HIGHLAND HEALTH & SOCIAL CARE GOVERNANCE COMMITTEE
Report by Committee Chair

The Board is asked to:

- **Note** that the Highland Health & Social Care Governance Committee met on Wednesday 11 January 2023 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Gerry O'Brien, Board Non-Executive Director - In the Chair
Tim Allison, Director of Public Health
Louise Bussell, Chief Officer
Cllr, Christopher Birt, Highland Council
Ann Clark, Board Non-Executive Director and Vice Chair of NHSH
Cllr, Muriel Cockburn, Board Non-Executive Director
Claire Copeland, Deputy Medical Director
Cllr, David Fraser, Highland Council (until 2pm)
Cllr, Ron Gunn, Highland Council
Joanne McCoy, Board Non-Executive Director
Michael Simpson, Public/Patient Representative
Wendy Smith, Carer Representative
Michelle Stevenson, Public/Patient Representative
Simon Steer, Director of Adult Social Care
Neil Wright, Lead Doctor (GP)
Mhairi Wylie, Third Sector Representative

In Attendance:
Rhiannon Boydell, Head of Service, Community Directorate
Stephen Chase, Committee Administrator
Lorraine Cowie, Head of Strategy & Transformation
Pam Cremin, Deputy Chief Officer, Highland Community
Frances Gordon, Finance Manager
Arlene Johnstone, Head of Service, Health and Social Care
Fiona Malcolm, Head of Integration Adult Social Care, Highland Council (until 2pm)
Jo McBain, Deputy Director for Allied Health Professionals
Kara McNaught, Area Clinical Forum Representative (until 3pm)
Boyd Robertson, Chair of NHS Highland Board
Ian Thomson, Head of Service: Quality Assurance; Adult Social Care

Apologies:
Kate Dumigan and Elaine Ward.

1 WELCOME AND DECLARATIONS OF INTEREST

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

The meeting was quorate.

- The Chair thanked A Clark for her considerable work as outgoing Chair to the Committee, and that the change in chairing arrangements reflected good governance procedures as agreed by the Board.
- M Stevenson noted an interest in item 3.3.1 as Patient Representative but on consideration felt that there was no conflict of interest.
- The Chair congratulated Louise Bussell on behalf of the Committee following her appointment to Director of Nursing for NHS Highland to take effect from February 2023. Pam Cremin will be undertaking a recruitment exercise for the Interim Chief Officer and a Mental Health Service Manager will be able to be recruited.
- The Chair requested that item 5.2 be considered at this point in the meeting.

2 FINANCE

2.1 Year to Date Financial Position 2022/2023 [PP.1-9]

F Gordon gave an overview of the month 8 position from the paper on behalf of E Ward and invited questions from the Committee.

During discussion, the following points were addressed,

- A Clark requested more information about the year-end position and how things have changed in terms of the overall picture for Adult Social Care over the course of the year, and how much of the non-recurring monies had NHS Highland invested across the year with the aim of mitigating the overspend position at the year end?
- F Gordon noted that there had been considerable investment within the partnership on various services and a plan is in development to identify areas to target. It was suggested that a fuller breakdown of what remains in the balance and allocations in the Partnership for Adult Social Care can be brought for future meetings.
- M Simpson asked if it was feasible for NHS Highland to set up its own agency for staffing in order to address the spend on locum and agency staff.
- F Gordon answered that NHS Highland does have a bank service agency (which is promoted to reduce agency costs), however the setting up of an additional company is not something that had been explored.
- L Bussell and the Chair added that one of the significant challenges is that bank service will never be able to offer as high a rate of pay as an agency. There are further challenges that would have to be met in setting up an ‘in house’ agency regarding the legal implications and demands of terms of conditions which set pay at Agenda for Change levels.
- L Cowie commented that there is a specific workstream in progress to look at how the organisation contracts different agencies, works to address expanding the skill mix and makes for more attractive conditions of work.
- J McCoy asked if there had been any update on a work stream with Scottish Government to reducing agency costs that had been mentioned at a previous reporting.
- L Cowie commented that this national piece is encountering several challenges to its progress but that the committee will be informed of progress as it arises.
- J McBain commented that anecdotal evidence had shown that flexibility of working had been one of the key factors in people wanting to work on a locum basis even though the package for NHS Highland has many benefits including sickness cover and maternity rights which agency staff lack, and that therefore there is a need to understand these other motivations in aiming to attract permanent staffing.

- P Cremin commented that discussions have been had on a North Scotland basis to address these issues and that a solution had not yet been found.

- G O'Brien asked what approach could be tried to achieve a different outcome for next year in terms of operational overspends and identifying significant areas of transformation and savings.
- L Bussell noted that a number of meetings had been had with the Highland Council, on these challenges and changing needs, and to consider what areas might require a reduction in funding. These conversations are ongoing with the Highland Council and proposals are being worked up over the next couple of weeks. The Committee will be kept informed at its meetings of these developments.

After discussion, the Committee:	
– **AGREED** to receive **limited** assurance from the report.	

3 PERFORMANCE AND SERVICE DELIVERY

It was agreed that item 3 of the Chief Officer's report on Care Home Pressures would be discussed at this point in the meeting to allow for fuller participation (see 3.7 below for minuting).

3.1 Assurance Report from Meeting held on 2 November 2022 [PP.10-21]

The draft Assurance Report from the meeting of the Committee held on 2 November 2022 was approved by the committee as an accurate record.

The Chair noted that he had reviewed the rolling actions and proposed a course of action for each in order to close off these items.

The Committee
– **Approved** the Assurance Report, and – **Noted** the Action Plan.

3.2 Matters Arising From Last Meeting

3.2.1 Following M Simpson's request for information on energy costs for NHS Highland a spreadsheet was made available to the committee detailing costs.

3.2.2 Following W Smith's request for further information on Carer pay a spreadsheet was made available to the committee.

In discussion, the following points were addressed,

- I Thomson responded to questions about the document, noting that he was not involved in setting the budget but had some oversight of the Carers' Programme Budget.
- He noted that there had been some unused expenditure and in order to use it up it was determined that it should be used as an accelerated means to support short breaks for carers targeted for eligible need especially in light of current cost of living pressures over the winter period, provided not as a power under the act but as a duty.
- These funds are non-recurrent and there will be a need to address how such support can be met in the future.
- A Clark commented that it was difficult to get a sense of the scale of what the potential problem might be for addressing this and other unmet need for carers if it is not possible to fund this next year.
- The Chair commented that he will meet with the Chief Officer to address when the Carer Strategy should next come to the Committee and address these concerns.
- J McCoy asked for more detail about Carer Involvement in the 2023-24 projection.

- I Thomson answered that this was connected to consultation on the new care strategy in order to support the independent voice of unpaid carers. The line is there to support provision of replacement care costs for those carers involved in the consultation and to support some grassroot initiatives to bring the carers together with the potential for assisting support for a carers union.
- W Smith asked if the financial support for carers was to meet assessed needs.
- I Thomson confirmed that it is about a duty under the act and is to support assessed need as the result of an adult carer support plan and where people have been seen to be in critical or substantial need. There are existing routes through traditional district care planning, but this acts as a quick route to address difficult circumstances provided as a duty given the circumstances of the winter cost of living crisis.
- I Thomson added that there are some rules that still apply to the assessment, for example, if a person was a power of attorney or a proxy of any sort, then they cannot be paid.
- W Smith asked if instead of some of the activities on offer to unpaid carers funds would be better spent on supporting breaks or the fast-tracking of care packages.
- I Thomson acknowledged the suggestion and noted that he would like to take this area forward with a disinterested group of unpaid carers to shape future expenditure.
- M Cockburn commented that it is essential that unmet needs are identified especially in addressing early support and prevention.
- In summing up, the Chair noted that he would be speaking to L Bussell, I Thomson and W Smith to ensure that the next update sufficiently addresses the above discussion in the implementation of the Carers Strategy.

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

3.3 Community Services District Reports (Nairn and Mid Ross) [PP.22-45]

R Boydell introduced the reports which were presented for information and discussion by the Committee as to what information and format would be most beneficial.
The reports had been written by district managers and reflected different styles of presentation and kinds of information.
The Mid Ross District report featured successful work with its Assessed to Home Programme.

In discussion,
- M Simpson commented on the need for a framework to assist the Committee in assessing the reporting with some consistency.
- Clarity was sought on reference to the backlog of maintenance at Mid Ross Memorial Hospital (p.25) and if fire compliance was a part of this backlog and if the recommendations made by the Fire Service had been carried out.
- R Boydell answered that there is a visit by the Fire Service every year and that the Estates Department work with the Fire Service to ensure work is done and mitigating actions are carried out.
- There has been a short delay in carrying out some of the work but there is a plan in place and contingency planning around staffing and evacuation is in place.
- L Bussell added that an interim plan has been developed with Estates. Some of the fire compliance work is disproportionately expensive for the part of the building concerned and therefore the plans involve a reconfiguration of the layout of services so that the firework is appropriate for the services within that part of the building,
- T Allison commented that with the particular demography of Highland there is a need to take care with locality reporting especially around the reporting of percentages rather than absolute numbers due to the sometimes significant variance in age groups and associated health needs in different localities.

- M Stevenson commented that fire compliance work that was meant to have taken place within the General Ward had not started yet, and asked if there was funding to carry out that work and if the Rheumatology Unit would be impacted by proposed changes to the layout.
- L Bussell answered that all fire compliance work would be carried out but that due to the age of the building it had been necessary to consider reconfiguring service use and layout. There would not be additional funding available in the short term which would give some time to consider best use of the facilities of the building as a whole. The Rheumatology Unit would not be impacted by the changes.
- L Bussell commented that the reports were very much a first attempt at locality reporting for the Committee and would be developed further with the possibility of including reporting on Mental Health and Third Sector provision for districts and how these align with the NHS Highland Annual Delivery Plan.
- A Clark commented that she would send the Chair some thoughts on the format and content of the reports.
- A Clark noted that the reports laid bare the challenge faced by staff faces in meeting increasing demand within fixed or reducing real term budgets, and raised interesting questions about how successful approaches to addressing equity across the health board are addressed.
- It was asked if the data on average length of stay in the Mid Ross report would be useful to compare across our community hospitals and future within the IPQR.
- L Cowie noted that discussions are underway about delayed discharge in local hospitals but that further meetings are planned where comparable factors across Highland, Argyll and Bute and the rest of Scotland could be considered for future reporting.
- It was asked what the outcome was of the discussions at SLT I response to these reports and what can you know, conclusions or key issues were raised.
- L Bussell answered that different local reports had been considered at the last SLT meeting
- And it was felt that such reports had given managers a rich picture of exactly what had been happening in each of the areas and the unique challenges for those areas and what were the replicable challenges.
- M Stevenson asked if the underspend of £78,000 for Mid Ross Memorial Hospital had been reallocated within the hospital.
- R Boydell clarified that the figure was for the previous year and was not a true underspend at end of year having been taken into the bottom line at the end of the year.
- M Cockburn asked if it was possible to use these reports to raise awareness of good practice among areas.
- R Boydell answered that there is programme of work focused on the movement of patients through the system to ensure people go through the system and avoid admission and stay wherever possible, in their community. These pieces of work are being shared in various working groups. The aim is to standardize as much as possible of this work and measure its impact.
- N Wright commented that the district managers had used the reports to highlight some of the really positive work and asked if this would be shared with other stakeholders in areas which are under development such as Caithness or Lochaber.
- C Birt commented on the percentages reported and that the data as presented was not necessarily comparable across different localities.
- T Allison commented that with the particular demography of Highland there is a need to take care with locality reporting especially around the reporting of percentages rather than absolute numbers due to the sometimes significant variance in age groups and associated health needs in different localities. He noted that percentages reflected reporting within practices and the measure of the burden of a disease in that local area and therefore not necessarily comparable across localities. However, there was opportunity here to work with colleagues in Health Intelligence and elsewhere to try and standardize the reporting as much as possible. The data, even unstandardized, demonstrated the level of need in those particular areas.

- L Cowie added that there is an agreement with Primary Care under review to get standardized data extracted direct from Primary Care systems to address these concerns for benchmarking. Some of the other health boards currently do this data extraction work and therefore it would be possible to benchmark against their figures.

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

3.4 SDS Strategy Assurance Report [PP.46-52]

I Thomson provided an overview of the report and noted that the SDS Strategy implementation had focussed on the culture and practice of Integrated Care and Adult Social Care. He noted that there had been a number of national reports that suggested SDS had lost its way across Scotland with various hurdles and convoluted assessments, losing some of the creativity needed to find community solutions for individuals.
The workforce have felt the impact of increasing levels of paperwork which have tied them to traditional ways of working, and this has meant that staff had not often been accessing solutions from the community.
A reference group of interested parties, workers, supported individuals, carers and some national groups were brought together to develop a new strategy and a consultation document was produced to set out its ambitions and plans to enable person-centred care.
The aim of the planning is to build relationships and find solutions from the bottom up and deal with the complexity of negotiating the various elements, and to make those who need support aware of the packages and potential help available.
The strategy is still a live work in progress.

- C Birt asked for clarity as to whom Self-Directed Support was aimed at.
- I Thomson confirmed that older people make the largest component of those concerned but a number of other groups under the remit included adults with a learning disability, adults with mental health difficulties and physical disability.
- P Cremin commented that events such as the recent closure of a nursing home had shown that not all staff wanted to transfer to NHS Highland but that some wished to have a more flexible arrangement in terms of their hours and therefore could be engaged as a workforce to respond to self-directed support and thereby strengthen work around care in communities and provide an alternative to the problems around recruitment in areas such as care at home. Respite Care has been temporarily suspended at Dalmore and some staff have gone into the community. I Thomson and P Cremin are working with the partnership group there as a test case for responsive self-directed support in the community.
- A Clark commented that constant evaluation was key to demonstrating success against the key measures and asked if work had been identified to address this.
- I Thomson answered that plans were not at this stage yet and that there would be a need for a number of proxy measures to do simple evaluation work with partners and get processes up and running.
- A Clark commented that with Scottish Government interest in this area that it would be worth seeing what could be done to obtain funding to partner with UHI or another partner with experience of setting up an evaluation program for this kind of culture change such as Evaluate Scotland.
- W Smith added that there has been recent work carried out in related areas by the University of Strathclyde in relation to developing awareness of human rights across Scotland which had involved evaluating the work of unpaid carers.
- R Gunn commented that this would be a good project to demonstrate more widely how NHS Highland is listening to its population to effect real change.

- The Chair, in summing up, noted the importance of implementing evaluation work and that it would be valuable to explore partner opportunities with researchers and organisations with experience of relevant research methodologies.
- The Chair added that for the next update in around a year's time it would be useful to demonstrate some such evaluation process notwithstanding the long term nature of the work.
- I Thomson thanked the Committee for its comments and noted that he would explore the suggested partner opportunities.

The Committee:
– **AGREED** to accept moderate assurance from the report.
– **Agreed** that an update return to the committee in a year's time.

The committee held a short break at this juncture and reconvened at 3.10pm.

3.5 Community Services Risk Register [PP.53-57; Updated version circulated separately]

P Cremin introduced the report and circulated an updated version of the paper, which included additional detail around the DATIX system. The paper was brought for assurance of regarding the actions and mitigations to manage risks.

During discussion the following questions were addressed,

- W Smith asked if the focus around health and safety ligature points came under general safeguarding and if it had been picked up by the Mental Health Commission or another kind of inspection.
- P Cremin answered that there had been an expected visit from Health and Safety Executive to mental health hospitals as part of their national work across health boards looking at buildings, compliance and NHS Highland's ability to provide safe areas of care.
- W Smith asked how NHS Highland is meeting its outcomes for compliance in these areas and if there had been any specific concern for New Craigs.
- A Johnstone answered that there were a series of different routes for overseeing ligature risks within NHS Highland. There is steering group which feeds into Mental Health and Learning Disability groups, which then feed into the Capital Assets Group. The team work closely with Estates colleagues, however there are complications due to New Craig's operating under a PFI with the building owned by Robertson's, and therefore it is a triangulated discussion.
- Audits have been carried out in each ward and these are being currently being refreshed as a result of demands from the recent HSE inspection. A series of meetings have been set up to ensure compliance with the requirements of the inspection.
- A number of the ligature risks have already been removed from the wards within New Craigs, and there is a long term piece of work to assess which parts of New Craigs are high risk or high cost and how to work pragmatically to close wards and decant the patients in order to carry out the necessary work.
- The bigger pieces of work, for example the doors and the windows, will require extensive capital funding and funding applications are in process.
- A Clark commented that she would send some ideas for developing the work of the report to P Cremin and asked if earlier risks around the premises of Sexual Health Services had been resolved.
- P Cremin answered that there had been positive developments with the purchasing of another modular building to be placed adjacent to the current location and that she would come back with more detail on this.
- A Clark also asked what would be required to elevate the recommended assurance level to 'substantial assurance'.
- P Cremin answered that this would be a case of demonstrating areas of escalation and mitigation and where there had been good outcomes in terms of recognizing risks and working through the mitigation to a successful outcome or an adverse outcome. It would

be key to show learning from these processes and that work to develop the process was ongoing. The team have recently partnered up with support from the Planning and Performance team to consider dashboard reporting to better demonstrate actions and outcomes around the risks to better give assurance to the Committee.

- L Cowie commented on the need to carry out training for senior leaders across the organization to help understand the difference between risks and issues and how each are scored, to provide more context on a Health and Social Care Partnership basis, but also to the wider Board Risk Register to better understand what can be done at an individual and at a Board level.
- J McCoy thanked P Cremin for the additional information provided by the updated version of the report and commented that timescales would also be a useful addition.
- P Cremin noted that the DATIX system records when a risk is due for review and that all action plans have associated dates for completion which are updated in the risk register. The Community Risk Register Monitoring Group oversees these risks for the purposes of assurance.
- J McCoy also asked if the figures in the report had been discussed with staff so that they understand the implications of this work and be offered support in terms of their work capacity.
- A Johnstone noted that the HSE inspection had asked that frontline staff be included more in planning meetings to address some of these issues so that they are more fully involved in the piece of work. Work towards implementation is at an early stage but it is likely to include a module on TURAS around ligature risks.

- The Chair suggested that risk of access to medium and low secure beds be considered at the next meeting as a part of the Mental Health update, especially in terms of mitigation to address individuals best served by medium and low secure units.
- The Chair also suggested that an update to this work come in around 9 months (to be determined with the Chief Officer) to get a sense of the direction of travel.

The Committee:	
– **AGREED** to accept **moderate** assurance from the report.	

3.6 IPQR Dashboard Report [PP.58-61]

L Cowie introduced the report and noted that this was the second time the IPQR had come to the Committee and demonstrated an iterative process as work continues to align the metrics with Together We Care, the Annual Delivery Plan, the needs of the Committee and the Joint Strategic Plan with Highland Council.
The latest version had included much information on delayed discharges to show particular challenges in areas such as Care At Home, Care Homes and Adults with Incapacity to show you the individual areas that pose challenges within delayed discharges.
Drug and Alcohol reporting was a new addition as was Non Reportable Waiting Lists, the latter of which encompass the work of community mental health teams. The next aim for the report is to incorporate areas such as Dietetics and Podiatry.

In discussion,

- The Chair asked, when can the Committee expect to start to see this data reflected and picked up in other reports that come to the Committee.
- L Cowie noted the aim to the reporting. of bringing data together in a consistent manner across the organisation in order to have greater consistency more broadly of reporting and responses and commented that it was a gradual process but one that should be come clearer over the next 12 months.
- A Clark asked for some more detailed commentary on what the data was telling the Board in specific areas such as Physiotherapy and Community Mental Health.

- A Clark questioned whether the proposed level of moderate assurance proposed was appropriate given general levels of waiting times and the fragility of some service areas.
- L Bussell responded that one of the challenges faced by individual teams is that they will need to be cited regularly on the data in order to better understand the position. Where teams have been cited on reporting improvements have been seen but many are at an early stage in terms of understanding the data and responding appropriately as with the Drug and Alcohol team for example which is an area where a level of moderate assurance could be relevant.
- L Cowie noted the difficulty of providing assurance to cover a wide range of performance indicators which made it difficult at times to highlight areas of success within teams.
- A Clark suggested that discussion at Committee was a good opportunity to highlight positive team stories and show the effort and context within which teams are working.
- T Allison commented on the need for both report authors and committees to work to better understand the ask of each in terms of what the committee is being assured of and that this is a process of development.
- A Clark suggested that a discussion be had with the Board Secretary, Ruth Daly about how best to address levels of assurance at the governance committees for better consistency of reporting and understanding.

In summing up, the Chair proposed that the Committee **accept limited assurance** overall but aim to capture recognition of areas which are performing well in future minuting.
He noted that there is a strong argument for consistency of assurance received between governance committees and that limited assurance is suitable in these circumstances due to the scale of the work and the wider risks involved.

The Committee:
- **Accepted limited assurance** from the report.

3.7 Chief Officer's Report [PP.62-69]

L Bussell introduced the report having spoken in more detail earlier in the meeting about part 3 of the report on Care Home Pressures (see below), and invited questions from the committee.

In discussion,
- A Clark asked about MAT standards and to what extent the quality improvement codesign has involved people with lived experience in the improvement actions in areas such as the proposed advocacy services.
- L Bussell noted that she would discuss the detail with A Johnstone and provide an update at a later time.
- M Stevenson requested that there be a glossary for acronyms for reports.
- L Bussell apologised and noted that future reports would be more mindful of this issue.
- T Allison commented that a constructive meeting had been had between A Clark, L Bussell, T Allison and C Birt about content for item 4 on Health Improvement. There was appraisal about what information is available and shared work in Public Health regarding population indicators, governance oversight of areas such as, for example, drug-related deaths. A good degree of assurance was noted from the discussion.
- The Chair asked if a paper on governance arrangements for Adult Social Care fees could be presented to the March committee.

<u>Care Homes Update</u>
L Bussell noted that the past two years had taken their toll on the Care Home sector and current cost of living pressures were also having a knock-on effect. Work had been ongoing with Highland Council to address these matters.

- Work to look at how other regions are considering these pressures is underway, such as Moray's housing-based solutions, in order to find an optimum model for care within each of NHS Highland's localities.
- There is a good understanding of where there is a good level of care homes and where there is more vulnerability across the geography, and there is a process of mapping out where the loss of any more care homes cannot be afforded and those areas with more capacity to understand the risks and address mitigation.
- The Chair asked for a broad idea of the number of care homes and residents at risk.
- L Bussell noted that this was a difficult area to be certain of as there had been significant change in some areas that had been thought stable, and the current situation was reactive out of necessity. It is thought that currently there are close to 200 residents that are in care homes who are exposed to a more vulnerable position. There is not anything imminent for any of the homes concerned but there is a need to be mindful of the current risks.

In the discussion that followed the following areas were addressed,

- Cllr Fraser noted the importance of looking ahead to develop a medium to long-term situation for Highland in the knowledge that it is not possible to continue to build enough homes to address current rates of admission.
- He noted that he would like to see within the strategy what can be done with housing but that prevention of many of the issues starts at community level with things such as social daycare and lunch clubs which keep people active within their communities, and delay the journey of going into care or nursing care.
- L Bussell commented that the ultimate aim is ensure that people who do not want to go in a care home can stay in their own home with care homes as a last resort. It is a matter of getting a right balance of people's preferred options and supporting that. There is much work to be done.
- M Stevenson asked about urgent care and if the same pressures within community hospitals are the same as for care homes.
- L Bussell agreed and noted that there are a number of people in community hospitals whose end destination would be either to go home with care at home or to go into a care home. Due to pressures in those sectors there has been a need to open additional beds in community hospitals and some are working at full capacity.
- Staffing is a particular challenge in order to achieve more availability of beds. The remote and rural nature of Highland means that community hospital beds are not always in an appropriate location for the person and there is a need to avoid moving people out of area because getting them back to their local area is more difficult. There is a difficult balance in conversations with people about this transition and a need to engage with families and the community.
- The Chair asked if this was a particular issue for Highland and how it may be impacted by the recent announcement by the Cabinet Secretary about utilizing beds to support delayed discharges.
- L Bussell answered that every board and every locality will have a huge variation in the challenges they face. Highland is to some degree an 'early adopter' in terms of facing these challenges due its older population and a disproportionately high number of very small and often remote care homes where staffing and recruitment face several challenges The physical environment of some older care homes and the need to achieve care inspectorate standards increases these pressures. Other boards are starting to see these issues too.
- Conversations are ongoing with Scottish Government to highlight the challenges faced by Highland.
- Highland has one independent provider and they are expanding, however it has been more difficult to recruit for the independent sector in Highland than it is in other areas of the country.

- Scottish Government have an appreciation of the position, however there is still expectation that a local solution is found, all of which is feeding into discussion with Highland Council which will also be affected by the National Care Service when it arrives.
- L Bussell commented that an update on progress would come to the next meeting following further conversations over the next month or so.
- Chair commented that there would be further discussion of Care Home-related matters at a forthcoming meeting of the Board.

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

4 HEALTH IMPROVEMENT

See discussion in item 3.7.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Committee Annual Work Plan [PP.70-72]

The Chair noted that the workplan would be reviewed at the next agenda planning meeting in light of the fragility of the current situation, and would be presented for consideration at the next meeting.

– **The Committee noted** that the Work Plan would be reviewed for 2023-24 and presented at the March meeting for approval.

6 AOCB

- None.

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 1st March 2023** at **1pm** on a virtual basis.

The Meeting closed at 4.04 pm