NHS Highland Strategic Quality and Sustainability Plan: 2017/18 to 2019/20

Report by Elaine Mead, Chief Executive NHS Highland

- The Board is asked to endorse the strategic direction set out in the plan
- Note the efficiencies identified to date and the process for addressing the unidentified savings
- Approve the proposed rolling planning cycle
- Note detailed papers to follow for 2017/18 annual plan and rolling three year plan

1. Summary and Background

- Our Quality and Sustainability Plan describes the national and local strategic context, and sets out a compelling case for change as well as NHS Highland’s approach to addressing some of the challenges.

- Increasing costs and demands, staffing pressures and unprecedented savings targets mean that the current model of health and social care delivery is not sustainable in Highland.

- Over the next three years it is estimated that NHS Highland will need to deliver efficiencies of around £100 million with around £47million in 2017/18 (around 7% of the annual budget).

- On top of this the board has struggled to meet some of the national waiting time targets and to sustain some services. When taken all together it is clear that a ‘more of the same’ approach will not be sufficient to provide sustainable and affordable services.

- There is an overreliance on costly hospital and institutional care which needs to change in order to invest in community based services to meet future needs. While in 2015 about one in twenty people in Highland are aged over 80 years old, by 2035 this figure will be over one in ten.

- Initiatives identified for 2017/18 are themed under seven main headings: Adult care, Flow, New models of care, Realistic medicine, Drug costs, Remodelling assets and Continuous quality improvement / local initiatives

- Our approach to delivering the changes is described including embedding continuous quality improvement and engagement to improve care.

- Service re-design work is ongoing across many districts and for a range of services including outpatients, out of hours and Rural General Hospitals. Local regional and national collaboration will be required to develop solutions for some services.

- As the changes become embedded it will see a reduction in our footprint as well as the workforce over the next three to five years.

- Although NHS Highland is well placed to deliver the new approaches this will be challenging. The biggest hurdle is how best to speed up the pace of change while at the same time taking staff, communities and partners with us.
Background

The Health and Social Care Delivery Plan by the Cabinet Secretary for Health and Sport published in December 2016 brings into sharp focus the urgent need to address the rising demands and other challenges facing the NHS in Scotland (which had been summarised in a report entitled NHS in Scotland 2016 - published by the Auditor General in October 2016).

The combined impacts of our ageing population, reduced workforce, problems with recruitment, unsustainable models of care and financial pressures mean that the way we provide health and social care services has to change. While there is a clear need to speed up the pace of change it is also important to recognise that there is already momentum and we are not working from a standing-start.

As set out in our 10 year operational plan published in February 2015, work has been ongoing for some time to transform models of care and services. The changes are supported by a number of underpinning principles and measures, including:

- Support for people to stay at home for longer
- Supporting people and communities to be more independent and resilient
- Increase choice for end of life care and more realistic medicine
- Greater integration, co-location and co-ordination of care
- Greater Regional collaboration and solutions
- Greater use of technology
- Reduction the length of time people spend in instructional care
- Reduction unnecessary attendances and appointments
- Reduction waste, harm and unwarranted variation

As services and models of care are transformed it will see a changing workforce requirement, with new roles, and in turn, a reduction in use of locums and agency staff in relation to those and health and social care professions which cannot be easily recruited to.

The changes flowing from implementing our clinical and care strategy will therefore require us to remodel our workforce and our assets. Overtime this will bring a reduction in the number of staff, and in our foot-print, with fewer but better hospitals, care homes, facilities, offices and other assets.

Our Quality and Sustainability Plan describes the national and local strategic context, and sets out a compelling case for change as well as NHS Highland’s approach to addressing some of the challenges.

Initiatives identified for 2017/18 are themed under seven main headings: Adult care, Flow, New models of care, Realistic medicine, Drug costs, Remodelling assets and Continuous quality improvement / local initiatives

In reality trying to summarise these initiatives and actions in a linear way is inevitably artificial as the various themes are inter-linked and inter-dependent. However, there are distinct elements in each initiative and describing them illustrates how the complex jigsaw of health and social care starts to fit together. Inter-dependencies will be managed in detail by the operational units to ensure that the changes are delivered in a balanced way to support overall improvements and gains. Significant redesign on models of care are ongoing from previous years such as Out of Hours, Transforming Outpatients, Office Redesign and major service redesign and elements of these will be completed during 2017/18. NHS Highland also has a
good track record of realising savings through initiatives related to procurement, prescribing and quality improvement.

The plan is underpinned by our various strategies including Workforce, Asset Management and eHealth as well by more detailed operational plans for both Health and Social Care Partnerships and Corporate Services. The work programmes all sit within our framework of the Highland Quality Approach and ten year operational plan.

2. Contribution to Board Objectives

The Quality and Sustainability Plan sets out the vision and strategy through which to deliver the board’s corporate objectives. The seven initiatives relate back to People, Quality and Care and will support the reduction of waste, harm and unwarranted variation, allow new models of care to be introduced and in turn will reduce costs.

It builds on our ten year operational plan published in 2015. The vision and strategy have not substantially changed since then, however, there is an even more urgent need to deliver some of the changes and improved ways of working.

3. Governance Implications

Staff

In many areas there are now significant staffing challenges and its clear the the shape of the work-force will have to change. This will have implications for all staff of all grades and all professionals. Over time this should have far-reaching impacts on how people practice their clinical care, the different conversations they will need to have with patients and services users and the new locations they will work from. These changes will need to be led and managed in a supportive way with appropriate training and inductions as required.

As reducing costs by continuous quality improvement is a key element of the plan staff will be further supported to learn and use various tools and techniques. As new models of care are brought in it will be important to have workforce and transitions plans in place. Therefore while there are clear implications for staff as we roll out new arrangements and ways of working, doing nothing is not an option and already has some governance implications which this plan seeks to address.

There is clear guidance through Staff Guidance Standard and Organisational Change Policy to support any changes. There will be a clear role for Staff-side representatives, the Highland Partnership Forum and Staff Governance Committee to oversee, lead and guide any implications for the workforce. The 2017/18 and three year plan will be subject to wider engagement with Highland Partnership Forum and Senior Management.

Clinical

As described in the Plan many of the current clinical models are not sustainable and therefore pose risks for some services including clinical. The delivery of realistic medicine, new models of care and greater local, regional and collaborative working are designed to reduce clinical risks as well as making models of care safer and more sustainable. Overall reducing waste, harm and unwarranted variation will improve clinical governance. Monitoring will be through the Clinical Governance Committee. The 2017/18 and three year plan will be subject to wider engagement with the Area Clinical Forum.

Financial
Over the next three years it is estimated that NHS Highland will need to deliver efficiencies of around £100 million with around £47 million in 2017/18 (around 7% of the baseline budget). The plans sets out the governance arrangements including actions that will be taken to deliver a break-even position and the associated monitoring.

The regular financial monitoring reports that the Director of Finance presents to each Board meeting sets out the financial governance arrangements in more detail and in particular the various forums for scrutiny. It is proposed that the Delivering Financial Balance Programme Board will continue to play a key role in terms of oversight and that it will take a more programme-based approach than previously.

On 28 February 2017, a draft financial Local Delivery Plan template was submitted to the Scottish Government. This presented a balanced plan – however this was dependent on savings of £47m, of which £15.5m were flagged as unidentified. Further progress has been made and as at the date of this report, £33.2m had been identified with £13.8m unidentified. Work is continuing on closing this gap and a verbal update will be given at the Board meeting. It is likely that a substantial part of this gap will need to come from a significant ramping up of the implementation of continuous improvement methodology at scale.

4. Risk Assessment

The board will consider a paper on ‘Risk Appetite’ as its meeting in March 2017 and depending on the outcome of the discussion some of the plans may need to be altered or additional proposals brought forward.

The major risk to delivery is believed to be the pace with which we will be able to initiate the necessary change and capacity to deliver, whilst coping with the inevitable impact of meeting current needs within resources.

Despite significant engagement in all areas about the need to change over the years the pace of change has been slow. There has been some resistance and further can be anticipated. However there are greater risks of not changing. If the current ways of working continue then sooner or later they will ‘fall over’ in an unplanned way which is inherently more risky. As appropriate specific work programmes already have risks registers.

5. Planning for Fairness

Our high-level strategic plan sets out the future direction of how services will be redesigned. Impact assessments will be carried out before any changes are implemented. Assessments are already in place for many of the service redesigns underway or planned.

6. Engagement and Communication

Increasing costs and demands, staffing pressures and unprecedented savings targets mean that the current model of health and social care delivery is not sustainable in Highland. These are stark messages which can’t reasonably be refuted yet are still not necessarily believed, taken seriously or being owned by staff and or communities. Relationships and leadership are therefore key to getting these messages to be believed, accepted and acted upon.

A key enabler to support Realistic Medicine must be to get better shared decision making. To achieve this needs clinicians to be supported to have the time to have the necessary conversations with patients, carers and families. Overall, more work needs to be done to raise awareness with the public about their choices.
Delivering continuous quality improvement will drive down costs and forms a significant element of delivering savings and improving quality of care. Critically this does not require consultation, is already underway and with more support will be rolled out at scale.

Nevertheless it is clear that some difficult decisions and choices need to be made. Understandably, this will create concerns if people don’t understand or accept that there is a fundamental problem and credible alternatives are in place. The challenges described are not new. Issues around needing to change models of care were described in our first NHS Highland Newspaper published in August 2011 and delivered to every home in our area. It described ‘why we need to change’ and ‘shaping the future’.

What is new is the scale of change now required and the pace at which we need to reform. Therefore we will need to work together with staff, service users, communities and influential leaders to support the move to new and improved models of care across our wide geographic area. Key work programmes will be underpinned by communications and engagement plans as well as impact assessments where appropriate. The different stages of engagement to date are summarised in the plan. The detailed plans including the approach to communications and engagement will be revised following ongoing feed-back with various staff groups, communities, Scottish Health Council and board committees.

Elaine Mead
Chief Executive

15 March 2017

Appendix 1 - NHS Highland Quality and Sustainability Plan: 2017/18 to 2019/20
DRAFT
NHS Highland Strategic Quality & Sustainability Plan
2017/18 to 2019/20

Better health, better care, better value

March 2017

Contents
Foreword

Executive Summary

1. Introduction to the Plan
2. Strategic Context
3. Case for Change
4. Our Approach
5. Analysis of Spend and Costs
6. Developing our three year Quality and Sustainability Plan
7. Supporting Strategies
8. Communications and Engagement
9. Assurance, Performance, Risk and Planning Cycle

Annexes

I) Annual Quality and Sustainability Plan
II) Communications and Engagement Tracker
III) Monitoring Framework
Foreword

The current models to deliver health and social care across our complex and changing environment in Highland is no longer sustainable. Meeting the needs of the population has become increasingly difficult and now requires fundamental change to ensure sustainable models are in place for future generations. Challenges are being experienced across the country and include the shortage of some professionals, an ageing workforce, rising costs and demands. These challenges were set out in our 10 year plan published in February 2015 and our strategic case for changes is supported by the Operational and Delivery Plan for Health and Social Care in Scotland published in December 2016.

While NHS Highland is on-track to breakeven financially this financial year (2016/17) - with savings totalling £28 million - this was to the detriment of some access waiting times with patients waiting for new out-patient appointments and surgery in excess of the specified government-defined waiting time guarantees. This position was largely replicated across Scotland as the whole service came under significant pressure. NHS Highland sought to prioritise and maintain treatment times for emergency and urgent care which included A&E waits and cancer treatment times.

Going into 2017/18, it is anticipated that there will be a need to deliver at least seven per cent of savings in order to breakeven. On the current budget and allocations this amounts to around £47 million to be delivered from a budget of £800 million. Over a three period it is estimated we will need to save around £100 million. Therefore, it is clear that a ‘more of the same approach’ will not deliver sustainable solutions, here in Highland, across the North of Scotland or nationally.

Over the past five years, in particular, NHS Highland has put in place a number of arrangements which mean we should be well placed to respond to these challenges. The Highland Quality Approach encompasses both the aspiration and techniques to deliver the changes in a planned and timely way. However, it will only be an operational reality if there is a willingness to change (and to change quickly). To achieve that, we need to persuade people that the problems are real and pressing, and that we have credible plans to deliver better alternatives. We must move with pace to lead, engage and describe with enthusiasm the benefits of the new models and how everyday improvements can scale up to make significant gains.
Executive Summary

- Our Quality and Sustainability Plan describes the national and local strategic context, and sets out a compelling case for change as well as NHS Highland’s approach to addressing some of the challenges.

- Increasing costs and demands, staffing pressures and unprecedented savings targets mean that the current model of health and social care delivery is not sustainable in Highland.

- Over the next three years it is estimated that NHS Highland will need to reduce costs by £100 million with around £47 million in 2017/18 (around 7% of the annual budget).

- On top of this the board has struggled to meet some of the national waiting time targets and to sustain some services. When taken all together it is clear that a ‘more of the same’ approach will not be sufficient.

- There is an overreliance on costly hospital and institutional care which needs to change in order to invest in community based services to meet future needs. While in 2015 about one in twenty people in Highland are aged over 80 years old, by 2035 this figure will be over one in ten.

- Initiatives identified for 2017/18 are themed under seven main headings: Adult care, Flow, New models of care, Realistic medicine, Drug costs, Remodelling assets and Continuous quality improvement and local initiatives and opportunities.

- Our approach to delivering the changes is described including embedding continuous quality improvement and engagement to improve care.

- Service re-design work is ongoing across many districts and for a range of services including outpatients, out of hours and Rural General Hospitals. Local regional and national collaboration will be required to develop solutions for some services.

- As the changes become embedded the number of facilities we require will reduce as well as the workforce.

- Although NHS Highland is well placed to deliver the new approaches this will be challenging. The biggest hurdle is how best to speed up the pace of change while at the same time taking staff, communities and partners with us. Key points underpinning the case for change are summarised (Box1).
Box 1 Summary of key points underpinning the case for change

1. People are living longer and will require more support from the health and care systems
2. 30 per cent of the population are living with one or more long term conditions
3. Two per cent of the population use 50% of the total resource and spend per person differs markedly between areas
4. There is a difference of 15 years in life expectancy across parts of Highland highlighting current inequalities
5. Every day patients are medically fit to leave hospital in-patient care but there are currently 135 delayed transfers of care (March 2017) highlighting the need to make changes in where we invest resources
6. Our models for Rural General Hospitals, Community Hospitals, Out-of-Hours, Out-patients are not as clinically safe as they could be nor are sustainable without marked changes
7. The care home sector is struggling to meet increasing demand and complexity of need
8. Many of our services are very fragile due to workforce issues linked to recruitment and retention including GPs, general surgeons, some consultant specialists, Allied Health Professionals, midwives and care at home workers
9. Local health and social care services (as well as local authorities) are under severe financial pressures and will not be able to deliver statutory requirements unless there are significant and rapid changes.
10. Over the next three years it is estimated that NHS Highland will need to reduce costs by £100 million with around £47 million in 2017/18 (around 7% of the annual budget).
1. Introduction to our Plan

Across the country - and beyond - the challenges to bring in better ways of working and new models of care that are sustainable from both a staffing and financial viewpoints are significant. Here in Highland we also face some additional pressures due to the remoteness and rurality of some of our communities, plus we have a higher proportion of older people. Many of our communities are, therefore, fragile. As an important partner in maintaining the social and economic vibrancy, concerns around health service quality or service changes can, and do, generate considerable attention from communities, local and national politicians as well as staff.

While there appears to be a general understanding and acceptance that the models of care have to change, there are differing views on what and where these changes should be. In addition it is clear that significant gains across a £800 million budget can be achieved through continuous quality improvement. The biggest challenge is how best to speed up the pace of change while at the same time taking staff, communities and partners with us.

This plan sets out our commitment to continue to transform care and the ways we manage our ‘business’ to deliver the best possible outcomes for the people of Highland and Argyll & Bute. Our transformational journey includes working in ways which deliver continuous quality improvement. In terms of models of care we continue to move towards more people being cared for at home which will be delivered through a combination of prevention and anticipatory care, better use of technology and developing and embedding more community capacity. It will also need to be a collaborative approach, working with our statutory partners, voluntary and third sectors as well as our staff and local communities. Clearly, wider work delivered through Public Health, Primary Care, Dental and Children’s services are ongoing, and will further shape improved outcomes in the longer term.

The vision to deliver better health, better care and better value was adopted by the board on 3rd February 2015 and has not substantially changed. This three year approach and plan, therefore, builds on progress to date and further describes actions to deliver safe, sustainable, integrated and affordable care. Our strategic direction of travel is underpinned by seven initiatives which will direct the necessary changes and reform required over the next three financial years (Figure 1).
Figure 1 Summary of seven strategic high level initiatives and associated spend and savings requirement in 2017/18

- Adult care
- Flow
- New models of care
- Realistic medicine
- Drug costs
- Remodelling assets
- Quality Improvement, Local Initiatives and Opportunities

Safe, effective and quality of care
£47 million savings (minimum)

Safe, effective and quality of care
£800m spend
Breakeven
Delivery of TTG
2. Strategic Context

• National Context

The Scottish Government’s 2020 vision, published in 2010, articulated the ambition of “Safe, effective and person-centred care which supports people to live as long as possible at home or in a homely setting.”

This vision was supported by the Healthcare Quality Strategy 2012, which called for accelerated quality improvement to ensure that care is person-centred, safe and effective.

While these strategy documents remain the central vision for the Health Service in Scotland, four reports published in 2016 further strengthen the strategic direction and describe a compelling case for change: Realistic Medicine - The Chief Medical Officer for Scotland’s Annual Report for 2014/15, published in January; The National Clinical Strategy for Scotland published in February; Audit Scotland ‘NHS in Scotland 2016 (October 2016) and most recently the Health and Social Care Delivery Plan by the Cabinet Secretary for Health and Sport published in December.

In particular, the Health and Social Care Delivery Plan sets out the transformation required for health and social care to make care and services sustainable for the future. The plan is designed to help address the combination of rising demand being faced by health and care services, the changing needs of an ageing population, increasing costs, staffing pressures and unprecedented financial challenges. The new GP contract due in April 2017 is also proposing significant change. The strategic direction is all around increasing more resources to primary and community care.

• Overview of Highland Context

NHS Highland is committed to providing high quality, effective care to the population of the Highlands in a safe, efficient and person centred way. This was initially set out in August 2014, when the board endorsed “The Highland Care Strategy: NHS Highland’s Improvement and Co-production Plan”.

The Care Strategy outlines NHS Highland’s vision for the future delivery of health and social care services for the people of Highland over a ten year period and set out a number of goals including:
- Provide services and facilities which meet 21st century health and social care needs and are acceptable to both staff and patients;
- Provide high quality, integrated and cost-effective services;
- Reduce waste and inefficiency across services; and
- Ensure services are sustainable.

The requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the Act”), which puts in place the framework for integrating health and social care, places a duty on Integration Authorities to develop a “strategic plan” for integrated functions and budgets under their control. Since April 2016 services are planned through two health and social care partnerships, working with two local authorities (Highland Council and Argyll and Bute Council) – see further in Section four.

- **Profile**

NHS Highland is the largest and most sparsely populated Scottish Health Board area, covering 41 per cent of the country’s landmass. We provide health and social care services to our resident population of 320,000. Our diverse area includes Inverness, one of the fastest growing cities in Western Europe and 36 populated islands - 23 in Argyll & Bute in 2011 and 13 in Highland (excluding Skye connected to the mainland by a road bridge).

The shape of our changing population, age, distribution and deprivation was described in our 10 year plan (under section 4 of that report). The number of people aged 65 years or over is expected to increase by 17,000 in NHS Highland area between 2014 and 2025 to 26 per cent of the total population (Figure 2).

---

1 Since 1st April 2012, health and social care in the Highland region has been formally integrated with NHS Highland the lead agent for the delivery of adult services across health and social care and the Highland Council the lead agency for children's services
2 In Argyll & Bute an Integrated Joint Board between NHS Highland and Argyll and Bute Council was established on 1st April 2016
In 2015 about one in twenty people in Highland are aged over 80 years old, but by 2035 this figure will be over one in ten.

The general epidemiological picture in NHS Highland is similar to that nationally and is one in which adult mortality predominates and chronic and degenerative diseases are the most common form of morbidity (Figure 3).

Multi-morbidity is already very common and continued population ageing will mean that there will be a rising demand for the prevention and management of multi-morbidity rather than of single diseases.
Figure 4: Number of chronic disorders by age group in patients registered with 314 Scottish General Practices

Figure 4 highlights that the majority of patients over 65 have two or more conditions and the majority of over 75s have three or more conditions. More people have two or more conditions than only have one.

Data source: Scottish School of Primary Care’s Multi-morbidity Research Programme Slide Pack.
In our ten year plan we also described diffuse settlement patterns emphasising the challenges in delivering health and social care to a widely spread out and in some cases low population density. Despite the often popular image of a rural idyll, deprivation, fuel poverty and inequalities also affect many parts of the population of the area. As shown in Figure 5 some people living in the most deprived areas of NHS Highland will experience life limiting health problems 20 years earlier than people living in the least deprived areas.

Figure 5: NHS Highland population with day to day activity limited a lot by longstanding health problem or disability by age in the most and least deprived deciles of multiple deprivations
In many parts of Highland, the NHS and other public sector agencies are major employers, and changes to services can impact on socially and economically fragile areas (Figure 6).

As an important partner in maintaining the social and economic vibrancy of the areas, concerns around health service quality or reduction in service changes can generate considerable attention from communities, local and national politicians as well as staff. Any such change therefore needs to be carefully thought through and managed. It will be important to demonstrate what safe and sustainable options were considered prior to making changes.
• **End of Life and Place of Care**

Another key piece of contextual information relates to end of life care and place of care. Providing greater choice including more people to be supported at home has been a theme that has been debated through our various consultations on redesigns. It is clear however, that we are not meeting the needs of many people with 71% people dying in institutional care (hospital, care home or hospice) vs 29% dying at home. Yet almost two thirds (63%) said they wished to die in their own home (Figure 7).

**Figure 7 End of life care - place of death in NHS Highland**

Where people die in NHS Highland and end of life care choice
The historical trend in Highland is for the majority of people to die in hospital and with deaths in care homes steadily rising (Figure 8).

**Figure 8 End of life care - place of death in NHS Highland**

Number of deaths by place, NHS Highland residents
Financial context

Whilst NHS Highland is anticipating a small cash uplift to its baseline in 2017/18 equivalent to 1.5% (of which 1.1% is for social care and 0.4% is for health). Cost pressures such as the Living Wage in the social care sector and the increasing cost of acute medicines plus inflation far outweigh the uplift. In addition there are underlying cost pressures (most notably in North West Highland and Raigmore Hospital) that largely reflect the difficulty in sustaining the current models of care (see below). These challenges have necessitated a requirement to carry over, from 2016/17 an estimated at £13 million of savings, made through non-recurring initiatives. Clearly this has further exacerbated the financial challenges for 2017/18. Anything to reduce that will have a benefit going forward.

Therefore, a savings target of £47 million is required in order to deliver breakeven this financial year (2017/18) (7.9 per cent of NHS baseline or 7 per cent if the funding for Adult Social Care from Highland Council is included as effectively part of the baseline). Of this it is estimated that £43.5 million is a recurrent target and £3.5 million non-recurrent.

This target is considerably higher than 2016/17 which has been our most challenging year (Table 1). Moreover, some of the £28 million savings achieved in 2016/17 to deliver financial breakeven resulted in some patients waiting for new out-patient appointments and surgery in excess of the specified government-defined waiting time guarantees. This position was largely replicated across Scotland. NHS Highland sought to prioritise and maintain treatment times for emergency and urgent care which includes A&E waits and cancer treatment times. Maintaining waiting times for some specialities has been a challenge for a number of years Historically, we addressed this by costly waiting times initiatives which did not address the root cause of the problem which is partly due to shortage of consultants in some specialities, and growing demands.

<table>
<thead>
<tr>
<th>Table 1 Summary of savings delivered/forecast by financial years: 2014/15 to 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings delivered/forecast</td>
</tr>
</tbody>
</table>

Over the course of the next three financial years an estimate of £100 million will be required to be reduced from our overall expenditure.
3. The Case for Change: Why our health and care model is unsustainable?

The *Health and Social Care Delivery Plan* by the Cabinet Secretary for Health and Sport published in December 2016 highlights the urgent need to address the rising demand being faced by health and care services, and the changing needs of an ageing population across Scotland.

As described in our “The Highland Care Strategy: NHS Highland’s Improvement and Co-production Plan” (2014) and ten year plan (2015) this is not a new situation for Highland. However, what is different is that the scale of the financial pressures and the pace of change now required is unprecedented.

The combined impacts of our ageing population, reduced workforce, problems with recruitment, financial pressures mean that the way we provide health and social care has to urgently change. Despite the best efforts of staff the current ways of working are not matched to future requirements and the way our systems are organised are very inefficient and historic (Box 1).

<table>
<thead>
<tr>
<th>Box 1 Summary of the Case for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People are living longer and will require more support from the health and care systems</td>
</tr>
<tr>
<td>2. 30 per cent of the population are living with one or more long term conditions</td>
</tr>
<tr>
<td>3. Two per cent of the population use 50% of the total resource and spend per person differs markedly between areas</td>
</tr>
<tr>
<td>4. There is a difference of 15 years in life expectancy across parts of Highland highlighting current inequalities</td>
</tr>
<tr>
<td>5. Every day patients are medically fit to leave hospital in-patient care and there are currently 135 delayed transfers of care (March 2017) highlighting the need to make changes in where we invest resources</td>
</tr>
<tr>
<td>6. Our models for Rural General Hospitals, Community Hospitals, Out-of-Hours, Out-patients are not as clinically safe as they could be nor are sustainable without marked changes</td>
</tr>
<tr>
<td>7. The care home sector is struggling to meet increasing demand and complexity of need</td>
</tr>
<tr>
<td>8. Many of our services are very fragile due to workforce issues linked to recruitment and retention including GPs, general surgeons, some consultant specialists, Allied Health Professionals, midwives and care at home workers</td>
</tr>
<tr>
<td>9. Local health and social care services (as well as local authorities) are under severe financial pressures and will not be able to deliver statutory requirements unless there are significant and rapid changes.</td>
</tr>
<tr>
<td>10. Over the next three years it is estimated that NHS Highland will need to reduce costs by £100 million with around £47 million in 2017/18 (around 7% of the annual budget).</td>
</tr>
</tbody>
</table>
While in many cases the money is not the primary driver, it is now an increasingly critical factor. The Revenue position for 2017/18 and beyond requires a cash releasing target that is unprecedented for NHS Highland. Moreover, Raigmore Hospital and the North & West Operational Unit overspent their budgets in 2016/17 highlighting that the current clinical and financial models are not sustainable.

The pressures facing Raigmore Hospital have been long-standing. They are numerous and complex and reflect the position across the country in terms of acute hospital pressures, rising demand, waiting times, increased specialisation and rising drug costs. The hospital also at times struggles to discharge patients in a timely manner resulting in an overreliance of expensive acute beds and services, and delays for patients. Changing this requires taking actions both in the hospital and across community services to make sure patients are better able to flow through the system by getting rid of any delays.

In North and West there are extreme pressures including due to the inability to recruit to, sustain or afford historical models of care for Rural General Hospitals, Out of Hours and, in some parts, Primary Care resulting in exorbitant locum costs. There are also a number of small care home units which are not viable. While most keenly felt in North and West, these are challenges increasingly being felt in Argyll and Bute, as well as elsewhere across the country.

NHS Highland also faces the additional challenges of how to best provide specialist support to all of our communities. While outreach models support our desire to deliver as much care as close to home as possible, our current reliance on face-to-face consultations make either this expensive to deliver or delivered via unpopular centralised models. In some cases centralisation is necessary for safety considerations.

It is clear that some difficult decisions and choices need to be made and understandably this will cause concerns if people don’t understand or accept the case for change.

It is within this context that the £100 million reduction in costs over the next three years must be considered.
4. Our Approach

In considering these challenges the board has had to consider how to re-design care, services and ways of working to ensure we deliver safe, quality care services that are also sustainable and affordable.

It is clear from the scale of the financial challenges faced in 2017/18, and beyond, that the current models of care are unsustainable. This will be a major challenge and a ‘more of the same approach’ will not deliver the scale of change required. There needs to be a radical shift to embedding more permanent cost effective models of care.

One example the Health and Social Care Delivery Plan outlines is the requirement for more investment in the community services to allow more people to stay at home, whilst not continuing to grow the acute sector. This remains a fundamental goal of our strategic plans. The lack of bridging funds to double-run to can present a difficulties for some of the changes required and so it will be important to have effective and credible transitions plans in place.

- Remodelling of Assets including ‘Major’ Service Change

The reconfiguration of the footprint and associated staffing models is ongoing. Where the changes were considered to be major, formal public consultation has been required. The main drivers for these major change are that our current dispersed models of care, significant back-log maintenance, and workforce challenges are not sustainable. Many of our assets are also not strategically located and this also needs to be addressed. Guidance on what is deemed major service change has been provided by the Scottish Health Council and is also discussed with Scottish Government and the Board. Changes required on grounds of safety do not require formal public consultation.

- Quality Improvement and Marginal Gains: Reducing Waste and Inefficiencies

It is easy to overestimate the importance of making ‘big’ decisions yet underestimate the value of making better decisions on a daily basis. A one per cent improvement on everything aggregates up to important gains and equally one per cent deterioration leads to significant increases on demand, harm and so on. So a daily focus on high volume, every day activities is critical and forms a key part of our approach. The key benefit is these are within our control and don’t require lengthy consultation processes. As we go on to illustrate later, a closer look at how we manage service users who require significant levels of care will impact significantly on spend and fits within the wider context of realistic medicine.
Our partnership with the Virginia Mason Medical Centre since 2012 has been productive and has helped us to shape our approach. They are a world leader in delivering safe, high-quality health care. Their experience is that, on average, there can be in the region of up to 30 per cent waste in healthcare systems (Berwick and Hackbarth, 2012). They began implementing their system in 2002 and since then they have been able to deliver higher quality healthcare with significant cost savings in particular services.

NHS Highland has steadily built capability and capacity (and this is ongoing) to deliver effective solutions for the removal of waste, harm and unwanted variation in practice. We now have many of our own examples of areas of improvement to increase capacity, to improve flow and reduce costs and this offers significant potential for making recurring savings, year on year.

While Lean and quality improvement tools, including through the Scottish Patient Safety Programme, have been effective, it is the spread of these initiatives across the organisation which will have maximum impact and influence the marginal gains.

To create sustainable improvements the challenge is how best to integrate work on quality improvement into the organisation’s daily work, while keeping the service functioning. The move to daily management with the support for the implementation of daily huddles, production boards, visual control and 5S to reduce, for instance, unnecessary stock levels and the application of standard work will further embed this approach across all of the business.

- **High Level Value Streams**

The development of high level value streams has allowed the co-ordination of work across key organisational objectives to transform adult flow, out-of-hours and out-patients. All three value streams have pursued initiatives which will result in new models of care, improve reliability and reduce costs. They will continue to form part of our ongoing delivery plans.

- **Regional Working and Wider Collaborations**

The Health and Social Care Delivery Plan sets out a clear expectation that Boards will collaborate across regional areas in an attempt to deliver care more safely, effectively and sustainably. Our three year plan will take full cognisance of the North of Scotland Regional Clinical Strategy 2017-2022 which is due to be signed off by Boards between June to September 2017.
The case for change to regional working was considered by the Board in May last year. There are a number of services across the North of Scotland area where more effective services could be delivered through a regional approach including Radiology, Urology, Oncology, Maxillofacial services, Upper GI and Diabetic Foot Network. Collaboration will also be required across elective centres and out-of-hours and will be underpinned by appropriate eHealth and workforce strategies and plans. We will also need to develop, with the Scottish Ambulance Service and others, plans to deliver robust infrastructure for the transport of patients to the most appropriate points of care. This will need to also consider any support for people who need to travel for more specialist care. National working in line with the ‘Once for Scotland’ shared service models will also need to be considered.

Within Highland it will be important to sustain core services at Raigmore District General Hospital in Inverness, as well as the strategic clinical necessity to provide services from our three rural general hospitals located in Wick, Fort William and Oban. It will be increasingly important to ensure that clinical services are planned and delivered across the wider Highland and Island area in order to make the training and jobs attractive. This will require close working both with other providers and local universities. Close working with Scottish Ambulance Services is also required for planning, redesign and delivering services.

- **Working with local authorities and our other partners**

NHS Highland has been fully integrated in the North Highland area for five years through the creation of the Highland Health and Social Care Partnership in April 2012. In Argyll and Bute, the Integrated Joint Board was established in April 2016.

Our approach has been to have the whole of the care system to be within one finance, management and governance arrangement, thus allowing the maximum opportunity to vire resources from one sector to another to meet needs. In North Highland we have taken this a step further and integrated health services through the creation of the Inner Moray Firth Operational Unit which includes all health and social care services (eg Acute, Community, Primary Care and Adult Social Care under one Director of Operations.

The different partnership arrangements mean that children’s service are managed differently in Highland and Argyll and Bute. However under both model the board seeks to ensure that children and young people to have the best experience of growing up and have a good experience of health and well being into adulthood and through to the older years. Investment in the early years has demonstrable benefit across the life course, with growing awareness of the window of opportunity presented in adolescence to take stock of life experiences to date, and further enhance health and well being.
The Lead Agency Model for integrated services in North Highland involves Care and Learning Highland Council delivering a range of commissioned health services on behalf of NHS Highland. Medical and community paediatrics, inpatient paediatrics and Tier 3 and 4 Child and Adolescent Mental Health Services are provided by the Highland Health and Social Care Partnership.

Within Argyll and Bute, a similar range of health services for children and young people are provided through the Integrated Joint Board. Greater Glasgow and Clyde provide in patient care and acute/community paediatrics.

NHS Highland spends a minimum of £65 million on children and young people. In the last few years year additional funding has supported increases in Health Visitor numbers the Family Nurse Partnership and Child and Adolescent Mental Health Services. There are also notable cost pressures with regard to an increase in need for home ventilation, peg feeding/ home parenteral nutrition.

Work streams are orientated around the well being indicators that children and young people are safe, healthy, active, nurtured, achieving, respected and included. Cross cutting themes include consideration of age and stage, workforce, training and skills development, improvement and quality and engagement and consultation with children, young people and their families.

As reflected throughout this report both Local Authorities and NHS Highland face financial pressures and priorities for the years ahead will require consideration of savings and new ways of working. Within integrated models there are opportunities to align services, create different service models and add value to journeys of care.

Integrated Service Planning in Highland and Argyll and Bute brings the key services together. Argyll and Bute are in the process of developing a new integrated plan (2017-2020) and in Highland planning for the next plan (2018/21) will take place over the next year.

NHS Highland fully supports the developments in Community Planning that bring together the Public Bodies (Joint Working) (Scotland) Act 2014 with the Community Empowerment (Scotland) Act 2016 and the 2013 guidance on Community Learning and Development. The strategic partners across the area – Highland Council, Argyll and Bute Council, NHS Highland, Police Scotland, Fire and Rescue Scotland and Highlands and Islands Enterprise - have in place a practical planning framework with colleagues across the third and independent sectors to develop community partnerships where community engagement and co-production can happen more effectively.
The revised arrangements are focussed on developing plans and effective priority setting to improve outcomes for communities. They should also enhance resilience, sustainability, and efficiencies across public sector services.

We are work closely with a wide range of partners including The Highland Hospice, Marie Curie, Macmillan, Alzheimer Scotland and others. We also believe we have also enjoyed much closer working with third and independent sectors. One example is the introduction of the Living Wage for the independent care-at-home sector which has supported a transformation of the delivery of care at home. This is one example of how innovative thinking and collaboration can delivery both better quality care but at lower cost. Similarly, our collaboration with Albyn Housing Society and Carbon Dynamic in the ‘Fit Homes’ project is also bringing new solutions to long standing problems which will further help to support our new models of care.
5. Analysis of Spend and Costs

A high-level summary of how NHS Highland spends £800milion by category (Figure 9) and Unit (Figure 10) is set out below.

![Figure 9 Analysis of £800m Spend by Category](image-url)
Figure 10 Analysis of £800m spend by Unit

- Raigmore: £170m
- S&M: £200m
- N&W: £150m
- A&B: £250m
- Corporate: £50m
- Facilities: £30m
- Tertiary: £20m
- Others: £40m
The costs in Table 2 also illustrates indicative costs in different settings. The key point to note is it neither makes sense from a care point of view or costs to have someone being looked after in a higher level of care than they require.

**Table 2 Indicative costs associated with places of care**

<table>
<thead>
<tr>
<th>Place of care</th>
<th>Cost per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>District General Hospital</td>
<td>£3,500</td>
</tr>
<tr>
<td>Rural General Hospital</td>
<td>£4,200</td>
</tr>
<tr>
<td>Community Hospital</td>
<td>£2,500</td>
</tr>
<tr>
<td>NHS Highland Care Home</td>
<td>£1,000</td>
</tr>
<tr>
<td>Private Care Home</td>
<td>£649</td>
</tr>
<tr>
<td>Care at Home</td>
<td>£200</td>
</tr>
</tbody>
</table>

The costs per cases also varies enormously across our health and social care systems such as for out of hours, Care Homes and Primary Care highlighting the further challenges of sustaining remote and rural health and social care. Maintaining reasonable access is a priority whenever possible is a priority but it comes with a cost in part linked to low volume, current models and staffing challenges.

- **High Resource Individuals**

Health and social care resources are not utilised evenly across the population and by understanding more about the cohort of individuals who account for any disproportionate spread of resource could allow for more effective planning and delivery of services and an improved service user experience. Information Services Division (ISD) has undertaken cost per patient analysis on various inpatient and day-case hospital admissions to support Health and Social Care Partnerships in deepening their knowledge of High Resource Individuals.

High Resource Individuals are classified by calculating the total expenditure for an individual service user during a financial year. Health costs incurred across a range of services are all taken into account when identifying a high resource individuals including: acute inpatient and day-case activities; geriatric long stay; mental health; maternity activity; new consultant-led outpatient attendances; accident & emergency and community prescribing. The total costs for individuals are ranked in order of total resource
consumption and those who have the highest individual costs and make up the top 50% of total expenditure have been defined as High Resource Individuals.

During the financial year, 2013/14, Highland Health & Social Care partnership (H&SCP) provided health care for 4,121 HRIs which equates to 2.2% of Highland’s overall population. The accumulated expenditure for HRIs was £112.6M over the same time period equating to 50% of the total health care costs for Highland H&SCP (Table 3). Costs per person for HRIs ranged from £10,590 to a maximum of £394,766 with an average cost of an HRI was £27,329 compared to an average cost of £89 for a lower cost individual. This is pattern of spend is not specific to Highland.

Table 3 Highland H&SCP: HRIs breakdown by Population and Expenditure, 2013/14

<table>
<thead>
<tr>
<th>H&amp;SC Partnership</th>
<th>Number of HRIs</th>
<th>% of Population</th>
<th>Total HRI Cost (£)</th>
<th>% of Total Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highland</td>
<td>4,121</td>
<td>2.2</td>
<td>112.6M</td>
<td>50%</td>
</tr>
</tbody>
</table>
6. Developing Our Three Year Quality and Sustainability Plan

- Overview

NHS Highland has embarked on a high profile and impactful transformational programme which has maximised a wide range of quality improvement, service redesign and staff engagement tools and techniques.

In this section of the document, initiatives identified for 2017/18 are themed under seven main headings: Adult Care; Flow; New Models of Care; Realistic medicine; Drug Costs; Remodelling Assets and Continuous Quality Improvement, Local Initiatives and Opportunities.

In reality, trying to summarise the initiatives and actions in a linear way is inevitably artificial as the various themes are inter-linked. However, there are distinct elements in each of the initiatives and describing these should help to illustrate how the complex jigsaw of health and social care starts to fit together. Inter-dependencies are considered in detail by the operational units to ensure that the changes are delivered in a balanced way to support overall improvements and efficiencies. These initiatives reflect the board’s strategic direction as set out in our 10 year operational plan. Detailed Actions Plans for each Initiative are being prepared and the underpinning workstreams are briefly described in this section:

- Adult Care

One of the fundamental decisions underpinning the plan is predicated on further implementing an integrated care model that is significantly less reliant on hospital and institutional bed-based care. The changes we are proposing will result in further reduction of acute, community hospital and care home beds across Highland and Argyll and Bute.

Actions will be taken to invest in greater 24/7 provision in community and home-based settings and associated technologies resulting in beds no longer being required. Work will also be required to enhance support and empower people, their carers and local communities to take a more pro-active role to support people to be more independent and keep people well. It will see a focus on delivering high quality ‘end of life’ care. Two key metrics for this workstream are to support a reduction in emergency hospital admissions and an increase in the percentage of people who chose to die at home.
• Adult Flow

Improving patient flow through our hospitals will support safer and more effective care. Actions will include a move to more senior decision support, new triage and ambulatory care approaches and more effective discharge planning. These actions will support reduction in length of stay and shorter waits in Emergency Departments. The combination of this workstream and adult care will support much more efficient ways of working in hospital settings and reduce many of the current defects in our systems across both elective and emergency care pathways. A key measure will be a reduction in length of stay.

• New Models of Care

New clinical models of care are underway and include transforming out-of-hours, out-patients, maternity services, Rural General Hospitals, Primary Care and Cardiac Rehabilitation. Adult care and flow will also be supported by some new models. Many of the new models will see less reliance on doctors, fewer face-to-face interventions and less hospital-based care. Key measures will be less reliance on locums, fewer return hospital out-patient appointments, better use of the clinical estate supporting a reduction in the the number of buildings we require.

• Realistic Medicine

This workstream perhaps offers the greatest challenges but biggest benefits in terms of delivering more person-centred care. The Chief Medical Officers’ Annual Report on Realistic Medicine (published in February 2016), followed up with Realising Realistic Medicine (February 2017), clearly set out the need to reduce the burden and harm that patients experience from over-investigation and overtreatment. The importance of the need to reduce unwarranted variation in clinical practice to achieve optimal outcomes for patients and how to prevent waste is highlighted. As more realistic medicine is delivered it will bring a move towards more shared decision making and that will require more realistic conversations. Realistic Medicine captures all elements of our Highland Quality Approach. Actions will include implementing new models for consent and creating time to discuss choices with patients and their families. The sole driver for this initiative is to improve quality albeit there will be potential implications for costs by reducing waste, harm and unwanted variation. This part of the plan, however, will not have financial costs attributed to any actions.
Investment in medicines represents one of the most costly outlays in health care, often second only to staff costs. Over 10 per cent of NHS Highland’s expenditure is on medicines. Medicines, of course, also bring significant benefit to patients and to society at large. For instance, NHS Highland allocates a significant resource to paying for drugs to prevent or delay blindness in patients with macular degeneration. Early work in Edinburgh showed that the number of individuals being registered as blind had fallen by over 50 per cent in an early treatment cohort.

Alongside this it is important to set the overall cost of access to new and existing medicines. It is Scottish Government policy to increase access to new medicines. A proportion of the cost of these new medicines has been offset by the New Medicines Fund (NMF). It is estimated that across Scotland the NMF meets about half the cost of the new medicines covered by the policy. The new access to medicines policy requires the Scottish Medicines Consortium (SMC) to apply new acceptance criteria to medicines for rare and ‘end of life’ conditions. Health Boards are also required to make available medicines if a clinician believes the patient will benefit, even where the SMC has not accepted the medicine for routine use in Scotland. This places significant pressure on the Secondary Care drugs budget. NHS Highland in common with other Health Boards has seen an average rise in costs of around 15 per cent per annum for the last five years.

Primary Care drug costs are also on the rise albeit at a lower rate. Whilst the individual medicines prescribed are cheaper than in Secondary Care they are prescribed in significantly greater volume. The cost pressures associated with Primary Care drug costs are mainly around an aging population that requires more medicines and fluctuation in market prices that affect the cost of medicines on the Scottish Drug Tariff. The number of items prescribed per patient is levelling off thanks in part to initiatives like ‘polypharmacy’. The cost of some routine and long established medicines, e.g. metformin and co-codamol, can rise steeply with little warning. Few medicines are made in the UK and, therefore, medicine supply and costs are subject to influence by international factors including fluctuations in exchange rates and changes in demand. The UK Government has announced plans to tackle excessive profit-making from companies that buy up the rights to old medicines and then increase the price significantly.

The impact on medicine prices of a weakened Sterling is hard to predict with any accuracy. However, it is reasonable to assume that it won’t lead to a fall in the prices of medicines.

There are a large number of ongoing initiatives in NHS Highland that aim to reduce unnecessary costs associated with medicines. In Primary Care this includes reducing waste, increasing the number of polypharmacy reviews in General Practice, reviewing the
prescribing of high cost medicines and patients whose medicine costs are high, reviewing the prescribing of oral
nutrition supplements, arranging for some high cost medicines to be dispensed via community pharmacies, increasing the rate of
generic prescribing and reviewing the prescribing of medicines to patients in nursing homes. Board leadership will be required
around some of these initiatives especially where there might be a requirement to stop the prescribing of medicines of no, or very,
low value.

Where they are available these changes will be led by advanced pharmacists in General Practice in line with Scottish Government
Policy ‘Prescription for Excellence’. Where available these staff will generate medicines efficiencies in a similar manner to those

In Secondary Care, ongoing work will focus on efficient distribution and recycling of medicines, increased use of patients own
medicines, reducing inventory, and greater pace of switch from originator to biosimilar products. This work is all in line with
recommendations in the Carter Report. These initiatives will be led by the clinical pharmacists in Raigmore Hospital.

Nationally, Highland plays a lead role in the Effective Prescribing Programme and new initiatives from that programme have, and
will be, introduced as they arise. As an example, work is almost complete on an initiative that will save NHS Highland around
£200K per annum on melatonin prescribing in sleep disorders.

- Remodelling Assets

With new models of care becoming embedded, attendance at out-patients, admissions and length of stay will reduce in both
hospitals and care homes and so the need for beds will also reduce. This provides opportunities to enhance community and home
based services. In turn this will allow us to remodel our assets to reflect the reduced need for number of beds required as well as
hospitals or in-patient facilities. It will also be important to make sure that we make best use of all of our clinical space and align it to
best fit patient flow and clinical requirements. The board has already approved major service redesigns in Badenoch and
Strathspey, Skye, Lochalsh and South West Ross, the North Coast (Sutherland), and the development of the elective centre and
critical care upgrade in Raigmore Hospital. All these have implications for remodelling our assets.

Work is also ongoing to remodel office space and space in Rural General Hospitals, Mental Health Units, Care Homes, and Day
Care Services to ensure only medical care is delivered from our hospitals. Many of these projects are well advanced and will come
to conclusion during this three year plan. Opportunities to accelerate some of the changes may also need to be considered. Key
measures will be a reduction in our foot-print and clinical space being used for clinical services. As mentioned earlier, many of our assets are also not strategically located and there are overall benefits of making sure our assets are aligned to reflect the current and future transport networks; IT and changing settlement patterns.

- **Continuous Quality Improvement, Local Initiatives and Opportunities**

NHS Highland also has a good track record of delivering significant financial savings and reducing costs from continuous quality improvement and local initiatives and opportunities. This will include everyday improvements linked to daily management and Rapid Process Improvement Workshops to specific initiatives around procurement, vacancy management and a move to more shared services.

Plans are also being prepared to support a significant scaling up of the implementation of continuous improvement methodologies across the organisation. This will build on our examples of successful improvements including, for instance on the reduction in falls in hospital and the new approach being tested through Lean accounting at ward level.
6. Supporting Strategies

• **Workforce**

People strategy is a key element of the Highland Quality Approach. The workforce challenges alone are significant drivers requiring us to urgently remodel our care, create new roles and new ways of working. Some of the solutions will require regional and national approaches, as well as local innovations.

Although our workforce is ageing we have seen over the last three years an increase in the number of employees in the lower age bands. For the past two years or so sickness absences has been around 5 per cent and consistently slightly lower than the Scottish Average (5.15 vs 5.23).

Annual turnover as at 31 December 2016 was 10.7 per cent but showing significant variation, ranging from 24 per cent (medical support) and 23 per cent (medical) to less than 10 per cent for Administrative Services, Dental, Nursing and Senior Management. Our overall turnover rate is higher than the national average (6.2 per cent).

In terms of vacancies there were just over 500 posts vacant equates to 6.2% of our filled possess at December 2016 again with significant variation. There are particular challenges for some staff groups including GPs, midwives, care at home, radiologists, health care scientists, sonographers and some allied health professionals.

Our latest workforce strategy was endorsed by the Board in August 2016 and annual updates are provided as part of Local Delivery Planning Process. A range of workforce plans are in place or being developed including:

- Increased flexibility in the workforce
- Work towards seven day working for some clinical staff to enhance senior decision making at week-ends
- Develop and strengthen new roles such as Health and Social Care Support workers
- Expansion Advanced Practitioners including Nurse Practitioners and Pharmacists working in GP Practice
- Consideration of adopting shared services
- Alignments of workforce to new models of care
- Development of new employment routes such as apprentice roles and developing the young workforce
• Development of a Care Academy
• Collaboration with partner organisations, locally, regionally and nationally

Developing community resilience approaches and providing support to develop support for First Responders will also impact on the workforce. Through our Research, Development and Innovation Department opportunities for recruitment and retention of all levels of staff will be created.

• Asset Management Strategy

Many of our assets are not strategically located or aligned to new models of care, infrastructure (roads, technology, changes in clinical models and practice and so on). We, therefore, need to look at many things afresh and consider whether the location of our assets (people, buildings, equipment) make sense today and are right for the future.

Our rolling five year Asset Management Strategy published in August 2015 is ambitious and will transform the assets we deliver health and social care from right across Highland and Argyll & Bute. Our assets are being re-shaped to underpin our new models of care. We continue to drive forward the work to deal with backlog maintenance and to renew our infrastructure, equipment and other assets.

There has been, and continues to be, significant community and staff engagement about any changes and in particular around any changes to location of buildings. Notably while there is strong consensus for the new models of care to look after more people at home there remains strong association with buildings and even space within buildings. This is an important consideration because it can be a significant factor dictating the pace of change and the capacity to deliver and execute changes.

The Integrated Joint Board does not have a budget for capital and so any capital requirements need to be considered by the Board. While NHS Highland run adult social care services, in the Highland Council area, the Council own the buildings and are responsible for the upkeep and replacement as required.

• e-Health

Our eHealth Strategy is aligned with NHS Highland’s corporate objectives and the National Strategy. Key aims are:
• enhance the availability of appropriate information for healthcare workers to communicate information effectively to improve quality.
• support people to communicate with NHS Highland to manage their own health and wellbeing, and to become more active participants in the care and services they receive.
• support people with long term conditions.
• improve the safety of people taking medicines and their effective use.
• provide clinical and other managers across the health and social care spectrum with the timely management information they need to inform their decisions on service quality, performance and delivery.
• maximise efficient working practices, minimise wasteful variation, bring about measurable savings and ensure value for money.
• contribute to innovation occurring through the Health Innovation Partnerships, the research community and suppliers

A Regional eHealth Strategy is also being developed by the North of Scotland Planning Group which will reflect the need to better integrate services. Areas will be mapped to identify where technology can better support remote decision making for clinicians and where remote contact with patients and service users can add value for individuals and communities. There will need to be an ongoing programme to prioritise investment in technology.

Immediate priorities for NHS Highland are to fully develop an integrated Electronic Patient/Person Record to replace existing paper records and to provide Equity of Access to Systems and Services including to ensure NHS Highland users have access to modern technology to support care to patients/persons.

• **Research, Development and Innovation**

Our principal aims are to bring equity of access to Research, Development and Innovation (RD&I) activity to the entire population of the Highlands and Islands. The RD&I department supports a variety of studies which range from cancer drug trials to the deployment of new technological innovations in health and social care. They support core NHS activity by seeking to solve some of the major challenges that the organisation faces on a daily basis.

They offer expertise to solve problems and are the key link between the NHS, the academic sector and commercial partners. Increasingly the RD&I team will engage with small and medium-sized enterprises (SMEs) to form partnerships with the NHS which
help create new solutions for our challenges. Staff support the health department with a pipeline of innovations and products that could be helpful to the organisation.

One of the main pillars of our current strategy is to support the health and social care service by developing innovative models of efficient and sustainable care for our citizens. Specifically, we are supporting projects that encompass remote clinical decision support and home consultation. Another of our principal aims is to ensure that our RD&I activity is distributed across all sectors of our workforce and geography.
7. Communication and Engagement

A key enabler to support Realistic Medicine must be to get better shared decision making. To achieve this needs clinicians to be supported to have the time to have the necessary conversations with patients, carers and families. Overall, more work needs to be done to raise awareness with the public about their choices. The Chief Medical Officer’s latest Annual Report (2015/16) ‘Realising Realistic Medicine’ published in February 2017 offers some thoughts and case-studies to guide these conversations and practical actions. The report also sets out the involvement of the Scottish Health Council to support wider public engagement. Work needs to continue to prevent ill health and greater support for self management especially through public health and primary care routes.

Scaling up the benefits from continuous quality improvement is particularly attractive as this is designed to drive out waste while delivering better care and value. The impacts can be significant and do not require long lead in times or public consultation. It will require skilled leadership and more buy-in from staff and local examples promoted to share learning and provide encouragement.

CEL 4 (2010) provides guidance on informing, engaging and consulting people in developing health and community care services including requirements for a public consultation. The critical point to note from the CEL is the ongoing need to engage with local communities, partner agencies, politicians and staff not just at the point of change becoming a necessity. Across Highland and Argyll and Bute considerable work is ongoing around all of the workstreams.

The guidance also clarifies the role of the Scottish Health Council during service change which is to quality assure the engagement process and produce a report on their findings for the Board to submit to the minister, alongside the final proposals. NHS Highland works very closely with the Scottish Health Council on the communications. The Board is not required to consult on any changes required on the grounds of safety though appropriate communications and engagement is, of course, necessary.

Over the last four years, officers have initiated formal and informal processes to support the changes outlined in the 10 year plan. All of the change programme being delivered are underpinned by local communication and engagement plans and local groups which are proportionate to the changes under consideration. There will be further opportunities to engage with Community Partnerships (Highland Council) and Locality Planning Groups (Argyll & Bute) across the whole area, where detailed priorities will be identified for both Adults and Childrens services. A communications and engagement tracker (Annex II – to follow) and a monitoring framework of key metrics is also being prepared (Annex III- to follow).

8. Assurance, Performance, Risk and Planning

- **Assurance**

The Board will continue to receive monthly updates on progress with more formal presentations to the board meetings held in public every other month. The content of these reports and presentations will be derived from the governance reports provided to both the Argyll and Bute Integrated Joint Board and the Highland Health and Social Care Partnership Committee.

The regular financial monitoring reports that the Director of Finance presents to each Board meeting sets out the financial governance arrangements in more detail and in particular the various forums for scrutiny. It is proposed that the Delivering Financial Balance Programme Board will continue to play a key role in terms of oversight and that it will take a more programme-based approach than previously.

- **Performance**

The Delivering Financial Balance meeting, chaired by the CEO, will coordinate the programme of work and oversee the delivery plans, navigating the continued progress towards breakeven throughout the year. Additional remedial action to ensure delivery will be initiated and reported to the Board. Monthly reports will continue to be provided to the Scottish Government with a forecast against delivery.

NHS Highland has restructured to create a Business Support Services Directorate with a specific planning and performance remit. A performance management framework is being developed to underpin the annual and longer term plans. This will include looking at benchmarking data to look at areas for potential improvements such as costs per case across theatres, out-patients, in-patients, theatres and so on. For each initiative, performance measures have been identified so progress can be tracked. This will be further refined and developed (Annex III).

It will be important to monitor progress in terms of delivering both the new models and the savings targets. One of the key drivers is sustainability and some of those challenges can not be addressed simply by investing more resource.
• Risk

The Board will consider a paper on ‘Risk Appetite’ as its meeting in March 2017 and depending on the outcome of the discussions and decisions, some of the plans may need to be altered or additional proposals brought forward.

One risk to delivery is believed to be the pace with which we are able to initiate the necessary change and capacity to deliver, whilst coping with the inevitable impact of meeting current needs, targets within resources. Despite significant engagement in all areas about the need to change over the years, some ongoing resistance is experienced and further can be anticipated. However, if the current ways of working continue then, sooner or later, more services will ‘fall over’ in an unplanned way which is inherently more risky. Recent examples of staffing challenges in out of hours/Minor Injury Units (Dunbar, Ross Memorial/Invergordon/ Nairn), inpatients (Dunbar, Portree, St Vincent’s, Ross Memorial) have seen short-term disruptive to services, either through reduced hours or temporary bed closures. These all serve to illustrate why these services need to be redesigned to have safe and sustainable staffing models.

Therefore, we will need to work together with staff, service users, communities and influential leaders to support the move to new and improved models of care across our wide geographic area.

Whilst the Public Bodies (Joint Working) (Scotland) Act 2014 supported the principle of integration, the reality continues to be pressures between NHS Highland and both partner local authorities in attempting to agree a quantum for delivery in advance of each financial year. This poses further risks for all organisations and a more satisfactory approach should be sought that gives the public more confidence in planning process and appropriate allocation of resource, based on need.

• Planning Cycle

If the board endorses the strategic direction in March further work will be brought back to the board in May including a detailed annual plan (2017/18) and three year plan. They will be underpinned by more detailed operational and corporate plans which will be overseen by Health and Social Care Partnerships. Going forward the annual planning process will get underway in September with draft plans ready for consideration ideally at the November Board Meeting. Once the Board approve the plan, the operational units and corporate services will prepare their local plans for consideration by their Health and Social Care Partnership Committees in Highland and Argyll and Bute. They would also be required to update longer term plans (Table below).
### Proposed Time-Line for developing and approving Annual and three year plan

<table>
<thead>
<tr>
<th>Time-frame</th>
<th>Description of document</th>
<th>Requirement</th>
<th>Board or Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 17</td>
<td>Development of annual three year plan</td>
<td>Discussion on prioritisation, monitoring and risks</td>
<td>• NHS Highland Board Development</td>
</tr>
<tr>
<td>Mar 17</td>
<td>NHS Highland Strategic Quality and Sustainability Plan</td>
<td>Approval of Plan</td>
<td>• NHS Highland Board</td>
</tr>
<tr>
<td>Mar–May 17</td>
<td>NHS Highland Strategic Quality and Sustainability plan and developing action plans</td>
<td>Engagement</td>
<td>• Highland Partnership Forum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Area Clinical Forum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Clinical Governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Staff Governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Asset Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Senior Management Teams</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Operational Units</td>
</tr>
<tr>
<td>Mar 17</td>
<td>Argyll &amp; Bute Strategic Plan</td>
<td>To note</td>
<td>• Argyll &amp; Bute Integrated Joint Board</td>
</tr>
<tr>
<td>May 17</td>
<td>North Highland Action Plan</td>
<td>Approval of Plan</td>
<td>• Highland Health and Social Care Committee</td>
</tr>
<tr>
<td>May 17</td>
<td>NHS Highland Strategic Quality and Sustainability detailed plan (2017/18)</td>
<td>Approval of Plan</td>
<td>• NHS Highland Board</td>
</tr>
<tr>
<td>Sep – Nov 17</td>
<td>Development of Annual (2018/19) and rolling three year plan</td>
<td>Discussion on prioritisation, monitoring and risks</td>
<td>• NHS Highland Board</td>
</tr>
<tr>
<td>Dec17- Mar 18</td>
<td>NHS Highland Strategic Quality and Sustainability Plan and update on strategy</td>
<td>Approval of Plan and any refresh to strategy (IJB to note)</td>
<td>• NHS Highland Board</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Highland Health and Social Care Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Argyll &amp; Bute Integrated Joint Board</td>
</tr>
</tbody>
</table>
Annexes

These are being drafted and will be available for comment in April 2017

I) Annual Quality and Sustainability Plan
II) Communications and Engagement Tracker
III) Monitoring Framework
IV) Gant Chart, setting out key initiatives and time-frame