
Longest Wait > 390 weeks

This is new data to the service so requires further consideration of what it is showing.
An ongoing piece of waiting list validation work to uphold the data quality of the records continues.

We need closer scrutiny in each of the areas in relation to data cleansing, waiting list management, waiting time targets and forward service planning.

All areas will have a level of waiting times and we need to understand what is reasonable and where the service is outside of this what are our options to reduce waiting times.

14/02/2024

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**06 March 2024**
Title:	**Chief Officer Assurance Report**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer**
Report Author:	**Pamela Cremin, Chief Officer**

1. Purpose

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

2. Major Redesign Programmes

The Scottish Government announced last month that funding for all NHS Capital Projects is to be paused. This means that a number of refurbishment, redesign and capital build projects will be paused across Highland HSCP operational area.

Plans for the redesign of Caithness General Hospital is paused.

North Coast Redesign: At the North Coast Redesign Programme Board held on Friday 23rd February an outline workforce plan was discussed. The work on the workforce plan needs to be further progressed with the hard stop date of March 2024. However, the translation of the strategic concept to an operational plan is now impacted by pause on capital spend. In this project there is a query whether or not the lease of the new build would fall under IFRS16 and would therefore be capital. This has to be clarified with Scottish Government at the time of report writing.

As part of joint work in Caithness to redesign services and deliver the Local Care Model we have been working very closely with Highland Council, as owners of Pulteney House. Our aim, to develop two step up beds, has been supported by Highland Council who agreed to development work to refurbish a former Day Care Area to provide two ensuite rooms, a kitchen and sitting room. Reflecting the local area and the historical name of the unit the service is called “Longberry Care”. It is a fantastic facility and will be a great resource for us as we develop our Care & Support Team, incorporating the step-up beds and discharge to assess models of care will enable people to stay at home longer or be discharged quicker from hospital.

Belford Hospital capital project is paused.

Lochaber Community Redesign: The Lochaber Community main elements continue to be focussed around the following work established workstreams: .

Project 1 – Living/ Waiting Well
Project 2 - Developing Care at home service and MDT support worker roles
Project 3 – Single Point of Access (SPOA) Service
Project 4 – Frailty service
Project 5 – Intermediate Care Services

The project topics represent the priority areas of focus for redesign and development of a high-level programme of work aligned to the Local Care Model Framework incorporating the Rainbow Model, developed in Caithness and the North Coast redesign work.

The projects demonstrate the interoperability and mutually supportive approach across health development in Lochaber.

3. Joint Inspection Adult Support and Protection for Highland HSCP Area

All Health and Social Care staff contribute to the risk assessment, support and protection of adults at risk of harm as defined by the Adult Support and Protection (Scotland) Act 2007, including; Community Nursing and Midwifery, GP's, dental staff and allied Health Professionals, Social Workers and adult social care support staff including care home staff and care at home staff, and our public protection partners such as Police, fire and rescue and Highland Council Colleagues for example housing.

Scottish Ministers requested the Care Inspectorate, Healthcare Improvement Scotland, and His Majesty's Inspectorate of Constabulary in Scotland carry out a phase 2 joint inspection of adult support and protection in six partnership areas (those previously inspected in 2017) in Scotland.

The purpose of this joint inspection is to seek assurance that adults at risk of harm in Scotland are supported and protected by existing national and local adult support and protection arrangements.

The Care Inspectorate will lead this programme which is based on a 13 week programme. The Care Inspectorate has attended NHS Highland and met with key stakeholders to engage them in the work required for the inspection.

Methodology: The Inspectorate will scrutinise partnerships' **key processes** (duty to inquire, investigation, management of risk etc.) to ensure adults at risk of harm are safe, protected and supported. They will look at **leadership** for adult support and protection within the partnership.

The joint inspection will:

- scrutinise the social work, police, and health records of adult at risk of harm
- scrutinise the recordings of duty to inquire episodes related to adults at risk of harm
- survey of staff within the adult protection partnership
- analyse minimal documentary evidence and a succinct position statement submitted by the partnership.
- engage frontline staff and middle managers focus groups, and discussion with senior managers.

The Inspectorate have developed quality indicators and quality illustrations for this joint inspection.

Partnership's submission and supporting evidence

- The Inspectorate have a supporting evidence request document for partnerships.
- Partnerships are asked to submit **best evidence not all evidence – 20 – 25 documents maximum**
- The Inspectorate ask partnerships to submit a **succinct position statement** ***(****maximum of 20 pages)*. We will provide guidance on format and content.
- The Care Inspectorate ask partnerships to populate our template (provided) with details of their stated timescales for the completion of various elements of adult protection activity – initial inquiries, investigations.

Discussion of findings with partnership & reporting

- After file reading, the Inspectorate will provide the partnership with written copies of the data from:
    - staff survey
    - analysis of partnership's handling of initial inquiries
    - main file reading analysis.
    - Following file reading, the Inspectorate will meet with the partnership to discuss their joint inspection findings.
    - The Partnership will get the opportunity to check factual accuracy of our draft report prior to publication.
    - The Inspectorate reports will **not** provide evaluations using the standard six-point scale, rather they will provide concise judgements on progress with key processes for adult support and protection and leadership.
    - Joint inspection reports will be published on the websites of the Care Inspectorate, Healthcare Improvement Scotland and HMICS. The Inspectorate will ask the partnership for an improvement plan.

Key Dates: file reading and meeting activity

- Staff survey opened 29 January, closed 16 February 2024
- Initial Partnership Return – noon, 26 January
- Case sample sent to Partnership – 5 February
- Professional Discussion 1 – 8 February
- Key Processes Meeting – 26 February
- Draft report sent to partnership for factual accuracy – 8 April
- Professional Discussion 2 – 10 April
- Embargoed report 23 April

4. Enhanced Services

The proposal for Enhanced Services that was communicated to General Practice has been paused and a revisit of communication and engagement governance with GP Sub Committee and Local Area Medical Committee (LMC) representation has taken place. An agreed governance and communication framework between NHS Highland and LMC is being developed and meetings focussed on Enhanced Services position are planned in order to negotiate and agree a position that is clear for practices from 1st April; and how we develop contracts going forward.

Highland Health and Social Care Committee

01 March 2024

Item 4.2

NHS Highland

Highland Health and Social Care Committee Annual Report

To: NHS Highland Audit Committee

From: Gerry O'Brien, Chair, Highland Health and Social Care Committee

Subject: Highland Health and Social Care Committee Report 2023/24

1 Background

In line with sound governance principles, an Annual Report is submitted from the **Highland Health and Social Care Committee** to the Audit Committee. This is undertaken to cover the complete financial year, and allows the Audit Committee to provide the Board of NHS Highland with the assurance it needs to approve the Governance Statement, which forms part of the Annual Accounts.

2 Activity April 2023 to March 2024

The Highland Health and Social Care Committee met on six occasions during 23/24. Development sessions formed an important element of committee development opportunities and three were held in 23/24. The minutes from each meeting have been submitted to the appropriate Board meeting. Membership and attendance are set out in the table below. Membership and Attendance from 02 March 2023 to 31 March 2024

MEMBER (Voting)	15/03/23	26/04/23	28/06/23	30/08/23	01/11/23	17/01/23	06/03/23
Gerry O'Brien, Chair 2022	✓	Apols	Apols	✓	✓	✓	
Philip Macrae, VC 2023	✓	Chair	Chair	✓	✓	✓	
Ann Clark	✓	✓	✓	✓	✓	✓	
Joanne McCoy	✓	✓	✓	✓	✓	✓	
Muriel Cockburn	✓	✓	✓	✓	✓	✓	
Pam Cremin, CO	✓	✓	✓	✓	✓	✓	
Tim Allison, Dir of Public Health	Apol	✓	✓	✓	✓	✓	
Claire Copeland, Medical Lead	Apol	✓	✓	✓	✓	Apols	
Cllr David Fraser	✓		✓	✓	✓	Apols	
Cllr Chris Birt	✓	✓	Apols	✓	✓	Apols	
Cllr Ron Gunn	✓	Apols	✓	✓	✓	✓	
Simon Steer, Dir of Adult Social Care	✓	✓	✓	✓	✓	✓	
Elaine Ward, Deputy Dir of Finance	✓	✓	Apols	✓	✓	F Gordon	
Nurse Lead (rotational: Julie Gilmore & Sara Sears)	Apols			J Gilmore	Apols	S Sears	

IN ATTENDANCE (Stakeholders)							
Michael Simpson, Public/Patient 2023	✓	✓	n/a	n/a	n/a	n/a	
Diane van Ruitenbeek, Public/Patient 2024	n/a	n/a	n/a	n/a	n/a	✓	
Michele Stevenson, Public/Patient	✓	✓	✓	✓	Apols	✓	
Wendy Smith, Carer					✓		
Catriona Sinclair, ACF	Apols	Apols	Apols		Apols	X	
Kara McNaught, ACF	✓	✓	✓	✓	✓	✓	
Neil Wright on behalf of Iain Kennedy, Lead Doctor (GP)	✓	✓	✓	✓	✓	✓	
Mhairi Wylie, Third Sector	✓	✓	Apols	Apols	Apols	✓	
Kate Dumigan, Staffside	n/a	✓	✓	✓	Apols	Apols	
Kaye Oliver, Staffside	n/a		✓	✓	✓	✓	
Fiona Malcolm, Head of Integration, Highland Council	✓	✓	Apols	✓	✓	✓	

During the period covered by this report the Committee Chair was Gerry O'Brien. Philip Macrae fulfilled the role of vice-chair for the period covered by this report. During the year Michael Simpson came to the end of his term as a lay member of the committee and the committee thank him for his contributions over his term of appointment. Following a recruitment process Diane Van Ruitenbeek joined the committee as lay member from February 2024.

2.1 The Pandemic

The pandemic continued to impact on the business of the Committee and delivery of services with reports regularly describing the long-lasting impact of the pandemic. The Committee has been particularly concerned to understand the impact on users and carers of the changes to services necessitated by measures to control COVID-19.

2.2 Service Planning and Commissioning

The Committee considered various aspects of the planning, commissioning and co-ordination of services across Highland Health and Social Care Partnership including: Commissioned Care at Home services, Care at Home Oversight Group, Primary Care Improvement Plan implementation, Mental Health Services, Children's and Young People's Services, progress with the commissioning of services from the Third Sector, Carer's Strategy implementation and implementation of a new strategy for Self-Directed Support services for adult social care. Common themes across all of these reports were the impact of the cost-of-living crisis, rising energy costs and continued recruitment and retention difficulties. The absence of an agreed commissioning strategy for services continues to hinder the introduction of revised commissioning arrangements. Following agreement of the Joint Strategic Plan 2024-2027 in January 2024, it is essential that commissioning arrangements are reviewed and revised within that strategic context. The Committee noted on several occasions' issues arising from the utilisation of the National Care Home Contract as a basis for commissioning care home services. The construct of the contract appears to be unsuitable for the majority of care homes across North Highland leading to increased sustainability issues for service providers.

2.3 Scrutiny of Performance

2.3.1 Service Delivery

The Committee has received assurance reports on particular areas of service delivery including mental health services, learning disability services, children's services and a range of reports covering adult social care services and Primary Care Services including Dentistry. The question of assurance on Clinical and Care Governance in relation to areas within the committee's remit is now close to being resolved with significant work having been undertaken by Highland Health and Social Care Partnership Quality and Patient Safety forum which is multi professional and now reflects care governance in line with the Vincent Framework. At each meeting the Committee received an exception report from the Chief Officer focusing on current service issues, developments in relation to local care home discussions, the National Care Service, significant capital developments underway, and celebration of team and individual staff awards and achievements and recognition for service delivery.

The Committee received an excellent report from the Director of Dentistry in relation to the provision of NHS Services across North Highland. A series of factors including recruitment, retention and national contractual issues have resulted in a significant proportion of the population being unable to routinely access NHS Dental services and those that can, may have to undertake significant and arduous travel to their nearest location. As well as the impact on dental and oral health, emergency requirements of the population are placing an increased strain upon the Public Dental Services as the provider of last resort.

Although an undoubted success story, the implementation of the Medical Assisted Treatment standards for addiction services highlighted once again the geographical issues facing services and the problem of ensuring that transport issues are not permitted to prevent full access to services. We heard through a number of service reports the vital importance of listening to the voices of carers and ensuring that solutions and services are truly co-designed and implemented appropriately.

2.3.2 Finance

The Committee received regular reports on the financial position of services within its remit. The 23/24 financial position was extremely challenging with the opening financial plan supported by the utilisation of £9.734m of non-recurring reserves carried forward from financial years 21/22 and 22/23 and the delivery of a savings target of £11.012m. During the year it became apparent that the £11.012m target for recurring savings from transformational redesign of services and efficiencies would not be achieved. Forecast savings sit at £4.633m for the full year. Additional expenditure pressures arose during the year in relation to locum and agency costs, particularly in Primary Care and Mental Health, rising costs associated with care home, care at home and a significant increase in the number and associated cost of care packages for individual clients. The forecast outturn position at month 09 sits at £15m and this position assumes a degree of non-recurring support from The Highland Council in relation to the non-delivery of Adult Social Care savings. Progress on the transformational change required to return to a sustainable financial position can only be achieved through the implementation of the Joint Strategic Plan and implementation of a new Health and Social Care Partnership Commissioning Strategy addressing continued financial pressures in adult social care.

3 Corporate Governance

The committee undertook a self-assessment exercise in December of 2023 and the results and resulting actions will be reflected in our 24/25 work plan and operational methodology. Terms of Reference have been reviewed and no significant changes have been made although there may be changes arising from the self-assessment exercise.

4 External Reviews

None

5 Key Performance Indicators

The agreed workplan for the year attempted to group key service issues together to allow committee members the opportunity to explore areas in more detail at individual meetings. Following implementation in 22/23 we have been able to make use of the Highland Health and Social Care IPQR for all of the year. This report has graphically illustrated the unmet need in our Adult Social Care Services with the report regularly showing a shortfall of 2,600 hours per week in Care at Home services, utilisation of available Care Home beds at 94%-95% and a steadily increasing number of Hospital Delayed Discharges, sitting at 186 at January 2024. These stark figures mask the collective efforts of our staff to deliver health and care services in an extremely challenging environment. On a more positive note, we have seen a steady increase in Self Directed Support Option One, with current performance now at 12.88% of all clients. However, there must be a sense of caution when looking at this figure as it may well be a manifestation of no other options being available. Currently the IPQR concentrates primarily on adult social care indicators, further development work is required in areas such as mental health, primary care and community services and this will be a major thrust of 24/25 work.

Performance against the CAMHS target has been encouraging in the first half of the year with an increase to 80% in those receiving services within the 18-week target. The second half of the year has not been as positive with performance levels now dropping back to 74%. Performance against the NDAS target is significantly below required levels. Waiting lists now sit at 1,336 children, almost 50% of that figure now waiting in excess of 52 weeks. An improvement action plan is expected to be produced shortly following a successful multi agency event in December 2023. Performance in both of these areas will be closely monitored by the committee in the year 24/25.

A report on performance for the 23/24 year will be published in July 2024. The 22/23 Performance Report showed improvement is required in the following areas: delayed discharges, capacity within Social Work services to undertake legal duties of assessment and review and timescales for accessing drug and alcohol services.

6 Emerging issues for 2024/25

It is likely that workforce issues of recruitment, retention and staff wellbeing will be critical to NHS Highland's ability to manage the competing priorities of post pandemic service recovery and improving outcomes for our population. Decisions about the scope and implementation of a National Care Service and the extreme financial pressure across the entire health and care system will inevitably mean discussions will need to take place about new models of integration and service delivery. As the vaccination programme moves to a locality-based model the committee will closely monitor performance level as well as the more qualitative aspects of patient experience

7 Conclusion

Gerry O'Brien, as Chair of the Highland Health and Social Care Committee has concluded that the systems of control within the respective areas within the remit of the Committee are considered to be operating adequately and effectively.

Gerry O'Brien, Chair

Highland Health and Social Care Committee

DATE 6 March 2024

Agenda Item 4.3

# NHS Highland	

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**06 March 2024**
Title:	**Committee Self-Assessment Review**
Responsible Executive/Non-Executive:	**Pam Cremin/Gerry O'Brien**
Report Author:	**Pam Cremin/Gerry O'Brien**

1 Purpose

This is presented to the Committee for:

- Discussion
- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Safe
- Effective

This report relates to the following Corporate Objective(s)

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

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2 Report summary

2.1 Situation

NHS Boards across the UK operate in an increasingly demanding environment. Good governance is essential in providing high quality, safe, sustainable health and social care services. Governance issues are increasing in the public sector, as is the public interest in governance problems being experienced by public bodies. Regular assessment of the effectiveness of governance arrangements within NHS Boards is a fundamental building block for improvement. NHS Highland introduced a self-assessment of the effectiveness of the governance committees and the Board in 2021 and improvement plans were agreed in 2022. A further round of self-assessments has taken place in 2023, following a refresh of the Blueprint for Good Governance in NHS Boards and the overall Board self-assessment exercise, which took place early in 2023. This report advises of the results of the latest Staff Governance Committee self-assessment and seeks agreement to hold a short development session to address issues arising therefrom.

2.2 Background

NHS Boards are expected to work towards the Blueprint for Good Governance and to regularly assess the effectiveness of their governance arrangements. The Board piloted a self-assessment against the revised Blueprint with support of Scottish Government and an external facilitator. Board wide actions are being implemented to address common themes. Committee self-assessments were paused for a period during the pandemic. It was agreed that these would be re-instated during 2023 to inform action plans for 2024/25.

2.3 Assessment

All Committee members were invited to complete a self-assessment questionnaire during November 2023. 15 out of the 26 members of the Committee completed the questionnaire. A summary of responses to the individual questions are set out in the attached Appendix, with some potential areas to explore highlighted in bold. Key themes arising from the responses and comments are summarised below under strengths and areas for improvement.

STRENGTHS	AREAS FOR IMPROVEMENT
• Engaged membership willing to challenge and add value • Effective leadership from Chair and Lead Executive • Development opportunities provided • General consensus amongst	• Lack of clarity for some about role of the committee • Ensuring that we hear from everyone and that those inputs are respected • Is the agenda balanced in terms of health and care • Timeliness and content of papers

respondents in answers	• Assurance to the Board

Committee members met on 31st January 2024 to discuss the findings of the self-assessment exercise and following a wide ranging discussion the following areas were identified by those present as area requiring further exploration by the committee and potential discussion by the Board of NHS Highland.

- There was general agreement that the summary table presented represented a consensus of opinion across committee members;
- The purpose and the mission of the committee, as set out in the Terms of Reference, required to be revisited in order to establish if it was still relevant, or has the health and care system and landscape evolved to an extent that the purpose of the requires to be amended in some way to reflect the evolving nature of health and social care planning and delivery;
- If the committee is truly to perform the purpose set out in its Terms of Reference and provide full assurance to the Board in areas such as finance, workforce, quality then reports need to provide a greater level of detail in order that committee members can fully understand the key drivers for adverse variance and actions being undertaken being taken to address such;
- Following on from this point was the issue of time and size of agenda, if reports were to become more detailed, also raised was the issue of cross over with other Board Committees, e.g. Staff Governance, Finance and Performance, if they are providing scrutiny, why does it need to be done again and what does this mean for committee assurance requirements;
- It was agreed that subject to appropriate amendments to the committee Terms of Reference then it would be possible for this committee to receive finance and workforce information on a 'information only' basis;
- A more general issue of duplication across committees was raised examples cited included, the NHS Board, Joint Monitoring Committee and Children's Strategy Group;
- The question of committee membership was raised and the question of why are certain people on this committee when it is, as per its Terms of Reference, an internal committee of NHS Highland presenting assurance to the Board of NHS Highland;
- Recent discussions in NHS Highland in relation to 'frugal governance' were highlighted and the benefit to be obtained from utilisation all committees to provide assurance, this would also involve cross committee assurance;
- Members agreed that committee work plans had not really satisfactorily addressed the key platform of Public Health and the absolute necessity to ensure that Public Health and inequalities were at the heart of service provision;

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- The continued use of Teams as the only means of the committee meeting was questioned. Members recognised the advantages of virtual meetings but felt that at least one face to face meeting per annum would be beneficial for engagement, committee development and perhaps would help others to more fully participate;
- A counter to this was more use of the full functionality of Teams and a move away from a strict business agenda e.g. break out rooms;

Members present agreed that the discussion had been extremely worthwhile and allowed them to express some opinions that had been forming for a while. There was agreement that priorities for moving forward were a) Revised Terms of Reference, b) Interface with other committees and groups, c) membership and d) Roles and Responsibilities of members.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	x
Limited		None	

The assurance level will be raised to substantial following implementation of any actions arising from discussion of the self-assessment responses.

3 Assessment

3.3.1 Quality/ Patient Care

An engaged workforce operating within a culture that promotes psychological safety and staff wellbeing will make better decisions leading to improved outcomes for those receiving our services and their families.

3.3.2 Workforce

There are no direct workforce consequences of this paper.

3.3.3 Financial

There are no direct financial consequences of this paper. Good governance contributes to the efficient and effective use of resources within the Committee's control.

3.3.4 Risk Assessment/Management

An effective Committee will be better placed to identify risks and opportunities and scrutinise proposed mitigating action by management.

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3.3.5 Equality and Diversity, including health inequalities

No immediate impacts identified.

3.3.6 Other impacts

N/A

3.3.7 Communication, involvement, engagement and consultation

All members of the Committee received an invitation to complete the original self-assessment questionnaire and were likewise be invited to the Development Session discussion.

3.3.8 Route to the Meeting

Discussion between Lead Executive, Chair and Vice Chair.

4 Recommendation

The Committee are recommended to discuss the findings of the self-assessment exercise and suggest actions to address areas for improvement.

The Committee are recommended to take moderate assurance that the self-assessment for 2023 has been completed appropriately. The assurance level will be raised to substantial following implementation of any agreed actions.

4.1 List of appendices

The following appendices are included with this report:

- Appendix No 1 Summary of Responses 2023

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APPENDIX ONE: RESULTS OF COMMITTEE SELF ASSESSMENT 2023

	Question	Strongly Agree	Agree	Undecided	Disagree
05	*I am clear about my role and how my participation can best contribute to the Committee's overall effectiveness*	7	5	1	2
07	*I am able to express my opinions openly and constructively*	6	5	3	1
09	***There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive***	3	7	2	3
11	*I have received appropriate development opportunities/briefings in relation to the areas applicable to the Committee's areas of business*	3	8	2	2
13	*I have received appropriate development opportunities/briefings in relation to the areas applicable to the Committee's areas of business*	3	11		1

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15	The leadership of the Committee by the Committee Chair is effective and supports input from all members	6	7	2	
17	The lead executive of the Committee is effective and is supportive of the constructive challenge from committee members	4	10	1	
19	**Information and data included within the papers is sufficient, not too excessive, and easy to understand so as to allow members to reach an appropriate**		9	4	2
21	Papers are provided in sufficient time prior to the meeting to allow me to effectively scrutinise and challenge the assurances given		8	5	2
23	**Committee meetings allow sufficient time for the discussion of substantive matters**	1	11	1	2
25	Minutes are clear and accurate and are circulated promptly to the appropriate people	3	11		1

DRAFT

27	*Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete*	*3*	*11*		*1*
29	***I believe the Committee gives assurance to the Board on areas within its Terms of Reference and makes clear recommendations on areas under its remit when necessary***	*4*	*8*	*1*	*2*
31	*The Committee's agenda is well managed and ensures all topics within the Committee's Terms of Reference are appropriately covered*	*2*	*10*	*1*	*2*
33	*The committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently*	*1*	*11*	*2*	*1*

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