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 05 March 2025 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
Philip Macrae, Vice Chair and Non-Executive
Cllr, Christopher Birt, Highland Council
Ann Clark, Non-Executive Director and NHSH Board Vice Chair
Cllr Muriel Cockburn, Non-Executive (till 3.45pm)
Claire Copeland (from 1.20pm)
Cllr David Fraser, Highland Council (from 1.45pm)
Julie Gilmore, Nurse Lead and Assistant Nurse Director
Joanne McCoy, Non-Executive
Kara McNaught, Area Clinical Forum Representative
Kaye Oliver, Staffside Representative
Simon Steer, Director of Adult Social Care
Pamela Stott, Chief Officer, Highland Health and Social Care Partnership (HHSCP)
Neil Wright, Lead Doctor (GP)
Mhairi Wylie, Third Sector Representative

In Attendance:
Rhiannon Boydell, Head of Integration, Strategy and Transformation, HHSCP
Paul Chapman, Associate Director AHP
Jennifer Davies (for Tim Allison), Deputy Director of Public Health
Fiona Duncan, Chief Social Work Officer, Highland Council
Frances Gordon (for Elaine Ward), Head of Finance for HHSCP (item 2.1)
Arlene Johnstone, Head of Service, Mental Health, Learning Disability and DARS (until 2.50pm)
Michelle Keir, Carers Services Development Officer
Ruth MacDonald, Interim Deputy Director Adult Social Work and Social Care Leadership Team
Fiona Malcolm, Highland Council Executive Chief Officer for Health & Social Care (until 2.30pm)
Ian Thomson, Head of Service: Quality Assurance; ASC
Natalie Booth, Committee Administrator
Kira Brown, Committee Administrator
Stephen Chase, Committee Administrator
Nathan Ware, Governance & Corporate Records Manager

Apologies:
Cllr Ron Gunn.

1 WELCOME AND DECLARATIONS OF INTEREST

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

The meeting was quorate.

J McCoy noted that she had considered making a declaration in relation to section 7.7 of the Chief Officer Report (item 3.5) and having applied the objective test declared her interest but felt that it did not interfere with the business of the committee.

The Chair expressed thanks on behalf of the committee to outgoing members, Ann Clark, who was stepping down from the Board from April, and Neil Wright as GP representative to take up a non-executive role on the Board (the GP Subcommittee would nominate a replacement in due course); and S Chase who would be replaced as committee administrator by N Booth from the next meeting.

The Chair noted that D van Ruitenbeek had resigned from the committee and that therefore the committee had no current lay representation. He noted that he would discuss the matter of recruitment of new lay representatives with the Board Chair.

The Chair requested that item 3.3 be taken ahead of 3.1, and that item 4.1 be considered ahead of 3.5.

1.2 Assurance Report from Meeting held on 15 January 2025 and Rolling Actions

The draft minute from the meeting of the Committee held on 15 January 2025 was approved by the Committee as an accurate record.

It was noted that there was only one rolling action and that this would be closed in item 4.1.

The Committee

- **APPROVED** the Assurance Report, and
- **NOTED** the Rolling Actions.

1.3 Matters Arising From Last Meeting

2 FINANCE

2.1 Financial Position at Month 9 and the remainder of the 2024/25 Financial Year

The Head of Finance for HHSCP presented the report and a PowerPoint which summarised the financial position for NHS Highland at Month 9 with further detail presented on the HHSCP position. The forecast year end deficit £45.1 million with the assumption that additional action was taken to deliver breakeven ASC position. The forecast is £4.6 m better than the revised brokerage limit set by Scottish Government and £5.5 m better than the target agreed with the Board in May 2024. £1.102 m of funding was confirmed in Month 9, which had included an adjustment to the Mental Health Outcome Framework funding and Tranche 2 of ADP funding.

Key risks were presented which included, ongoing to deliver a breakeven position for ASC, the potential that spend on supplementary staffing could increase over the winter period, that prescribing and drugs costs could see increases in volume and cost, that ASC suppliers could continue to face sustainability challenges, alongside other ongoing issues such as recruitment and retention. Corresponding mitigations were outlined which included, that Adult Social Care had received a higher than anticipated allocation from SG, that robust governance structures around agency nursing utilisation continued to progress, that additional New Medicines funding had been received, and that MDT funding had been reinstated by SG following productive discussions.

A year-to-date (Month 9) overspend of £19.963 m was reported within the HHSCP, and it had been forecast that this would decrease to £5.060 m by the end of the financial year based on the assumption that further action would enable delivery of a breakeven ASC position. A £3.042 m overspend had been built into the forecast to acknowledge the continuing pressures around prescribing and drugs. A high risk was noted around the assumed delivery of £2.319 m of ASC

value and efficiency cost reductions and improvements in the forecast. Further detail was provided in a slide presentation circulated to the members around North Highland Communities; Mental Health Services; Primary Care; Adut Social Care; Cost Reduction/Improvement Target; Value and Efficiencies; HHSCP Supplementary Staffing.

In discussion, the following topics were discussed:

- The Chair noted a £3.5 million increase in the forecast for North Highland communities from month 9 to month 12. This was due to higher social care costs from ASC packages and sustainability payments and increased primary care costs from unaccounted invoices. It was noted that month 10 showed a slowdown, therefore there were no major concerns.
- Members asked about the strategy for managing the rise in National Insurance costs for Commission services without extra funding, stressing the need for a collective approach and clarity on the timing and decision process. The HSCP were reviewing their financial plan with the Scottish Government to address the National Insurance increase, but it was still early days with no commitment for extra funding yet.
- The Chief Officer for the HSCP advised that there had been national meetings and discussions about the impact of increased costs on the sector, including talks with the cabinet secretary and ongoing discussions about the National Care Home contract, but complete information and assurances were still pending.
- The Chair noted that the funding situation from the Scottish Government was still fluid, requiring a strategic approach to handling National Insurance requirements for providers, with plans to address these issues at the next committee meeting and the third sector programme board next week.

The Committee:

- **NOTED** from the report the financial position at month 9 and the associated mitigating actions, and
- **ACCEPTED** limited assurance.

3. PERFORMANCE AND SERVICE DELIVERY

3.1 Self-Directed Support Assurance Report

I Thompson noted that the strategy aimed to transform adult social care by aligning with SDS standards, fostering strong relationships between social workers, unpaid carers, and those needing support, and providing flexible access to resources. It emphasised creating tailored care plans and support solutions based on individual needs, promoting a learning culture, worker autonomy, and integrating community supports. The strategy also called for reevaluating policies and procedures to ensure systems supported workers and individuals effectively. This involved promoting local models of care, integrating community activities, and ensuring that systems acted intelligently and supportively, creating a supportive environment for quick decision-making and realistic resource information.

S Steer highlighted that the committee received moderate assurance due to the significant changes needed in adult social care, stressing the need for a major shift in service delivery. Efforts focused on monitoring service satisfaction, financial spending, and infrastructure support to improve decision-making speed and ease, with the strategy representing a fundamental change in practice requiring honest reporting and resource allocation

In discussion,

- The Chair questioned the ability to change the commissioning strategy, highlighting the need to rethink option two and remove barriers limiting effectiveness. He emphasised addressing unregulated staff like personal assistants and clearly outlining changes to improve resource utilisation and service delivery.
- Significant apprehension around SDS as a commissioning model within the third sector was highlighted, requiring substantial work to build confidence over the next few years. SDS should be seen as an enabler rather than a barrier, with efforts underway to shift this perception and use it effectively.
- It was noted that addressing issues would require more than one session and emphasised presenting the work as a programme linked to the strategic plan.
- The need for diverse relationships in adult social care beyond option three and registered services was highlighted, proposing a new model of eligibility for accessing community supports through advice and guidance.
- Incremental changes like third sector organisations offering option two services were suggested to better tailor care and strengthen community support.
- The importance of offering all four options of self-directed support for a more engaged commissioning landscape was emphasised, highlighting the need for a balance between safety and flexibility.
- The need for equal access to services, especially in rural areas where accessing services was explained as a significant challenge.
- S Steer emphasised the importance of ensuring equity across different populations and geographical areas in commissioning activities, noting that the strategic health needs assessment is being finalised by early February, with further work on commissioning intentions and care strategies expected by June.

The Committee:

- **NOTED** the report and recommendations.
- **ACCEPTED** moderate assurance that purposeful work is being undertaken to ensure compliance with Self Directed Support legislation and policy.

3.2 Carers Strategy Update

The committee received an update on the unpaid carers' work, focusing on the refreshed carers' strategy, which was in draft and being shared with key stakeholders. This strategy, developed with carers, aimed to support the whole system approach for SDS, recognising unpaid carers as vital to the community and ensuring they had access to services, support, and information. The committee was moderately assured and informed that a clear framework for the strategy's outputs would be presented later.

M Keir noted the strategy, developed over a year, highlighted that unpaid carer in the Highlands provided vital support worth an estimated £694.5 million annually, yet less than 8% accessed support, indicating a critical service gap. The objectives included increasing carer awareness, expanding respite care, and enhancing partnerships for tailored support. The plan involved proactive engagement, early intervention, training, and creating a care-centric approach by involving carers and using their feedback. Additionally, it aimed to better utilise funding for respite services, raise awareness of various respite options, and strengthen partnerships to improve access to support.

In discussion,

- The committee noted the need for clarity on percentages in the report and suggested including examples of current work to illustrate the strategy's vision.
- They recommended creating an easier-to-read version for unpaid carers, celebrating achievements while acknowledging future ambitions.
- Insights from carers on broader issues like employment and housing were raised, emphasising the importance of addressing these factors through a population health lens.
- The strategy's link with the employability strategy was suggested, with questions on how changes would be implemented and funded.
- The importance of community awareness alongside carer awareness was highlighted, aiming for meaningful change beyond a healthcare-centric approach.
- The interaction between the adult carer strategy and the young persons' carers strategy was emphasised, maintaining connectivity between the two.
- The need for accessible and fit-for-purpose services, including flexible respite care options, was highlighted.

The Committee:

- **NOTED** the report.
- **ACCEPTED** moderate assurance that the strategy is complete, and that there is a requirement for it to have further socialisation and feedback from stakeholders in the HHSCP and with community stakeholders.

3.3 DPH Annual Report and Service Planning Update

The Deputy Director of Public Health emphasised health inequalities were significant, often stemming from avoidable factors. These disparities were measured in various ways, including life expectancy and healthy life expectancy which revealed stark differences between the least and most deprived areas and genders. Financial insecurity was a primary driver and impacted quality of life, disability, and premature death. While health services played a role, their contribution was small compared to factors like income security and living conditions. Addressing these would have the most significant impact on health equity. She highlighted NHS Highland was committed to tackling these issues and by considering all conditions of life, they could effectively reduce health inequalities and improve overall health outcomes.

In discussion,

- The committee valued the report on population health, noting the significant issue of years of life lost in the Highlands due to ischemic heart disease. Improving the Highland diet was deemed crucial, with a need to update outdated dietary guidelines to reflect current science. A joint post between the health service and local authority for Tim's successor was suggested to enhance public health efforts.
- Access to fresh food and proper cooking education in schools, especially in rural areas, was highlighted as crucial for healthy diets.
- Members questioned concrete ways the Community's directorate could contribute to implementing the report's recommendations. The joint strategic needs assessment provided essential data for the joint strategic plan, emphasising engagement with district planning groups and sector partners to improve service delivery and access.
- It was suggested that next year's work plan include specific reports on the progress of implementing the board's recommendations, with more frequent discussions agreed upon as beneficial.

- Addressing health inequalities requires political bravery and resource reallocation, even if unpopular. Resources should be directed to those in need rather than those capable of challenging decisions. Robust commissioning practices focused on impactful demographics were emphasised over non-essential activities.

The Committee:
- **NOTED** the update.
- **ACCEPTED** substantial assurance that the requirement for the publication of the report has been met.

The Committee took a Break between 2.44pm and 3pm

3.4 IPQR for HHSCP

R Boydell discussed the executive summary performance indicators, noting improvements in SDS, waiting times for psychological therapies, and chronic pain. Care homes saw reduced longer stays and increased activity. However, delayed discharges and outpatient waits for the health and social care partnership were areas of concern. The number of delayed discharges decreased from 220 to 196 in the following month's data. Additionally, the Community Assessment Day by musculoskeletal physiotherapy significantly reduced waiting lists for physiotherapy, with findings to be applied to other services.

Members highlighted issues with SDS options one and two due to a lack of preferred services and suggested an indicator for budgets spent or recouped to show struggles in employing personal assistants. The Chair questioned how to measure SDS effectiveness, particularly option one, to avoid returning unspent money. The Chief Officer for the HSCP proposed discussing SDS development in a session, focusing on carers' experiences and choice, and acknowledged recruitment challenges for personal assistants, suggesting strategies for future changes.

Members inquired about delayed discharges due to guardianship and the complexity of the system, asking for a date for more data on wait lists post-Morse system move. The Chief Officer for the HSCP explained work on guardianship needs, monthly reports, and delays due to court closures, highlighting efforts to prioritise assessments and prevent hospital admissions. There was no confirmed date for the Morse system move. The Chair suggested emailing the date once available, with the committee agreeing to note the report and accept limited assurance.

The Committee:
- **NOTED** the report.
- **ACCEPTED** limited assurance from the report.

3.5 CHIEF OFFICER'S REPORT

The Chief Officer spoke to the report and noted:

- North Skye Actions: Efforts continued as per the Sir Lewis Ritchie report, with wider engagement to deliver the Joint Strategic Plan.
- Lochaber Projects: The Single Point of Access Project was in place, with progress on the Belford Hospital build, Falls Workstream, and Local Care Model.
- Digital Service Tender: A joint tender was issued for a digital service supporting recovery, focusing on rurality and access inequalities.
- Joint Inspection: An inspection was carried out by Care Inspectorate and Healthcare Improvement Scotland on partnership effectiveness for adult services.

- New Craigs Hospital: Significant pressures were experienced; exploration of redesigning the Critical Pressure Escalation Process was underway.
- Recruitment Success: Positive impacts were seen on patient discharge, reopening of beds and care facilities.
- Community Appointments: Beds were increased at Invernevis House and the MSK Community Physio Appointment Day was successful.
- Medical Practice Transformation: Alness and Invergordon Medical Practice recruited nine GPs.
- Time to Care Group: Weekly meetings were held to improve care productivity and support systems.
- QNIS Development Programme: A colleague was selected for the third consecutive year; Barry Muirhead was to be elected as Cochair of the National Mental Health Group.
- Tender Process: An alternative to tender wavering was needed to increase capacity.
- Governance and Marketing: These needed to be aligned with the Commissioning Strategy, with updated service specifications due by June.
- Service Specifications: Discussions took place on enhanced service specifications for diabetes, care homes, and urology.
- National Care Service: The integration model was reviewed as the Lead Agency Model needed dissolution.
- Steering Group Development: The development of a steering group with NHS Board and Highland Council was proposed.

The Chief Officer reiterated the importance of coproduction, community and partnership engagement, and staff retention in remote rural areas.

The Committee:

– **NOTED** the Chief Officers report.

4 COMMITTEE FUNCTION AND ADMINISTRATION

4.1 Care Governance Final Report

C Copeland emphasised the collaborative effort behind the paper, highlighting significant work since autumn 2023, the embedding of a new system for recording and investigating issues, and the need for further refinement in governance practices. R MacDonald discussed integrating social work and social care governance into the clinical governance framework, noting improvements in language and reporting processes, the establishment of a multi-agency group, and the importance of retaining learning from adverse events.

In discussion,

- Members sought clarification on whether the new system, InPhase, would incorporate learnings from Datix to ensure user-friendliness for social work and social care staff, and expressed interest in hearing from frontline staff about workplace safety. The Committee were reassured that InPhase would allow for necessary adaptations and improvements, highlighting positive outcomes like reductions in falls and medication errors, and emphasising the importance of creating a safe space for learning rather than blame.
- Members reflected on the cultural shift in using Datix, noting positive progress in reporting adverse events and suggesting a review of the impact of these changes. F Duncan emphasised the need to balance data with broader governance and narrative for

comprehensive assurance. C Copeland highlighted the framework's blend of data and narrative to assess effectiveness and the importance of capturing team discussions for a culture of learning and safety.

- The Chair expressed appreciation for the progress made over the past 15-16 months, proposed closing the original action item related to concerns from 18 months ago, and suggested incorporating care governance into future reports, emphasising the importance of ongoing assurance and noting substantial progress.

The Committee:

- **NOTED** the report, and
- **ACCEPTED** substantial assurance

4.2 Committee Workplan 2025-26

The Chair noted the draft committee workplan was presented with the expectation of making addendums throughout the year. He highlighted the challenge was to avoid continuously adding to it as this would be impractical. A discussion with the Chief Officer for the HSCP would be held to tweak the workplan to maximise efficiency. The first draft for 2025-2026 was provided for consideration.

The Committee:

- **APPROVED** the Committee Workplan for 2025-26.

4.3 Committee Annual Report 2024-25

The Chair highlighted the annual report for 2024-2025, which would be submitted to the Audit Committee in May as part of the overall assurance process for the board, leading to the Chief Executive signing the annual assurance statement. A discussion on this will be held at the next committee meeting or a future development session.

The Committee:

- **APPROVED** the Committee Annual Report for 2024-25.

5 AOCB

D Fraser inquired about the letter on the hubs and whether it would be discussed, noting emails received the previous day. The Chair confirmed that the issue would be addressed at the third sector programme board meeting next week, with ongoing internal discussions to conclude and respond accordingly.

DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 7th May 2025** at **1.00 pm** on a virtual basis.

The Meeting closed at 15.54 pm

Agenda Item 3.1

NHS Highland

Meeting:	**Health and Social Care Committee**
Meeting date:	**7 May 2025**
Title:	**Independent Sector Care Home Overview and Collaborative Support Update**
Responsible Executive/Non-Executive:	**Pamela Stott, Chief Officer**
Report Author:	**Ruth MacDonald, Interim Depute Director of Adult Social Care / Gillian Grant, Interim Head of Commissioning**

Report Recommendation:
The Health and Social Care Committee is asked to **note** the content of this report.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

NHS Highland (NHSH) relies heavily on the capacity, availability and quality of independent sector care home provision as part of the wider health and social care system, and crucially, to enable flow within this system.

As in previous years, there have been continued concerns regarding independent sector viability over the last 12 months, mainly around the ongoing operational and financial sector pressures relating to small scale, remote and rural provision and the challenges associated with attracting and retaining staff, and the financial impact of agency use.

Whilst there has been some recruitment improvement arising from the support of the Care Home Career and Attraction Lead (noted later), these issues are generally continuing and are compounded with further additional financial pressures.

Care home quality across Highland is generally good, although there has been experience of some quality issues. In such instances, there is close cooperation and collaboration with and between NHSH and individual providers.

NHSH has sought to build on existing supportive and collaborative arrangements to best support the delivery of care home services and to improve the lives of those living in care homes.

This report provides an updated overview of current commissioned independent sector care home issues as at April 2025 and describes the embedding collaborative approach and arrangements in place to support independent sector care home delivery and the achievement of good outcomes for residents across Highland.

2.2 Background

Independent Sector Care Home Overview

There are a total of 62 (1 April 2025) care homes across north Highland, 45 of which are operated by independent sector care home providers and 17 of which are in house care homes operated by NHSH.

Spend on commissioned care home provision is around £59.9m pa, with in house costs around £19.2m pa – a total of £79.1m pa on care home spend.

There are currently around 1,856 care home beds commissioned or delivered, with approximately 84% of beds commissioned from independent providers.

In terms of size of care homes within Highland:

- 16% (7) independent sector care homes have 50 beds or over; 3 of these care homes have more than 80 beds.

- 84% (38) care homes are under 50 beds, with 22 care homes operating with 30 beds or less.

2024-2025 Key Issues

Over the course of 2024 / 2025 the following areas have represented key issues in relation to independent sector care home delivery:

- **NCHC:** fee settlement was reached in March 2024 for fees to apply for 2024-2025. Whilst this was accepted nationally by the majority of Scottish Care members, this was highlighted by Highland providers as not fully covering the cost of care. The NCHC presents increased financial sustainability and vulnerability risks, particularly given that the National Care Home Contract (NCHC) rate is calculated on the basis of a 50 bed care home, operating at 100% occupancy.

- **Financial viability:**
  - Scale - smaller size of provider and care home, impacting on economies of scale
  - Geography – staff scarcity, supply costs, staff accommodation, transport accessibility for staff to get to work
  - Ageing stock – higher maintenance costs / utility inefficiency
  - Smaller customer base – (unevidenced) lower self funding demand to off-set costs
  - Sector fragility - several financial risk situations have arisen over the last year.

- **Recruitment:** Independent providers (and NHSH care homes) continue to experience difficulties in recruiting and retaining staff and this represents a high risk across the sector. The most significant difficulties are with recruiting nurses to work in care homes. There is an increasing use and reliance on overseas recruitment, which is a slow and expensive process, time consuming and requires available accommodation and additional support for these staff to settle, learn cultural differences in delivering care and integrate into a foreign country. The input from the Care Home Career and Attraction Lead has been key to supporting this area.

- **Moss Park:** HC-One served notice to NHS Highland on 17 September 2024, providing 13 weeks notice of their intention to close Moss Park care home. This development occurred following the care home being on the market since 2021 and various previous attempts at alternative provider interest and transfer. The Highland Health and Social Care Partnership explored various opportunities to avoid the closure of the care home and the necessary relocation of the 32 residents to alternative locations, some proximity from Fort William. The Highland Council subsequently considered a confidential item on Moss Park in late October 2024 and the arising decision was that The Highland Council would seek to purchase the care home, to be operated by NHS Highland. The acquisition and transfer took place on 1 April 2025.

- **Large Scale Investigations (LSIs):** there were 4 LSIs in care homes across Highland during 2024-2025. All of these care homes received significant support from NHS Highland across a number of areas to support the provider to make and sustain improvements.

- **Listening and Learning Event, August 2024:** this was a session hosted jointly by NHSH and Scottish Care, to enable senior managers from the Partnership to hear directly from care home providers on operational challenges, what is going well, and how we can all improve the lives of people living in care homes. An action plan was developed from this event, which is being overseen by the Collaborative Care Home Support Strategic Group.

Quality

Whilst operational challenges and financial pressures persist, the quality of care home services has, overall, continued to be delivered to a good standard.

The attached **Appendix 1** sets out the Care Inspectorate grading summary as at March 2025. The majority of services are graded as good or better.

Where there are gradings of weak or below, there is proactive work alongside providers to develop, support and oversee Supported Improvement Plans. This input is provided by contracts, operational colleagues and the collaborative care home support team with other specialist input as required.

Market and Service Changes

There have been no new care home closures since the previous update to this committee in May 2024.

A reminder of the closures since March 2022 is as noted:

1. Shoremill in Cromarty (13 beds), March 2022
2. Grandview in Grantown (45 beds), May 2022
3. Budhmor in Portree, (27 beds), August 2022
4. Mo Dhachaidh in Ullapool, (19 beds), March 2023
5. Castle Gardens, Invergordon, (37 beds), June 2023
6. Cradlehall Care Home, Inverness, (50 beds), April 2024

There have been three care home acquisitions by NHS Highland / The Highland Council since November 2020, these being:

1. Home Farm, Portree, November 2022 – secured by NHSH during Covid, arising from quality issues
2. Main's House, Newtonmore, April 2023 - secured by the Partnership to avoid the loss of this and Grandview at the same time
3. Moss Park, Fort William, April 2025 (as noted above) – no buyer identified and secured by the Partnership to avoid the loss of this care home.

A common theme across all of the closure and acquisition situations relates to staff recruitment and retention, the cost of securing agency cover and financial viability.

It is also relevant to note that there have also been a number of in house care home closures. These have arisen due to acute staffing shortages which has meant that the services have not been able to be safely and sustainably staffed. The status of these care home are as noted:

1. Dail Mhor, Strontian, (6 beds), December 2022 (temporarily closed, options under discussion)
2. Caladh Sona, Talmine (6 beds), May 2023 (closed)
3. Mackintosh Centre, Mallaig (6 beds), August 2023 (was temporarily closed, reopened in November 2024)
4. Strathburn, Gairloch (7 beds), July 2024 (temporarily closed, to reopen in May 2025)

The current impact of the care home closures since March 2022, is a reduction of 204 registered beds.

In terms of forward developments and expected capacity, the following is understood:

- There is additional capacity becoming available in June 2025 in the new build 56 bed care home at Milton of Leys in Inverness.

- There are planning applications intended for 2 care homes for additional wings, which will provide a further 22 beds. Subject to planning approval, work is expected to begin later in 2025.

The above developments will create a total of 78 beds.

Strategic Direction

NHSH / THC have been developing a locality model as a preferred and intended direction of travel for the provision of health and social care services, the key objectives of which are safe, sustainable and affordable locality provision. This is the direction as set out in the Joint Strategic Plan.

However, there has been and continues to be, immediate and operational challenges from arising and anticipated care home closures, which require to be addressed.

Given the evolving nature of the developing situation, the available courses of action to prevent a significant scale of lost provision may not entirely align with the intended strategic direction but these actions are being taken or considered out of necessity.

Work to progress a care home strategy, commissioning plan and market facilitation plan has been delayed due to operational pressures.

Capacity has now been created within the Partnership's joint Transformational Programme, which will now see some much needed progress in these areas. This transformational activity will consider sustainable forward care models, with an initial Lochaber care village focus.

The key ongoing actions currently being progressed to address concerns around viability and recruitment and provide clarification on strategic direction, are:

1. Ongoing dialogue with Scottish Ministers, Scottish Government, Cosla for a national care home contract rate (and funding) which recognises Highland delivery scale and geography.

2. Ongoing dialogue and engagement with providers

3. Continued investment in a Scottish Care hosted Independent Sector Care Home Career and Attraction Lead.

Collaborative Support

Background

There have been ongoing support requirements of NHS Highland in respect of independent sector care homes since May 2020, when the Scottish Government mandated Boards to have clinical and care oversight of all care homes, in addition to their existing adult social work and social care, commissioning and public health responsibilities.

The focus and emphasis has shifted since this time from oversight to collaboration, following both the publication of the My Health, My Care, My Home - Healthcare Framework for Adults Living in Care Homes in June 2022 My Health, My Care, My Home - healthcare framework for adults living in care homes - gov.scot and also the updated direction from Scottish Government in December 2022 and March 2023 around collaborative support to care homes to improve the lives of people living in care homes.

This area of activity falls under a Collaborative Care Home Support – Strategic Group, co-chaired by the Chief Officer and Director of Nursing.

There has been specific funding from Scottish Government in relation to collaborative care home support. This funding has been non recurring to date, but has been received annually in different forms since 2020, all associated with supporting care homes and improving the lives of people living in care homes. In 2024-2025, the Partnership's allocation was £681k.

The cyclical nature of the funding has resulted in the need to annually rebuild the collaborative care home support team, as staff have moved on to other roles for job security. This disruption has heavily impacted on the ability to achieve sustainable outcomes and ongoing representations have been made to SG to mainstream this funding, to improve impact.

In December 2024, the EDG of NHSH agreed to extend the posts within the current team on an "at risk" basis. This enabled the work of and support from the team to continue and develop.

The Scottish Government has since (March 2025) confirmed that the funding will continue for 2025-2026 and has now been baselined. Plans are therefore in development for forward arrangements to be put in place.

Collaborative Care Home Support Team

Throughout 2025/2026 the CCHST has established themselves as a core team compromising nursing, physio and OT. There has been a strengthening of MDT working with multiple professionals including pharmacy, SALT, dietetics and older adult mental

health services. There are also close links with Lead Nursing, ASC Lead Officers, Contracts and Commissioning Team and Scottish Care colleagues.

The Team have been reporting into a Steering group who have been able to support the development of the team on the advice of the Strategic Group in terms of required outcomes of the service.

The Team has been able to develop from primarily a training resource in its initial year (due to funding and recruitment restrictions) to a service that can be proactive through support visits and reactive when there are any concerns raised. Training has been tailored to individual service needs. An informal network has been created that allows for drop in sessions, sign posting and forward advice to ensure access to timely information and support.

The team have been a crucial support during any Adult Support and Protection improvement activity and have contributed to timely progression through protection plans but also to assist with assessing prior to any Adult Support and Protection activity progressing, or being resolved due, in part to their support.

A sample of the work from key areas are included in **Appendix 2**.

Independent Sector Care Homes Career and Attraction Lead

At the sector's request, this post was created in January 2024 and is hosted by Scottish Care. The focus of this role is to increase number of people working in independent sector care homes and specifically, to:

- Lead and support coordinated sector care home attraction activity
- Create single online presence and positive social media content
- Proactively identify potential new employees, generate interest in care home employment, raise positive profiles and support locality attraction initiatives

A summary of the activity supported by this post is provided at **Appendix 3**.

This role has had made a demonstrable impact in creating and maintaining awareness and a social media profile of independent sector care home roles and has also had a significant reach into secondary and further education to innovatively promote care as a positive career option.

Resident Wellbeing Fund

Following on from the successful wellbeing fund in 2023-2024, £200k of the available Scottish Government funding was again redirected from unfilled posts for the purpose of a resident wellbeing fund in 2024-2025:

- Care home managers, staff and residents were approached for input as to where the money would be best spent to help improve residents' experience of being in a care home.

- 4 themes were identified for spend (experiences, activity, sensory and technology) and funds were directly issued to care homes based on bed capacity.

- a significant number of outcomes were met from the fund, positively impacting the lives of the residents in the care homes.

98% of residents in Highland (1,798 people) were able to directly benefit from the fund.

A detailed outcome report around this fund is provided at **Appendix 4** which clearly illustrates the positive and direct impacts.

2.3 Assessment

Commissioned care home services represent a key area of activity and a key component of the wider health care system.

It is essential that residents continue to receive good care experiences and that care homes continue to be supported to deliver quality and sustainable care.

It is also important that this support is provided collaboratively, in partnership, and that we look for opportunities to further develop these collaborative aspirations.

There is a need to involve care home providers and wider stakeholders in the forward direction of care home provision in Highland.

The following specific actions will progress the above intent:

a) Continued dialogue and escalation to Scottish Ministers, Scottish Government and Scotland Excel for a national care home contract rate (and funding) which recognises Highland delivery scale and geography.

b) Development of a specific care home strategy and market facilitation plan.

c) Embedding of collaborative support from baselined funding.

2.4 Proposed level of Assurance

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

NHSH is unable to individually control the circumstances around sector turbulence. This is a broader national issue, but one that NHSH is seeking to influence through regular dialogue with the Scottish Government.

NHSH can however be confident in its organisational response to any arising situation.

The following specific assurances are noted:

- There is a good understanding of the Highland market, issues and current challenges.
- There is a clear direction of travel for future delivery – quality care home provision in locations where they can be safely, sustainably and affordably resourced.
- The Partnership is responsively and comprehensively responding to individual viability issues as they emerge, the arising actions from which may by necessity not accord with the intended and desired direction of travel.
- There is senior Partnership visibility of issues, risk and impact.
- There are ongoing and open channels of communication and support with providers and sector representation forums.

3 Impact Analysis

3.1 Quality/ Patient Care

There are positive impacts from the continuation of provision at Moss Park, given that this care home has not closed and residents are not now required to relocate out of the locality.
There are also positive impacts from the reopening of the MacIntosh Centre.
There remains continuity risks across the sector due to the ongoing challenges in recruiting and sustaining workforce levels.

3.2 Workforce

There are significant challenges to all providers in attracting and retaining staff within care home provision, and pressures on existing staff working within these services. These pressures are exacerbated where independent sector staff move to NHSH employment for better terms and conditions.

3.3 Financial

Commissioning care home services in Highland using the nationally negotiated National Care Home Contract, presents particular challenges to providers operating on a scale below 50 beds.
There are significant financial impacts associated with the Partnership's operational response to arising care home sustainability situations and the implementation of any agreed solutions. Further, where any closures occur, there are costs associated with alternative placements and resourcing implications.

3.4 Risk Assessment/Management

There are significant risks identified with the foregoing detail. The key risk areas are noted as follows:

- System impact from reduced care home bed capacity and availability from care home closures. Seeking to mitigate by increasing visibility of issue, contingency and strategic planning.

- Residents requiring to relocate a significant distance from their current location. Seeking to mitigate by contingency and strategic planning.

- Further care home closures occurring. Mitigating by close sector liaison and early response and also ongoing escalation to SG on NCHC arrangements.

3.5 Data Protection

None.

3.6 Equality and Diversity, including health inequalities

None.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

As and when, upon care home closure announcement or any significant change, this is supported by a communication plan.

3.9 Route to the Meeting

There have been various prior reports / updates on care home sustainability and collaboration as follows:

- Reports to the Joint Monitoring Committee
- NHSH Board
- Health and Social Care Committee (26 April 2023, 8 May 2024)

4.1 List of appendices

The following appendices are included with this report:

- **Appendix 1:** Care Inspectorate Grading Summary, March 2025

2025-05-08 HHSCC
Care Home Report - A

- **Appendix 2:** Collaborative Care Home Support Team Summary

Appendix 2
Collaboartive Care Ho

- **Appendix 3**: Independent Sector Career and Attraction Lead

2025-05-08 HHSCC
Care Home Report - A

- **Appendix 4:** Resident Wellbeing Fund Outcomes

2025-05-08 HHSCC
Care Home Report - A

Care Homes and Care at Home services in North Highland - Care Inspectorate Grades effective as at 31 March 2025

* Data is based on the Care inspectorate Datastore as at 28 February with updates for homes inspected since then to reflect the most up to date grading position

** Note Key Question 1 is always inspected, however some inspections only focus on specific Key Questions and some grades will be from the previous inspection.

Care Homes in North Highland

Service Town	Service Name	Subtype	In-House or Independent Sector	Number of Registered Places	Last Inspection Date	Quality Inspection Framework Evaluations				
						Key Question 1: How well do we support people's wellbeing?	Key Question 2: How good is our Leadership?	Key Question 3: How good is our staff?	Key Question 4: How good is our setting?	Key Question 5: How well is care and support planned?
Ballachulish	Abbeyfield Ballachulish (Care Home)	OP	Independent	37	09/12/2022	5	5	6	6	6
Inverness	Aden House (Care Home)	OP	Independent	24	21/02/2025	4	4	4	4	4
Inverness	Ballifeary House	OP	Independent	24	11/03/2025	3	5	4	4	4
Inverness	Beechwood House	Alcohol & Drug	Independent	15	16/08/2022	4	4	4	5	5
Inverness	Birchwood Highland Recovery Centre	MH	Independent	23	12/08/2024	4	3	4	4	3
Nairn	Bruach House	OP	Independent	22	27/02/2025	5	4	5	4	4
Inverness	Cameron House (Care Home) - active SIP	OP	Independent	30	21/02/2025	3	3	3	3	3
Nairn	Carolton Care	OP	Independent	20	19/12/2024	4	4	5	4	4
Inverness	Castlehill Care Home - active SIP	OP	Independent	88	10/02/2025	3	3	2	4	3
Alness	Catalina Care Home	MH	Independent	28	13/05/2024	4	4	4	4	4
Inverness	Cheshire House (Care Home)	PD	Independent	16	18/07/2024	4	5	4	6	5
Inverness	Culduthel Care Home	OP	Independent	65	24/06/2022	4	5	4	4	4
Inverness	Daviot Care Home	OP	Independent	94	05/12/2024	4	4	5	5	4
Fortrose	Eilean Dubh	OP	Independent	40	30/09/2024	5	5	5	5	5
Muir of Ord	Fairburn House	LD	Independent	40	08/08/2022	5	4	5	5	5
Dingwall	Fodderty House	OP	Independent	16	07/11/2024	4	4	5	4	4
Beauly	Fram House	LD	Independent	5	21/11/2023	5	4	5	5	5
Nairn	Hebron House Nursing Home Ltd	OP	Independent	22	14/11/2024	4	4	4	4	4
Inverness	Highview Care Home	OP	Independent	83	03/10/2024	5	5	5	5	5
Nairn	Hillcrest House	MH	Independent	23	24/03/2025	5	5	5	5	5
Tain	Innis Mhor Care Home	OP	Independent	40	28/08/2024	5	5	5	5	5
Achnasheen	Isle View Care Home	OP	Independent	25	13/06/2024	5	4	5	4	4
Inverness	Isobel Fraser Home	OP	Independent	30	31/07/2024	5	5	5	5	4
Inverness	Kingsmills Care Home - Grades from feedback 18/07/2024	OP	Independent	60	17/07/2024	3	4	3	4	4
Inverness	Kinmylies Lodge	MH	Independent	18	04/10/2022	5	5	4	5	4
Invergordon	Kintyre House (Care Home)	OP	Independent	41	01/10/2024	4	4	4	2	5
Grantown-on-Spey	Lynemore	OP	Independent	40	17/12/2024	3	4	4	5	4
Inverness	Maple Ridge (Care Home)	LD	Independent	18	05/10/2023	4	4	4	4	4
Inverness	Mayfield Lodge - active SIP	LD	Independent	12	26/03/2025	2	2	3	3	2
Fort William	Moss Park Nursing Home	OP	Independent	40	24/07/2023	4	4	4	4	4
Invergordon	Mull Hall (Care Home)	OP	Independent	42	24/12/2024	4	3	4	3	3
Dornoch	Oversteps (Care Home)	OP	Independent	24	28/02/2025	3	3	3	4	4
Thurso	Pentland View - Highland	OP	Independent	50	17/10/2024	5	4	5	4	5
Alness	Redwoods (Care Home)	OP	Independent	42	06/08/2024	5	5	5	5	5
Wick	Riverside House Care Home	OP	Independent	44	26/09/2024	4	4	4	4	4
Dingwall	Seaforth House Ltd (Care Home)	LD	Independent	22	14/11/2024	4	4	4	4	4
Wick	Seaview House Nursing Home	OP	Independent	42	17/10/2024	5	5	5	4	5
Inverness	Southside Care Home	OP	Independent	33	21/03/2025	5	4	5	4	4
Nairn	St. Olaf - Cawdor Road	OP	Independent	44	11/09/2024	5	4	4	5	4
Strathpeffer	Strathallan House (Care Home)	OP	Independent	32	10/06/2024	5	4	5	4	4
Nairn	The Manor Care Centre	PD	Independent	43	10/05/2024	4	4	4	4	4
Dornoch	The Meadows (Care Home)	OP	Independent	40	20/06/2023	4	4	4	4	4
Muir of Ord	Tigh-na-Cloich	LD	Independent	4	21/11/2023	5	4	5	5	5
Muir of Ord	Urray House	OP	Independent	40	18/09/2023	5	5	5	5	5
Nairn	Whinnieknowe (Care Home)	OP	Independent	24	19/02/2025	5	4	4	4	4
Dingwall	Wyvis House Care Home	OP	Independent	50	23/07/2024	4	4	4	4	4
Inverness	Ach-an-Eas (Care Home)	OP	NHS Highland	24	10/01/2025	3	4	4	4	3
Isle of Skye	An Acarsaid (Care Home)	OP	NHS Highland	10	25/10/2022	5	4	5	4	4
Thurso	Bayview House (Care Home)	OP	NHS Highland	23	08/09/2022	5	4	4	4	4
Acharacle	Dail Mhor (Care Home) - Temporarily closed	OP	NHS Highland	6	21/09/2022	4	3	4	4	5
Grantown-on-Spey	Grant House	OP	NHS Highland	20	12/04/2023	4	4	4	4	4
Portree	Home Farm Care Home	OP	NHS Highland	35	10/01/2025	4	3	4	3	3
Fort William	Invernevis House (Care Home)	OP	NHS Highland	32	07/08/2023	5	4	4	4	4
Ullapool	Lochbroom House (Care Home)	OP	NHS Highland	11	05/11/2024	5	5	5	5	5
Mallaig	Mackintosh Centre - Reopened November	OP	NHS Highland	8	22/08/2023	4	2	4	4	3
Newtonmore	Mains House	OP	NHS Highland	25	24/05/2024	4	3	4	3	3
Thurso	Melvich Community Care Unit (Care Home)	OP	NHS Highland	6	17/12/2024	4	3	3	4	3
Wick	Pulteney House (Care Home)	OP	NHS Highland	18	26/09/2022	5	4	5	5	5
Golspie	Seaforth House (Care Home)	OP	NHS Highland	15	14/06/2022	4	5	5	5	5
Gairloch	Strathburn (Care Home) - Temporarily suspended	OP	NHS Highland	13	20/05/2024	4	3	4	4	3
Fort Augustus	Telford Centre (Care Home)	OP	NHS Highland	10	28/06/2024	4	4	5	4	4
Kingussie	Wade Centre (Care Home)	OP	NHS Highland	40	30/01/2025	5	4	5	4	4

Grading Legend	
0	Not inspected
1	Unsatisfactory
2	Weak
3	Adequate
4	Good
5	Very Good
6	Excellent

Appendix 2
Care Home Collaboration Team Overview

The CCHST core team has implemented a comprehensive work plan to enhance training delivery to care homes, focusing on immediate, practical, and lasting benefits. Key areas of training include nutrition, pressure ulcer prevention, falls prevention, meaningful activities, and medication management.

Nutrition and MUST (Malnutrition Universal Screening Tool)

- **Training Sessions**: Weekly mandatory training on MUST and nutrition facilitated by both the Dietician and Nurse.
- **Issues Identified**:
- **Errors in MUST Score Calculation**: Incorrect calculations have led to delayed or missed referrals to Dieticians.
- **Misunderstanding of Fortification Practices**: Confusion among chefs and care staff has resulted in missed opportunities to address malnutrition.
- **Inadequate Documentation**: Poor record-keeping has hindered the ability to demonstrate efforts and interventions.
- **Improvements**:
- Increased staff confidence in handling nutrition-related issues.
- Better communication among staff, including catering personnel, fostering a unified approach to the "food first" strategy.
- Reduction in the number of residents at risk of malnutrition.

Medication Management

- **Epilepsy and Buccal Midazolam**: Training initiated for proper administration protocols, following focus visits that revealed a need for all medication administrators to be trained.
- **Collaboration**: Senior Nurse and Prescribing Support Nurse from the Pharmacy Department have been working together to deliver this training.

Pressure Ulcer Prevention

- **Waterlow Assessment**: Improved accuracy in assessments has led to better prevention of pressure ulcers and more robust support planning.
- **Training Focus**: Ensuring correct use of pressure-relieving equipment (mattresses and cushions) and accurate recording on SSKIN bundles.

Falls Prevention

- **Physiotherapy Focus**: Falls awareness training has been conducted in several care homes, focusing on identifying risk factors, creating individualised falls care plans, and increasing confidence in responding to falls.
- **Training Needs Identified**:
- Positioning and postural management.
- Walking aids.

- Physical activity.
- **Collaboration**: Development of training has involved collaboration with key professionals in each field.

Meaningful Activities

- **Occupational Therapy**: High interest in training on meaningful activities has been reported.
- **Work Completed**:
- Introductory presentations on what constitutes meaningful activity.
- Screening tools to specify training needs, trialled with several care homes and modified following PDSA cycles.
- **Next Steps**:
- Specific training and support sessions.
- Creation of an activity bank and guidance on adapting activities.
- Documentation of activities (activity care plan/diary) and sensory activities.

Face-to-Face Training - Overview

Training Topic	Independent Sector Care Homes	NHSH Care Homes	Total Homes
Meaningful Activities	0	2	2
MUST & Nutrition	6	9	15
Waterlow Assessment	1	3	4
Skin Integrity	3	5	8
Falls Awareness	2	4	6
Epilepsy Awareness	0	2	2
Rescue Medication	0	2	2

Support Topic	Independent Sector Care Homes	NHSH Care Homes	Total Visits

Support Topic	Independent Sector Care Homes	NHSH Care Homes	Total Visits
MUST & Nutrition	25	12	37
Waterlow Assessment	8	18	26
Skin Integrity	6	12	18
Falls Awareness	10	10	20
Medication	4	6	10

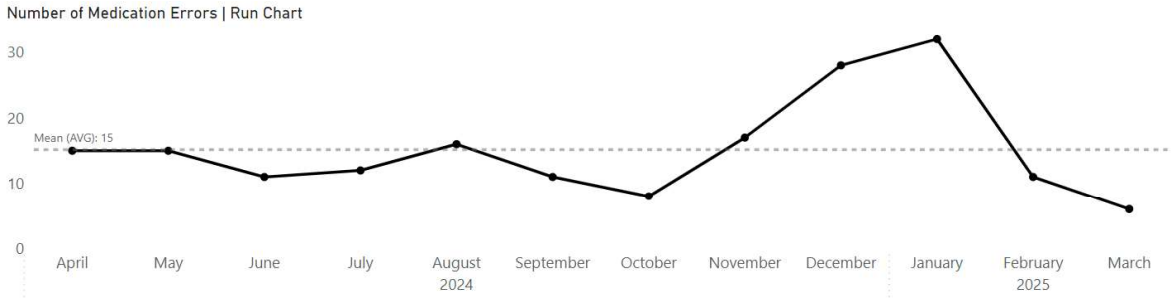
Stress and Distress Management

- **Support Provided**: The Stress and Distress Team in Inverness Sector continues to support care homes, providing assistance to teams and patients with distressed behaviours.
- **Training**: Psychological interventions and regular consultation slots for care home staff to discuss current cases or obtain general advice.

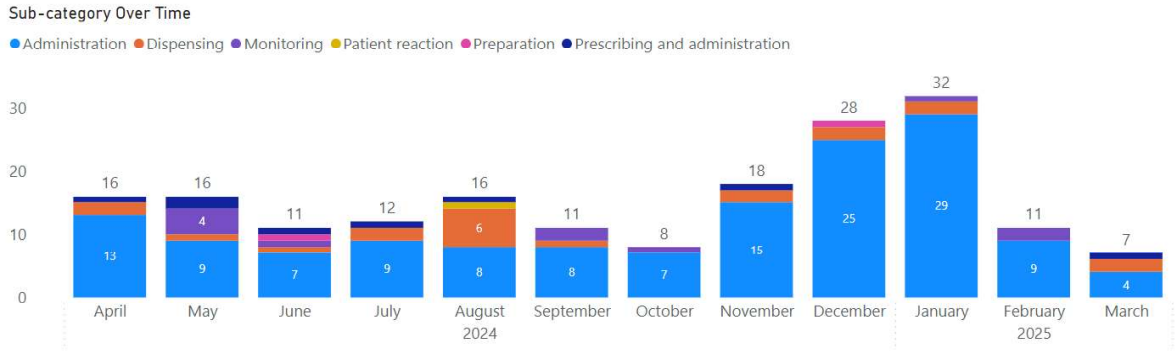
Pharmacy.

- Aim to collaborate with Care homes to review residents medications, enhance medicines management, and reduce medication incidents, therby improving residents' pharmaceutical and clinical care.
- These efforts are also expected to improve stock management, minimise waste, leading to financial benefits.
- Training Topics:
- Documentation and completion of medication administration record (MAR) charts.
- Care planning and administration of 'when required' medications.
- Correct use of creams and emollients.
- Palliative care medications.
- Self-audit by homes to identify areas for improvement.
- **Improvements**: Reduction in medication incidents in NHS care homes, as evidenced by data tracking.

Graph 1 – Medication Incidents NHS Care Homes, HHSCP



Graph 2 – Medication incidents by Sub-Category NHS Care Homes, HHSCP



Health Protection Team Activities

- **Outbreak Management**: Managed 123 outbreaks (respiratory/gastrointestinal) and provided IPC support.
- **Training**: IPC education delivered to 889 staff, interactive sessions with residents, and IPC Link Practitioner training.
- **Additional Activities**:
- Hand hygiene sessions with residents.
- Ongoing data collation and feedback for Care Home COVID-19 Inquiry requests.
- Development of support materials based on training feedback.

Lead Nurse Activities

- Visits and Support: Regular visits to care homes for support and completion of mandatory documentation.
- Training Initiatives:
- Development of Waterlow training material with competency assessment.
- Training on venepuncture, verification of death, and catheterisation.
- Participation in various groups and committees to enhance care home support.
- Developing a services who to call poster and when – to be released soon in collaboration with Highland Hospice, SAS, NHSH, Scottish care colleagues hopefully including a Prof to Prof line.

- Linking in with SAS for data surrounding call outs and hospital conveys with reasons of call, linking in with practical sessions on RESTORE 2 roll out and SAS webinar on what to expect when you phone 999 to be rolled out soon.

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Date	Independent Sector / NHSH	Purpose/Activity
Nov 2024	IS x2	Support as under LSI
	IS	Support as under LSI
Dec 2024	IS	Support
	IS	Support
	IS	Support
Jan 2025	NHSH	Support and completion of mandatory documentation
	IS	Support and completion of mandatory documentation
	NHSH x2	Support and completion of mandatory documentation
	NHSH	Support and completion of mandatory documentation
Feb 2025	IS	Support as under LSI process
	NHSH	RIDDOR report with H&S (31/1/25)
	NHSH	RIDDOR report with H&S (28/2/25)
	NHSH	Recruitment
	IS	Support
	IS	Review
Mar 2025	NHSH	Support

Date	Independent Sector / NHSH	Purpose/Activity
	NHSH	Support
	IS	Support for manager
	NHSH	RIDDOR checklist with health and safety (19/3/25)
	IS	Support for manager

Independent Sector Career & Attraction Lead (Care Homes) Annual Summary 2024 - 2025

Scottish Care – Social care that works for Scotland

Partners for Integration

Collaboration & Engagement

Visited and/or engaged with 96% of IS CHs

9,400 visits to CH Map

Joint working with NHSH colleagues

VR Collab with UHI Inverness

CARE REALITY

Directly engaged with 1,032 people at Career Events

22 Care Homes participated in Career activity

External Partners

job centre plus · Triage · The Highland Council Comhairle na Gàidhealtachd · work.life.highland · UHI · DYW · Skills Development Scotland

Online Presence & Media

Reach 50,072
Views 143,427

Impressions 15,923

Impressions 15,502

CARE HOME CAREERS HIGHLAND

'What I love about working in a care home' - viewed over 10,000 times

HIGHLIGHTS talking health and social care

Careers in Care Podcast with NHSH Partners

Ministerial Visit - *'Its really powerful to see and hear the challenges facing the Care Home……helps me to fight hard for social Care' – Maree Todd*

BBC Alba 'Who Cares?' programme

EÒRPA

Professional Carers Week

Opportunities & Employment

Identifying opportunities to utilise Third sector paid placements

hi-hope.org

Experiences for students to try care through interactive activities or in a work experience

Developing resources to support to C&A Lead activity

Hosted a targeted Care Home Careers Event

Ensuring Care Homes are represented at all job fairs by keeping up to date with Job vacancies

Promoting Apprenticeship opportunities

23.66% reduction in staff vacancies across Independent Sector Care Homes compared to March 2024

'I don't know how you come up with all your ideas, I think it's great' – Care Home Manager

"Fabulous piece of work" - NHSH colleague in ref to Care Home Map

"It was really good to connect with young people, I would definitely do this again" – Care Home Manager

"Having Laura in this post has been great, it's the best engagement we've had from the sector in a long time" – UHI Partner

Agenda Item 3.2

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**7 May 2025**
Title:	**Vaccination Update**
Responsible Executive/Non-Executive:	**Dr Tim Allison, Director of Public Health and Pamela Stott, Chief Officer**
Report Author:	**Dr Tim Allison, Director of Public Health and Pamela Stott, Chief Officer**

Report Recommendation: Members are asked to consider and discuss the issues raised in this paper.

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.
- Government policy/directive

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

2 Report summary

2.1 Situation

The purpose of this paper is to provide the Committee with an update of the outcome of the options appraisal submitted to Scottish Government, the Response from the Cabinet Secretary for Health, and an outline of the plan for implementation of the option appraisal for Highland HSCP.

2.2 Background

Concern about performance of the vaccination programme within Highland HSCP led to escalation in performance management framework from Scottish Government in November 2023 for Highland HSCP. A peer review from Public Health Scotland had been planned and this was accelerated following a serious adverse event. The peer review reported on the whole of NHS Highland. Work has been progressed to assess the best delivery model for vaccination in Highland HSCP and an option appraisal for rural flexibility for primary care delivery of vaccinations was submitted to Scottish Government for consideration in November 2024, for consideration at the GMS Oversight Committee.

A response to the options appraisal was received from the Cabinet Secretary for Health and Social Care, Scottish Government at the end of January. There was support for implementation of a new system in line with the submitted appraisal and limited to Highland HSCP.

Vaccination improvement work has been reviewed and consolidated into a work plan. This plan includes actions to implement the options appraisal as well as carry on the work to address the findings from the Public Health Scotland peer review and Serious Adverse Event Report.

2.3 Assessment

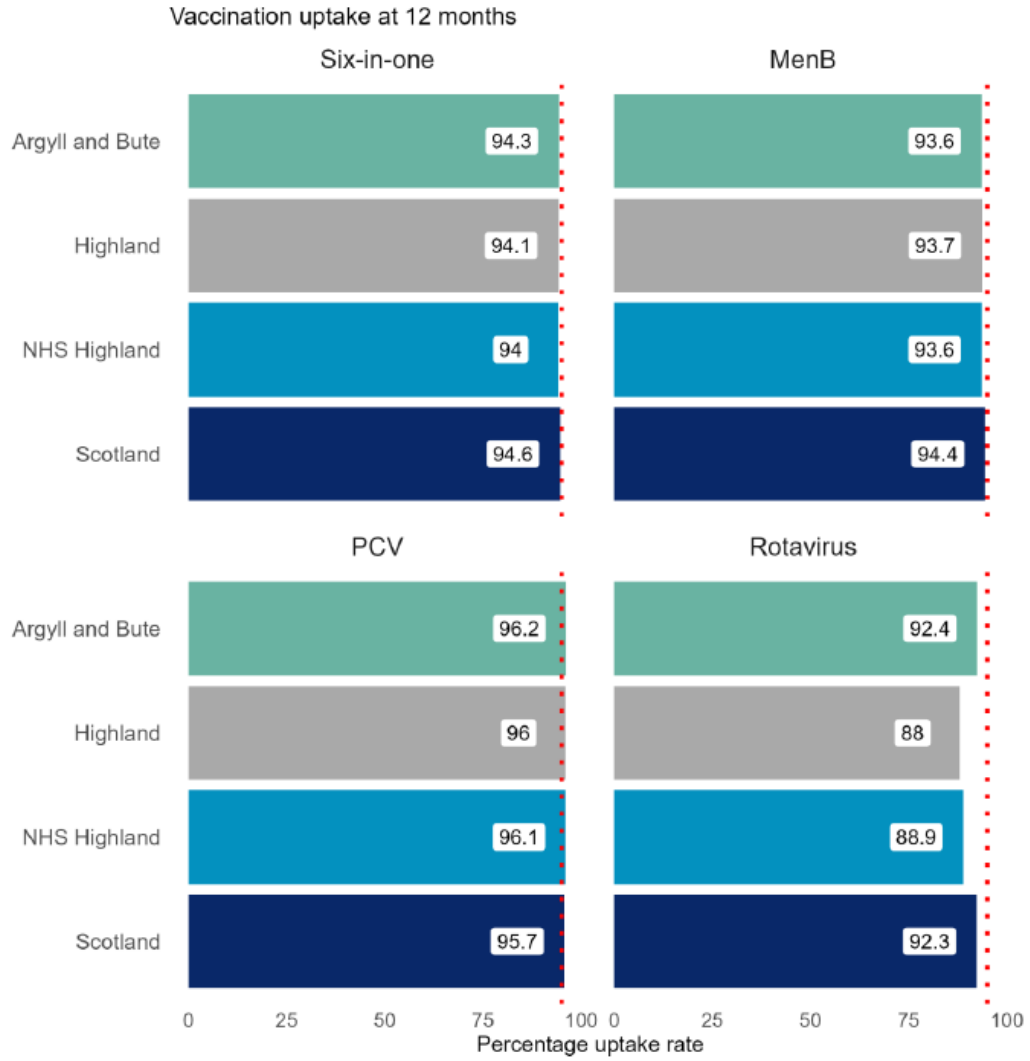
2.3.1 Vaccine Performance

Childhood Vaccination

Childhood vaccination figures have shown some improvement in uptake, especially for the first course of vaccination within Highland HSCP. However, there is still a need to improve childhood uptake figures as well as other measures of performance. The following table shows the latest available quarterly

performance in one part of the programme and there are regular reviews of performance across the different elements and localities.

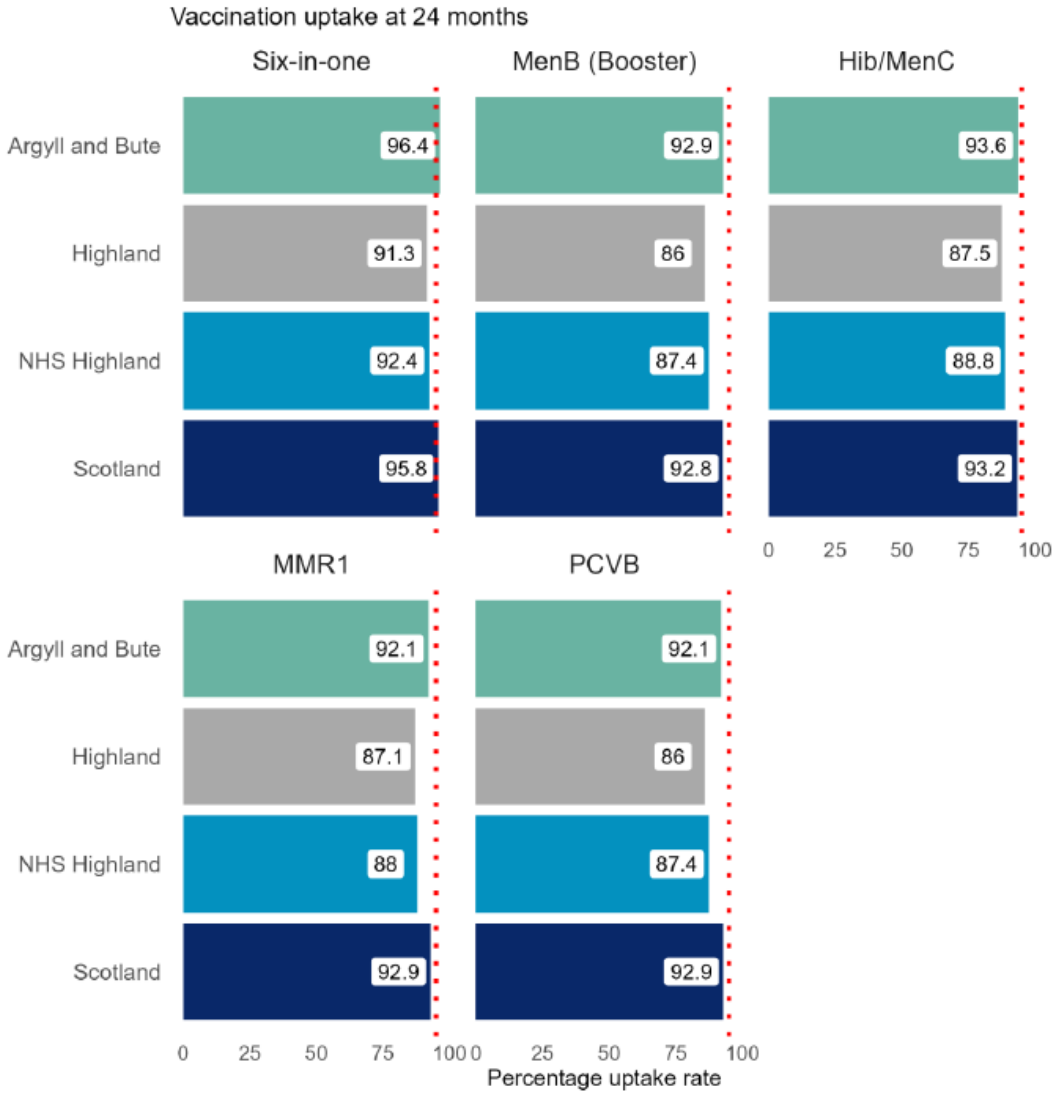
Figure 1: Primary immunisation uptake rates by 12 months of age[1,2]
Quarter ending 31 December 2024



Childhood vaccination uptake at 12 months of age for the last quarter of 2024 showed similar figures to the previous quarter. Uptake of 6 in 1 vaccination has maintained its recovery, although it is still slightly below the WHO target figure of 95%. There is also a need to improve the timeliness of vaccinations.

The uptake of vaccines at 24 months such as MMR remains a concern with a continued decline and actions are being identified for implementation to improve coverage.

Figure 5: Primary and booster immunisation uptake rates by 24 months of age[1,2]
Quarter ending 31 December 2024



Adult Vaccination

The autumn and winter programme of seasonal COVID and influenza vaccination has nearly closed and the great majority of uptake both locally and nationally happened before the end of 2024. The following table shows uptake within NHS Highland compared with Scotland and uptake figures for NHS Highland are similar to those nationally.

Seasonal Vaccination Uptake as of 16 February 2025

	NHS Highland	Scotland
Total COVID	49.0%	47.4%
Total Influenza	53.4%	53.1%
Care Home Residents COVID	80.9%	81.5%
Care Home Residents Influenza	82.6%	83.5%
NHS Front-Line Staff COVID	21.8%	20.7%
NHS Staff Influenza	28.8%	30.2%

Argyll and Bute HSCP tends to have slightly higher figures than Highland HSCP and the overall uptake figure for NHS Highland tends to be relatively higher than that for individual age groups given the age structure. So, the total figure for NHS Highland is higher than an age-adjusted figure would be. COVID vaccination has been available only for frontline NHS staff while influenza vaccination has been available for all NHS staff.

2.3.2 Vaccine Service Implementation for Highland HSCP and General Practice

The NHS Highland Health and Social Care Partnership (HHSCP), in collaboration with General Practice, aims to implement a collaborative vaccination service delivery model.

This hybrid model seeks to enhance immunisation coverage, improve patient access, and optimise healthcare resources through an integrated, multidisciplinary approach.

The attached report Implementation of a Collaborative Vaccination Service within Highland Health & Social Care Partnership and General Practices (APPENDIX 1) details the approach, risks, and benefits of implementing this model, with a primary focus on patient safety. It highlights collaboration with healthcare staff to ensure best practices are followed and outlines strategies to minimise barriers, making vaccinations more accessible and efficient for all.

An implementation Plan Timeline is outlined at APPENDIX 2.

Key Milestones:

Birth and Pre-school Vaccinations: Mobilisation will take place from June 2025.

Adult Vaccinations: Mobilisation will take place between September - December 2025 in line with the Winter vaccination programme.

2.3.3 Vaccine Tripartite Advisory Group

Scottish Government and Public Health Scotland have agreed to implement a working group to support the delivery of the mixed model for vaccinations. The advisory group will include representation from Highland HSCP, PHS and the Scottish Government.

The advisory group's primary purpose will be to offer external support and challenge to Highland HSCP as it develops and implements the mixed model of vaccine delivery. This will be done in the context of the Cabinet Secretary for Health and Social Care's agreement to the mixed model as per his letter of 27 January and the recommendations of PHS's peer review of NHS Highland, as well as the policy priorities represented on the group; and will:

- Provide a route for PHS to offer advice on the mixed model as it is developed and implemented.
- Support a co-ordinated and coherent communications strategy about the mixed model between the three partners.
- Allow SG to ensure Ministers are kept updated on the progress of the mixed model.
- The group will meet once per month.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	X	None	

Comment on the level of assurance

Vaccine Performance: Assurance for Argyll and Bute is moderate or substantial depending on the impact of finance. Assurance is limited for Highland.

For both HSCP areas there is a need to ensure that an effective model in remote and rural areas can be sustained and that staffing challenges can be met, especially in Highland HSCP.

Once there is an agreed delivery model in place and evidence of its effect on performance, assurance may be able to increase to moderate for Highland HSCP.

3 Impact Analysis

3.1 Quality/ Patient Care

Delivering a good quality and accessible vaccination service is important. Patient and public experience and feedback needs to be a major driver of the improved service.

3.2 Workforce

Recruitment and retention of staff is continuing to be a challenge especially in Highland and further plans for delivery models need to address this, engaging with staff. It is also important to have good measures of staff satisfaction.

3.3 Financial

Financial considerations were undertaken as part of the options appraisal process but delivering existing and new vaccination programmes within the current budget is challenging.

3.4 Risk Assessment/Management

The main risks for delivery of the programme relate have been identified through consideration of the recommendations of the peer review and include risks relating to leadership, workforce, systems and service model.

3.5 Data Protection

There are no new data protection issues connected with this work.

3.6 Equality and Diversity, including health inequalities

The work to implement vaccination programmes has sought to address issues of isolation and to provide an equitable service across NHS Highland. Further work will be needed to promote uptake and reduce inequalities.

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

Discussions have been undertaken with various stakeholders since the start of delivery of vaccination programmes and there is active communication with Scottish Government, GPs, staff and with politicians. Improvement in engagement is a recommendation from the peer review.

3.9 Route to the Meeting

This paper is based on discussions with NHS Highland staff, Public Health Scotland staff and Scottish Government escalation meetings.

Implementation of a Collaborative Vaccination Service within Highland Health & Social Care Partnership and General Practice

Version 6 – final version

27 March 2025

Executive Leads: Pamela Stott, Chief Officer, Highland Health & Social Care Partnership; Tim Allison, Director of Public Health & Policy

1. Introduction

The NHS Highland Health and Social Care Partnership (HHSCP), in collaboration with General Practice, aims to implement a collaborative vaccination service delivery model. This is based on an Options Appraisal compiled by a multi-disciplinary stakeholder group which was presented in December 2024, to the Scottish Government General Practice Programme Board. This hybrid model seeks to enhance immunisation coverage, improve patient access, and optimise healthcare resources through an integrated, multidisciplinary approach. This report details the approach, risks, and benefits of implementing this model, with a primary focus on patient safety. It highlights collaboration with healthcare staff to ensure best practices are followed and outlines strategies to minimise barriers, making vaccinations more accessible and efficient for all.

Whilst the delivery of the routine immunisation programme will be a collaborative hybrid model which will be led principally by general practices and vaccination teams, it is recognised that other services and teams have an integral role in the delivery of the programme (i.e. the role of midwifery within the maternal programme, the role of community pharmacy in the delivery of the travel health service and the seasonal campaigns and the role of occupational health in the delivery of staff vaccinations, for example). Further detail regarding the programme is incorporated within the NHS Highland Strategy for Vaccination and Immunisation.

2. Vision

To ensure our communities are protected from vaccine preventable diseases and that the risk of outbreaks is minimised, and health inequalities are reduced through the delivery of an effective, safe, person-centred accessible vaccination service.

3. Aims and Objectives

The overall aim of the HHSCP immunisation programme is to protect the population from vaccine preventable diseases and reduce the associated morbidity and mortality and minimise the risk of outbreaks.

To achieve this aim, we would be seeking to deliver a population-wide programme which delivers against the following objectives:

- Identifies the eligible population and ensures effective timely delivery which enables the highest possible uptake rates within the eligible population and reduces the risk of outbreaks of vaccine-preventable diseases
- Is patient-centred and is delivered as close to home as reasonably practicable with at least an equivalent level of access compared to pre-VTP
- Is safe, effective, of a high quality and is independently monitored
- Is efficient, cost-effective and sustainable
- Is targeted to support increased uptake across hard-to-reach groups and underserved populations to address existing health inequalities
- Is delivered and supported collaboratively by suitably trained, competent and qualified staff who participate in recognised ongoing training and development and who are respected and feel valued
- Supports opportunistic catch up as part of holistic care
- Delivers, manages and stores vaccine in accordance with national guidance
- Supported by regular and accurate data collection using the appropriate recording mechanisms which provides information at a local, regional and national level
- Is supported and informed by regular public and professional stakeholder engagement and communication
- There is strong leadership and effective governance across local vaccination delivery

4. Approach to Implementation

The project will be underpinned by a comprehensive change management plan that includes a clear, detailed timeline for all phases of the implementation process. This timeline will span from planning to full rollout, incorporating key milestones, deadlines, and checkpoints to ensure that the service model is delivered on time and within scope. An implementation group will be accountable for progress, ensuring that any obstacles are addressed swiftly, milestones are completed on time and risk managed accordingly if delays anticipated and regular updates will be communicated to all stakeholders. The timeline will be finalised by the end of March 2025, ensuring a coordinated and structured implementation process.

As aforementioned, the NHS Highland vaccination programme is expansive, therefore not all areas of the programme are in scope of this work.

Areas of scope have been summarised below:

Birth and Pre-school Vaccinations

Our delivery model will be aligned to the strategic intent to best meet the needs of Scotland's immunisation programme. As part of this collaborative approach, general practice will deliver birth and pre-school immunisations, and vaccination teams will be critical in the delivery of outreach and targeted work to address inequalities in childhood vaccinations.

The initial focus of delivery within General Practice will be birth and pre-school vaccinations. Significant improvement work has been required to improve the uptake and safe delivery of birth and pre-school vaccinations. To ensure sustained improvement and quality assurance, all GP practices, irrespective of rural classification, will be provided with the option of delivering birth and pre-school vaccinations for their registered population. This will be through a local enhanced service specification (birth and pre-school vaccinations) aligned to payment mechanisms outlined in PCA2022-M-07. For those practices who do not take up this offer, NHS Highland vaccination team will continue to deliver this service. Mobilisation will take place from June 2025.

Adult Vaccinations

The delivery of adult vaccinations will be through both GP practices and vaccination teams with the respective teams leading on different parts of the adult programme. Additional opportunistic vaccination will be supported by both primary care and vaccination teams.

Once the first phase of vaccination delivery (birth and pre-school vaccinations) has been tested and rolled out in full, a detailed implementation plan will be defined for the delivery of adult vaccinations. The plan will take into consideration the total cohort number of patients eligible for vaccination as the volume of vaccination activity as has increased significantly since 2023 when vaccinations transferred out of General Practice under VTP. Local discussions will be undertaken with GP Practices as to the capacity that can be offered and a hybrid delivery plan put in place. This will be through a local enhanced service specification (adult vaccinations) aligned to payment mechanisms outlined in PCA2022-M-07. For those practices who do not take up this offer, NHS Highland vaccination teams will continue to deliver this service. Mobilisation will take place between September - December 2025 in line with the Winter vaccination programme.

The implementation of the collaborative vaccination service model will be guided by the following key components:

4.1 Stakeholder Communications and Engagement

- Establishing an Implementation Group comprising operational and professional leads from HHSCP and General Practice (i.e. nurses, practice managers, GPs), pharmacists, public health and immunisation specialists, finance, strategy & transformation and child health professionals who deliver vaccinations.
- Conducting stakeholder meetings to define roles, responsibilities, and service expectations.
- Implementing a comprehensive communication and engagement strategy to support the lifecycle of the project, including public engagement for information dissemination, workforce engagement to support collaborative efforts, and intra-project engagement to facilitate assurance and accountability mechanisms required to implement the model safely.

4.2 Service Integration and Delivery Model

- Implementing a hybrid, collaborative and strategically aligned model, ensuring patients have the flexibility to receive immunisations at their general practice where possible. Where the use of GP practices is not possible, the priority is to deliver in health board venues such as community hospitals and clinics.
- Utilising shared IT systems across HHSCP and GP for patient scheduling/appointing, data recording and reporting in line with the expectations of the Scottish Vaccination and Immunisation Programme (SVIP).
- Optimising timely vaccination uptake through ensuring consistent, standardised approaches to service delivery processes from supply chain through to service delivery.

4.3. Workforce Development

- Two Staff-Side representatives have been identified to support General Practice and HHSCP vaccination teams through workforce development processes entailed with the implementation of a collaborative model; both representatives attend the Implementation Group.
- Recognising that effective training is key to a smooth transition to a collaborative vaccination service, a tailored training plan will be developed for general practice and HHSCP vaccination teams utilising the national resources provided through SVIP where appropriate. This will cover the necessary clinical protocols, digital systems, patient communication and vaccine administration procedures. The training plan will include both initial and regular training sessions to address evolving needs, ensuring all staff are confident and competent in their roles. The training plan will also involve

support for new staff and refresher courses for existing teams, with an emphasis on maintaining consistent standards across the service, including all participating General Practices. A pre-audit process will be undertaken in advance of the service commencing in General Practice and will capture personnel delivering the service and details of training undertaken.

- Understanding whether additional capacity will be required to safely sustain vaccination service delivery through a collaborative approach; The service is required to adapt to changing incidence, emergent infections and outbreaks whilst responding to the development of new programmes or declining uptake rates.
- Developing a collaborative, hybrid model will require a review of the configuration and remits of NHS Highland Vaccination Team. Once the totality of GP flexibility is defined through acceptance of a local enhanced service for respective patient cohorts, a piece of work will be undertaken to review the staffing requirements and components of the existing programme.

4.4. Digital and Operational Infrastructure

- Use of existing IT systems to support seamless record-keeping and reporting across HHSCP and GPs in line with SVIP expectations.
- Clear data entry protocols will be established, and regular audits will ensure compliance. The enabling digital infrastructure will be identified and implemented early in the process, with data-sharing systems that comply with regulations and a robust security framework to protect patient information. This ensures real-time monitoring of vaccination coverage and enables the continued efficient reporting to the Board and PHS.

4.5. Community Outreach and Targeted Work to Address Inequalities

- Running targeted approaches to support increased uptake across our hard-to-reach groups and underserved populations in order to address existing health inequalities.
- Running targeted vaccination campaigns for priority groups (e.g., elderly, immunocompromised, and children).
- Ensuring public awareness of a dually operational GP and HHSCP vaccination delivery model.

4.6. Ensuring the Service Continuously Improves Once Mobilised

- The strategic plan will set out how the vision will be met through the objectives. Local objectives align with the goals set out within Scotland's 5-year vaccination and immunisation framework and the vaccination standards set for NHS Boards as part of the Annual Delivery Plan. A robust performance

and quality assurance framework will be established monitor and evaluate the service's performance throughout its rollout in keeping with the expectations of SVIP

- A measurement plan will be set to ensure service quality is consistently met across all localities and services in keeping with the expectations of SVIP and as set out within the NHSH vaccination strategy.
- Feedback loops will be incorporated to address any gaps in service provision, with rapid adjustments made based on data and evaluations, ensuring continuous improvement and equitable service delivery.

5. Implementation Summary

The implementation of a collaborative approach to vaccination service delivery within the HHSCP vaccination teams and general practice aims to streamline the process of vaccine administration, enhance patient access, and leverage the expertise of both HHSCP vaccination teams and general practice. This collaborative approach ensures the efficient use of resources, with clear governance, communication, and support frameworks throughout the entire process.

Phase 0: Project Initiation

In Phase 0, the first critical steps include the approval of the proposal to deliver a collaborative vaccination service delivery model by relevant stakeholders, such as the Scottish Government, and the formal closure of the Vaccination Implementation Group (VIG). This phase lays the groundwork for the project by ensuring that all necessary planning documents, such as the milestone plan, are in place to guide future actions. A multi-disciplinary project implementation group is established, including representatives from various sectors, such as general practice, public health, and eHealth. This collaborative group ensures that all perspectives are considered when defining the project's scope, goals, and governance structure. It also ensures that clear lines of communication are established, and roles and responsibilities are defined. This phase focuses on setting up a framework for the vaccination programme that ensures alignment with best practices and facilitates a structured, coordinated approach to transformation.

Additionally, detailed service specifications for birth and pre-school and adult vaccination delivery will be developed, ensuring alignment with best practice guidelines. These specifications will outline costing methodologies, role delineations between general practice and HHSCP vaccination teams, IT system requirements, and vaccine delivery responsibilities. The Local Enhanced Service (LES) specification for adult vaccinations will be aligned with the payment mechanisms outlined in PCA2022-M-07 with annual uplifts applied.

To support digital and operational infrastructure, a framework for eHealth and IT systems will be determined to facilitate seamless service delivery. A Short-Life

Working Group (SLWG) will also be established to develop an approach to planned childhood vaccination schedule changes. This approach will undergo review by the Implementation Group before final approval by the vaccination governance structure, ensuring readiness for transition and long-term sustainability.

Phase 1: Planning – Birth and Pre-school and Adult Vaccinations in a Collaborative Model

Phase 1 focuses on assessing preparedness of all general practices and vaccination teams for the implementation of the collaborative vaccination service model. A detailed service specification will be shared with GP Sub Committee and Highland Local Medical Committee (LMC).

A key action in this phase is conducting a pre-audit to gauge each practice's capacity and ability to meet the requirements of the new service delivery model, as articulated in the service specification. The timeline for rollout is established, and training programmes are designed to ensure that all relevant staff are well-prepared for the transition. This phase ensures that all necessary resources, such as staffing, technology, and infrastructure, are identified, reviewed and planned for on a practice-by-practice basis. Additionally, the eHealth systems required to manage patient scheduling and reporting are implemented, ensuring data management complies with privacy and security regulations. Effective communication with all stakeholders, including those within general practice, is crucial at this stage to ensure everyone is aligned and ready for the upcoming phases.

The pre-audit data collated from General Practice will provide an assessment of the requirements for the Board delivery aspect under a hybrid model and identify any associated workforce issues that may need to be addressed through an organisational change process. A task and finish group will be established in partnership with staff side to plan this.

Phase 2: Implementation of a Collaborative Vaccination Service Delivery Model

Phase 2 involves the three-phase expansion of the birth and pre-school vaccination service and full mobilisation of the adult vaccination service across all participating GP practices. During this phase, the service model for birth and pre-school and adult vaccinations is implemented methodically at pace with each GP practice receiving comprehensive training and support. A clear communication plan ensures that both staff and patients are informed about vaccination availability, booking procedures and any changes in the process for accessing vaccination. The planned phased rollout allows for careful monitoring of childhood vaccination uptake and timeliness of delivery, patient management and process efficiency. Data collection is critical in this phase to monitor key performance indicators track vaccination rates, monitor the accuracy of reporting and ensure that any issues are addressed in a timely manner. Support systems are in place to assist GP practices and vaccination teams throughout the process, ensuring that any operational challenges are quickly

resolved. By the end of this phase, the service model for birth and pre-school and adult vaccinations should be fully operational across all teams and participating practices, with continuous oversight to ensure quality standards are maintained in line with clinical guidelines and in accordance with the SVIP standards.

Phase 3: Evaluation, Continuous Improvement and Stabilisation

Phase 3 is focused on ensuring the long-term sustainability of the vaccination service model. In this phase, data from the implementation across the service all general practices is analysed to identify areas for improvement in service delivery, efficiency and staff/patient satisfaction. Coupled with this, a needs assessment is utilised to inform of future opportunities to improve and sustain service delivery within a collaborative vaccination service model. A post-rollout survey is conducted to gather feedback from both staff and patients and wider stakeholders, which will help refine the service model and improve future vaccination efforts. Regular evaluations, in line with NHS Highland clinical governance practices, track progress against key performance indicators, such as vaccination uptake rates and timeliness of vaccination, patient feedback, and the accuracy of data reporting. Any challenges or barriers identified during Phase 2 are addressed through continuous improvement initiatives, ensuring that the system remains flexible and responsive to changing needs. As the service stabilises, the focus shifts to ensuring its sustainability, with processes in place to maintain the quality and efficiency of the vaccination service over time, and to adapt as necessary for future population needs and the implementation of new programmes.

A robust evaluation programme will be established to assess the effectiveness, impact, and sustainability of the collaborative vaccination service model compared with the previous delivery model. This evaluation will focus on indicators such as vaccination uptake, patient satisfaction, cost-effectiveness and overall service quality and will reflect the key performance indicators developed to support the SVIP standards. This evaluation will take place as part of project closure once the service is stabilised.

6. Risks to Implementation and Mitigation Strategies

The risks associated with implementing a collaborative vaccination service model are systematically addressed through task-based mitigation strategies within the implementation plan and accompanying documents, such as the communications and engagement plan. A summary of the highest impact (high likelihood and consequence) risks is noted below, however it is noted that this not a complete list of all the risks entailed with this work.

Risk Description	Mitigation

Digital and Data Infrastructure - Inadequate and inconsistent IT infrastructure could hinder the efficient and safe management of patient scheduling, reporting and tracking of vaccinations.	Digital option review commissioned by Implementation Group to identify gaps in current system and propose options for consideration and decision for implementation as part of a collaborative, integrated vaccination service delivery model. It is currently undetermined whether an IT solution will require funding to address.
Communications and Engagement – staff and public – Unclear communication with staff and the public could lead to confusion, misinformation and low participation in the vaccination programme.	Develop a clear and consistent communications plan that includes messaging for both staff and the public, with regular updates at key milestones. Use multiple channels (e.g., email, internal portals, social media, posters, newsletters, websites) to communicate with different audiences, ensuring the information is accessible and understandable. Provide detailed training for staff on key vaccination programme components, including timelines, processes, and frequently asked questions (FAQs). Launch a public awareness campaign using various platforms to inform patients about vaccination availability, the importance of getting vaccinated, and how to access the service. Implement feedback mechanisms (e.g., surveys, focus groups, digital platforms such as CareOpinion) to gather input from both staff and patients to continuously improve service delivery process and identify opportunities to improve communications.
GP Contractual Arrangements - GP practices may be unwilling or hesitant to engage in the collaborative vaccination service due to concerns about contractual obligations, remuneration, or changes in workload.	Engage with GPs early in the planning process to discuss contractual terms, expectations, and the benefits of participating in the vaccination programme. Ensure that the service specification clearly outlines the roles, responsibilities, and remuneration models for GP practices, ensuring these are fair and in line with policy. Consult with the Highland Local Medical Committee (LMC) to ensure that the contractual arrangements are acceptable and feasible for all involved parties. Offer flexibility in the implementation to allow GP practices to scale their participation based on their available capacity. Develop a clear process for contract negotiation that addresses any concerns or issues raised by GP practices.

GP Interest and Involvement - The number of GPs committing to delivering vaccinations may be smaller than originally surveyed through the options appraisal (August 2024) and rural GPs may opt-out which would not address inequalities	Offer dedicated support and training to help GP practices implement the new service model efficiently. Facilitate peer discussions and forums where GP practices that have successfully implemented the model can share best practices and lessons learned with others. Identify and address concerns early, ensuring that GPs feel their concerns are being heard and addressed by the implementation group.
Alignment to National Plan for Vaccinations - Misalignment between the collaborative vaccination service delivery model and the broader national vaccination strategy could lead to inefficiencies, waste or gaps in service delivery.	Ensure that the service specification and implementation plan are aligned with national immunisation guidelines and objectives, including age groups, vaccine types, and schedules. Regularly consult with national public health agencies (e.g., Public Health Scotland) to ensure that the local programme is in sync with national priorities and best practices. Incorporate feedback from national immunisation experts into the design and delivery of the programme to ensure consistency with broader policy. Ensure continued involvement with the Scottish Vaccination and Immunisation Programme (SVIP). Monitor and benchmark the implementation against national vaccination targets and peer Boards, ensuring that the delivery model contributes effectively to achieving vaccination coverage goals and standards set for vaccination. Regularly review and update the vaccination protocols to ensure that changes in the national strategy are reflected in the local service delivery.
Clear Governance and Accountability Structure	Establish a clear governance structure that includes a steering group with defined roles and responsibilities for all stakeholders, such as HHSCP teams, general practices, public health teams, and eHealth services. Define accountability and reporting mechanisms to ensure that all parties are aware of their responsibilities and completion timelines. Regularly review progress against KPIs ensure that the project is on track and any issues are quickly identified and addressed. Provide clear decision-making protocols, ensuring that issues can be escalated promptly

	to the appropriate level within the agreed governance structure. Foster transparent communication between teams and the Implementation Group to ensure that all parties are informed and can contribute to decision-making processes. Ensure ongoing engagement through regular meetings and updates, which will help maintain accountability and alignment throughout the project.
Readiness of new child health system (for call and recall), which is dependent on a provisional National go-live date of 23rd June 2025	Legacy system can be utilised in the current form, however the new system will be different and contingency arrangements may be required as part of detailing IT requirements in the service specification.
Risk to overall logistical cold chain due to challenges in stock management, including inconsistent pharmacy communication, increased distribution demands across multiple sites and potential transport pressures from local stock movement	Ensure regular communication methods used across practices, using learnings from A&B vaccination supply chain model. Ensure procurement/pharmaceutical/logistical model sufficiently staffed.

7. Benefits to the Health Board and Highland Population

A collaborative vaccination service leverages a more inclusive, patient-centred healthcare system, where the benefits of timely immunisation are accessible to all, leading to improved public health outcomes and stronger community resilience. A summary of the relevant benefits and impacts associated with the project has been provided below.

7.1 Enhanced Accessibility through Multiple Service Points, Increasing Immunisation Rates

- **Benefit**: By establishing locally accessible vaccination services, patients can access vaccination services in a more convenient, opportunistic and timely manner. This geographic and logistical flexibility makes it easier for individuals from all demographics (especially those in rural or underserved areas) to get vaccinated.

- **Impact**: Increased accessibility lowers the barriers to vaccination, particularly for vulnerable populations such as the elderly, children, and individuals with mobility challenges. This will support increased uptake of timely vaccination,

contributing to herd immunity and reducing the overall prevalence of vaccine-preventable diseases within the community and improving health outcomes for the population.

7.2 Reduced Burden on Health Services Due to a Lower Incidence of Vaccine-Preventable Diseases

- **Benefit**: A robust vaccination program directly impacts the incidence of preventable diseases such as influenza, pneumococcal disease and measles, which in turn reduces healthcare presentations, hospital admissions and the need for intensive care services.
- **Impact**: By preventing diseases that can otherwise lead to healthcare presentations and hospitalisations, there is less strain on healthcare resources. This allows hospitals and healthcare facilities to allocate resources more efficiently to non-preventable conditions, thereby improving overall health system performance. Additionally, reducing preventable diseases means fewer long-term complications, decreasing the burden on both primary and secondary care services.

7.3 Improved Workforce Utilisation by Involving Multiple Healthcare Professionals in Service Delivery

- **Benefit**: The involvement of a diverse group of healthcare professionals, including trained HHSCP staff and GPs, maximises the use of the existing workforce to support service delivery. Each healthcare professional can contribute according to their expertise and role, allowing for a more efficient and coordinated service delivery model which aims to fulfil all of the objectives of the vaccination programme.
- **Impact**: This approach ensures that staff are deployed where they are most needed, reducing bottlenecks and improving overall efficiency in service delivery. This will also enable further capacity for addressing health inequalities which has been a significant challenge within the current model.

7.4 Financial Value Through Shared Infrastructure and Reduced Duplication of Efforts

- **Benefit**: Collaborating between GP practices and vaccination teams allows for the sharing of infrastructure, such as vaccination clinics, technology platforms for scheduling and reporting, and logistical resources like vaccine storage and transportation. This collaborative infrastructure significantly reduces the need for separate venues, systems, equipment, and training, which can be costly to duplicate.

- **Impact**: The pooling of resources and collective purchasing power can lead to cost efficiencies. Moreover, centralised data reporting systems ensure that resources are deployed more effectively, preventing wastage or underutilisation of vaccines.

7.5 Increased Patient Trust and Confidence in Vaccination Programmes Through Better Communication and Accessibility

- **Benefit**: A well-delivered vaccination programme that is easily accessible and supported by transparent communication fosters greater trust in the vaccination process. When patients have clear, consistent information about the benefits and safety of vaccines, and can easily access them at convenient locations and times, they are more likely to engage in vaccination programmes.
- **Impact**: Higher patient confidence translates into improved immunisation uptake, which is essential for achieving herd immunity. Over time, this increases the public's general acceptance of vaccines and helps combat vaccine hesitancy, ultimately leading to better overall health outcomes for the community. Effective communication, including addressing concerns and educating patients, empowers individuals to make informed decisions about their health.

7.6 Strengthened Public Health Response & Resilience

- **Benefit**: A collaborative vaccination service delivery model enables a rapid, coordinated response to vaccine-preventable outbreaks and better supports pandemic preparedness. In times of crisis, the established infrastructure can be swiftly scaled up to reach large numbers of people efficiently, ensuring that immunisation efforts are timely and comprehensive.

- **Impact**: By having a more responsive delivery model which can adapt to emergent infections and outbreaks, responses to public health emergencies can be more agile and precise. This helps support outbreak management and prevention of transmission which in turn can support a reduction in morbidity and mortality. Additionally, rapid deployment of vaccines can prevent further strain on healthcare systems during pandemics or seasonal outbreaks.

7.7 Real-Time Monitoring and Reporting for Evidence-Based Decision-Making

- **Benefit**: With a strong digital infrastructure aligned with the Vaccine Management Tool and integrated reporting systems, which is a key requirement as part of this service model, vaccination uptake and outcomes can be monitored consistently across general practices and vaccination teams. This data provides valuable insights into the effectiveness of vaccination campaigns, patient demographics, geographic coverage and any areas requiring additional focus.
- **Impact**: Data that is readily available allows for proactive decision-making and adjustments to the vaccination programme. For example, if certain regions are experiencing low uptake, targeted interventions can be deployed to address barriers or gaps. Additionally, this evidence can be used to inform future public health strategies, ensuring that the vaccination programme evolves in response to changing needs and conditions. This data-driven approach strengthens the overall resilience of the healthcare system, making it more responsive to emerging public health challenges.

8. Conclusion

The successful implementation of the vision for a collaborative vaccination service delivery model requires careful planning, time resource, stakeholder engagement, robust governance and effective communication. Through the strategic phases outlined in this plan, and through careful adherence to risk mitigation strategies, the collaboration between HHSCP vaccination teams and GP practices will provide a streamlined, efficient, and accessible vaccination service that meets both local and national health objectives.

Agenda Item 3.3

NHS Highland

Meeting:	**Health and Social Care Committee**
Meeting date:	**7 May 2025**
Title:	**Fees and Charges Report**
Responsible Executive/Non-Executive:	**Pamela Stott, Chief Officer**
Report Author:	**Colin Stewart, Acting Commissioning, Contracts and Compliance Manager on behalf of the Chair of the Adult Social Care Fees Commissioning, Briefing and Instruction Group.**

Report Recommendation:
The Health and Social Care Committee is asked to **note** the content of this report.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Emerging issue

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

NHS Highland (NHSH) relies heavily on the capacity, availability and quality of independent sector care home provision as part of the wider health and social care system.

As in previous years, there have been continued concerns regarding independent sector viability over the last 12 months, mainly around the ongoing operational and financial sector pressures relating to small scale, remote and rural provision and the challenges associated with attracting and retaining staff, and the financial impact of agency use

The Scottish Government has provided funding to deliver a £12.60 minimum wage for all adult social care staff providing direct care in commissioned services from April 2025.

Delivering a £12.60 minimum wage requires an increase to the fees paid to providers delivering registered commissioned services.

Registered commissioned services include care at home, supported living, housing support, home based respite, registered daycare and care home services. SDS Option 1 direct care assistants are also included within the scope of the funding.

2.2 Background

A pay uplift for adult social care workers was announced on 04 December 2024 by the First Minister as part of the Scottish Budget for 2025/26. COSLA Leaders agreed the initial details of this uplift on 28 February 2025.

The details of the uplift for adult social care workers to a minimum of £12.60 per hour were confirmed in a letter from Donna Bell, Director of Social Care and National Care Service Development, Scottish Government on 11 March 2025. A copy of this letter is attached as **Appendix 1**.

The funding to enable payment of the £12.60 per hour was detailed in a letter from Alan Gray, Director of Health and Social Care Finance, Scottish Government on 19 March 2025. A copy of this letter is attached as **Appendix 2.**

2.3 Assessment

NHS Highland currently commissions approximately £141m of adult social care registered services. This also includes SDS option 1.

To uplift within the scope of the Scottish Government expectations to a minimum of £12.60 per hour, at current level of commissioning is expected to cost around £7.59M.

As part of the implementation planning for the Scottish Government minimum payment of £12.60 per hour, the NHS Highland Adult Social Care Fees Commissioning, Briefing and Instruction Group developed a series of recommendations based on the expectations of the minimum payment and to ensure affordability.

In line with recent practice, the Scottish Government has set out their minimum expectations for registered residential and non residential services. These expectations do not apply to National Care Home Contract (NCHC) care homes, which are subject to the agreement reached between Scotland Excel, COSLA and Scottish Care. The detail of this separate agreement is provided in **Appendix 3**. Whilst separate, this arrangement also includes the minimum £12.60 per hour pay rates.

Calculations of the impact of the minimum £12.60 per hour payment were undertaken by financial colleagues, this along with the proposed fee rates for each type of registered service were considered by the Adult Social Care Fees Commissioning, Briefing and Instruction Group. When satisfied with the affordability, a recommendation was made to the Chief Officer and Director of Finance.

The Chief Officer and Director of Finance agreed the Adult Social Care fee uplift to the minimum payment of £12.60 per hour.

The recommendations that were agreed by the Chief Officer and Director of Finance were then cascaded to the Joint Officer Group for homologation.

2.4 Proposed level of Assurance

Substantial	X	Moderate	
Limited		None	

Comment on the level of assurance

The established process for considering and agreeing fees for 2025/2026 has been followed with the necessary approvals and funding agreement sought before implementation. The increase for non residential registered services has followed the Scottish Government requirements and the residential registered services has followed the National Care Home Contract Settlement as agreed by Scotland Excel and COSLA with Scottish Care the representative body for the care home sector.

3 Impact Analysis

3.1 Quality/ Patient Care

It is anticipated that the commitment to funding and care staff wages will assist to enable providers to recruit and retain staff but we are aware that care providers continue to face significant recruitment challenges with the rate paid to staff identified by providers as being insufficient to recruit and retain staff.

Providers have flagged the impact of the changes to Employers National Insurance and also the increased minimum salary requirements that require to be met by any providers seeking to recruit overseas workers.

3.2 Workforce

The continued commitment to the Scottish Living Wage is anticipated to assist retain care staff, although as noted above providers are advising that a higher rate is required to attract and retain staff.

3.3 Financial

Funding for the minimum £12.60 per hour payment was provided by the Scottish Government. The Highland Council Executive Chief Officer Health and Social Care & Chief Social Work Officer confirmed on 25 March 2025, as per Council budget report the share of the £125m for Highland is £5.625m. Separately there is a national £10m uplift in Free Personal and Nursing Care of which Highland share is £0.438m. Both funding combined built into The Highland Council budget and for pass through to NHS Highland Adult Social Care, a. total of £6.063m.

Any additional financial gap between the £6.063M and the cost to uplift within the scope of the Scottish Government expectations to a minimum of £12.60 per hour, has been included within the estimated £26M funding gap.

3.4 Risk Assessment/Management

The fee uplift has been undertaken in line with governance and to support Scottish Government policy. There is a risk that providers do not pass on the fee increase to their staff, whilst this is unlikely, to provide assurance, providers have been required to sign a declaration confirming the minimum payment of £12.60 per hour will be made. This will be followed up as part of the monitoring of the provider during 2025/2026.

3.5 Data Protection

None.

3.6 Equality and Diversity, including health inequalities

None.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

See 3.9 below

3.9 Route to the Meeting

The fee approach has been previously considered by the following groups as part of the development and approval of the Adult Social Care Fees for 2025/2026.

- Adult Social Care Fees Commissioning, Briefing and Instruction Group 14 March 2025
- Chief Officer and Director of Finance Recommendations Meeting 17 March 2025
- Joint Officer Group, 21 March 2025

4 List of appendices

The following appendices are included with this report:

- **Appendix 1:** Letter from Donna Bell, Director of Social Care and National Care Service Development, Scottish Government

Adult Social Care Pay Uplift 2025-26.pdf

- **Appendix 2:** Letter from Alan Gray, Director of Health and Social Care Finance, Scottish Government.

RLW Funding Letter 2526 125m.pdf

- **Appendix 3**: Letter from Scotland Excel, Scottish Care and COSLA.

2025.04.04 Settlement Letter.pdf

Director of Social Care and National Care Service Development Directorate
Donna Bell

E: donna.bell@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

To: Integration Authority Chief Officers
Integration Authority Chief Finance Officers
Local Authority Chief Executives
Local Authority Directors of Finance
COSLA
Scotland Excel
ILF Scotland
Chief Social Work Officers
Scottish Care
CCPS
Care Inspectorate
Unite
UNISON
GMB
STUC
Care providers

From: Donna Bell, Director of Social Care and National Care Service Development, Scottish Government

Date: 11 March 2025

Adult Social Care Pay Uplift

Dear colleague,

Following agreement at COSLA Leaders on 28 February 2025, I am writing to confirm the initial details of the pay uplift for adult social care workers that was announced on 4 December 2024 by the First Minister as part of the Scottish Budget for 2025/26.

As you are aware, in the Scottish Budget for the 2025/26 fiscal year, it was announced that £125 million will be transferred to Local Government to support the delivery of a £12.60 minimum wage for all adult social care staff delivering direct care in commissioned services from April 2025. This funding will be paid to Local Authorities in the weekly General Revenue Grant payments from April 2025.

There has been political agreement that the uplift to £12.60 per hour will be delivered in the same manner as the uplift to £12.00 per hour for these workers, which was delivered in the 2024/25 financial year.

Scope

The pay uplift will apply to staff providing direct care within Adult Social Care in commissioned services in the third and independent sectors. This will include Supervisors, Practitioners, Support Workers, Personal Assistants, and staff providing overnight support. This funding will apply to workers in care homes, care at home, day care, housing support, adult placement services, respite services and those delivering direct support through all SDS Options.

This funding will enable pay for these workers, in these services, to be uplifted from at least £12.00 per hour to at least £12.60 per hour.

Full details of scope and eligible services can be found at Annex A.

Timing and Process

This funding will take effect from April 2025.

In line with existing process and previous years approach, Local Government and Integration Joint Boards will be working through the required governance, legal and contractual arrangements to deliver this to providers.

Local indications suggest that most payments will be made across April and May, with funding back dated and provided from April 2025. Best endeavours will be made to have all payments with providers by July 2025. However, this relies on the timely return of contract variation letters by providers and payments will not be released until providers return their signed contract variation letters.

The Scottish Government and COSLA will meet with Scottish Care, Coalition of Care and Support Providers Scotland (CCPS) and Trade Union representatives to discuss any concerns or questions around implementation and will work together to resolve these quickly through the established troubleshooting process.

Policy Implementation

The uplift to £12.60 per hour will be distributed to providers in the same manner as the previous uplift to £12.00 per hour for the workers in scope.

This will mean a 5% uplift will be applied to a set percentage (national weighting) of contract values, in line with the **average full workforce costs** for residential and non-residential services. A separate agreed weighted percentage has been set for Personal Assistants who are paid directly through SDS Option 1 budgets.

The current approach provides funding for wages and on-costs and the national weightings are based on the **average full workforce costs** within a contract.

The term **average full workforce cost** references and means that the weightings do not only include workers on the £12.00 per hour in direct care roles - that this uplift to £12.60 is intended for - but that the calculation also provides for all workers

employed directly within services and the associated on-costs. This includes workers on higher rates and in non-direct care roles as are included in the contracts.

National Weightings

The national weightings for the £12.60 uplift will be the same as those used for the uplift to £12.00. These percentages are below:

- Residential care – uplift applied to **71.8%** of full contract value.
- Non-residential – uplift applied to **86.9%** of full contract value.
- SDS option 1 Personal Assistants – uplift applied to **90%** of budgets.

This equates to contract uplifts of:

- Residential Care **3.59%**
- Non-Residential Care **4.35%**
- SDS Option 1 **4.50%**

Due to the nature of this approach, this may result in some providers having funds remaining once the policy intent - **to uplift pay for the workforce delivering direct care to at least £12.60 per hour** - has been fully delivered.

Any additional funds that providers may have from this policy must be spent on uplifting pay for the directly employed workforce working within services for the 2025/26 financial year. It is the provider's discretion of how any remaining funds are to be spent within these stipulations, but this can be used to support differentials.

The residential care uplift does not relate to National Care Home Contract rates which are dealt with separately and incorporate the pay uplift using the established Cost Model.

Non-workforce costs

This policy, to uplift the minimum rate of pay for adult social care workers, provides funding for wages and on-costs within providers contracts.

Local areas still have the ability to offer increases to providers on the non-workforce costs within their contracts.

Any changes on the rest of local contracts, or on Scotland Excel's Adult Social Care National Flexible Frameworks, to address other increasing and inflationary non-workforce costs would be out with the remit of this policy and would form part of the normal local contractual negotiating process with providers and their local commissioners and finance departments. For national arrangements, Scotland Excel will work in collaboration with providers and commissioners in line with the Framework's Price Review process.

Assurance process

For this uplift, and in line with previous practice, providers will be required to sign and return contract variation letters. This will confirm that the funding must only be used for uplifting pay and local areas will be responsible for assuring this funding is used for these purposes through their normal contract monitoring processes.

As per usual process, funding will then be released to providers as soon as possible after they return their signed contract variation letters.

Personal Assistants

Separate guidance will be issued for PA employers.

ILF Scotland

Separate guidance will be issued for ILF Scotland recipients.

Children's Social Care

Separate guidance will be issued by the Children and Families Directorate for Children's Services.

Next steps

I hope this provides clarity on the pay uplift for 2025/26.

The Scottish Government recognises the exceptional work of the social care workforce, and we thank them for the most important role that they play in our communities.

We appreciate you sharing this with your networks and working with us to get this uplift delivered to the workforce at speed.

Yours sincerely,

Donna Bell
Director of Social Care and National Care Service Development

Annex A

Workforce in scope (those eligible to be paid a minimum of £12.60)

Broad title	Role description
Supervisor in Care Home Services / Care at Home Services / Housing Support Services / Day Care Services / Adult Placement Services / Respite Services	Worker who holds responsibilities for providing and supervising the provision of care and/or support provided directly to adults using residential care / a user within a care at home service or of a housing support service. This also includes workers providing overnight support[1]
Practitioner in Care Home Services / Care at Home Services / Housing Support Services / Day Care Services / Adult Placement Services / Respite Services	Worker who provides care and support to adults using residential care and who has responsibility for co-ordinating the implementation of care plans. This may include holding keyworker responsibilities. This also includes workers providing overnight support.
Support Worker in Care Home Services / Care at Home Services / Housing Support Services / Day Care Services / Adult Placement Services / Respite Services	Worker employed in providing care / and or support directly to adults using residential care / a user of service within a care at home service or of a housing support service. This also includes workers providing overnight support.
Personal Assistants	Separate guidance will be provided.

[1] Overnight support is where a care worker sleeps, provides a waking night service or night sitting service, in the home of someone they support or in work premises, so that they are on hand in case of an emergency or any other issue during the night.

Services in scope

The uplift applies to commissioned services for adult social care in the independent and third sectors.

This does not include workers in children's, justice, or homelessness services.

Type of service	Definition of services
Care homes	A service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need this may include for: alcohol & drug misuse, blood borne virus, learning disabilities, mental health problems, older people, physical and sensory impairment or respite care and short breaks.
Care at home	Care at home is registered by the Care Inspectorate as a support service – "Support Service – Care at home." A support service is defined as a personal care or personal support service provided by arrangement made by a local authority or health body to a vulnerable or person in need. This does not include a care home service or a service providing overnight accommodation.
Day care	Adult day care is registered as a support service – "Support service – Other than care at home." See definition above.
Housing support	A service, also defined as Supported Living, which provides support, assistance, advice or counselling to a person who has particular needs, with a view to enabling that person to occupy residential accommodation as a sole or main residence. This will include delegated and non-delegated services. The nature of the work within the contract (either residential or non-residential care) should attract the current percentage uplifts applied to the total value of the contract.

	While homelessness services largely fall out-with the scope of this policy, the Scottish Government recognises that homelessness services within the housing support sector as defined by the SSSC, where staff provide direct care, fall within the parameters of this policy.
Adult placement services	A service which consists of, or includes, arranging for the provision of accommodation for an adult (age of eighteen years or over), together with personal care or personal support or counselling, or other help, provided other than as part of a planned programme of care by reason of the person's vulnerability or need, by placing the person with a family or individual; but a service may be excepted from this definition by regulations.
All SDS options (1, 2, 3 and 4)	All SDS options where workers provide direct Adult Social Care support, either in a social care provider organisation or someone paying a Personal Assistant.
Respite services	Registerable under a care home and housing support as per the definitions above.
Shared Lives	Shared Lives services are a form of care that supports people to live safely and comfortably in a home and community of their choosing. Care is provided by professional carers - either individuals, couples, or families - in their homes and as part of their local community. The services in scope are. • Live-in support • Daytime support The nature of the work within the contract (either residential or non-residential care) should attract the current percentage uplifts applied to the total value of the contract.

Integration Authority Chief Finance Officers
Integration Authority Chief Officers
Local Government Directors of Finance
Local Authority Chief Executives
COSLA

via email
19th March 2025

Adult Social Care Pay Uplift in Commissioned Services

Dear colleagues,

Following agreement at COSLA Leaders on 28 February 2025, I am writing to confirm the distribution of the £125 million funding for the pay uplift for workers providing direct adult social care in commissioned services in the third and independent sectors that was announced on 4 December 2024 as part of the Scottish Budget for 2025-26.

The uplift for children's social care workers will be communicated separately by the Children and Families Directorate in due course.

This funding will deliver a minimum rate of £12.60 per hour for all adult social care staff delivering direct care in commissioned services in the third and independent sectors.

Annex A to this letter sets out the distribution of the funding that must be passed to Integration Authorities for delegated services to cover the period from April 2025 to March 2026. Local agreement should be made in respect of eligible non-delegated services such as housing support where required.

Funding will be distributed to Local Authorities in the weekly General Revenue Grant payments from April 2025 and will be based on GAE for 'H&SC Uplift, Carers Services and Respite Care'. This is consistent with the distribution of recurring funding for previous pay uplifts. Funding allocated to Integration Authorities should be additional and not substitutional to each Local Authority's 2024-25 recurring budgets for social care services.

Details regarding implementation of the uplift to a minimum of £12.60 per hour applicable from April 2025 are provided in a separate letter from Donna Bell dated 11 March 2025.

Yours sincerely,

Ala Gray

Director of Health and Social Care Finance

Annex A - Adult Social Care Pay Uplift

Integration Authority	Total funding (£)	% of Funding
Aberdeen City	4,647,000	3.72%
Aberdeenshire	5,406,000	4.32%
Angus	2,966,000	2.37%
Argyll & Bute	2,344,000	1.88%
Clacks and Stirling	3,218,000	2.57%
Dumfries & Galloway	4,140,000	3.31%
Dundee City	3,569,000	2.86%
East Ayrshire	2,952,000	2.36%
East Dunbartonshire	2,570,000	2.06%
East Lothian	2,543,000	2.03%
East Renfrewshire	2,157,000	1.73%
City of Edinburgh	10,417,000	8.33%
Falkirk	3,548,000	2.84%
Fife	8,813,000	7.05%
Glasgow City	13,280,000	10.62%
Highland	5,625,000	4.50%
Inverclyde	2,102,000	1.68%
Midlothian	1,978,000	1.58%
Moray	2,263,000	1.81%
Na h-Eileanan Siar	777,000	0.62%
North Ayrshire	3,507,000	2.81%
North Lanarkshire	7,502,000	6.00%
Orkney Islands	577,000	0.46%
Perth & Kinross	3,764,000	3.01%
Renfrewshire	4,287,000	3.43%
Scottish Borders	3,086,000	2.47%
Shetland Islands	517,000	0.41%
South Ayrshire	3,091,000	2.47%
South Lanarkshire	7,535,000	6.03%
West Dunbartonshire	2,150,000	1.72%
West Lothian	3,669,000	2.94%
Total	**125,000,000**	**100%**

Email: JJ.Turner@scotland-excel.org.uk
Tel: 0141 488 8710
Our Ref: NCHC2025/26
Date: 7th April 2025

NATIONAL CARE HOME CONTRACT 2025/26

We are pleased to advise that the National Care Home Contract rate for 2025/26 has been agreed, and we are able to confirm the terms of this years settlement which takes effect from 7th April 2025.

Financial Settlement

The Nursing and Residential Care Home rates are based on benchmarks for direct care costs and care home costs in the National Care Home Contract ("NCHC") Care Home Cost Model. It should be noted that Scottish Care does not accept this Cost Model as illustrative of the true cost of care.

The rates which will apply to payment for Nursing and Residential Care for 2025/26, effective from 7th April (commencement of the tax year for pension uprating) are as undernoted:

- **Nursing Care Rare per person per week - £1,013.05**
- **Residential Care Rate per person per week - £881.98**

The settlement reflects the challenging environment faced and the desire for all stakeholders to work in partnership. This recognises the Scottish Government's policy of increasing the earnings of direct care staff within commissioned adult social care to £12.60 per hour in line with the Adult Social Care Pay policy commitment.

The Care Home Cost Model benchmarks Domestic and Catering staff to the National Minimum Wage which is set by the UK Government and, as of 1 April 2025, this is £12.21 per hour.

The rate currently excludes an increase in pay for nurses and associated differentials within the nursing rate including management pay. The offer comes with a commitment to consider the approach to nurse pay once Agenda for Change (AfC) pay negotiations are concluded. The Care Home Cost Model has been adjusted to enable management pay elements within residential care rates to be increased in line with the Consumer Price Index (CPI).

Staffing costs have also been adjusted to reflect the costs associated with changes to employer's National Insurance contributions (eNIC). This unfunded commitment has been included to protect the integrity of the Care Home Cost Model. Should any further change to eNIC take place during the course of the year, placement fees will be adjusted accordingly.

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Tel: 0141 488 8230
Email: contactus@scotland-excel.org.uk
Web: www.scotland-excel.org.uk

Non-Staff Costs

The settlement reflects changes in the cost calculations in the non-staffing areas of the cost model.

- The Standard approach of applying CPI to all inflationary increases
    - The cost line for registration fees continues to be the exception to this and there has been no change to the Care Inspectorate s registration fee charges.
- The apprenticeship levy/small care home supplement has been continued for 2025/26
- Efficiencies have been maintained at their current level of 2.5% of non-staff costs
- The eNIC cost element has been removed for the provider return calculations in recognition of the significant cost pressure the inclusion of eNICs creates within the settlement rate.

Further Commitments

The settlement recognises that the sector is seeking to discuss a number of issues faced by providers which have been highlighted by Scottish Care. There is therefore a commitment for local government representatives to explore these issues ahead of a joint meeting of providers and local government representative to discuss a mechanism through which each of these issues can be appropriately considered.

Adult Social Care Pay

This arrangement requires all providers to pay all workers providing direct care, regardless of age, experience or time in employment, a minimum of £12.60 per hour. This is in line with the commitment to the Adult Social Care Pay policy which has been agreed between Scottish Government and COSLA. On this basis, the National Care Home Contract will be varied to ensure:

• The provider is funded to ensure that all direct adult social care workers are paid a minimum of £12.60.
• Providers agree that remuneration can be periodically monitored by the commissioning authority, including direct verification with employees of the provider.
• There will be no displacement of any other costs onto staff by the employer.

All other staff roles directly linked to Adult Social Care Policy are subject to the maintaining of their differentials in the cost model. The Care Home Cost Model provides a level of transparency on the cost of care to inform the national rate, but as it is based on benchmark averages, it may not directly match the costs or staff structure of individual care homes. In keeping with previous agreements, however, displacement of cost onto staff by the employer, for example payment for uniforms or service costs, is not permitted. In the event of non-compliance, the uplift can be withheld until such time as the matter is resolved.

Personal Expense Allowance (PEA), Capital Thresholds, Savings Disregard and Free Personal and Nursing Care Rates

The information below is drawn from the advance notice of uprating for 2025/26. It is not expected that there will be any deviation from the agreed rates outlined.

The uprating for 2025/26 rates is outlined below.

- The personal Expenses Allowance is set at £35.90 per week
- The Lower Capital Limit is set at £22,000 and the Upper Capital Limit £35,500
- The Savings Disregard is (for a single person) from £8.50 and (for couples) from £12.60 per week.
- For care home care, the Free Personal Care payment is £254.60 and Free Nursing Care rate is £114.55

Please note that the Free Personal and Nursing Care Rates upratings are effective from 1st April 2025. The PEA, Capital Threshold and Savings Disregards are effective from 7th April 2025.

Default Rate

The "Default Rate" is the rate applied where the provider is in breach of contract as outlined in Clause A.20.10 of the National Care Home Contract (2013-14 as varied). It is determined by applying a percentage reduction of 7.38% to the nursing fee rate and 8.58% to the residential fee rate.

Contract Management

Public contracts in Scotland are governed by the provisions of the Public Contracts (Scotland) Regulations 2015 and Clause A.1.1 of the National Care Home Contract brings all current regulations into force. Those regulations require public bodies to verify that operators have not engaged in corruption, bribery, fraudulent trading or tax evasion, money laundering and human or drug trafficking. Scotland Excel will seek to revisit discussions in relation to introducing a national self-evaluation approach to meeting these requirements as part of the wider review of the NCHC. In the meantime, a local consideration will continue to be required.

The attached MOV sets out the rates and clauses relating to the NCHC to apply the new rate structure. The MOV will have to be sent out to care home providers for signing in order for the new placement rates to be implemented. Scotland Excel, Scottish Care and COSLA will continue to work in partnership to promote the NCHC.

Yours sincerely

Julie Welsh

Julie Welsh
Chief Executive
Scotland Excel

Donald Macaskill
Chief Executive
Scottish Care

Mirren Kelly
Chief Officer
Local Government Finance
COSLA

c.c. Jane O'Donnell, Chief Executive, COSLA
Jackie Irvine, President, Social Work Scotland
Health and Social Care Partnership, Chief Officers
Health and Social Care Partnership, Chief Finance Officers
Chief Executive, NHS Highland

Agenda Item 3.4

NHS Highland

Meeting:	**HHSCC**
Meeting date:	**7th May 2025**
Title:	**Dental Services Update**
Responsible Executive/Non-Executive:	**Pamela Stott, Chief Officer**
Report Author:	**John Lyon, Director of Dentistry**

Report Recommendation: The Committee are asked to note the update on Dental Services.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This report will align to the following NHSScotland 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		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well		**All** Well Themes			

2 Report summary

2.1 Situation

Update on Dental Services for HHSCC for information.

2.2 Background

As at Sep 2024 83% of the NHSH population was registered with a dentist. 56.4% of these registered patients had attended the Dentist in the previous 2yrs. The most deprived quintiles had the lowest level of registrations and participation. (PHS publication Nov 2024- **Appendix 1**).

Lack of specific dental management information at HHSCP and practice level, limits monitoring and planning dental services.

Recruitment and retention of clinicians to deliver NHS dentistry continues to be a major challenge for dental practices/Public Dental Service and this is most acute in rural areas.

To increase access to NHS dentistry within the independent contractor sector, grant assistance through the Scottish Dental Access Initiative (SDAI) is the singular tool available to Health Boards at present. There is no national Scottish Government strategy or associated policies focused on maintaining and developing access to NHS dental services in rural areas.

General waiting times for specialist services is increasing - including Paediatric/Special Care General Anaesthetic Services and Oral Surgery referral service provided by the Public Dental Services.

National Dental Inspection Programme 2024 report available, which demonstrated some improvement in child oral health but with continuing inequalities growing between groups. https://publichealthscotland.scot/publications/national-dental-inspection-programme/national-dental-inspection-programme-2024/

Oral Health Initiatives continue both national and local programmes, ongoing review of the efficacy of Fluoride varnish programmes delivered in the Nursery environment.

2.3 Assessment

There has been some limited success with incentivising newly qualified Dentists, and Dentists practising in Scotland for the first time to commit to delivering NHS in the HHSCP area for a 3 year period. Currently 13 dentists have received the associated Recruitment & Retention allowance and are within their 3 year period of required service.

NHSH Health Intelligence Unit now produces a biannual Mapping of Dental Registrations and Participation report which will highlight patterns of change in smaller geographies. Variation in participation patterns across NHS Highland will also be identified. **(Appendix 2)**

NSS to introduce Practice Level Management Information for HBs from Q1 of 2025/26.

During 2024/25 a total of 2 SDAI grants were approved and which will result in an additional 3000 patients having access to NHS dental registration.

Public Dental Services dental teams continue to review, prioritise care and accept ad hoc theatre slots and referrals.

Ongoing Development opportunities for Dentists to shadow in specialist services, including oral surgery services in primary care and hospital services.

One General Dental Practice has contacted NHS Highland, from the HHSCP area, to seek additional funding to maintain NHS dental services, otherwise the Practice may be closed. NHSH is reviewing this request and the potential for support for other General Dental Practices, particularly in rural areas.

Analysis of complaints received by Dental Services, continue to highlight challenges in accessing NHS dental services, including MSP/MP complaints. However, no major adverse events have been noted. (Appendix 3).

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	x	None	

Comment on the level of assurance

Increase in recruitment of dentists would improve assurance. Including amendment of the following barriers to recruitment of dentists (outwith the control of NHSH)-

- Amendment to mandatory training regulation in Scotland
- Amendment of VT equivalence certificates to allow listing of Dentists, with no current NHS experience, to ensure listing with a Health Board to provide NHS dental services
- Amendment to national Allowances to increase the pool of Dentists that would be considered for Recruitment and Retention allowances
- Incentives to encourage and sustain Dental Practices in rural area, similar to Scottish Dental Access Initiative grants.

3 Impact Analysis

3.1 Quality/ Patient Care

Growing waiting times for treatment and increase in waiting times for referrals to the PDS.

3.2 Workforce

Increased stress for dental staff to maintain service provision..

3.3 Financial

Failure to recruit to dental clinical post may result in underspend on allocated PDS dental budgets. Use of dentist locums has not been approved so far, there may be an ongoing need to consider locum use to maintain basic services. It should be noted there is a very limited pool of dentists with sufficient experience and available to take on locum work.

3.4 Risk Assessment/Management

Dental department risk register updated.

3.5 Data Protection

Not applicable

3.6 Equality and Diversity, including health inequalities

3.7 Other impacts

3.8 Communication, involvement, engagement and consultation

3.9 Route to the Meeting

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

Dental Senior Management Team

4.1 List of appendices

The following appendices are included with this report:

Appendix 1-

PHS Activity qe 30-09-24.xlsx

Appendix 2-

phi_dental_rep_f20092024 (1).docx

Appendix 3-

2025 01Clinical Gov Update (Dental CG&R

Mapping of NHS Highland Dental Registrations and Participation

The Public Health Intelligence team is part of the Directorate of Public Health of NHS Highland and provides an expert resource on epidemiology, demography and population health evidence.

nhsh.publichealthintelligence@nhs.scot

Public Health Intelligence team
Directorate of Public Health
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Version	Issued	Next review	Prepared by	Authorised by
1	24/09/2024	-	ID	CHR
2				
3				

Distribution	Method
NHS Highland Dental Service	PDF and intranet link

Contents

Mapping of NHS Highland Dental Registrations and Participation

Key Points

Registration

In May 2024, 271,611 NHS Highland residents were registered with an NHS dentist, equivalent to 84% of the population.

48,839 (85%) of NHS Highland children under 18 and 222,772 (84%) adults were registered.

Bute and Cowal (57%) in the Argyll and Bute HSCP and Nairn & Nairnshire (69%) in the Highland HSCP are identified as planning partnership areas with the lowest population levels of registration in NHS Highland.

Across smaller areas of NHS Highland, registration of children under 18 varies between 55.7% and 100%, while adult registrations vary between 30.5% and 100%.

Children under 18 living in the most deprived areas of NHS Highland are less likely to be registered with an NHS dentist. As of 31 May 2024, 79.4% were registered in the most deprived quintile compared to 85.8% in the least deprived quintile.

Participation

In May 2024, 76.8% of NHS Highland children and 51.7% of adults participated in NHS dentistry.

There has been a long-term decline in the proportions of both children and adults participating.

Given lifetime registration, participation is a better measure of the impacts of dental services' closures and limitations resulting from the public health response to the pandemic.

Bute and Cowal (49%) in the Argyll and Bute HSCP and Caithness (45%) in the Highland HSCP are identified as planning partnership areas with the lowest population levels of participation in NHS Highland.

Participation is as low as 54.9% in children and 27.8% in adults in smaller areas of Caithness.

Children under 18 living in the most deprived areas of NHS Highland are less likely to participate in NHS dentistry. As of 31 May 2024, 69.1% participated in the most deprived quintile compared to 83.8% in the least deprived quintile.

Introduction

NHS Highland Dental Services commissioned this work to provide details of registration and participation patterns in NHS Dentistry in NHS Highland up to May 2024.[1]

The General Dental Service (GDS) is usually the first contact point for people needing NHS dental treatment. Independent (high-street) dentists provide most GDS through contractual arrangements with the NHS Board, and registered patients can receive the full range of NHS treatment (Map 1).

The Public Dental Service (PDS) provides dental services for people who cannot access care from an independent dentist, including those with complex special care needs and those referred by independent dentists for specific treatment[2]. The PDS also provides GDS in remote rural and island locations in NHS Highland without a GDS practice (Map 2).

Throughout this report, an 'NHS dentist' is a dentist providing GDS as a contracted independent dentist or a PDS dentist.

We identify NHS dental registrations in NHS Highland and highlight patterns of change in registration over time for small area geographies in the Highland Health and Social Care Partnership (HSCP) and Argyll and Bute HSCP.

The data does not include services provided by private dentists.

Changes in national registration policy have impacted registration numbers. Before April 2006, patients were de-registered if they had not attended an NHS dentist within 15 months. The registration period was extended to 36 months in April 2006 and 48 months in April 2009. Lifetime registration was introduced in April 2010, and registration numbers have generally increased with non-time-limited dental registration.

In addition, we examine variations in the pattern of participation across NHS Highland. Participation is defined as contact for examination or treatment in the last two years. This measure is restricted to only those patients registered with an NHS dentist and, therefore, does not include patients who only see a dentist for occasional or emergency treatment.

[1]. The Dental Information Team at Public Health Scotland (PHS) provided details of registrations with an NHS dentist from the Management Information and Dental Accounting System (MIDAS), the payment system for General Dental Services (GDS) and Public Dental Service (PDS) dentists.
[2] PDS has operated since January 2014, following the merger of the Community Dental Service (CDS) and the Salaried General Dental Service (SGDS).

COVID-19

The pandemic severely impacted dental services, with the risk of infection from aerosol-generating procedures, resulting in NHS dental practices being unable to treat patients on their premises. Urgent Dental Care Centres were established for emergency dental treatment. The remobilisation of dental services occurred in phases, and by 1 April 2022, dentists were allowed to scale back infection prevention and control measures[3].

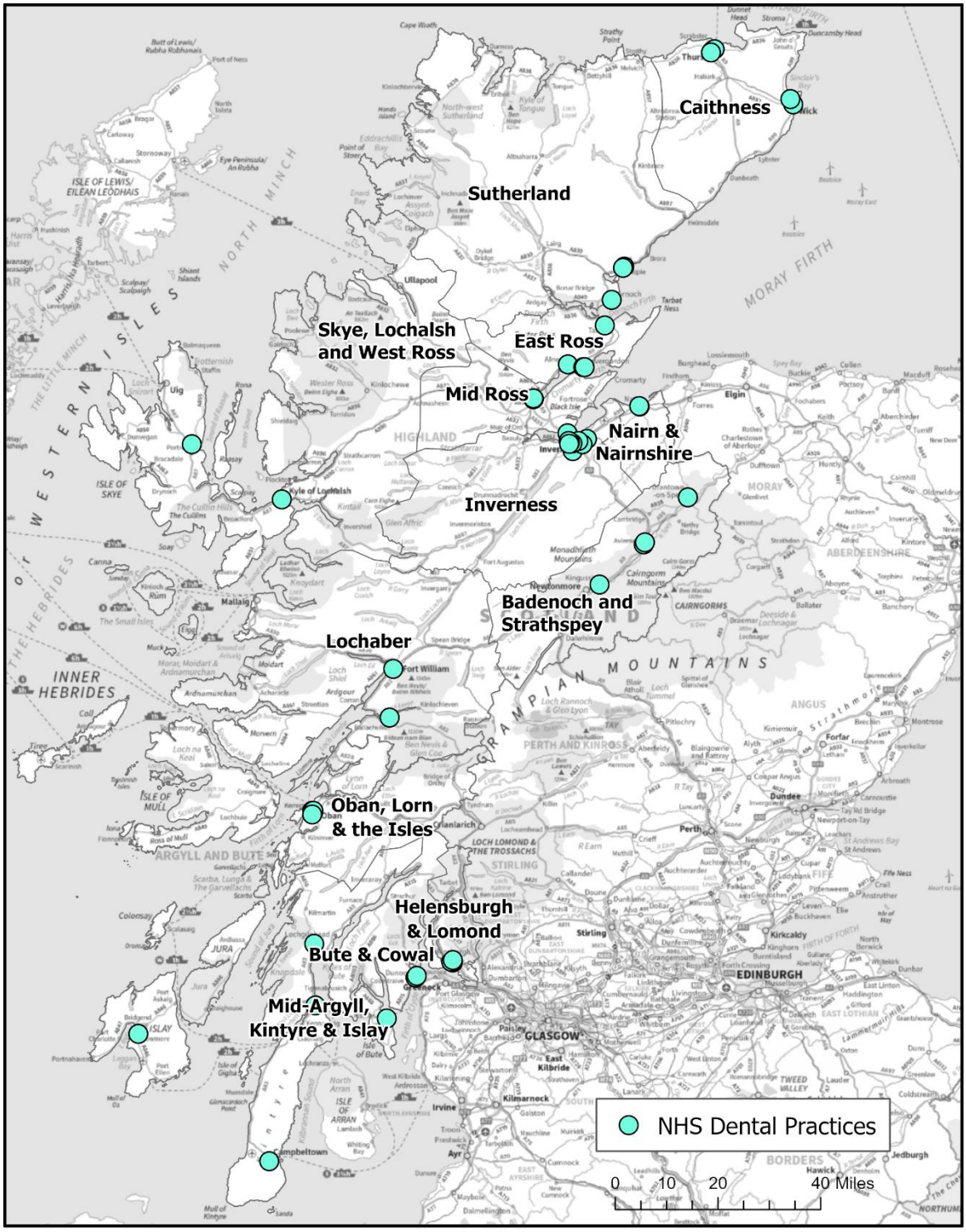
Interpretation

The report highlights geographic areas that have seen significant reductions in the proportion of their populations registered with NHS dentistry in recent periods. The patterns suggest changes in service delivery, including practices no longer offering NHS treatment or not accepting new patients, impacting local access to care.

The data available to the Public Health Intelligence team does not include service configuration details and contractual commitments. The NHS Highland Dental Service should be contacted to provide information on service disposition and arrangements relating to the NHS Highland Dental List that have impacted service provision.

[3]. The Scottish Dental web portal's COVID-19 hub provided dentists with official guidance and information throughout the pandemic.

Map 1: General Dental Service locations

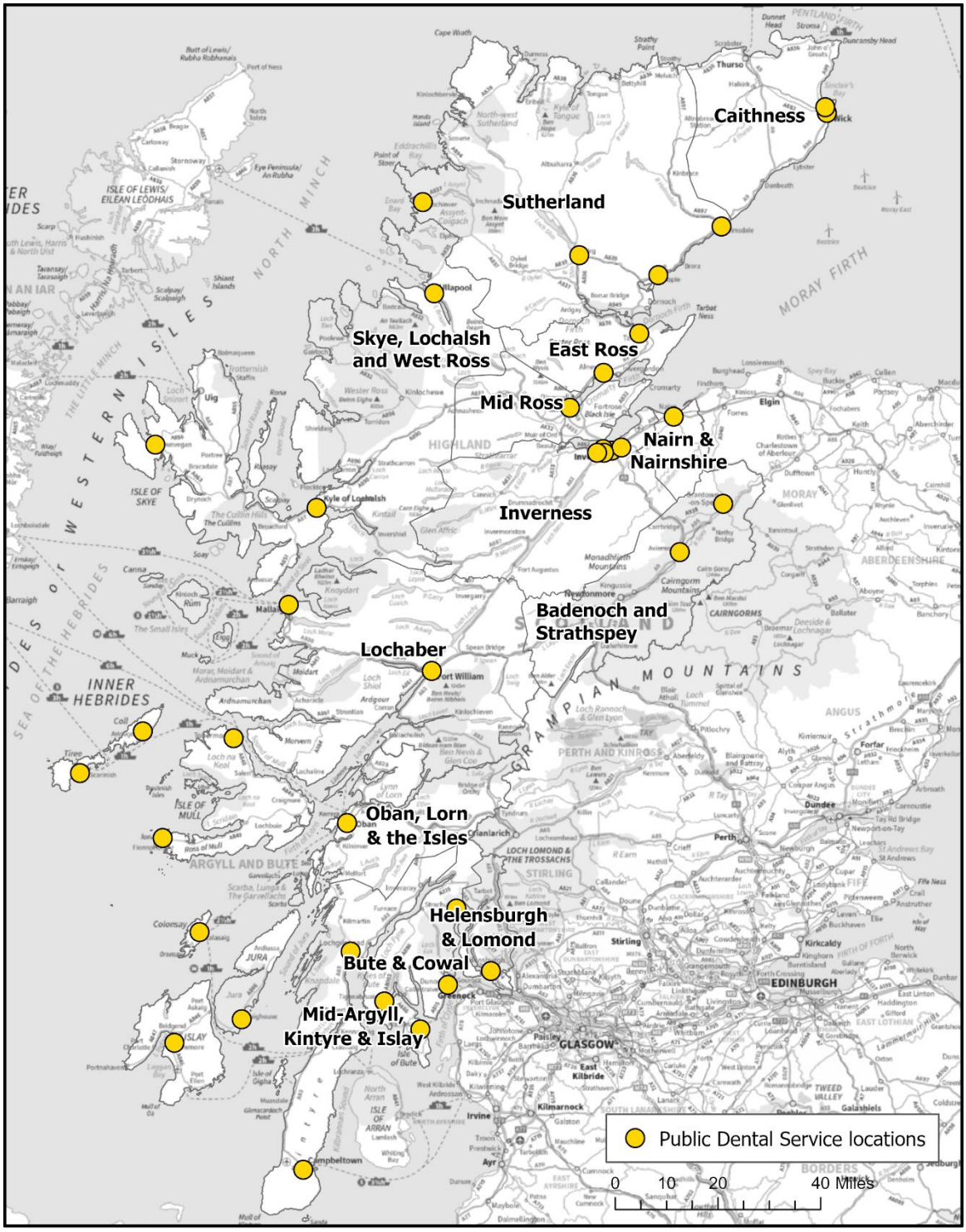


General Dental Services (NHS Dental Practices)

NHS Highland
Directorate of Public Health
Public Health Intelligence Team
Assynt House, Inverness

Date: September 2024

Map 2: Public Dental Service locations



Public Dental Service locations

NHS Highland
Directorate of Public Health
Public Health Intelligence Team
Assynt House, Inverness

Date: October 2024

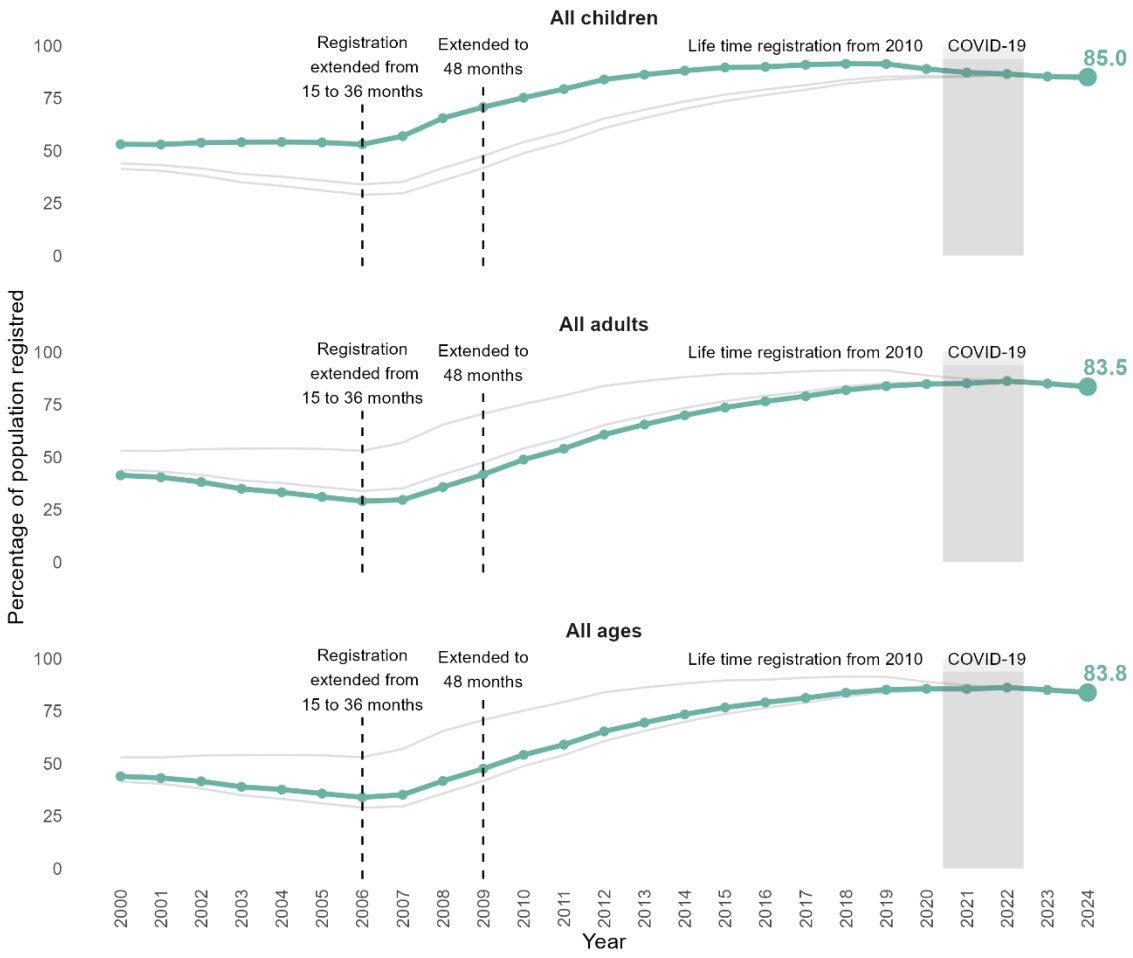
Registration

In May 2024, 271,611 NHS Highland residents were registered with an NHS dentist, equivalent to 84% of the population. 48,839 (85%) of NHS Highland children under 18 and 222,772 (84%) adults were registered.

Adult registration continued to increase during the pandemic, influenced by registered children reaching 18. However, in 2023, the percentage of adult registrations reduced for the first time since 2007, with a further reduction seen in May 2024.

The proportion of children registered with NHS dentistry living in NHS Highland has been declining since 2019, suggesting that access was already an increasing issue for some younger patients before the impact of the pandemic on services.

Figure 1: Percentage of children and adults resident in NHS Highland registered with an NHS dentist [1]



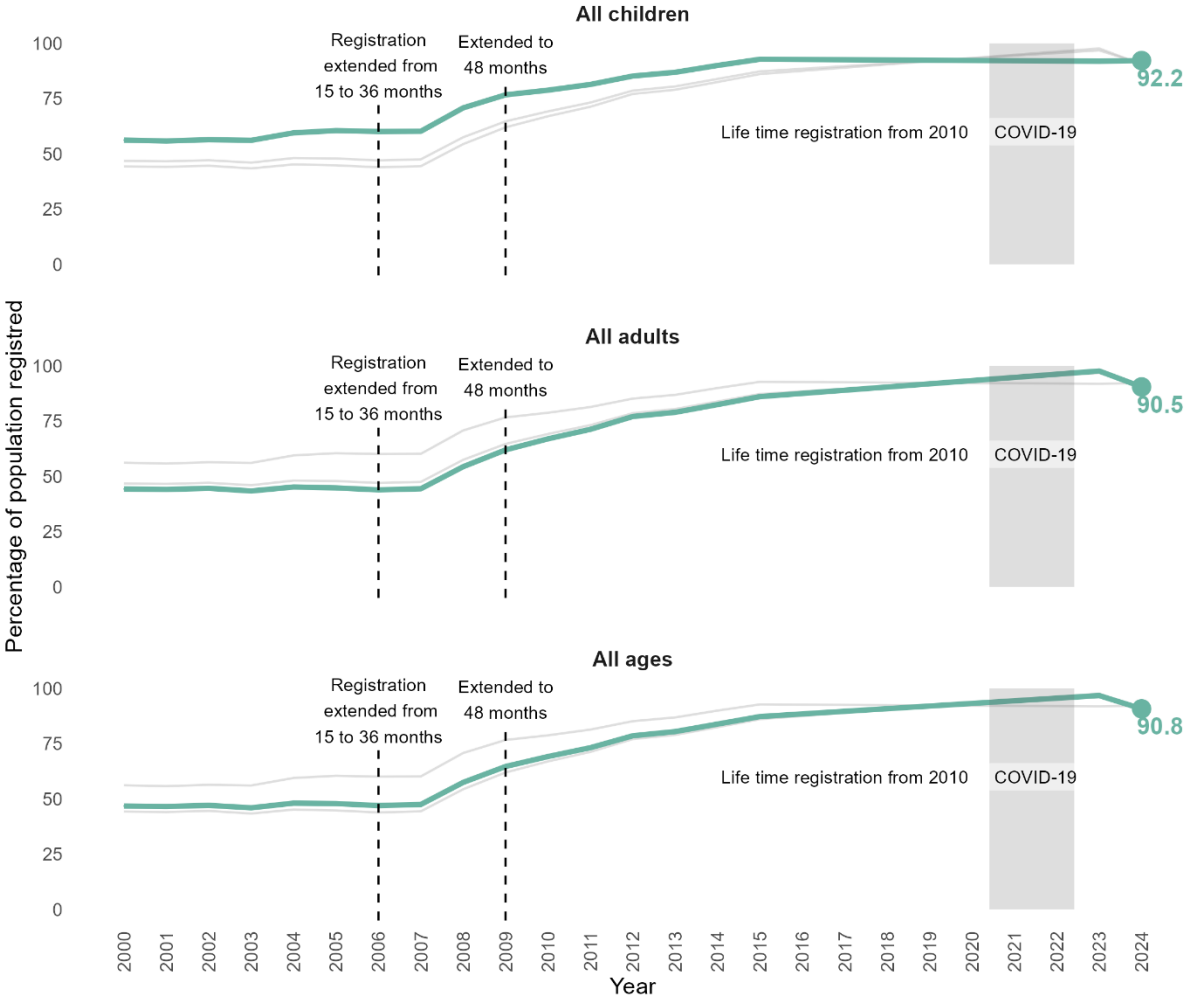
Source: Public Health Scotland (PHS) Dental Statistics 2023 – NHS registration and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

In May 2024, 13,092 children under 18 and 65,198 adults living in Argyll and Bute HSCP were registered with NHS Dentistry.

Registration rates in Argyll and Bute are higher than in the Highland HSCP, and children's registration rates have been consistently high over the last ten years. Adult registration rates had consistently increased with lifetime registration until 2024. The drop in adult registration in 2024 suggests a practice's withdrawal of service provision.

Figure 2: Percentage of children and adults resident in Argyll and Bute HSCP registered with an NHS dentist [1]



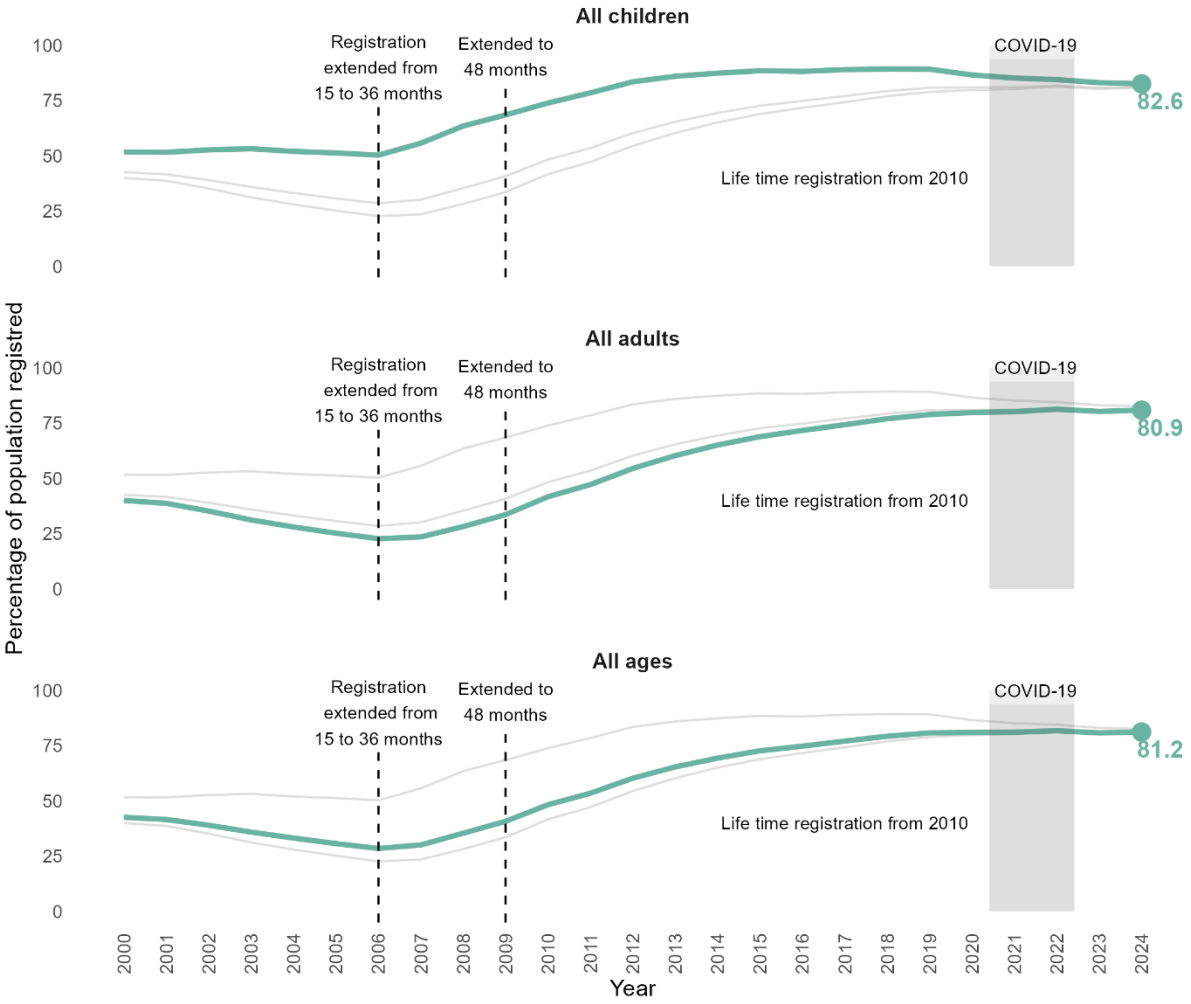
Source: Public Health Scotland (PHS) Dental Statistics 2023 – NHS registration and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Restrictions in effect during the COVID-19 pandemic had little impact on adult registrations in Highland, which have continued to rise. The reduction in the proportion of children registered predates the pandemic and will have been impacted by the closure of practices from 2020 to 2022.

In May 2024, 35,747 children under 18 and 157,574 adults resident in the Highland HSCP were registered with an NHS dentist.

Figure 3: Percentage of children and adults resident in the Highland HSCP registered with an NHS dentist[1]



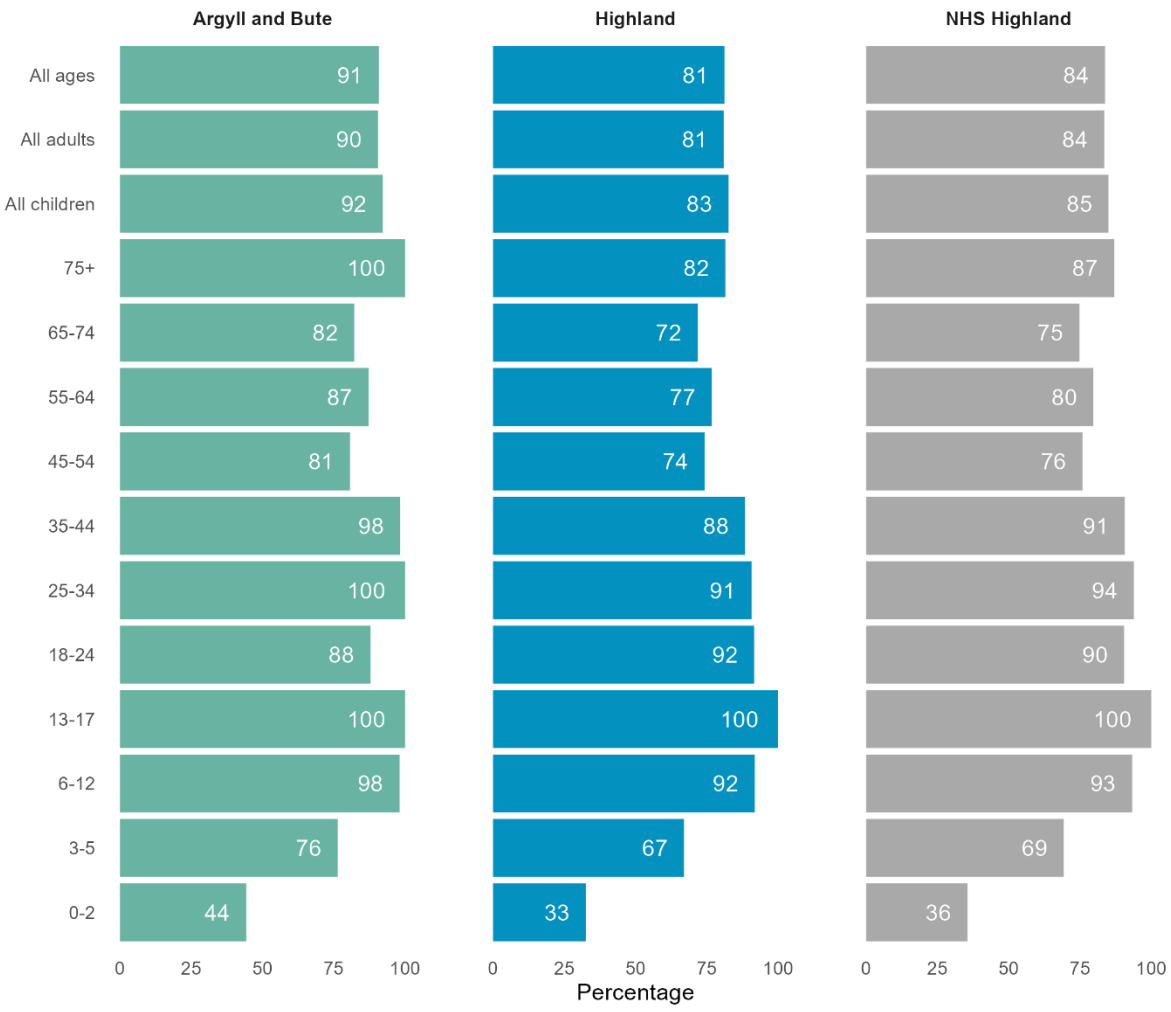
Source: Public Health Scotland (PHS) Dental Statistics 2023 – NHS registration and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Registration rates by age of patient

A breakdown of the percentage of patients registered with an NHS dentist by age group as of 31 May 2024 is shown in Figure 4

Figure 4: Percentage of the population in Argyll and Bute HSCP, Highland HSCP, and NHS Highland registered with an NHS dentist as of 31 May 2024[1]



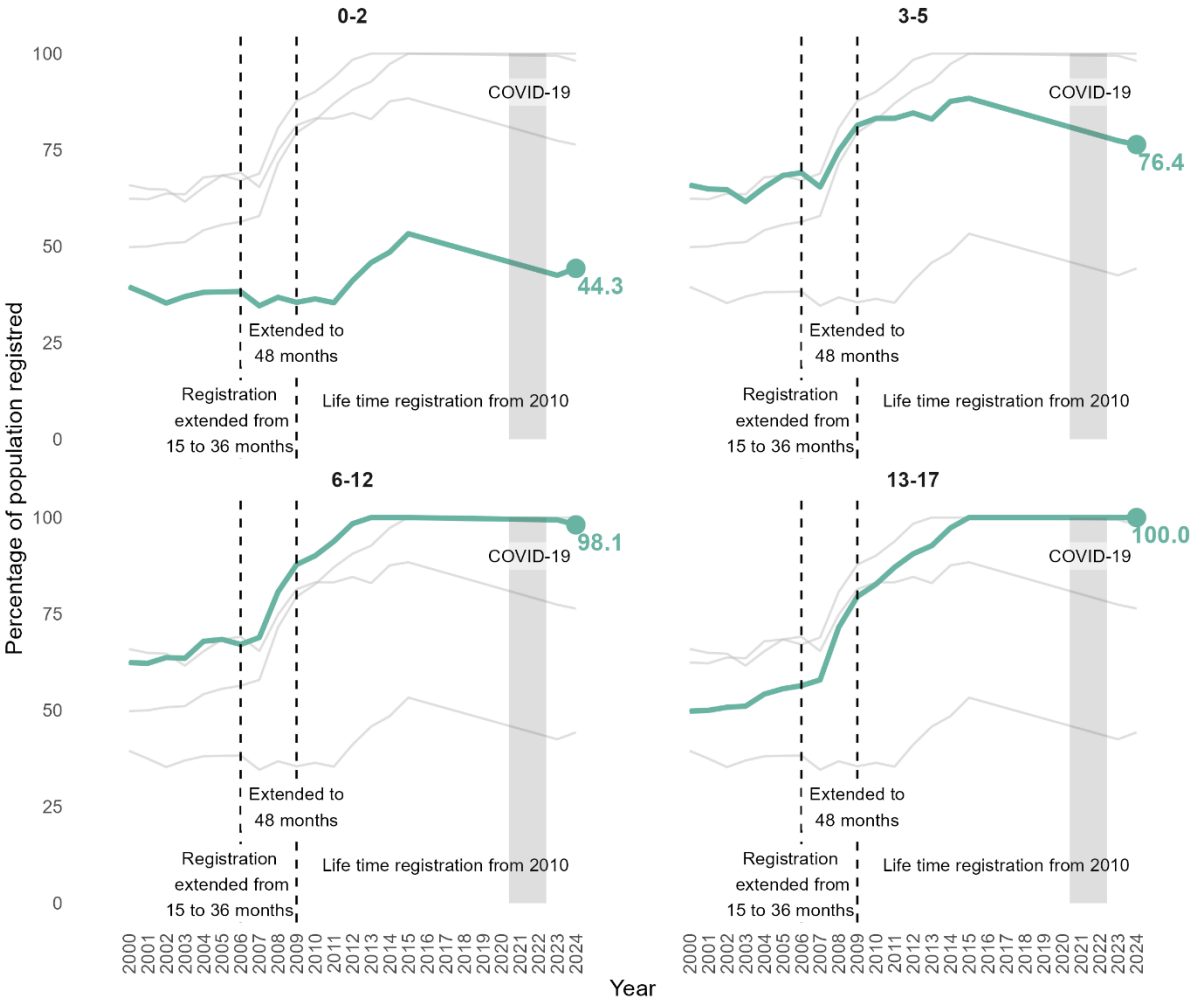
Source: Registration data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Registration of children

Figure 5 highlights the almost complete registration of children over six living in the Argyll and Bute HSCP, but access at younger ages has generally been falling. The increase in the proportion of children aged 0-2 years registered in 2024 is of note, breaking a downward sequence extending nine years.

Figure 5: Percentage of children resident in Argyll and Bute HSCP registered with an NHS dentist by age group [1]

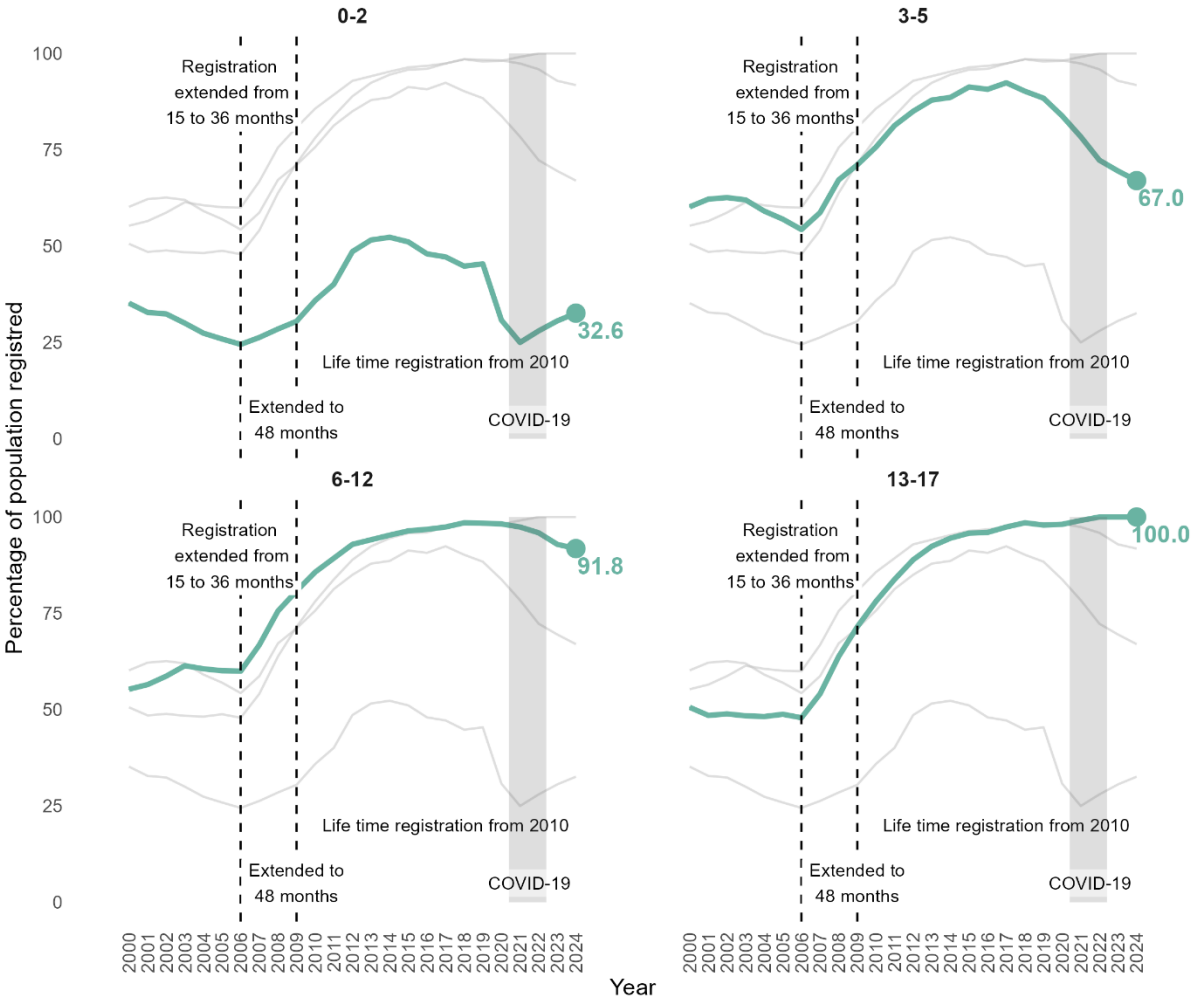


Source: Public Health Scotland (PHS) Dental Statistics 2023 – NHS registration and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Dental registration trends of children living in Highland vary by age group. In 2024, all children aged 13-17 years resident in Highland were registered with an NHS dentist. Registration among those aged 6-12 years has declined from the beginning of the pandemic. Registrations of those aged 3-5 years have decreased from 2017, while there has been an increase in the proportion of those registered under three since 2021, although rates remain low.

Figure 6: Percentage of children resident in Highland HSCP registered with an NHS dentist by age group [1]



Source: Public Health Scotland (PHS) Dental Statistics 2023 – NHS registration and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

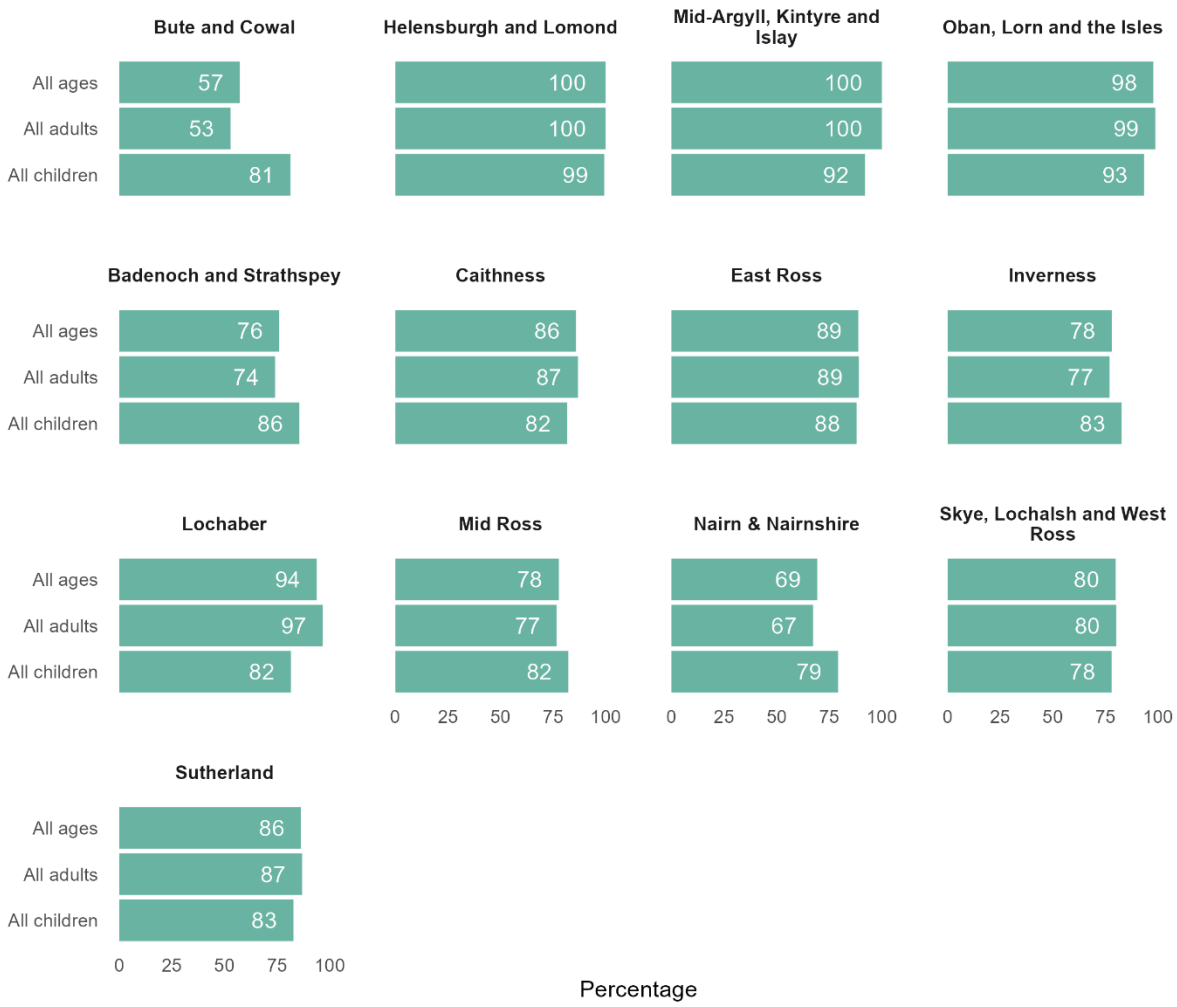
1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Registration rates in Community Partnerships and Localities

In the Argyll and Bute HSCP as of 31 May 2024, residents of the Bute and Cowal area have much lower registration rates with an NHS dentist than the other three localities.

In the Highland HSCP, the Nairn & Nairnshire area has the lowest adult registration rate with NHS dentistry and the second lowest rate of children's registration. The lowest rate of children's registration with NHS dentistry was in Skye, Lochalsh and West Ross as of 31 May 2024.

Figure 7: Percentage of patients registered with an NHS dentist living in Argyll and Bute HSCP Localities and Highland HSCP Community Partnerships as of 31 May 2024



Source: Registration data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Table 1: Number and percentage of patients registered with an NHS dentist living in Argyll and Bute HSCP Localities and Highland HSCP Community Partnerships as of 31 May 2024

Area	Population	Registered	% Registered
All children			
Bute and Cowal	3,151	2,565	81.4
Helensburgh and Lomond	4,250	4,221	99.3
Mid-Argyll, Kintyre and Islay	3,372	3,103	92.0
Oban, Lorn and the Isles	3,429	3,203	93.4
Argyll and Bute	**14,202**	**13,092**	**92.2**
Badenoch and Strathspey	2,319	1,985	85.6
Caithness	4,628	3,776	81.6
East Ross	4,509	3,968	88.0
Inverness	15,925	13,166	82.7
Lochaber	3,754	3,062	81.6
Mid Ross	5,002	4,110	82.2
Nairn & Nairnshire	2,304	1,825	79.2
Skye, Lochalsh and West Ross	2,946	2,298	78.0
Sutherland	1,881	1,557	82.8
Highland	**43,268**	**35,747**	**82.6**
NHS Highland	**57,470**	**48,839**	**85.0**
All adults			
Bute and Cowal	17,195	9,092	52.9
Helensburgh and Lomond	21,584	22,738	100.0
Mid-Argyll, Kintyre and Islay	16,660	17,008	100.0
Oban, Lorn and the Isles	16,579	16,360	98.7
Argyll and Bute	**72,018**	**65,198**	**90.5**
Badenoch and Strathspey	11,722	8,688	74.1
Caithness	20,719	17,987	86.8
East Ross	17,749	15,808	89.1
Inverness	66,458	51,195	77.0
Lochaber	16,288	15,766	96.8
Mid Ross	22,231	17,061	76.7
Nairn & Nairnshire	11,366	7,646	67.3
Skye, Lochalsh and West Ross	16,998	13,639	80.2
Sutherland	11,261	9,784	86.9
Highland	**194,792**	**157,574**	**80.9**
NHS Highland	**266,810**	**222,772**	**83.5**

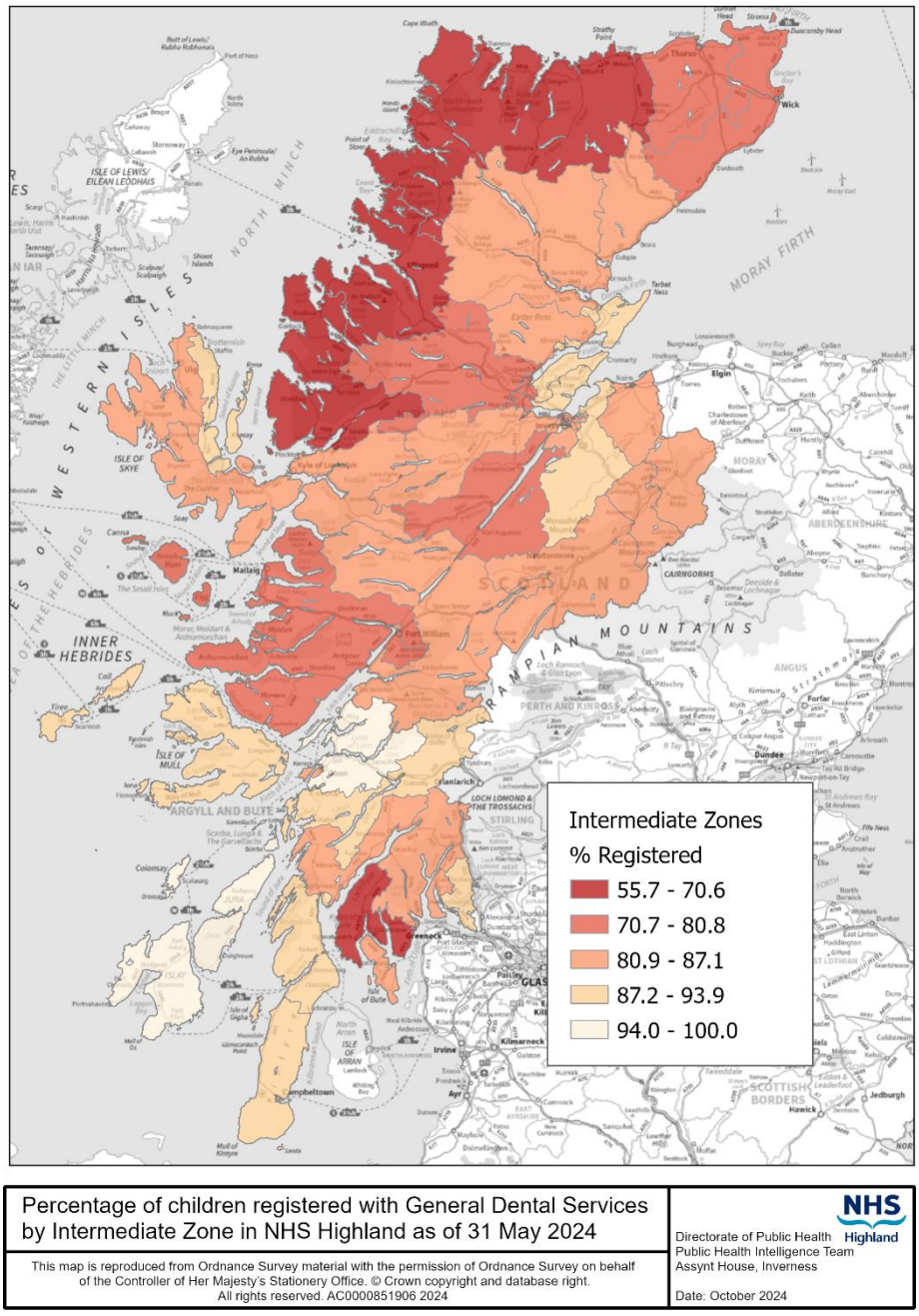
Source: Registration data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Registration rates in NHS Highland in Intermediate Zones[4]

Children

The lowest rates of children's registration as of 31 May 2024 are in Wester Ross, Nairn & Nairnshire, Sutherland and Inverness in the Highland HSCP. The lowest rates in Argyll and Bute are in the Cowal area (Map 3, Figure 8 and Table 2).

Map 3: Percentage of children aged under 18 registered with an NHS dentist by Intermediate Zone in NHS Highland as of 31 May 2024



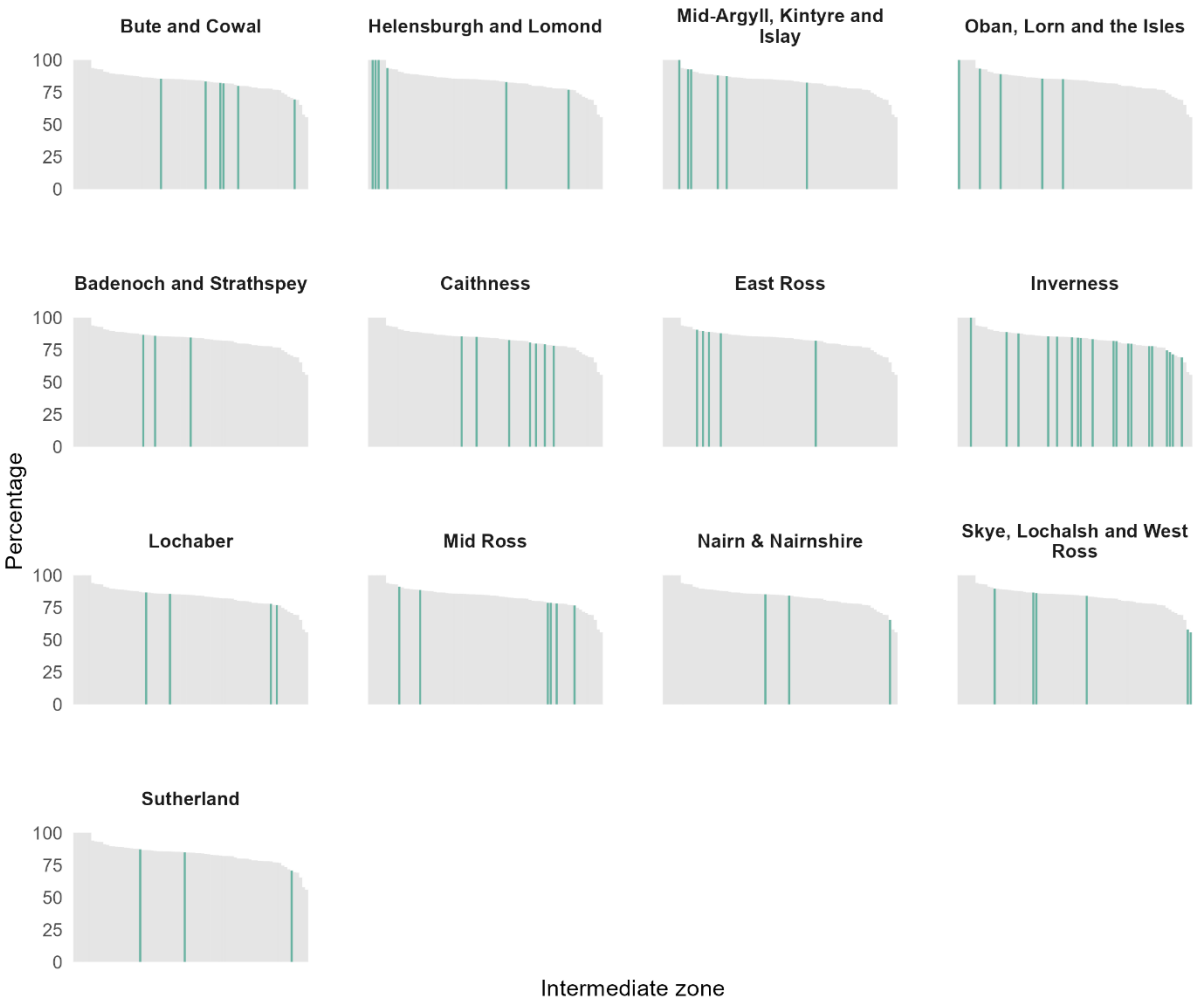
Percentage of children registered with General Dental Services by Intermediate Zone in NHS Highland as of 31 May 2024

NHS Highland
Directorate of Public Health
Public Health Intelligence Team
Assynt House, Inverness

Date: October 2024

[4] Intermediate zones are small geographical areas with a population of 2,500 to 6,000 household residents. There are 1,279 intermediate zones in Scotland and 79 in NHS Highland, often used to disseminate small-area statistics.

Figure 8: Percentage of children aged under 18 registered with an NHS dentist resident in Intermediate Zones in NHS Highland by Community Partnerships and Localities as of 31 May 2024



Source: Registration data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Table 2: Number and percentage of children aged under 18 registered with an NHS dentist resident in Intermediate Zones in NHS Highland by Community Partnerships and Localities as of 31 May 2024

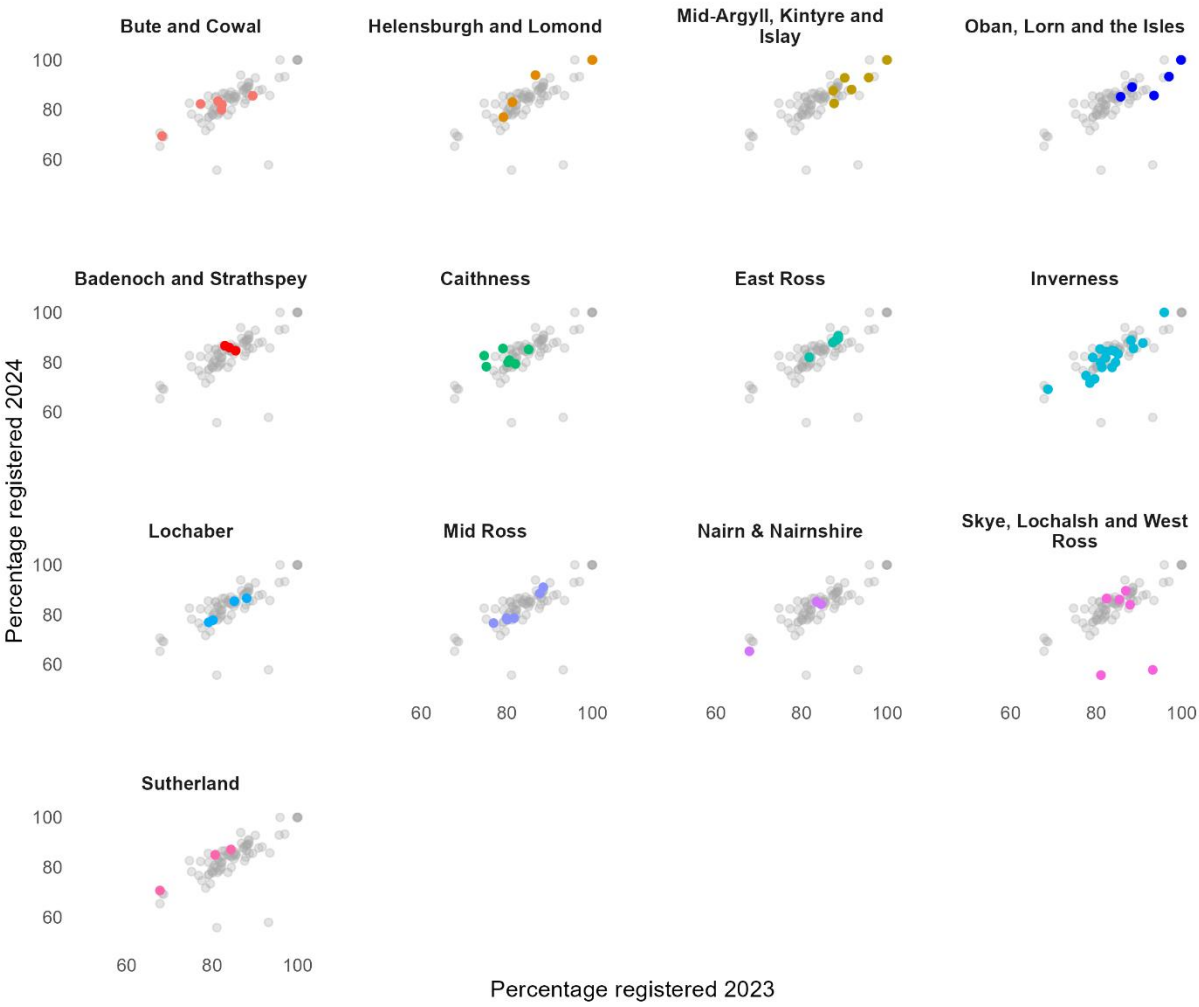
HSCP	Community Partnership / Locality	Code	Intermediate Zone	Population	Registered	% Registered
Highland	Skye, Lochalsh and West Ross	S02002012	Ross and Cromarty North West	481	268	55.7
Highland	Skye, Lochalsh and West Ross	S02002011	Ross and Cromarty South West	367	212	57.8
Highland	Nairn & Nairnshire	S02001986	Nairn East	640	418	65.3
Highland	Inverness	S02002001	Inverness Muirtown	517	357	69.1
Argyll and Bute	Bute and Cowal	S02001383	Cowal South	363	252	69.4
Highland	Sutherland	S02002033	Sutherland North and West	463	327	70.6
Highland	Inverness	S02002002	Inverness Merkinch	786	563	71.6
Highland	Inverness	S02001996	Inverness Hilton	765	561	73.3
Highland	Inverness	S02002006	Loch Ness	786	586	74.6
Highland	Mid Ross	S02002016	Conon	798	611	76.6
Highland	Lochaber	S02001978	Lochaber West	856	658	76.9
Argyll and Bute	Helensburgh and Lomond	S02001390	Helensburgh Centre	361	278	77.0
Highland	Lochaber	S02001980	Fort William South	1072	834	77.8
Highland	Inverness	S02002000	Inverness Ballifeary and Dalneigh	854	665	77.9
Highland	Inverness	S02002003	Inverness Scorguie	362	282	77.9
Highland	Mid Ross	S02002013	Ross and Cromarty Central	644	502	78.0
Highland	Caithness	S02002030	Caithness North West	956	748	78.2
Highland	Mid Ross	S02002015	Muir of Ord	701	551	78.6
Highland	Mid Ross	S02002017	Dingwall	1010	794	78.6
Highland	Caithness	S02002027	Wick South	690	547	79.3
Highland	Inverness	S02001995	Inverness Drummond	657	524	79.8
Highland	Inverness	S02001999	Inverness Crown and Haugh	548	438	79.9
Highland	Caithness	S02002026	Caithness South	483	386	79.9

Source: Registration data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1
2. Table shows Intermediate Zones with fewer than 80% of children registered with NHS dentistry

Figure 9 compares the registration patterns of children under 18 registered with NHS dentistry on 31 May 2023 (x-axis) to registrations as of 31 May 2024 (y-axis) by Intermediate Zone. The areas discussed above in Bute and Cowal, Inverness, Nairn & Nairnshire and Sutherland are low registration outliers in both years. However, for children living in the West Ross area of the Highland HSCP, registration rates were over 80% in 2023 compared to under 60% in 2024.

Figure 9: Percentage of children aged under 18 registered with an NHS dentist by Intermediate Zone in NHS Highland on 31 May 2023 and 31 May 2024



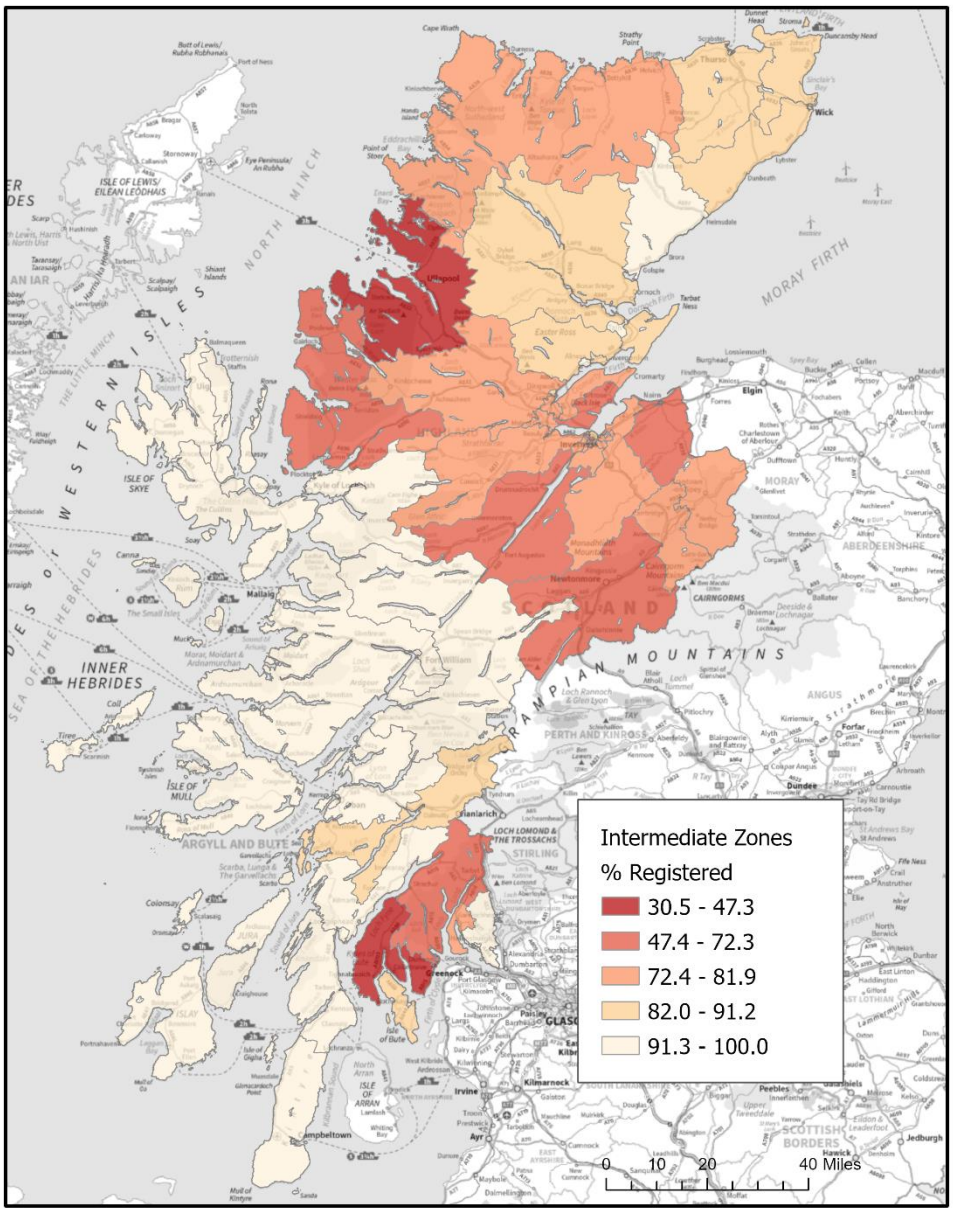
Source: Registration data as of 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Adults

In May 2024, several areas in the Bute and Cowal area of Argyll and Bute have very low rates of adult registration with NHS dental practice, including Dunoon, Hunter's Quay (north of Dunoon) and the Cowal peninsula. The lowest rates of adult registration in the Highland HSCP are in West Ross, Nairn & Nairnshire, Inverness, Badenoch & Strathspey and Mid Ross (Map 4, Figure 10 and Table 3).

Map 4: Percentage of adults registered with an NHS dentist by Intermediate Zone in NHS Highland as of 31 May 2024

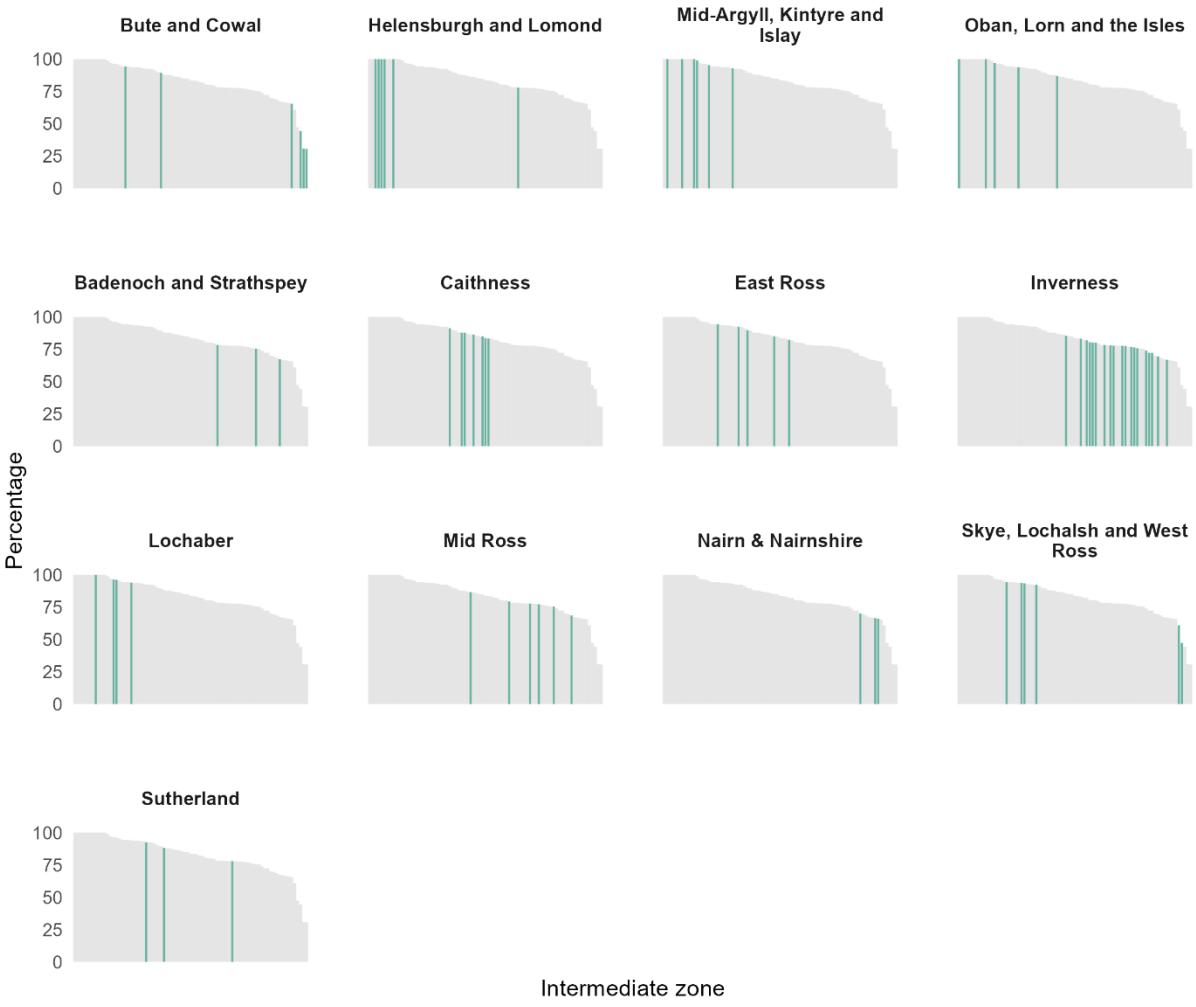


Percentage of adults registered with General Dental Services by Intermediate Zone in NHS Highland as of 31 May 2024

NHS Highland
Directorate of Public Health
Public Health Intelligence Team
Assynt House, Inverness

Date: October 2024

Figure 10: Percentage of adults registered with an NHS dentist resident in Intermediate Zones in NHS Highland by Community Partnerships and Localities as of 31 May 2024



Source: Registration data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Table 3:Number and percentage of adults registered with an NHS dentist resident in Intermediate Zones in NHS Highland by Community Partnerships and Localities as of 31 May 2024

HSCP	Community Partnership / Locality	Code	Intermediate Zone	Population	Registered	% Registered
Argyll and Bute	Bute and Cowal	S02001386	Dunoon	3474	1058	30.5
Argyll and Bute	Bute and Cowal	S02001385	Hunter's Quay	4233	1302	30.8
Argyll and Bute	Bute and Cowal	S02001383	Cowal South	2357	1043	44.3
Highland	Skye, Lochalsh and West Ross	S02002012	Ross and Cromarty North West	2873	1360	47.3
Highland	Skye, Lochalsh and West Ross	S02002011	Ross and Cromarty South West	2800	1705	60.9
Argyll and Bute	Bute and Cowal	S02001384	Cowal North	2721	1781	65.5
Highland	Nairn & Nairnshire	S02001985	Nairn Rural	4339	2862	66.0
Highland	Nairn & Nairnshire	S02001987	Nairn West	3770	2505	66.4
Highland	Inverness	S02001999	Inverness Crown and Haugh	3753	2510	66.9
Highland	Badenoch and Strathspey	S02001982	Badenoch and Strathspey South	3274	2201	67.2
Highland	Mid Ross	S02002018	Black Isle South	5808	3981	68.5
Highland	Inverness	S02002003	Inverness Scorguie	2506	1742	69.5
Highland	Nairn & Nairnshire	S02001986	Nairn East	3257	2279	70.0
Highland	Inverness	S02001995	Inverness Drummond	2740	1981	72.3
Highland	Inverness	S02002006	Loch Ness	3988	2883	72.3
Highland	Inverness	S02002005	Inverness West Rural	5635	4166	73.9

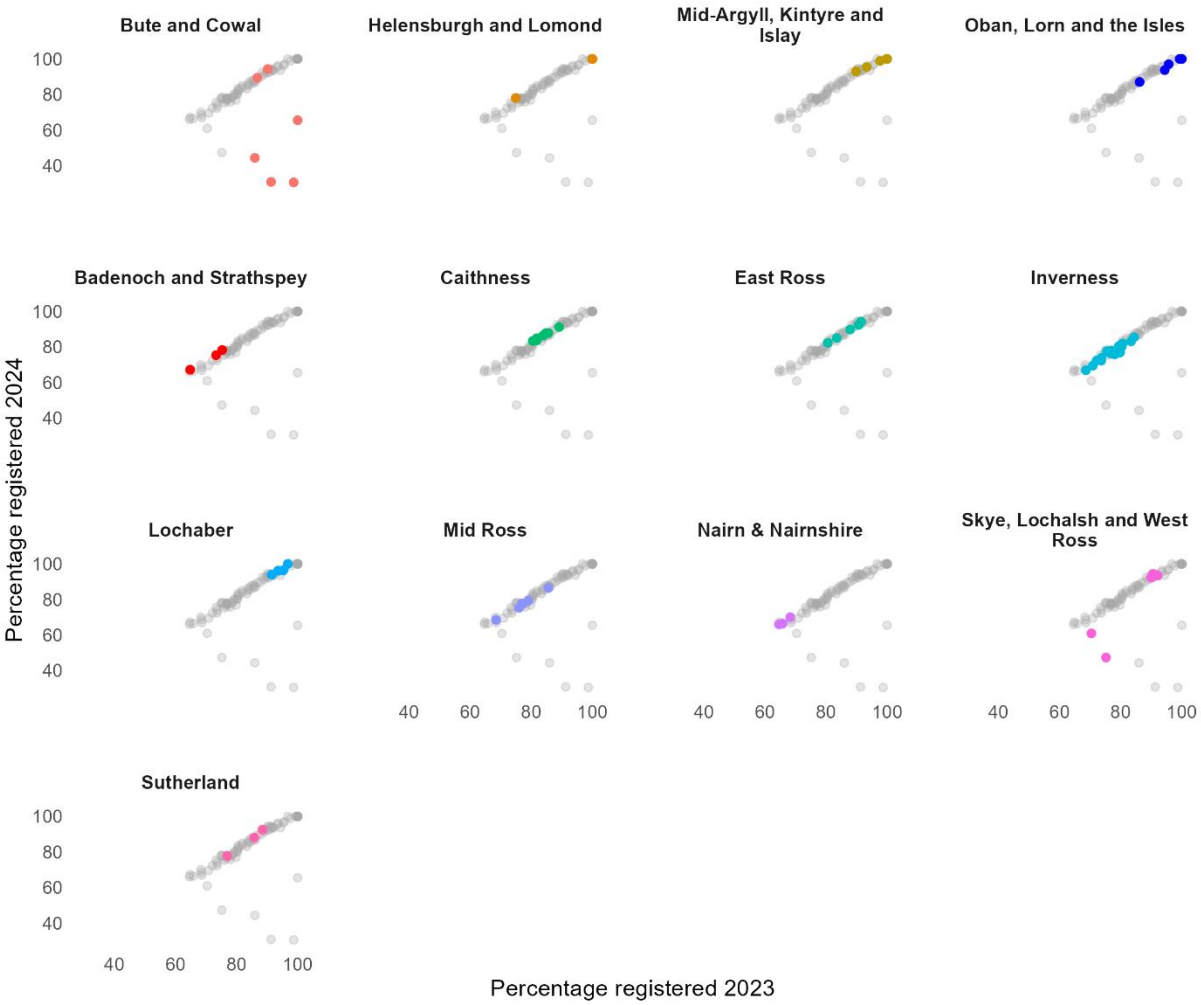
Source: Registration data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1
2. Table shows Intermediate Zones with fewer than 80% of adults registered with NHS dentistry

Figure 11 compares the registration patterns of adults with NHS dentistry on 31 May 2023 (x-axis) to registrations as of 31 May 2024 (y-axis) by Intermediate Zone across NHS Highland.

Bute and Cowal have seen the most prominent annual reductions in the proportion of adult residents registered for NHS dental services, with fewer adults also registered in areas of West Ross compared to 2023. Given lifetime registration, this suggests a significant change in the configuration of NHS dentistry in the areas, with the population of these remote rural communities having greater difficulty accessing local care.

Figure 11: Percentage of adults registered with an NHS dentist by Intermediate Zone in NHS Highland on 31 May 2023 and 31 May 2024



Source: Registration data as of 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

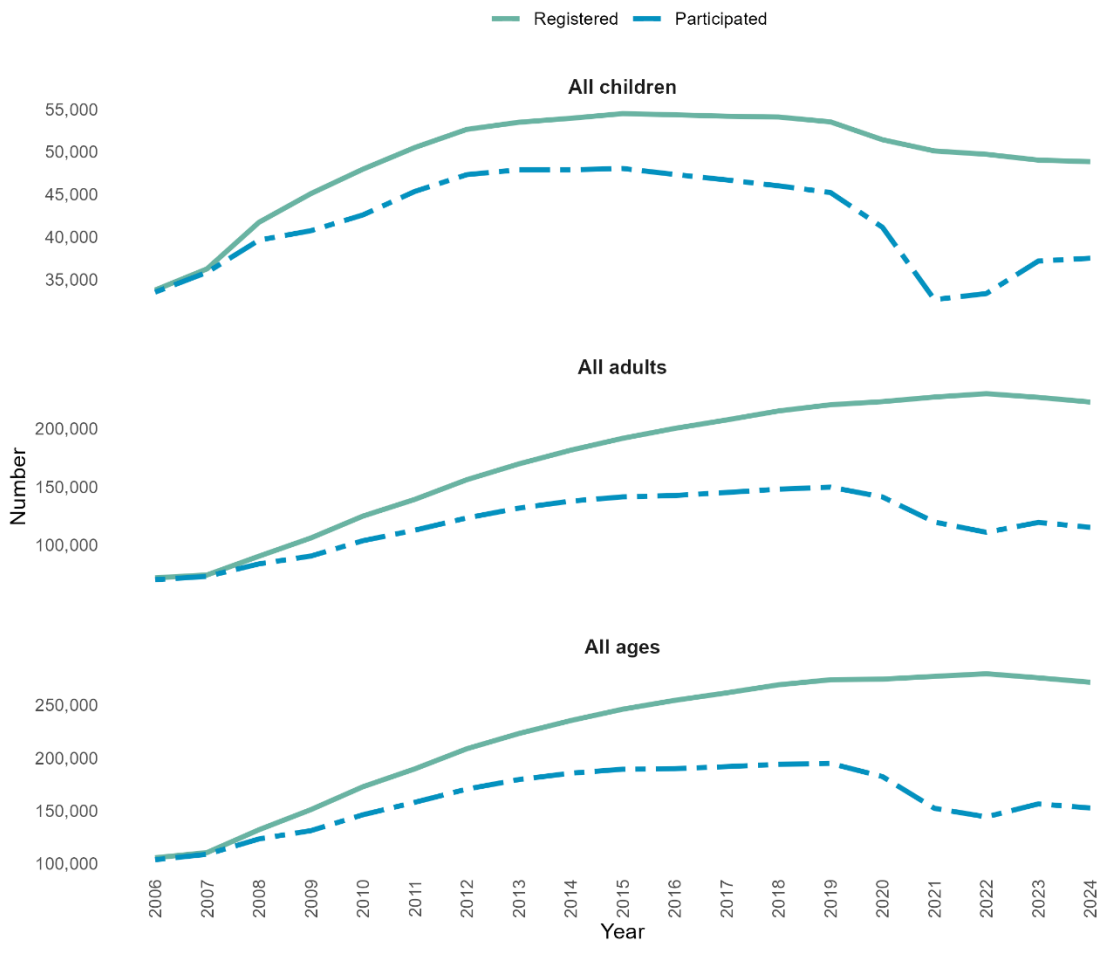
1. Registration rates calculated using mid-year population estimates published by the National Records of Scotland – see Appendix 1

Participation

Participation trends

Participation rates in NHS dentistry in NHS Highland had been consistently falling since 2007, and the closure of dental premises during the pandemic, with reduced access to protect patients from infection during service remobilisation, further contributed to lower participation rates for adults and children. There is evidence that participation has increased in 2024, which is more notable for children. However, before the pandemic, a patient would have to attend a dental practice to be counted as participating. Triage activity, telephone advice, and the issuing of prescriptions are now included as participation without attendance at an NHS dental practice.

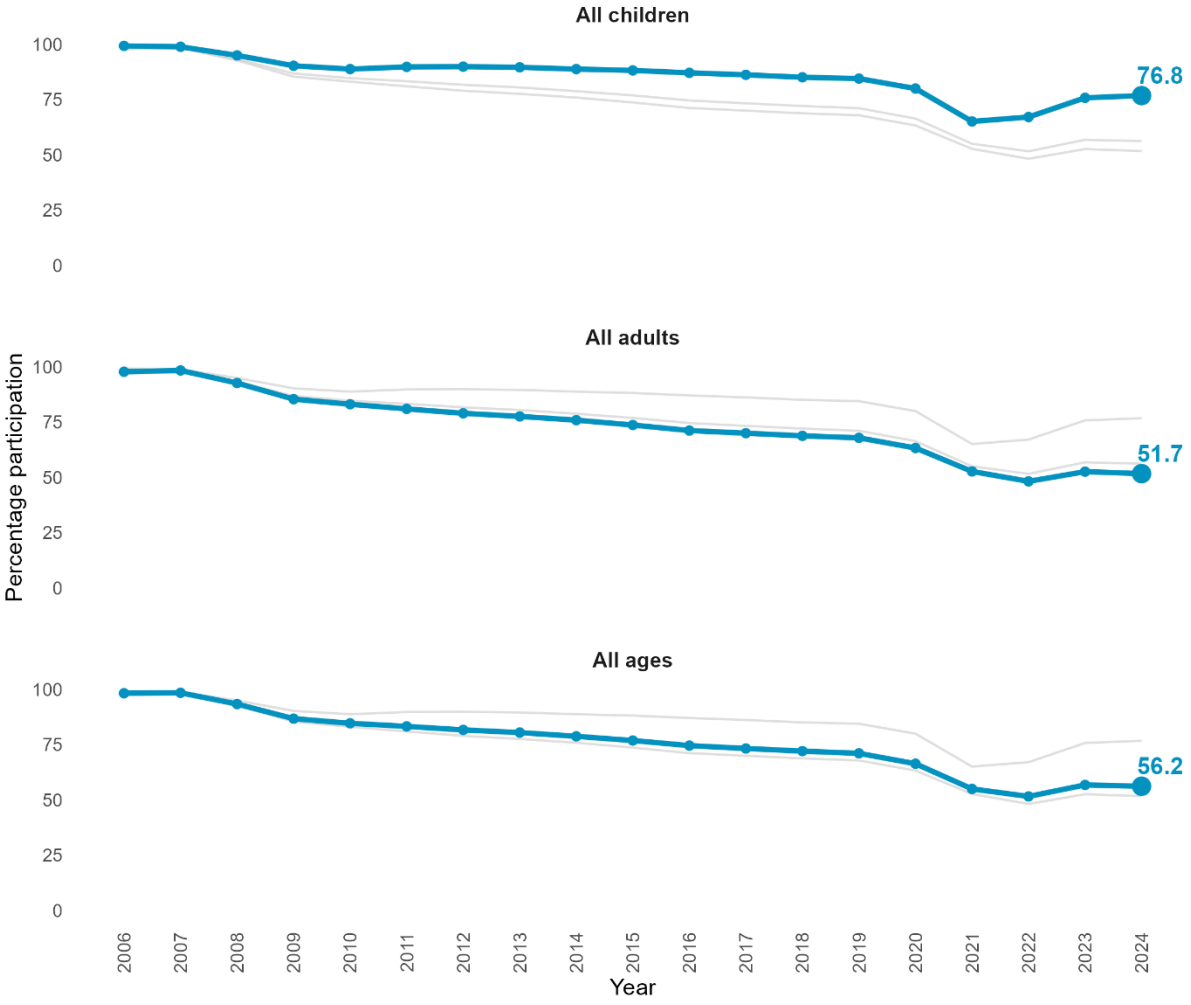
Figure 12: Number of registered patients in NHS Highland participating in GDS



Source: Public Health Scotland (PHS) Dental Statistics 2023 – NHS registration and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration and participation data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

On 31 May 2024, 48,839 children living in NHS Highland under 18 were registered for NHS dentistry, and 37,497 (77%) participated in the two years up to 31 May 2024. Of the 222,772 adults registered and living in NHS Highland, 115,172 (52%) had contact with an NHS dentist in the previous two years.

Figure 13: Percentage of registered patients in NHS Highland participating in GDS



Source: Public Health Scotland (PHS) Dental Statistics 2023 – NHS registration and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration and participation data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

Participation rates by the age of the patient

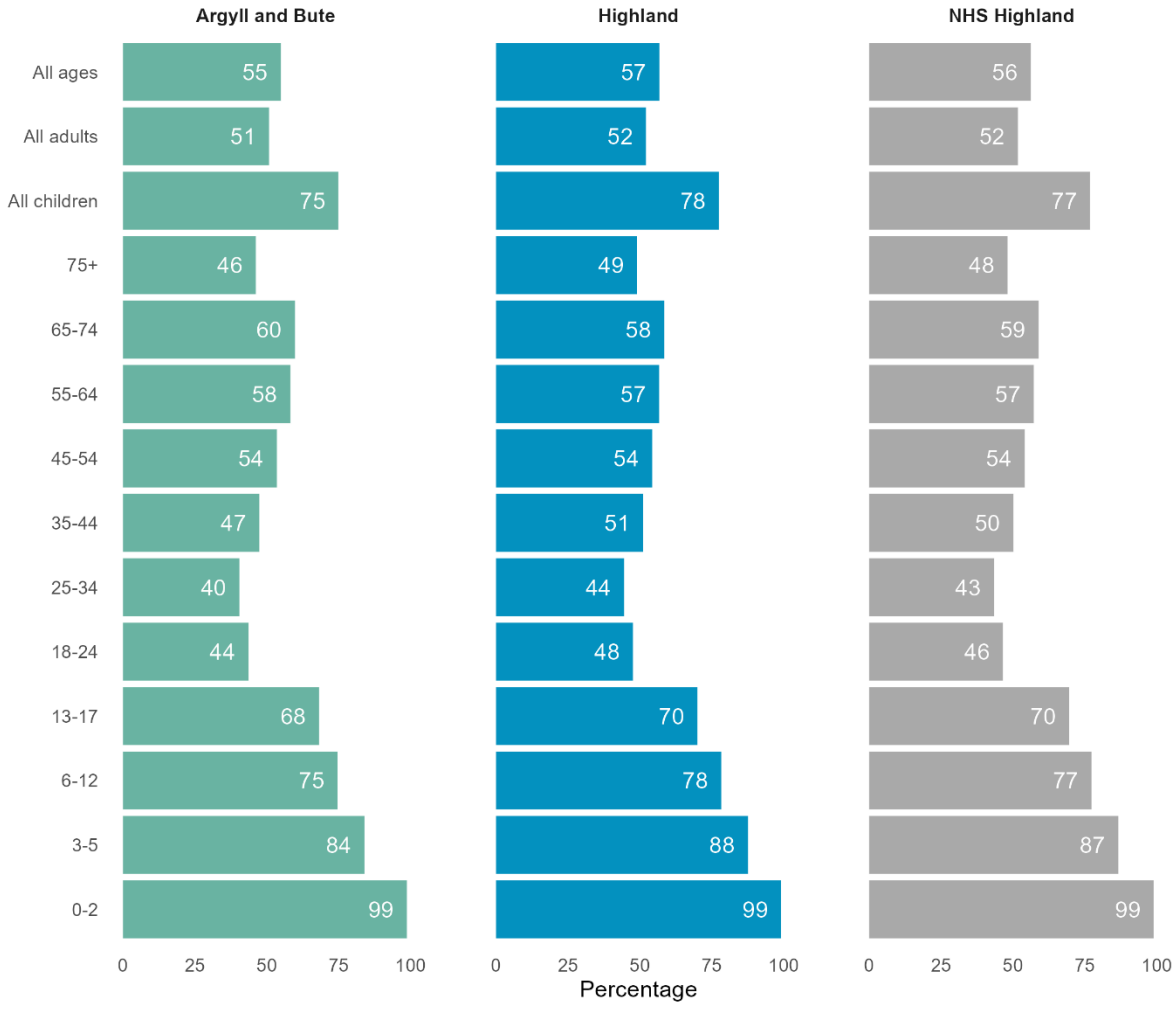
A breakdown of the percentage of patients participating in NHS dentistry by age group over the previous two years as of 31 May 2024 is shown in Figure 14.

The highest participation rates are in children aged 0-2 (99%), and the small number of children registered in this age group will have contributed to the high participation rate.

The participation rate in children subsequently decreases with age.

Adult participation is highest in the 55-64 and 65-74 year age ranges, with participation increasing through the age groups from 25 to 74 years before reducing in those 75 and over.

Figure 14: Percentage of patients resident in Argyll and Bute HSCP, Highland HSCP and NHS Highland participating in GDS by age group as of 31 May 2024



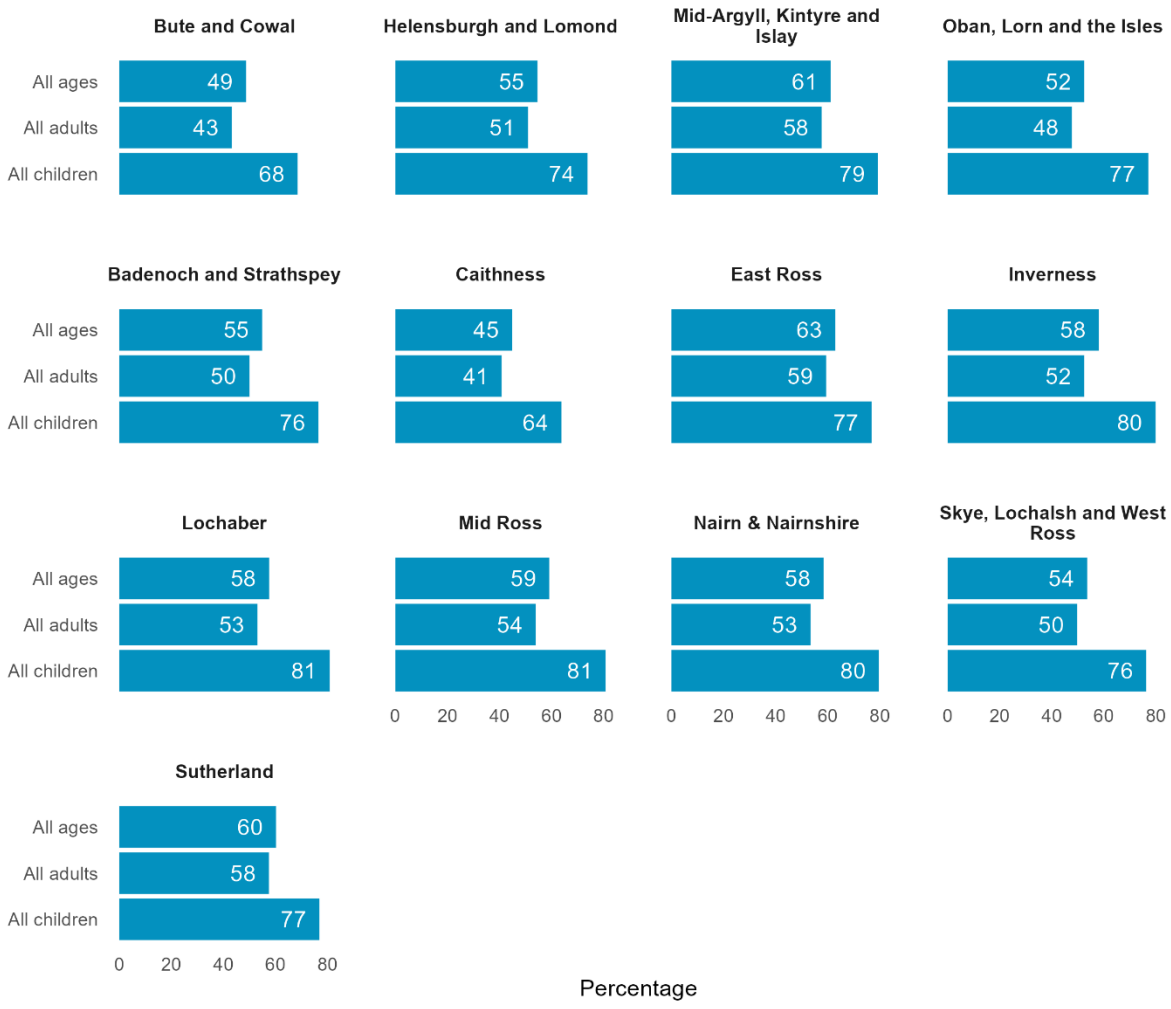
Source: Registration and participation data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Participation rates in Community Partnerships and Localities

As of 31 May 2024, the participation rates of children living in the Highland HSCP varied between 64% in Caithness and 81% in Lochaber and Mid Ross. The lowest rate of child participation rates in Argyll and Bute was 68% in Bute and Cowal.

Adult participation rates in May 2024 in the Highland HSCP were lowest in Caithness (41%) and highest in East Ross (59%), with the other six partnerships having similar participation rates between 50 and 54%. In the Argyll and Bute HSCP, adult participation was highest in Mid-Argyll, Kintyre and Islay (58%) and lowest in Bute and Cowal (43%).

Figure 15: Percentage of patients resident in Argyll and Bute HSCP Localities and Highland HSCP Community Partnerships participating in GDS by age group as of 31 May 2024



Source: Registration and participation data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Table 4: Number and percentage of patients resident in Argyll and Bute HSCP Localities and Highland HSCP Community Partnerships participating in GDS by age group as of 31 May 2024

Area	Registered	Participated	% Participated
All children			
Bute and Cowal	2,565	1,756	68.5
Helensburgh and Lomond	4,221	3,116	73.8
Mid-Argyll, Kintyre and Islay	3,103	2,461	79.3
Oban, Lorn and the Isles	3,203	2,469	77.1
Argyll and Bute	**13,092**	**9,802**	**74.9**
Badenoch and Strathspey	1,985	1,519	76.5
Caithness	3,776	2,410	63.8
East Ross	3,968	3,053	76.9
Inverness	13,166	10,515	79.9
Lochaber	3,062	2,474	80.8
Mid Ross	4,110	3,320	80.8
Nairn & Nairnshire	1,825	1,454	79.7
Skye, Lochalsh and West Ross	2,298	1,753	76.3
Sutherland	1,557	1,197	76.9
Highland	**35,747**	**27,695**	**77.5**
NHS Highland	**48,839**	**37,497**	**76.8**
All adults			
Bute and Cowal	9,092	3,926	43.2
Helensburgh and Lomond	22,738	11,598	51.0
Mid-Argyll, Kintyre and Islay	17,008	9,817	57.7
Oban, Lorn and the Isles	16,360	7,811	47.7
Argyll and Bute	**65,198**	**33,152**	**50.8**
Badenoch and Strathspey	8,688	4,341	50.0
Caithness	17,987	7,335	40.8
East Ross	15,808	9,388	59.4
Inverness	51,195	26,890	52.5
Lochaber	15,766	8,373	53.1
Mid Ross	17,061	9,201	53.9
Nairn & Nairnshire	7,646	4,080	53.4
Skye, Lochalsh and West Ross	13,639	6,787	49.8
Sutherland	9,784	5,625	57.5
Highland	**157,574**	**82,020**	**52.1**
NHS Highland	**222,772**	**115,172**	**51.7**

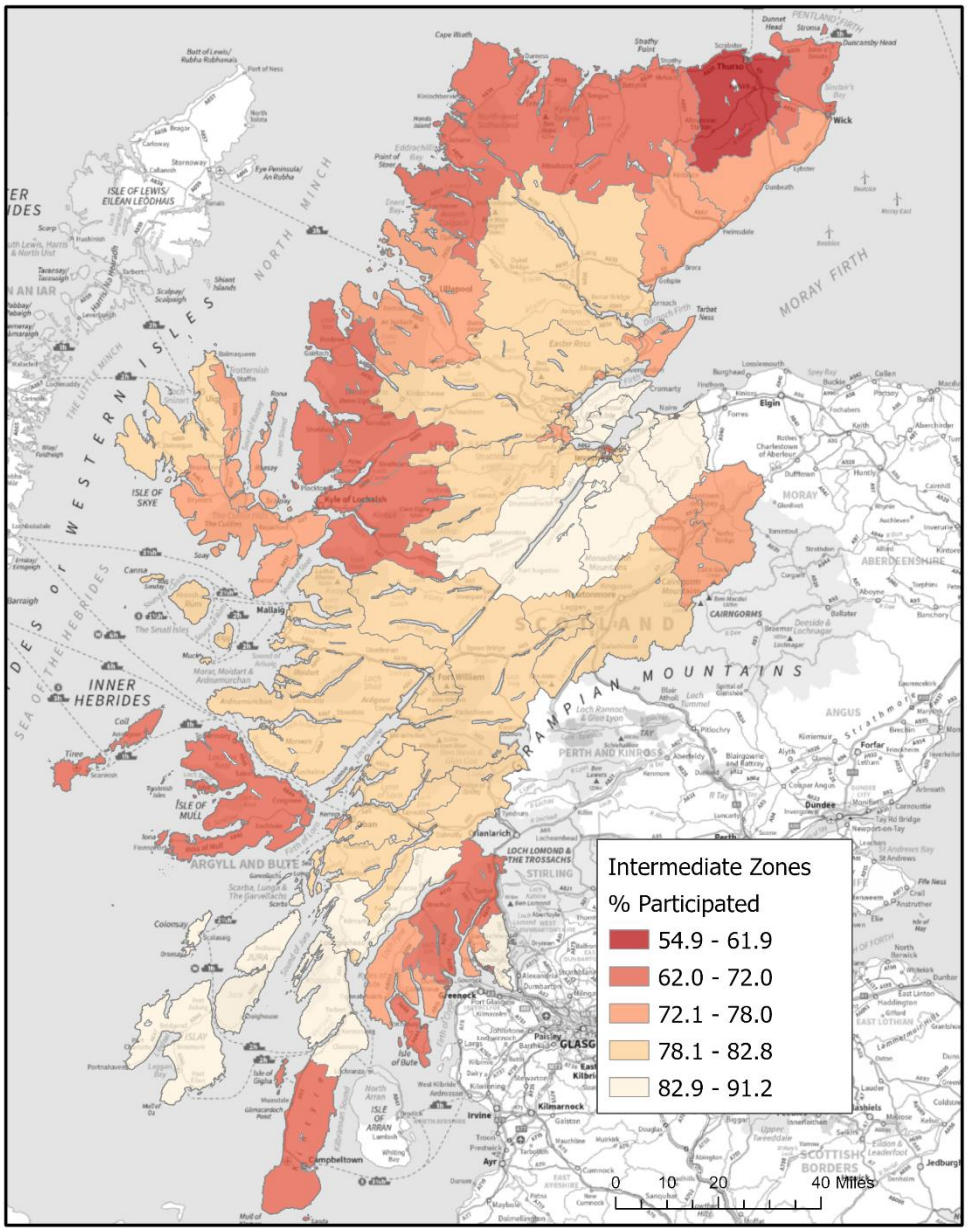
Source: Registration and participation data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Participation rates in NHS Highland in Intermediate Zones

Children

Small areas in Caithness and Bute and Cowal are identified as having the lowest rates of child participation in GDS on 31 May 2024 in NHS Highland (Map 5, Figure 16, Table 5 and Figure 17). Figure 17 suggests that the rates of the small areas identified in Caithness and the Bute and Cowal areas have been consistently low in 2023 and 2024.

Map 5: Percentage of children resident in NHS Highland Intermediate Zones participating in GDS as of 31 May 2024

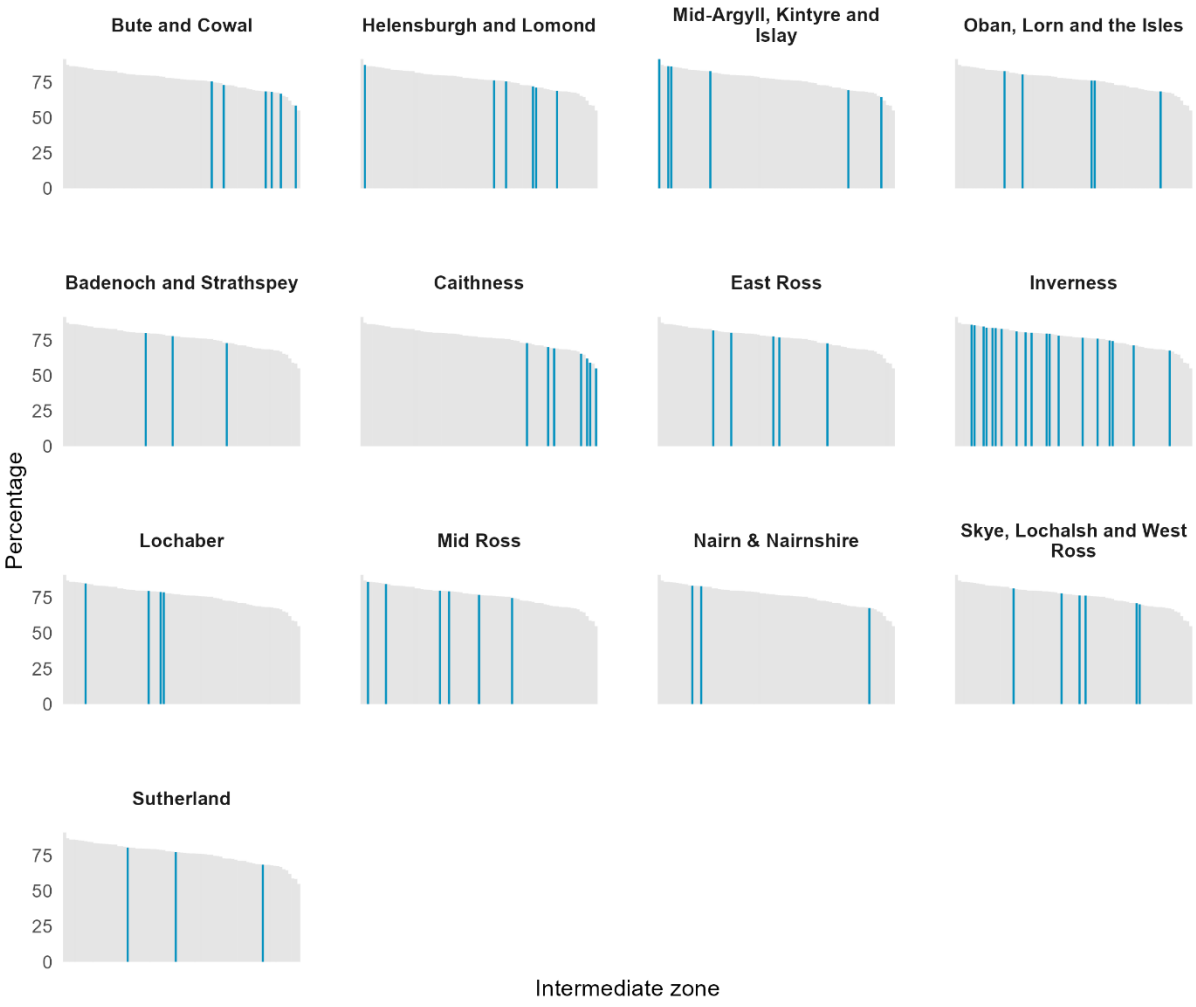


Number of registered children participating with General Dental Services by Intermediate Zone in NHS Highland as of 31 May 2024

NHS Highland
Directorate of Public Health
Public Health Intelligence Team
Assynt House, Inverness

Date: October 2024

Figure 16: Percentage of children resident in NHS Highland Intermediate Zones participating in GDS as of 31 May 2024



Source: Registration and participation data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Table 5: Number and percentage of children registered and participating in GDS by Intermediate Zones in NHS Highland by Community Partnerships and Localities as of 31 May 2024

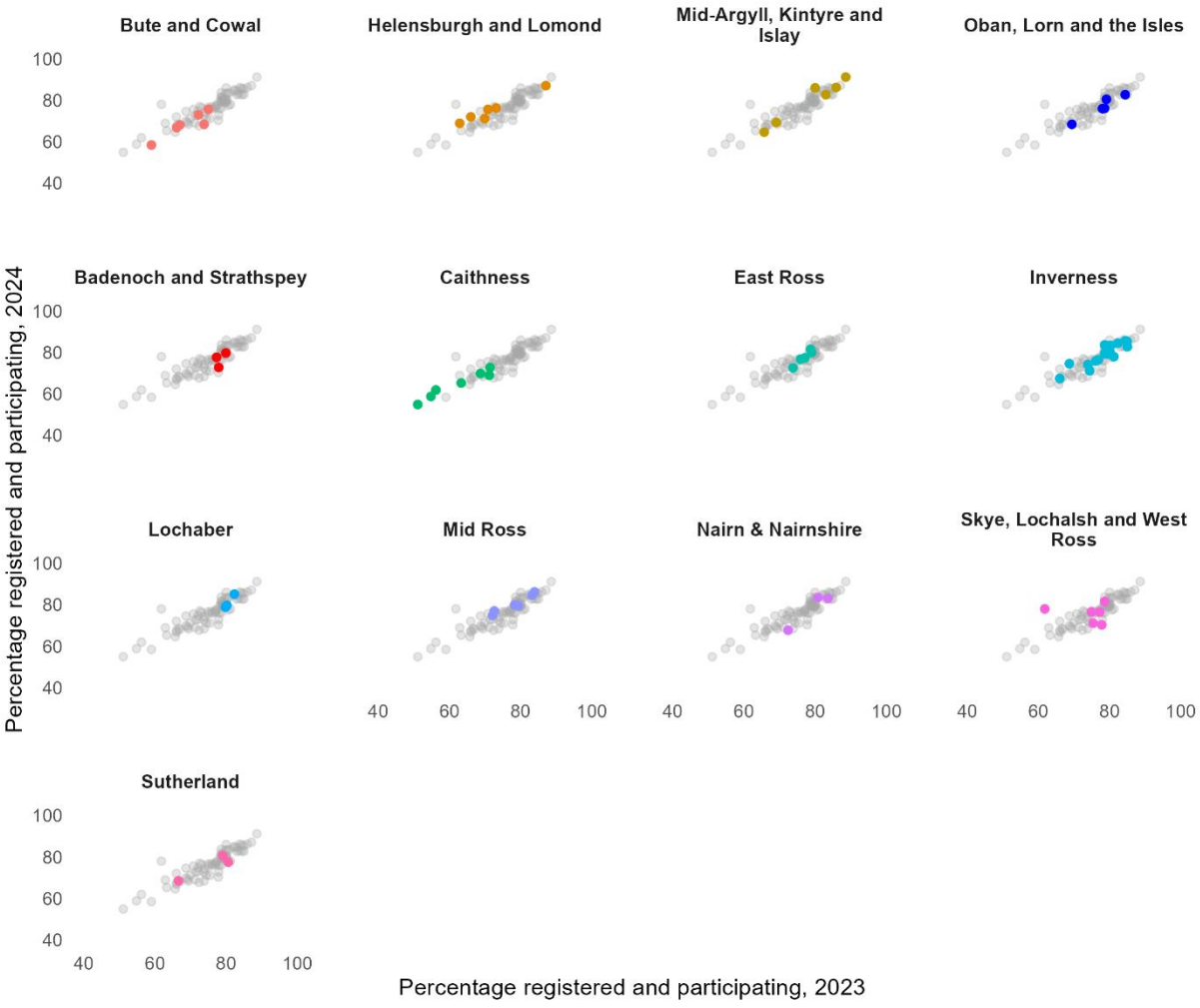
HSCP	Community Partnership / Locality	Code	Intermediate Zone	Registered	Participated	% Participated
Highland	Caithness	S02002032	Thurso West	774	425	54.9
Argyll and Bute	Bute and Cowal	S02001382	Rothesay Town	522	305	58.4
Highland	Caithness	S02002031	Thurso East	313	184	58.8
Highland	Caithness	S02002030	Caithness North West	748	463	61.9
Argyll and Bute	Mid-Argyll, Kintyre and Islay	S02001380	Campbeltown	728	470	64.6
Highland	Caithness	S02002027	Wick South	547	357	65.3
Argyll and Bute	Bute and Cowal	S02001381	Bute	232	155	66.8
Highland	Inverness	S02001998	Inverness Central, Raigmore and Longman	670	452	67.5
Highland	Nairn & Nairnshire	S02001986	Nairn East	418	283	67.7
Argyll and Bute	Bute and Cowal	S02001384	Cowal North	351	239	68.1
Argyll and Bute	Oban, Lorn and the Isles	S02001370	Mull, Iona, Coll and Tiree	623	426	68.4
Argyll and Bute	Bute and Cowal	S02001386	Dunoon	646	442	68.4
Highland	Sutherland	S02002033	Sutherland North and West	327	224	68.5
Argyll and Bute	Helensburgh and Lomond	S02001389	Helensburgh North	897	618	68.9
Highland	Caithness	S02002029	Caithness North East	487	336	69.0
Argyll and Bute	Mid-Argyll, Kintyre and Islay	S02001379	Kintyre Trail	374	259	69.3
Highland	Caithness	S02002028	Wick North	521	364	69.9

Source: Registration and participation data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Table shows intermediate zones, where fewer than 70% of children participate in GDS.

In Figure 17, most areas show only a slight variation in the proportion of the registered population participating in GDS between the snapshots.

Figure 17: Percentage of children aged under 18 participating in GDS by Intermediate Zone in NHS Highland on 31 May 2023 and 31 May 2024

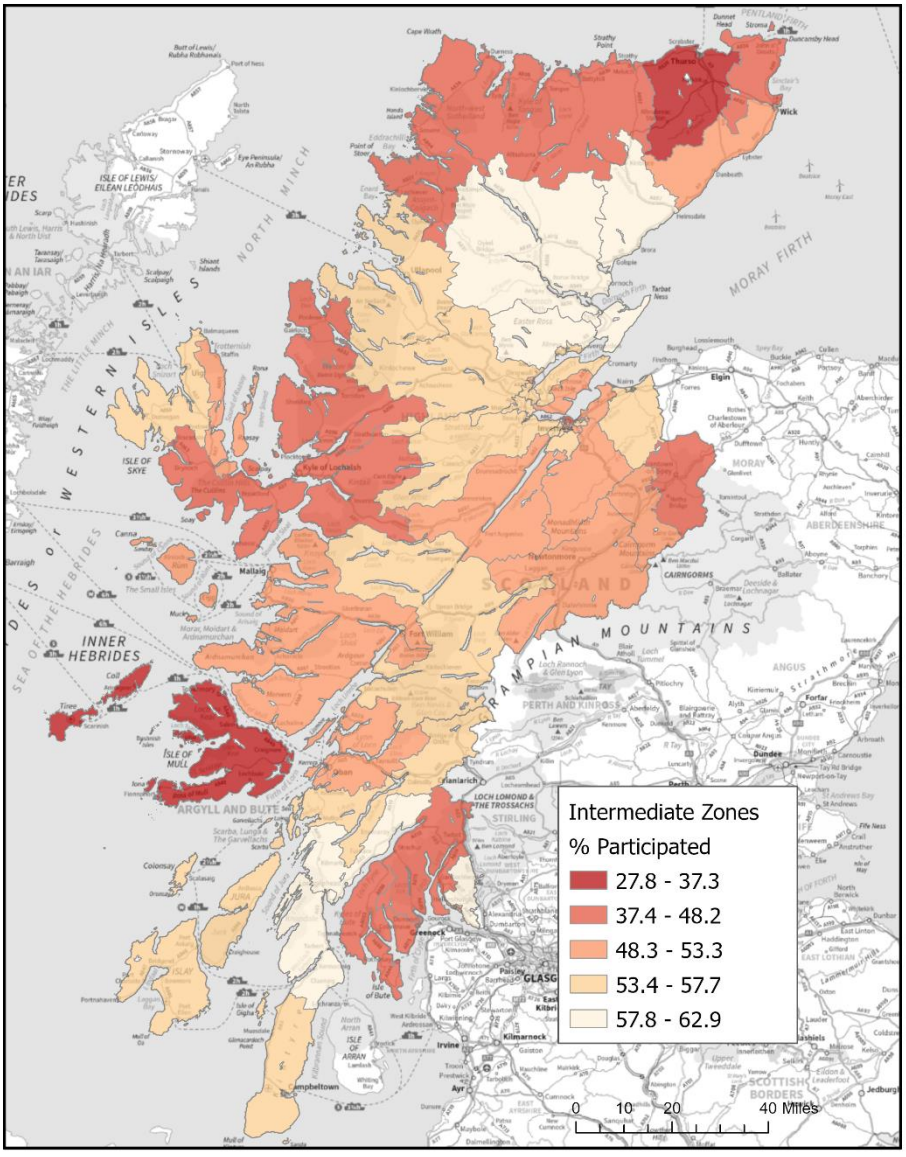


Source: Registration and participation data as of 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Adults

In the Highland HSCP, areas in Caithness, including Thurso, have low rates of adult participation in GDS. Other places in Highland with low levels of involvement are identified in Inverness, Lochalsh, and in Ross and Cromarty. In the Argyll and Bute HSCP, all areas in Bute and Cowal have lower levels of participation. The area covering the islands of Mull, Iona, Coll, and Tiree also has an adult participation rate in GDS below 40%. (Map 6, Figure 18, Table 6 and Figure 19).

Map 6: Percentage of adults resident in NHS Highland Intermediate Zones participating in GDS as of 31 May 2024

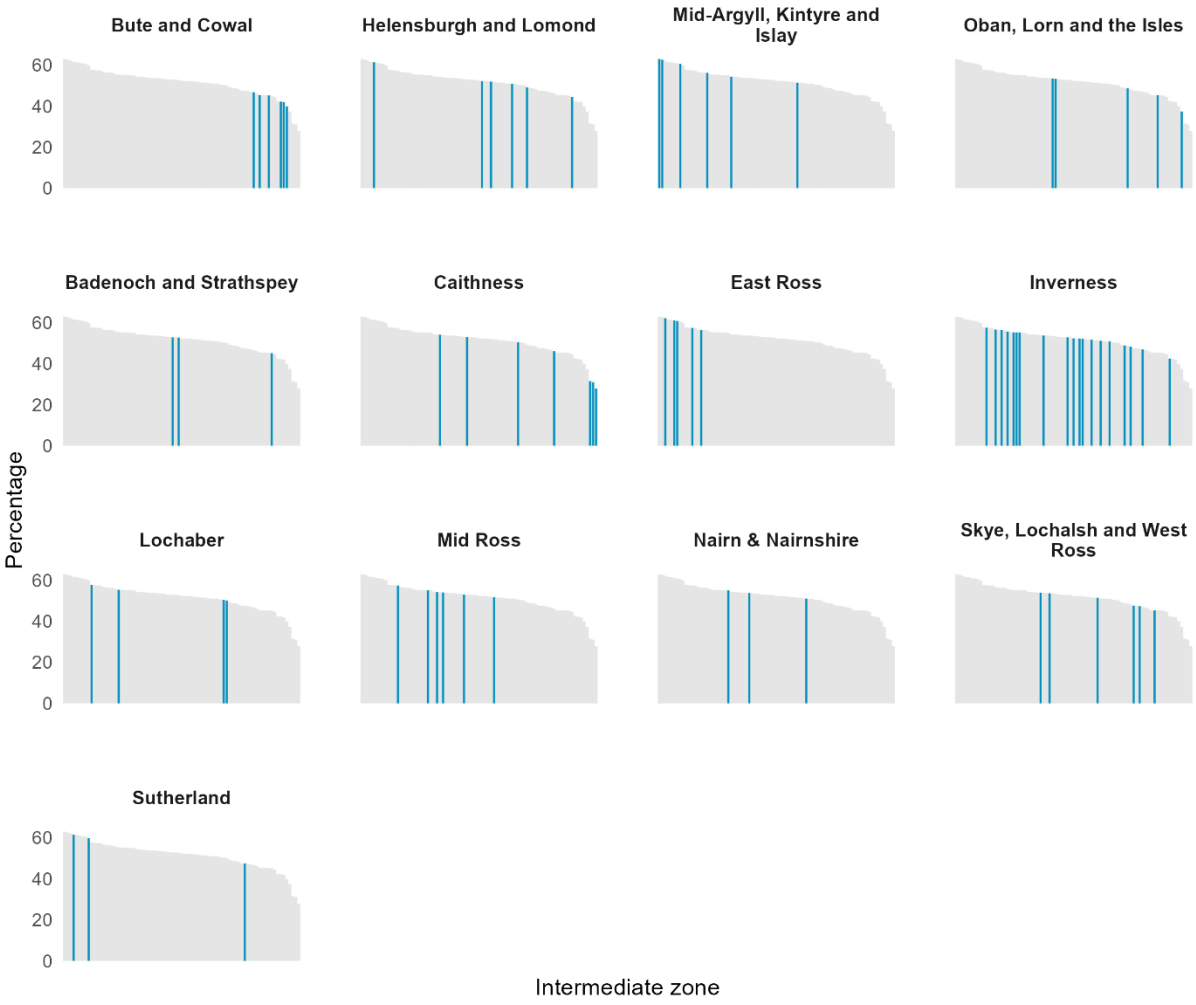


Number of registered adults participating with General Dental Services by Intermediate Zone in NHS Highland as of 31 May 2024

NHS Highland
Directorate of Public Health
Public Health Intelligence Team
Assynt House, Inverness

Date: October 2024

Figure 18: Percentage of adult patients resident in NHS Highland Intermediate Zones participating in GDS as of 31 May 2024



Source: Registration and participation data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Table 6: Number and percentage of adults registered and participating in GDS by Intermediate Zones in NHS Highland by Community Partnerships and Localities as of 31 May 2024

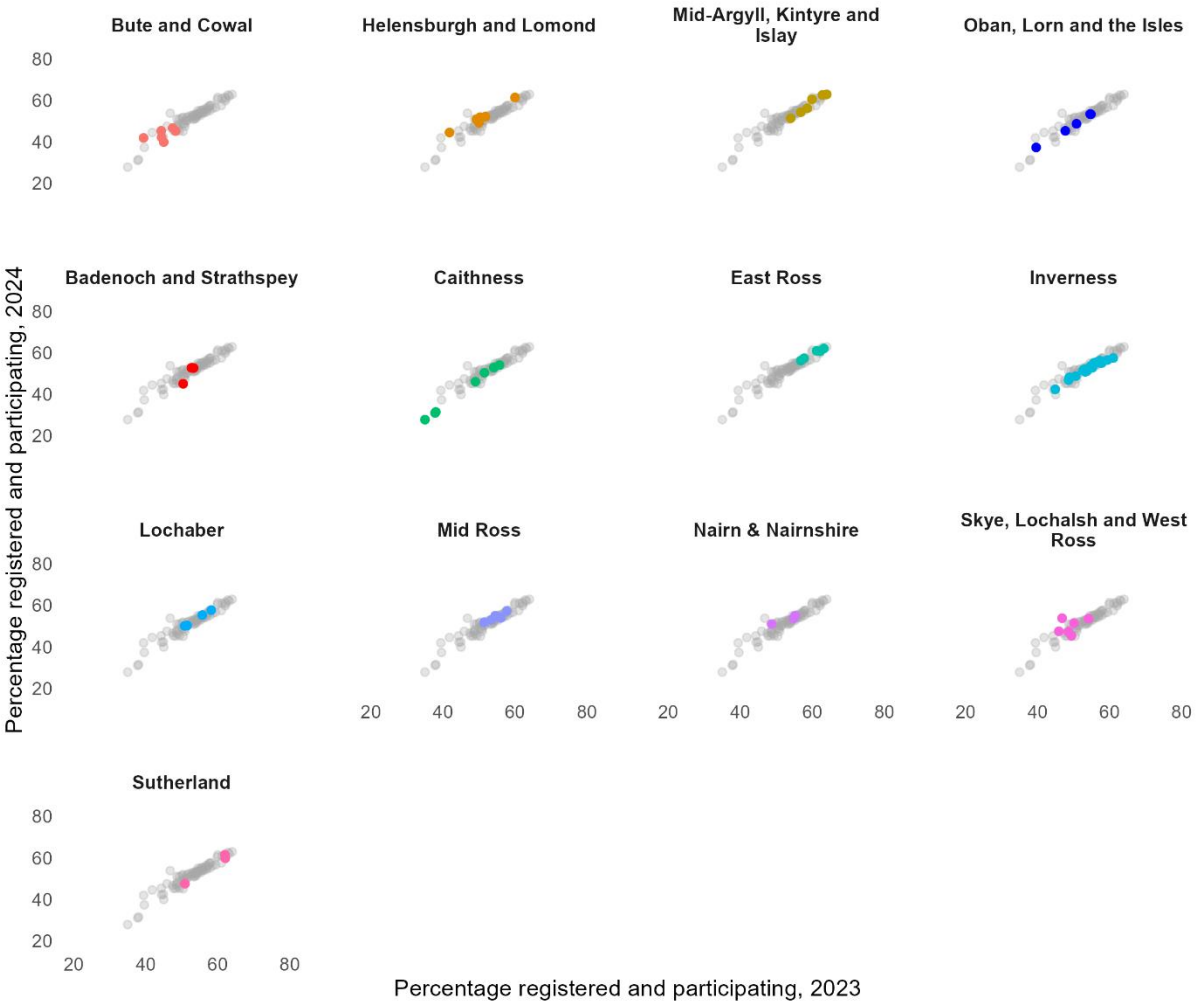
HSCP	Community Partnership / Locality	Code	Intermediate Zone	Registered	Participated	% Participated
Highland	Caithness	S02002031	Thurso East	1847	514	27.8
Highland	Caithness	S02002032	Thurso West	3311	1025	31.0
Highland	Caithness	S02002030	Caithness North West	3657	1153	31.5
Argyll and Bute	Oban, Lorn and the Isles	S02001370	Mull, Iona, Coll and Tiree	3419	1274	37.3
Argyll and Bute	Bute and Cowal	S02001383	Cowal South	1043	416	39.9
Argyll and Bute	Bute and Cowal	S02001382	Rothesay Town	2770	1161	41.9
Argyll and Bute	Bute and Cowal	S02001386	Dunoon	1058	447	42.2
Highland	Inverness	S02001998	Inverness Central, Raigmore and Longman	2556	1085	42.4
Argyll and Bute	Helensburgh and Lomond	S02001387	Garelochhead	4618	2055	44.5
Highland	Badenoch and Strathspey	S02001984	Badenoch and Strathspey North	3181	1435	45.1
Argyll and Bute	Bute and Cowal	S02001385	Hunter's Quay	1302	589	45.2
Argyll and Bute	Oban, Lorn and the Isles	S02001372	Oban North	2000	906	45.3
Argyll and Bute	Bute and Cowal	S02001381	Bute	1937	878	45.3
Highland	Skye, Lochalsh and West Ross	S02002007	Lochalsh	2178	986	45.3
Highland	Caithness	S02002029	Caithness North East	2610	1202	46.1
Argyll and Bute	Bute and Cowal	S02001384	Cowal North	1781	831	46.7
Highland	Inverness	S02002002	Inverness Merkinch	1961	919	46.9
Highland	Skye, Lochalsh and West Ross	S02002008	Skye South	2881	1362	47.3
Highland	Skye, Lochalsh and West Ross	S02002011	Ross and Cromarty South West	1705	810	47.5
Highland	Sutherland	S02002033	Sutherland North and West	2236	1063	47.5
Highland	Inverness	S02002001	Inverness Muirtown	2439	1176	48.2
Argyll and Bute	Oban, Lorn and the Isles	S02001371	Oban South	4381	2135	48.7
Highland	Inverness	S02002000	Inverness Ballifeary and Dalneigh	2667	1302	48.8
Argyll and Bute	Helensburgh and Lomond	S02001390	Helensburgh Centre	2928	1442	49.2

Source: Registration and participation data as of 31 May 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

1. Table shows intermediate zones, where fewer than 50% of adults participate in GDS.

There is little variation in the proportion of the registered population participating in GDS between the snapshots of 31 May 2023 and 2024

Figure 19: Percentage of adults participating in GDS by Intermediate Zone in NHS Highland on 31 May 2023 and 31 May 2024



Source: Registration and participation data as of 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

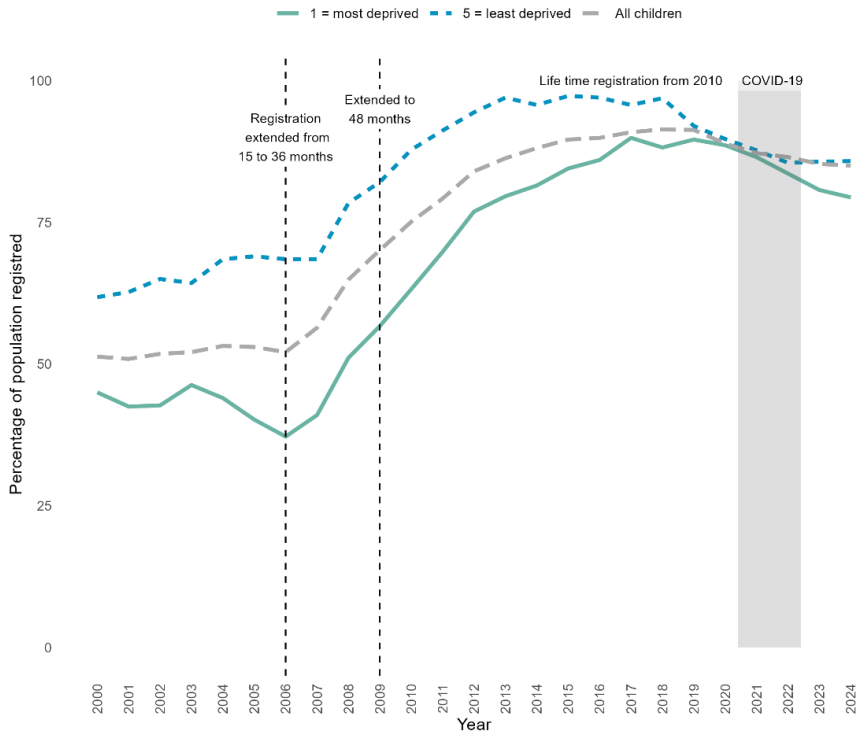
Deprivation

We explore population-level inequalities in access to NHS dentistry by linking registrations and participation activity to the area-based Scottish Index of Multiple Deprivation[5] and relevant population denominator estimates from the National Records of Scotland.

Inequalities in children's registrations

Over the long term (2000 – 2019), systematic inequality is observed in the deprivation gap of children registered in NHS Highland. The gap narrowed between children living in the most and least deprived quintiles as the proportion of children registered in the least deprived quintile levelled and then decreased. In contrast, registration rates of the most deprived continued to increase before levelling (2017 – 2019). Immediately before the pandemic, registration rates were similar for all children. However, as children's registration rates of the most deprived continued to decline from 2020, the inequality gap has started to reopen.

Figure 20: Percentage of children resident in NHS Highland registered with an NHS dentist living in the most and least deprived areas of the Scottish Index of Multiple Deprivation



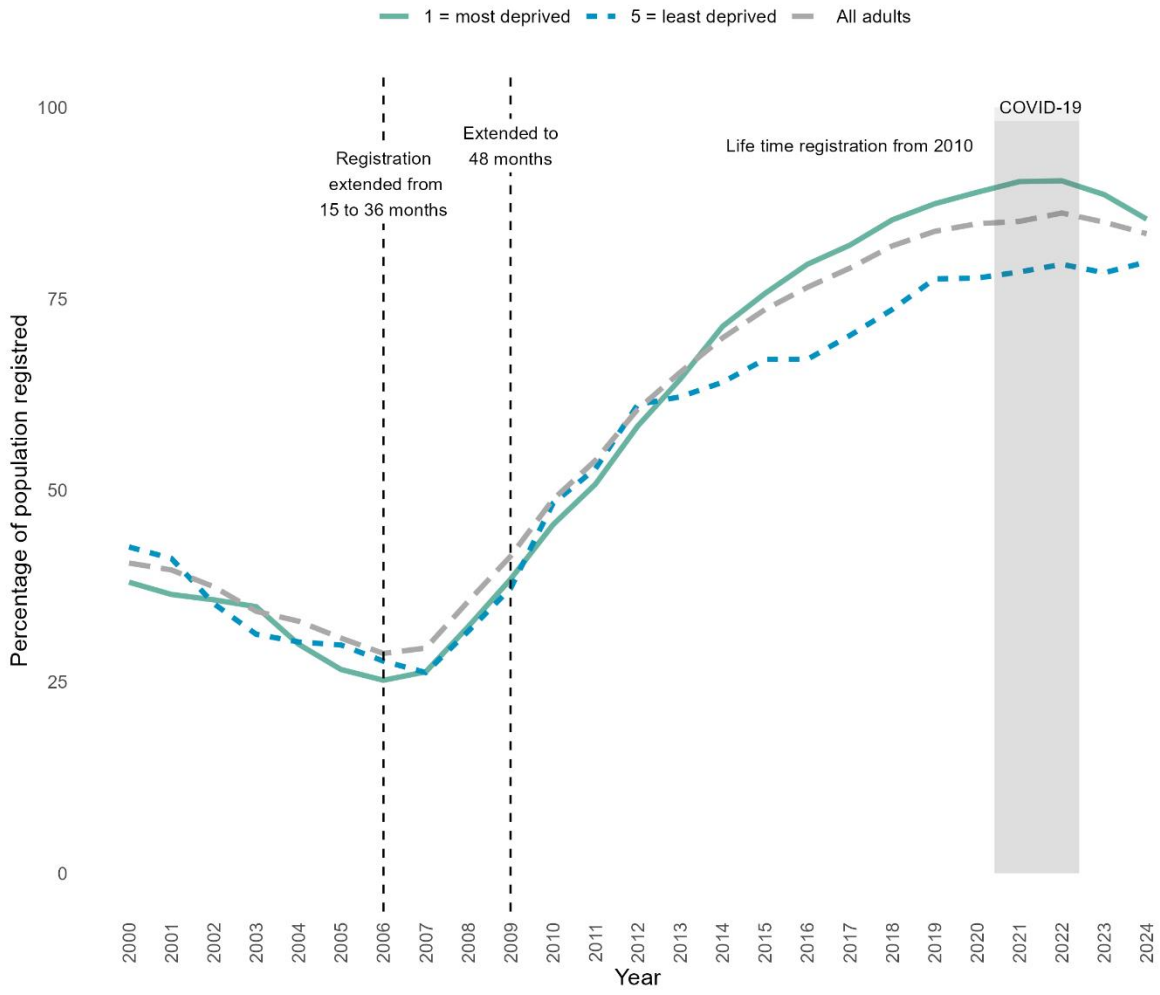
Source: Public Health Scotland (PHS) Dental Statistics 2023 –registrations for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

[5] Scotland's Index of Multiple Deprivation (SIMD) is a relative measure of socioeconomic deprivation across over 6,900 data zones (small areas). Data for NHS dental registrations and participation in this report are analysed by 'Scotland level' SIMD population-weighted quintiles, with deprivation quintile 1 indicating the population lives in an area in the most deprived 20% of Scotland. The most appropriate version of SIMD is used for each year of the analysis.

Inequalities in adult registrations

In contrast to children, adults in the most deprived quintiles are more likely to be registered with NHS dentistry. However, the gap in registration between the least and most deprived has reduced post-pandemic, with a fall in registration among those living in the most deprived areas in NHS Highland.

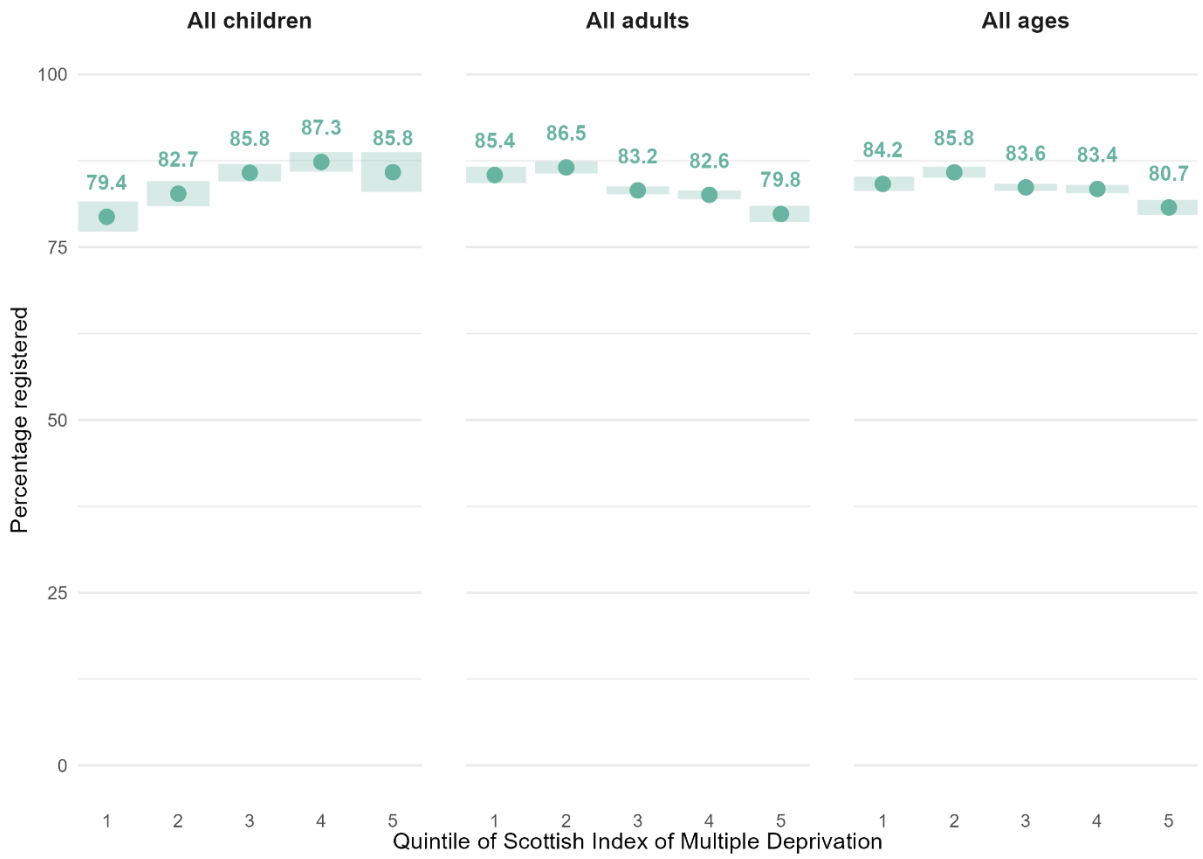
Figure 21: Percentage of adults resident in NHS Highland registered with an NHS dentist living in the most and least deprived areas of the Scottish Index of Multiple Deprivation



Source: Public Health Scotland (PHS) Dental Statistics 2023 –registrations for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

Figure 22 shows the deprivation gradients in registration in NHS Highland on 31 May 2024. The availability of free dental treatment for those with specific benefits and reliance on private dentistry may influence these patterns.

Figure 22: Percentage of patients resident in NHS Highland registered with an NHS dentist by quintiles of the Scottish Index of Multiple Deprivation on 31 May 2024[1]



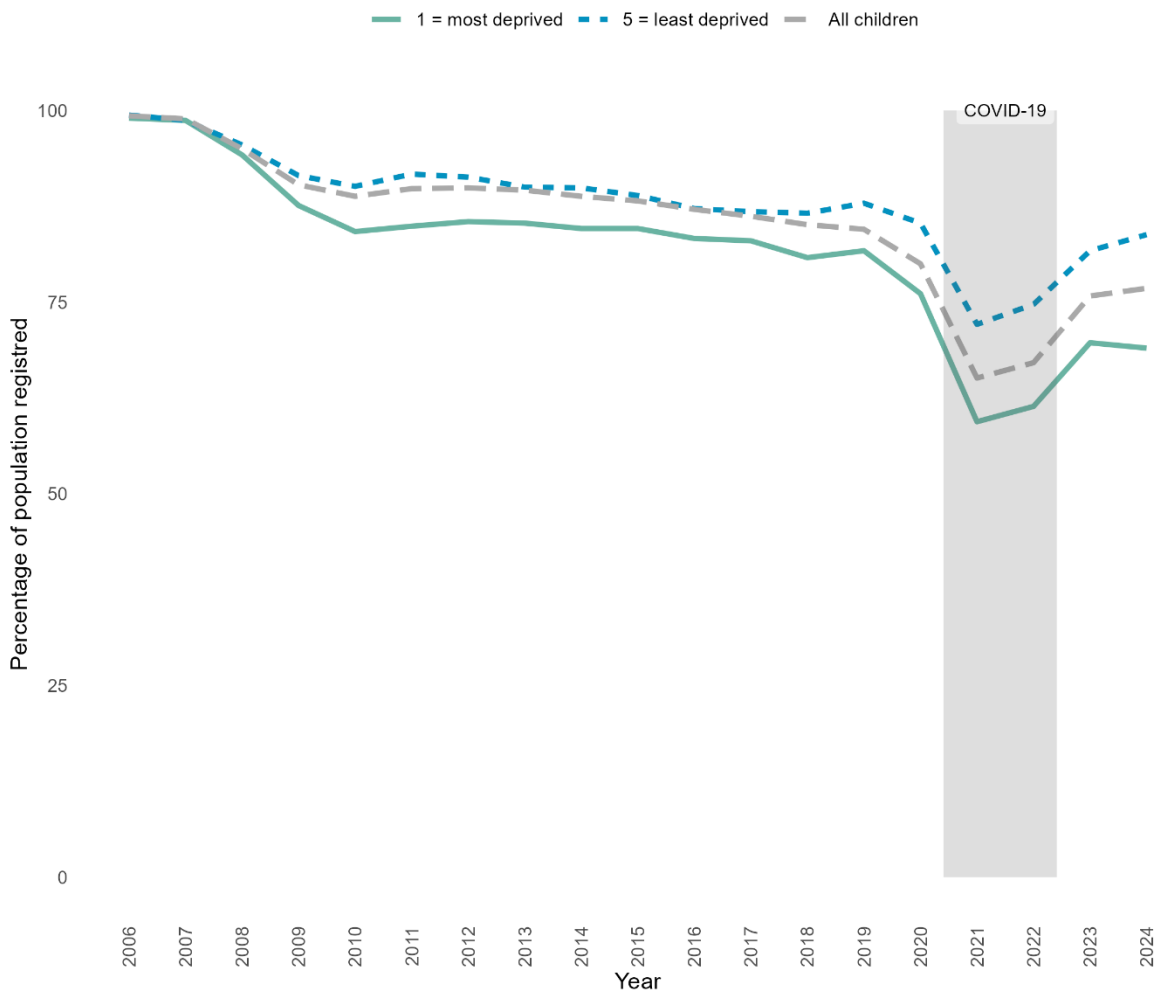
1. The shaded area represents the 95% confidence interval range of the rate

Source: Registration and participation data as of 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Inequalities in children's participation

Figure 23 shows the inequality gap in participation between children living in the most and least deprived areas of NHS Highland, which increased during the pandemic and continues to persist.

Figure 23: Percentage of children resident in NHS Highland participating with NHS dentistry living in the most and least deprived areas of the Scottish Index of Multiple Deprivation

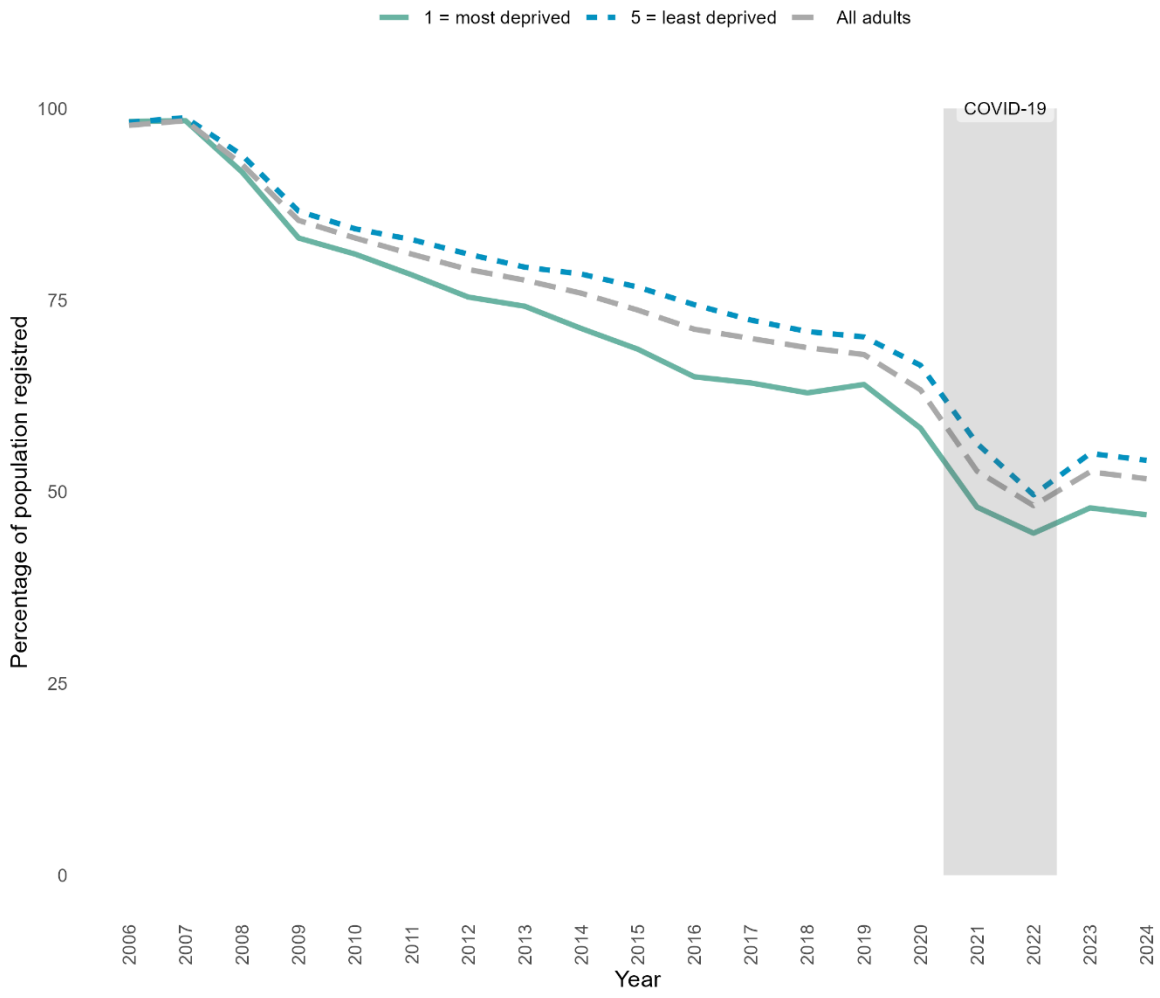


Source: Public Health Scotland (PHS) Dental Statistics 2023 –registrations and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

Inequalities in adult participation

Within the long-term downward trend in the adult population's participation in NHS dentistry, inequalities in access have remained, with no notable change in the deprivation gap following the pandemic period.

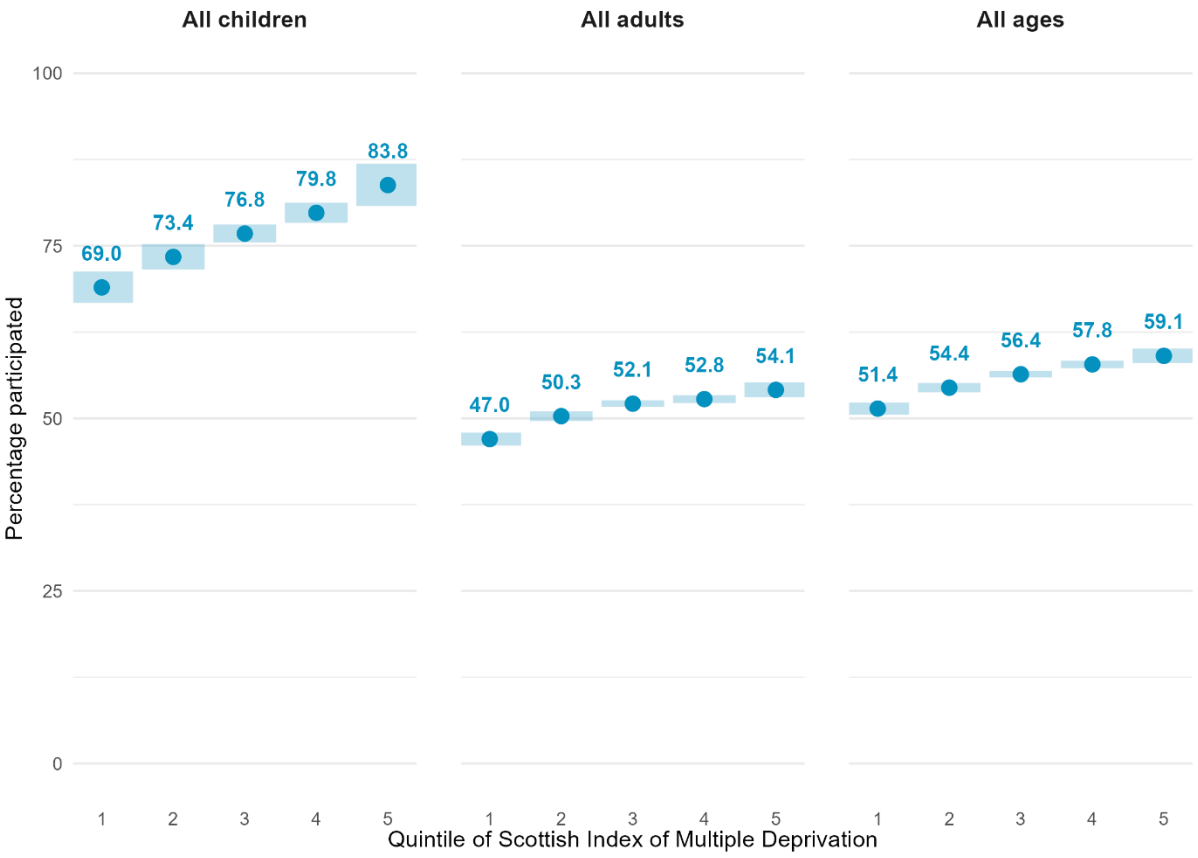
Figure 24: Percentage of adults resident in NHS Highland participating with NHS dentistry living in the most and least deprived areas of the Scottish Index of Multiple Deprivation



Source: Public Health Scotland (PHS) Dental Statistics 2023 –registrations and participation for years 2000 to 2022 (snapshot of statistical data as of 30 September of each year) and registration data at 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland as an information request.

Figure 25 highlights the gradient in participation in NHS dentistry, with rates decreasing as deprivation levels increase for children and adults as of 31 May 2024.

Figure 25: Percentage of patients living in NHS Highland participating in NHS dentistry by quintile of the Scottish Index of Multiple Deprivation on 31 May 2024[1]



1. The shaded area represents the 95% confidence interval range of the rate

Source: Registration and participation data as of 31 May 2023 and 2024 provided by PHS to the Public Health Intelligence team, NHS Highland, as an information request.

Appendix 1

Deprivation

The Scottish Index of Multiple Deprivation was revised in 2004, 2006, 2009, 2012, 2016, and 2020. The table shows the version of SIMD used for analysis for the reported years.

Year of analysis	SIMD version
2000 ,2001, 2002, 2003	SIMD 2004
2004, 2005, 2006,	SIMD 2006
2007, 2008, 2009	SIMD 2009
2010, 2011, 2012, 2013	SIMD 2012
2014, 2015, 2016, 2017, 2018	SIMD 2016
2019 onward	SIMD 2020

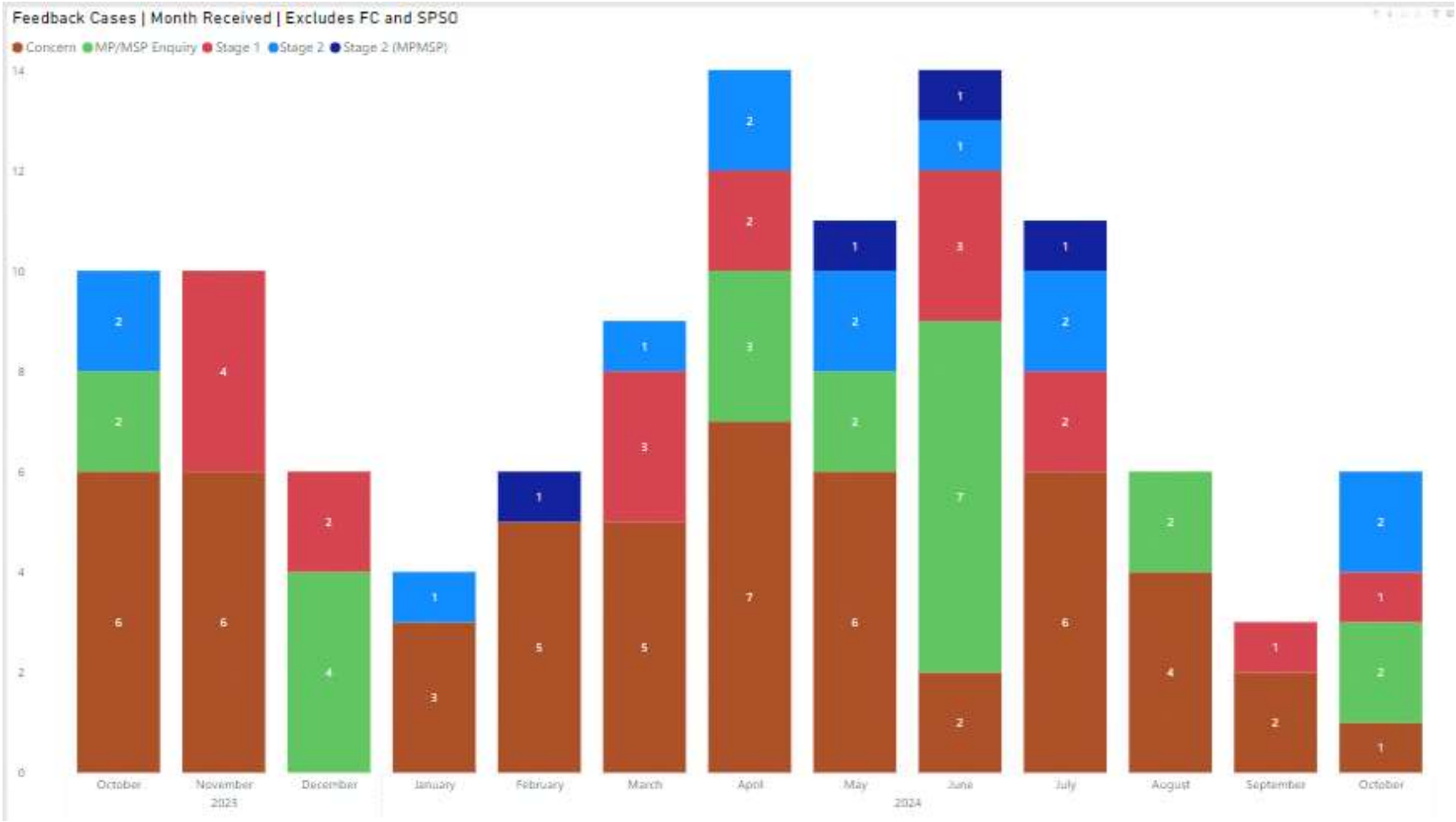
Population Estimates

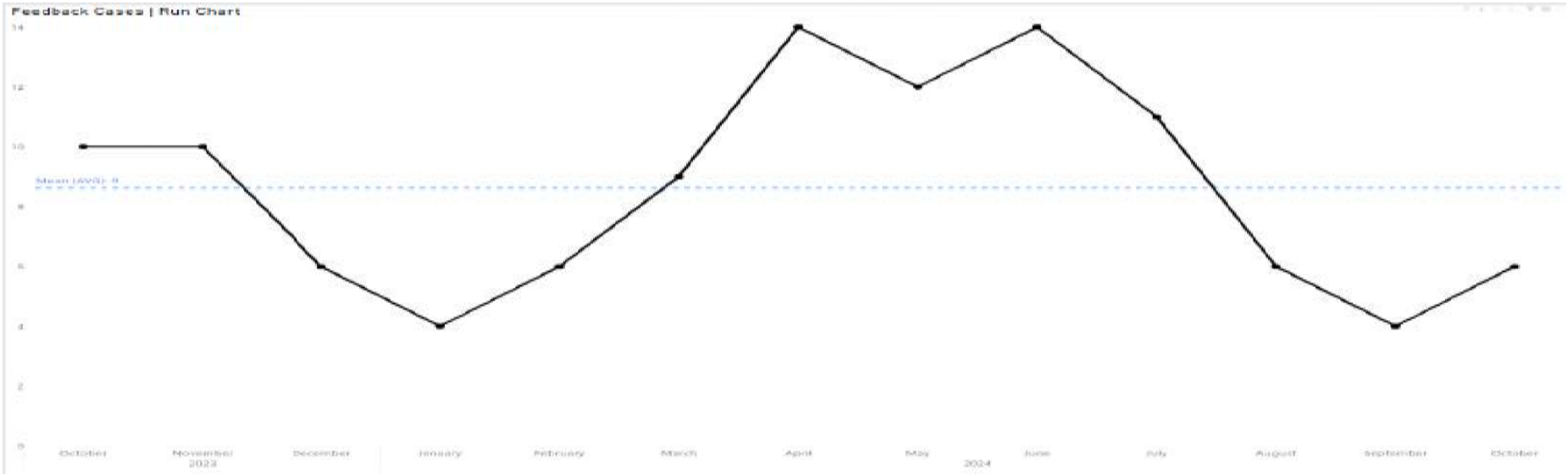
Population estimates available at the time are used in the analysis to report trends in registration rates. In the future, the National Records of Scotland will publish revised population estimates informed by Census 2022 for years from 2011, and the new denominators will change the point estimates reported but not the report's key messages about declining registration trends and systematic variation in registration rates with deprivation.

In August 2024, the latest available population for small areas were 2021-based estimates, and these were used to calculate rates reported for activity in 2022, 2023, and 2024.

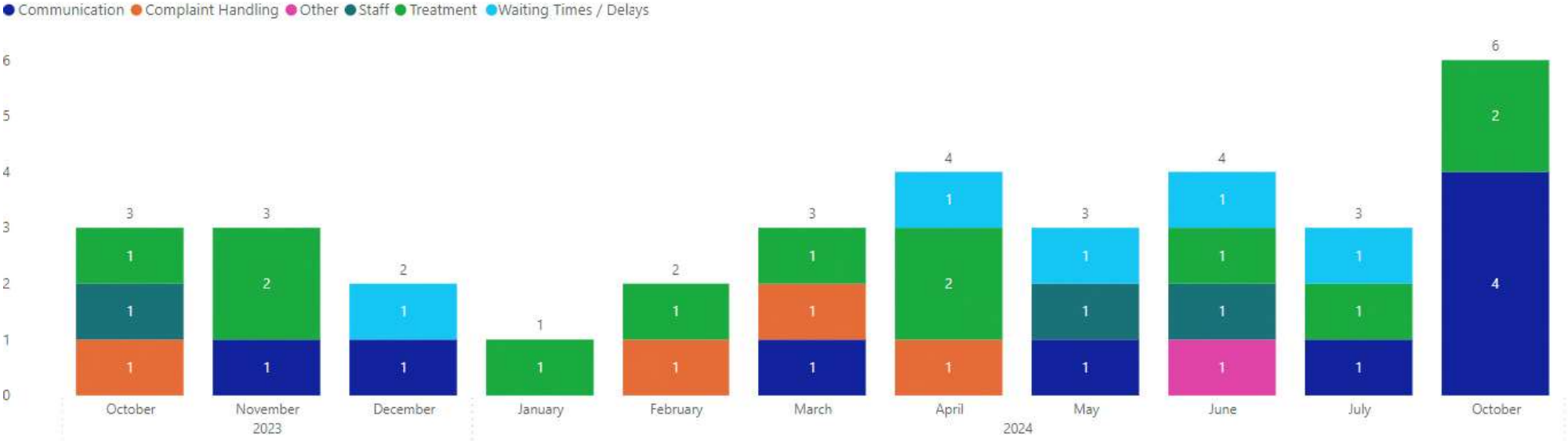
DENTAL CLINICAL GOVERNANCE & RISK MANAGEMENT GROUP – 15 January 2025
Update from Clinical Governance Support Manager

COMPLAINTS 01/10/2023 – 31/10/2024 – 110
(53) Concern **(22)** MP-MSP Enquiry **(18)** Stage 1 **(13)** Stage 2 **(4)** Stage 2 (MP-MSP)

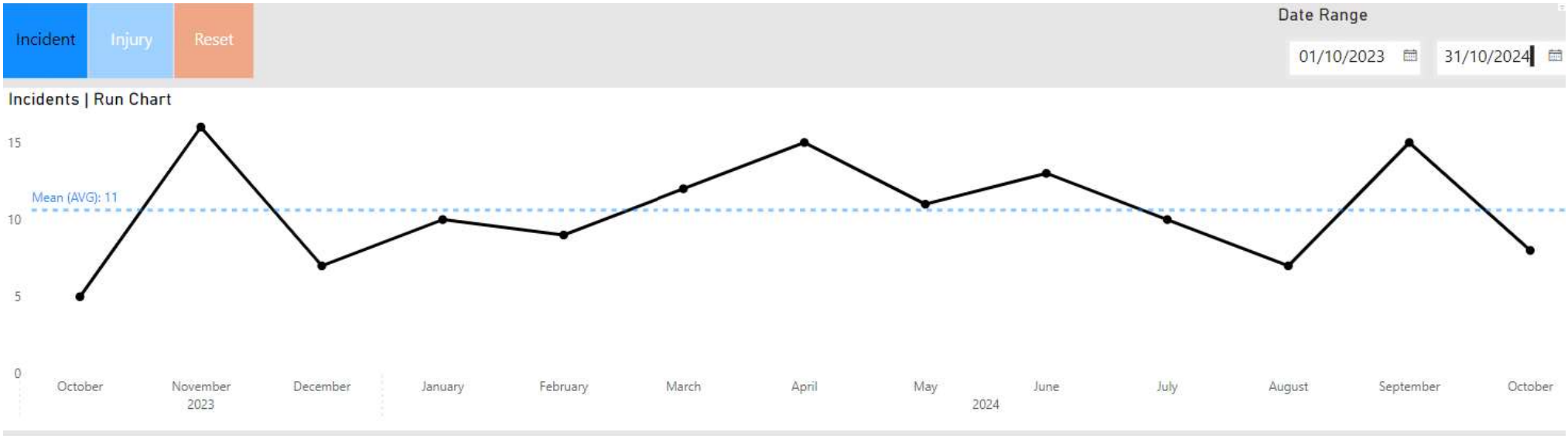


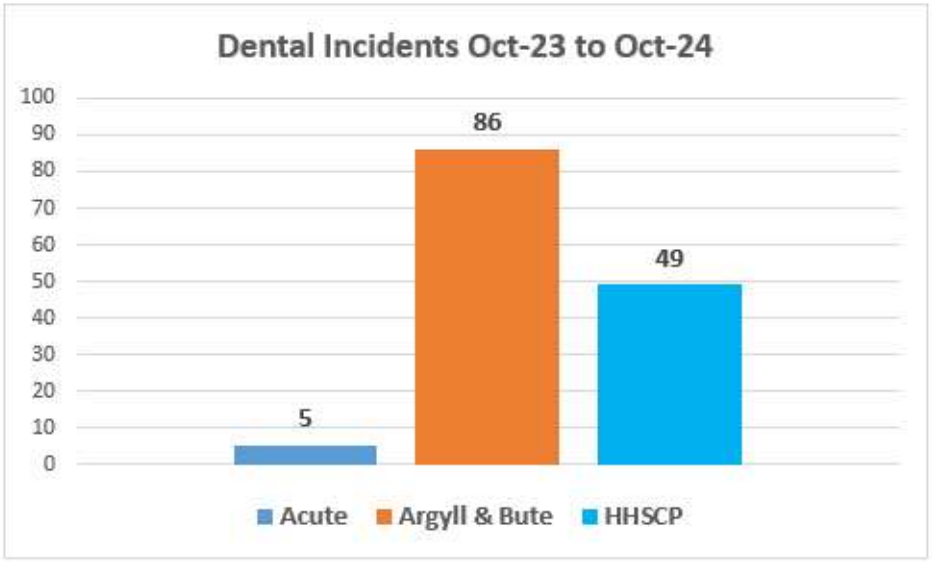


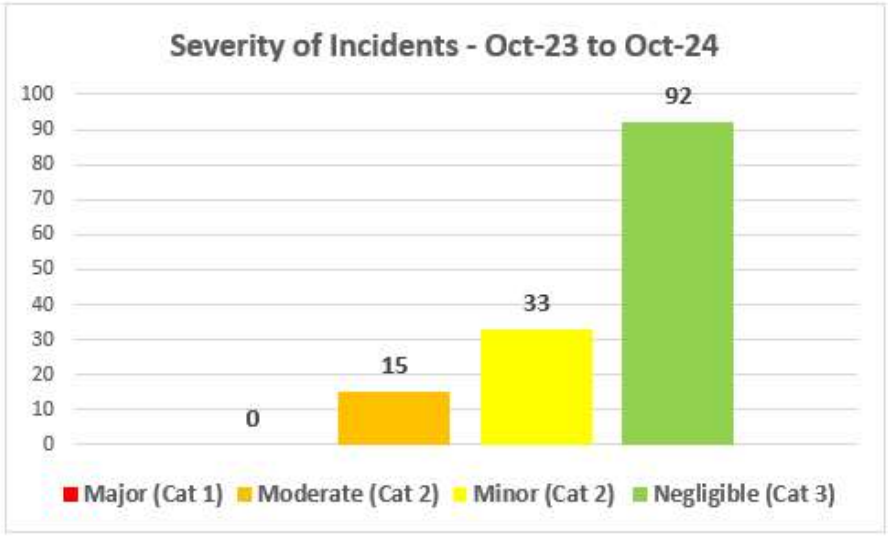
Feedback Cases | Issue Category | Excludes FC and SPSO



ADVERSE EVENTS – 01/10/2023 – 31/10/2024 – 140 Dental Incidents during this period







Themes

Major – there were no major incidents.

Moderate – there were 15 moderate incidents. 4 of these related to infection control and 3 involving staff availability.

Minor – there were 33 minor incidents. 5 of these were sharps incidents and 8 involving staff availability.

Negligible – the majority (115) incidents were negligible (Category 3) where there was either no injury or only minor injury or harm not requiring first aid, with no impact to service or standards of care.

Lorraine Power
Clinical Governance Support Manager
9 January 2025

Agenda Item 5.5

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**7th May 2025**
Title:	**Implementation of the Highland HSCP Joint Strategic Plan**
Responsible Executive/Non-Executive:	**Pamela Stott, Chief Officer**
Report Authors:	**Rhiannon Boydell, Head of Integration, Planning and Performance, HHSCP** **Fiona Malcolm, Chief Officer – Integrated People Services, The Highland Council**

Report Recommendation: The Committee are asked to accept moderate assurance that the Joint Strategic Plan is being Implemented effectively through partnership approaches.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This report will align to the following NHSScotland 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		**All** Well Themes			

2 Report summary

2.1 Situation

This report provides an overview of the transformation and planning work currently being undertaken by Highland Health and Social Care Partnership which will result in the implementation of the Joint Strategic Plan

2.2 Background

The Highland Health and Social Care Partnership Joint Adult Services Strategic Plan 2024 – 27 is entering it's second year of implementation. The plan sets out the direction for Health and Social Care in Highland for the period 2024 - 2027 and also the way in which the plan will be delivered, through engagement and collaboration with communities and partners. The plan acknowledges the challenges facing health and social care delivery, including service availability / capacity, financial and workforce challenges.

The plan committed to taking forward implementation in Districts and a Strategic Charter, "Home is Best", was developed to assist with local service planning through District Planning Groups. The work of the District Planning groups in shaping the strategy to their localities is overseen by the Strategic Planning Group.

Within NHS Highland, transformational change plans are taken forward within the Strategic Transformation Accountability Group (STAG) structure. All work streams align with the Joint Strategic Plan and contribute to the plan implementation. This includes work specific to Adult Social Care which is identified in the Highland Council Delivery Plan and is led by the Chief Officer – Integrated People Services in the Highland Council, as a People Transformation Programme.

2.3 Assessment

Strategic and District Planning Groups

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 area over the period of the plan and which also sets out how these arrangements are intended to achieve the national health and wellbeing outcomes.

This same Act also directs that a **Strategic Planning Group** requires to be established and in place in to support the development of the Joint Strategic Plan.

The group continues to have oversight of the implementation of the Joint Strategic Plan.

District Planning Groups (DPGs) were established in April 2024 and had their initial meetings during April and May. They are the main engagement vehicle with local communities and ensure that we work together and listen to people in communities to develop local implementation plans.

Meetings are scheduled every 3 months in line with the Strategic Planning Group and are supported by a standard Terms of Reference, Agenda, Action Plan and Action Note format. Meetings have been held for every District as per the following schedule:

District	**Date 1st Meeting**	**Date 2nd Meeting**	**Date 3rd Meeting**	**Date 4th meeting**
Caithness	08/04/2024	23/08/2024	06/11/2024	10/02/2025
Nairn	16/04/2024	27/08/2024	05011/2024	17/02/2025
Mid Ross	16/04/2024	13/08/2024	08/11/2024	14/03/2025
Sutherland	26/04/2024	Planned for 07/08/2024. Cancelled due to low attendance	10/12/2024	Planned for 11/03/25, cancelled due to low attendance
Lochaber	29/04/2024	01/08/2024	04/11/2024	06/02/2025
Skye, Lochalsh, Wester Ross	01/05/2024	12/09/2024	13/12/2024	12/03/2025
East Ross	09/05/2024	30/07/2024 (People Thematic Group)	05/11/2024	21/01/2025
Badenoch and Strathspey	13/05/2024	28/08/2024	11/11/2024	18/03/2025 Minutes not available at time of writing.
Inverness	14/05/2024	22/08/2024	05/11/2024	26/03/2025 Minutes not available at the time of writing)

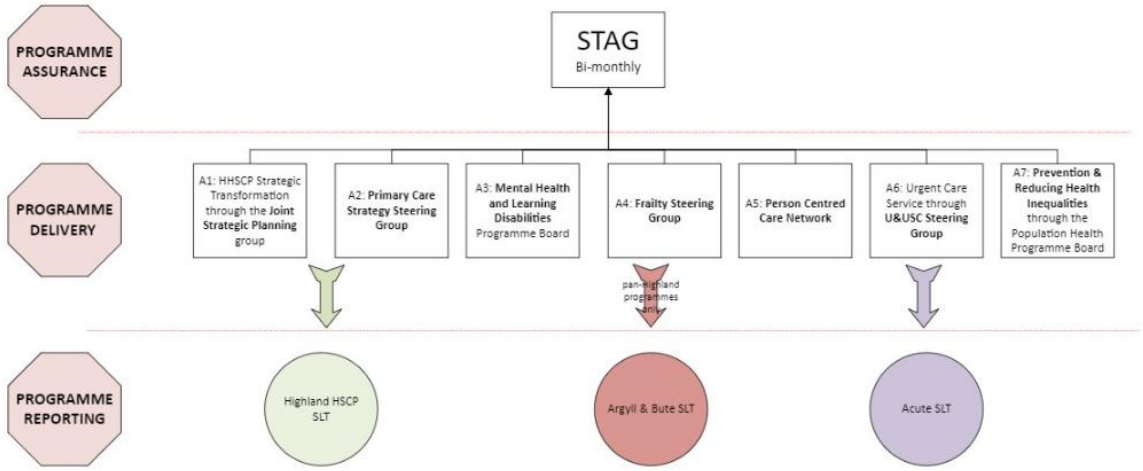
Key priority areas raised in the latest meetings include:

- Workforce challenges. Discussion has included opportunities for work experience and apprenticeships, enabling the workforce to be adaptable, flexible and innovative, actions to address recruitment challenges, child care
- Integrating care provision – concerns about future models and ongoing integration of health and social care.
- Alternatives to hospital acute hospital admission and attendance
- Expanding and maintaining membership
- Addressing Delayed Discharges
- Working with the third and voluntary sectors
- Opportunities to work differently with the communities to share plans and work together across the age ranges from cradle to grave
- Collaborative working
- Mental health and psychiatric service access
- Access to vaccinations services

All District Planning Groups receive feedback on the content and discussion of the last Strategic Planning group meeting and received the overview of the Adult Social Care Transformation Programme as delivered to the Strategic Planning Group development session in November.

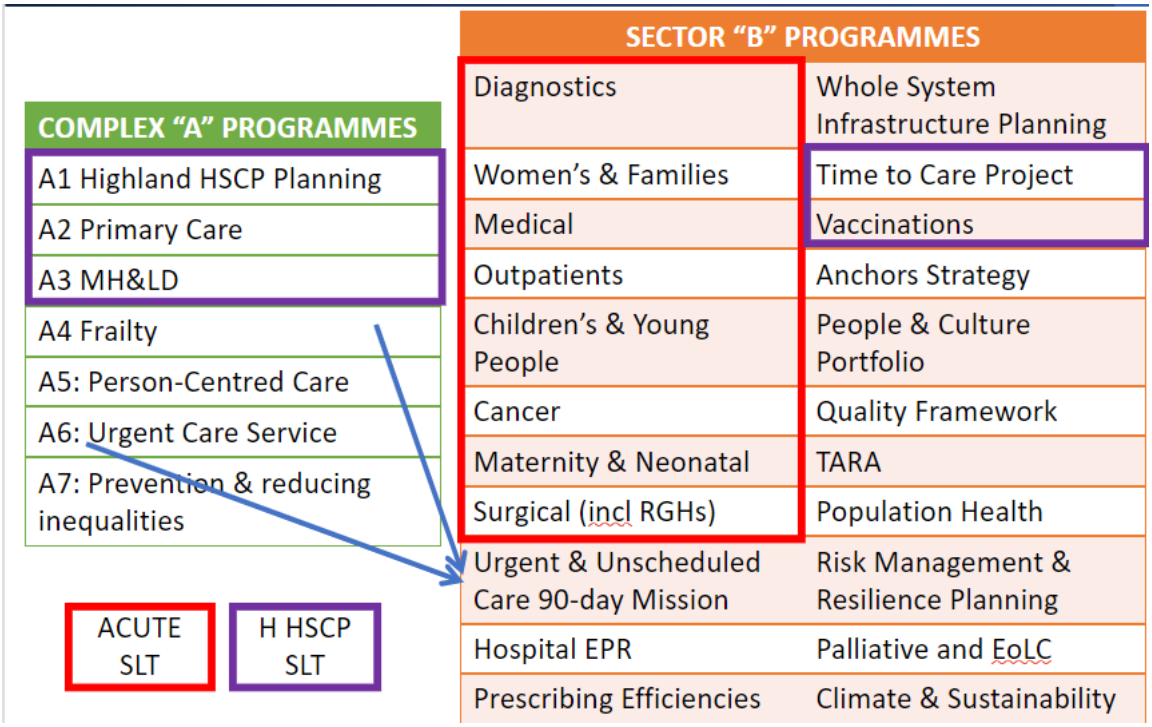
NHS Highland Strategic Transformation Accountability Group

Highland HSCP are delivering a number of complex transformation programmes which are overseen the formal Strategic Accountability Assurance group due to the complex nature. They are illustrated in the diagram below, which also illustrates the interdependencies with the acute system, and for pan highland programmes, also with Argyll and Bute. Work streams overseen by STAG are referred to as A programmes.



Highland HSCP also has a number of programmes, referred to as “B” programmes which are overseen by the HSCP Senior Leadership Team and

monitored by the formal STAG on a regular basis. These relate to single services or programmes with effect within HSCP teams only and are illustrated in the following diagram along with those led by Acute:



Transformation Programme

The vision outlined in the Partnership's Strategic Plan is vital for the successful delivery of the transformation programme which is being delivered jointly with the Highland Council.

In terms of that programme it should be noted that a sum of £20m has been identified by the Highland Council from reserves to support the delivery of change. A programme board has been developed which is attended by officers from both organisations which supports the delivery of 2 principal workstreams as follows:-

- Shifting the Balance of Care and Accommodation Solutions
- Improving Transitions Outcomes

The vision provides for: '*Working together to support our communities in Highland to live healthy lives, achieve their potential, and live independently where possible*.' This requires transforming service delivery, with a focus on shifting the balance of care to support people in their homes and communities for as long as possible.

It is also necessary to address accommodation solutions to meet the diverse needs of all age groups, which is relevant to both work streams namely older adults and younger adults including those transitioning from children's services.

A key aspect of these changes is the development of a Target Operating Model (TOM), which outlines how care services will be delivered, with an emphasis on reducing reliance on residential care. The TOM has been approved by the Joint Monitoring Committee and is attached as Appendix 1 to this report. It articulates the projects within the programme and serves as the focus for all projects in the Adult Social Care Transformation Programme.

More specifically the Highland Council has now purchased Moss Park Care Home in Caol, Fort William, which is now being operated by NHS Highland from 1st April 2025 as the registered care provider, in line with the lead agency model of integration in Highland HSCP. The aim of taking over the service is to secure care home provision in Lochaber for the next 2-3 years. In the longer term, a different care model, consistent with the aims set out in the Joint Strategic Plan.

A Strategic Outline Business Case is being developed and is exploring all options for the future delivery of care services in Lochaber that would be consistent with an overall strategic plan for the wider Highland HSCP area and the aims of the Joint Strategic Plan.

The first stage of this work will comprise the development of the strategic objectives and desired outcomes and is expected to take up to 3 months. An update will be brought to the Highland Council in June to request capital funding. The required housing solutions will require to be provided by the Highland Council in terms of the service model. A Principal Project Manager was appointed by Highland Council on 10 March 2025, who will lead the Project.

As part of the governance review, an Adult Social Care Programme Board has been established. The first meeting took place on 11 March 2025, and future meetings will take place approximately every six weeks. The Adult Social Care Programme Board has identified a number of strategic priorities including a Care Home Strategy, Care at Home Strategy and a Commissioning Framework which are being developed now at pace, to support service transformation.

The Adult Social Care Transformation Programme sits within the A1 Highland HSCP Planning STAG programme as illustrated in the diagram above.

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

The report provides moderate assurance in that transformation work is occurring in partnership, is managed, monitored and has oversight.

3 Impact Analysis

3.1 Quality/ Patient Care

Quality and patient care are expected to improve as a result of the transformation work. Work is undertaken through Project Implementation Plans which identify quality and patient care benefits.

3.2 Workforce

Transformation work may affect the way in which the workforce is structured and the way in which they work, including the development of new processes and roles. Work streams may aim to improve conditions for the workforce including new development opportunities and improved staff experience.

3.3 Financial

Financial efficiencies and savings are expected as a result of transformation work.

3.4 Risk Assessment/Management

Risks are identified and managed in the transformation work streams through project management methodology and risk and impact assessments for each work stream.

3.5 Data Protection

The work described in this report does not use person identifiable information.

3.6 Equality and Diversity, including health inequalities

Transformational work streams are managed through a project management approach which includes an impact assessment for each work stream. The implementation of the Joint Strategic Plan is supported by an Equalities and Impact Assessment and a Joint Strategic Needs assessment.

3.7 Other impacts

3.8 Communication, involvement, engagement and consultation

The District Planning Group role is primarily to engage with local communities and to enable localised implementation of the JSP to local circumstances. They are one of a number of community engagement groups and as such have formal links to Community Planning Partnerships through the District Managers.

Transformational work streams include stakeholder working groups

3.9 Route to the Meeting

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

- The extent of the transformational work in the HSPC is considered by the Strategic Planning Group and at HSCP Senior Leadership Team
- The work is an integral part of the NHS Highland Executive Directors Group (EDG) Strategic Transformation Accountability Group (STAG)

4. List of appendices

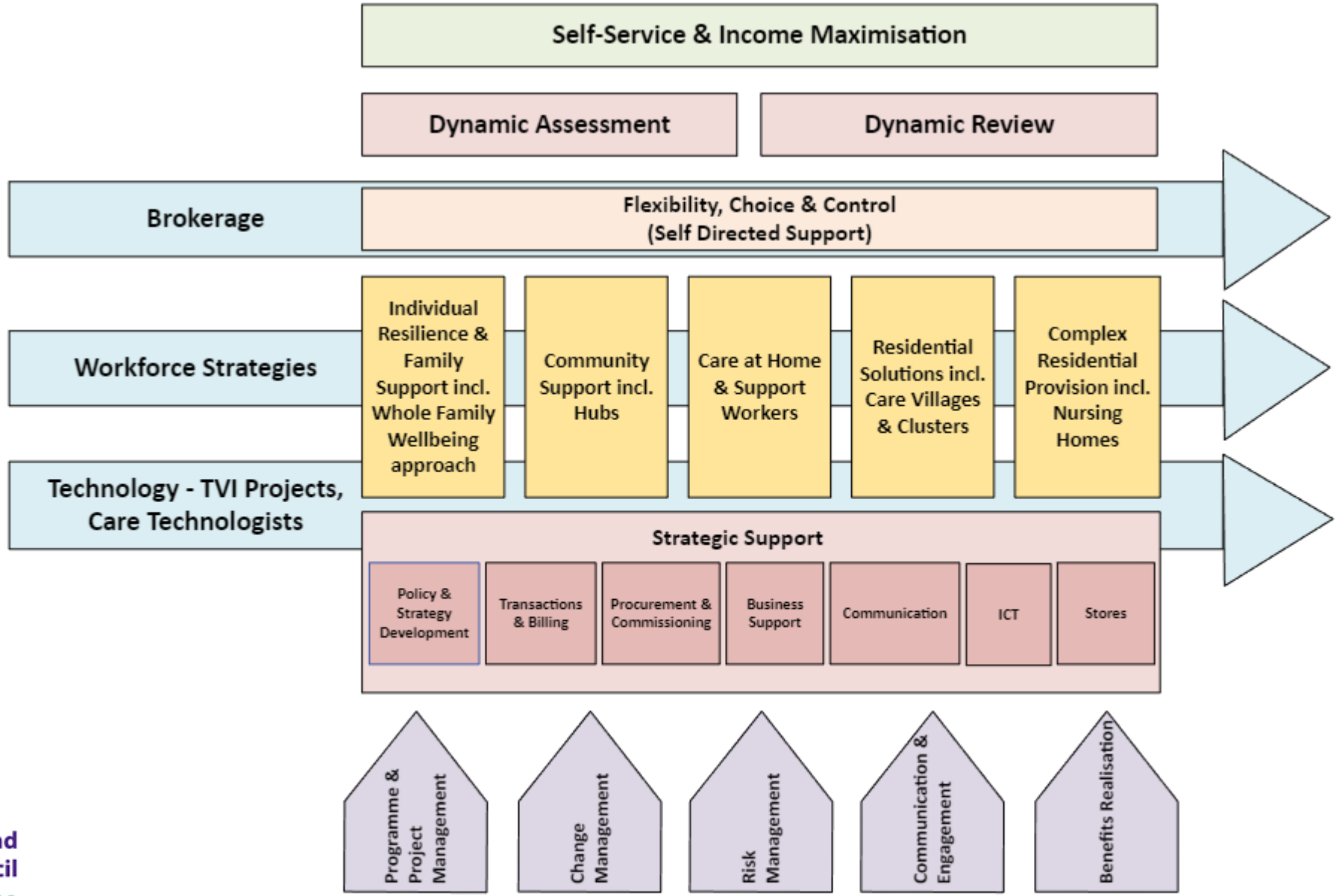
The following appendices are included with this report:

1 Transformation Programme Adult Social Care Target Model (TOM)

2 B25 STAG HSCP Planning

Draft Version 6

Adult Social Care Target Operating Model



Note: This Model applies to Transitions and Younger Adults as well as for Older Adults.

NHS Highland "B" Programmes Assurance Report

26/03/25

Item 3.5
Appendix 2

Programme	**B25: Highland HSCP Planning Structure**
Executive Lead	**Pamela Stott**
SRO	**Rhiannon Boydell**

Together We Care with you, for you

NHS Highland na Gàidhealtachd

Programme Charter:	Executive Summary and deliverables agreed March 2025
Programme Definition:	Delivering a single planning structure for Highland HSCP that brings together planning activities including Annual Service Planning, Operational District Planning, Quality Improvement actions and strategic development of services in line with current and future HSCP delivery models. Data analysis commenced and framework of population need including pathways mapping.

Area		Progress since last report	Actions/priorities for next report period	Risks and issues	Challenges for escalation	Measures of success	Timescale for completion
District Planning Groups		Update on DPG activity provided to JSPG on 27/03	• DPG meetings planned quarterly • Themes raised by latest round of meetings summarised for discussion at JSPG • Feedback will be provided at next DSG meetings			Communication and engagement with localities, currently on ASC Transformation and planning activity	Ongoing – quarterly meetings
Joint Strategic Planning group		JSPG continues to meet quarterly	Next meeting 27/06 with agenda items: • ASC Transformation Programme update • Joint Strategic Needs Assessment presentation • District Planning Groups update • Finance position				Ongoing – quarterly meetings
Whole Systems Planning Group for NHS Highland		Attendance at first meeting along with NHS and A&B colleagues, including alignment to regional and national planning	• Engagement on particular topic areas that impact across NHS Highland and ensuring continuous communications loop between local, board, regional and national planning activity			Planning activities at regional, national and board level align with Highland HSCP planning activity.	Ongoing
Articulate single planning structure for Highland HSCP		Agreement of deliverable to articulate single planning structure for Highland HSCP through an SOP by June 2025	• Develop SOP and share through Highland HSCP SLT in first instance			Agree SOP to articulate Highland HSCP planning structure	June 2025
Reporting against NHS Highland's Annual Delivery Plan		Deliverables agreed for ADP 25/26 in relevant Well themes	• Session to be arranged to agree KPIs for reporting through HHSCP IPQR and Performance Reviews • Q4 24/25 ADP Deliverables reporting to SLT in April 2025, before moving to EDG & FRPC in May			Completion of agreed ADP deliverables – review of Q1 25/26 in July 2025	Quarterly reporting on ADP deliverables in 2025/26
Annual Performance Report		Initial engagement with S&T on production of this year's Annual Performance Report	• Developing timeline for production of Highland HSCP Annual Performance Report • On agenda for Community SLT April 2025			Report presented to Highland Health and Social Care Committee	End of September 2025

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**07 May 2025**
Title:	**Chief Officer Assurance Report**
Responsible Executive/Non-Executive:	**Pamela Stott, Chief Officer**
Report Author:	**Pamela Stott, Chief Officer**

1. Purpose

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

2. New Craigs PFI

As previously reported, the PFI arrangement with Robertsons and NHSH will end on the 12th July 2025.

A managed process of transition is well underway and Facilities staff will be offered the opportunity to TUPE to NHS Highland at the time of the transfer. NHSH Facilities teams are working closely with the operational and clinical teams in New Craigs to ensure that there will be only minimal impact experienced by patients and staff. The transfer creates opportunities to transform the delivery of facilities within the New Craigs site and creates additional space in the FM building which will be used to offset the impact of the discovery of RAAC in 3 buildings on the site.

3. Joint Inspection of Adult Services

Under section 115 of the Public Services Reform (Scotland) Act 2010, together with regulations made under the 2010 Act, the Care Inspectorate and Healthcare Improvement Scotland are jointly inspecting health and social care services for adults in the Highland Health and Social Care Partnership, with inspection activity commenced on Monday 10 February 2025.

With the agreement of Scottish Ministers, the inspection is considering the following question: "**How effectively is the partnership working together, strategically and operationally, to deliver seamless services that achieve good health and wellbeing outcomes for adults?**" The inspection in Highland will consider the inspection question by examining the provision of services for and lived experience of adults living with mental illness and their unpaid carers.

We are now in Week 11 of the Inspection and have submitted the Position statement (available to Committee members on request). The next steps include a detailed inspection of records, discussions with users of services and scrutiny groups involving all levels of staff.

4. AHP's in the Emergency Department of Raigmore

A new initiative has commenced with the role of AHPs at the Emergency Department at Raigmore. The aim of the service is to offer AHP assessment in ED for alternative pathways of care for admission avoidance, as well as for functional Criteria [led] for Discharge (fCLD) to facilitate earlier return home.

The target population are people in mild to moderate frailty, attending ED for non-elective/non-surgical reasons.

Three seconded staff (2.0 WTE OT and 1.0 WTE Physio) started the service on the 3rd of March.

Up to the 15th of April 2025, 31 admissions have been avoided, with a reduction in length of stay for those patients assessed via ED to 3.5 days. Against length of stay data used for the business case that outlines the new service, this equates to 1100 bed days saved, whilst promoting independence and returning people to their own homes as early as safely possible to do so.

5. Mental Health & Learning Disability Strategy

Following feedback that the Mental Health & Learning Disability Strategy did not contain enough detail about the changes that would be made, the team have been working together to create a delivery plan. This has now been fully incorporated and an updated Strategy and Delivery Plan will be formally launched within the next few weeks.

6. Care at Home Services in Sutherland

NHS Highland provides the in-house Care at Home Service in Sutherland.

At the beginning of 2025, concerns had been raised by members of staff and staff side and this resulted in meetings between staff, staffside and Care at Home management. In addition to this, an audit of all client records was undertaken, and the findings identified a number of issues which required attention.

As a result of the concerns raised by staff, and an increase in complaints regarding the service and the results of the records audit, a Service Recovery Plan was put in place in February 2025. This plan includes the rota management, staff training, staffing (recruitment and vacancy management). Support to implement the plan was in place via a Service Improvement Practitioner as part of her wider role.

The service underwent a planned inspection from The Care Inspectorate during the week of the 7th of April.

Immediate actions have been taken in response to The Care Inspectorate feedback and subsequent Improvement Notice and include Large Scale Investigation (LSI) process has been put in place.

This is being chaired by the HSCP Head of Service for Social Work Services supported by the Sutherland Social Work Team.

An interim management team has been put in place and has completed work to review and amend schedules/rotas as well as staff training records. This has identified gaps.

Working with the Practice Development Team, a training programme is being implemented.

Interim arrangements have been put in place to support carers during the Out of Hours period.

Longer term solutions which will ensure stability across Highland are being developed with the support of the wider HSCP.

Agenda Item 3.7

NHS Highland

Meeting:	**HHSC Committee**
Meeting date:	**7 May 2025**
Title:	**Sir Lewis Ritchie Report Update**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer HHSCP**
Report Author:	**Karen-Anne Wilson, Area Manager West**

Report Recommendation: Committee members are asked to note the update and take moderate assurance.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

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

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

Sir Lewis Ritchie was asked in 2017 to undertake an independent review of out of hours (OOH) services in Skye Lochalsh and Wester Ross by the then chair of NHS Highland, Dr David Alston. The review was carried out in 2018 and the final draft report is now available.

There has been a huge amount of work by local groups, individuals and NHS Highland to achieve the 15 recommendations from that original report in 2018.

2.2 Background

This review was triggered by a review of services in Skye Lochalsh and Wester Ross, including the building of the new Broadford Hospital. The review has a clear vision for a collaborative public service approach for the future.

There were significant delays in its implementation including the effect of Covid 19 and the effect of changes in staffing in NHS Highland at a senior level which has resulted in increased participation and involvement from the Board which Sir Lewis pays particular credit to.

2.3 Assessment

The recommendations and formal response from Fiona Davies, Chief Executive NHS Highland is summarised below. The review final report is still in draft form but is expected to be finalised shortly.

Recommendation 1: Portree Hospital Out of Hours Services

Following the publication of the recommendations, NHS Highland established a 24/7 urgent care service from Portree. There were attempts to do this in collaboration with NHS 24 and Scottish Ambulance Service, but this proved unsuccessful. Despite the service running from 2019 until 2022 (with a short suspension for COVID and some later overnight closures) the model did not sustain, and this inconsistency was not well received by the community.

An agreed urgent care model is now established, which came into place on 16 August 2024. There are Advanced Practitioners based on site for the out of hours period seven days per week and extended hours throughout the weekend. They offer home visits where clinically appropriate, and are working in close collaboration with nursing and Scottish Ambulance colleagues to provide a 24/7 urgent care response at the Hospital.

To date, the data shows a low level of service requirement during daytime hours, but it is recognised the numbers will fluctuate throughout the year so the model will continue to be reviewed. The current model has been established to ensure resilience and best

use of skills and resource at optimum times. However staff turnover continues to be problematic but it is being addressed.

We will continue to develop the service based on need with our partners in the community and our agency partners through the re-established Urgent Care group. This has community and wider stakeholder representation including Primary care, Scottish Ambulance Service and NHS 24 and the group are exploring wider attendance including the police and fire service in order to ensure our future planning and decision making is collaborative and co-produced.

Recommendation 2: Future Community Bed and Care Provision

NHS Highland undertook a review of need as part of the original options appraisal that set out the bed number trajectories that would be required, depending on what the community provision would be provided as part of a future model. This work was not concluded, given the suspension of the options appraisal process, however the information remained of relevance.

However, in relation to action 2c we have not reached the conclusions we committed to. We set out that we would complete an options appraisal to establish a longer-term plan with regard to health and care provision in Portree. The options appraisal did not reach a conclusion and further work is required. To inform this, a new Joint Strategic Needs Assessment has been undertaken, and in addition, a Health Needs Assessment was presented to the Sir Lewis Ritchie Steering Group by Dr Tim Allison, Director of Public Health, NHS Highland at the end of 2022.

This supports our ongoing service planning on Skye and across all Board areas. Board representatives have been clear since the initial report that the beds will remain open in Portree Hospital. This would only change if there is an agreed plan for suitable bed provision in the north of Skye. NHS Highland remain committed to this position.

Currently the care bed provision outwith the hospital in the north of the island is at Home Farm. The additional beds that we had previously committed to, and referenced in the recommendations, did not come to fruition as this was to be via an independent provider who has subsequently closed their care home in Portree. The GP practice will not be moving into the hospital as the space would not permit that, but they have the comfort of an extended lease and they continue to work closely with us. There are a wide range of community health and care services and we are working to develop these, including local services such as our new facility in Staffin and implementation of the Highland Joint Strategic Plan.

In line with this, a District Planning Group has been established to engage with the community and to take forward the adult health and care provision elements for Skye, Lochalsh and Wester Ross. This will be the process, in line with Health Improvement

Scotland Guidance on identifying major health service changes, to consider and agree service transformation and redesign to meet the needs of Skye, Lochalsh and South West Ross residents.

Engagement in the District Planning Group and specifically the Urgent Care Group with key stakeholders will continue the collaboration and engagement. Importantly, there is now a Health and Social Care Partnership Joint Strategic Plan in place to guide progress. This is part of the legislative expectations in the Public Bodies (Joint Working) (Scotland) Act 2014.

We have established a co-produced community and NHS Highland recruitment group which is now well established and with good evidence of success. We have also had successful international recruitment to the island. We continue to work with the staff to develop their confidence in the longevity of services and our ongoing commitment to Portree Hospital in particular. Clinical and operational leadership is now in place and well established.

Recommendation 3: Closer Inter-Agency and Public Participation

There has been close inter-agency working over the last six years; however, this has not always been consistent and has had less success than may have been anticipated. NHS Highland colleagues and Scottish Ambulance Service in particular, have made strides in closer working at both of the hospital sites, including piloting new ways of working, but we know we can achieve more.

The pandemic did impact on some of the emerging work that was taking place and it has been a struggle to re-establish those links and working practices. We are more hopeful that the groups now emerging, such as the inter-agency group led by the area manager, the recruitment and retention group co-produced with the community, and the reconnection with NHS Education for Scotland, will prove beneficial in the future.

The public have been active participants over the last six years in a variety of ways. The success of this is evident in a number of specific locality projects such as “Work on Skye”. They have been both supportive and challenging and, understandably, at times frustrated with us. We know that we need to continue to build better approaches to inclusion and engagement.

The new district planning group is now established, with the intention of ensuring a forward focus together as the SLR Steering Group comes close to an end. In addition, we have re-established the communication group to complement the well-received recruitment and retention group that is really making a difference. The firmly established Community Project Officer post that is funded by NHS Highland and two partner organisations has been particularly helpful.

The final, but hugely important part of this recommendation, was engagement with frontline staff. This has not always been as good as it should have been, for a number of reasons. We have, though, reviewed and redesigned our leadership structure in order to provide much more focussed clinical and operational leadership. This recommendation as was set out in the original report has been achieved, recognising that inter-agency working and public participation require ongoing attention and oversight.

This co-production will continue via the District Planning, Urgent Care and Communication Groups in addition to routine partnership working and community engagement. Scottish Ambulance Service colleagues have actively engaged in our meetings with SOS-NHS and they and NHS 24 continue to attend the SLR Steering Group. We are engaging with other partners including the Highland Council, NES, Scottish Futures Trust and HITRANS as we plan for the future. We have good community engagement as we develop the new District Planning Group and are now seeking district wide community members for the re-established community and urgent care groups.

Recommendation 4: Collaboration with Scottish Ambulance Service

NHS Highland and the Scottish Ambulance Service have collaborated throughout the period since the report and remain committed to doing this in the future. This was highlighted in our meetings with the community. In relation to the specific points in this recommendation, as was referenced in the meeting on 31 July 2024, Scottish Ambulance Service did review their capacity and capability, including the potential for using the rapid response vehicle.

The outcome of this review was to increase their establishment by 14 paramedics and providing 24/7 (on site, rather than on call) provision based at Broadford and Portree Hospitals. The review did not evidence the need to staff the response vehicle. As you know, the community did express concerns about this and Scottish Ambulance Service colleagues advised that they would keep the level of need under review whilst working with us on collaborative models. Confirmation of completion was sent by Michael Dickson, Chief Executive Officer, Scottish Ambulance Service in correspondence to Louise Bussell on 3 July 2024.

This recommendation has been achieved for a number of years. Scottish Ambulance Service is committed to continued collaboration and review of service need. This will continue via the Urgent Care Group in addition to routine partnership working and engagement. They have actively engaged in our meetings with SOS-NHS and continue to attend the SLR Steering group.

Recommendation 5: Collaboration with NHS 24

Since 2018, NHS Highland has engaged with NHS 24 about the potential for joint service developments and new ways of working. Early on, in response to the report, there was

a pilot of a new collaborative approach with locally based staff in a shared working model. This proved to be a challenge in terms of workforce and was unfortunately suspended during the pandemic. Since then, NHS 24 have consistently confirmed that they would not be contributing to a future local staffing model.

The Chief Executive wrote to NHS 24 to seek their views on this recommendation, where they have affirmed this position and their view that the ongoing workforce challenges, coupled with a change in their model, means that they will not be pursuing the original ask. They have, though, committed to continuing to work with NHS Highland for future closer pathway working and Louise Bussell Nurse Director and Fiona Davies, Chief Executive will pursue this with them. Confirmation of NHS 24's position was sent by Jim Miller, Chief Executive Officer, NHS 24 in correspondence to Fiona Davies on 11 July 2024.

The recommendation is concluded rather than completed, as the original action is not being taken forward. NHS Highland and NHS 24 have, though, committed to ongoing engagement and exploration of future collaborations. This will continue via the Urgent Care Group in addition to routine partnership working and engagement. NHS24 have attended and actively engaged in the SLR Steering Group.

Recommendation 6: First Responders

This action has been completed. The Scottish Ambulance Service Chief Executive has confirmed this in his response to NHS Highland. Community First Responder Schemes are in place across Skye, Lochalsh and South West Ross, with work ongoing to build the number of Community First Responders further.

Scottish Ambulance Service currently has five Community First Responder Schemes active on Skye based at Dunvegan / Struan, Glendale, Portree, Sleat and Trotternish. Community First Responders are volunteers and therefore may not always be available as volunteers 24/7 as they book on and off, depending on their availability. Scottish Ambulance Service has a further five volunteers currently completing their four day Community First Responder training course being delivered on Skye.

There will always be a turnover in Community First Responders, so Scottish Ambulance Service works to maintain numbers through training programmes. Confirmation of completion was sent by Michael Dickson, Chief Executive, Scottish Ambulance Service in correspondence to Louise Bussell on 3 July 2024.

The original recommendation was completed, although it is always an area that will require ongoing support and development to achieve its intention. Scottish Ambulance Service have committed to further developments in this area and will report back via the Urgent Care Group.

Recommendation 7: Workforce Capacity and Capability

All agencies, including NHS Highland and Scottish Ambulance Service, have reviewed urgent care provision within their organisations and adjusted the workforce to meet need. Recruitment, retention and related resilience are the ongoing challenges to achieving establishments. Joint workforce planning and working was attempted and has been piloted with NHS 24 and Scottish Ambulance Service; however, there have been limitations to this. This was due to recruitment challenges, changes to how NHS 24 work nationally, and ambulance staff availability whilst the ambulance is out on calls.

There is now agreement of working practices where Scottish Ambulance Service can complement but not replace NHS Highland provision. Multi-professional clinical leadership is in place and supported at a local, service and board-wide level. There is evidence of clinically led developments, such as the model for out of hours provision in Portree and the implementation of local training and development plans. This recommendation is completed. There will of course need to be ongoing work to ensure workforce, capacity and capability.

Recommendation 8: Housing Solutions

NHS Highland has worked with The Highland Council, the local housing association and the local community to find novel solutions, as was the recommendation. The Board leases a number of properties to support staff moving to the island, as well as sending out the housing list to all new starters and linking in with the local community via the recruitment group members. This has led to some success, including for example the rental of a yurt and access to locally offered shared accommodation.

The Highland Council continues to work with partners, through the Highland Housing Hub, to identify housing solutions geared towards NHS staff. A recent project in Broadford by Highland Housing Alliance was advertised as priority for NHS staff. Lessons have been learned from this, including the need to provide for greater choice of tenure (including mid-market rent options) and house type.

Work continues in Portree and other locations in Skye to ensure a pipeline of housing supply, and to seek additional funding sources towards the provision of housing. Whilst this is an area requiring ongoing involvement of all agencies, the original recommendation action has been completed.

Recommendation 9: Road Issues

The Highland Council has confirmed that the road conditions on Skye have been the subject of much discussion within the Council and with partners. This has led to an increased level of capital investment for the Skye and Raasay area over the last two financial years, and the number of schemes being completed has been significant.

NHS Highland recognises there are still areas of concerns, and every effort is being made to accelerate activity on all routes throughout Skye and Raasay. The Highland Council works in partnership with NHS Highland in relation to any road concerns that are highlighted and continues to plan further developments. The original recommendation has been completed.

Recommendation 10: Transport and Accessibility

The original recommendation in the report was to review the Terms of Reference for the Transport and Access Group. This took place and the group was re-established. The group was chaired by Stagecoach and comprises a number of partners, including HITRANS, the Regional Transport Partnership.

It is currently not in place and a further consideration of future need is being explored as it is recognised a refresh to this group is required in order to reinvigorate the project. HITRANS has just started work to establish a Highland & Islands-wide Health and Transport Action Plan which will look at many of the access to healthcare issues that need addressed. However, it is considered that the Skye, Lochalsh and South West Ross issues may still require a separate dedicated group.

The Highland Council is aware of the position and will work with us and partners to ensure the right meeting infrastructure is in place to meet future needs. All of the evacuation plans were reviewed by the relevant agencies, with plans implemented following the report. I understand these will continue to be periodically reviewed. In the correspondence from Michael Dickson, Chief Executive, Scottish Ambulance Service to Louise Bussell on 3 July 2024 there was a commitment to review this again with partner organisations. The original recommendations have been completed.

There is, though, further discussion needed to consider future requirements for optimising transport and access for people in Skye, Lochalsh and South West Ross. In order to achieve this there have been three meetings chaired by Louise Bussell with community and local councillor representation as well as colleagues from the Board, SAS, HITRANS, Stagecoach and the Highland Council to consider how to take forward transport and accessibility matters for Skye, Lochalsh and South-West Ross.

From these discussions a short life working group for transport has been established, initially chaired by Louise Bussell until a chair is agreed. The group is considering the actions from the previous report in 2020 to ensure anything outstanding is completed as well as a look forward to what else would be of benefit for SLSWR. To achieve these actions the group now has membership from patient booking and outpatients at Raigmore and has sought advice from the South, West Ross Care Scheme. Richard MacDonald, Director of Estates, Facilities and Capital

Planning agreed to take forward access issues separately as part of his Equality, Diversity and Inclusion work.

Recommendation 11: Digital Innovation

Engagement in digital innovation has been ongoing and we continue to learn from other remote and rural areas. There are good IT links between sites via 'Near Me' and Microsoft Teams. There are 'Near Me' facilities in a variety of locations, including Portree Hospital, Broadford, Raasay and Staffin.

The board has a Digital Health and Care Group with a number of key areas of work that will have a positive impact on remote and rural communities and our staff groups. In addition, we are linking in regionally, in a remote, rural and island context and nationally to ensure we work in collaboration and innovate for the future. Examples of this are our engagement with the national work on the digital front door and remote home monitoring programme. In relation to the latter, we are now implementing the BP Connect Me monitoring pathway.

Since the report was published there has been significant development in response to the pandemic and staff are now familiar with using Microsoft Teams as a regular and routine method of communication. The original recommendation was completed; however, clearly digital innovation will remain an essential part of health, social care and community planning.

Recommendation 12: Specific Localities

The actions in the report were specifically related to the service models for, and ensuring sustainability of, services in Glenelg and Arnisdale, Raasay and the Howard Doris Centre, Lochcarron. The local team has worked closely with the community and partners in order to find a solution in West Ross for each of these three distinct areas.

Local solutions have been implemented in other areas of Skye, Lochalsh and South West Ross, such as the new facility at Staffin which is now being used well as both a health and care facility and a community resource. This recommendation has been achieved for a long period of time now, with further developments and adaptions in response to emerging issues and identified opportunities.

Recommendation 13: Centre for Excellence

Initially work was progressed locally with a number of organisations and community representatives. It was then progressed at a national level with NHS Education for Scotland taking the lead, but still ensuring support and engagement with Skye, Lochalsh and South West Ross. They have provided a helpful report of the progress, which includes some of the work to date.

Dr Pam Nicoll, Associate Director of Medicine & Interim Director of The National Centre for Remote and Rural Health and Care, provided a summary report to the Board on 13 August 2024 outlining the work that has followed on from the original recommendation. NES has continued to provide educational support and training to the health and care staff located within Skye, Lochalsh and South West Ross and throughout NHS Highland. In addition to this, the Centre for Excellence has taken forward a number of projects supporting needs identified within the joint working of the Centre for Excellence Working Group.

This currently includes three projects working collaboratively with the local multi-agency Skye Recruitment and Retention Group:

- Highland Community Induction Officer Project – joint funding and evaluation
- Making it Work Framework Implementation Project 1 – project support and evaluation
- NHS Recruitment Group Skye Evaluation – project support and evaluation

The remote, rural and island specific needs identified throughout the work of the Centre for Excellence Working Group in Skye, Lochalsh and South West Ross are also reflected in the Centre Priority Programmes of Work underway at national level in the four priority areas of remote, rural and island research and evaluation; recruitment and retention; education and training; and leadership and good practice. The recommendation was completed by the original work stream chaired by NES colleagues.

Recommendation 14: Best Use of Resources

This action was taken forward locally, including the partial funding of the Project Officer to assist in this work. This has included communication to and with the public in a variety of ways and using options for sign posting. Social media has been an increasing focus of this work as it has significantly developed since 2018.

This recommendation has been completed and work will be ongoing as part of our business as usual with our community groups and partners.

Recommendation 15: Making it Happen

Partners and community representatives have engaged well over the last six years with the ambition to Make it Happen. The community and staff participation has been exceptional in exploring alternative solutions and novel approaches. There have been forums to achieve the work together; some of these concluded once the work was completed, others did not sustain as we would have wanted them to, but throughout, people have come together via the Steering Group.

There have clearly been challenges along the way, not least the disruption and changes brought about by the pandemic, and obviously we would have wanted to have made it all happen much sooner. However, on reviewing the work achieved, many of the

recommendations have been completed and firmly established for a number of years. This is testament to the people who have been working and continue to work to make it happen.

As identified in this response, there are areas within the recommendations that require work to reach conclusion. This recommendation is therefore partially completed and the collaboration and co-production will need to be ongoing post conclusion of all the recommendations. To achieve this we have developed a new governance structure with a continued focus on community and partner engagement and co-production.

All of the meetings within this structure are now in place and becoming more established. This note is intended to reflect our achievements to date and what further work we are still to do, and provides assurance that NHS Highland is working in partnerships with other agencies to work collaboratively in partnership with the community.

2.4 Proposed level of Assurance

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

This note provides the assurance that while some projects have been completed, those that are still being completed are live and being progressed.

3 Impact Analysis

3.1 Quality/ Patient Care

The effect of the work on the Sir Lewis Ritchie report has increased the level of available services for patients on North Skye so has a positive impact on patient care.

3.2 Workforce

Staffing in the Out of Hours service has proved challenging but both fully qualified and trainees have been recruited to provide a stable workforce. The resignation of the Clinical Lead was disappointing and the first advert produced no applicants for the role so this is being readvertised in April 2025 and promoted widely to encourage applications,

3.3 Financial

There are no finaincial risks currently in this project.

3.4 Risk Assessment/Management

Risk assessments are in place for the service and a review of these is a regular part of the provision.

3.5 Data Protection

No issues.

3.6 Equality and Diversity, including health inequalities

There are no new issues.

3.7 Other impacts

None noted

3.8 Communication, involvement, engagement and consultation

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

- Stakeholder/Group Name, and date Sir Lewis Ritchie Steering Group Meeting at Portree on 26th March 2025

3.9 Route to the Meeting

The content of this report has been taken from the formal letter from Fiona Davies, Chief Executive NHS Highland to the Sir Lewis Ritchie Steering Group and inclusion in the draft final report March 2025.

4.1 List of appendices

The following appendices are included with this report:

Agenda Item 4.1

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**7 May 2025**
Title:	**Blueprint for Good Governance 6-Monthly Update – Implementing Self-Assessment Findings**
Responsible Executive:	**Chief Officer, Highland HSCP**
Report Author:	**Nathan Ware, Governance & Corporate Records Manager**

Report Recommendation: The Committee is asked to note the content of the report and take assurance on the progress achieved with the Blueprint for Good Governance Improvement Plan actions that relate specifically to this Committee's remit.

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Board Decision
- NHS Board/Integration Joint Board Strategy or Direction

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

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	X
Care Well		Live Well		Respond Well	X	Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well	X	**All** Well Themes			

2 Report summary

2.1 Situation

This report provides an update on the delivery of longer-term outstanding actions contained in the Board's agreed Blueprint for Good Governance Improvement Plan that are of relevance to the Highland Health and Social Care Committee.

2.2 Background

The Board approved its Blueprint Improvement Plan on 25 July 2023 and agreed that Governance Committees should provide informal oversight of progress and delivery of elements relevant to their functions.

The Board receives a six-monthly assurance report on progress against the elements of the Blueprint Improvement Plan and received its first full year review in July 2024.

2.3 Assessment

The Board's Blueprint for Good Governance Improvement Plan contains 17 actions of which nine have been completed and closed. Remaining actions have longer-term completion dates and have an organisation-wide focus.

The outstanding actions relating to this Committee's remit focus on quality of care. Feedback from a joint ACF and Board session in April 2024 had helped shape this workstream. Work was now underway to review how the organisation is working prior to introducing a quality framework through a measured and planned approach. Patient feedback and experience will be included in the framework dataset and the work is being benchmarked against the approaches other Boards have taken.

Further development of the Quality Framework/way forward was discussed at an EDG meeting in April 2025 through a paper. It was noted a quality lead post would be required to support next steps and once funding is finalised it would go out to advert.

Deputy Medical Directors & Associate Nurse Directors alongside AHP Leads would be among those involved in taking Quality forward.

The embedding of Care Opinion continues and the Board's Clinical Governance Manager is supporting this work. There were more than 250 instances of Care Opinion being used for NHSH services over the past 12 months.

The appendix to this report details the progress that has been made for Committee members' information and oversight.

2.4 Proposed level of Assurance

Formal assurance reporting on delivery of the Blueprint for Good Governance Improvement Plan will be provided to the Board on a bi-annual basis. Board-level Assurance will be based on delivery against the whole plan. This report is being presented to the Committee for oversight purposes only and indicates the following level of assurance at this stage:

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

Moderate assurance is offered to provide confidence that the actions are all being actively pursued and to reflect that on-going activity will be required to fully meet the objectives.

3 Impact Analysis

3.1 Quality/ Patient Care

3.2 Workforce

3.3 Financial

The provision of robust governance arrangements is key to NHS Highland delivering on its key objectives and to improving workforce, clinical and financial governance.

3.4 Risk Assessment/Management

A risk assessment has not been carried out for this paper.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

There are no equality or diversity implications arising from this paper.

3.7 Other impacts

No other impacts

3.8 Communication, involvement, engagement and consultation

The proposals in the recommendation have been agreed by the Board on 25 July 2023 and discussed with all Board members.

3.9 Route to the Meeting

The subject of this report has been agreed by the Board in July 2023 with an annual review against progress considered at the Board in July 2024. A paper covering Quality has been presented to EDG in April 2025 with further updates.

4.1 List of appendices

Appendix 1 Extract Blueprint for Good Governance Improvement Plan 2023 actions relating to this Committee's Terms of Reference as of May 2025.

Appendix 1

DATE of MEETING	Exec Lead	Objective	Specific Action	Update for Update for November 2024 meeting	Update for Update for May 2025 meeting
CGC **7 March 2024 and 2 May 2024** **HHSC** **6 March 2023 and 8 May 2024**	**Nurse Director** **Medical Director**	Establish and agree a plan to implement a Quality Framework arising from recent work undertaken with Amanda Croft.	Establish a clear definition, understanding and organisational prioritisation of quality that is underpinned by patient and colleague experience, and National Guidelines.	**Boyd Peters 23/10/2024:** The Quality framework has been formulated into a paper which has gone to EDG and now will be shared with the professional leadership and ACF in October, and will come to Board members before taking out further to pilot in services.	**Boyd Peters:** May 2025 Further development of the Quality way forward came to EDG in a paper in April 2025 "A Quality Framework for NHSH 20-25". A quality lead post is required to support next steps and once funding finalised will go to advert. Deputy Medical directors and Associate Nurse Directors & AHP leads among those who will be involved in taking Quality forward

CGC **7 March 2024 and 2 May 2024** **HHSC** **6 March 2024 and 8 May 2025**	**Nurse Director** **Medical Director**	Ensure that patient feedback is consistently collected, effectively shared, responded to and utilised across all areas of the Board.	Ensure systems and processes are developed to improve in the collection, reporting and use of patient experience feedback across the Board	**Boyd Peters 23/10/2024:** We have further explored the expanded opportunities to use Care Opinion across the board area, and QR code feedback mechanisms as piloted in one department in acute with success. Further work will be needed and this will take time to mature.	**Boyd Peters May 2025** - Embedding of Care Opinion continues, with the board's Clinical Governance Manager supporting this work. There were more than 250 instances of Care Opinion being used wrt NHSH services in the past year.

Agenda Item 2.1

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**7 May 2025**
Title:	**Finance Report – Month 11 2024/2025**
Responsible Executive/Non-Executive:	**Pamela Stott, Chief Officer**
Report Author:	**Elaine Ward, Deputy Director of Finance**

Report Recommendation:

The Board is asked to **Examine** and **Consider** the content of the report and take **Limited Assurance**.

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):

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	X	Progress well		**All** Well Themes			

2 Report summary

2.1 Situation

This report is presented to enable discussion on the NHS Highland financial position at Month 11 (February) 2024/2025.

2.2 Background

NHS Highland submitted a financial plan to Scottish Government for the 2024/2025 financial year in March 2023. This plan presented an initial budget gap of £112.491m. With a brokerage cap of £28.400m this meant cost reductions/ improvements of £84.091m were required. The Board received feedback on the draft Financial Plan 2024-27 on the 4 April 2024 which recognised that “the development of the implementation plans to support the above savings options is still ongoing” and therefore the plan was still considered to be draft at this point. The feedback also acknowledged “the significant progress that has been made in identifying savings options and establishing the appropriate oversight and governance arrangements”.

Since the submission and feedback from the draft Financial Plan confirmation has been received that the cost of CAR-T, included within the pressures, will be funded nationally.

There has also been a notification of an additional allocation of £50m nationally on a recurring basis, specifically to protect planned care performance. The NHS Highland share on an NRAC basis is £3.3 million. This funding will enable NHS Highland to maintain the current planned care performance whilst reducing the distance from the brokerage limit in 2024/25.

Additionally, Argyll & Bute IJB confirmed its ability to deliver financial balance through the use of reserves.

A paper was taken to the NHS Highland Board on 28 May recommending that the Board agree a proposed budget with a £22.204m gap from the brokerage limit of £28.400m – this was agreed and has been reflected in monitoring reports presented to the Finance, Resources & Performance Committee and the NHS Highland Board.

Following the quarter 2 review with Scottish Government the Board was informed of a revision to the brokerage cap. For the 2024/2025 financial year £49.700m of brokerage will now be made available. Based on current forecasts this will enable delivery of a breakeven position at financial year end – assuming ASC breaks even.

The position presented reflects current and forecast performance against this revised brokerage cap.

2.3 Assessment

For the period to end February 2025 (Month 11) an overspend of £59.182m is reported with an overspend of £44.792 forecast for the full financial year. The movement from ytd to year end forecast reflects the assumption that ASC will deliver a breakeven position by the end of the financial year.

The HHSCP is reporting a year to date overspend of £19.982m with this forecast to reduce to £2.481m by the end of the financial year based on the assumption that further actions will enable delivery of a breakeven position within ASC. This position assumes delivery of £2.519m of costs reductions/ improvements within Adult Social Care Value and Efficiency schemes.

2.4 Proposed level of Assurance

Substantial		Moderate	
Limited	X	None	

It is only possible to give limited assurance at this time due to the gap from Scottish Government expectations.

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 2024/2025 and beyond and are continuing to provide additional support to develop initiatives to reduce the cost base both nationally and within individual Boards. NHS Highland continues to be escalated at level 3 in respect of finance.

3.4 Risk Assessment/Management

There is a risk associated with the delivery of the Value & Efficiency programme. The Board are developing further plans to generate cost reductions/ improvements. There is an emerging risk associated with allocations – this has been reflected in the forecast year end position.

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
- 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

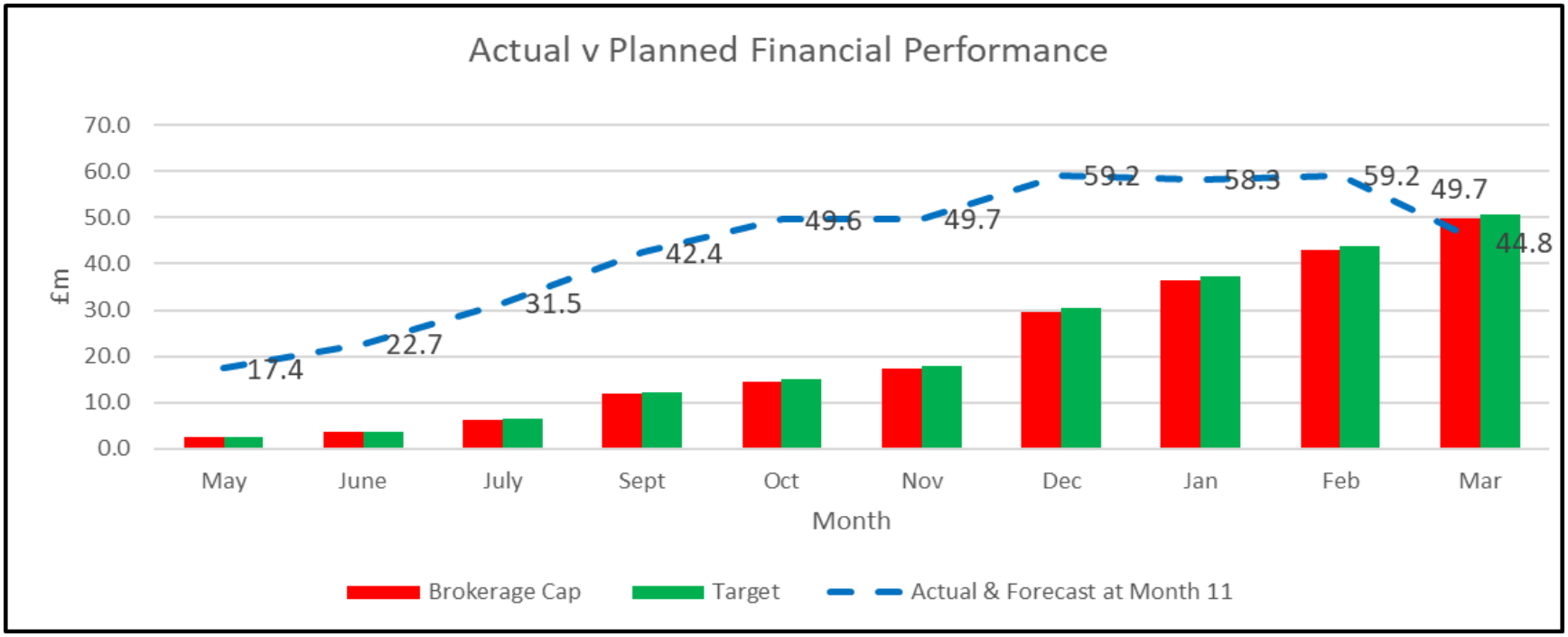
4.1 List of appendices

N/A

Finance Report – 2024/2025 Month 11 (February 2025)

HHSCP 7 May 2025

MONTH 11 2024/2025 – FEBRUARY 2025

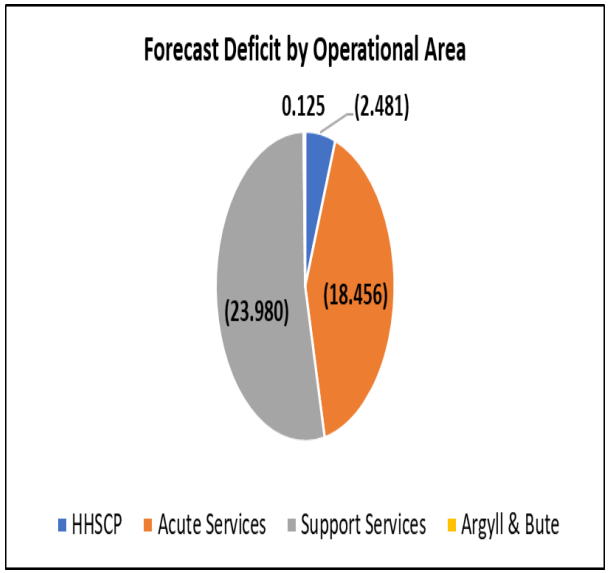


Target	YTD £m	YE Position £m
Delivery against Revenue Resource Limit (RRL) DEFICIT/ SURPLUS	59.2	44.8
Delivery against Brokerage Cap DEFICIT/ SURPLUS	16.1	4.9
Deliver against Target agreed with Board YTD DEFICIT/ SURPLUS	15.2	5.8

- Forecast year end deficit £44.8m – assuming additional action is taken to deliver breakeven ASC position
- £4.9m better than revised brokerage limit
- £5.8m better than target agreed with Board May 2024

MONTH 11 2024/2025 – FEBRUARY 2025

Current Plan £m	Summary Funding & Expenditure	FY Plan £m	FY Actual £m	FY Variance £m	Forecast Outturn £m	Forecast Variance £m
1,251.371	**Total Funding**	1,100.516	1,100.516	-	1,251.371	-
	Expenditure					
478.953	HHSCP	436.986	456.968	(19.982)	499.853	(20.900)
	ASC Position to breakeven				(18.418)	18.418
	Revised HHSCP				481.434	(2.481)
325.488	Acute Services	295.481	313.050	(17.569)	343.944	(18.456)
165.788	Support Services	116.459	137.900	(21.441)	189.768	(23.980)
970.229	**Sub Total**	**848.926**	**907.918**	**(58.992)**	**1,015.146**	**(44.917)**
281.142	Argyll & Bute	251.590	251.780	(0.189)	281.017	0.125
1,251.371	**Total Expenditure**	**1,100.516**	**1,159.698**	**(59.182)**	**1,296.163**	**(44.792)**



MONTH 11 2024/2025 SUMMARY

- Overspend of £59.182m reported at end of Month 11
- Overspend forecast at £44.792m by the end of the financial year – assuming further action will deliver a breakeven ASC position
- Forecast is £4.9m better than the revised brokerage limit set by Scottish Government and £5.8m better than the target agreed with the Board in May 2024

MONTH 11 2024/2025 – FEBRUARY 2025

Summary Funding & Expenditure	Current Plan £m
RRL Funding - SGHSCD	
Baseline Funding	909.532
Baseline Funding GMS	5.291
FHS GMS Allocation	73.949
Supplemental Allocations	48.952
Non Core Funding	-
Total Confirmed SGHSCD Funding	**1,037.724**
Anticipated funding	
Non Core allocations	80.517
Core allocations	3.802
Total Anticipated Allocations	84.319
Total SGHSCD RRL Funding	**1,122.043**
Integrated Care Funding	
Adult Services Quantum from THC	141.522
Childrens Services Quantum to THC	(12.194)
Total Integrated care	129.328
Total NHS Highland Funding	**1,251.371**

FUNDING

- £4.225m of funding confirmed in Month 11
- Most significant elements are junior doctors pay award funding and additional allocation for AfC non-pay costs

MONTH 11 2024/2025 – FEBRUARY 2025

KEY RISKS

- ASC – work ongoing to deliver a breakeven position but not yet confirmed
- Supplementary staffing – spend continues to fluctuate but overall less than 2023/2024
- Prescribing & drugs costs – increases in both volume and cost.
- Increasing ASC pressures – suppliers continuing to face sustainability challenges
- Health & Care staffing
- Ability to delivery Value & Efficiency Cost Reduction/ Improvement Targets
- SLA Uplift
- Allocations less than anticipated

MITIGATIONS

- Adult Social Care funding from SG confirmed as higher than anticipated
- Development of robust governance structures around agency nursing utilisation
- Additional New Medicines funding
- Financial flexibility / balance sheet adjustments
- MDT funding reinstated following positive discussion with SG
- Increase to the initial brokerage limit
- Reduction in CNORIS contribution
- Additional funding for AfC non pay element of 2023/2024 pay award

MONTH 11 2024/2025 – FEBRUARY 2025

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
272.688	NH Communities	249.211	254.909	(5.697)	279.743	(7.055)
57.928	Mental Health Services	53.248	53.989	(0.741)	59.194	(1.266)
164.568	Primary Care	149.431	151.665	(2.233)	166.943	(2.375)
(16.231)	ASC Other includes ASC Income	(14.904)	(3.594)	(11.311)	(6.027)	(10.204)
478.953	**Total HHSCP**	**436.986**	**456.968**	**(19.982)**	**499.853**	**(20.900)**
	HHSCP					
303.236	Health	276.248	278.607	(2.359)	305.874	(2.637)
175.717	Social Care	160.738	178.361	(17.623)	193.979	(18.262)
478.953	**Total HHSCP**	**436.986**	**456.968**	**(19.982)**	**499.853**	**(20.900)**
	Delivering ASC to Breakeven				**(18.418)**	**18.418**
478.953	**Revised Total HHSCP**	**436.986**	**456.968**	**(19.982)**	**481.434**	**(2.481)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	231	5,387
Agency (Nursing)	228	2,859
Bank	764	8,661
Agency (exclu Med & Nurs)	213	1,838
Total	**1,437**	**18,744**

HHSCP

- Year to date overspend of £19.982mm reported
- Forecast that this will decrease to £2.481m by FYE based on the assumption that further action will enable delivery of a breakeven ASC position
- Prescribing & Drugs continuing to be a pressure with £2.736m overspend built into forecast.
- Assuming delivery of £2.319m of ASC V&E cost reductions/ improvements in forecast – high risk
- Supplementary staffing costs continue to drive an overspend position – £2.483m pressure within the forecast
- £1.500m has been built into the forecast in respect of out of area placements

NORTH HIGHLAND COMMUNITIES - MONTH 11 2024/2025 – FEBRUARY 2025

Current Plan £000	Detail	Plan to Date £000	Actual to Date £000	Variance to Date £000	Forecast Outturn £000	Var from Curr Plan £000
79.363	Inverness & Nairn	72.615	75.673	(3.058)	83.238	(3.875)
57.459	Ross-shire & B&S	52.622	55.677	(3.055)	60.919	(3.460)
49.875	Caithness & Sutherland	45.692	46.380	(0.687)	50.892	(1.017)
58.140	Lochaber, SL & WR	53.239	53.172	0.067	58.388	(0.247)
12.607	Management	11.010	10.604	0.406	11.612	0.995
7.815	Community Other AHP	7.171	6.246	0.925	6.849	0.967
7.427	Hosted Services	6.861	7.158	(0.297)	7.844	(0.417)
272.688	**Total NH Communities**	**249.211**	**254.909**	**(5.697)**	**279.743**	**(7.055)**
94.425	**Health**	**86.111**	**84.303**	**1.808**	**92.229**	**2.196**
178.263	**ASC**	**163.101**	**170.606**	**(7.505)**	**187.514**	**(9.250)**

NORTH HIGHLAND COMMUNITIES

- £5.697m ytd overspend reported which is forecast to increase to £7.055m by the end of the financial year
- Within Health ongoing vacancies, particularly within Community AHPs, are mitigating cost pressures within Enhanced Community Services, Chronic Pain, community equipment and agency staffing
- Within ASC the main pressure areas are within independent sector provision in part due to the impact of the NCHC nursing rate.
- The year end forecast assumes delivery of ASC Value & Efficiency Cost Reductions/ Improvements of £2.519m

MENTAL HEALTH SERVICES - MONTH 11 2024/2025 – FEBRUARY 2025

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					
43.557	Adult Mental Health	39.920	40.344	(0.425)	44.254	(0.697)
9.417	CMHT	8.641	8.193	0.449	8.938	0.479
1.961	LD	1.960	3.075	(1.115)	3.352	(1.391)
2.994	D&A	2.727	2.376	0.351	2.650	0.344
57.929	**Total Mental Health Services**	**53.248**	**53.989**	**(0.741)**	**59.194**	**(1.266)**
44.243	**Health**	**40.707**	**42.640**	**(1.933)**	**46.701**	**(2.458)**
13.684	**ASC**	**12.541**	**11.349**	**1.193**	**12.493**	**1.192**

MENTAL HEALTH SERVICES

- £0.741m overspend reported ytd with this forecast to increase to £1.266m by financial year end
- Within this service area Health is the driver of the overspend position
- The main drivers for the overspend continue to be agency nursing and medical locums – although a significant piece of work is ongoing to reduce these costs with the position beginning to look more positive
- Buvidal and Clozapine drug costs account for a further pressure of £0.249m
- A forecast of £1.500m has been built in for out of area costs.

PRIMARY CARE - MONTH 11 2024/2025 – FEBRUARY 2025

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					
60.583	GMS	55.113	56.296	(1.183)	61.598	(1.015)
67.211	GPS	61.599	65.095	(3.496)	71.103	(3.892)
26.241	GDS	23.899	21.811	2.088	24.244	1.997
5.647	GOS	5.268	5.272	(0.004)	5.652	(0.004)
4.886	PC Management	3.553	3.192	0.361	4.346	0.540
164.568	**Total Primary Care**	**149.431**	**151.665**	**(2.233)**	**166.943**	**(2.375)**

PRIMARY CARE

- £2.233m overspend reported ytd with this forecast to increase to £2.375m by financial year end
- £2.486 overspend of prescribing has been built into the year end forecast – both cost and volume are contributing to this position
- £2.465m has been built in to the forecast in respect of locums in 2C practices
- Vacancies in primary care management and GDS are mitigating overspends in other areas

MONTH 11 2024/2025 – ADULT SOCIAL CARE

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	60.222	55.109	53.303	1.806	58.278	1.944
Total Older People - Care at Home	38.091	34.813	37.702	(2.889)	41.196	(3.104)
Total People with a Learning Disability	49.969	45.735	49.809	(4.075)	55.448	(5.479)
Total People with a Mental Illness	10.370	9.499	8.665	0.834	9.538	0.831
Total People with a Physical Disability	9.352	8.562	9.330	(0.769)	10.332	(0.979)
Total Other Community Care	13.160	12.062	12.256	(0.193)	13.401	(0.241)
Total Support Services	(4.917)	(4.556)	6.501	(11.057)	4.922	(9.840)
Care Home Support/Sustainability Payments	0.000	0.000	1.403	(1.403)	1.551	(1.551)
Total Adult Social Care Services	**176.247**	**161.223**	**178.968**	**(17.745)**	**194.665**	**(18.418)**
Less ASC Estates	0.530	0.486	0.607	(0.122)	0.686	(0.156)
Total Adult Social Care Services - Revised	**175.717**	**160.738**	**178.361**	**(17.623)**	**193.979**	(18.262)

Delivering ASC Position to Breakeven (including overspend on ASC Estates)	**18.418**

ADULT SOCIAL CARE

- A forecast overspend of £18.418m is reported. At this stage it is assumed that through further actions a position will be reached which will enable delivery of a breakeven position at FYE.
- Assuming delivery £2.319m of cost reductions/ improvements against the target of £5.710m
- £3.790m of supplementary staffing costs within in-house care homes are included within the year to date position

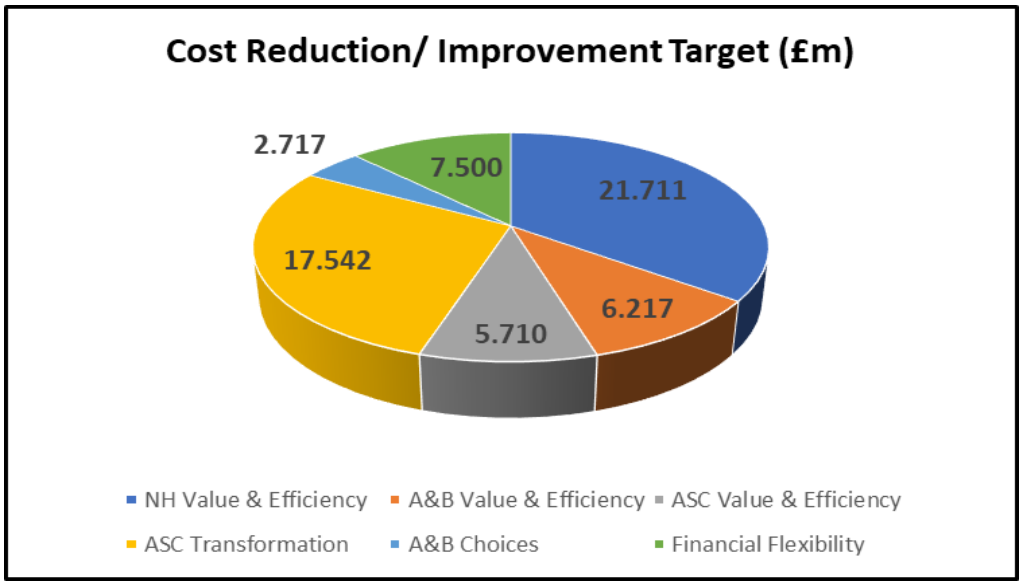
MONTH 11 2024/2025 – ADULT SOCIAL CARE

NHSH Care Homes Supplementary Staffing

	Month 11		
Care Home	Agency £000	Bank £000	Total YTD £000
Ach an Eas	-	29	**211**
An Acarsaid	-	16	**120**
Bayview House	-	19	**201**
Caladh Sona	-	-	**8**
Dail Mhor House		1	**3**
Grant House	27	28	**259**
Home Farm	72	8	**1,217**
Invernevis	16	17	**178**
Lochbroom		21	**192**
Mackintosh Centre		2	**6**
Mains House	42	6	**593**
Melvich		3	**59**
Pulteney		31	**264**
Seaforth		21	**261**
Strathburn		-	**70**
Telford	-	7	**46**
Wade Centre	-	16	**102**
Total	**157**	**225**	**3,790**

- Ongoing reliance on agency/ bank staffing within Home Farm and Mains House

MONTH 11 2024/2025 – FEBRUARY 2025



Board agreed plan	
	Target £000s
Opening Gap	**112.001**
Closing the Gap	
NH Value & Efficiency	21.711
A&B Value & Efficiency	6.217
ASC Value & Efficiency	5.710
ASC Transformation	17.542
A&B Choices	2.717
Financial Flexibility	7.500
GAP after improvement activity	50.604
GAP from Brokerage limit	**22.204**

COST REDUCTON/ IMPROVEMENT

- At the NHS Highland Board Meeting on 28 May the Board agreed to a proposed budget with a £22.204m gap from the brokerage cap – subsequently the brokerage cap has been increased to £49.7m but this has not impacted on the cost reduction/ improvement target
- Current forecasts suggest that year end out-turn will be £0.907m better that previously presented
- It should be noted that there is a risk around delivery of this position and recovery plan actions previously presented to FRPC will mitigate this position
- In addition there is an assumption that further activity will enable delivery of a breakeven position within ASC – this is a high risk assumption and we are working with Highland Council to progress.

MONTH 11 2024/2025 – FEBRUARY 2025

Value & Efficiency Planned Savings as at 10/03/2025

Planned Value of 24-25 Efficiency of **£26.034** (M9: £23.935m), is the value of the schemes currently listed on the Savings Tracker and is part of the total savings goal for the NH and A&B of **£51.180m**

	10/03/25	M9
Target:	**£51.180m**	£51,180m
Currently achieved	*£21.656m*	*£18.945m*
Forecast still to be delivered	*£2.958m*	*£3.572m*
Total achieved & forecasted	**£24.614m**	£22.517m
GAP:	**(£26.566m)**	(£28.663m)

Change in GAP: £2.097m

56% of efficiencies are currently forecasted to be delivered via Value & Efficiency Programme. This excludes ASC.

48% of efficiencies are currently forecasted to be delivered inclusive of ASC target and savings plan.

Reduction Programmes	V&E Original Plan				V&E Current Plan Fy 2024-25				Next Year
	2024-25 Original Target (£'000)	Total Achieved & Forecasted	GAP	% of In Delivery vs Original Target	2024-25 Current Target/Plan (£'000)	2024-25 Plan Achieved (£'000)	2024-25 Plan Forecasted (£'000)	GAP	2025-26 Plan Achieved (£'000)
Value & Efficiency - North Highland	**21,711**	10,082	-11,629	46%	**11,307**	8,553	1,529	-1,225	1,970
Value & Efficiency - Argyll & Bute	**6,217**	5,610	-607	90%	**5,805**	5,581	29	-195	0
Total Value & Efficiency	**27,928**	15,692	-12,236	56%	**17,112**	14,134	1,558	-1,420	**1,970**
Value & Efficiency - ASC	**23,252**	8,922	-14,330	38%	**8,922**	7,522	1,400	0	6,622
Total Value & Efficiency incl ASC	**51,180**	24,614	-26,566	48%	**26,034**	21,656	2,958	-1,420	**8,592**

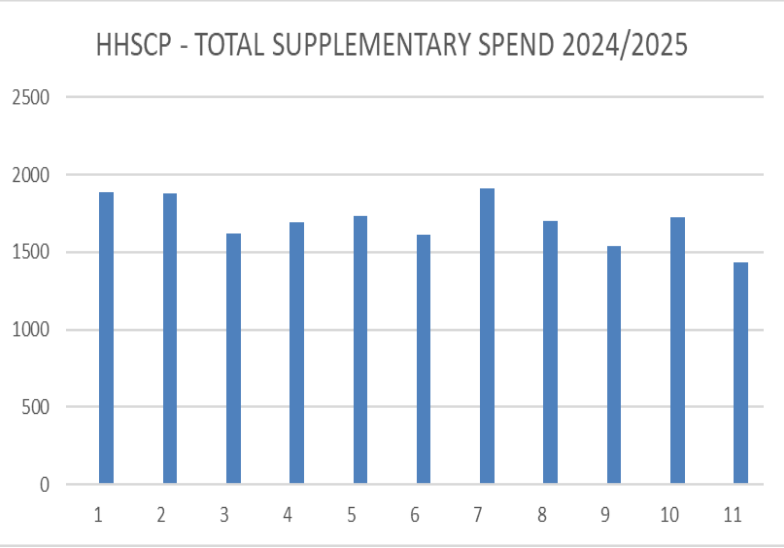
MONTH 11 2024/2025 – FEBRUARY 2025

	2024/202 YTD £'000	2023/2 YTD £'000	Inc/ (Dec) YTD £'000
HHSCP	18,744	22,366	(3,622)

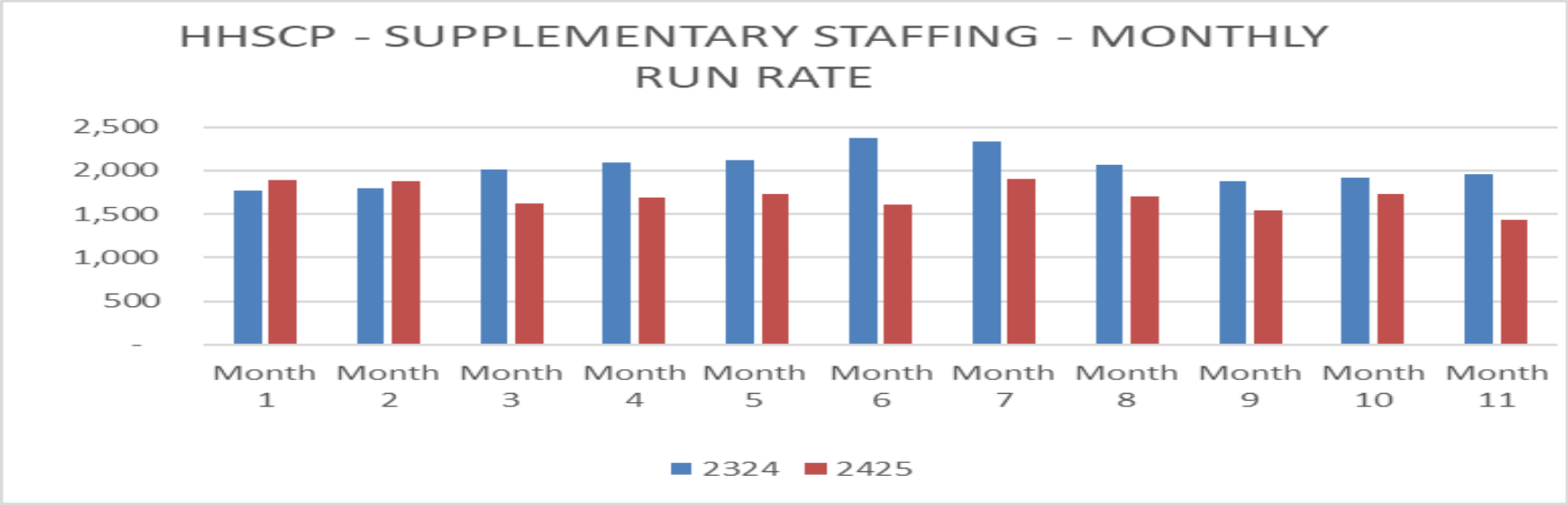
Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Pay			
28.768	Medical & Dental	26.404	25.601	0.803
4.396	Medical & Dental Support	4.032	4.061	(0.029)
69.978	Nursing & Midwifery	64.095	62.769	1.327
17.555	Allied Health Professionals	16.070	14.667	1.403
0.074	Healthcare Sciences	0.068	0.031	0.037
9.582	Other Therapeutic	8.747	9.094	(0.347)
6.968	Support Services	6.352	5.951	0.402
22.631	Admin & Clerical	20.621	19.829	0.792
0.398	Senior Managers	0.365	0.137	0.228
52.883	Social Care	48.422	46.000	2.422
0.424	Ambulance Services	0.388	0.400	(0.012)
(2.592)	Vacancy factor/pay savings	(2.382)	(0.041)	(2.341)
211.065	Total Pay	193.183	188.499	4.684

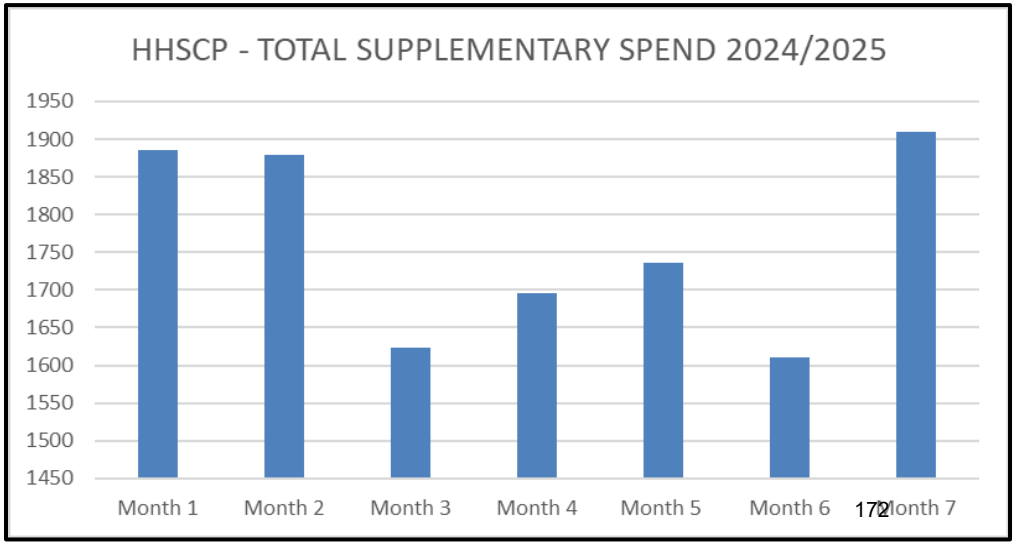
SUPPLEMENTARY STAFFING

- Total spend on Supplementary Staffing at end of Month 11 is £3.622m lower than at the same point in 2023/2024.
- There is an underspend of £4.684m on pay related costs at the end of Month 11



MONTH 11 2024/2025 – FEBRUARY 2024





- Month 7 spend is £0.292m lower than Month 10
- YTD Reduction of £3.622m compared to 2023/2024

MONTH 11 2024/2025 – FEBRUARY 2025

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Expenditure by Subjective spend			
209.007	Pay	193.183	188.499	4.684
57.371	Drugs and prescribing	52.577	55.211	(2.634)
3.357	Property Costs	3.045	3.790	(0.745)
21.005	General Non Pay	16.786	13.070	3.716
5.564	Clinical Non pay	5.055	6.327	(1.271)
7.257	Health care - SLA and out of area	6.652	6.786	(0.133)
115.826	Social Care ISC	106.011	114.729	(8.718)
85.544	FHS	77.039	76.986	0.053
	Allocations/commitments			
(6.910)	Operational income	(6.260)	(8.431)	2.171
(19.068)	Savings	(17.103)	0.000	(17.103)
478.953	**Total**	**436.986**	**456.968**	**(19.982)**

SUBJECTIVE ANALYSIS

- Pressures continued within all expenditure categories
- The most significant overspends are within Drugs and Presribing and Social Care ISC
- Pay is underspent by £4.684m – with the main driver being vacancies across the districts