NHS Highland

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Annual Performance Report 2020-21

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Introduction from Chief Officers, NHS Highland and The Highland Council

We welcome the opportunity to share our Annual Report setting out some of what we have achieved in 2020-21. The report provides us with a chance to share our achievements; reflecting on the impact of Covid-19 and to consider the challenges ahead.

Delivering the best possible health and social service together is at the very core of our business – we aim to be person-centred and are determined to make sure people's voices are heard and their needs are met. Everyone using our services, their families and carers, all staff and stakeholders are working hard together to improve the health and wellbeing of our local population.

Within the report you will see some examples of specific pieces of work which demonstrate positive change at a local level and improved outcomes for the population. Through the year we have also been working on our core governance by strengthening the partnership through updating the Integration Agreement and establishing our Joint Project Management Board.

We are proud of what we have achieved in 2020-21 whilst acknowledging the ongoing challenges for our communities and the need for ongoing service improvements. In these unparalleled times we have taken the opportunity to make decisions that we feel will impact positively on health and social care services in Highland.

Highlights included developing our Enhanced Community Service model in the Inverness area, bringing care as close to home as possible by changing the delivery of care and reducing the amount of time in hospital through development of local services.

During the troubling times of early lockdown we developed a rapid impact team to assist care teams when delivery of services was at risk due to limited staffing, and resources. This innovative model of care has been available across the vast Highland area, and are continuing to provide primary care support to patients and clients during the pandemic required different ways of delivering and supporting services.

Providing effective support for carers is central for those being cared for and our local communities. Providing the appropriate level of support is a key part of our locality planning.

Financially, the HHSCP position at month 12 showed an underspend of £2.984m of which £0.729m relates to Adult Social Care (ASC) and the balance being Health expenditure. This position includes Scottish Government funding which was provided in response to Covid-19 pressures.

Building on our developments and learning there are many opportunities for the future, not without challenge, but surmountable due to the excellent partnership approach of the communities of our local populations and service teams.

We would like to thank all of our colleagues for their help and support over the past year. With strong leadership, community participation and the support of our Partnership Board, we are confident that we will continue to strengthen our partnership governance to enable continued high quality service delivery as we move into the next stage of the pandemic and consider the way ahead.

Fiona Duncan, Executive Chief Officer, Health and Social Care, Highland Council

Louise Bussell, Chief Officer Highland Health and Social Care Partnership

Introduction

This annual report for 2020-21 confirms our commitment to the health, care and overall wellbeing of our community. We aim to give every child and young person in Highland the best possible start in life; enjoy being young; and are supported to develop confidence, capability and resilience, to fully maximise their potential, ensuring our children are safe, healthy, achieving, nurtured, active, respected & responsible and included. We aim to provide the right level of service provision, support and information to our adult population to ensure they have optimum opportunities to live well working in partnership across the statutory, third sector, voluntary and independent organisations.

2020-21 saw extraordinary challenges around growing demand for services, workforce pressures and finances and the Covid-19 pandemic. We remain committed to improving our services and have some very complex and testing decisions to make around what services will look like in the future, particularly writing this during the Covid-19 pandemic, and following the publication of the Feeley report.

These pressures however, did not prevent us from delivering high quality services. We continued to make progress across many areas with a number of largely positive comparisons against National performance. The challenge for the future is to focus on delivering care in a Covid-19 environment, to better support Carers, developing and extending home based care options and working with Highland communities to develop more local, community based provision and support.

Successes

This year has been challenging because of Covid-19, but we worked hard to provide excellent health and social care services for our people. There are areas where performance has been positive and innovative which we aim to maintain. In those areas where there is work still to be done we are planning our next steps. These are some of the areas that we feel have been particularly positive:

- We are focused on improving health and wellbeing as well as delivering high quality care for the people of Highland.
- We have applied resource to specific areas for improvement and change and these initiatives such as the Enhanced Community Service Pilot in Inverness, are helping to support the national health and wellbeing outcomes by which we are measured. As the Pilot develops through this year we are keen to strengthen this approach further afield.
- The engagement of all staff, volunteers and partners has been vital to the planning, developing and implementing of our Covid-19 response and we work hard to maintain positive relationships.

Much redesign activity has been around community based services to build community capacity and further develop an anticipatory and preventative approach to care. It is likely to be a number of years before we see the full impact of these changes. The development of the integrated children's service plan has caught the testimony and voice of children young people and their families and has supported the development of priorities for the next two years.

Challenges and Opportunities

This year brought about challenges of an unprecedented scale and pace of change. How to make long term shifts towards prevention in the face of immediate pressures from the changes brought about by Covid-19 was a major challenge in our partnership. This however was balanced by our agility and having good relationships, to enable positive change. Within this report you will see evidence of this.

Executive Summary

The commitment of staff and communities is unquestionable which resulted in many successes, albeit with work still to be done.

We wish to thank all for the tremendous contribution made the people dedicated to providing care, which include NHS and Council staff, Independent and Voluntary organisation staff, as well as other volunteers and carers

Executive Summary

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the publishing of the Annual Performance Report, assessing the performance and carrying out the integration functions for which Integrated Joint Boards in Scotland and Integration Authorities (in Highland's case) are responsible.
The Annual Performance Report 2020-21 therefore encompasses:

- Assessing Performance in relation to the National Health Wellbeing Outcomes
- Financial Performance and Best value
- Reporting on Localities and the work of Locality Planning groups and Community Stakeholders
- Inspection of services, including details of any inspections carried out in 2020-21 relating to the functions delegated to the Partnership, by scrutiny bodies
- The 9 National Health and Wellbeing Outcomes describe what people can expect from the HSCP. Performance against each outcome is analysed in the performance assessment sections, with illustrative practice examples demonstrating how local services are working to achieve the outcomes.

This report identifies the progress achieved and the work that is ongoing within our Localities, recognising the unprecedented impact, challenges and opportunities of Covid-19. It also demonstrates some of the challenges for the Health and Social Care Partnership (HSCP) and highlights the significant changes that will take place to shape services that respond to future need.

In Highland in 2020-21 our main aim during the pandemic was to maintain and deliver our wide range of health and social care services for our population, with investment made to either continue or commence development of service improvements. Additionally our aim has been to strengthen our governance arrangements within the Partnership through review of the Integration Agreement.

For NHS staff, a key aim was to develop our action plan for our Culture Fit for the Future, making Highland a great place to work and to improve sustainable and resilient services.
Financially, our drive was to recover our financial position.

Financially, the HHSCP position at month 12 showed an underspend of £2.984m of which £0.729m relates to ASC and the balance being Health expenditure.

Going forward, work will continue to improve services whilst focusing on the financial position.

All of these components co-exist and as we move forward we will seek to continue to build on this good work, evolving through the identification of local needs with the aim of building sustainable high quality services.

This is a review of what we faced in 2020-21, and what we learned.

Strategic Context

In 2012, The Highland Council and NHS Highland Board used existing legislation (the Community Care and Health (Scotland) Act 2002) to take forward the integration of health and social care through a lead agency Partnership Agreement. The Council would act as lead agency for delegated functions relating to children and families, whilst the NHS would undertake functions relating to adults.

"Our aim is: *"Making it better for people in the Highlands".*

Progress is measured through tracking work and improvement plans using key measures. This report sets out a number of important measures of progress. It also describes some of the main areas we have been working on and the difference this has made.

The Annual Performance Report is an opportunity to reflect on 2020-21 and the resilience of our workforce and partners in delivering services during the pandemic. It is also a chance to reflect on the key learning and ways we can develop, and to appreciate the presented opportunities.

Highland Health and Social Care Partnership

The Highland Partnership covers the Highland Council area. The total land mass is 25,659 square kilometres, which covers a third of Scotland, including the most remote and sparsely populated parts. We have the 7th highest population of the 32 authorities in Scotland at around 234,000, with a slightly higher percentage of children, and higher proportions in all of the age groups above 45 years.

This population is broadly equally divided across urban areas, small towns, rural areas and very rural areas. Outside Inverness and the Inner Moray Firth there are a number of key settlements around the area including Wick and Thurso in the far north, Fort William in the south west and Portree in the west. These towns act as local service centres for the extensive rural hinterland which makes up the majority of the region.

There are four coterminous managerial areas for NHS Highland and Highland Council children's services, and nine local Community Planning Partnerships.

Adult Social Care is commissioned by Highland Council from NHS Highland. Delivery of Adult Social Care is reported to Committees of both the Highland Council and the NHS Board and the governance of the partnership is managed by the Joint Monitoring Committee. With similar reporting arrangements, Childrens services are delivered with the Highland Council acting as lead agency.

Highland Council and NHS Highland have formal arrangements for engaging with Third Sector and Independent partners, service users and carers. These partners are represented in strategic planning and governance processes.

In 2021-22 work continues in the Integration Scheme review and also in considering the impact of the Independent Review of Adult Social Care (Feeley Review) Within children's services we have renewed our committment to;

Tackling Inequalities
Reduce the gap in outcomes between the most and least deprived children and young people in Highland by working to reduce child poverty within our communities and keep our children and young people safe from harm.

Love and Support for our Care Experienced Young People
Ensure children and young people who are care experienced are loved and supported

to improve their life experiences and life chances.

Good Health and Wellbeing including Mental Health
Ensure all children and young people are supported to achieve and maintain good physical and mental health and wellbeing.

Promoting Children's Rights and Participation
Work to ensure we are delivering on the provisions of the United Nations Conventions on the Rights of the Child (UNCRC) as incorporated into Scots Law. These could affect our service delivery and also in how we report our performance in the future.

Improvement Programmes currently underway in Highland include:

- Modernisation of Primary Care
- Redesigning Mental Health
- Redesigning Unscheduled Care
- Investing in Acute and Community Care Hospitals e.g National Treatment Centre, Badenoch & Strathspey and Broadford Hospitals
- Transforming Adult Social Care
- Review of Childrens' services in line with UN Rights of a Child

All of these components co-exist and as we move forward we will seek to build on this good work, evolving through the identification of local needs with the aim of building high class sustainable services.

Highland tends to have a health profile that is higher than the Scottish national average. E.g.:

- above average educational attainment, employment, income
- below average crime, homelessness, alcohol-related mortality and hospital admissions
- average smoking rates
- health condition prevalence rates that are similar to, and often lower than, the national average; some emergency hospital admission rates that are higher than elsewhere in Scotland
- geographical challenges in providing equal access to services: Low wage rates, high fuel poverty, higher numbers of older people, recruitment challenges.

Delivering on the commitments and priorities outlined in the integrated children's services plan.https://www.forhighlandschildren.org/index_70_464745328.pdf

Case Study 1.

Understanding and reacting to unique risk situations: i.e. respective risks occasionally impossible) to calibrate

- Managing Services in highly dynamic
- policy and practice environments.
- Respective risks very difficult (occasionally impossible) to calibrate
- Seeking to support adults' mental health in new ways – and coping with the impact on relationship based practice of social distancing and Personal Protective Equipment (PPE)
- Seeking to support carers with many respite services in lockdown
- Ongoing (increasing) impact on the health and well-being of adults with mental illness
- Care Homes: maintaining warm, homely environs with the impact of necessary Infection Prevention Control (IPC).
- Maintaining good communication with dispersed workforce
- Supplying PPE and Testing routes for staff
- Working with partners in new and unfamiliar ways with unprecedented risk situations.

What went well

- Staff, service users and carers working flexibly to promote welfare at almost every level: including taking on greater workloads etc.
- Increased flexibility and choice for people who access self directed support services under Options 1 and 2
- Light touch monitoring of budgets under Options 1 and 2; no monies withheld although aware of some changes to PA's, etc
- Staff (across all disciplines) were cohesive and focused on a common goal
- New organisational links have been made
- Staff demonstrated bravery and commitment to provide services in spite of risks
- Streamlined processes used to expedite valued outcomes: e.g.. processes fast-tracked to facilitate discharges from Hospital
- Enormous effort targeted at setting up logistical routes for PPE and Testing etc.
- Remote working and virtual meetings quickly established.
- Unnecessary bureaucracy was often successfully challenged
- Work with voluntary sector and strengthened community spirit
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Opportunities for Development

- Traditional service models have to change; this provides us with an opportunity to reconsider our services and how we make best use of resources
- The use of technology to maintain links with service users, carers and professionals needs to be both consolidated and accelerated to improve service provision
- Thinking about how to deliver personal outcomes in a wider variety of ways that was already required as part of our demographic challenge
- A consensus regarding the need to prioritise 'Services to Carers' should be helpful in fast-tracking new responses to meeting need in this area

Responses

Rapid responses

25 care staff were recruited by NHS Highland to complement existing, reassigned staff (mainly from the Mackenzie Centre) to form a Care Response Team. Taken together the Team had a deployable – hands-on – capacity of 30 individuals. It was formed to provide an effective response in situations where Care Services were impacted by Covid-19.

The team has played an important role from the beginning of May 2020 in supporting a Care Home for Older Adults in Portree where Covid-19 was having a severe negative impact.
Members of the team have also been able to provide valuable support to other Care Homes where staffing had been significantly compromised by Covid – albeit they were

not "outbreak sites".

Care at Home

At the outset of the pandemic, established and regular discussions were held with all providers to assess risk regarding service sustainability. Risk registers were collated centrally. A Partnership approach was taken to collate information on levels of care delivery and staffing resource. Collaborative planning to enable full oversight of critical care needs and staffing levels, in order that should there be a need, we could pool staff (from local providers and in-house services) and service user runs to ensure service continuity.

A complete staffing resource was compiled which showed the level of staffing across the whole area and the level of staff absence at which we would reach critical point in service provision. This data was shared with the Workforce Resource Centre and the NHS Volunteer manager, who were tasked with fast tracking new recruits, redeployed staff and NHS volunteers in order that we had access to a back-up workforce and volunteers who could step in to support in areas outside personal care. Tasks such as food and medication, deliveries, support, phone calls etc could be undertaken by voluntary supports.

Additionally, in each local area, we identified existing local charities and voluntary groups who could be called upon to support the local community.

Staffing levels across organisations reduced in the first two weeks of the lockdown with many self-isolating. By week 3 this had slowed and we saw the majority of staff back to work. Staffing has remained within our normal ability to resolve, and to date we have not had to use any of the additional staffing resources as detailed above. Local providers have teamed up with voluntary organisations to ensure meals deliveries in some areas.

Support Services

The support sector has adapted well to the challenges of Covid-19 and continued to deliver and maintain services for people with a learning disability and mental health issues in Highland. The sector has been meeting regularly with the Head of Service: Learning Disabilities and Autism in a huddle arranged to flag issues with regards to service delivery, PPE, and any other emerging issues. In addition, regular meetings with individual providers have been held in order to provide additional support and oversight of services.

Since the onset of Covid-19, there has been an expectation that providers would maintain regular contact with every person that they support even if they have ceased their support for a short period. Providers were expected to complete and submit notification of change of support forms for every individual they support where a change has been made. In addition, a RAG status was set up for every person with a Learning Disability that we know in Highland which involved provider support for monitoring and overseeing. These support mechanisms have been successful in flagging any emerging issues, maintaining stability in the service and enabling a quick response to any escalation of issues.

Care Homes

The Care Home Oversight Group was set up following guidance issued by the Scottish Government on 16 May 2020, as a result of the impact of the pandemic on Care Homes and in addition to the Social Work focus, added a requirement that Public Health and Nursing should also form part of that oversight group.

As such the Care Home Oversight Group includes representatives from all disciplines and considers issues on a fortnightly basis. To be responsive this was increased to

weekly where required. Operational meetings in terms of care homes operate as above. Safety Huddles consider each Care Home in Highland individually and report on relevant issues in terms of safe service delivery being primarily PPE, Staffing and Covid status.

The above oversight meetings provide a safe and robust process for the continuing delivery of adult social care services during the pandemic.

The broad functional areas covered at these meetings have been significant. There has been an enormous amount of guidance issued by the Government since the pandemic was announced and that guidance has led to the issuing of assurance reports by NHS Highland to Government and the preparation of guidance to the sector in relation to various matters, most significantly being guidance in relation to Infection, Prevention and Control measures and more specifically the use and availability of PPE and the testing regime in place.

Day Services

NHSH currently commissions Day Care services from 13 independent sector providers, 9 on a block purchase basis and 7 on a spot purchase basis, at a cost of approximately £1.5m.

NHSH wrote to providers on 1 April 2020 to provide reassurance that contracts which were due to end on 31 March 2021 would continue on current terms and payment levels until at least 30 June 2021, pending approval of fee rates for the financial year 2020-21.

NHSH agreed to uplift current fee rates by 3.3% (total cost now approximately £1.65m) in line with Scottish Government expectations, with the increase backdated to 1 April 2020, subject to providers signing their variation to contract, with funding levels reverting to 2019/2020 rates in the event of non-signing. This was communicated to providers during June 2020, with updated contractual documentation enclosed. Providers are now progressing the signing of the documentation.

It is highlighted, that due to Covid-19, the majority of day care providers have had to close their service with many establishing alternative means of delivering some form of service to their clients. NHSH has agreed to continue to make payment to providers, in accordance with their contractual terms and conditions during this time.

Other day and carers services have sought to creatively reassign their resources so that carers and service users receive some form support within the confines of lockdown; and a variety of new routes have been found to provide assistance. We have also streamlined our Assessment and Approval processes to seek to ensure that there are no unnecessary delays in people accessing appropriate support and to ensure increased flexibility of response during this time.

Services to carers

Carer Services adapted during Covid by supporting Carers to complete emergency plans and by undertaking mini adult Carer & young Carer plans that ascertained the best support for Carers during Covid. They offered a range of services either by phone, via Zoom or as newsletters which ensured that although no face to face contact was available workers were still available to offer advice and support to Carers.

There was also a selection of training provided on mindfulness, first aid as well as aspects of training related to specific conditions (such as Parkinson's and Alzheimer's). Craft boxes were sent out as short break opportunities for Carers and to stimulate the people they care for. Regular informal group chats were available via social media forums, all creative solutions that ensured Carers had access to support tailored to meet their own individual needs

when Carer services were not directly accessible.

Integrated Services

NHSH developed practice guidance in response to the Coronavirus 2020 Act. This allowed teams to undertake partial assessments and the guidance laid out the variations that this meant in practice in terms of service provision and charging for services. The guidance had cognisance of the impact on the supported person and carers. It also reduced bureaucracy for professionals. The guidance was also explicit that there was no variation in duties in relation to Adult Support and Protection and incorporated some guidance to support discharge from hospital taking account of the Adults with Incapacity principles but recognising the challenges when a legal order was not in place.

Remobilisation Planning

Service Remobilisation Plan
The Adult Social Care Remobilisation Plan describes a framework where the work we do (our activities and outputs) to reshape and restart our services is translated into positive outcomes for service-users and carers. This is the work that will support our "Phased Approach" to restarting services.

Short term service remobilisation plans will be prioritised for resetting of day care and respite, providing support to carers (including providing alternative types of Short Break) and to resume full, functional care assessments.

- Care Planning at a personal level is revisited to ensure personal outcomes are delivered safely and sustainably for those in greatest need
- Carers under greatest pressure have their needs assessed and care plans reshaped
- Service users and carers are actively engaged - at a service level to describe how they see their needs and outcomes being met in "Covid-proof" ways
- Necessary "in-person" services are delivered at a physical distance
- The efficacy of our service delivery strategies are reconsidered in the light of the Covid environment
- All 'in-person' service reconfiguration is fully informed by Infection and Prevention Control Good Practice

National Health and Wellbeing Outcomes

Indicator	Description
1	**People are able to look after and improve their own health, wellbeing and live in good health for longer.**
2	**People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**
3	**People who use health and social care services have positive experiences of those services, and have their dignity respected.**
4	**Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**
5	**Health and social care services contribute to reducing health inequalities.**
6	**People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.**
7	**People using Health and social care services are safe from harm.**
8	**People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**
9	**Resources are used effectively and efficiently in the provision of health and social care services.**

The National Health and Wellbeing Outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. These outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using these services, carers and their families.

The following pages provide an assessment of our performance against these outcomes; and against agreed core national integration indicators linked to these outcomes. The core integration indicators provide an indication of progress towards the outcomes that can be compared across Partnerships and described at a national level over the longer term.

Performance against the National Health and Wellbeing Outcomes

Performance against each of the National Health and Wellbeing Outcomes and associated National Performance Indicators is detailed in the following pages. Where relevant, performance against associated Local Performance Indicators is also provided. The extent to which implementation of the Plan is contributing towards meeting the National Health and Wellbeing Outcomes is noted below with each associated action cross referenced within the footnotes. Comparison is also made with the initial 2015-16 baseline figure.

National Health and Wellbeing Indicators

An associated core suite of 23 National

Performance Indicators has been developed, drawing together measures that were felt to evidence the 9 National Health and Wellbeing Outcomes. In addition, there are 2 Childrens Outcomes. Of the 23 indicators, 14 evidence the operational performance of Highland Health and Social Care - with the data provided by the NHS Information Services Division (ISD). The data for the remaining 9 indicators is taken from responses from the Scottish Government's biennial Scottish Health and Care Experience Survey.

Currently there is a national and local review of the performance management framework and outcomes.

Outcome 1

People are able to look after and improve their own health, wellbeing and live in good health for longer.

This indicator is intended to determine the extent to which people in Highland feel they can look after their health. It is recognised that this may be more difficult for people with long term conditions and these performance indicators provide a measure of that.

The 2019/20 Biennial Survey results showed NHS North Highland equal to or just slightly below the national average in a number of areas with an overall client satisfaction rating higher than the national average. We are committed to working with our services and partner organisations, to achieve sustainable improvement in client and patient satisfaction.

To support our strategic outcome 'more people will live well in their communities', we are committed to growing community capacity that focuses on early intervention and a preventative approach.

Our approach is to provide care, based on co-production principles, developing new community driven models of care, and to help people maintain their independence wherever possible.

Our relationship with the Third Sector will support us to continue the development of a Highland based third sector network focused on health and wellbeing in our communities.

Outcome 2

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

This indicator reflects whether people who need support feel that it helps them keep their independence as much as possible. This outcome is again supported by national survey and information gathered locally. Overall, the picture is one of maintaining previous performance. There was a continual increase in the numbers of clients referred for, and provided with, telecare to enable them to remain at home. The number of days' people spend in hospital when they are ready to be discharged, per 1,000 population (75+) declined over time but remains significantly above the national average. Details of performance are split over Tables 2.1 and 2.2.

A key indicator in this group is the number of delayed discharges which is well above the Scottish average. Delayed discharge continues to be a challenge. A programme of work was implemented in 2020-21 to improve the delayed discharge position with actions based on the Scottish Government Expert Group on Delayed Discharge recommendations.

The four options of Self Directed Support are available to any adult who has been assessed as requiring social care support. An outcomes-based assessment can be requested from any NHS Highland Integrated

District Team.

A personal, outcomes-focused assessment will be completed jointly by the person in partnership with one or more professionals to determine eligibility for assistance with care and support needs. Depending on the individual's circumstances, a financial assessment might also be undertaken. Assessments will normally be reviewed on an annual basis.

In adult services substantial growth in Self-Directed Support, and in particular Options 1 and 2, has been seen over the last four years as demonstrated in our table at appendix one. Throughout North Highland, albeit we recognise we are on a journey with still some way to go, the measures as described above have led to greater involvement of supported people and their family/networks in the assessment and decision making processes and increased flexibility, choice and control in relation to meeting desired outcomes.

Addressing unscheduled care was a key driver of the national Redesign of Unscheduled Care programme for 2020-21. In December we introduced the Flow Navigation Centre which helps to triage emergency calls and provide the most appropriate emergency care and sometime avoid the need to attend A&E. This is run in partnership with NHS24 and other national bodies.

The percentage of people aged 65 or over with long term care needs receiving personal care at home has increased year on year to 92%.

The proportion of people who spend the last 6 months of life at home or in a community setting (92%) has increased over the past year and higher than the national average of 89%.

Example: Care at Home (CAH)

The pandemic placed significant pressure on all parts of the care sector, including care at home. The stressors for both In-House and commissioned providers of maintaining standards while addressing supply and flow issues around PPE, fluid and fast changing guidance, reporting requirements and testing, were challenging. Nevertheless, there was remarkable commitment, contribution and care provided, by all, in this extremely challenging environment.

All care at home services quickly responded to the pandemic and adapted their contingency plans to reflect current and projected needs. By identifying high priority situations, the service was able to maintain a consistent support to those most vulnerable or at risk in the community.

Initial challenges in relation to PPE were addressed and teams were given extra input in relation to infection prevention control. Care at home staff displayed flexibility and professionalism and this approach assisted to keep the people they support and staff safe.

There is a need to have sustainable and available care at home capacity to assist with the discharge flow from hospital to home, and to prevent unnecessary hospital and care home admissions. Care at home capacity is sometimes only available where providers have additional capacity; this is not always at the volume or locations required across an urban, rural and remote dispersed geographical area such as Highland.

CAH Commissioned Services

It is clear that the previous commissioning approach has not delivered the necessary capacity improvements anticipated. In remote and rural areas there has been very little expansion from independent sector providers into remote/ rural areas whereas there has been significant growth in urban

and some rural areas.

In order to have sustainable care at home services available, there is still a need to commission the necessary capacity in the locations required and there is a requirement on the part of NHS Highland to encourage a range of providers to areas where additional capacity is still required. NHS Highland continues to commission high volumes of care at home from the independent sector; In house services remain in many areas, including North and West Highland.

Specialist services have been set up in Inverness such as the Enhanced Responder Service (ERS) and Overnight Service (SOS) to assist with flow from hospital and work is progressing in the North Area (Caithness and Sutherland) around service redesign for in house services. A number of block purchase commitments have been made to continue to support service certainty and improve flow.

The care at home sector adapted well to the challenges of the pandemic and continued to deliver services without significant disruption. This is testament to the commitment of our valued partners in delivering care. Several care providers have expanded their operations quickly and efficiently with demonstrable growth seen alongside the support of discharge and flow from hospitals during the pandemic.

The current contract with our external care providers was extended for a year in March 21 and there is an opportunity to review our approach, take learning from Covid and also of experiences of services such as the Enhanced Responder Services (ERS) and Overnight Service (SOS).

CAH In-House Services

Recruitment to care at home teams remain challenging within remote and rural areas and this is reflected in redesign proposals where job roles allow and encourage flexibility across services.

As with many services the ability for staff to attend face to face training was significantly affected and this has resulted in the need for extra focus in this area. A recent training needs analysis identified priority areas and plans are in place to address the shortfalls.

The teams have demonstrated further how critical their role is in supporting communities to remain safe within their home environment. Their dedication to continue to provide a high standard of support for everyone is notable.

CAH Business Process Payment Improvement

We transitioned to our new payment arrangements which were warmly welcomed by our partners during December 2020.

Before Covid, we paid all care at home providers in arrears. Now we pay in advance which has sustained short term cash flow, introduced flexibility within our system, secured a level of payment for care delivery and an agreed known and understood payment timetable for all providers. This enabling step is intended to assist providers but it does not resolve the need for service level certainty and to have available capacity when required.

Through the period we worked in improving patient flow by reducing delayed hospital discharges and through additional surge capacity provision and ensuring continuity of social and community care.
Our staff were committed in supporting people to remain at home.

Carers

Support services to carers were increasingly important due to the ongoing impact of Covid-19. This was manifest in the suspension of many Day and Respite Services which has significantly reduced the short-breaks available to carers to support them in their role.

The Highland Carers Improvement Group agreed that interim services for carers should be sought which could demonstrate that they can provide a significant impact in one, or more, of the following areas:

- Provide highly reactive supports to help carers at times of particular stress
- Link carers to their local communities and the sources of support they contain
- Prevent carer breakdown and obviate the need for more formal services to the cared for person (including admission to residential care or hospital);
- Support carers when the person they care for is being discharged from hospital;
- Offer a range of planned and 'Covid-proof' short-break alternatives which are attractive and/or acceptable to both carers and the cared-for person;
- Provide carers with the practical skills they need to manage their caring role; and
- Provide information and advice for carers that allow them to make informed choices about their role and supports decision making in line with Self-Directed Support principles.

A Carers Services Project Team was quickly brought together to structure a bidding process for Carers services/projects which were considered capable of mitigating the impact of Covid-19. Its work included:
Structuring an open invitation of bids
Setting out the parameters for applications, including evaluation criteria.
Working to an identified Implementation Budget (of which £250,000 of the earmarked £400,000k was deployed).

This work was undertaken to complement the ongoing work to identify a fully costed Carers Programme to develop good local services for carers which include; information, advice, completion of Adult Carer Support Plans and, crucially, a greater number and variety of short break opportunities.

Currently we have a great deal of work still to do to provide the tangible supports for carers that we know they need; however with the completion of our Strategy and the work to tender for services for carers that journey is now well underway.

Example: Pharmacotherapy

This service has been introduced as part of transforming primary care, to aid GP practices to support the implementation of serial prescriptions. This has helped to improve convenience and access for patients with long term prescriptions, whilst reducing footfall into practices and being more efficient for healthcare staff.

Some experiences and comments:

"Pharmacotherapy: This workstream is generally going very well. GP's and patients are benefiting hugely from this service. The cooperative activity here is an exemplar of a healthy partnership between Board officials (Director of Pharmacy/Lead Pharmacist) and GP Sub representatives"

Extract from letter from LMC to Assoc. Medical Director and Deputy Chief Exec re Primary Care Improvement Plan

One of the GP trainees just gave me some positive feedback re medicines reconciliation I did on XXXX.

"I had flagged incidental finding of hyperthyroidism and she's now being further investigated (and they think it could have contributed to her recent NSTEMI). Apparently it was a good catch as had not been picked up in hospital and, as not mentioned in IDL, then GP's wouldn't have been aware of the abnormal result"

Feedback from pharmacist re feedback she received from GP

"The Dr's have been really impressed with XXXX. She's fitted in really well with all our staff. She's very positive, gets on with the work, and really proactive. They're finally really feeling like their workload has decreased. I've heard them comment that they've gone to do scripts and XX has already beaten them to it"

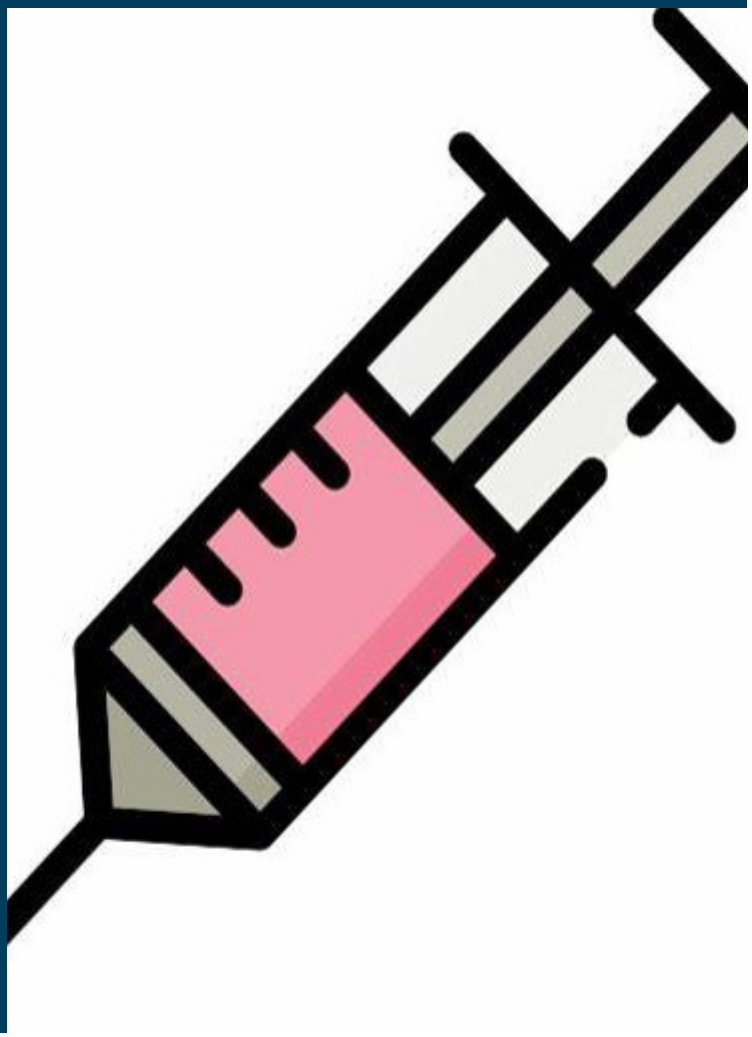
Feedback from Practice Manager re practice pharmacist

"I just wanted to say a huge Thank You to the pharmacy team. Sadly, I didn't catch a name but one female was a huge help in particular. I called on Tuesday to ask about a complicated Prescription repeat to England and I received the best service. The member of staff was polite and went out of her way to help me at what I know must be a very busy time. I am so grateful, please pass on my thanks"

Feedback from patient re pharmacy technician

"So far XX has done a brilliant job in reducing several patient's meds who were overtreated and switching to formulary alternatives etc., and patient satisfaction has been subjectively very good!"

Feedback from GP re pharmacist medication reviews



Outcome 3

People who use health and social care services have positive experiences of those services, and have their dignity respected.

This indicator is about the quality of the services provided and client's ability to manage and be in direct control of the services that they require. Other indicators such as enablement and self-directed support are also relevant.
Overall there was a decline in performance in these areas in 2019-20. The percentage of people rating the care provided by their GP practice as significantly above the national average. To further improve services in 2019-20 we employed a Head of Primary Care to work across the north of Highland and in 2020-21 primary care services were a key element of our Covid-19 response.

The Highland Learning Disability Listening Group was established to ensure that the voices of people with a learning disability are heard by NHS Highland managers. The majority of group members are people with a learning disability from Inverness, Fort William and Thurso, other members are paid professionals. A Human Rights Approach, using the PANEL principles forms the foundation of the group. The group have been testing technology to ensure that participation is fully accessible.

"75% of adults are supported at home agreed that they had a say in their help, care or support, which is a slight decrease from previous years. The national average is 75%"

"80% of adults receiving care or support rated it as good or excellent. That's comparable to previous years. The national average is 83%"

Example: **First Contact Physiotherapy Service NHS North Highland**

As part of the Primary Care Modernisation Improvement Plan, the FCP service provides fast access to expert physiotherapists for musculoskeletal (MSK) assessment/opinion in the general practice setting.
From its creation in May 2019, this service benefitted from all partners having a joint sense of purpose and a commitment to create a culture of collaboration. This commitment laid the foundations of the group, forming strong working relationships and governance based on honesty, trust and openness. Fuelled by regular communication this approach underpinned the planning and implementation stages of the service. The work stream was fully supported by AHP leadership, GPs, practice managers, e-health facilitators, primary care modernisation project manager, human resources, staff side representatives and FCP clinical leads.

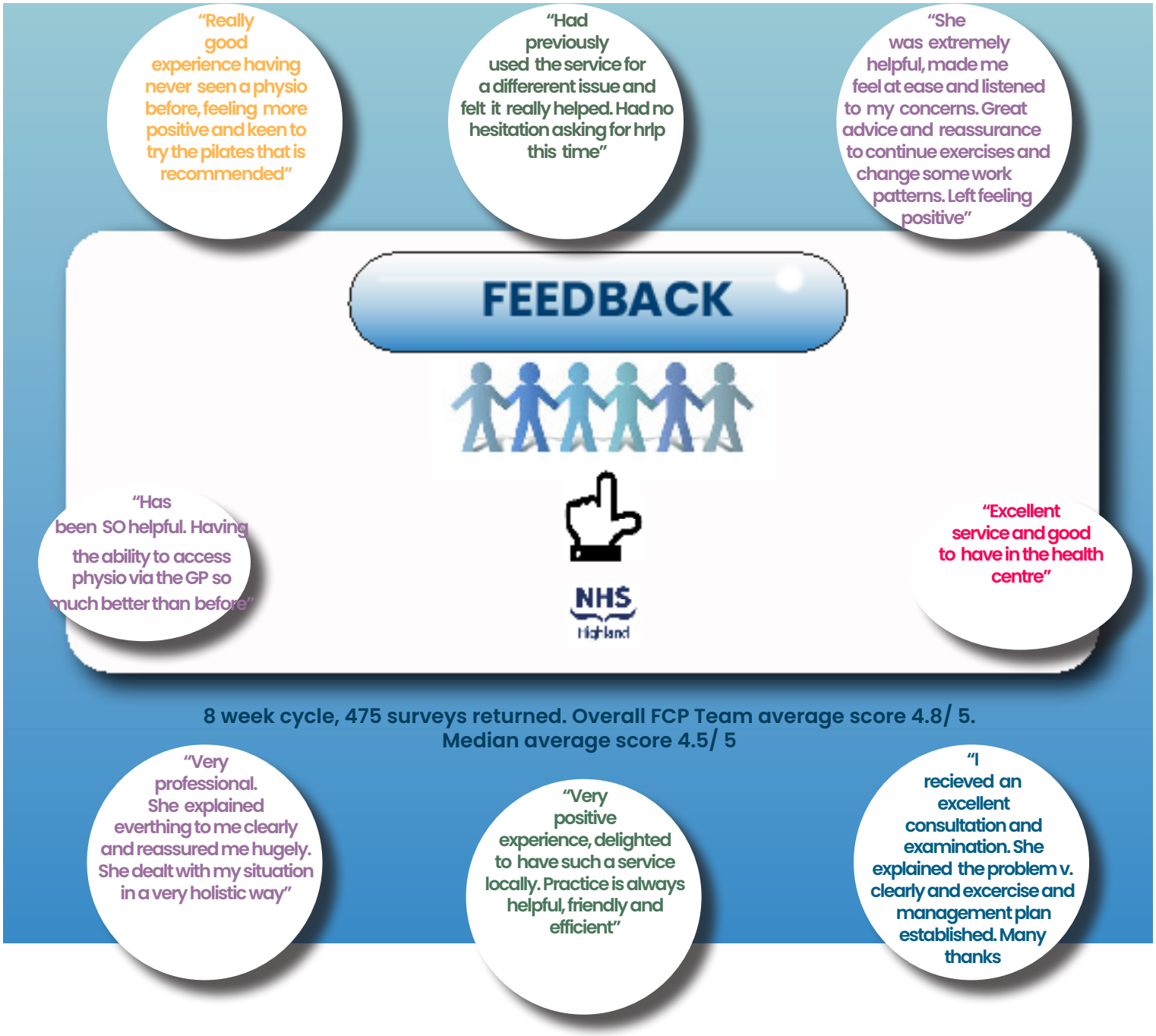
By moving the MSK pathway upstream into the practice setting, the service transformed how patients access MSK Physiotherapy. Without the need to see the GP first, patients can now be assessed, diagnosed and treated, often without the need for onward referral. This helps promote earlier self management of acute conditions and adds to the prevention of and management of longer term MSK conditions. Current MSK Physiotherapists were able to progress into Advanced Practitioner roles, developing new skills and embracing the opportunities to learn from and share knowledge with new colleagues in the wider GP setting. Joining up patient care with shared records and timely case discussions also became a welcome reality, with the Physiotherapists feeling their contribution being more timely and of recognised value for patients' care.

Implementation of a service is never in isolation. Pragmatic solutions were sought to meet the challenges of delivering this service to practices across the unique geography of NHS North Highland. Individual practice and population needs as well as clinician availability meant a significant degree of flexibility was required. The concurrent service redesign within Physiotherapy added further complexity and introduced additional and particular challenges around staff movement and recruitment.

A recent patient survey using the validated CARE survey measure reflects a high positive patient experience of their consultations and in how easily they can now access MSK Physiotherapy. Below is a selection of their comments.

Full quantitative evaluation of the service has been interrupted by the response to the pandemic however some limited interim data is encouraging.

Two years on the FCP service continues to evolve. The original implementation group continues to find mutually agreeable solutions to the inevitable challenges that delivering this service brings. This is a major factor in its success so far and will be integral to ensure the FCP service is fit for the future MSK needs of our communities in North Highland.



FIRST CONTACT PHYSIOTHERAPY SERVICE NHS NORTH – CARE MEASURE PATIENT EXPERIENCE SURVEY

Due to a variety of ongoing pandemic adaptations within practices, the group recognise the following limitations that may affect the data and the ability to collect it:
Potential bias with handing survey out directly to patients, where they filled it in and who/how they returned it.

- Potential bias with positive patient selection
- Impact of PPE on effective communication, facial expression and non verbal communication
- Smaller practices with infrequent clinic delivery affected the ability to reach required volume of patients using the tool
- Anonymity in smaller communities

Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

We continue to review all overnight support provision across Highland. The Inverness Waking Night Responder Service has proven to be a highly effective model of night support and responds to approx. 40 people a night across Inverness.

The demand for the service continues to grow and we are reviewing the existing capacity to enable more support provision. The service also now provides a responder service to individuals in Sheltered Accommodation that do not have the required number of telecare responders.

This indicator is about the quality of life of the people who use those services. Again, this generally shows maintenance of previous performance plus a substantial reduction at year end in delayed discharges awaiting care in the private sector.

The percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life shows a substantial decline, as does the national average. As mentioned previously, this does appear to be a facet of the redesign of the Biennial National survey with both local and national outcomes reducing by the same amount.

To improve Delayed Discharge flow, work commenced to develop a more robust approach to data quality recording and reporting and continues into 2020-21.

In East Ross a falls prevention pilot is being undertaken using the Scottish Patient Safety Programme methodology. This involves all professionals asking the same initial falls screening questions, to identify those needing the full multi-factorial screening (MFS) tool to be used. The aim is to increase the number of social work and social care staff who are able to complete the MFS tool, thus speeding up identification and interventions for those most at risk.

Example:

The Government requested more multi-disciplinary care home assurance visits. This is to provide assurance that measures to mitigate risk of Covid transmission are in place and that physical, emotional and spiritual needs of residents are being met. This requires a blend of professional clinical and social work skills to identify any particular support needs the care home may have to enable a timely response by NHS Highland of any appropriate clinical support, advice or escalations.

A Project Team was set up involving social work, nursing, public health, infection, prevention and control, and allied health professional colleagues.

Assurance visits commenced in February 2021. All 69 care homes in Highland received a quality assurance visit, and any support areas identified as part of the visit have been followed up during 2021-22.

The majority of co-morbidity of physical and mental illness in acute hospitals affecting older people is due to three disorders:

- dementia
- depression
- delirium.

These conditions are a predictor of increased length of stay.

Mental Health

We developed our improvement plans during the year reflecting on the impact of delivering services in a Covid-19 setting. to

provide opportunities for better promotion, prevention and early intervention in mental health while creating more responsive and effective services for people with mental health problems.

Multi Outcomes Case Study Enhanced Community Care Services in Inverness Area

NHS Highland's strategy during 2020-21 was to sustain and accelerate the Covid-19 related shift in the balance of care from acute to community services and to deliver acute care in the community where appropriate.
This would enhance our ability to:

- deliver care and support closer to homes;
- reduce unnecessary admission to acute settings; and
- enhance patient outcomes in line with the principles of realistic medicine.

Funding was provided by Scottish Government in Sept 20, to support Enhanced Care in the Inverness area initially, as this would test the proof of concept and also positively affect the greatest number of patients and client who live in the greater Inverness area. The intention is to rollout the model of care across Highland, if funding is available from 2021-22.

Individual Workstreams include:

- Expansion in community nursing, AHP and social care provision with enhanced teams
- As part of the Inverness pilot we have used additional Scot Govt. funding to support 9 posts in nursing and AHP for anticipatory planning / OOH support / evening district nursing support in Inverness area -some B&S and Nairn developments. We established a Covid (rapid) response team to include nursing and ASC support during 20-21. This helped over2 patients per week to be discharged earlier - 20 in total Oct to Dec. This service is being developed to increase these numbers.
- HomeFirst (treating people at home) helped 2-3 patients per week - 31 in total from Oct to Dec, with an AHP test of change underway.
- The new Coordination Hub led to no Care at Home waits in Inverness, but some future capacity issues are likely e.g. due to winter pressures and sustainability of services.
- Anticipatory Care - This service is facilitating the early identification of a crisis in the community to enable us provide a step up community bed or palliative care, in order to keep people out of hospital when appropriate. At least 4 admissions avoided and 1 appropriate admission per week with 36 patients assisted Oct to Dec.
- The plan, if funding is available, is to roll out the pilot across North Highland from 2021-22. The new bid will include 5 additional nursing posts.
- Enhancing Out of Hours and Primary Care Emergency Centre (PCEC) staffing.

This is linked with the existing OOH care programme as part of our USC redesign.

Another aim is to expand palliative end of life care provision. This work is under development and will dovetail with the Coordination Hub service, with the partnership of Highland Hospice.

The Pilot is also looking at redesign of our Community Assets:

- Re-configure community hospitals as step-up facilities (not step-down)
- We have invested in staff (nurse and AHPs and medical) to enable a community response service to crises and to provide more effective and timely decision making if hospital or home required. 4 beds have been allocated at the Royal Northern Infirmary for this service and since November it has helped to provide rapid response and reduce acute hospital admissions.
- We are looking to develop this service

across North Highland in 2021-22, if funding is available.
- Re-configure NHS Highland care homes as advanced care facilities
- This was not in the bid, and is part of the strategic ASC redesign. It is likely that there will be a nursing resourcing requirement
- Permanently align Care Homes, Community Hospitals and Care at Home services to GP Practices. During 20-21 GPs have aligned to Care Homes as part of the Inverness trial
- Create Community Diagnostic and Treatment Centre in the community

This is a future intention, should funding be available. This will enable more local and agile diagnostic and treatment provision.

Outcome 5

Health and social care services contribute to reducing health inequalities.

This indicator is about ensuring that communities in Highland are safe and healthy and that individual circumstances are taken into account. The premature mortality rate in Highland is lower than the National average.

Performance regarding the time taken to access drug or alcohol treatments services is similar to the performance the previous year, with a gradually improving trend over time. We undertook and continued to implement further substantial strategic work on providing access to Psychological Therapies which commenced 2019-20 and into 2020-21.

Example: Care Home Supports and Engagement

NHS Highland supported care homes and care home providers in a number of ways:

- Development of Covid-19 response framework in March 2020, and establishment of Covid-19 response team to provide mutual aid
- Daily safety huddle (established in March 2020 and now operating as the daily clinical and care oversight group)
- Public Health - Health Protection Team daily contact, outbreak and incident management
- Care Home IPC training resource
- Wellbeing supports, particularly for outbreak situations
- Provider Sustainability payments (through SG programme) for all adult social care providers in Highland
- Open and ongoing communications with the sector, both through dissemination of information (distilled for clear information and key points) and weekly meetings, enabling shared learning and regular opportunities to raise issues.

NHS Highland continues to support care homes and care home providers and following input, the engagement approach with care homes was reviewed to ensure that our contact continues to meet provider and NHSH needs.

Outcome 6

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Carers play a particularly important role in ensuring the health and wellbeing of clients, patients and communities. The purpose of this indicator is to determine if they are supported in that role and takes into consideration their own quality of life. Historically, this has always been a different area in which to capture and record performance information.

The Biennial Survey, which asked this specific question of carers, has been used in the past, but is no longer part of the survey. A review of alternative performance information is programmed for the 1st Quarter of 2021. We are meeting our duties to Carers within current practice and contractual arrangements, whilst reviewing processes to meet the intent, ethos and duties contained within the Carers Act, to deliver an open and flexible response to meeting Adult Carers' needs.

Self-Directed Support

Work is gathering momentum to develop a Highland Self Directed Support (SDS) Strategy. It is being taken forward collaboratively with people with lived experience, unpaid carers, a number of representative groups including Partners in Policymaking, SDS Scotland, SWS Scotland, Community Connections (locally funded SIRD organisation), service providers, social work staff and managers (among others).

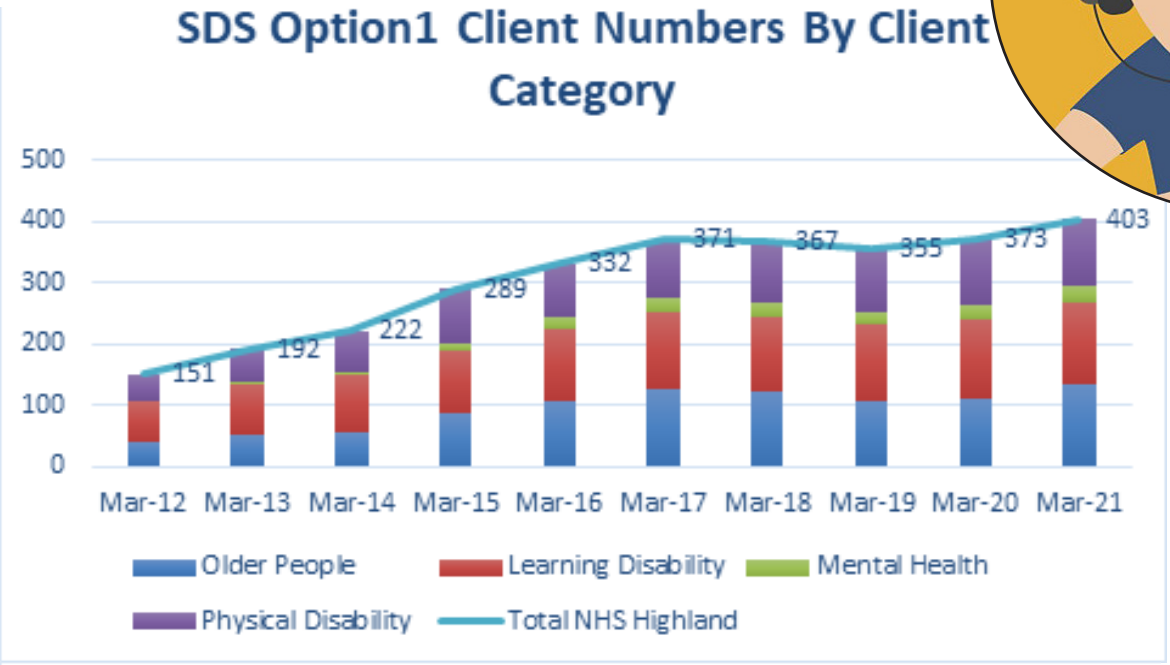
The work on the development of the strategy is being informed by the SDS Change Map, the SDS Standards and the Independent Review into Adult Social Care. Crucially however we are aiming to ensure it will also be shaped by a wide ranging and in-depth engagement and consultation process. Underpinning the work is recognition of the need to address cultural and service change. With the publication of both the SDS Standards and the Independent Review, we believe the timing is absolutely right to progress this important area of work within NHS (North) Highland.

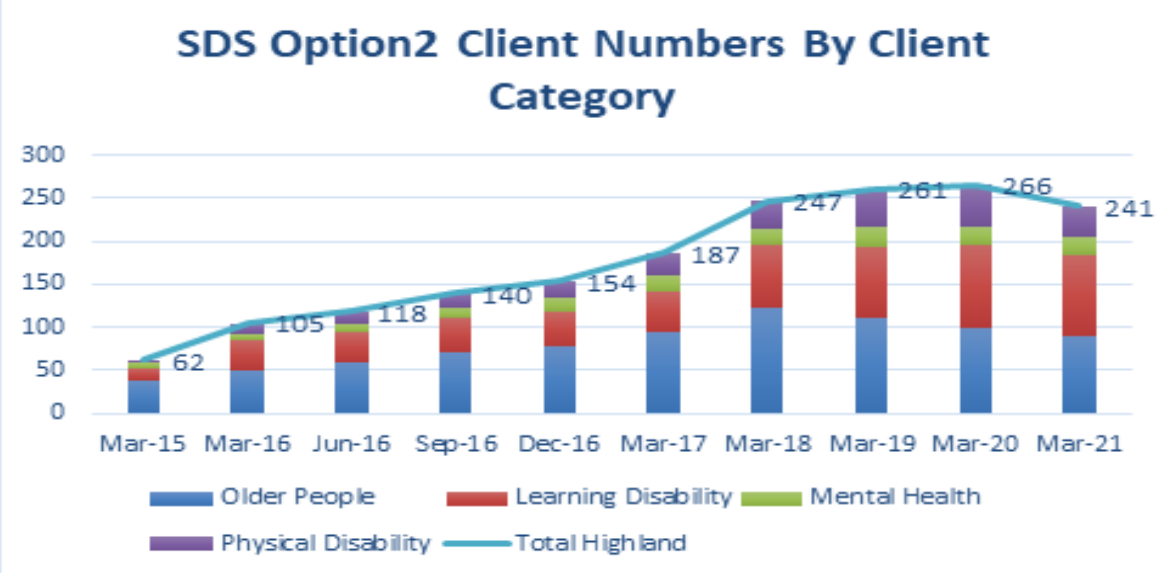
The four options of Self Directed Support are available to any adult who has been assessed as requiring social care support. An outcomes-based assessment can be requested from any NHS Highland Integrated District Team. A personal, outcomes-focused assessment will be completed jointly by the person in partnership with one or more professionals to determine support requirements, with the aim of adopting a strengths-based approach to meeting identified outcomes and considering eligibility for assistance with care and support needs where required. Depending on the individual's circumstances, a financial assessment might also be undertaken. Assessments will normally be reviewed on an annual basis.
In adult services, substantial growth in Self-Directed Support, and in particular Options 1 and 2, has been seen over the last six years as demonstrated at Charts 2 and 3 below, albeit there has been a slight decrease in the number of Options 2s within the past year specifically due to one provider ceasing to provide services which were replaced by an Option 3 traditional service delivery model. We recognise, in keeping with the national picture and the development of SDS Standards, that change is required at a transformational level to ensure more consistent practice in terms of adopting

strengths-based and community-led approaches to practice and highlighting the importance of good conversations, i.e. the development of relationship based practice to inform assessments and support options. As a supportive measure to staff, lead professionals are able to discuss complex cases and the variety of possible support options.

"During lockdown we ensured that all child vulnerable groups were identified and we kept in touch every week using tablet technology and traditional face to face means"

SDS Client numbers by category - Options 1 and 2





Outcome 7

People using health and social care services are safe from harm.

The purpose of this indicator is to ensure that there is support and services in place which ensure that clients are safe and protected from abuse and harm.

There is a drop reported in the percentage reporting as feeling safe, as is reflected elsewhere in the performance outcomes arising from the Biennial Outcomes survey both locally and nationally.

There has been a significant drop in the completion of Guardianship reviews within the required timescale, whilst the number of Guardianships have significantly increased. The total number of reviews undertaken in 2019/20 (which includes both those completed within and outwith timescale) was 40% of the total number of reviews required.
Although the national survey results suggest that clients in the Highlands do feel safer in comparison to the national average, local targets in respect of guardianship are not being met. There is also on-going work underway to define and more accurately record performance with regard to adult protection plans.

This report also reflects on the outcomes of the previous Adult Support and Protection thematic inspection. This provided the Partnership with a strong foundation for improvement that has seen an increase in focus on ASP performance. In 2020-21 we continued in the investment of process improvements and in service data quality recording improvements.

No elements of Adult Protection work were stood down. There were 7 Large Scale Investigations (LSI) in Highland over the past year, with 2 being active at the time of writing. With the exception of one small independently owned care home all had themes relating to senior management not proactively being in care homes, systemic staffing issues leading to unsafe and restrictive practice as well as poor infection prevention control compliance being the main themes. Fire Safety concerns featured in 2 of the investigations. One LSI commenced due to a Covid outbreak, and another experienced an outbreak after the commencement of the LSI.

The number of Adult Protection referrals received for 2020-21 was 636. This represents a 21% increase from last year, 525, and the year before, 344.

One area for improvement has been to improve the timescales for completion of inquiries and investigations. This remains an area for continuous improvement, however there is recognition that some of the factors impacting on timescales – complexity; delays in gathering information from partners and others; and ensuring interventions are conducted sensitively and safely – are not always a reflection of poor practice.

People supported at home reporting feeling safe declined slightly to 82% compared to the national average of 84% in 2019-20. We will continue to address this.

The aim of the Scottish Patient Safety Programme is to reduce the number of events which could cause avoidable harm from care delivered in any setting. Work has been undertaken in the following areas in primary care:

- safety culture
- high risk medicines
- safer medicines
- pressure area care
- safety at the interface including results handling.

The work of the Child Protection Committee

have strengthened their role in undertaking work in the following areas;

- Developing culture and practice in relation to trauma informed and responsive approaches to child protection.
- Review and update Highland Child Protection Guidance in line with updated National Guidance.
- Implementation of National Learning Review Guidance locally.
- Work with the Corporate Parenting Board in developing plans to deliver on 'The Promise'.
- Identify methods for consulting with parents and carers about their experiences of child protection processes.
- Community Engagement Strategy and Plan to be developed to raise awareness of child protection in local communities and encourage communities to report concerns.
- Develop a suite of recommended resources for use with young people in relation to exploitation.

Outcome 8

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Staff attending training find that the training is useful and increases confidence and abilities.
Although the ways of providing that training has changed and developed over the period shown, the measure as to whether it increases staff confidence has been maintained.

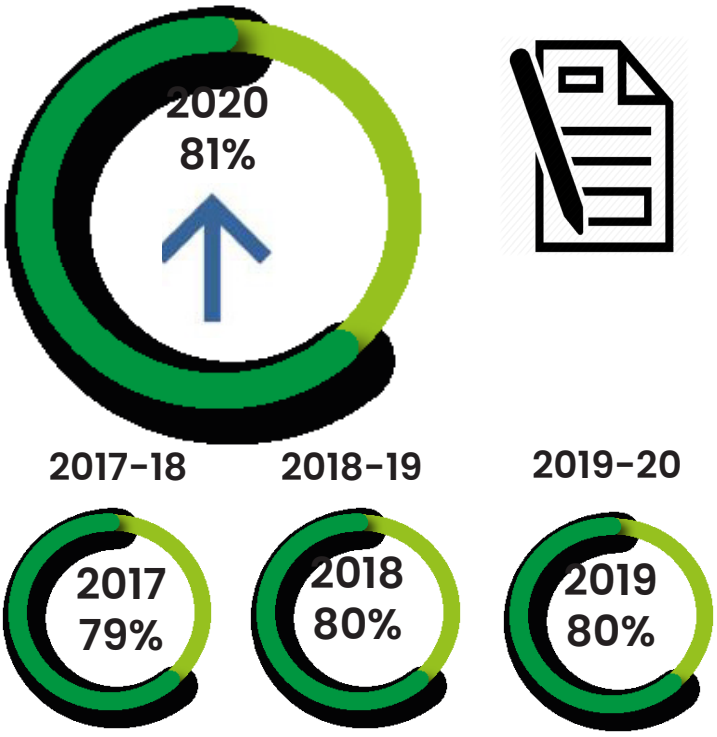
The system for review that staff have the required knowledge and skills framework has changed considerably and are no longer comparable - hence the provision of the 2019-20 figure only. Sickness absence improved in 2020-21 from c. 5.3% to 4.67%.

Workforce development and planning is being taken forward on a number of levels and this is being translated into our Workforce Plan due in September 2021.

During lockdown our gold silver bronze command communications structure was established for key decision making along with regular wellbeing communications to ensure a healthy work-life balance for our staff. Our work on developing our workforce culture continued through 2020-21.

We are measuring our success by the implementation of the iMatter programme which seeks to empower staff in fulfilling their potential as teams.

iMatter results



iMatter 2020

24 of iMatter question responses are in the highest quartile “strive & celebrate”

4 are in the “monitor to further improve” category

There are no responses in the “Monitor to improve” or “Focus to improve” categories

All responses show improvement since 2017

Children & Families

Within children and families our objective is
The achievement of better outcomes for Highland's children, their families and the communities in which they live

Our outcomes
Our outcomes consider the ways in which children and young people;
receive the help and support they need to optimise their well-being at every stage.
get the best start in life and enjoy positive, rewarding experiences growing up.
benefit from clear protocols, procedures and effective systems for recording observations and concerns which take account of best practice in information-sharing.
Our outcomes relate to the impact of services on the well-being of children and young people using the SHANARRI indicators. It focuses on their experiences and the extent to which their lives and life opportunities will be enhanced to ensure they are;
Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included.

This outcome has a specific focus on the following outcomes developed within our quality assurance and improvement framework.

1. Children are protected from abuse, neglect or harm at home, at school and in the community.
2. Children are well-equipped with the knowledge and skills they need to keep themselves safe.
3. Young people and families live in increasingly safer communities where antisocial and harmful behaviour is reducing.
4. Children and young people thrive as a result of nurturing relationships and stable environments.
5. Children, young people and their families are supported well to develop the strengths and resilience needed to overcome any inequalities they experience.

Case Study

Background

The Highland Council successfully bid for 308 Chromebooks and 302 iPads – a total of 610 devices which were allocated to 111 young care leavers and 499 families as part of Connecting Scotland, a Scottish Government programme set up in response to coronavirus.

The programme provides iPads, Chromebooks and support to develop digital skills for people who digitally excluded and on low incomes.

Connecting Scotland is a partnership between the Scottish Government, local councils and SCVO. It's supported by a range of organisations from across Scotland and the UK.

• households with children, or where a child is normally resident. This included pregnant women with no child in the household.

• care leavers up to the age of twenty six (in line with eligibility for aftercare support)

Organisations working with people in the target groups for Phase 2 were able to apply for devices to distribute.

Pregnant women were identified where they couldn't access the patient portal due to digital exclusion. We also asked caseload holders to identify women who disclose financial difficulties during routine questioning at booking and those who may be at higher risk of poverty such as asylum seekers, single parents, unemployed, parents with a learning disability. Health Visitors were asked to identify families on their caseload when routinely enquiring about money worries.

Also identified were digitally excluded children, young people and families working with local Social Work Teams and Aftercare providers who had experienced difficulties with connectivity, particularly during Covid-19 where many have been unable to

participate fully in meetings, social events advocacy and support services.

During Covid-19, a number of families requiring support from Social Work Teams were limited in their ability to fully participate in meetings and reviews. As families relied on virtual contact for continued support this became a particular concern.

Highland currently has 249 young people eligible for an aftercare service. During Covid-19 there was a great deal of work to ensure the needs of care leavers are met. Digital services available for young people in aftercare include home and belonging sessions, provision of advocacy and support, financial advice and skills development. The bid emphasised that digital inclusion will support young people in writing applications, applying for grants or benefits and keeping in touch with loca support networks. This will help improve their life chances and inclusion the care experienced community.

Reporting on localities

As part of Integrated Services, NHS, Council staff and those from the third and independent sectors work with service users, carers and community-based groups to plan and deliver care and support that is designed for the individual.

This is known as 'locality planning' and it is a key part of health and social care integration. It is also a legal requirement under the Public Bodies (Joint Working) (Scotland) Act, 2014.

During lockdown this created opportunities and challenges e.g. establishment of rapid support unit to support hose social care services in need; development of enhanced community services in Inverness to support the needs of a greater population area. This work continues to be developed in line with Covid-19 regulations, in order to optimize our resource and to provide services in line with our strategic objectives.

Inspection of Services

Internal

Internal care services, such as Home Care, Day Care and Respite are regulated and inspected by the Care Inspectorate.

External

Commissioning Officers are responsible for managing the relationship between external providers and our service users.

Any concerns raised about the quality of care provided by an external provider are recorded and considered against other known information about the provider,

such as previous concerns raised; and reports produced by the Care Inspectorate.

Where a concern has been raised, providers are responsible for developing and delivering an action plan identifying planned improvement activity which satisfies the Partnership (and Care Inspectorate if they are involved). This action plan will be monitored by Commissioning Officers to ensure it is being progressed and that improvements are being delivered within agreed timescales. This level of contract monitoring activity will continue until such times until we are satisfied that the provider has made the necessary improvements to ensure the care, safety and wellbeing of residents.

Where no improvement is evidenced, the Senior Management Team will take decisions in relation to any further action required to address on-going concerns, such as reductions in rates paid, increased monitoring activity such as on-site visits, and imposing conditions on the service until issues are resolved or contracts are terminated. Any action taken to address concerns raised about provider's service provision will attempt to do so in ways that put the best outcomes for service users first and which promote safety and wellbeing.

During 2020-21, external inspections into the management of Home Farm Care Home, resulting in the unit being transferred into the management of NHS Highland. The Care Inspectorate carried out a national investigation into the number of care home deaths.

The Mental Welfare Commission also noted the increase of people detained under the Mental Health Act compared with previous years.

A Care Home Oversight Board was established, following a requirement from the Cabinet Secretary for Health and Sport on 17 May 2020, for enhanced clinical and care oversight of care homes. This group considers:

- RAG status (whether there are any care homes on "red" or "amber" status) and actions taken
- Public Health closure status
- Bed capacity
- TURAS compliance (completion of daily TURAS portal by all care homes)
- Care Inspectorate gradings
- New Scottish Government guidance/ requirements and update on implementation
- Mutual aid deployment
- Risks
- Escalations
- Characteristics and dynamics of factors which may impact on the provider base.

Outcome 9

Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services.

Home care costs and residential costs are published nationally. However, there are so many different factors contributing to these costs that national comparisons are largely meaningless. Similarly, the changes made to the payments system for the independent sector means the original indicator is no longer comparable.

Three of these 4 indicators depend on the compilation of national data, which have been delayed during the Covid pandemic.

The number of people waiting to be discharged from hospital when they are ready (Delayed Discharges) decreased during 2020-21. This improvement continues to be a key focus to improve patient flow through the whole health and social care system.

Finance Report to 31st March 2021

Financial Performance and Best Value

Financial modelling for service delivery 2020-21. Despite the operational and financial challenges of the Covid-19 pandemic, there is still a requirement to deliver on savings and a similar programme managed approach will be taken to try and address the funding gap.

For 2021-22 and beyond, discussions continue, with our partners in The Highland Council to develop and agree a Three year cost containment and transformational plan within a joint governance and programme management structure. This is necessary to address the known budget quantum gap with continued support from Scottish Government as required with precise detail of plan, scale of savings and joint ownership to deliver on this ambitious transformational change programme.

Year One
Cost containment, transformation planning and resourcing of programme management team

Years Two and Three
Continued cost containment whist taking forward a comprehensive strategy of transformational change and system wide integration.

Summary

- **Note** HHSCP financial position at month 12 which shows a year end underspend of £2.984m of which £0.729m relates to ASC and the balance being Health expenditure.
- Position includes SG funding in response to Covid-19

Final position to March 2021

For the 12 months to March HHSCP have underspent against budget by £2.984m, components of this overspend can be seen in Table 1 below.

2020 - 2021 Plan		Month 12 - March 2021	YTD Position		
annual budget £000	current plan £000	Summary Funding & Expenditure	Plan to date £000	Actual to date £000	Variance to date £000
		HHSCP			
		NH Communities			
57,452	57,452	Inverness & Nairn	57,452	56,407	1,044
44,885	44,885	Ross-shire & B&S	44,885	44,175	711
39,009	39,009	Caithness & Sutherland	39,009	38,483	525
45,110	45,110	Lochaber, SL & WR	45,110	45,261	(151)
11,624	11,624	Management	11,624	11,582	43
3,677	3,677	Community Other	3,677	3,360	317
1,580	1,580	ASC Other	1,580	1,383	197
5,691	5,691	Hosted Sevices	5,691	5,493	198
209,028	**209,028**	**NH Community**	**209,028**	**206,144**	**2,884**
40,374	40,374	Mental Health Services	40,374	39,869	505
136,547	136,547	Primary Care	136,547	137,013	(466)
5,293	5,293	Adult Social Care Central	5,293	5,234	60
391,243	**391,243**	**Total HHSCP**	**391,243**	**388,259**	**2,983**
		Support Services			
(16,518)	(16,518)	ASC Income	(16,518)	(16,518)	1
7,271	7,271	ASC - Covid 19	7,271	7,271	0
7,526	7,526	Health - Covid 19	7,526	7,526	0
(3,100)	(3,100)	PMO Workstreams	(3,100)	(3,100)	0
(4,821)	**(4,821)**	**Total HHSCP Support Services**	**(4,821)**	**(4,821)**	**1**
386,422	**386,422**	**Total**	**386,422**	**383,438**	**2,984**

Within the Highland (NH) Communities year end out-turn of £2.884m, an underspend of £0.729m relates to Highland Adult Social Care expenditure – see appendix 1 for further detail on Social Care. Adult Social Care for 2020-21 saw a reduction in activity due to Covid-19 and this was reflected in the year end position. The balance within Highland Communities mainly relates to underspends due to both vacancies and non pay this is a direct consequence of Covid-19 due to delays in recruiting and a reduction in community activity.

Mental Health Services have a £0.505m underspend, vacancies (mainly nursing) account for £1.678m of this variance with pressures of £1.081m in medical cover for both the Police Custody/Forensic Service and General Psychiatry.

Primary Care showed an overspend of £0.466m. Pressures in prescribing and locum usage

(2c Practices) are the main drivers for this overspend.

Within HHSCP Support Services, costs for Covid-19 were fully funded by the Scottish Government as well as slippage on the CIP target being covered.

Savings

NHS Highland identified a savings challenge of £28.875m to deliver a balanced position, of which £4.742m identified as part of the GAP and funding of £8.800m provided by the Scottish Government as part of the Covid-19 funding package in respect of slippage against the CIP. The HHSCP received £3.100m of a PMO target along with a £0.900m efficiency target of which £0.788m was met on a recurrent basis.

Conclusion

HHSCP financial position completed the year end with an underspend of £2.984m. This position reflects costs and funding associated with Covid and funding to cover slippage against the CIP.

Governance Implications

Accurate and timely financial reporting is essential to maintain financial stability and facilitate the achievement of Financial Targets which underpin the delivery and development of patient care services. In turn, this supports the delivery of the Governance Standards around Clinical, Staff and Patient and Public Involvement. The financial position is scrutinised in a wide variety of governance settings in NHS Highland.

Risk Assessment

Risks to the financial position are monitored monthly. There is an over-arching entry in the Strategic Risk Register.

Planning for Fairness

A robust system of financial control is crucial to ensuring a planned approach to savings targets – this allows time for impact assessments of key proposals impacting on services.

Engagement and Communication

The majority of the Board's revenue budgets are devolved to operational units, which report into two governance committees that include staff-side, patient and public forum members in addition to local authority members, voluntary sector representatives and non-executive directors. These meetings are open to the public. The overall financial position is considered at the full Board meeting on a regular basis. All these meetings are also open to the public and are webcast.

services category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's	Forecast Variance £000's
Older People - Residential/Non Residential Care	11,563	11,563	11,594	(31)	11,594	(31)
Older People - Care Homes (In House)	29,993	29,993	30,224	(231)	30,224	(231)
Older People - Care Homes (ISC/ SDS)	1,091	1,091	850	241	850	241
Older People - Other Non-Residential Care (In House)	1,151	1,151	1,032	120	1,032	120
Older People - Other Non-Residential Care (ISC)						
Total Older People - Residential/ Non Residential Care	**43,798**	**43,798**	**43,699**	**99**	**43,699**	**99**
Older People - Care at Home						
Older People - Care at Home (In House)	13,966	13,966	13,383	584	13,383	584
Older People - Care at Home (ISC/SDS)	14,534	14,534	14,537	(3)	14,537	(3)
Total Older People - Care at Home	**28,500**	**28,500**	**27,920**	**580**	**27,920**	**580**
People with a Learning Disability						
People with a Learning Disability (In House)	4,079	4,079	3,575	504	3,575	504
People with a Learning Disability (ISC/SDS)	29,620	29,620	29,835	(215)	29,835	(215)
Total People with a Learning Disability	**33,698**	**33,698**	**33,409**	**289**	**33,409**	**289**
People with a Mental Illness						
People with a Mental Illness (In House)	511	511	312	199	312	199
People with a Mental Illness (ISC/SDS)	7,372	7,372	7,531	(159)	7,531	(159)
Total People with a Mental Illness	**7,883**	**7,883**	**7,843**	**40**	**7,843**	**40**
People with a Physical Disability						
People with a Physical Disability (In House)	1,030	1,030	622	407	622	407
People with a Physical Disability (ISC/SDS)	5,905	5,905	5,886	19	5,886	19
Total People with a Physical Disability	**6,983**	**6,983**	**6,508**	**427**	**6,508**	**427**
Other Community Care						
Community Care Teams	6,737	6,737	6,370	368	6,370	368
People Misusing Drugs and Alcohol (ISC)	35	35	21	13	21	13
Housing Support	5,200	5,200	5,229	(29)	5,229	(29)
Telecare	897	897	641	256	641	256
Total Other Community Care	**12,869**	**12,869**	**12,261**	**608**	**12,261**	**608**
Support Services						
Business Support	1,986	1,986	1,788	199	1,788	199
Management & Planning	29	29	1,541	(1,512)	1,541	(1,512)
Total Support Services	**2,015**	**2,015**	**3,329**	**(1,314)**	**3,329**	**(1,314)**
Covid 19	**7,271**	**7,271**	**7,271**	**(0)**	**7,271**	**(0)**

services category	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's	Forecast Variance £000's
Total Adult Social Care Services	**142,970**	**142,970**	**142,241**	**729**	**142,241**	**729**
ASC Services now integrated within health codes	**3,764**	**3,764**	**3,764**	**0**	**3,764**	**0**
Total Integrated Adult Social Care Services	**146,734**	**146,734**	**146,005**	**729**	**146,005**	**729**
Three Care Categories account for 74% of total spend on ASC						

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
1.1	Percentage of adults able to look after their health very well or quite well	To maintain or increase	95% (2015/16)	93% 2019/20	A	A	94%	Current (Biannual Report 2019/20)
1.2	Emergency admission rate (per 100,000 population)	To reduce	10,971 (2014/15)	10,779 2020/21	G	R	9,666	Current
1.3	**South & Mid** Enablement: % of people receiving enablement interventions that do not require ongoing care interventions after initial 6 weeks	40%	39%			R	19%	Current
	North & West Enablement: % of people receiving enablement interventions that do not require ongoing care interventions after initial 6 weeks	40%	29%			A	25%	Current
1.4	The number of health screenings provided for people with learning disabilities: all people with learning disabilities and epilepsy are offered an annual nurse led review of their condition	To maintain or increase	97%			R	98%	Current
1.5A	Sensory Impairment (Sight)- Self Management (Client Outcomes), % of completed rehabilitation courses who have achieved independence or achieved independence above expectation	90%	71.6%				85%	Current
1.5B	Sensory Impairment (Hearing)- Self Management (Client Outcomes), % of completed rehabilitation courses who have achieved independence or achieved independence above expectation	90%	47%			R	84%	Current

Outcome 2
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
2.1	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	To increase	83% (2015/16)	81% 2019/20	A	R	82%	Current (Biannual Report 2019/20)
2.2	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	To increase	77% (2015/16)	75% 2019/20	R	R	75%	Current (Biannual Report 2019/20)
2.3	Readmission to hospital within 28 days (per 1,000 discharges)	To reduce	92 (2014/15)	116 (2020/21)	G	R	113	Current
2.4	Proportion of last 6 months of life spent at home or in a community setting	To increase	89% (2014/15)	91% 2020/21	G	G	92%	Current

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
2.5	Percentage of adults with long term care needs receiving care at home (LTCs are health conditions that last a year or longer, impacts on a person's life, and may require ongoing care and support)	To increase	54% (2014/15)	63% 2019/20	R	A	55%	Current
2.6	% of people aged 65 or over with long term care needs receiving personal care at home	To increase	51.03%	60%	R	G	56%	2018/19 Waiting SOLACE pub
2.7	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)	Better joint working and use of resources	1455 (2014/15)	774 - 2019/20	R	G	834	Current
2.8	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (cost of emergency bed days for adults)	To reduce	23% (2014/15)	20% 2020/21	A	A	20%	Current
2.12	Uptake of SDS option 1 - Mid	To increase	72				115	Current
	Uptake of SDS option 1 - South		143				114	Current
	Uptake of SDS option 1 - North		35				52	Current
	Uptake of SDS option 1 - West		82				122	Current
	NHS Highland Option 1 Total Clients		332			G	403	Current
	Uptake of SDS option 2 - Mid		26				57	Current
	Uptake of SDS option 2 - South		55				110	Current
	Uptake of SDS option 2 - North		5				16	Current
	Uptake of SDS option 2 - West		19	N/A			58	Current
	NHS Highland Option 2 Total Clients		105			R	241	Current
	Uptake of SDS option 3 - Total		4541	TBC		G	4987	Current
	Uptake of SDS option 4		120	TBC			164	Current
2.13A	Age of admission to long-term residential and nursing care (All Adults)	To increase	76	78	R	A	73	Last published 2017
2.13B	Age of admission to long-term residential and nursing care (Older People)	To increase	81	81	A	G	82	Last published 2017
2.14A	Length of stay in long-term residential and nursing care (All Adults)	To reduce	2.5 YRS	2.3 YRS	R	G	0.4 YRS	Last published 2019
2.14B	Length of stay in long-term residential and nursing care (Older People)	To reduce	2.7 YRS	2.3 YRS	R	G	0.6 YRS	Last published 2019
2.15A	Total number of adults receiving basic or enhanced Technology Enabled care	To increase	Basic 1,929	N/A	R	R	Basic 2332	Current
			enhance 419				enhanced 529	
			total 2348				total 2861	

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
2.15B	Percentage of referrals received per quarter with reason given 'to enable to remain at/return home' & 'to enable independence'	To increase	46/137 33.6%	This is a national dataset but there are no published results at this time	R	R	126/772 16.32%	Current
2.15C	Percentage of new installations in quarter with activity monitors i.e falls monitors	TBD	30.5%	This is a national dataset but there are no published results at this time		G	43.6%	Current

Outcome 3

People who use health and social care services have positive experiences of those services, and have their dignity respected.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
3.1	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	To increase	73% 2015/16	74% 2019/20	R	R	69%	Current (Biannual Report 2019/20)
3.2	Percentage of adults receiving any care or support who rate it as excellent or good	To increase	83% 2015/16	80% 2019/20	G	R	79%	Current (Biannual Report 2019/20)
3.3	Percentage of people with positive experience of the care provided by their GP practice	To maintain	89% 2015/16	79% 2019/20	G	R	85%	Current (Biannual Report 2019/20)
3.4	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections and proportion graded 5 or above	To increase	76.8% 2015/16	83% 2019/20	R	A	83%	Current
3.4A	Care Homes with grade 4 or better Independent Sector (Local Indicator)	100%	78.6%		R	A	82.4%	Current
3.4B	Care Homes with Grade 4 or better In House (Local Indicator)	100%	82.4%		R	A	80%	Current
3.4C	Care Homes with grade 5 or better -Independent Sector (Local Indicator)	To maintain or increase	35.7%		R	A	47.1%	Current
3.4D	Care Homes with grade 5 or better In House (Local Indicator)	To maintain or increase	29.4%		R	A	46.7%	Current
3.4E	Care at Home with grade 4 or better Independent Sector (Local Indicator)	To increase	87.5%		G	A	100%	Current
3.4F	Care at Home with grade 4 or better In House (Local Indicator)	To increase	100%		A	A	100%	Current

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
3.4G	Care at Home with grade 5 or better Independent Sector (Local Indicator)	To increase	37.5%		G	R	52.6%	Current
3.4H	Care at Home with grade 5 or better In House (Local Indicator)	To increase	0%		G	A	33%	Current
3.5A	People with a Sensory Impairment(s) - Sight - who have undergone an assessment, confirm an understanding of their condition	90%	96%			G	96%	Current
3.5B	People with a Sensory Impairment(s) - Hearing -who have undergone an assessment, confirm an understanding of their condition	90%	65%			G	90%	Current
3.6A	People with a Sensory Impairment(s) - Sight -who have undergone an assessment, confirm information on their condition is available and accessible in a format of their choice	90%	96%			G	96%	Current
3.6B	People with a Sensory Impairment(s) - Hearing -who have undergone an assessment, confirm information on their condition is available and accessible in a format of their choice	90%	57%			R	17%	Current

Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
4.1	Delayed hospital discharges for service users residing within areas covered by ISC C@H providers	ZERO	20 Total 13 IMF 7 N & W	N/A		G	20 Total 17 IMF 3 N & W	Current
4.3	Emergency bed day rate (per 100,000 population)	To reduce	116,910 2014/15	95,155 2020/21	G	G	91,908	Current
4.4	Falls rate per 1,000 population aged 65+	To reduce	17 2014/15	21 2020/21	G	R	15	Current
4.5	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	To increase	85% 2015/16	80% 2019/20	G	R	78%	Current

Outcome 5
Health and social care services contribute to reducing health inequalities.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
5.1	Premature mortality rate (per 100,000 population)	To decrease	374 2014/15	527	G	G	390	Last published 2019/20
5.2	People who have dementia will receive an early diagnosis: maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources	To increase	N/A		G	G	2284	Last published 2019/20
5.3	The number of people with learning disabilities who are in further education	To increase	9.32%	7.6%	G	G	10.4%	Last published 2018
5.4	Deliver faster access to mental health services and 18 weeks referral to treatment for Psychological Therapies	90%	80%	80.9% Mar 21	G	G	76.9%	Current
5.5	The time taken to access drug or alcohol treatment services	90% or higher	77%	Full Year %s 95.6% Mar 21	R	R	81.4%	Current

Outcome 6
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
6.1	Percentage of carers who feel supported to continue in their caring role	To increase	37% 2015/16	34% 2019/20	R	R	33%	Last published 2019/20

Outcome 7
People using health and social care services are safe from harm.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
7.1	Percentage of adults supported at home who agree they felt safe	To increase	84% 2015/16	83% 2019/20	G	R	82%	Current Biannual Report 2019/20
7.2	Adult Protection Plans are reviewed in accordance with Adult Support and Protection (ASP) Procedures	90%	57%	N/A	N/A	G	73%	Last published 2019/20
7.3	Reviewing and monitoring of Guardianships. Number of Guardianships reviewed - annual required timescale.	TBC	50%	N/A	N/A	R	5.8%	Last published 2019/20
7.4	Reviewing and monitoring of Guardianships. Number of New Guardianships reviewed within required timescale of 3 months	TBC	57%	NA	N/A	G	13.6%	Current

Outcome 8
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
8.2	Workforce is Adult Support and Protection effectively trained	TBC	100%	N/A		R	886	Current
8.3	People and professionals across Highland can access and benefit from Sensory awareness training "I have increased skills and tools that enable me to communicate in a way that I want"	100 People annually				G	722	Current
8.4	Employee Engagement Index (from iMatters) (EEI Score calculated based on the number of responses for each point on the scale (Strongly Agree to Strongly Disagree) multiplied by its number value (6 to 1). These scores are added together and divided by the overall number of responses to give the score to show level of engagement)	To increase	74% 2019	H&SC Response rates 76 - 2019	R	G	74%	Measure changed - clarity required
8.5	Uptake of Knowledge and skills Framework	TBC	27.3%			R	14.9%	2019
8.6	Sickness absence levels	TBC	4.88%	4.67 Mar 21	G	G	4.43%	Current

Outcome 9
Resources are used effectively and efficiently in the provision of health and social care services.

KEY	INDICATOR	TARGET	BASELINE	BENCHMARK	COMPARISON	CURRENT	CURRENT VALUE NH	DATA CURRENCY
9.1	NHSH make payment of the C@H tariff rate within 28 days of receipt of a valid invoice	To increase	83.34%				89.56%	2018/19 measure no longer valid
9.2	Home Care costs per hour for people aged 65 or over	No target	£31.18	£20.24	N/A	N/A	£29.46	2018/19 Waiting SOLACE publication
9.3	Self Directed Support (option 1) spend on people aged 18 or over as a % of total social work spend on adults	No target	4.16%	6.9%	R	A	6.40%	2019/20 Waiting SOLACE publication
9.4	Net Residential costs per resident per week for Older Persons (over 65)	No target	£410.77	£371.43	N/A	N/A	6.40%	2019/20 Waiting SOLACE

Key for all tables

Benchmark is Scottish Average or local average where known
Comparison benchmark is Scottish Average

Performance is improving
Performance is stable
Performance is declining