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 10 July 2024 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Gerry O'Brien, Committee Chair, Non-Executive
Tim Allison, Director of Public Health
Ann Clark, Non-Executive Director and NHSH Board Vice Chair
Cllr, Muriel Cockburn, Non-Executive
Pam Cremin, Chief Officer
Julie Gilmore, Assistant Nurse Director on behalf of Nurse Director
Joanne McCoy, Non-Executive
Kara McNaught, Area Clinical Forum Representative
Kaye Oliver, Staffside Representative
Simon Steer, Director of Adult Social Care
Neil Wright, Lead Doctor (GP)
Elaine Ward, Deputy Director of Finance
Mhairi Wylie, Third Sector Representative

In Attendance:
Rhiannon Boydell, Head of Strategy and Transformation
Fiona Duncan, Chief Executive Officer and Chief Social Work Officer, Highland Council
Arlene Johnstone, Head of Service, Health and Social Care
Ian Kyle, Chair of the Integrated Children's Services Planning Board
Fiona Malcolm, Executive Chief Officer for Health and Social Care, Highland Council
Jill Mitchell, Head of Primary Care
Ian Thomson, Head of Service, Adult Social Care
Stephen Chase, Committee Administrator
Amanda Johnstone, member of the public

Apologies:
Philip Macrae, Diane Van Ruitenbeek, Jo McBain.

1 WELCOME AND DECLARATIONS OF INTEREST

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

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

1.2 Assurance Report from Meeting held on 8 May 2024 and Work Plan

The draft minute from the meeting of the Committee held on 8 May 2024 was approved by the Committee as an accurate record.

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

1.3 Matters Arising From Last Meeting

The Chair noted that recruitment for to the two unfilled lay member posts had been unsuccessful and was in the process of going out to advert again with the expectation that the posts would be recruited in time for the next committee meeting.

The Chair also noted that there would be a development session for the Committee to be held on Wednesday 24 July at 1pm on the theme of Strategy.

The Chair noted that items 2.1, 2.2 and 3.1 would be discussed together due to the close relationship between the items. The items were taken in the order given below of 2.1, 3.1 and 2.2.

2 FINANCE

2.1 Financial Position at 2023/24 Year End

The Deputy Director of Finance noted that the annual accounts for NHS Highland had concluded following auditing and had been submitted to Scottish Government. The position was unaffected during the audit and no adjustments were required. There had been an expected a gap of £68.7m, however during quarter one, Scottish Government announced significant additional funding to support the overall financial position and therefore an underspend of approximately £300,000 was delivered at the year end.

- Sustainability funding had been received in June at just over £8m as was support from Scottish Government to meet the pay award for Adult Social Care. Additional allocations from the New Medicines Fund of £6.6m had been received and a supplemental allocation for pay of over £6m. At the approach of the year end there was a significant allocation for health consequentials received from UK government in addition to some sustainability funding which took the Board to a position of nearly £35m of unanticipated additional funding.
- Taking into account some short-term cost reductions and slippage in allocations of £18m and a brokerage value of £29.5m, there was a year-end surplus of £265,000. This was split across operational areas within the HHSCP.
- Argyll and Bute IJB delivered a break-even position by using its flexibility as an IJB to take any underspend to reserve.
- The significant level of allocations received towards the latter part of 2023-24 did not impact the financial position, however this has created some uncertainty into the 2024-25 year.
- The HHSCP position showed an overspend driven by the use of supplementary staff in both agency nursing and medical locums within primary care. There was an element of overspend for drugs costs which reflected an increase in drug volume and drug pricing.
- The presentation showed the breakdown across the different service categories and the spend on agency nursing within in-house care homes.
- Work is at an early stage with Highland Council to agree a quantum position for 2024-25 with the expectation that this will improve the position for 2024-25.
- The supplementary staffing position was an ongoing issue: a number of schemes within the cost reduction/cost improvement programme for 2023-24 had related to reducing supplementary staffing, agency nursing and medical locums. Spending over 2023-24 was £7.8m higher than in 2022-23 and work was continuing to try and address the issue into 2024-25 to bring costs down.

During discussion, the following areas were addressed,

- It was confirmed that at present the trend towards an overspend in Learning Disability Services was continuing with a forecast overspend of nearly £2m at the end of the financial year. A number of high-cost packages were contributing to the overspend. The Head of Service noted the split between delivery via the specialist Mental Health services sat within Health Services budget and services delivered via Adult Social Care. It was noted that there was very little in-house support provision within NHSH for adults with learning disabilities with the majority delivered from commissioned support. There had been seen an increase in individuals with complex care needs requiring high levels of support.
- The Chair noted the need for the Board to deliver 3% recurring savings target which assumed that the Adult Social Care position would deliver a break-even position and that this also assumed delivery against operational budgets.
- The Deputy Director of Financial Services noted that currently there was a forecasted overspend within Adult Social Care £16.2m to the end of 2024-25. This assumed delivery of 5.71% of value efficiency schemes within Adult Social Care. Current messaging from Scottish Government was clear that it would not be acceptable to have an overspend within Adult Social Care impacting on the overall health position. A large amount of work is currently focussed on this area.

3.1 Transformation Plans 2024/25 and beyond

The report noted that Highland HSCP were taking forward an extensive work plan of transformational change to develop safe, sustainable and affordable services across the region. The work sits within the NHS Highland performance and governance structure and its work streams interconnect with Acute transformation work streams to address whole system challenges. Transformational work streams were being taken forward under the strategic direction, and in delivery of, the HHSCP joint Adult Services Strategic Plan 2024-2027. The work was extensive and the risk presented by limited leadership and management capacity to deliver was being managed by the Senior Leadership Team Transformation Group. Organisational collaboration had been ensured through the NHS Highland performance governance structure.

- The Head of Strategy and Transformation gave a slide presentation which provided an overview of the pieces of the transformation work in its totality that the HHSCP was undertaking. All of the transformation work had been developed under the guidance of the Joint Strategic Plan which the committee had seen in depth and signed off and would take the partnership from 2024 through to 2027. The focus in the strategic plan was around enabling independent living as close to home as possible, ensuring that services were efficient effective, equal, affordable and sustainable.
  A strategic charter (‘Home is Best’) had been developed to implement the Joint Strategic plan and ensure that localities are properly engaged.
- District Planning Groups had all had their first meetings and had given their first reports to the Strategic Planning Group. The first meetings shared the Joint Strategic Plan and the strategic charters and some of the transformation work that had already been undertaken. The meetings also addressed use in order to encourage the groups to address local issues and gaps that had been identified.
  The process of movement from Driver Diagrams into work plans for urgent and unscheduled care were shown to give a sense of the detail involved at the decision

making level and how this fed back into the strategy .
The NHSH approach to performance and efficiency would from the 2024-25 period onward be informed by two structures: the Strategic Transformation Assurance Group (STAG), who would address longer term redesigns, scoping, and strategic needs analysis for organisational choices; the Value and Efficiency Accountability Group (VEAG) form the second structure and is concerned with shorter term, within year outcomes, particularly based around savings.

The Chief Officer noted that the district planning groups were key to improving delivery through working with the population and partners across the strategic planning partnership to ensure good community engagement using the available data to discuss services and how people want to receive services in their area. The Chief Officer also noted that there were a number of value and efficiency work streams addressing workforce efficiency. However, it was noted that there were significant workforce challenges across Highland. It was felt that technology provided a good opportunity to streamline services to in order to support the workforce to better manage staff time and to release staff back into operational service.

2.2.1 Adult Social Care Cost Reduction Plan

The Chief Officer gave a slide show presentation regarding the Adult Social Care cost reduction plan. It was noted that HHSCP was spending more on Care Homes with significant costs for in house services and Care at Home services. The variation of spend across urban and remote and rural areas was noted.

- NHS care homes were using a notable amount of supplementary staffing with high agency costs which increase in more remote and rural areas. The Chief Officer noted the need to change the model to address these issues. Value and Efficiency targets had been identified for specific programmes to meet the 3% target for Adult Social Care with £3.6m of savings identified. Some of this work had already begun in terms of managing staffing and income maximisation. There was an active programme underway to address increased service user contribution to care home costs. In House services were undergoing a redesign with a commissioning approach to change the model.
  The Chief Officer noted that some of the action to support a change in the model involved a hold on all vacancies in order to engage with the external sectors and enable them to recruit a workforce to be the primary providers of Care at Home and avoid the current competitive recruitment market.
- Certain areas were out of scope for savings as agreed with Highland Council, such as non-residential care and specialist areas of care such as that for younger adults.
- The Chief Officer commented that there would be a twin-track commissioning approach to reduce in-house spending and provision, and to increase work with the wider sector to ensure robust commissioning process. It was felt that there were very good relations with the wider sector and market understanding.

In discussion, the Chair and committee members noted that several of the issues outlined formed a good basis for the development session scheduled for the Committee on 24 July, especially in terms of governance arrangements and understanding the relationships between the different groups from district to Board level.

- It was felt that issues raised of staff retention (in addition to recruitment) would be better addressed by the Staff Governance Committee and that issues of quality and patient safety around moving and handling would also be addressed by the SGC. The importance of suitable levels of staffing for Day Care Services was noted, especially in the context of moving and handling, and quality and patient safety.
- It was noted that recently qualified nurses from UHI were largely keen to remain in the region but that opportunities were likely to take them away elsewhere as this was a wider structural issue for Scottish Government in terms of the cost of living and attracting recruitment.
- The Chief Officer noted that she would be developing the agenda for the JMC with F Duncan, the Chief Executive Officer for Highland Council.

2.2 Year to date Financial Position to month 2 for 2024/25

The Deputy Director of Financial Services provided an overview of the position for the partnership and noted the four trajectories which were plotted on a monthly basis.

- At the end of month two, there was an overspend of £17.4m within NHSH and this was forecast to increase to about £67m.
  For HHSCP there was a £4.764m overspend reported to date and it was forecast that this will increase to just under £24m by the end of the financial year.
- The breakdown against the individual service categories and the breakdown of agency nursing costs within care homes was shown. There was significant agency spend within three homes with a high reliance on bank staff within the remainder. This was explained as a positive move due to the need to focus supplementary staffing away from agency staff and towards bank workers to reduce costs.
  The quantum had still be formally agreed with Highland Council, but it was anticipated that this could improve the position by about £3m to £3.5m, and it was hopeful that this would be resolved by the time for month three reporting.
  North Highland communities showed a forecast overspend in most of the geographic areas with an overspend to date of £1.6m which was forecast to increase to just over £17m by the end of the year.
- Regarding Mental Health spending, the split between Health and Adult Social Care budgets was noted, with most of the overspend coming through Health Services.
- A built-in pressure was noted for pain drug costs of £900,000.
- Primary Care showed a current overspend of £796,000 with a forecast increase to £2.9m by the end of the year. Much of the pressure was seen to be coming from prescribing in terms of volume and rising drug costs. Vacancies in Primary Care management and within Dental services had been mitigating overspend in other areas. Scottish Government allocations for Primary Care were yet to be determined when the report was written, however there had been a number of allocation letters received in the past week in order to have allocations ready for quarter 3.
  Argyll and Bute had seen a significant increase in spending over month one, but it was expected that they would move into balance overall.

During discussion, the following areas were raised,

- The Chair noted some of the worrying trends of expenditure but noted the need at this early stage in the year to deliver on operational budgets.
- The Chief Officer provided assurance that the transformation fund held by the Highland Council on behalf of the HHSCP had a process by which the partnership request monies and that there was joint engagement about how the funds should be spent in relation to strategic transformation aims. The fund is to cover the next three years, and is not to be used for just the current year in order to focus attention on larger strategic transformation change projects.
  The Chair requested that more information be provided regarding the process for

reaching agreement or not reaching agreement.

The Committee:

- **NOTED** the report detailed in items 2.1, 2.2 and 3.1 above and the savings plan, and that work was underway to confirm the plan which would be brought to the August meeting.
- **ACCEPTED limited** assurance from items 2.1, 2.2 and 3.1 above in light of the ongoing financial challenges and ongoing work with Scottish Government to approve the financial position.
- **AGREED** that an update on the process for reaching agreement around the HHSCP Transformation fund be provided to the September meeting of the Committee.
- **AGREED** that details of LD spend in 2023/24 and how this will roll forward into 2024/25 be circulated to the Committee.
- **AGREED** that an update be provided concerning when the process by which the £20m reserve allocated for ASC transformation will be approved and implemented.
- **AGREED** that an update on numbers around health checks for people with Learning Disabilities be provided to the committee.

3.2 IPQR for HHSCP

The item would be presented to the next meeting.

The Committee took a comfort break from 2.45pm to 2.55pm.

3.3 Learning Disability Services Assurance Report

The Head of Service provided an overview of the position and noted that within Highland, there were approximately 1,034 people with a learning disability known to Adult Social Care services within the HHSCP area. This was in line with the population data but it was noted that not everyone with a learning disability would be known to the services or in receipt of services. Work was ongoing with Scottish Government about how to record data more effectively. It was clarified for the Committee that Learning Disability Services were delivered both within Health teams and Social Care teams, therefore learning disability spend within Adult Social Care was attributed within the partnership and not to Mental Health Services spend.

The paper followed on from earlier reports relating to the provision of care and support to individuals with a Learning Disability in Highland. The paper presented focused on the delivery of Health Checks, and work with independent sector support providers to commission support for individuals and to create opportunities to enable ordinary living and the ongoing risks relating to the work to achieve the recommendations of the Coming Home Report. The committee was asked to note the progress achieved in delivering Annual Health Checks to people with a Learning Disability, to support the actions to enable individuals with a learning disability to lead full and active lives in their own homes in community settings, and to note the risks associated with the provision of support to individuals with complex needs and the recruitment and retention difficulties being experienced by the support sector.

In discussion, issues of employability and the time it takes to place clients in suitable work were commented on. It was noted that a piece of work led by Scottish Government was beginning in which Highland would participate to ensure that people with a disability were offered opportunities of employment and how best to support this via the relevant services and partner organisations.

- Regarding health checks, it was noted that Scottish Government funding had been allocated via the NRAC formula and that there was further work to be undertaken to address imbalances by linking up with community learning disability teams in each of the localities. For those clients already known to the community and disability nurse it was likely that the nurse would carry out the majority of a health check with a staff practitioner

to address the specialist elements. It was felt that by the autumn figures for the number of health checks undertaken would be available especially in relation to clients in cluster housing which research had shown to be the most efficient way of delivering individualised care in community settings, and that this could be reported back to committee. It was commented that clients with learning disabilities were more likely than other areas of the population have additional long-term conditions which were likely to be addressed on an annual basis by GPs and that this could help to focus the study of health checks.

- It was commented that there were 58 people currently on the Dynamic Support Register. The tool had been developed at a national level with input from Highland and had enabled teams to identify which individuals should be prioritised when resources were limited in order to inform strategic discussions about commissioning.

The Committee:

- **NOTED** the report and recommendations.
- **ACCEPTED moderate** assurance from the report.

3.4 Primary Care Services Update

The Head of Primary Care introduced the report which had been circulated in advance of the meeting.

- It was noted that the Community Glaucoma service had completed staff training and was currently engaged on development work with community and Acute colleagues, and was working to have IT equipment implemented and have the pathway up and running alongside the Stroke pathway. Governance visits across Argyll and Bute and North Highland were back on track on a rolling 3 year programme, and there had been development around foundation training offered by NIS as well.
- Access to Dental services displayed a mixed picture with three practices offering NHS dental registrations, however, there had been a recent practise closure in Kyle, and other practices in remote and rural areas were struggling to recruit. The SDI Grant Assistance Scheme had been welcomed in Highland, and one application to the scheme was taking new registrations.
- Responses to the Dental payment reforms received by NHSH's dental providers had been largely positive.
- There were ongoing recruitment issues within the PDS service. It was noted that this reflected a shortage of dentists across the country and that there was work underway at a national level to consider the options around skill mix.
- The comprehensive list of Board-managed GP practices, had recently been updated which included a couple of practice mergers in Caithness and in Loch Allen. Recruitment remained a challenging issue with vacancies across remote and rural areas and a reliance on locums.
- Two pilot sites for a quality improvement project around asthma care had been identified and work would be reported to a future committee meeting.
- Work was progressing on a revised set of enhanced service specifications with discussions active with Highland Local Medical Committee. Agreement had been reached on five service specifications to be implemented over coming months. The remainder of service specifications were due to be signed off by the end of July.
- The Primary Care Improvement Plan 7 tracker document was completed and submitted to Scottish Government in May and provided information about the primary care workforce, the services being delivered by these staff and related financial information. A new section was included inviting reflection on the top three achievements during the 2023/24 year, and also any persisting barriers to work to be overcome. The tracker will form the basis of the update to the September meeting.
- Notification was awaited of the PCIF allocation for year 2024/25 and it was felt that this was unlikely to be received until after the election on July 4. Current indications were that the payment to Boards would be made in a single tranche.
- Regarding the Pharmacotherapy Workstream, a total of 16 GP practices were receiving support from the Inverness-based Pharmacy Hub. Positive recruitment levels have been

observed for the Inverness base, and the employment of Trainee Pharmacy Technicians was contributing to the development of the workforce. A live dashboard detailing the allocation of resources to GP Practices from the Pharmacotherapy service would soon be accessible via the NHSH intranet.

- The First Contact Physiotherapy service had successfully achieved a full staffing establishment and a total of 22 out of 30 FCPs now held a NMP qualification with 26 out of 30 FCPs having completed their joint injection training.
- The contract retendering process for Community Link Workers was complete and correspondence issued to practices advising that the current service provider would continue in place. The service will extend to all GP Practices from August 2024. The CLW year two annual report was being compiled and would include patient input and an evaluation based on data from when the service commenced. Referral rates into the service had remained high with the main reasons for referrals unchanged, which included mental health and well-being, loneliness and social isolation. The majority of referrals were from female patients aged 35 to 65, and the three most commonly prescribed therapies were Listening Ear, Highland Council welfare support, and Decider skills.
- Childhood vaccination data from Public Health Scotland (PHS) had identified that NHSH is tracking below the Scottish national average due to operational constraints and significant resource pressures affecting capacity to provide additional clinics. PHS conducted a peer review in June 2024 and an action plan was in development.
- A Community Treatment and Care (CTAC) Rural Options Appraisal SBAR was submitted to Scottish Government along with the PCIP 7 tracker in May 2024. Feedback had been received which would be submitted to SG for discussion with the GMS Oversight Group in August 2024. Transitional payment arrangements to GP Practices would continue during 2024/25.

During discussion, it was noted that in cases where someone cannot register with their local GP, as in the Culloden case above, the Board signposts the person to other practices or allocates an appropriate practice where the person can register. It was commented that this is a dynamic process of ongoing work.

The Committee:

- **NOTED** the report.
- **ACCEPTED moderate** assurance from the report.

3.5 Adult Support and Protection

Due to technical difficulties the Director of Adult Social Care provided an overview of the findings of the report and I Thomson re-joined the meeting to receive questions.

The Director of Adult Social Care commended the work done around the report and noted that it provided a comprehensive review that described the context, duties and processes required for Adult Support and Protection. The Committee's attention was drawn to the increasing number of incidents such as large-scale investigations in care homes and the amount of work and reporting involved and the potential impact in cases where this goes wrong. Regarding the recent inspection of services, it was commented that this had been approached as a learning and development journey from the previous inspection carried out five years previously. The view of the inspectors was that whilst there were areas for improvement, there was a level of robustness and assurance that could be taken from the changes that had been implemented. A series of recommendations and areas of work would be taken forward through the vehicle of the Adult Support and Protection Committee. The Director of Adult Social Care noted that it had been gratifying to see the extent to which health services had embraced the work of Adult Support and Protection

The Chair commended the report and noted that it had been presented for the Committee's awareness and understanding of Adult Support and Protection. The discussion noted the hard work that had resulted in considerable improvement.

- Assurance was requested regarding a recent independent review of a particular case that had been recently published, and it was noted that the actions arising from that particular review would be taken separately from those of the inspection referenced in the main report. The findings would be incorporated into the improvement action plan as part of an ongoing learning review.

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

3.6 Chief Officer's Report

The Chief Officer provided an overview of the report to the Committee which noted,

- That the fire upgrade and in patient ward and out patient redesign plan had been agreed for Ross Memorial Hospital in Dingwall and work was due to start in the autumn.
- A national Collaborative Response and Assurance Group (CRAG) had been set up to provide weekly oversight to the Cabinet Secretary for NHS Recovery, Health and Social Care to take forward intensive, focussed activity with the aim of achieving material and sustained reduction in people in delay to discharge.
- An internal audit had been undertaken of Adult Social Care Services Multi-Disciplinary Planning For Discharge Across Community and Acute Services, and for Care at Home Review & Systems. The audit findings were disappointing and found confusion among staff about their role in discharge planning and a lack of SOPs or training which staff felt was causing more delay. Areas for urgent improvement in six areas were set out in the Chief Officer's report to address these concerns.
- There had also been undertaken an audit of the Governance Arrangements for Complex Care Packages for younger adults with improvement recommendations in three areas to address clearer policies and procedures for the development and approval of complex care packages; an analysis of need and availability of resource to ensure appropriate oversight of all packages in the context of the entire service model; and work to monitor and report on the packages in place to management and the governance structure with any issues being escalated in a timely manner. Both Audit Reports and their Improvement Plans will be submitted to the next HHSCC Meeting in September.
- A weekly NHS Highland Vaccine Improvement Group (VIG) had been set up to determine the most appropriate future delivery model to ensure Highland citizens can access safe high quality immunisation services within their local community. Senior GPs and the Board had agreed that a Short Life Working Group (SLWG) should report to the VIG to help compile a general practice options appraisal assessment informed by vaccination uptake and delivery rates, vaccine accessibility, quality and patient safety, and capacity and workforce. The development of a questionnaire to survey GP practices will be the first stage in assessing general practice ability. The SLWG will hold its first meeting on 4th July.
- Details of the agenda items presented to the JMC were given.
- Five new contracts for Enhanced Services had been developed and were in the final stages of negotiation with Highland LMC, with a further four which were being progressed.
- Inaugural District Planning meetings regarding the Joint Strategic Plan had taken place for every district. A meeting of the Strategic Planning Group took place on Thursday 20th June.
- The National Care Service (NCS) Bill was currently at stage 2 in progressing through the Scottish Parliament. Draft amendments had been published by the Scottish Government and the NCS Stage 2 list of draft amendments was available to view at www.parliament.scot. It was anticipated that the new arrangements would not come into force for at least another 18-24 months, providing time for legal and other implications to be worked through. The Highland Council and NHS Highland will work closely with the Scottish Government to assess what assistance may be required to deliver transition to the new model. The Chief Officer suggested that the HHSCC may wish to consider a

more detailed paper or hold a development session on the proposed arrangements for the NCS amendments and any implications for health and social care delivery.

During discussion, it was noted that the Scottish Government would visit each integration authority to discuss issues around Delayed Discharges and the interventions that could be addressed. Work between the Chief Officer and the Head of Strategy and Transformation was underway in preparation. It was unclear at present if it would be possible to negotiate the trajectory with the Minister, however detailed feedback had been provided to COSLA and the Scottish Government in June intended to provide necessary and consistent context for the strategic challenges faced by the organisation such as those particular to the remote and rural geography of much of the region.

- Regarding vaccination delivery it was noted that the Clinical Governance Committee would be discussing a paper on vaccination delivery the next day. In addition, the Chief Officer offered to bring figures regarding the increased level of delivery across the different vaccination programmes. Regarding implementation of the options appraisal of the new district model by the SLWG before winter, it was felt that this was a longer-term piece of work than the proposed autumn timeline. It was commented that due to the small business model of most GP practices there was a need to see that the delivery model was sustainable to assist with employing the appropriate level of staffing. It was also suggested that work should continue to move outward aware from central organisation to a community-led model.

The Committee:

- **NOTED** the report.
- **AGREED** to review the Audit Reports and associated improvement plans for the audit of Complex Care Packages at the next HHSCC Meeting in September.
- **AGREED** that a report on Vaccination Improvement Plans be taken to the September meeting.
- **AGREED** that an update on People experiencing delay be provided in the next Chief Officer report.

4 AOCB

There was none.

5 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 4 September 2024** at **1pm** on a virtual basis.

A development session for the Committee on the theme of Strategy will take place on **Wednesday 24 July 2024** at **1pm** on a virtual basis.

The Meeting closed at 4.15pm

Agenda Item 2

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**4 September 2024**
Title:	**Finance Report – Month 3 2024/2025**
Responsible Executive/Non-Executive:	**Pam Cremin, Chief Officer**
Report Author:	**Elaine Ward, Deputy Director of Finance**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to a:

- Annual Operation Plan

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This report is presented to enable discussion on the summary NHS Highland financial position at Month 3 (June) 2024/2025 with further detail presented on the HHSCP position.

2.2 Background

NHS Highland submitted a financial plan to Scottish Government for the 2024/2025 financial year in March 2023. This plan presented an initial budget

gap of £112.491m. With a brokerage cap of £28.400m this meant cost reductions/ improvements of £84.091m were required. The Board received feedback on the draft Financial Plan 2024-27 on the 4 April 2024 which recognised that "the development of the implementation plans to support the above savings options is still ongoing" and therefore the plan was still considered to be draft at this point. The feedback also acknowledged "the significant progress that has been made in identifying savings options and establishing the appropriate oversight and governance arrangements".

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

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

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

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

2.3 Assessment

The NHS Highland position for the period to end June 2024 (Month 3) is an overspend of £22.659m with this forecast to increase to £49.696m by the end of the financial year. The current forecast assumes that those cost reductions/ improvements identified through value and efficiency workstreams will be achieved and that further cost reduction/ improvement activity will enable the delivery of a balanced ASC position at the end of the FY. This forecast is £21.296m worse than the brokerage limit set by Scottish Government.

The HHSCP is reporting a year to date overspend of £6.973m with this forecast to increase to £24.216 by the end of the financial year. It is assumed that further action on cost reductions/ improvements will reduce this to £7.293m. This position currently only assumes delivery of £5.710m of costs reductions/ improvements within Adult Social Care Value and Efficiency schemes.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	x	None	

Comment on the level of assurance

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

3 Impact Analysis

3.1 Quality/ Patient Care

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

3.2 Workforce

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

3.3 Financial

Scottish Government has recognised the financial challenge on all Boards for 2024/2025 and beyond and are continuing to provide additional support to develop initiatives to reduce the cost base both nationally and within individual Boards. NHS Highland continues to be escalated at level 3 in respect of finance.

3.4 Risk Assessment/Management

There is a risk associated with the delivery of the Value & Efficiency programme. The Board are developing further plans to generate cost reductions/ improvements

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

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

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

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

- Executive Directors Group – via monthly updates and exception reporting
- FRPC
- Value & Efficiency Assurance Group
- Monthly financial reporting to Scottish Government

3.9 Route to the Meeting

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

- EDG
- HHSCP SLT

4 Recommendation

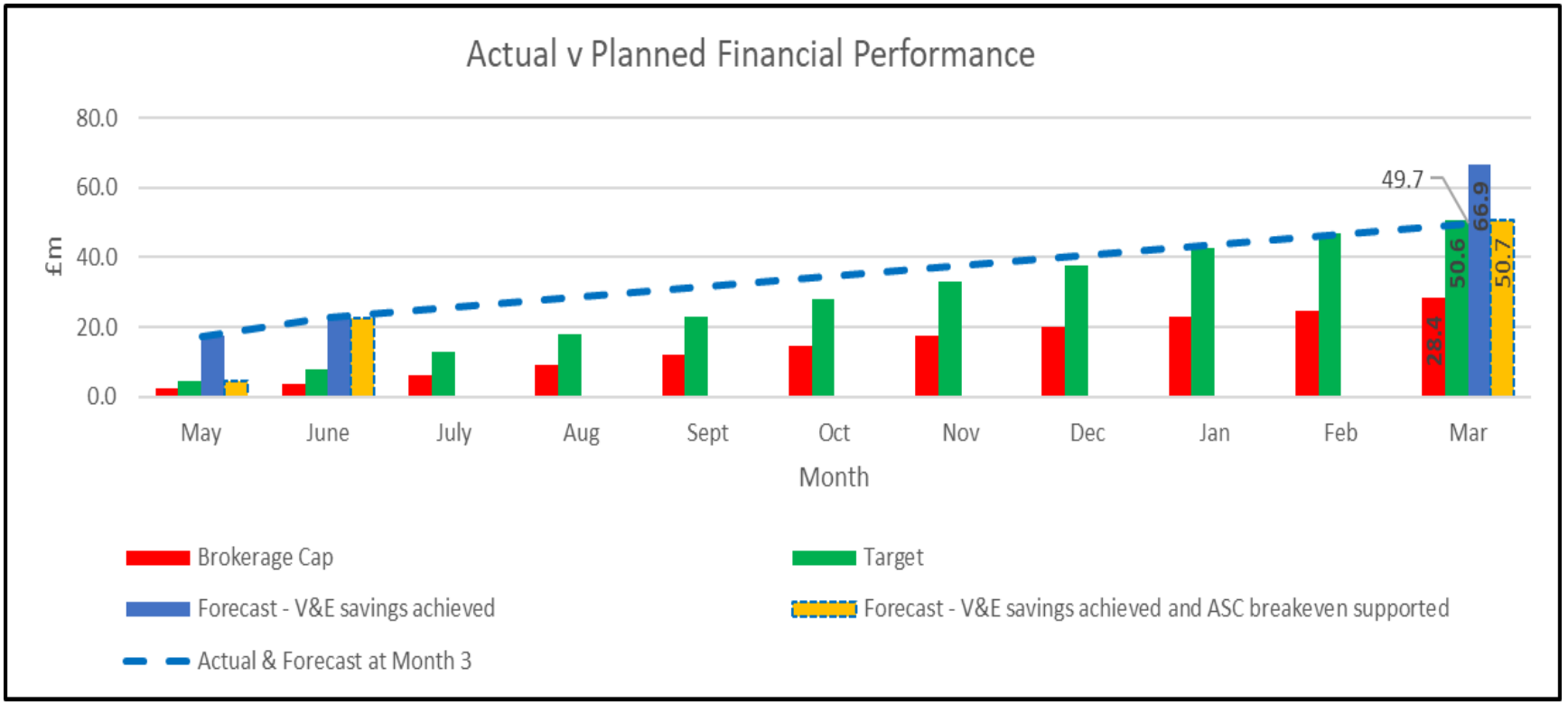
Discussion – Examine and consider the implications of the matter.

4.1 List of appendices

No appendices accompany this report.

HHSCC Finance Report – 2024/2025 Month 3 (June 2024)

MONTH 3 2024/2025 – JUNE 2024

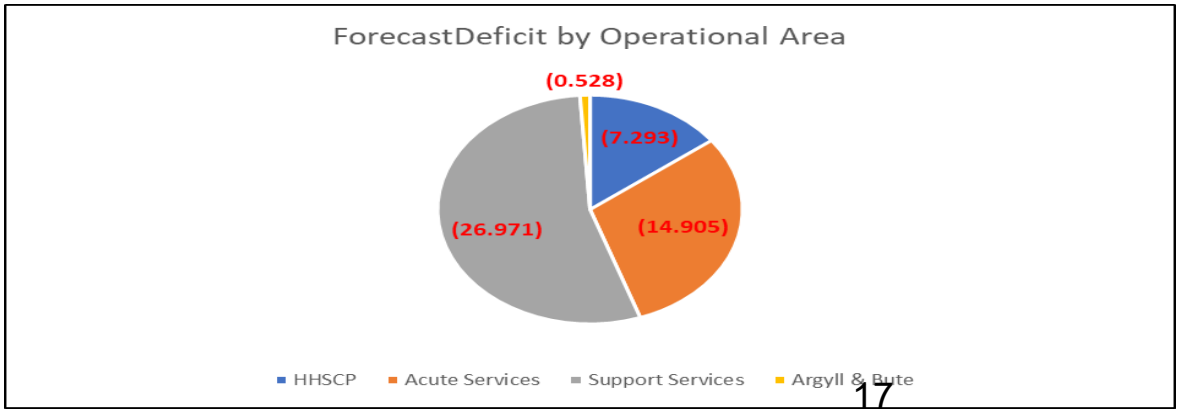


Target	YTD £m	YE Position £m
Delivery against Revenue Resource Limit (RRL) DEFICIT/ SURPLUS	22.7	49.7
Delivery against Brokerage Cap DEFICIT/ SURPLUS	19.2	21.3
Deliver against Target agreed with Board YTD DEFICIT/ SURPLUS	14.7	0.9

- Forecast year end deficit £49.7m – assuming support to deliver breakeven ASC position
- £21.3m adrift from brokerage limit
- £0.900m better than target agreed with Board May 2024

MONTH 3 2024/2025 – JUNE 2024

Current Budget £m	Summary Funding & Expenditure	FY Plan £m	FY Actual £m	FY Variance £m	Forecast Outturn £m	Forecast Variance £m
1,187.400	**Total Funding**	288.792	288.792	-	1,187.400	-
	Expenditure					
461.273	HHSCP	112.158	119.131	(6.973)	485.489	(24.216)
	Support to bring ASC Position to Breakeven				(16.923)	16.923
	Revised HHSCP				468.566	(7.293)
307.007	Acute Services	75.561	79.814	(4.252)	321.912	(14.905)
158.890	Support Services	37.234	48.371	(11.137)	185.861	(26.971)
927.171	**Sub Total**	**224.954**	**247.316**	**(22.363)**	**976.339**	**(49.168)**
260.229	Argyll & Bute	**63.838**	**64.134**	(0.296)	260.757	(0.528)
1,187.400	**Total Expenditure**	**288.792**	**311.451**	**(22.659)**	**1,237.096**	**(49.696)**



MONTH 3 2024/2025 SUMMARY

- Overspend of £22.659m reported at end of Month 3
- Overspend forecast to increase to £49.697m by the end of the financial year – when assuming support to deliver a breakeven ASC position
- At this point it is forecast that only those cost reductions/ improvements identified through value and efficiency workstreams will be achieved
- Forecast is £21.296m worse than the brokerage limit set by Scottish Government but £0.904m better than the target agreed with the Board in May 2024

MONTH 3 2024/2025 – JUNE 2024

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
256.283	NH Communities	63.666	65.645	(1.979)	274.245	(17.962)
53.770	Mental Health Services	13.163	14.280	(1.116)	58.026	(4.256)
156.950	Primary Care	38.655	39.464	(0.809)	159.798	(2.847)
(5.730)	ASC Other includes ASC Income	(3.327)	(0.257)	(3.070)	(6.579)	0.849
461.273	**Total HHSCP**	**112.158**	**119.131**	**(6.973)**	**485.489**	**(24.216)**
	HHSCP					
286.941	Health	70.543	72.941	(2.398)	294.355	(7.414)
174.332	Social Care	41.615	46.191	(4.575)	191.134	(16.802)
461.273	**Total HHSCP**	**112.158**	**119.131**	**(6.973)**	**485.489**	**(24.216)**
	Support to Bring ASC Position to Breakeven				**(16.923)**	**16.923**
461.273	**Revised Total HHSCP**	**112.158**	**119.131**	**(6.973)**	**468.566**	**(7.293)**

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	388	1,525
Agency (Nursing)	211	793
Bank	895	2,641
Agency (exclu Med & Nurs)	128	427
Total	**1,623**	**5,386**

HHSCP

- Year to date overspend of £6.973m reported
- Forecast that this will increase to £7.293m by financial year end – assuming support to balance ASC to breakeven at financial year end
- Prescribing already emerging as a pressure with £3.200m overspend built into forecast.
- Assuming delivery of £5.710m of V&E cost reductions/ improvements in forecast
- Supplementary staffing costs continue to drive an overspend position – £2.900m pressure within the forecast
- £1.500m has been built into the forecast in respect of out of area placements

MONTH 3 2024/2025 – JUNE 2024

Services Category (HHSCP - less ASC Estates)	Annual Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Outturn £000's	YE Variance £000's
Total Older People - Residential/Non Residential C	57.557	14.300	14.389	(0.090)	57.882	(0.325)
Total Older People - Care at Home	35.226	8.785	9.661	(0.876)	39.201	(3.975)
Total People with a Learning Disability	45.477	11.340	11.776	(0.436)	56.414	(10.937)
Total People with a Mental Illness	9.759	2.438	2.271	0.166	10.224	(0.465)
Total People with a Physical Disability	8.739	2.184	2.310	(0.126)	10.022	(1.283)
Total Other Community Care	13.145	3.295	3.768	(0.472)	13.956	(0.812)
Total Support Services	4.429	(0.726)	1.415	(2.142)	1.951	2.478
Care Home Support/Sustainability Payments	0.000	0.000	0.599	(0.599)	1.483	(1.483)
Total Adult Social Care Services	174.332	41.615	46.191	(4.575)	191.134	(16.802)

	Month 3		
Care Home	Bank £000's	Agency £000's	Total YTD £000's
Ach an Eas	8	-	40
An Acarsaid	4	-	20
Bayview House	11		51
Caladh Sona	-	-	3
Dail Mhor House			-
Grant House	8	-	21
Home Farm	8	88	314
Invernevis	5		17
Lochbroom	14	-	56
Mackintosh Centre	-		4
Mains House	-	47	149
Melvich	5	-	15
Pulteney	18	-	81
Seaforth	24		61
Strathburn	-	10	35
Telford	-		1
Wade Centre	3	-	10
Total	108	145	878

ADULT SOCIAL CARE

- A forecast overspend of £16.802m is reported within ASC - this in the main relates to a projection of undelivered cost reductions / improvements. This has been adjusted within the overall Board report to assume breakeven with a funding source to be identified
- Additional payments to providers of £1.470m has been built into the forecast position
- A reliance on agency staff in NHS run care homes continues to present a financial risk
- The 2024/2025 quantum has still to be formally agreed but it is anticipated that this will improve the position once there is clarity on the recurring nature of some allocations.

NORTH HIGHLAND COMMUNITIES - MONTH 3 2024/2025 – JUNE 2024

Current Plan £000	Detail	Plan to Date £000	Actual to Date £000	Variance to Date £000	Forecast Outturn £000	Var from Curr Plan £000
73.721	Inverness & Nairn	18.402	18.649	(0.248)	82.330	(8.609)
53.717	Ross-shire & B&S	13.423	14.724	(1.301)	59.383	(5.666)
47.402	Caithness & Sutherland	11.850	12.119	(0.269)	50.342	(2.941)
55.848	Lochaber, SL & WR	13.955	13.932	0.022	57.048	(1.200)
12.392	Management	2.734	2.900	(0.167)	11.902	0.490
7.107	Community Other AHP	1.788	1.660	0.128	6.760	0.346
6.096	Hosted Services	1.515	1.660	(0.145)	6.479	(0.383)
256.283	**Total NH Communities**	**63.666**	**65.645**	**(1.979)**	**274.245**	**(17.962)**
88.414	**Health**	**21.773**	**21.951**	**(0.178)**	**88.509**	**(0.095)**
167.869	**ASC**	**41.893**	**43.694**	**(1.801)**	**185.736**	**(17.867)**

NORTH HIGHLAND COMMUNITIES

- £1.979m ytd overspend reported which is forecast to increase to £17.962M by the end of the financial year
- Within Health ongoing vacancies are mitigating cost pressures within Enhanced Community Services and Chronic Pain – both forecast overspends are lower than the 2023/2024 financial year
- Within ASC the main pressure areas are within independent sector provision particularly in Inverness & Nairn and Ross-shire & Badenoch & Strathspey
- £0.692m of pressure associated with supplementary staffing in NHS ran care homes and £1.470m of additional payments to providers further impacts on the position
- The year end forecast assumes delivery of ASC Value & Efficiency Cost Reductions/ Improvements of £5.710m

MENTAL HEALTH SERVICES - MONTH 3 2024/2025 – JUNE 2024

Current Plan £m's	Summary Funding & Expenditure	Plan to Date £m's	Actual to Date £m's	Variance to Date £m's	Forecast Outturn £m's	Var from Curr Plan £m's
	Mental Health Services					
26.235	Adult Mental Health	6.503	6.494	0.009	26.517	(0.282)
14.422	CMHT	3.535	3.894	(0.359)	15.868	(1.446)
6.714	LD	1.675	2.064	(0.389)	8.670	(1.956)
6.399	D&A	1.450	1.828	(0.378)	6.972	(0.572)
53.770	**Total Mental Health Services**	**13.163**	**14.280**	**(1.116)**	**58.026**	**(4.256)**

MENTAL HEALTH SERVICES

- £1.116m overspend reported ytd with this forecast to increase to £4.256m by financial year end
- Within this service area Health is the driver of the overspend position
- The main drivers for the overspend continue to be agency nursing and medical locums – although a significant piece of work is ongoing to reduce these costs with the position beginning to look more positive
- Buvidal and Clozapine drug costs account for a further pressure of £0.200m
- A forecast of £1.500m has been built in for out of area costs with negotiations ongoing with the provider to bring these costs down

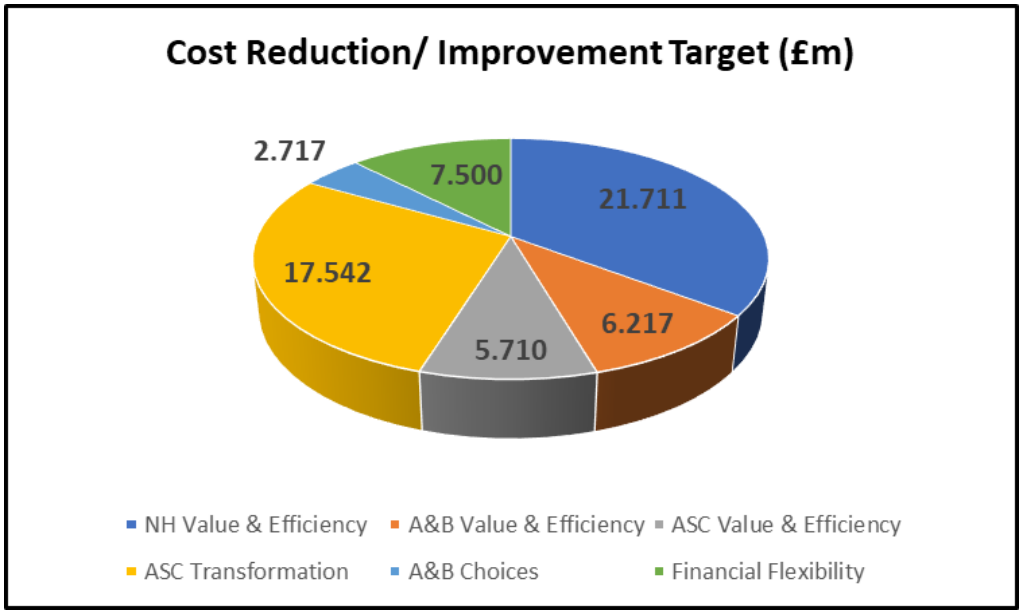
PRIMARY CARE - MONTH 3 2024/2025 – JUNE 2024

Current Plan £m's	Detail	Plan to Date £m's	Actual to Date £m's	Variance to Date £m's	Forecast Outturn £m's	Var from Curr Plan £m's
	Primary Care					
54.356	GMS	13.642	14.151	(0.509)	55.468	(1.112)
67.563	GPS	16.614	17.330	(0.716)	70.021	(2.458)
24.432	GDS	6.215	5.795	0.420	23.715	0.716
5.438	GOS	1.469	1.473	(0.004)	5.448	(0.010)
5.162	PC Management	0.715	0.714	0.001	5.146	0.016
156.950	**Total Primary Care**	**38.655**	**39.464**	**(0.809)**	**159.798**	**(2.847)**

PRIMARY CARE

- £0.809m overspend reported ytd with this forecast to increase to £2.847m by financial year end
- A £2.700m overspend of prescribing has been built into the year end forecast – both cost and volume are contributing to this position
- £0.841m has been built in to the forecast in respect of locums in 2C practices – this is reducing following successful recruitment in the Alness/ Invergordon practice
- Vacancies in primary care management and GDS are mitigating overspends in other areas
- SG allocations for Primary Care are yet to be confirmed

MONTH 3 2024/2025 – JUNE 2024



	Board agreed plan		
	Target £000s	Forecast £000s	Variance £000s
Opening Gap	**112.001**	**112.001**	-
Closing the Gap			
NH Value & Efficiency	21.711	25.881	4.170
A&B Value & Efficiency	6.217	5.513	(0.704)
ASC Value & Efficiency	5.710	5.710	-
ASC Transformation	17.542	17.542	-
A&B Choices	2.717		(2.717)
Financial Flexibility	7.500	7.500	-
GAP after improvement activity	50.604	49.855	(0.749)
GAP from Brokerage limit	**22.204**	**21.455**	

COST REDUCTON/ IMPROVEMENT

- At the NHS Highland Board Meeting on 28 May the Board agreed to a proposed budget with a £22.204m gap from the brokerage cap
- Current forecasts suggest that delivery will be £0.749m better that previously presented
- It should be noted that there is a high risk around delivery of this position as plans continue to be developed to support delivery of V&E targets
- In addition there is an assumption that additional activity on costs reductions/ improvements will support delivery of a breakeven position within ASC

MONTH 3 2024/2025 – JUNE 2024

2024-25 Value & Efficiency Dashboards as at 12/07/2024 (Month 3)

Value & Efficiency Reduction Programmes	V&A Plan			V&A Current Plan			
	2024-25 Original Target (£'000)	2024-25 Current Target/Plan (£'000)	Plan Gap	2024-25 Plan Achieved (£'000)	2024-25 Plan Forecasted (£'000)	Total Achieved & Forecasted	Current Target GAP
Value & Efficiency - North Highland	21,711	3,543	-18,168	1,340	434	1,774	-1,769
Value & Efficiency - Argyll & Bute	6,217	5,635	-582	4,284	1,229	5,513	-122
Total Value & Efficiency	**27,928**	**9,178**	**-18,750**	**5,624**	**1,663**	**7,287**	**-1,891**
Value & Efficiency - ASC	23,252	5,700	-17,552	30	5,670	5,700	0
Total Value & Efficiency incl ASC	**51,180**	**14,878**	**-36,302**	**5,654**	**7,333**	**12,987**	**-1,891**

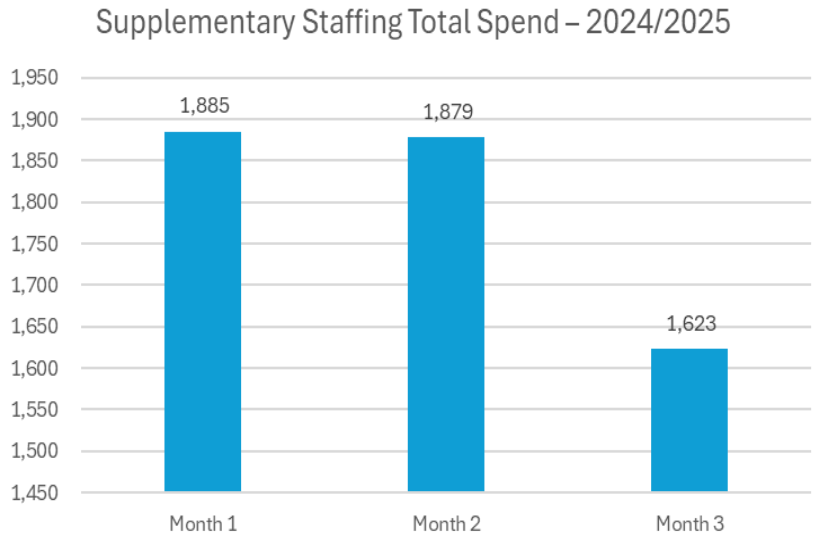
MONTH 3 2024/2025 – JUNE 2024

2024/2025 YTD £'000	2023/2024 YTD £'000	Inc/(Dec) £000's
5,386	5,905	(519)
5,386	**5,905**	**(519)**

SUPPLEMENTARY STAFFING

- Total spend on Supplementary Staffing at end of Month 3 is £0.519 lower than at the same point in 2023/2024.
- There is an overspend of £1.080m on pay related costs at the end of Month 3

Current Plan £m	Detail	Plan Detail £m	Actual Detail £m	Variance Detail £m
	Pay			
24.801	Medical & Dental	6.216	6.618	(0.402)
4.139	Medical & Dental Support	1.035	1.039	(0.004)
63.723	Nursing & Midwifery	15.923	16.312	(0.389)
16.069	Allied Health Professionals	4.082	3.834	0.248
0.072	Healthcare Sciences	0.018	0.009	0.009
7.817	Other Therapeutic	1.996	2.310	(0.314)
6.594	Support Services	1.646	1.525	0.121
19.157	Admin & Clerical	4.787	5.186	(0.399)
0.389	Senior Managers	0.097	0.035	0.062
51.298	Social Care	12.884	12.094	0.790
0.402	Ambulance Service	0.101	0.125	(0.024)
(3.035)	Vacancy factor/pay savings	(0.777)	0.000	(0.777)
191.429	Total Pay	48.007	49.087	(1.080)



MONTH 3 2024/2025 – JUNE 2024

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m
	Expenditure by Subjective spend			
191.429	Pay	48.007	49.087	(1.080)
56.711	Drugs and prescribing	14.178	15.180	(1.003)
2.415	Property Costs	0.601	0.694	(0.092)
33.829	General Non Pay	7.509	3.325	4.184
5.217	Clinical Non pay	1.310	2.271	(0.962)
7.017	Health care - SLA and out of area	1.757	1.764	(0.007)
123.890	Social Care ISC	30.860	33.717	(2.858)
78.160	FHS	19.965	19.300	0.665
	Allocations/commitments			
(23.027)	Operational income	(6.216)	(6.209)	(0.008)
(23.252)	Savings	(5.813)	0.000	(5.813)
452.390	**Total**	**112.158**	**119.131**	**(6.973)**

SUBJECTIVE ANALYSIS

- Pressures continued within all expenditure categories
- The most significant overspends are within pay – as a result of supplementary staffing spend which is in part mitigated by vacancies – and the provision of social care from the independent sector
- Drugs and prescribing expenditure is currently overspent by £1.003m - this is split £0.322m within hospital drugs and £0.681m in primary care prescribing – this is a significant area within the Board's Value and Efficiency programme

Agenda Item 3.1

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**04 September 24**
Title:	**Primary Care Improvement Plan Assurance Report**
Responsible Executive/Non-Executive:	**Jill Mitchell, Head of Primary Care**
Report Author:	**Catriona Naughton, Primary Care Project Manager**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Government policy/directive

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

This Assurance Report has been prepared in relation to the implementation of the 2018 General Medical Services Contract in Scotland and provides a

summary of planning and progress achieved on the project to date and forecast for the coming period. The report covers the period to 31/08/2024.

2.2 Background

The Scottish Government and the SGPC share a vision of the role of the GP as the expert medical generalist in the community. In line with commitments made in the MOUs (1 & 2), HSCPs and NHS Boards will place additional primary care staff in GP practices and the community who will work alongside GPs and practice staff to reduce GP practice workload. Non-expert medical generalist workload needs should be redistributed to the wider primary care multi-disciplinary team ensuring that patients have the benefit of the range of expert advice needed for high quality care.

Specific priority services to be reconfigured at scale are:

- Pharmacotherapy
- FCP MSK
- Community Link Workers
- Primary Care Mental Health
- Vaccinations
- CTAC
- Urgent Care

The Primary Care Improvement Fund: Annual Funding Letter 2024-25 issued by the SG on 05 July 24 notes good progress on implementation of primary care multidisciplinary teams. A workforce of over 4,900 whole time equivalent in post are supporting service delivery in March 2024, of which there are over 3,500 funded through the Primary Care Improvement Fund (PCIF). The letter confirms the 2024-25 funding allocations for the PCIF element of the wider Primary Care Fund.

The letter sets out the planning assumptions for Boards to continue to use in year 2024-25, including:-

- Ensure that plans are developed and implemented through local engagement and collaboration.
- Prioritise Pharmacotherapy and CTAC services to ensure regulatory requirements are met while maintaining and developing other MoU services.
- Recognise the interdependences between all three levels of Pharmacotherapy which require focus on the delivery of the Pharmacotherapy service as a whole. CTAC services should continue to be designed locally, taking into account local population health needs, existing community services as well as what will deliver the most benefit to practices and people.

- Where necessary, continue with local transitionary arrangements with practices from within the existing PCIF envelope on the condition that there must be a clear plan for how that MDT support will be delivered on a long term and sustainable basis.
- Assume the SG will not bring forward regulations on Urgent Care services.

2.3 Assessment

The key priority areas are set out below:-

2.3.1 Pharmacotherapy

A total of 16 x GP practices are receiving support from the Inverness-based Pharmacy Hub. Positive recruitment levels have been observed for the Inverness base, and the employment of Trainee Pharmacy Technicians is contributing to the development of a staffing pipeline. Pharmacotherapy transitional payments to GP Practices for financial year 2023/24 were approved through the PCIP governance structures, making a one-off payment to GP Practices using Pharmacotherapy PCIF allocation in-year slippage. The payments recognised a variation in levels of service delivery across the financial year 23-24. Practices with a partial service across the year received their single payment in May's PSD statement. A live dashboard detailing the allocation of resources to GP Practices from the Pharmacotherapy service —both planned and current—is now visible and accessible on the NHSH intranet.

2.3.2 First Contact Physiotherapy

The FCP service has successfully achieved a full staffing establishment of 18.5 WTE (30 staff). There are 2 x maternity leave's pending which will affect Lochaber (2 x Practices) and Inverness (2 x Inverness Practices, 1 x Drumnadrochit Practice) and interviews scheduled for week of 05 August 24. A total of 22 out of 30 FCPs now hold their NMP qualification and 26 out of 30 FCPs have completed their joint injection training. The PHIO Access trial continues apace, offering a digital MSK self-referral pathway to GP Practice patients. By mid-June 24 a total of 996 patients engaged with the product from 94% of all GP Practices. 76% patients have entered PHIO rehab programme, 18% put back to GP and only 5% experiencing tech limiting issues. Patients returning to GP Practice/FCP will be identified through the creation of a new guideline. On May 5, 24, the PCIP Programme Board granted an SBAR request to extend the PHIO study for an additional four months, ending on March 31, 25. In order to look into the possibility of offering patients this particular type of digital tool in the longer term, FCP Leads and Procurement have begun collaborating on preliminary scoping studies.

2.3.3 Community Link Worker

The contract retendering process is complete and correspondence issued to practices advising that the current service provider, Change Mental Health, remains unchanged. The service will extend to all GP Practices in Highland from August 24, recruitment dependent. Preparations in-hand including the installation of the Elemental software package, gathering of data regarding the

requirements of practices, establishing formal information sharing agreements and the recruiting and on boarding new staff. The CLW year two annual report is drafted and will include patient input and an evaluation of the entire years' worth of data. Referral rates into the service remain high, 353 referrals received in 3 months 01 May to 19 July 24, creating 600 social prescriptions. The key reasons for referral remain unchanged and these are social isolation, loneliness, and mental health and well-being. The most commonly used interventions are Decider Skills, Nature for Health, Partnerships for Wellbeing and Highland Council Welfare Support.

2.3.4 Primary Care Mental Health

The PCMH Service Specification now includes the breakdown of the team's roles, responsibilities and sessional detail and has been shared out to all GP Practices. Recent successful recruitment achieved to a number of vacancies including Band 3 post, Fort William, Band 6 posts in Inverness and Skye, Lochalsh and Wester Ross and Band 4 Guided Self Help worker. These new post holders will make a significant and positive impact on the delivery of the service. A live dashboard detailing the allocation of resources to GP Practices from the service —both planned and current—will shortly be visible accessible on the NHSH intranet.

2.3.5 Vaccination Transformation Programme

Following a PHS Peer Assessment of VTP, a weekly Vaccine Improvement Group has been set up to determine the most appropriate future delivery model for vaccination to ensure Highland citizens have access to safe high quality immunisation services within their local community.As part of this process, senior GPs and the Board have agreed that a Short Life Working Group (SLWG) which will report to the Vaccine Improvement Group. The SLWG will compile general practice options appraisal assessment informed by population vaccination uptake and delivery rates; vaccine accessibility; quality and patient safety; and capacity and workforce. The assessment will be undertaken at a general practice population level and will also consider the different vaccination programmes. A co-produced questionnaire to survey GP practices to assess general practice ability to input to the vaccination programmes has been circulated and returned by 61 out of 62 Practices. Of these responses, 6 practices indicated no interest in the future delivery of some or all of the vaccination programme (5 x 2C Practices and 1 x GMS Practice).

2.3.6 Community Treatment and Care

The approved CTAC Rural Flexibility and Options Appraisal SBAR was submitted to SG along with the PCIP 7 tracker document in May 24. A meeting was held with SG representatives on June 12, 24 to discuss the document and agree next steps. The SBAR is to be developed further to

provide additional evidence and detail for resubmission to SG ahead of the next National GMS Oversight Group meeting at the end of August 24. CTAC transitional payment arrangements to GP Practices will continue until the options appraisal process has concluded.

2.3.7 Premises

A dedicated resource has been recruited to a 12 month fixed term post of Primary Care Manager (Premises), and started on May 20, 24. The initial focus will be on GP Leased Premises.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	☐	**Moderate**	☑
Limited	☐	None	☐

Comment on the level of assurance

The programmes of Pharmacotherapy, MSK Physiotherapy, CLW and PC Mental are well established and providing services to GP Practices. The VTP model is being re-examined to identify the most appropriate future delivery model for the vaccination Highland citizens. A Rural Flexibility Options Appraisal for CTAC is being redrafted and supplemented prior resubmission to SG for comment and consideration.

3 Impact Analysis

3.1 Quality/ Patient Care

Primary care multi-disciplinary teams are working alongside GPs and practice staff to ensure that patients have the benefit of the range of expert advice needed for high quality care. As services become further embedded and evaluations completed, a superior understanding of impact on quality and care will be determined and evidenced.

3.2 Workforce

PCIP offers new opportunities for clinical and non-clinical staff to positively impact patient care and outcomes. There are opportunities for personal development, training, up-skilling, flexibility, collaboration and building relationships with the broader MDT both in a GP Practice and community based setting. Development and retention of the PCIP workforce is paramount to service provision and sustainability. The services face recruitment challenges impacting on their ability to provide equitable services across Practices. Lack of room space within GP Practice premises can provide a challenge to accommodate the wider MDT.

3.3 Financial

The Primary Care Improvement Fund: Annual Funding Letter 2024-25 issued by the SG on 05 July 24 confirmed the 2024-25 funding allocation for PCIF. Whilst the SG are providing the full PCIF allocation in a single payment tranche this year, where an IA's 2023-24 PCIF spend was 90% or less than allocation, the SG will provide a 90% allocation in a payment, with a second tranche payment being made available later in the year, subject to reporting confirming latest spend and forecast data. Agenda for Change uplifts for all IA's will be provided in a separate allocation once pay negotiations have concluded.

The SG has allocated a total of £190.8 million for IAs in 2024-25 for PCIF. The minimum funding position for PCIF is guaranteed at £190.8 million annually with additional funding being provided in full to support Agenda for Change uplifts for recruited staff. The National Oversight Group has agreed to look into the potential of baselining all of PCIF in year 2026/27.

The total PCIF allocation to Highland is £9,058,239 of which a 90% allocation payment has been received. An email exchange with SG on 01.08.24 set out our position and forecast to spend the full (100%) allocation in the current financial year. The basis of which is the extension of the Community Link Worker project to all 62 GP Practices in Highland as well as local transitionary arrangements with Practices for CTAC, whilst a plan is agreed and finalised on how CTAC can be delivered long term and sustainably.

3.4 Risk Assessment/Management

PCIP Assurance Report and Risk Register are reviewed and updated bi-monthly and reported into bi-monthly PCIP Project Team and quarterly to PCIP Programme Board for scrutiny and approval. The PCIP risk register was fully reviewed in July 24 detailing identified risks, controls, risk level and current mitigations and actions.

3.5 Data Protection

At the strategic level, the PCIP program does not include any personally identifying information.

3.6 Equality and Diversity, including health inequalities

PCIP activity and services are focused on improving patient experience and care across all GP Practices, urban and rural and recognising and responding to locations experiencing higher levels of social deprivation. The development of services will contribute to achieving better health outcomes for the population. The development of primary care service redesign adheres to the seven key principles which includes equitable, fair and accessible to all.

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

- GP Sub representation on Workstreams, Project Team and Programme Board.
- All Workstream Groups include GP Practice representation.
- Communications Team collaborating at Workstream Leads and Project Team and developing engagement activities, including service promotion videos and reaching out to patient groups.
- Workstreams gathering in patient feedback on their services.
- PCIP updates included in weekly GP Practice bulletin.
- PCIP key documents shared on NHS intranet under Projects.

3.9 Route to the Meeting

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

- PCIP Project Team meetings 28 May 2024 and 31 July 2024.
- PCIP Programme Board meetings 08 May 2024 and 14 August 2024.

4 Recommendation

- **Assurance** – To give confidence of compliance with legislation, policy and Board objectives.

4.1 List of appendices

The following appendices are included with this report:

- Appendix 1, PCIF 24-25 Allocation Letter July 2024
- Appendix 2, PCIP Summary of Implementation Progress at March 2024
- Appendix 3, PCIP Assurance Report July 24

Susan Gallacher
General Practice Policy Division
Primary Care Directorate
Scottish Government
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

E: susan.gallacher@gov.scot

Integration Authority Chief Officers
NHS Board Chief Executives
Integration Authority Chief Finance Officers
NHS Board Director of Finance
Primary Care Improvement Plan leads
Primary Care Clinical and Management leads

5 July 2024

Dear colleagues

PRIMARY CARE IMPROVEMENT FUND: ANNUAL FUNDING LETTER 2024-25

Thank you for providing the data requested through the Primary Care Improvement Plan (PCIP) 7 tracker exercise which has been used to produce our annual statistical publication. We continue to make good progress on implementation of primary care multidisciplinary teams with a workforce of over 4,900 whole time equivalent in post supporting service delivery in March 2024[1], of which there are over 3,500 funded through the Primary Care Improvement Fund (PCIF).

I am writing to confirm the 2024-25 funding allocations for the PCIF element of the wider Primary Care Fund (PCF) to help you develop your PCIPs to support our core aims of sustaining investment in general practice and improving outcomes for people, workforce and the wider healthcare system, in line with our commitments in the policy prospectus[2]. The PCIF is an earmarked fund which should be used to support the implementation of PCIPs and should not be used for other purposes.

Given that the programme has now reached a more mature phase, and following agreement with CFOs, for the vast majority of Integration Authorities (IA's), we are providing the full PCIF allocation in a single payment tranche this year. Where an IA's 2023-24 PCIF spend was 90% or less than allocation, we have provided a 90% allocation in this payment, with a second tranche payment being made available later in the year, subject to reporting confirming latest spend and forecast data. Arrangements for reporting will be provided in due course. Agenda for Change uplifts for all IA's will be provided in a separate allocation once pay negotiations have concluded.

[1] Primary care improvement plans: implementation progress summary - March 2024 - gov.scot (www.gov.scot)
[2] A fresh start for Scotland - gov.scot (www.gov.scot)

Funding will be allocated based on 2023-24 NRAC shares and will be disbursed via Health Boards to IAs. **As agreed with CFO representatives, these shares will now be the basis for future allocations**.

Available Resources

I can confirm that we will allocate **£190.8 million** for IAs in 2024-25 under the auspices of the PCIF. This comprises funding for PCIF inclusive of previous years' AfC uplift costs. The allocation will be reduced to account for baselined pharmacy funding. Note that baselined pharmacy funding of £7.8m has been allocated separately and must also be treated as part of the PCIF.

2024-25 Agenda for Change uplifts have not been included in allocations at this stage as pay negotiations are currently ongoing. Funding allocations for 2024-25 pay uplifts will be provided in full as outlined in Richard McCallum's Scottish Government Budget letter to NHS Board Chief Executives on 19 December 2023.

Reserves

As in previous years, reserves carried over into 2024-25 financial year will contribute to your overall 2024-25 allocation. Where reserves are held, allocations have been reduced accordingly.

Legal Commitments

Any funding held in reserves for legal commitments in 2024-25, where these were agreed with Scottish Government in August 2022, will not be deducted from your 2024-25 allocation.

Annex A shows the full allocation of the fund, by Health Board and by IA. The funding must be delegated in its entirety to IAs.

Planning Assumptions for 2024-25

HSCPs/Boards should continue to use the following planning assumptions for the year ahead:

- Continue to ensure that plans are developed and implemented through local engagement and collaboration with practices, Integration Authorities, Health Boards and GP Sub-Committees and agreed with Local Medical Committees to meet local population needs.
- Prioritise Pharmacotherapy and CTAC services to ensure regulatory requirements are met while maintaining and developing other MoU services (i.e. Urgent Care, Community Link Workers, Additional Professional Roles) in line with existing local arrangements.
- Based on PCIP progress as well as progress with separate vaccination regulations and directions, the Vaccination Transformation Programme

element of PCIPs is complete and should be maintained. PCA(M)(2022)13 provides the current position on the programme.

- In line with MoU2, recognise the interdependences between all three levels of pharmacotherapy which require focus on the delivery of the pharmacotherapy service as a whole. CTAC services should continue to be designed locally, taking into account local population health needs, existing community services as well as what will deliver the most benefit to practices and people.
- Where necessary, continue with local transitionary arrangements with practices from within the existing PCIF envelope on the condition that there must be a clear plan for how that MDT support will be delivered on a long-term and sustainable basis.
    - Working with local partners, IA's should ensure that they are not divesting from existing services or undermining the establishment or development of services in order to fund any transitionary arrangements.
    - Surplus PCIF funding can be used to support time-limited transitionary arrangements on the proviso that IA's are working to the planning assumptions set out in this letter as well as the policy framework of the Contract and MoUs; arrangements should be agreed locally, in line with local circumstances and need. This use of funding will be kept under review.
- Assume we will not bring forward regulations on Urgent Care services.
- Assume that in future years you will continue to receive your 2023/24 NRAC share of PCIF, uplifted to apply Agenda for Change and that you will be required to provide extended MDT support to practices with that funding.
- Note that reserves carried over into 2024-25 financial year will contribute to your overall 2024-25 allocation and your allocation will be adjusted accordingly to reflect this.

Baselining

The minimum funding position for PCIF is guaranteed at £190.8 million annually with additional funding being provided in full to support Agenda for Change uplifts for recruited staff. Following agreement at National Oversight Group, we have agreed to explore the potential for baselining the full PCIF in 2026/27. In the interim, we will establish a sub-group to further work through the issues presented by baselining including options to mitigate the risks that baselining could present, as well as to consider the processes for baselining the VTP element of PCIF prior to 26/27.

Monitoring and evaluation

We continue to work with all partners to consider next steps on national monitoring and evaluation. A key part of our approach over the next 18 months will be the evidence and learning from the Phased Investment Programme and we encourage all areas to join the Primary Care Improvement Collaborative to access learning and updates directly.

I trust this update gives you the assurances you need to continue to progress implementation of your PCIPs in 2024-25 and I look forward to working with you towards our shared goal of delivering improved care in our communities.

Yours faithfully

Susan Gallacher
Deputy Director, General Practice Policy
Primary Care Directorate

ANNEX A

PRIMARY CARE IMPROVEMENT FUND: ALLOCATION BY BOARD AND INTEGRATION AUTHORITY

Allocation By Territorial Health Board

Health Board	NRAC Share 2023-24	2023-24 PCIF	2023-24 AfC uplift	2024-25 Total Available	Reserves	Retention	2024-25 Total less reserves & retention	*less* PCIF baselined funds	PCIF T1 allocation 2024-25 (£)
NHS Ayrshire and Arran	7.31%	12,419,970	1,551,000	13,970,970	0	0	13,970,970	-569,300	13,401,670
NHS Borders	2.15%	3,659,639	449,000	4,108,639	0	0	4,108,639	-161,300	3,947,339
NHS Dumfries and Galloway	2.96%	5,039,527	694,000	5,733,527	-162,916	0	5,570,611	-229,100	5,341,511
NHS Fife	6.85%	11,648,976	1,568,000	13,216,976	0	0	13,216,976	-521,800	12,695,176
NHS Forth Valley	5.47%	9,291,966	1,129,000	10,420,966	0	0	10,420,966	-415,000	10,005,966
NHS Grampian	9.74%	16,554,003	1,884,000	18,438,003	0	0	18,438,003	-755,400	17,682,603
NHS Greater Glasgow & Clyde*	22.14%	37,638,815	4,362,000	42,000,815	-227,000	-641,690	41,132,125	-1,718,200	39,413,925
NHS Highland*	6.59%	11,203,724	1,468,000	12,671,724	0	-905,824	11,765,900	-494,100	11,271,800
NHS Lanarkshire	12.31%	20,931,062	2,288,000	23,219,062	0	0	23,219,062	-947,700	22,271,362
NHS Lothian*	15.07%	25,611,369	3,329,000	28,940,369	-208,000	-602,369	28,130,000	-1,132,000	26,998,000
NHS Orkney*	0.50%	851,053	122,000	973,053	-209,000	-97,305	666,748	-75,000	591,748
NHS Shetland	0.48%	813,856	114,000	927,856	0	0	927,856	-76,200	851,656
NHS Tayside	7.77%	13,211,219	1,827,000	15,038,219	-96,000	0	14,942,219	-601,900	14,340,319
NHS Western Isles*	0.66%	1,124,821	52,000	1,176,821	-236,000	-117,682	823,139	-103,000	720,139
		170,000,000	**20,837,000**	**190,837,000**	**-1,138,916**	**-2,364,870**	**187,333,214**	**-7,800,000**	**179,533,214**

*Board with an IA where 10% of PCIF 2024-25 allocation has been retained and will be made available at tranche two, subject to reporting confirming latest spend and forecast data.

Allocation by Integration Authority

NHS Board	Integration Authority	IA NRAC Share 2023-24 (£)	2023-24 PCIF	2023-24 AfC uplift	2024-25 Total Available	Reserves	Retention	2024-25 Total *less* reserves & retention	*less* PCIF baselined funds	PCIF T1 allocation 2024-25 (£)
Ayrshire and Arran	Ayrshire combined	7.31%	12,419,970	1,551,000	13,970,970	0	0	13,970,970	-569,300	13,401,670
Borders	Scottish Borders	2.15%	3,659,639	449,000	4,108,639	0	0	4,108,639	-161,300	3,947,339
Dumfries and Galloway	Dumfries and Galloway	2.96%	5,039,527	694,000	5,733,527	-162,916	0	5,570,611	-229,100	5,341,511
Fife	Fife	6.85%	11,648,976	1,568,000	13,216,976	0	0	13,216,976	-521,800	12,695,176
Forth Valley	Forth Valley combined	5.47%	9,291,966	1,129,000	10,420,966	0	0	10,420,966	-415,000	10,005,966
Grampian	Aberdeen City	3.78%	6,425,049	731,231	7,156,280	0	0	7,156,280	-298,317	6,857,963
	Aberdeenshire	4.23%	7,197,962	819,195	8,017,157	0	0	8,017,157	-324,766	7,692,391
	Moray	1.72%	2,930,992	333,574	3,264,566	0	0	3,264,566	-132,317	3,132,249
Greater Glasgow & Clyde	East Dunbartonshire	1.85%	3,151,403	365,219	3,516,622	-11,000	0	3,505,622	-140,141	3,365,481
	East Renfrewshire	1.58%	2,682,743	310,906	2,993,649	-90,000	0	2,903,649	-120,632	2,783,017
	Glasgow City	11.95%	20,319,427	2,354,839	22,674,266	0	0	22,674,266	-928,315	21,745,951
	Inverclyde	1.60%	2,728,381	316,195	3,044,576	0	0	3,044,576	-126,472	2,918,104
	Renfrewshire*	3.38%	5,750,476	666,428	6,416,904	-126,000	-641,690	5,649,214	-261,903	5,387,311
	West Dunbartonshire	1.77%	3,006,385	348,413	3,354,798	0	0	3,354,798	-140,737	3,214,061
Highland	Argyll and Bute	1.88%	3,194,868	418,617	3,613,485	0	0	3,613,485	-141,683	3,471,802
	Highland*	4.71%	8,008,856	1,049,383	9,058,239	0	-905,824	8,152,415	-352,417	7,799,998
Lanarkshire	Lanarkshire combined	12.31%	20,931,062	2,288,000	23,219,062	0	0	23,219,062	-947,700	22,271,362
Lothian	East Lothian	1.89%	3,215,085	417,901	3,632,986	0	0	3,632,986	-140,067	3,492,919
	Edinburgh	8.40%	14,271,709	1,855,056	16,126,765	0	0	16,126,765	-634,173	15,492,592
	Midlothian	1.64%	2,793,788	363,140	3,156,928	0	0	3,156,928	-120,660	3,036,268
	West Lothian*	3.14%	5,330,787	692,903	6,023,690	-208,000	-602,369	5,213,321	-237,100	4,976,221
Orkney	Orkney Islands*	0.50%	851,053	122,000	973,053	-209,000	-97,305	666,748	-75,000	591,748
Shetland	Shetland Islands	0.48%	813,856	114,000	927,856	0	0	927,856	-76,200	851,656
Tayside	Angus	2.16%	3,670,680	507,624	4,178,304	-65,000	0	4,113,304	-165,208	3,948,096
	Dundee City	2.82%	4,802,335	664,122	5,466,457	-13,000	0	5,453,457	-226,196	5,227,261
	Perth and Kinross	2.79%	4,738,204	655,254	5,393,458	-18,000	0	5,375,458	-210,496	5,164,962
Western Isles	Western Isles*	0.66%	1,124,821	52,000	1,176,821	-236,000	-117,682	823,139	-103,000	720,139
			170,000,000	**20,837,000**	**190,837,000**	**-1,138,916**	**-2,364,870**	**187,333,214**	**-7,800,000**	**179,533,214**

*IA where 10% of PCIF 2024-25 allocation has been retained and will be made available at tranche two, subject to reporting confirming latest spend and forecast data.

Primary Care Improvement Plans

Summary of Implementation Progress at March 2024

June 2024

Scottish Government
Riaghaltas na h-Alba

Introduction

This management information publication provides a national summary of the progress towards implementation of the Memorandum of Understanding ("MoU": see background section below for more information about what this is). It covers the period up to the end of March 2024 and is based on data provided by Integration Authorities (IAs) in May 2024. It updates the information published in June 2023. The data at IA/NHS Board level is available in the spreadsheet accompanying this publication.

Data Quality

The data included in this report is provided by IAs. Workforce numbers come from local systems. These systems are dynamic and primarily used for operational purposes. As the data can change over time, the figures presented here are the best available estimates. The Scottish Government is working with IAs to improve data quality. Therefore, previously published information may change to reflect these refinements.

The publication contains data on two broad areas: workforce numbers and access to NHS Board provided services.

Information on staff funded by the Primary Care Improvement Fund and also other sources was collected, which is the same approach as was taken with last year's collection. This has improved understanding of the wider workforce providing services. For this collection, the only change from 2023, is that we have separated the "Occupational Therapy" role within "Additional Professional Roles". This should allow greater clarity over the number of these staff, but should not affect overall workforce total as these should have previously been included elsewhere.

As with the last collection, we have asked only if practices have access to a health board provided services. As a result, these figures include access from minimal access to full access and any interpretation should take account of this. Scottish Government continues to work with IAs to improve our understanding of levels of access to services, by enhancing data collection on service capacity and delivery models.

Background

The 2018 GMS Contract Offer ("the Contract Offer") and its associated Memorandum of Understanding ("MoU") between the Scottish Government (SG), the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities (IAs) and NHS Boards was a landmark in the reform of primary care in Scotland. The Contract Offer refocused the General Practitioner (GP) role as expert medical generalists. This enabled General Practitioners to do the job they train to do and deliver better care for patients. The Contract Offer committed to a vision placing general practice at the heart of the

healthcare system. This vision sees multidisciplinary teams (MDT) inform, empower and deliver services to communities in need. To support these aims, it set out the intent to redistribute non-expert medical generalist workload to the wider primary care MDT. This aims to ensure that patients can benefit from a wider range of expert advice, receiving high quality care. It recognised the statutory role of IAs in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. It also recognised the role of NHS Boards in service delivery and as NHS staff employers, and parties to General Medical Services (GMS) contract.

The MoU set out the six priority service areas where IAs, in partnership with Health Boards and GPs, would focus for service redesign and expansion of the MDT:

- Vaccination Transformation Programme (VTP);
- Pharmacotherapy;
- Community Treatment and Care Services (CTAC);
- Urgent Care;
- Additional Professional Roles;
- Community Link Workers (CLW).

In 2021 the MoU was refreshed (the MoU2) to cover the period 2021-2023. It reaffirmed the commitment to expanding and enhancing multidisciplinary teams to help support the role of GPs as expert medical generalists and to improve patient outcomes. The MoU parties recognised a great deal had been achieved while acknowledging there was still a way to go to fully deliver the GMS Contract Offer commitments. In particular, the MoU noted a focus on three services - Vaccination Transformation Programme, Pharmacotherapy and CTAC. Regulations have since been amended to place a legal responsibility on Health Boards to provide Pharmacotherapy and CTAC services to general practices and their patients, alongside Health Boards' responsibility for the provision of vaccinations services.

In September 2023, in a communication to all MoU parties, the Scottish Government restated the commitment to MoU implementation and enhancing and expanding the MDT. It recognised that good progress had been made, while acknowledging that implementation gaps remained. It detailed the intention to take a twin-track approach over the following 18 months. This would comprise of the introduction of an additional phased investment programme, supported by additional funding, working with a small number of areas, at different stages of implementation, and from different settings. This aimed to demonstrate what a model of full implementation can look like in practice. It noted that the learning from the programme would be used to inform long-term Scottish Government investment in the MDT. It also set out the intent to continue to work with all areas to support improvement of the MDT within the existing funding envelope.

In February 2024, the Scottish Government confirmed that, following conclusion of the bidding process, the sites chosen as demonstrator areas are Ayrshire and Arran, Edinburgh City, Scottish Borders and Shetland. The site teams will work

closely with Healthcare Improvement Scotland (HIS) to use improvement methodologies to more fully implement Pharmacotherapy and CTAC services locally. They will also aim to understand the impact for people, the workforce and the healthcare system. HIS have established a national Primary Care Improvement Collaborative which will support local teams outwith the demonstrator sites to implement quality improvement approaches in pharmacotherapy and CTAC services and in access to primary care services.

Funding to support the implementation of the MoU has been allocated to IAs through the Primary Care Improvement Fund (PCIF). Locally agreed Primary Care Improvement Plans (PCIPs) covering all 31 IAs in Scotland have been developed and implemented since July 2018. The PCIPs set out in more detail how implementation of the six priority service areas will be achieved. IAs are required to provide annual updates on their PCIPs. These updates are supplied via an agreed standard tracker template, with a focus on workforce and access data.

The delivery of primary care transformation is occurring within a complex local landscape. IAs must work closely with local communities and stakeholders to ensure that PCIPs address specific local challenges and population need. They must also agree where the local priorities lie for the services being reformed. As a result of this, there is geographical variation in service design and delivery models.

Workforce numbers

Table 1 shows the number of whole time equivalent (WTE) staff working to support implementation of the six MOU agreed priority services.

The data shows 4,925.1 WTE staff working in the MOU services in March 2024. Of these, 3,540.4 were funded by the Primary Care Improvement Fund and 1,384.8 were funded through other sources.

There was an overall increase of 196.4 WTE staff between March 2023 and March 2024. This represents an increase of 310.4 funded through the Primary Care Improvement Fund and a fall of 113.9 funded through other sources.

Increases in workforce may represent progress towards delivery of the MoU. However, there is no agreed target for specific service or total workforce levels required across Scotland.

It should also be recognised that there may be variation in appropriate staffing numbers depending on the clinical model developed, the skills mix of the workforce and local population needs.

Table 1: Number of Staff: Scotland - Whole time equivalent at 31 March

		PCIF funded	Other funded	Total	PCIF funded	Other funded	Total
		Mar-23	Mar-23	Mar-23	Mar-24	Mar-24	Mar-24
Pharmaco-therapy	Pharmacist	558.1	101.9	**660.1**	550.1	107.2	**657.3**
	Pharmacy Technician	384.1	37.7	**421.8**	408.5	42.1	**450.6**
	Assistant/Other Pharmacy Support Staff	116.5	11.8	**128.2**	143.9	14.6	**158.4**
Vaccinations	Nursing	224.6	298.4	**523.0**	238.7	289.9	**528.6**
	Healthcare Assistants	68.6	305.9	**374.6**	62.7	203.6	**266.3**
	Other	66.8	146.7	**213.5**	78.0	115.9	**193.9**
CTAC	Nursing	370.4	154.0	**524.4**	430.7	152.6	**583.3**
	Healthcare Assistants	441.9	91.3	**533.1**	489.0	70.8	**559.8**
	Other	86.9	8.4	**95.4**	125.2	4.7	**129.9**
Urgent Care	Advanced Nurse Practitioners	201.6	20.6	**222.2**	197.9	26.7	**224.5**
	Advanced Paramedics	11.8	1.0	**12.8**	12.0	1.0	**13.0**
	Other	17.6	27.7	**45.3**	39.5	32.6	**72.0**
Additional professional roles	Mental Health workers	186.5	207.9	**394.3**	182.5	216.4	**398.9**
	MSK Physios	202.1	23.8	**225.9**	227.8	24.3	**252.1**
	Occupational Therapists	8.5	0.0	**8.5**	28.1	1.7	**29.8**
	Other	30.4	7.0	**37.4**	60.5	20.7	**81.2**
Community Link Workers		253.6	54.6	**308.2**	265.4	60.1	**325.5**
TOTAL		**3230.0**	**1498.7**	**4728.7**	**3540.4**	**1384.8**	**4925.1**

NHS Board Provided Services

NHS Boards are placing the additional primary care staff described in the workforce numbers section in general practices and the community. Here they can work alongside GPs and practice teams to deliver an increased range of services, in accordance with the MoU. In doing so, they can support the expert medical generalist model and improve patient care. While some of these services and sub-services represent new areas of activity, in most cases, these had historically been provided by individual general practices. Chart 1 illustrates the percentage of general practices whose patients can now access these services directly from their NHS Board. The data relating to this chart can be found in the spreadsheet which accompanies this publication.

It is not expected that all general practices in Scotland will take up these NHS Board provided services. Since service delivery models are designed specifically according to local population needs, there are variations in approach across the country. For example, there may be some general practices where there is no defined need for a particular professional role. These services may therefore never reach 100 per cent coverage. There may also be local circumstances where local Primary Care Improvement Programme Boards determine it is necessary for one or more local genral practices to continue delivering one or more services intended to transfer to board-employed MDT under the MoU.

Between 83 and 98 percent of practices have access to different level 1 pharmacotherapy subservices as at March 2024. Between 64 to 94 percent of practices have access to level 2 pharmacotherapy subservices, and between 52 and 82 percent of practices have access to level 3 pharmacotherapy subservices.

For CTAC services as at March 2024, 86 percent of practices have access to Phlebotomy, 61 percent of practices have access to Chronic Disease Monitoring. Ninety percent of practices had access to Other CTAC services.

The roll out of the Vaccination Transformation Programme is well advanced. Ninety-nine percent of practices have access to school age, pregnancy, pre-school, out of schedule, adult immunisations and adult flu vaccinations. Travel vaccinations are accessed by 98 percent of practices.

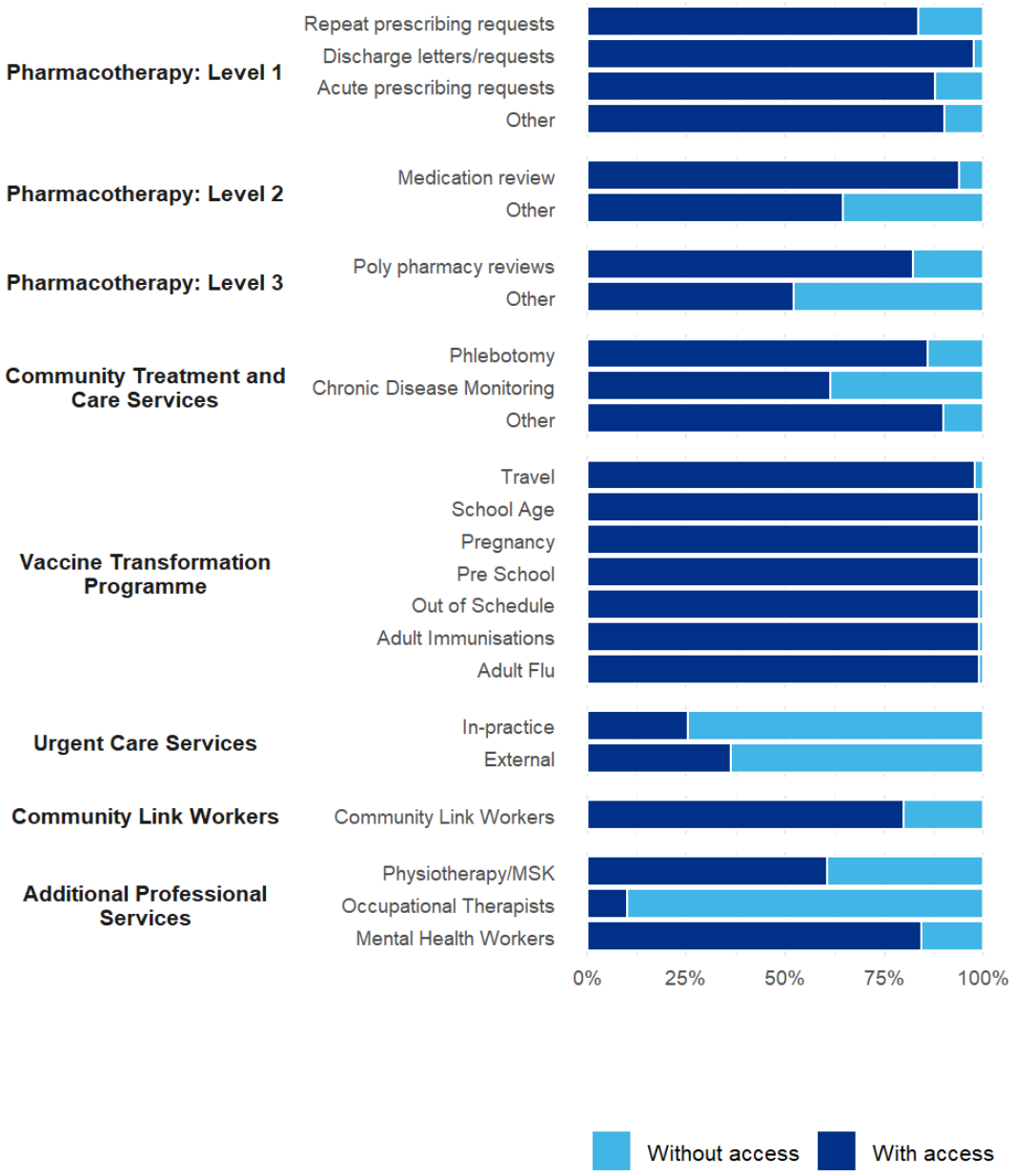
Of NHS Board-provided urgent care services, 26 percent of practices have access to services delivered in-practice and 36 percent of practices have access to external services.

Eighty percent of practices have access to a Community Link Worker. However, CLW services are not intended to be universal but should, primarily, be targeted where there is greatest need, in line with deprivation and health inequalities.

Additional professional services include physiotherapy, mental health workers, and occupational therapists. Sixty-one percent of practices have access to a

musculoskeletal physiotherapist, 84 percent of practices have access to a mental health worker, and 10% of practices have access to an occupational therapist.

Chart 1: Access to Health Board provided services as at March 2024, Scotland



Background notes: Definitions

There may be geographical and other limitations to the extent of any service redesign and local needs which need to be determined as part of the PCIP. The services included in the MoU are defined as follows:

Vaccination Transformation Programme - VTP was announced in March 2017. It reviewed and transformed vaccine delivery in light of the increasing complexity of vaccination programmes in recent years. It also reflected the changing roles of those historically tasked with delivering vaccinations.

IAs have delivered phased service change based on locally agreed plans as part of the PCIP. These meet a number of nationally determined outcomes including redistributing work from GPs to other appropriate professionals. In October 2021, regulation change removed vaccinations from the GMS contract. This was supplemented by legal directions which were issued in August 2022. These provided a framework to conclude the role of most general practices in providing vaccinations. PCA(M)(2022)13 provides the current position on the programme.

Pharmacotherapy – There are three levels of service provision covering core and additional activities.

The level one (core) pharmacotherapy service includes activities at a general level of pharmacy practice including actioning acute and repeat prescribing requests and medicines reconciliation activities.
Level two (advanced) and three (specialist) are additional services. They describe a progressively advanced specialist clinical pharmacist role with a focus on high-risk medicines and working with patients to undertake medication and polypharmacy reviews.

The MoU2 recognised the interdependencies between all three levels of pharmacotherapy and the need to focus on the delivery of the pharmacotherapy service, as a whole.

Regulations have now been amended by Scottish Government so that NHS Boards are responsible for providing a pharmacotherapy service to patients and practices.

Community Treatment and Care Services - These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear care, suture removal, and some types of minor surgery as locally determined as being appropriate.

Scottish Government have amended regulations for the delivery of CTAC Services. Boards are now responsible for providing a Community Treatment and Care service. These services will be designed locally, taking into account local population health needs, existing community services, and optimising benefit to practices and patients.

Urgent Care - These services provide support for urgent unscheduled care within daytime primary care. For example, providing advance nurse or paramedic practitioner resource for general practice clusters and practices to respond to a range of ill health need which requires senior clinical decision making capacity. Activities range from house calls, demand from care homes, or on the day urgent care response in practice. This creates capacity to enable GPs to better manage their time for more complex cases.

Additional Professional Roles - Additional professional roles provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT or in an advance practitioner capacity). These roles could include, but are not limited to:

- Musculoskeletal focused physiotherapy services
- Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice.

Specialist professionals will work within the local MDT to see patients at the first point of contact. They will assess, diagnose and deliver treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

MoU Parties will consider how best to develop the additional professional roles element of the MoU. In particular with Mental Health, there is a need to consider how PCIF funded posts interface with posts funded through other streams (such as Action 15).

Scottish Government continues to work with local areas on how we best align funding and reporting arrangements across different mental health funding streams. This aims to ensure better co-ordination and integration across the wider system.

It should be noted that, given the expansion of occupational therapy services and roles within a number of IA areas in recent years, we have included occupational therapy as a distinct workforce category for the first time this year. Occupational therapists are dual trained in providing assessment, self-management advice and therapy to people with both physical and mental health conditions. They support people with environmental adaptation and rehabilitation, to access or return to work, education and social activities. Variation in the development of services comprising additional professional roles reflects a number of factors including local needs and existing community services.

Community Link Worker (CLW) - Non-clinical, generalist practitioner, based in or aligned to a general practice or cluster, often in more deprived communities. They work directly with patients to help them deal with socio-economic challenges associated with poor health which cannot be addressed clinically. CLWs help people navigate and engage with a wide range of health and social statutory and voluntary services. They may also work with patients who need support because of

the complexity of their care and support needs, rurality, or a specific status (e.g. asylum seeker/refugee or homeless). CLW services should be targeted to local need and provide connection between general practice and wider community resources.

Access data - reflects how many general practices have access to a given service or sub-service. There is no additional data provided on levels of access. The access data therefore represents a range of access levels from minimal to full access and should be interpreted as such.

Contact

For more information or queries on the information presented here please contact the Primary Care Policy Team at PCImplementation@gov.scot.

North Highland H&SCP – Primary Care Modernisation Programme

Project Manager's Assurance Report

Issued By Catriona Naughton, Project Manager

Employer NHS Highland
Address Assynt House
Beechwood Business Park,
Inverness, IV2 3BW

Report No 50
Date 31/07/24

1. INTRODUCTION

This Assurance Report has been prepared in relation to the **implementation of the 2018 General Medical Services Contract in Scotland**. This strategic document is supported by a memorandum of Understanding and proposes a refocusing of the General Practitioner role as expert medical generalists. This refocusing of the GP role will require some tasks to be carried out by members of the wider primary care team where it is safe, appropriate and improves patient care. It is expected that these new arrangements will see a reduction in risk for GP partners and a substantial increase in practice sustainability.

Pam Cremin, Senior Responsible Officer has executive responsibility for the delivery of the programme and chairs the Programme Board.

Jill Mitchell is responsible for delivering the programme of work and is supported by a core project team of Catriona Naughton (Project Manager) and work stream leads. Highland GP Sub and LMC are key partners in the development of the programme.

This document provides a summary in relation to progress achieved on the project to date, activity in the previous period and forecast for the coming period. This progress report covers the period to **31/07/2024**.

2. Project Status - RAG

	Previous RAG	Current RAG	Comments
Timeline	Amber	Red	Programmes of Pharmacotherapy, MSK physiotherapy, CLW and PC Mental Health and VTP services are established. RAG status remains at red due to the delayed progression of CTAC **and initiation of VTP review of current delivery model.**
Scope	Green	Amber	Workstream outputs continue to be developed and agreed broadly in line with the plan**. Additional supporting detail requested by SG to supplement the CTAC rural options appraisal document. For resubmission to SG ahead of the Oversight Group meeting at the end of August 24.**
Budget (Aspirational)	Amber	Amber	The funding will not deliver all of the tasks and services across all workstreams to all practices. Clarity on service delivery against funding will become clearer as CTAC hybrid model is developed.
Budget (Actual)	Amber	Amber	Track workstream progress against budget/spend. **PCIF Annual Funding letter 2024-25 has been received. Total share as in previous year amounts to £9,058,238. NHSH will be provided with a 90% allocation payment, with a second tranche payment being made available later in the year subject to reporting confirming latest spend and forecast data.**

3. PROJECT PROGRAMME

Current Programme:	Rev Date: 31/07/24	Rev: 42	**Current Status:**	Update	Amber

Milestone Activity	Due date	Estimated / actual date	RAG Status
CTAC model not implemented	2022/23	2024/25	Red
Resubmission of expanded CTAC rural options appraisal to SG.	**August 24**	**July/August 24**	**Amber**

4. KEY PROJECT DELIVERABLES COMPLETED THIS PERIOD (TO 31 July 24)

Description	Status	Owner
CTAC Rural Options Appraisal meeting with SG	**Complete**	Jill Mitchell
Move PT meetings to bi-monthly	**Complete**	Catriona Naughton
FCP SBAR - Extension of PHIO Access approved and PCIF allocation of in year underspend agreed.	**Complete**	Jude Arnaud/Fiona Ward
Smart Survey SBAR - Approval to purchase digital product	**Complete**	Catriona Naughton
Pharmacotherapy Live resource dashboard	**Complete**	Thomas Ross

5. KEY PROJECT DELIVERABLES TO BE COMPLETED IN NEXT PERIOD (TO 30 September 24)

Description	Status	Owner
CLW SBAR – take forward to Programme Board 14.08.24 (subject to PT approval)	**Green – in progress**	**Cathy Steer**
FCP SBAR - take forward to Programme Board 14.08.24 (approved PT 28.05.24)	**Green – In progress**	**Paul Chapman**
Submit updated CTAC SBAR/Rural flexibility and Options Appraisal to SG	**Green – in progress**	**Jill Mitchell**

6. KEY PROJECT RISKS IN THE REPORTING PERIOD

Current Risks:	Rev Date: 31/07/24	Rev: 31	**Current Status:**	Update	Amber

Key **high** level risks with **updated mitigation/actions within the current period**.

Description	Risk level (current)	Current Mitigation/Action
Continued viability of current Vaccination Programme model.	**HIgh**	**A weekly Vaccine Improvement Group has been set up to determine the most appropriate future delivery model for vaccination to ensure Highland citizens have access to safe high quality immunisation services within their local community. As part of this process, senior GPs and the Board have agreed that a Short Life Working Group (SLWG) which will report to the Vaccine Improvement Group, will compile general practice options appraisal assessment informed by population vaccination uptake and delivery rates; vaccine accessibility; quality and patient safety; and capacity and workforce.**

North Highland H&SCP – Primary Care Modernisation Programme

Project Manager's Assurance Report

Issued By Catriona Naughton, Project Manager

Employer Address NHS Highland
Assynt House
Beechwood Business Park,
Inverness, IV2 3BW

Report No 50
Date 31/07/24

7. ADDITIONAL PROFESSIONAL ROLES – MSK PHYSIO

Current Programme:	Rev Date: **31/07/24**	Rev: 27	**Current Status:**	Update	GREEN

Current Plan	**Progress**	**Due date**	**Est. / actual date**
Planned compliment of FCP staff in WTE	18.48 WTE	On-going	On-going
Current gaps in FCP staffing in WTE	**2 x maternity leave posts out to advert**	**August/Sept 24**	**August/Sept 24**
PHIO access to General Practice and patients.	**Active 16 month trial to 31 March 25**	On-going	On-going
SBAR – FCP Non Pay Budget	**Approved PT 28.05.24, now to Programme Board for ratifying**	**14.08.24**	**14.08.24**

8. PHARMACOTHERAPY

Current Programme:	Rev Date: **31/07/24**	Rev: **20**	**Current Status:**	Update	GREEN

Current Plan	**Progress**	**Due date**	**Est. / actual date**
Develop monitoring and evaluation reports	Awaiting HIS reporting tool	May 24	tbc
Planned compliment of Pharmacotherapy staff in WTE	**47.9 WTE**	On-going	On-going
Current gaps in Pharmacotherapy staffing in WTE	**6.5 WTE**	On-going	On-going

9. ADDITIONAL PROFESSIONAL ROLES – MENTAL HEALTH

Current Programme:	Rev Date: 31/05/2024	Rev: 22	**Current Status:**	Update	**GREEN**

Current Plan	**Progress**	**Due date**	**Est. / actual date**
Planned compliment of PCMH staff in WTE	22.8 WTE	n/a	n/a
Current gaps in PCMH Nurse staffing in WTE	2.6 WTE B6 Nurses	live	live
Development of live resource dashboard	In progress	March 24	?

10. COMMUNITY LINK WORKERS

Current Programme:	Rev Date: **31/07/24**	Rev: 25	**Current Status:**	Update	GREEN

Current Plan	**Progress**	**Due date**	**Est. /actual date**
Planned compliment of CLW staff in WTE	15.5 WTE	On-going	On-going
Current gaps in CLW staffing in WTE	**1.8 WTE**	On-going	On-going
Commissioning process complete	**Contract awarded. Work underway for the extension to remote and rural practices on a cluster basis.**	July 24	**August - October 24**
SBAR submission – underspend proposal	**For hearing at Project Team**	**30.07.24**	**30.07.24**

11. VACCINATION TRANSFORMATION PROGRAMME

Current Programme:	Rev Date: **31/07/24**	Rev: 13	**Current Status:**	Update	AMBER

Current Plan	**Progress**	**Due date**	**Est. / actual date**
Planned compliment of VTP staff in WTE (funded by PCIF)	23.5 WTE	March 23	March 23
Current gaps in VTP staffing in WTE	0.0 WTE	n/a	n/a
A Vaccination Improvement Group has been established in NHS Highland following a peer review undertaken by Public Health Scotland (PHS) in June 2024. This group has oversight and responsibility for a programme of improvements as recommended by PHS, including a Rural Flexibility and Options Appraisal.	**Live**	**On-going**	**On-going**

12. COMMUNITY TREATMENT & CARE

Current Programme:	Rev Date: **31/07/24**	Rev: 19	**Current Status:**	Update	RED

Current Plan	**Progress**	**Due date**	**Est. / actual date**
Resubmission of CTAC Rural Options appraisal document with supplementary information to SG ahead of GMS Oversight Group meeting at end of August 24.	**Live**	**August 24**	**July/August 24**

Agenda Item 3.2

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**4th September 2024**
Title:	**Highland Drug & Alcohol Recovery Service (DARS) Summary Report**
Responsible Executive/Non-Executive:	**Pam Cremin, Chief Officer, NHS Highland**
Report Author:	**Teresa Green, Service Manager DARS, Prison & Custody Healthcare, SARCS, NHS Highland**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to:

Medication Assisted Treatment (MAT) standards: access, choice, support (2021)
National Mission on Drug Deaths: Plan 2022-2026 (2022)
Rights, Respect and Recovery (2018)

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

Safe, Effective and Person Centred

2 Report summary

2.1 Situation

NHS Highland Drug and Alcohol Recovery Services (DARS) continue to focus on delivering Medication Assisted Treatment Standards (MAT). Alcohol continues to be the prominent reason for referral into the DARS specialist service which can occasionally lead to competing priorities; balancing the requirements of MAT alongside individuals also at high risk of harm due to alcohol dependency. It has been a challenging year with progress and Referral to Treatment (RTT) compliance variable due to a number of internal and external factors impacting on performance. To manage demand, the service continues to evolve and develop new ways of working to enable a timely response to those most at risk.

2.2 Background

For over a decade there has been a national focus in reducing the harms caused by substance use. DARS performance is monitored against the 2011 target of 90% of people waiting no longer than three weeks to access treatment as well as Medication Assisted Treatment Standards (MAT) (2021) which requires same day assessment and treatment for those

dependant on opioids. National benchmarking exercises confirm a journey of improvement for DARS over the past two years. Working in partnership with Highland Alcohol & Drug Partnership and public health, DARS has a key role in the delivery or MAT. A summary of NHS Highland's progress since 2022 is provided below.

Progress made against the MAT Standards in Highland across 3 reporting periods from years ending March 2022 to 2024.

Reporting Year	MAT 1	MAT 2	MAT 3	MAT 4	MAT 5
2022					
2023					
2024					

2022 – MAT 6 to MAT 10 were not assessed
2023 – MAT 6 and MAT 10 were assessed separately
2024 – MAT 6 and MAT 10 were assessed jointly

Reporting Year	MAT 6	MAT 6 & 10	MAT 7	MAT 8	MAT 9	MAT 10
2022	N/A	N/A	N/A	N/A	N/A	N/A
2023		N/A				
2024	N/A					N/A

RAGB colour legend
- Red
- Provisional Amber
- Amber
- Provisional Green
- Green

Summary of the standards

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.
4. All people are offered evidence based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.
7. All people have the option of MAT shared with Primary Care.
8. All people have access to independent advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. All people receive trauma informed care.

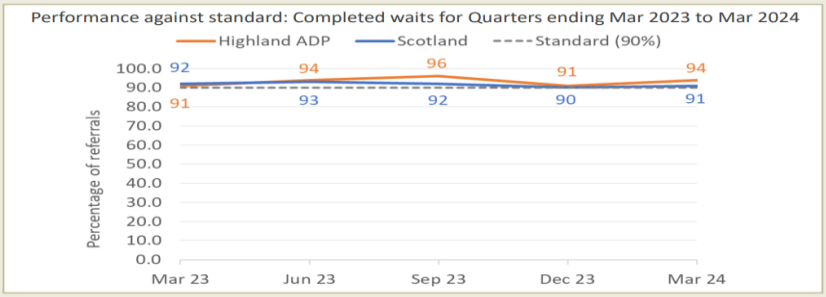
- For reporting year ending March 2024, all 10 MAT Standards had a Green or Provisional Green RAG status. MAT 1 – Provisional Green because numerical data indicates that it takes 5 days from initial presentation to the first MAT assessment. The parameter applied for remote and rural areas is 4 days.

Reference: https://publichealthscotland.scot/media/28214/v12_national-benchmark-report-on-mat-standards-2023-24.pdf

2.3 Assessment

Improvements in waiting times for alcohol assessment and treatment have been evident until recently. Although national data reports a healthy position for NHS Highland this was not the experience being reported from within DARS service. A recent internal review identified process errors which have since been rectified. The anticipated impact will be a marked decrease in performance at next quarterly report. This is already an improving position as work is well underway to reduce waiting times within the service.

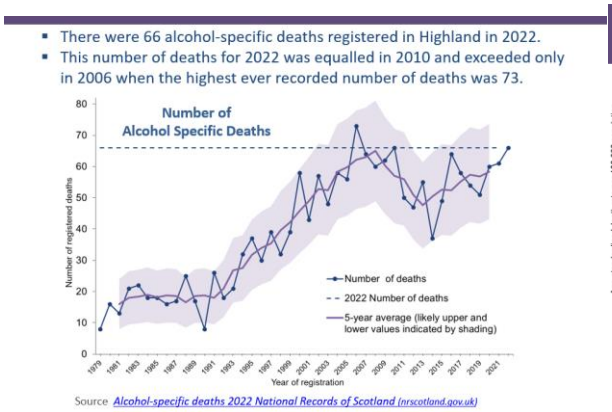
Treatment Waiting Times Standard (Qtrs Mar 23 – Mar 24

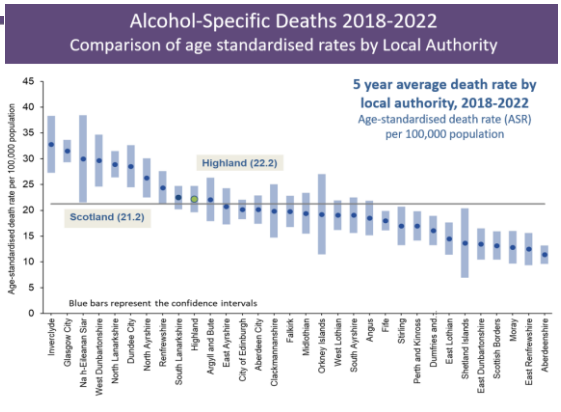


In quarter ending Mar 2024, of 138 referrals seen by community-based specialist treatment services
- 94% overall involved a wait of 3 weeks or less;
- 98% for specialist drug treatment involved a wait of 3 weeks or less; and
- 91% for alcohol treatment involved a wait of 3 weeks or less.

Alcohol Related Harm

Highland has a slightly alcohol specific death rate than the national average and continues to be the prominent reason for referral to DARS. The national three week Referral to Treatment (RTT) target is aimed at ensuring that individuals have timely access to recovery based treatment services. The charts below are from 2022. 2023 figures are anticipated in September 2024.

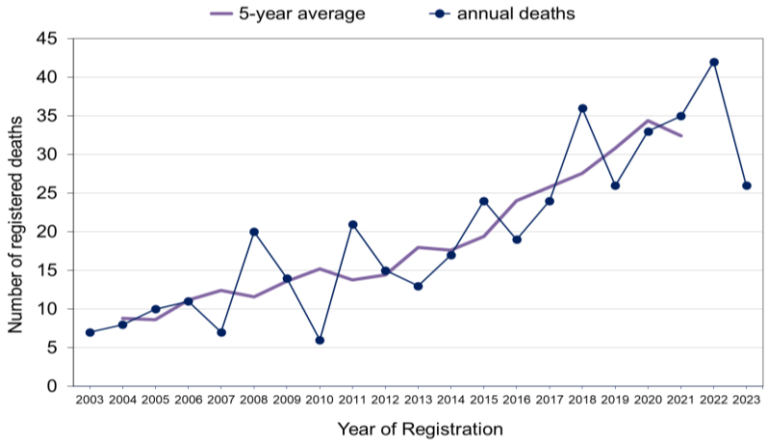




Drug Related Deaths

National Records for Scotland (NRS) confirms that nationally 1,172 people died due to drug-related death in 2023 which is an increase of 121 (12%) compared with 2022.

- Every life lost to drugs is a tragedy, for the person, for those who loved them, for our communities and for our services who are striving to eliminate drug related deaths.
- 26 drug-related deaths were registered in Highland in 2023.
- This is a reduction on the highest figure ever recorded with a decrease of 16 deaths on 2022 figure of 42 deaths
- 77% of Highland deaths were classified as accidental poisoning
- five deaths were classified as intentional self-poisoning



The number of drug-related deaths in Highland can be compared with those nationally by expressing the average number of deaths as a rate per 1,000 population. The Highland rate is below the national average of 0.24 per 1,000 population and is sixth lowest of the thirty-one council areas reported in Scotland.

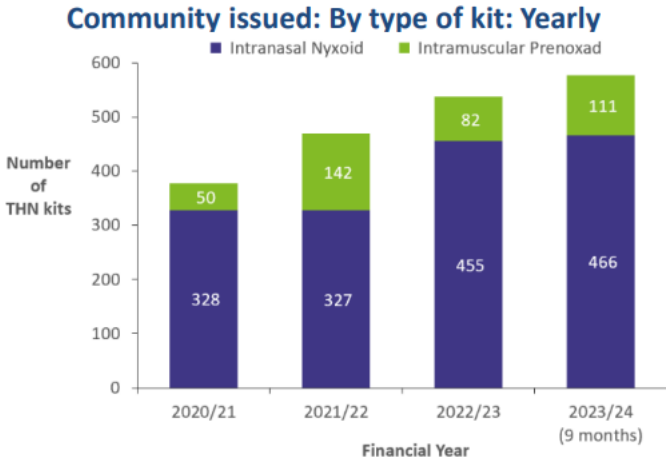
	Average annual deaths 2009-2013	Average annual deaths 2019-2023	Rate per 1,000 population 2009-2013	Rate per 1,000 population 2019-2023
Highland	14	32	0.06	0.15
Scotland	554	1234	0.10	0.24

Source: National Records of Scotland

Every premature death due to substance use is considered preventable. Despite progress in NHS Highland, the position remains fragile and there is still much work to be done, to reduce the harm caused by drugs. Across NHS Highland, work continues to support those most at risk of harm. Examples of NHS Highland initiatives to reduce drug related harm include:

Take Home Naloxone Kits

Naloxone distribution across the Highland region continues to show a year on year increase. In the first nine months of 2023-24, 577 take home naloxone kits were administered by community services, including HMP Inverness who administered 50 kits. The current budget allocated towards naloxone falls short of actual costs. At the end of 2023-24 DARS had an overspend of 17k specifically attributed to naloxone. Naloxone distribution is expected to increase based on current trends.



Tackling Health Inequalities

The DARS Specialist GP alongside the DARS homelessness nurse recently completed a six month pilot aimed at reducing health inequalities for those most at risk. This was undertaken with support of Inverness Foodstuff. The project is being formally evaluated, with examples of qualitative feedback below.

Thanks to the healthcare service, not only is the man getting the medical and mental health support he needs, he was also referred to Cale House, where he is now living, and he hasn't had a drink for 33 days. A life transformed, because he got the right help at the right time. And there are others like him who have seen their lives transformed following their engagement with the service

We aim to provide a holistic support model … Having the healthcare service has frankly been a game changer. Some of the most vulnerable people in Inverness are having their healthcare needs being met, they are being kept safe and well and we are seeing lives being transformed.

Implementing MAT Standards

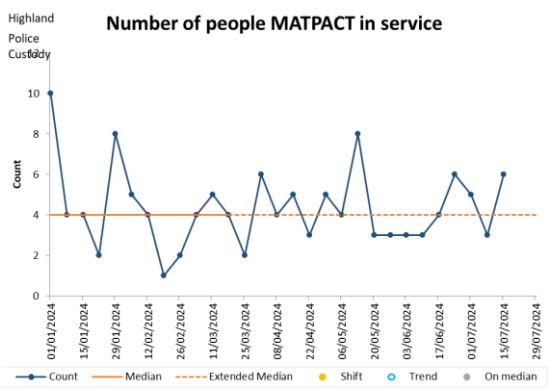
The MAT Implementation Group continues to meet on a monthly basis and there are other short life working groups in place. The MAT Oversight Group has reviewed its terms of reference and meets bi-monthly chaired by the Head of Service for Mental Health & Learning Disabilities.

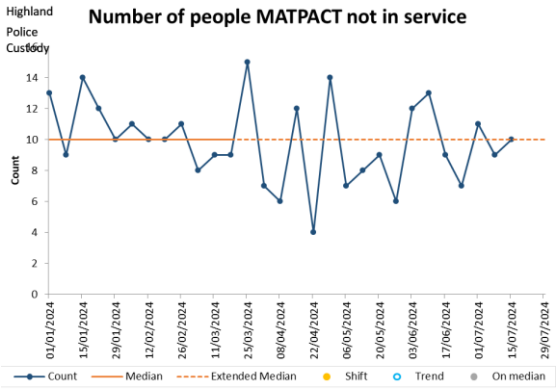
MAT 9

CMHT and DARS leads have worked closely together to develop interface protocol for individuals presenting with substance use and mental health issues. The aim of this work is to improve joint working and ensure that individuals don't fall between service criterions. The protocol is in testing phase and progress is monitored via monthly implementation groups.

MAT Delivery In Custodial Settings

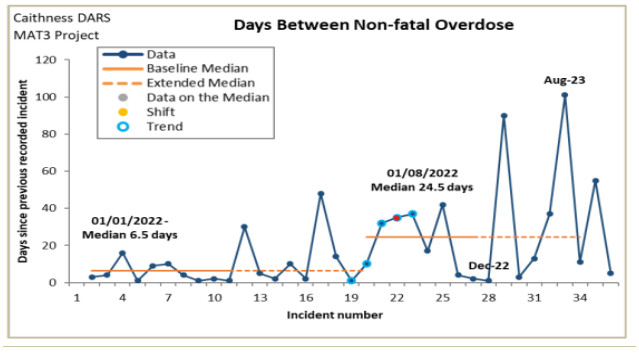
24% of all drug related deaths have been in prison / police custody in the six month prior to their deaths. The MAT pilot at custody toolkit (MATPACT) was created to proactively identify those at risk and offer health interventions from Burnett Road Custody Suite. MATPACT has received national recognition, receiving an award in Mental Health Nursing Forum, Scotland Awards and is also now included in the national Justice Toolkit. It has been rolled out to HMP Inverness. The tables below demonstrate that the use of MATPACT is proactively reaching high risk individuals not known to service.





Trigger Checklist

Within a remote and rural context, Caithness DARS continue to monitor the impact of the 'Trigger Checklist'. This harm reduction initiative works on a low threshold, opt-out approach to preventative care. The trigger checklist also received national recognition at the Mental Health Nursing Forum, Scotland Awards, and has recently made a successful bid to Q community funding, receiving 40k to embed and test the effectiveness of the approach within the Emergency Department of Caithness General Hospital. The chart below demonstrates the continuous improvement approach Caithness DARS uses, showing real time improvement in non-fatal overdoses (NFOD).



Assertive Outreach
Assertive outreach teams continue to respond to NFOD in Inverness Ross-shire and Caithness. There is a single point of referral for all NFODs and outreach practitioners liaise with local DARS staff to ensure follow up where no local team exists.

NHS Highland Drug and Alcohol Recovery Services (DARS)
DARS has struggled to maintain a timely response throughout 2024. The main causative factors are increased demand coupled with reduced capacity. Waiting Lists are in place in most localities.

Financial instability and limited access to finance support has delayed planning and recruitment as well as the progression of a joint (NHS Highland / HADP) tender for a North Highland wide commissioned service for substance use. Although DARS within North Highland HSCP have traditionally operated an open referral system, this is no longer sustainable and the service cannot meet national treatment time targets. To reverse this position DARS is exploring a shift to move towards dependent substance use only with the vision that a North Highland commissioned service will be available for non-dependant use.

NICE guidelines define dependency as '3 *months daily /12 months problematic or chaotic use*'. New ways of working have been successfully trialled in Inverness and Ross-shire which were the two areas with the largest waiting lists but who also have access to current third sector commissioned services.

Osprey House had over 100 individuals waiting for an assessment. A waiting list initiative suspected not all individuals required specialist services and needs could be met elsewhere. To test this hypothesis everyone was contacted via telephone and outcomes are recorded below.

Number of Patients	**Triage Outcome**
50	After discussion the individual agreed another service would be best placed to meet their needs and would come off the waiting list. Signposting was provided to the: - NHS Highland Alcohol &Drug Advice & Support Service (HADAS) - ACI - Apex - Alcoholics Anonymous (AA) - Cocaine Anonymous (CA) - Group work sessions within Osprey House
25	Were offered appointments at Osprey House
24	Did not respond to two telephone calls so were written to and advised of removal from waiting list and how to re-refer
14	Continued to remain on Osprey House Waiting List
4	Were referred to GP for onward referral to NHS Highland primary mental health care services
3	Were referred to NHS Highland specialist Community Mental Health Team due to complex mental health needs
3	Did not want any service
1	Was in residential rehabilitation
1	Was already in treatment (DTTO / criminal justice team)
1	Hung up telephone and didn't want to engage so received a letter
Total 126	

This exercise was repeated in Ross-shire which resulted in a waiting list of 100 being reduced to 20. Both services have adopted this way of working. DARS is keen to move towards treating dependency only in order to manage current and future levels of need. Successful implementation is dependent on Highland wide availability of a commissioned service for non-dependent use.

Residential Rehabilitation
The Highland Residential Rehabilitation Pathway is in the process of review. Staffing challenges and competing service pressures delayed progress but a work stream has been re-established led by HADP.

2.8 Proposed level of Assurance

Substantial		Moderate	x
Limited		None	

Comment on the level of assurance

Although National Benchmarking Scores for MAT are reassuring, delivery remains challenging. There are creative plans in place to meet need but balancing resource, skillset and capacity across the service continues to require ongoing planning. The main areas affecting performance and plans to address are summarised below:

- MAT 1 relates to same day prescribing where clinically appropriate. Areas in Highland (Lochaber, Ross-shire and Sutherland continue without prescribers with plans to increase Non-Medical Prescribers unsuccessful. Recruitment to psychiatry vacancy remains outstanding. DARS is progressing a business case for an electronic prescribing platform which provides opportunity to develop new ways of working to improve MAT 1 waiting times.
- MAT 7 outcomes relate to MAT being shared with primary care. Due to competing pressures there has been limited appetite to progress this work. The DARS specialist GP and pharmacist continue to develop tools and work with interested colleagues to increase MAT prescribing in primary care.
- MAT 6 & 10 is in relation to the availability of psychological interventions within trauma informed settings. Existing staff capacity, access to training and supervision, coupled with inadequate clinical space / trauma informed rooms are continue to prevent full implementation. A steering group led by DARS specific psychology continues.
- The various funding streams associated with DARS causes delays in progressing necessary recruitment. Work is planned with finance colleagues aimed at increasing transparency and improving governance arrangements. This will reduce delays.
- Progressing plans for an NHS Highland wide commissioned service for non-dependent use will enable the service to concentrate on treatment for dependency, including delivery of psychological interventions

3 Impact Analysis

3.1 Quality/ Patient Care

Quality and patient experience is integral to the successful delivery of MAT. In 2024 HADP commissioned Scottish Drugs Forum to gather lived and living experience. The findings of this

report were on the whole positive and will be used to inform service improvement over the coming year.

3.2 Workforce

Having access to a DARS specific skilled workforce in all localities continues to be challenge. Areas of most concern are Ross-shire due to vacancies and Wester Ross Skye and Localsh and Lochaber who have no access to DARS specific leadership. Plans to address using unallocated MAT funding have yet to progress.

3.3 Financial

DARS year-end forecast is a £572k overspend mainly attributed to prescribing costs. £600k has been identified to offset buvidal costs.

3.4 Risk Assessment/Management

Each MAT outcome is RAG rated and monitored via MAT Implementation and oversight groups. Progress continues to be reported to MIST on a monthly basis despite positive RAGB status.

3.5 Data Protection

The report does not involve personally identifiable information..

3.6 Equality and Diversity, including health inequalities

MAT and wider service delivery focuses on addressing health inequalities for a marginalised and stigmatised patient group. It is assumed an impact assessment is not required.

3.7 Other impacts

N/A

3.8 Communication, involvement, engagement and consultation

DARS service delivery planning is regularly discussed in following forums:

HADP structures

DARS Senior Management Team

MAT Implementation Group

MAT Oversight Group

MIST / MATSIN Meetings

3.9 Route to the Meeting

Service Update following request from HHSCC

4 Recommendation

Assurance to HHSCC in relation to DARS compliance with national alcohol / drug related policy

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**4 September 2024**
Title:	**Vaccination Improvement**
Responsible Executive/Non-Executive:	**Tim Allison, Director of Public Health & Policy** **Pam Cremin, Chief Officer HHSCP**
Report Author:	**Tim Allison, Director of Public Health & Policy**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

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

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

Vaccination programmes are extremely important for protecting the health of the population. This is the case at all stages of life but is especially important for

protection against childhood illness and for those people who are more vulnerable to infection. Vaccination against COVID has been a principal factor in control of the pandemic. There has been concern about the performance of the vaccination programme within Highland HSCP and performance management was escalated by Scottish Government. This paper outlines the current position and actions being taken to improve performance

2.2 Background

There have been three main approaches for improvement within Highland HSCP:

- Response to the escalation to level 2 of Scottish Government's performance framework
- Peer review from Public Health Scotland for NHS Highland, acting as a critical friend
- Development of a new delivery model within Highland HSCP with the potential for a more local service including the potential for general practice delivery

In addition to this, a serious adverse event review has been carried out in connection with pertussis (whooping cough) and vaccination. Following recognition of the incident, an incident management team was established which addressed immediate concerns and risks. This has now been stood down with continuing actions taken

2.3 Assessment

2.3.1 Public Health Scotland Peer Review

The peer review took place mainly during the week 10-14 June and several Public Health Scotland staff including their head of vaccinations Dr Sam Ghebrehewet spent the week in Inverness. The review was undertaken as a critical friend, not as performance management and comprised review of documents and confidential discussion with staff and other stakeholders. The reviewers visited vaccination clinics in Inverness and Dornoch and PHS staff also supported pertussis incident management work. The report has now been received and is attached as an appendix to this paper.

2.3.2 Management Action

A Vaccination Improvement Group has been established reporting to the Executive Directors Group which is tasked with developing and implementing an action plan to improve performance and quality and ensure a safe, effective and

efficient vaccination service. Its remit includes implementation of the recommendations from the peer review, management of performance escalation from Scottish Government and oversight of the assessment of the best delivery models for Highland HSCP.

Monthly performance meetings are also held with Scottish Government which consider an agreed set of performance metrics including childhood and adult vaccination uptake, access to tetanus vaccination, complaints and progress with consideration of new models of delivery. There are also separate monthly informal meetings with Scottish Government.

2.3.3 Current performance

Childhood vaccination rates have shown some improvement especially in terms of the reduction in delay between the time when the vaccine is due and when it is delivered. Figures for Highland HSCP are shown below.

Quarter:	Q3 2023-24 (Baseline)	Q4 2023-34 (Jan-Mar)	Q4 Relative to Baseline	Q1 2024-25 (Apr-May Available)	Q1 Relative to Baseline
Data available:	End May 2024	End May 2024	End May 2024	End Aug 2024	End Aug 2024
6-in-1 doses administered by 12 weeks	84.4%	85.5%	1.1%	92.6%	8.2%
6-in-1 doses administered by 24 weeks	95.5%	96.5%	1.0%	95.5%	0.0%
MMR 1st doses administered by 13 months	52.2%	57.7%	5.5%	67.9%	15.6%
MMR 1st doses administered by 16 months	76.9%	84.6%	7.7%	82.9%	6.0%
MMR 2nd doses administered by 3 years 5 months	37.4%	41.3%	4.0%	51.0%	13.6%
MMR 2nd doses administered by 3 years 8 months	72.2%	76.9%	4.6%	68.2%	-4.0%

Performance for overall COVID vaccination from the Spring programme was reported in July 2024. This showed an overall uptake of 63.5% for NHS Highland as against 76.4% for 2023. However, the national average for 2024 was 65.2% and there has been a considerable decline nationally in COVID uptake rates.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	X	None	

Comment on the level of assurance

There is a need to ensure that an effective model in remote and rural areas can be sustained and that staffing challenges can be met. Once the work of the Vaccination Improvement Group is progressing well, assurance may be able to increase to moderate for Highland HSCP.

3 Impact Analysis

3.1 Quality/ Patient Care

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

3.2 Workforce

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

3.3 Financial

The vaccination programme has been able to manage within budget last year but a major contributor to this was the difficulty in staff recruitment. There will be continued challenges with a reducing budget allocation.

3.4 Risk Assessment/Management

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

3.5 Data Protection

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

3.6 Equality and Diversity, including health inequalities

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

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

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

3.9 Route to the Meeting

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

4 Recommendation

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

4.1 List of appendices

The following appendices are included with this report:

- Appendix No, 1: Peer Review Report

CONFIDENTIAL REPORT TO NHS HIGHLAND BOARD

Public Health Scotland (PHS)

Peer Review Report

PHS Vaccination and Immunisation Division

PEER REVIEW VISIT DATE: 6th June – 14th June 2024

TEAM MEMBER	TEAM MEMBER TITLE
Sam Ghebrehewet	Head of Vaccination and Immunisation Division, SRO, PHS (Peer Review Lead)
Claire Cameron	Consultant in Health Protection, Vaccination and Immunisation Division, PHS
Michelle Falconer	Nurse Consultant, Vaccination and Immunisation Division, PHS
Cheryl Gibbons	Lead Healthcare Scientist (epidemiology) Vaccination and Immunisation Division, PHS
Andrina Hunter	Acting Head of Service, Vaccination and Immunisation Division, PHS
Alistair Smith	Service Manager, Vaccination and Immunisation Division, PHS
Gill Marsh	Senior Clinical Nurse Specialist, Vaccination and Immunisation Division, PHS
William Malcom	Pharmaceutical Adviser, Vaccination and Immunisation Division, PHS
Barry Melia	Principal Pharmacist, Vaccination and Immunisation Division, PHS
Clare Walker	Senior Clinical Nurse Specialist, Vaccination and Immunisation Division, PHS
Brian Orpin	Project Office Team Manager, PHS
Nikki Colvin	Project Support Officer, PHS

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Acknowledgements

We would like to thank all staff within the NHS Highland area who work hard to protect the health of the population. This includes colleagues who gave their precious time for one-to-one sessions, and those who engaged with the peer review team individually or collectively, as they all provided invaluable insight and discussion points to support the peer review process achieve its objectives.

PHS acknowledges the comprehensive information and documentation provided in advance of the visit and recognises the positive contribution this made to preparation and execution of the peer review visit.

Particular thanks are due to NHS Highland Director of Public Health (DPH) and Immunisation Coordinator (IC) for the support they provided both during the pre-visit work and during the visit week including the access to information, staff, and the provision of hospitality. We would also like to thank NHS Highland Board CEO, who formally requested the peer review visit and helped to guide the peer review process through supporting the relevant professionals and stakeholders who contribute to the delivery of vaccination and immunisation service across NHS Highland Board.

Executive Summary

This peer review of vaccination and immunisation services of NHS Highland Board was officially requested by NHS Highland Board Chief Executive Officer at the beginning of May 2024. However, following a Public Health Scotland (PHS) Vaccination and Immunisation Division visit to NHS Highland Board at the end of Feb 2024 initial discussions between NHS Highland Board and PHS about the concept of a peer review process were underway.

The peer review had four key components:
1) one-to-one sessions (n=39) with NHS Board staff and key stakeholders (lasting on average 2 hours),
2) review of relevant NHS Highland Board public health (including vaccination and immunisation) and other relevant documents (>100 documents),
3) meeting with vaccination and immunisation teams [individually and collectively (n=2)], and
4) visits to immunisation clinics (one urban and one rural).

Key findings considered of high priority for attention and improvement are listed below. Further detail is within the main body of the report.

Good Practice

1. Governance: A Clinical Governance Committee is in place, and all areas are aware of incident and adverse event reporting system (Datix process).

2. Leadership: Current leadership structures for vaccination & immunisations (V&I) are in place, and progress has been made in the leadership of V&I with good examples of team leadership in some areas, particularly in operational delivery.

3. Immunisation strategy: There is evidence in some areas of delivery plans and models, with milestones. Local immunisation teams have a high degree of local ownership and awareness of the need for local strategy.

4. Stakeholder engagement: Highland Immunisation Coordination Group (HICOG) is a multidisciplinary group that aims to coordinate and communicate the implementation of national immunisation policy across the board area; and there is wide representation on the group from education, midwifery, child heath, health visiting, data and digital, scheduling, nursing, pharmacy plus programme and operational management.

5. Public / Community engagement: There are opportunities for patients and the public to share their experience of the vaccination service through Care Opinion in addition to the patient feedback service.

6. Service arrangements and models of service delivery: The current service delivery model is striving to get as close to people as possible with some successes in getting appointments within reasonable distances; and there are some good examples where non-responders/attenders for immunisation are actively followed up.

7. Staffing of immunisations service (including skill mix): The Board has a committed, hardworking, dedicated, and caring vaccination workforce with relatively good skill mix utilised across all areas. One Health and Social Care Partnership (HSCP) utilises staff across Vaccination and Community Treatment and Assessment Centres (CTAC) which supports integrated service delivery and flexibility.

8. Vaccination and Immunisation (V&I) training and updates: There is good awareness of staff across NHS Highland regarding the availability of national training resources on TURAS; NHS Highland Public Health continue to provide immunisation specific educational sessions; training framework in draft, and mentorship is provided when required, often by ex-practice nurses.

9. The supply and management of vaccine stocks: There is close liaison between operational teams and pharmacy staff including the vaccination and immunisation pharmacist. There is a Standard Operating Procedure (SOP) to support stock management. Destination codes are used for the various vaccine team sites acting as a system which can be audited as and when appropriate.

10. Reporting and communication (internal and external): There are good examples of reporting on vaccination uptake and immunisation services to groups such as the Clinical Governance Committee. The relationship with local media and newspapers is good, and there are examples of good standard immunisation information published regularly in local newspapers, and there is good use of social media.

11. Monitoring vaccine uptake: There is good monitoring and reporting of vaccination uptake data at NHS Board level allowing comparison with Scotland and with other NHS Boards.

12. Local record keeping: The vaccination management tool (VMT) is used to record those vaccinations which are supported by VMT. For vaccines not on VMT, there are two recording forms (one for childhood vaccinations, and one for non-routine vaccinations). The non-routine forms are uploaded onto the individual patient record within SCI stores which is the electronic record system used by primary and secondary care. Whilst a national IT system is awaited, this process enables shared access to the patient's vaccination history for those vaccinations not held on VMT.

13. Data and digital, including call and recall: The Scottish Immunisation Recall System (SIRS) system is used across NHS Highland Board to support the delivery of the childhood immunisation programme. For seasonal programmes, the cohorts are provided by PHS. Scheduling is either undertaken at a local or national level. The local scheduling is not supported by a system such as TrakCare as of yet.

14. Quality improvement activities: Primary care quality cluster groups are in place, with some good examples of localised quality improvement activities. Within one HSCP, primary care modernisation has resulted in tests of changes that lead to service improvements over time.

Areas for Improvement

1. Governance: The current governance arrangements should be reviewed as a matter of priority to ensure representation of relevant professionals and partners, to clarify the decision-making process, and to ensure communication and monitoring of actions.

2. Leadership and decision-making: There is a need for improved relationships, cohesion and understanding of roles and responsibilities within the NHS Board leadership, vaccination and immunisation operational and clinical leadership areas. Those in leadership roles at all levels need to be empowered to act, and provided with the resources, and authority to make decisions, with clear and transparent accountability lines.

3. Immunisation Strategy: There is an urgent need to review the current position and co-develop a strategy and action plan as a collaborative process between key multi-agency stakeholders. The strategy should then be communicated and disseminated to all staff, partners, and stakeholders.

4. Model of service delivery: In remote and rural areas, a review of options for local flexibility should be undertaken as a matter of priority to enable increased primary care provision to meet vaccination and immunisation requirements and local population needs. The review should also include Post Exposure Prophylaxis (PEP) accessibility in primary care to ensure timely administration when indicated, for example tetanus. Overall, the current service delivery requirements need to be reviewed to ensure a patient-centred, efficient, and sustainable offer is provided across NHS Highland Board.

5. Staffing and capacity (including skill-mix): There needs to be a targeted focus on vaccination and immunisation staff wellbeing and development to maintain and boost staff morale, confidence, and resilience. This should include ensuring and regularly monitoring that there are sufficient numbers of trained staff with the right skill-mix available to provide safe, effective, efficient, and sustainable vaccination and immunisation programmes across NHS Highland Board.

6. Vaccination and Immunisation (V&I) training and updates: There is a need to complete the training framework (currently being drafted) with a clear implementation and oversight plan as a matter of priority; ensure relevant staff get opportunities for shadowing and exposure to practical skills after TURAS training; and increase access to local face-to-face and live webinar training to consolidate online learning.

7. Data & Digital: There is a need for improving the current feedback system to ensure non-attenders and decliners are followed up with robust documentation process; and NHS Highland Board need to review the current system in order to facilitate the process for ensuring individual vaccination records are up to date in the GP-IT system.

8. Stakeholder engagement: There is a need for sustained and meaningful multidisciplinary and multi-agency engagement at all levels to be able to bring the

required improvements; and this should be done proactively with constructive and integrated public health agendas across NHS Highland Board.

9. Public / community engagement: The Board should ensure that the public and communities are included as key stakeholders in all vaccination and immunisation engagements.

10. Quality Improvement: A culture of quality improvement should be embedded throughout NHS Highland Board vaccination and immunisation strategic and operational delivery systems, with clear and transparent accountability, and monitoring arrangements.

11. Reporting and Communication: There is an urgent need to review and improve communication of the decision-making process with staff; formal communication with all stakeholders where there are service changes, in particular substantive changes; and to maximise the strong relationships that primary care has with patients to enhance communication relating to vaccination programmes and access.

Conclusions

This peer review was undertaken at a time when the NHS in Scotland is facing a challenging financial environment. Nevertheless, it is the peer review team assessment that focusing on vaccination and immunisation services **quality improvement** activities, and reviewing the most appropriate **model of service delivery** for some remote and rural areas should be of central consideration to the NHS Highland Board.

It is also imperative that priority is given to **staff wellbeing**, **staff development**, and **stakeholders engagement** (including public and communities). The issue of clear **leadership** roles and responsibilities for vaccination and immunisation programme with transparent decision-making processes around **governance**, distributive leadership and subsidiarity with appropriate accountability should not be underestimated. All the improvement areas identified in this peer review require an overarching and robust **communication strategy** across NHS Highland Board to achieve the full impact.

Proposed next steps

- Establish a time limited task and finish group with representation from all relevant stakeholders (including PHS) to review and consider implementation of the peer review findings.
- Develop an action plan with a clear timeline and roles and responsibilities.
- Agree procedures for monitoring vaccination and immunisation programme effectiveness, efficiency, and sustainability.

1. Background and Introduction

An independent peer review of NHS Highland Board vaccination and immunisation services was undertaken by PHS professionals and colleagues with specialist knowledge and experience on vaccination and immunisation. The peer review team employed methods that would enable identification of best practice, improvement, and development areas.

This peer review in support of NHS Highland Board took place over a ten day period from 6th – 14th June 2024, concluding with summary feedback presentation to NHS Highland Board, staff and stakeholders at the end of the visit week.

It was agreed, post visit, that this report, including proposed next steps, would be sent to NHS Highland Board CEO for factual accuracy, within 4 weeks. This draft report will be finalised by the peer review team leader and sent to the NHS Highland Board CEO to share with relevant Board members and stakeholders.

2. Aim(s) and objectives of NHS Highland Peer Review

The overall aim of NHS Highland peer review was to identify and share good practice and, equally, areas for development and improvement. It was based on mutual respect, where professionals critically appraise, systematically assess, monitor, determine strengths and weaknesses of the current vaccination and immunisation services, and review the quality of their practice.

2.1 Objectives

To provide support for NHS Highland Board to improve the delivery of current vaccination and immunisation programmes, promote and raise the quality of immunisation services by ensuring effective, efficient, and sustainable working systems and procedures are in place. The specific objectives of this peer review were to:

- improve the quality of vaccination and immunisation service delivery through engagement of staff;
- identify, recognise and share good practice;
- promote safe, effective, efficient, and sustainable models of service delivery; and
- provide added value, building on existing standards and achievements.

3. Methods

Public Health Scotland peer review team commenced the review on the 6th June 2024 and visited NHS Highland Board, 10th to 14th June 2024. Prior to the visit, NHS Highland Board provided comprehensive background information, and documentary evidence around working protocols, procedures, plans, and guidelines. Further documents were provided on request following initial review of the relevant documents. One-to-one thematic discussion points were constructed by the visiting / peer review team to address specific areas of practice such as governance, leadership, data and digital, and model of service delivery arrangements. The peer review team also undertook meetings with individual front-line staff and collective meetings that were held in immunisation clinics.

The report findings are structured around the key discussion “themes” that were constructed for one-to-one sessions. In order to contextualise the findings, the peer review team framed this report in “themes” and each “theme” categorised further into current practice / situation; good practice; and areas for improvement.

4. Findings

4.1 Governance arrangements

4.1.1 Current situation / practice

- There is a Highland Immunisation Coordination Group (HICOG) which coordinates and communicates the implementation of national immunisation policy across the NHS Highland board area to both HSCPs. This group reports to the Vaccination Programme Board.
- The Immunisation Coordinator of NHS Highland Board is the Chair of HICOG, and they will escalate and report adverse events to PHS in accordance with the PHS Vaccination Adverse Event Management Protocol. The Datix system is in use for reporting adverse events locally.
- There are operational groups for vaccination in each of the HSCPs.
- In Argyll and Bute there is a specific CTAC and vaccination quality, professional and practice standards meeting.
- Quality and Patient Safety (QPS) groups report to Highland HSCP Senior Leadership Teams (SLTs) and Argyll and Bute SLTs.
- NHS Highland Board Vaccination and Immunisation Group provides advice to both HSCPs i.e., in addition to reporting to the Vaccination Strategy Group, which reports to the Population Health Programme Board.
- The Population Health Programme Board reports to the Executive Directors Group, Clinical Governance Committee, and/or to Finance Resources and Performance Committee as appropriate. All these groups report to the NHS Highland Board.

4.1.2 Good practice

- All areas seem aware of Datix process for reporting adverse events.
- Highland Immunisation Coordinating Group (HICOG) process established.
- A Clinical Governance Committee is in place.
- Immunisation is part of the wider Primary Care Modernisation Board.
- Formal Quality and Patient Safety Structures exist.
- Clear routes of escalation were described in certain areas.

4.1.3 Areas for Improvement

- Provide clarity on the overall governance structure and ensure communication to all stakeholders, both internal and external.
- Review with the aim to simplify and streamline governance structures.
- Ensure appropriate representation of all relevant staff and stakeholders on the current Clinical Governance Committee.
- Provide clarity on roles and responsibilities of the Vaccination Programme Board.

- Provide clarity and transparency of the escalation process for all issues ensuring acknowledgement and feedback within defined timelines.
- Build stronger relationships, cohesion and understanding of roles and responsibilities between operational and health protection / clinical areas.

4.2 Leadership

4.2.1 Current situation / practice

- There is a Senior Responsible Officer (SRO) for vaccination and immunisation who is accountable for immunisation across both HSCPs.
- The Chief Officers are responsible for delivery within the HSCPs.
- There is also an Immunisation Coordinator (IC) for the Board area in addition to operational or programme managers and Professional Lead Nurses for vaccinations across both HSCPs.
- The nursing, operational managers and the IC work closely together at an operational level.
- The Immunisation Coordinator and the two lead nurses for vaccination are members of and contribute to the national Immunisation Coordinators Group and the Lead Nurses Group within SVIP respectively. This enables peer support and sharing of good practice with colleagues across the boards.
- At an operational level, in addition to the Lead Nurse for vaccination in each HSCP, there are operational leads who are senior nurses who provide leadership for their team. There is an operational lead for each team.
- Several staff feel the current leadership and decision-making process is not transparent.
- In the documents reviewed there was evidence of a sense of frustration amongst some professionals about a lack of progress and inflexibility (particularly in remote and rural areas) in developing services, and lack of clarity on leadership, accountability, and decision-making processes.
- Regular mentions of low morale amongst staff and some suggestions that people raised issues not being listened to.
- Regular mentions that perceived performance issues were unrelated to staff willingness to succeed, and it was acknowledged that staff were working incredibly hard to provide a good service.

4.2.2 Good practice

- Current leadership structures for Vaccination & Immunisation are in place.
- Progress has been made recently in the leadership of vaccination and immunisation programme.
- There are good examples of team leadership in some areas particularly in operational delivery.
- The leadership structure represents a range of relevant posts and professional groups, which indicates that there is diversity and inclusiveness in representation.
- Operational leads are committed and dedicated to the delivery of a good service and recognise the need for ongoing development.

- Many primary care leaders still wish to share their experience and expertise including to provide leadership.
- Responsibility for vaccination and immunisation delivery sits within the two HSCPs.
- Professional leadership for patient safety is delivered through the QPS.
- There are some good indicators that vaccination and immunisation leadership utilise the national support available to them.

4.2.3 Areas for Improvement

- Those in leadership roles should be empowered to act with clear accountability for decision making to ensure action.
- Increased clarity is required around roles across HSCPs, Health Protection Team(s), professional clinical staff, and vaccination workforce.
- Develop constructive engagement with primary care leadership to support delivery of effective vaccination programmes.
- Strengthen the understanding of the local geographical challenges by all stakeholders across vaccination.
- There is a need for improved relationships, cohesion and understanding of roles and responsibilities within NHS Board leadership, vaccination and immunisation operational and clinical leadership areas.
- Strengthen executive leadership around vaccination and immunisation.
- Develop the critical role of GPs, child health and other professional groups in promoting vaccination and signposting for advice and services, as appropriate.

4.3 Immunisation strategy

4.3.1 Current situation / practice

- From the documents reviewed and one-to-one sessions, the key issues around local immunisation strategy relate to the Vaccination Transformation Programme (VTP) and the perception is that this led to a single model of NHS Highland Board led service delivery irrespective of the differing impact in urban and rural areas.
- There were several mentions (both in the documents reviewed and one-to-one sessions) which suggested that the previous model of GP led service delivery had been meeting population needs and the VTP had no local strategy on how to achieve the perceived aims and objectives.
- There was no NHS Board wide immunisation strategy to deliver VTP. However, this is not to say that attempts were not being made to take a strategic approach to immunisation delivery. The peer review team understanding is that a draft document for Highland HSCP was shared with the SRO and Chief Officer in the Autumn of 2023 for consideration.

4.3.2 Good practice

- There is evidence in some areas of delivery plans and models, with milestones.
- Vaccination and Immunisation Teams have a high degree of local ownership and awareness of the need for a local plan and strategy, and as such they continue to demonstrate commitment to deliver an effective and efficient vaccination and immunisation service to their communities.

4.3.3 Areas for Improvement

- The lack of a strategy is hampering the development of a workforce plan and the need to focus on inequalities. Therefore, there is a need to:
- review and co-develop a strategy and action plan for vaccination and immunisation as a collaborative process between key multi-agency stakeholders;
- develop a greater emphasis on strategic planning and delivery which will reduce the need for reactive problem solving; and
    - enable leadership to operationalise strategy and ensure measures of success are included in the strategy.
- The strategy should have a focus on improving uptake in all groups and communities and on tackling inequalities.
- The strategy should be communicated and disseminated to all staff, key stakeholders and the public.

4.4 Stakeholder engagement

4.4.1 Current situation / practice

- HICOG, which is a multidisciplinary group, aims to coordinate and communicate the implementation of national immunisation policy across the Board area; and there is wide representation on the group from education, midwifery, child health, health visiting, data and digital, scheduling, nursing, pharmacy plus programme and operational management.
- The peer review team understands that there has been some collaborative working with primary care. For example, the Chair of GP subcommittee is a member of the vaccination programme board which is chaired by the SRO for vaccination. The Deputy Medical Director for Primary Care also sits on the vaccination programme board, but it is acknowledged that representation at the relevant meeting is different to pro-active engagement by the Board across the whole of primary care.
- There was little evidence presented to the peer review team on engagement with primary care following the transition to VTP. However, this is not to say that there has not been ongoing communication on a reactive basis in relation to queries and also proactive communication in relation to acute situations such as the increased incidence of measles and pertussis and changes to vaccination programmes such as the extended shingles programme.
- Although no specific issues were identified regarding engagement with health visiting services, there was no clear collaborative working that demonstrates effective engagement.
- No significant engagement issues were identified with secondary care, midwifery services, or educational establishments.

4.4.2 Good practice

- There were several examples of good communication with GPs and primary care in the run up to transition from GP to Board led delivery (VTP). There were two FAQ documents produced to address questions and issues raised by GP practices – this appeared to be an example of good communication.

- One HSCP produced a document to brief all stakeholders ahead of vaccination campaigns.
- The work undertaken within one HSCP to engage GPs through options appraisal and local flexibility has helped build relationships.
- One HSCP team lead holds GP/PM meetings monthly to discuss vaccination programme and issues in different parts of the HSCP area.
- There are structures that include primary care representation, both employed clinical leads and independent contractors, and there is professional willingness to engage in vaccination and immunisation across NHS Highland Board.
- There is a weekly NHSH bulletin to communicate with staff, and good use of social media for raising awareness on vaccination and immunisation issues.

4.4.3 Areas for Improvement

- There is a need for:
    - a consistent and transparent understanding of stakeholder engagement with clear agreements on how to move forward; and
    - proactive, constructive, and integrated multidisciplinary and multi-agency engagement at all levels to be able to bring about improvements including:
        - primary care,
        - midwifery services,
        - health visiting & school nursing,
        - secondary care,
        - education, and
        - other professionals working with patient to ensure “make every contact count” is implemented across all settings.
    - Use the weekly NHS Highland E- Bulletin to include key communications on vaccination and immunisation.

4.5 Patient / public engagement

4.5.1 Current situation / practice

- There was little detail in the documents reviewed or one-to-one sessions on the approach of NHS Highland Board on patient and public engagement regarding VTP.
- There are, however, opportunities for patients and the public to share their experience of the vaccination service through Care Opinion in addition to the patient feedback service.

4.5.2 Good practice

- There are examples of good social media use in local areas to share information on vaccination and immunisation.
- There is also a good relationship with local media to promote vaccination and immunisation on a regular basis through printed press and other media outlets.

4.5.3 Areas for Improvement

- There is a need for NHS Highland Board to:

- ensure the public and communities are included as stakeholders in all vaccination and immunisation engagement;
- utilise patient lived experiences of vaccination and immunisation to develop and inform the operational delivery model; and
- develop a public engagement strategy for vaccination and immunisation.

4.6 Service arrangements and models of service delivery

4.6.1 Current situation / practice

- There are two HSCPs within NHS Highland Board area, Highland HSCP and Argyll & Bute HSCP.
- Highland HSCP incorporates nine districts. Within Highland HSCP, the transfer of vaccination delivery from primary care to NHS Highland Board led delivery occurred on 1st March 2023.
- A single NHS Highland Board led model has been progressed within the partnership with delivery largely supported through four operational teams (South and Mid; Caithness and Sutherland; Lochaber and Skye, Lochalsh and Wester Ross).
- A recurring theme was concerns about the feasibility of the centralised model of service delivery. These concerns centred around issues related to staffing clinics, especially in remote and rural areas.
- Concerns were expressed about staff travel time and impact of adverse road conditions due to weather conditions.
- There were several instances where the documents, one-to-one discussions, clinic visits and meetings with staff highlighted that in remote and rural areas there were relatively small numbers of children requiring vaccination and a sense that the centralised model was inefficient, with the previous GP practice model having delivered a good patient centred service.

4.6.2 Good practice

- Current delivery model strives to get as close to people as possible with successes in getting appointments within reasonable distances in most circumstances.
- There are good practice examples where flexible teams provide opportunistic vaccination when possible.
- The flexibility offered within one HCSP for primary care provision in some remote and rural areas is perceived as an example of a good hybrid-model of service delivery.
- There is some evidence of NHS Board service provision offering flexibility, for example with the option of families calling for appointments for childhood immunisations.
- There are some good examples where non-responders/attenders for immunisation are actively followed up by NHS Board vaccination teams.
- The NHS Board vaccination centre in Inverness demonstrated a good model of vaccine delivery for an urban area.

4.6.3 Areas for Improvement

- NHS Highland Board needs to review:

    - Service delivery requirements to ensure a patient-centred efficient offer, based on performance and feedback, finance, feasibility, and sustainability.
- Options for local flexibility in remote and rural areas to enable increased primary care provision to meet vaccination and immunisation requirements and local population needs.
    - PEP accessibility in primary care in order to ensure timely administration of appropriate intervention, for example tetanus PEP when indicated.
- Implementation of robust system across NHS Highland to follow up non-attenders (children and adult immunisations), and feedback any information, as appropriate to relevant team e.g., child health.
- Undertake a review of childhood immunisation appointment scheduling system options to identify if current method is appropriate (currently method 5).
- Seek improvement in efficiency of delivery for instance by considering appropriate balance of clinic proximity versus frequency.
- There needs to be a review of the NHS Highland Service Delivery Centre (SDC) to ensure that processes are fit for purpose, that call handlers have appropriate knowledge of vaccinations/the vaccination schedule and local geography, they have access to relevant systems, and the service is adequately funded.
- Develop Standard Operating Procedures to address variability in practice whilst still enabling local flexibility when required.
- Review NHS Highland digital systems used for scheduling of adult vaccinations to ensure they meet requirements and are utilised effectively.

4.7 Staffing of immunisations service (including skill mix)

4.7.1 Current situation / practice

- There was limited or no detail in the documents reviewed and in the one-to-one sessions on vaccination and immunisation workforce plan.
- Issues relating to recruitment and retention were frequently mentioned throughout the documents. This often included concerns in relation to uncertainty regarding funding, and the challenges related to recruitment and retention of staff in the rural and remote areas.
- The limited number of vaccinators and nursing capacity was frequently raised as a concern throughout the one-to-one sessions and in the documents reviewed, and this was particularly acute in remote and rural areas, and this is not helped by all health services depending on the same pool of health professionals.
- There were several mentions where staffing issues resulted in the cancellation of clinics and individuals not being vaccinated. This was said to be compounded by staff having to travel long distances and often impacted by adverse weather conditions.

4.7.2 Good practice

- The vaccination and immunisation workforce of NHS Highland Board at all levels, including partner and stakeholder organisations staff demonstrated passion, commitment, dedication, and caring for their patients, communities and their colleagues.

- One HSCP utilises staff across Vaccination and CTAC to support integrated service delivery with greater flexibility.
- NHS Board vaccination and immunisation teams have relatively good skill mix utilised across all areas, but it could be further optimised; and operational leads have good knowledge of their localities.

4.7.3 Areas for Improvement

- Staff wellbeing and development should be a key focus going forward to strengthen staff morale, confidence, retention, and resilience across the system.
- Ensure staff are supported and their needs are met by avoiding silo working and promoting integrated service delivery to maximise efficiency and support wider healthcare provision resilience.
- In line with the review of service delivery requirements, scope efficiencies of skill mix and capacity to provide a resilient and effective service.
- Consider use of Health Care Support Workers (HCSWs) in the future to support vaccination and immunisation programme.
- Need to develop capacity and capability within vaccination and immunisation workforce to ensure staff have time to spend on vaccine promotion within the wider community.
- Roles and responsibilities of different professional groups with vaccination and immunisation teams should be better communicated and understood.

4.8 Vaccination and Immunisation (V&I) training and updates

4.8.1 Current situation / practice

- One senior health protection nurse holds the lead role for workforce education and training and provides representation for NHS Highland on the National Workforce Education Leads forum.
- There is a draft education and training plan for vaccinators across NHS Highland. This has been in place since the transition to Vaccination Transformation Programme (VTP) with several updates taking place over the last 15 months.
- There is also a draft competencies document which has been drafted by the lead nurse for vaccinations; and a Vaccination and Immunisation education strategy for NHS Highland is planned.
- An education matrix has been developed for the service outlining all mandatory, vaccination specific and additional training. This is held on TEAMs and is used by the Operational Leads to record staff training completion dates.
- In advance of the transition a programme of shadowing and observed practice was undertaken for each vaccinator but this was compressed due to the tight time-frames for the transition to VTP.
- In general, training for vaccination and immunisation staff is provided via completion of TURAS online modules.
- With respect to updates and dedicated education events, there is a monthly vaccination forum which includes an educational component. Any links to national webinars are circulated to teams to promote attendance. Any key updates are also communicated to teams.

- Little mention of immunisation training provided to health and social care and other partners in the documents reviewed and one-to-one sessions.
- No evidence presented on the approach to staff training other than staff were required to have mandatory basic life support and that national workforce education resources were used.

4.8.2 Good practice

- Awareness across NHS Highland is high regarding the availability of national training resources (TURAS), all vaccinators undertake Promoting Effective Immunisation Practice (PEIP) initially then attend webinars when there are changes or new vaccines.
- NHS Highland Public Health continue to provide on-going immunisation specific education sessions.
- Regular 'huddles' take place in some teams that include updates on changes in programmes, and this helps staff to reflect on practice and learn from each other's experiences.
- Mentorship is provided when required often by ex-practice nurses.
- Recognition that training can also include elements such as PGD and Green Book update review.
- With respect to updates and dedicated education events, there is a monthly vaccination forum which includes an educational component.
- There have been workshops and education sessions provided since the beginning of 2023; and these have been accessible to both HSCPs and have been recorded to ensure they are available to vaccinators not able to attend. The recordings are stored in the TEAMs channel so they are accessible to all vaccinators.

4.8.3 Areas for Improvement

- Training framework requires completion and comprehensive implementation and oversight.
- Develop consistent access to opportunities for shadowing and exposure opportunities for practical skills after TURAS training.
- Increase access to local face-to-face and live webinar training to consolidate online learning and highlight and discuss local nuances and issues.

4.9 The supply and management of vaccine stocks

4.9.1 Current situation / practice

- There is very close liaison between operational teams and pharmacy staff including the vaccination and immunisation pharmacist.
- There is an SOP to support the management of vaccine stock. Stock is ordered in from suppliers and kept to a minimum level based on activity/ordering by team leads.
- The hospital stock is controlled by a system called CMM which records current stock holding and where stock is sent to.
- Vaccination Transformation Programme (VTP) destination codes are used for the various vaccine team sites acting as a system which can be audited if required.

- One of the teams uses a stock management spreadsheet and there is an aim to replicate this across the teams.
- NHS Highland is part of the North of Scotland Patient Group Direction (PGD) group. Several medical, nursing and pharmacy staff contribute to this process as reviewers. NHS Highland also have a process in place for the provision of Patient Specific Directions (PSDs) where needed.

4.9.2 Good practice

- Extensive stock management systems in place with valued pharmacy involvement and input.
- There is good awareness of staff on stock and cold chain management, and Datix processes are used when required e.g. when vaccination errors occur.
- NHS Highland Board use North of Scotland PGDs, and there is clear cascade process for authorised PGDs via public health.
- In order to provide a streamlined approach by all teams working within the vaccine service a number of SOPs have been developed including on recording refrigerator temperatures, receipt of cold chain product, transportation of vaccine to schools, outlying clinics and domiciliary visits etc.

4.9.3 Areas for Improvement

- Ensure continual assessment of vaccine programme cohort denominators to optimise vaccine requirement estimates to reduce excess stock and potential vaccine wastage.
- Review storage capacity ahead of vaccine delivery for Winter programmes.
- Review SOPs for Vaccine transportation to ensure these meet JCVI, MHRA and other national recommendations and consider audits to ensure they are being followed.
- Strengthen the process of dissemination of authorised PGDs to immunisation workforce to maximise timely receipt by immunisation workforce.
- Consider how vaccine fridges across the NHS Highland estate could be used more effectively and ensure oversight by appropriate services e.g. Estates Service
- Review processes for stock management and transport to clinics to try to minimise waste whilst ensuring appropriate stock available to vaccinate, including enabling possibility of opportunistic vaccination.
- Ensure all relevant areas aware of local and national processes to escalate adverse events including situations where vaccines have been held outwith specified temperature ranges.

4.10 Reporting and communication (internal and external)

4.10.1 Current situation / practice

- Within both HSCPs there are operational vaccination groups which should feed up to HICOG and vice versa. The operational vaccination groups have representation from all of the teams involved in delivery.
- HICOG reports to the NHS Highland Vaccination Programme Board on matters relevant to vaccination and immunisation including the VTP.

- Any concerns identified within HICOG, in addition to proposed solutions, were regularly escalated to the Vaccination Programme Board by the Chair and other members.
- The NHS Highland Vaccination Programme Board reports to the Executive Team and also feeds into the Clinical Governance Group.
- There are good examples of reporting on vaccination uptake and immunisation services to groups such as Clinical Governance Committee. Reports acknowledged issues and challenges across delivery but there was no evidence presented on the actions agreed at the groups reviewing the data which is a gap.
- Within NHS Highland there is a heavy dependence on social media due to geography.
- Several examples were given regarding emergent structures and new initiatives for reporting immunisation and vaccine related issues.
- There are issues related to internal communication centred around a sense that professional and operational concerns were not being addressed as quickly as required. A sense of dissatisfaction was noted in some elements of internal communication with a lack of progress and inflexibility.
- With regard to the reporting of adverse events and near misses at a local level, internal NHS Highland processes are followed, but this is not specific to vaccination.
- From a national perspective, NHS Highland Board follow the PHS Adverse Event protocol in relation to external reporting of adverse events. This protocol has been communicated to vaccinators and vaccination support staff so that everyone is aware of the process and the need for escalation in addition to Datix reporting which includes escalation to QPS.
- There is also reporting to each of the Health and Social Care Partnerships by the respective Chief Officers.
- There has also been considerable escalation from a range of staff in relation to concerns about the delivery of the programme and the potential implications for patient care and staff wellbeing. This has been verbal and written.
- Immunisation information is disseminated internally to vaccinators and vaccination staff about vaccination programmes and updates through HICOG; information is also cascaded by the operational leads in addition to communication through their TEAMs channel.
- There is also a staff vaccination group which covers both HSCPs. This group would lead on the communication to staff in relation to staff vaccination programmes.
- With respect to external communication, the nationally produced materials for promoting vaccination are shared through social media.

4.10.2 Good practice

- There is good relationship with local media, especially print press.
- There are good examples of communication with staff and wider partners and stakeholders e.g. weekly internal newsletter to NHS Highland, and primary care newsletter to GPs.
- Datix is well understood by most if not all relevant staff and is integrated into wider QPS governance structures.

- NHS Highland is part of the North of Scotland PGD group. There is a local distribution group for PGDs.

4.10.3 Areas for Improvement

- There is a need for improving formal communication:
    - with internal staff on decision-making processes at all levels; and
    - with all stakeholders where there are service changes, in particular substantive changes.
- There is a need to maximise the strong relationships that primary care has with patients to enhance communication relating to vaccination programmes and access.
- Improve communication with public as to who to contact and where to find information in addition to website information.
- There is a need to:
- Support and empower staff to answer queries in as timely a manner as possible, as appropriate to their roles and responsibilities, within a clear accountability framework.
- Ensure information coming from PHS is repackaged or adapted in a way that fits NHS Highland systems and operation delivery approaches to facilitate wider dissemination.
    - Review processes around supporting training and learning and communication of lessons learned following review of Datix submissions.
- Rationalise the dependence on complex spreadsheets, currently used for scheduling, into a more secure system.

4.11 Monitoring vaccine uptake

4.11.1 Current situation / practice

- The one-to-one sessions and documents reviewed provide assurance that vaccine uptake monitoring was undertaken and reported regularly to a variety of groups.
- There was good evidence of monitoring and reporting across localities in the two health and social care partnerships in NHS Highland.
- Some of the documents containing reports on vaccine uptake also noted that uptake was falling, and that action locally and nationally was required.
- The documents reviewed indicated that NHS Highland team were aware of comparative performance issues in vaccine uptake.

4.11.2 Good practice

- Monitoring and reporting at NHS board level occurs regularly allowing comparison with Scotland and with other NHS boards.
- Timely uptake data available at strategic level for vaccination data from VMT.
- There is good awareness and use of national data for management information provided on the Discovery platform by PHS.

4.11.3 Areas for Improvement

- Ensure that there is appropriate access to data and data systems for staff to carry out their role.

- Capability should be expanded for resilience around vaccine uptake and monitoring work with protected resources within NHS Highland.
- There should be clear local responsibility for monitoring local vaccine uptake, with information readily available for smaller geographical areas and population groups to ensure timely decision making and proactive action is taken when required.
- Regular extracts of school denominator data from the Scottish Education Management Information System (SEEMIS) should be shared with child health and vaccination services to enable monitoring uptake and allow targeting intervention.
- Vaccination service should have access to SIRS system, where appropriate, for vaccination monitoring and service delivery.
- Ensure timely sharing of localised vaccination uptake data with local teams (or access where appropriate) to support improvements and actions.
- Ensure better understanding of a range of metrics at senior and executive levels to enable effective decision making.

4.12 Local record keeping

4.12.1 Current situation / practice

- The one-to-one sessions identified a lack of data sharing regarding childhood immunisation records with primary care which is reported as a barrier to engagement and promoting vaccination programme.
- For vaccines not on the VMT, there are two recording forms (one for childhood vaccinations and one for non-routine vaccinations). Non-routine forms are uploaded onto the individual patient record within SCI stores which is the electronic record system used by primary and secondary care allowing the records to be viewed.
- Whilst a national IT system is awaited, the above process enables shared access to the patient's vaccination history for those vaccinations not held on VMT. This system is also shared across the NHS Boards which means the record is viewable across boards and can also be transferred with the patient if they move NHS Boards.
- There is a decision outstanding in relation to whether the completed childhood vaccination SIRS sheets are sent to GP practices for practices to input the data or whether the practices enable access for NHS Board vaccination support staff to input the data.
- The adult vaccination data for vaccines that are recorded on VMT is directly transferred to GPIT.
- Vaccinations administered in pregnancy are recorded on Badgernet and VMT.
- All queries pertaining to vaccination received by the health protection team are stored on HPZone. (HPZone is the electronic system used within health protection teams for all enquiry, case and outbreak management). From a governance perspective, this ensures that every event and correspondence associated with a referral is recorded electronically. It also enables actions to be set to monitor the management of the query.

4.12.2 Good practice

- In some areas general workarounds were in place to enable GPs to see records from individual childhood immunisation appointments and detail of do not attends (DNAs).
- The new pupil questionnaire has a section on vaccination status, and this will be expected to have positive impact on improving uptake.
- There is good practice with the maternal vaccination programme, as midwives provide a continuous offer of vaccine even if previously declined.

4.12.3 Areas for Improvement

- Scoping of alternative options where manual processes and paper-based systems are in place is required e.g., childhood and school programmes.
- Consideration should be given to design systems to improve on the current manual process for scheduling adult vaccinations, including consideration of having dedicated scheduling software.
- Develop standardised processes for recording DNA or Did not respond to invite especially for cohort-based childhood programmes.
- Ensure those that need access to data and data systems have appropriate access to enable them to effectively do their role.
- There should be shared learning between maternity and vaccination services to understand and improve record keeping and reporting across both areas.

4.13 Data and digital including call and recall

4.13.1 Current situation / practice

- With respect to the childhood programme, the SIRS system aims to ensure that children under the age of six years receive the appropriate immunisations in accordance with the UK childhood immunisation schedule. This is undertaken through the automation of call and recall of children for scheduled immunisations and allows the recording of data on immunisations given.
- For seasonal programmes, the vaccination cohorts are provided by PHS. Scheduling is either undertaken at a local or national level. The local scheduling is not supported by a system such as TrakCare as yet, although this has been requested.
- With respect to non-routine vaccinations, the referral route is via the health protection team. This enables a central, single point of contact which supports a coordinated clinical approach to the management of the pathway.
- The one-to-one sessions identified lack of data sharing regarding childhood immunisation records with primary care which is reported as a barrier to engagement and promoting vaccination programme.

4.13.2 Good practice

- There is an acknowledgment that this area is currently under review nationally and work underway to consider new digital systems.
- There is currently accurate and efficient vaccination record keeping.
- VMT is utilised effectively across the Board, with an overall positive experience.

4.13.3 Areas for Improvement

- NHS Highland Board need to facilitate the process for ensuring individual vaccination records are up to date in the GP-IT system.
- There should be a feedback system to ensure non-attenders and decliners are followed up and processes for documenting appropriately is in place.
- Ensure those that need access to data and data systems have appropriate access to enable them to effectively do their role.
- There is a need to increase the use of the full range of available data to be able to identify areas of particular challenge, e.g., within certain geographical areas or population groups.
- Review internet access issues for all venues to ensure timely inputting of vaccination records.
- Ensure vaccination programme has access to updated school lists to better understand school children with outstanding vaccinations.
- Use of SIRS /CHIS scheduling to full potential and to standardise where possible potentially including electronic transfer of info if only by email.
- Dedicated digital systems should be utilised for scheduling and recording of vaccinations where there is currently dependence on spreadsheets and manual processes.

4.14 Quality improvement activities

4.14.1 Current situation / practice

- No / limited systematic area-wide quality improvement activities were shared with the peer review team since VTP was introduced. However, this does not mean that there are no quality improvement activities across NHS Highland Board, as a few SBARs were shared with the peer review team that would be considered as good quality improvement activities if implemented.
- There were relatively few mentions of issues related to specific and detailed quality improvement activities in the documents reviewed. However, NHS Highland Board works closely with other boards as part of SVIP and try to both share learning and also benefit from learning elsewhere.
- The lead nurses for vaccination have been liaising with other Boards in relation to the delivery of the school programme and to learn from other areas and support improvement. This has resulted in the development of a SOP for the school programme.
- There has also been a pilot of the locally arranged appointments for the second and third primary immunisations in order to reduce DNAs in one of the teams.
- There is also on-going work within the HPT for the reconciliation of records for children new to area from the UK or elsewhere abroad to ensure they are up-to-date with all necessary vaccinations.
- Work is also on-going to support improvement in delivery of non-routine vaccinations and to ensure safe and effective processes were in place locally.
- From a pharmacy perspective, there are also quality improvement activities e.g., audit of electronic temperature recording devices; the use of logtags in porters for the childhood nasal flu vaccine; and activities to reduce vaccine wastage.

- There is appreciation that quality improvement is required and good practice, but challenge in establishing this. There was some evidence that reflection occurs on programme delivery at an operational level and suggestions for improvement however there are no formal improvement mechanisms in place which some responders felt would be helpful.

4.14.2 Good practice

- Primary care quality cluster groups are in place.
- In one HSCP, there is a group focussed on CTAC and vaccinations quality, professional and practice standards.
- Within one HSCP, primary care modernisation has resulted in tests of changes that result in service improvements over time.

4.14.3 Areas for Improvement

- There requires to be a joint understanding of quality improvement approaches with appropriate senior leadership.
- There is a need to support staff training on quality improvement to ensure understanding of the concept, language and processes, as there are some quality improvement activities that are not formally labelled as such.
- A culture of quality improvement should be embedded throughout the vaccination and immunisation programme and systems, with clear mechanisms and accountability, and linked to operational delivery.
- Integrated service planning should be linked to quality improvement with a focus on reducing inequalities.
- Learning from quality improvement approaches in other areas of service provision, such as screening could be considered.
- There is a need for more staff with the right background and interest participating in national fora where quality improvement activities are discussed and shared.
- Identify and implement recommendations from national reports that may be appropriate for local implementation.

5. Discussion: Peer review team assessment, observations, and comments

We cannot emphasis enough the passion, dedication, and commitment that was demonstrated by staff, partners, and stakeholders. All our assessments, observations and comments discussed below need to be taken within this context, and the hard work, and unwavering devotion of all those involved in vaccination and immunisation service to deliver patient-centred service across NHS Highland Board.

Governance arrangements including structural hierarchy and reporting systems are clearly articulated on paper and most if not, all staff are aware of the leadership team(s) at all levels. However, what was consistently reported to the peer review team was a perception by staff that they are raising issues and concerns repeatedly, which are not acknowledged/responded to and there was no clarity about the decision-making process and who ultimately is expected to make decisions. This is supported by the documents we reviewed, as there are examples of reporting into governance

structures, where there was limited evidence of consequent action. Reviewing current processes and addressing these issues may take some time and understanding from staff will be expected if a new way of working with a transparent process is to be established.

In relation to leadership of the vaccination and immunisation programme, again most staff and partners are aware of the two HSCP leadership responsibilities for the operational delivery of the programme supported by the wider NHS Highland leadership including the Immunisation Coordinator, Director of Public Health, and other NHS Highland Board senior leadership team members. There is wider acknowledgement across the Board that staff are working incredibly hard to provide a good service, and the lack of progress in resolving long-standing issues is in some situations impacting on this. Addressing the roles and responsibilities of those in leadership roles, at all levels, and supporting them to make day-to-day operational decisions with clear escalation routes and expectations for a response within a reasonable timeframe will help to build staff confidence and boost staff morale.

In 2017, as part of the commitment to reduce GP workload, the Scottish Government and Scottish General Practitioners Committee (SGPC) agreed vaccinations would progressively move away from a model based on GP delivery to one based on NHS Board delivery through dedicated teams. In addition to reducing GP workload, the other potential benefits of VTP included standardisation of delivery across geographical areas, economies of scale, increased scheduling flexibility (both regarding timings and venues), better handle on queues/waiting lists if any, and adopting one strategy for dealing with DNAs. Some of the draw backs of VTP were acknowledged during its introduction, and these include lack of opportunistic vaccinations by GP practices, possible additional journeys for some patients and parents, losing the experience of GP practices including the risk that some GPs will no longer see immunisation discussions or referrals within their responsibilities, and some safety concerns (from parents) about venues other than GP practices. However, this is not to say that the above are the only benefits and drawbacks of VTP, as local professionals have shared with us more benefits and drawbacks. However, the most consistent concern amongst professionals across NHS Highland Board is the lack of flexibility in service delivery model in some remote and rural areas. A substantial number of documents that we reviewed also outlined the concerns raised around this issue and the escalation process that followed, indicating that this is still an acute issue in some remote and rural areas of NHS Highland Board.

It is clear from our one-to-one sessions that the introduction of the VTP was extremely challenging, particularly for NHS Highland Board. A recurring theme across our one-to-one sessions and the documents reviewed was concerns about the feasibility of a centralised model of service delivery in remote and rural areas. This included concerns centred around issues related to staffing clinics, recruitment, and retention, especially in remote and rural areas. There were several instances where staff reported in the one-to-one sessions that in remote and rural areas, where relatively small numbers of children required vaccination, that the centralised model was inefficient. The previous GP practice model had delivered a good patient centred service. The documents we reviewed emphasised these issues and our own observations and discussions corroborated these views. There were also concerns about the timely delivery of post exposure prophylaxis when needed.

Therefore, taking into account all the information collated from the different sources, it is the peer review team's independent assessment that the service delivery model across NHS Highland Board needs to be reviewed as a matter of priority.

It is the peer review team's overall assessment that the option of having increased flexibility in the delivery model for some remote and rural areas could be the start for improving the wider engagement with primary care in general, and GPs in particular.

Apart from some isolated examples in some areas, stakeholder engagement, particularly with primary care services including GPs, should be improved. The peer review team would like to emphasise that meaningful engagement all key stakeholders would require further structural review of current governance arrangements to enable acceptable participation and engagement of all relevant professionals.

The emergence of the COVID-19 pandemic impacted not only the VTP implementation timeline but also communication with professionals, patients, and members of the public. There is a perception amongst professionals that VTP was implemented with extremely short deadline (March 2023) across NHS Highland Board following a long gap / absence of information and engagement. This amongst other factors has resulted in resistance and sometimes a hostile atmosphere for vaccination and immunisation teams to implement the programme effectively and efficiently. To our knowledge, there were not many examples of patient / public engagement prior to VTP implementation, and there was little detail in the documents reviewed on the approach NHS Highland Board has taken on patient and public engagement other than data from a survey undertaken in one GP cluster.

It is the peer review team assessment that there is a need for NHS Highland Board to develop a robust communication strategy (internal and external) that would facilitate proactive staff, partners/stakeholders, and public/patient engagement.

6. Conclusion

This peer review was undertaken at a time when the NHS in Scotland is facing a challenging financial environment. Nevertheless, it is the peer review team's assessment that by focusing on vaccination and immunisation service **quality improvement** activities, and reviewing the most appropriate **model of service delivery** for some remote and rural areas should be of central consideration for NHS Highland Board.

It is also imperative that priority is given to **staff wellbeing**, staff development, and **stakeholders engagement** (including patient and public). The impact of clear **leadership** roles and responsibilities for vaccination and immunisation programme with transparent decision-making processes around **governance**, distributive leadership and subsidiarity with appropriate accountability should not be underestimated. All the improvement areas identified in this peer review require an overarching and robust **communication strategy** across NHS Highland Board to achieve the full impact.

This peer review demonstrated that support provided to NHS Highland Board staff and stakeholders could be not only effective but valued and welcomed by staff. The positive verbal feedback from those who had one-to-one sessions during the visit or virtually is testimony to this, as one member of staff summarised the personal impact, it "…helped me to focus, it was not the way I was thinking, and I now feel that I am listened to…".

The peer review team are confident, that given the optimism expressed by a number of staff, that solutions could be found to develop and deliver an improved vaccination service with all key stakeholders working together across NHS Highland Board, given the multiple areas of good practice already identified, and the willingness demonstrated by the dedicated workforce.

7. Limitations

The preparation time for the peer review was short and the number of staff coming forward for one-to-one sessions outstripped the peer review team capacity. Therefore, it is possible that there will be some staff who may feel their points of view were not considered. However, the peer review team encouraged all staff, especially those who did not get the chance to have a one-to-one session to provide written statement and some did. We also reviewed over 100 documents that were submitted by NHS Highland Board. Furthermore, there was consensus among participants, particularly those who have had one-to-one sessions, that all main areas were covered in the themes reviewed.

8. Proposed next steps

- As outlined in the executive summary, the peer review team proposes NHS Highland Board establish a time limited multiagency task and finish group with representation from all vaccination and immunisation stakeholders to ensure meaningful engagement and co-produce / develop an action plan with a clear timeline and responsible professionals (including PHS).

- The action plan will need to be monitored and reviewed in collaboration with relevant partners and stakeholders by NHS Highland Board.

- Going forward, PHS Vaccination and Immunisation Division will provide relevant input during monitoring and review of the action plan. This will ensure the collation of good practice, learning from the key themes and trends shared wider beyond NHS Highland.

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**4 September 2024**
Title:	**Highland Health and Social Care Partnership - Integrated Performance and Quality Report (IPQR)**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer, HHSCP (Highland Health and Social Care Partnership)**
Report Author:	**Lorraine Cowie, Head of Strategy & Transformation**

1 Purpose

This is presented to the Committee for:

Assurance

This report relates to a:

Annual Delivery Plan

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

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

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

2.1 Situation

To standardise the production and interpretation, a common format is presented to committee which has been aligned to the Clinical and Care Governance Committee and the Finance, Resources and Performance Committee. Within this version the HHSCP IPQR has been updated to include some additional metrics and narrative aligned to the Annual Delivery Plan summarising current performance position, plans, and mitigations to improve/sustain performance and the anticipated impact these plans will have on performance once achieved. It is acknowledged that further work is required on targets and trajectories within some of the key areas.

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

The health and wellbeing indicators will be included at appropriate times along with consideration of the approved joint strategic plan indicators.

2.2 Background

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

2.3 Assessment

As per **Appendix 1**.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	
Limited	X	None	

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

3 Impact Analysis

3.1 Quality / Patient Care

IPQR provides a summary of agreed performance indicators across the Health and Social Care system.

3.2 Workforce

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

3.3 Financial

The financial summary is not included in this report.

3.4 Risk Assessment/Management

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

3.5 Data Protection

This report does not involve personally identifiable information.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement, and consultation

This is a publicly available document.

3.9 Route to the Meeting

This report has been considered at the HHSCP previously and is now a standing agenda item.

4 Recommendation

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

- Consider and review the performance identifying any areas requiring further improvement and in turn assurance of progress for future reports.
- To accept limited assurance and to note the continued and sustained stressors facing both NHS and commissioned care services.
- Consider any further indicators that are required to support the assurance for the Highland Health and Social Care Partnership

4.1 List of appendices

The following appendices are included with this report:

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

Highland Health and Social Care Integrated Performance and Quality Report

Assuring the HHSCP Committee on the delivery of the well outcome themes aligned to the Annual Delivery Plan

NHS Highland
na Gàidhealtachd

Together We Care
With you, for you

HHSCP Integrated Performance and Quality Report

- The Integrated Performance & Quality Report (IPQR) contains an agreed set of measurable indicators across the health and social care system aimed at providing the Finance, Resource and Performance Committee, Clinical and Care Governance Committee and the Health and Social Care Partnership committees a bi-monthly update on performance and quality based on the latest information available.

- For this IPQR the format and detail has been modified to bring together the measurable progress aligned to the actions within the Annual Delivery Plan that will be reviewed by Finance, Resources and Performance Committee and the Clinical and Care Governance Committee

- In addition, a narrative summary table has been provided against each area to summarise the known issues and causes of current performance, how these issues and causes will be mitigated through improvements and what the anticipated impact of these improvements will be.

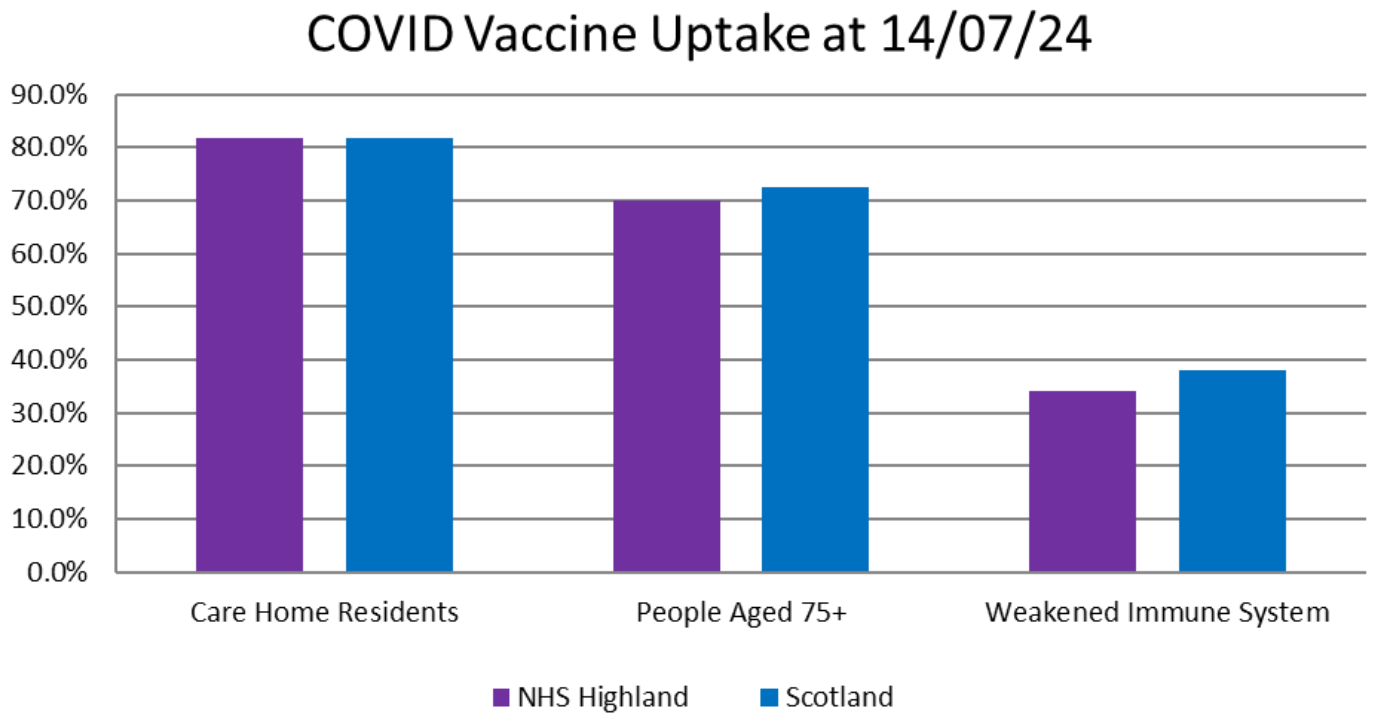
- We will continue to develop this report to include further metrics as described on the following pages and to provide assurance of progress on the annual delivery plan

Together We Care – Well Outcomes Alignment

Population Well Outcomes	Slides	Key Areas	Governance Committee Review
OUR POPULATION – Deliver the best possible health and care outcomes			
Start Well	n/a for HHSCP	Maternity & Neonatal Services	CCGC and FRPC
Thrive Well	n/a for HHSCP	CAMHS & NDAS	CCGC and FRPC
Stay Well	4-5	Vaccinations Screening	CCGC, FRPC and HHSCP CCGC and FRPC
IN PARTNERSHIP – Create value by working collaboratively to transform the way we deliver health and care			
Care Well	7-14 15-16 17 18	Care Homes and Care at Home Delayed Discharges Community Hospital Length of Stay Adult Protection	HHSCP HHSCP, CCGC and FRPC HHSCP HHSCP
Live Well	19 20	Psychological Therapies Community Mental Health Waiting List	HHSCP, CCGC and FRPC HHSCP
Respond Well	n/a for HHSCP	Emergency Department	CCGC and FRPC
Treat Well	n/a for HHSCP n/a for HHSCP 21-23 24 25	Planned Care Diagnostics Community Waiting Lists Chronic Pain Alcohol & Drug Partnership Waiting Times	CCGC and FRPC CCGC and FRPC HHSCP, CCGC and FRPC HHSCP HHSCP
Journey Well	n/a for HHSCP	Cancer Waiting Times and SACT	HHSCP, CCGC and FRPC
Age Well	Future version for HHSCP	Rehab, Dementia & Long Term Conditions	Metrics to be defined
End Well	26	Palliative & End of Life Care	HHSCP, CCGC and FRPC
Value Well	Future version	Carers and Third Sector	Metrics to be defined

OBJECTIVE	Our Population	OUTCOME	Stay Well	EXEC LEAD	Tim Allison, Director of Public Health	Service	Vaccinations and Immunisations

PERFORMANCE OVERVIEW	TARGET	c.70% uptake in general for each programme	NATIONAL TARGET ACHIEVEMENT		TREND	New campaign commenced	BENCHMARK	See below



Comparative Covid vaccine uptake for all eligible people at 14/07/24:

NHS Board	Covid
Ayrshire & Arran	66.4%
Dumfries & Galloway	69.3%
Fife	67.1%
Grampian	68.6%
Highland	63.5%
Tayside	70.1%

OBJECTIVE	Our Population	OUTCOME	Stay Well	EXEC LEAD	Tim Allison, Director of Public Health	Service	Children's Vaccinations

PERFORMANCE OVERVIEW	TARGET	95% Uptake	NATIONAL TARGET ACHIEVEMENT		TREND		BENCHMARK	

6 in 1 @24 weeks	Q3 23/24	Q4 23/24	April/May 24
Highland HSCP	96%	97%	96%
Argyll & Bute HSCP	95%	99%	98%
NHS Highland	95%	97%	96%

Scotland 4/5 24: 97%

MMR 1 @16m	Q3 23/24	Q4 23/24	April/May 24
Highland HSCP	77%	85%	84%
Argyll & Bute HSCP	91%	88%	87%
NHS Highland	79%	86%	84%

Scotland 4/5 24: 88%

MMR 2 @3y 8m	Q3 23/24	Q4 23/24	April/May 24
Highland HSCP	72%	77%	68%
Argyll & Bute HSCP	78%	85%	76%
NHS Highland	73%	79%	70%

Scotland 4/5 24: 81%

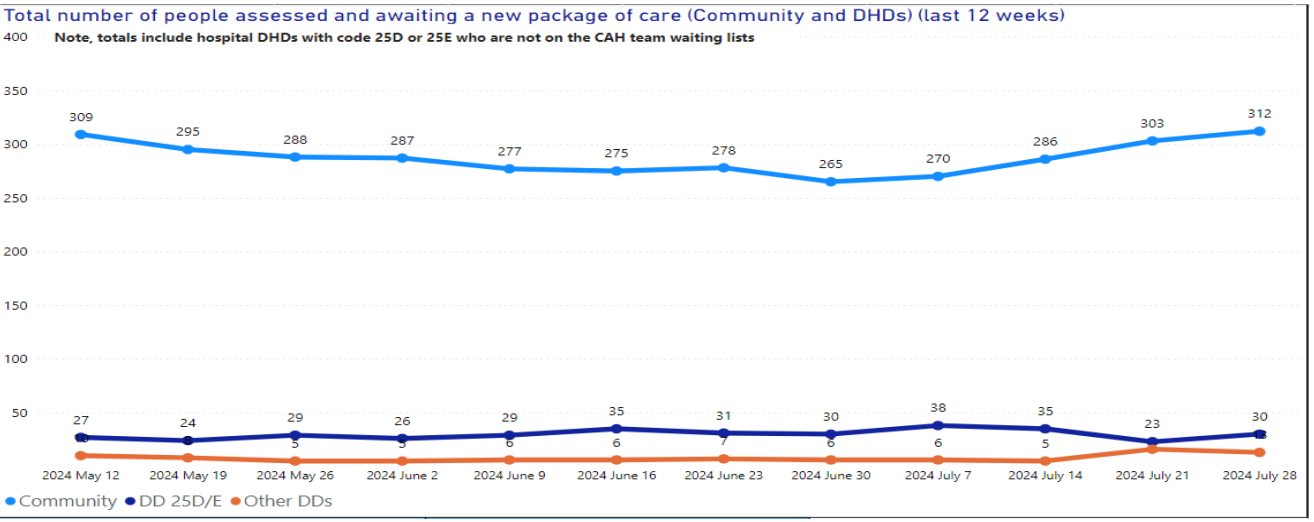
OBJECTIVE	Our Population	OUTCOME	Stay Well	EXEC LEAD	Tim Allison, Director of Public Health	Service	Vaccination and Immunisations

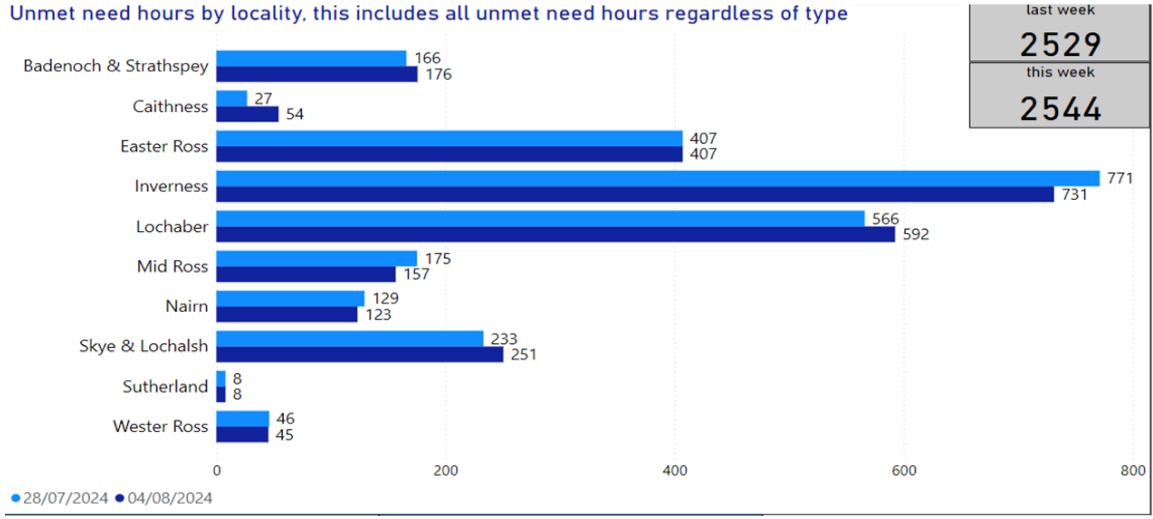
Annual Delivery Plan (ADP) 24/25 Deliverables – Progress as at 30th June 2024	Due Date
Vaccination Programme: consider the options for consolidation of delivery of vaccination activity required across NHS Highland.	October 2024
Continue to ensure that locality-based vaccination teams and campaign planning are sufficiently robust to deliver vaccination and immunisations' and childhood vaccination following their removal from GP practices from 1 April 2022 (A&B) Qtr1 target 64%, actual 66%	March 2025
Identify any ongoing practice involvement in delivery of vaccinations beyond 1 April 2022 under the terms of the transitionary service arrangements (including additional payment arrangements) (A&B) Qtr1 target 64%, actual 66%	March 2025
Improved disease prevention and reduced inequalities in access through consolidated NHS Highland vaccination programme.	MTP – March 2027

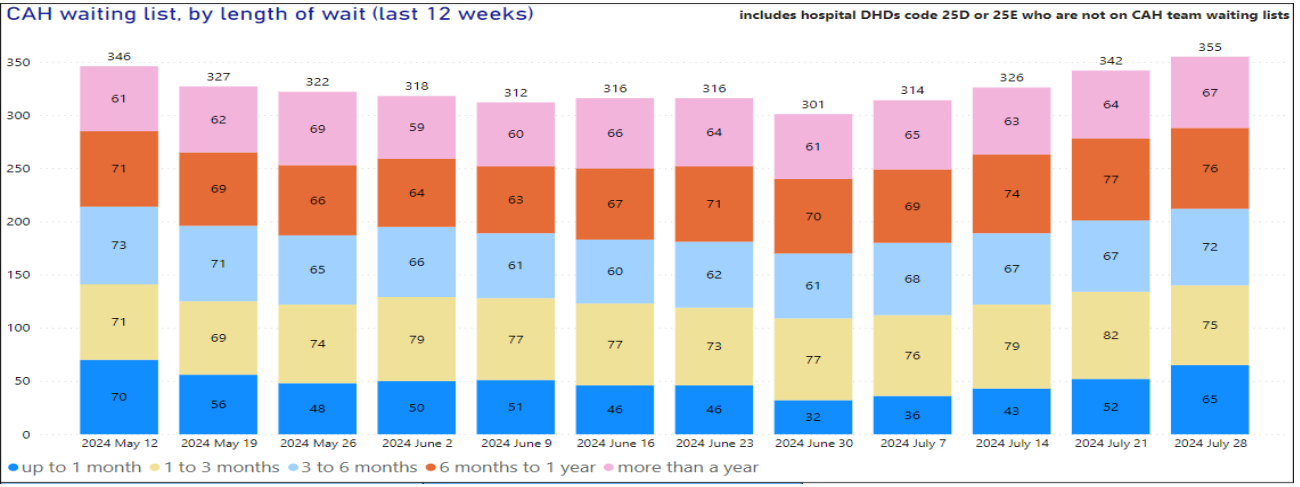
Reasons for current Performance	Plan and Mitigation	Expected Impact
•Overall COVID & 'Flu uptake has been reasonable, but the quality of performance delivery needs to be improved as does uptake in these programmes and for children's vaccination. •The spring COVID vaccination programme has been undertaken for people aged 75+ and those more vulnerable. Other adult and child programmes also continue. •There has been some improvement in the timeliness of children's vaccination, but overall vaccination rates remain low, especially in Highland. Delivery models and staffing need to be improved. This is especially important for those missing vaccinations.	•Scottish Government is working with Highland HSCP in level 2 of its performance framework. •Public Health Scotland is acting as a critical friend. The peer review has been carried out and recommendations are being implemented. •Options are being considered for delivery models in Highland HSCP. •The Vaccination Improvement Group has a detailed action plan for service improvement	Improved uptake rates for vaccinations Improved service with better satisfaction from public and staff

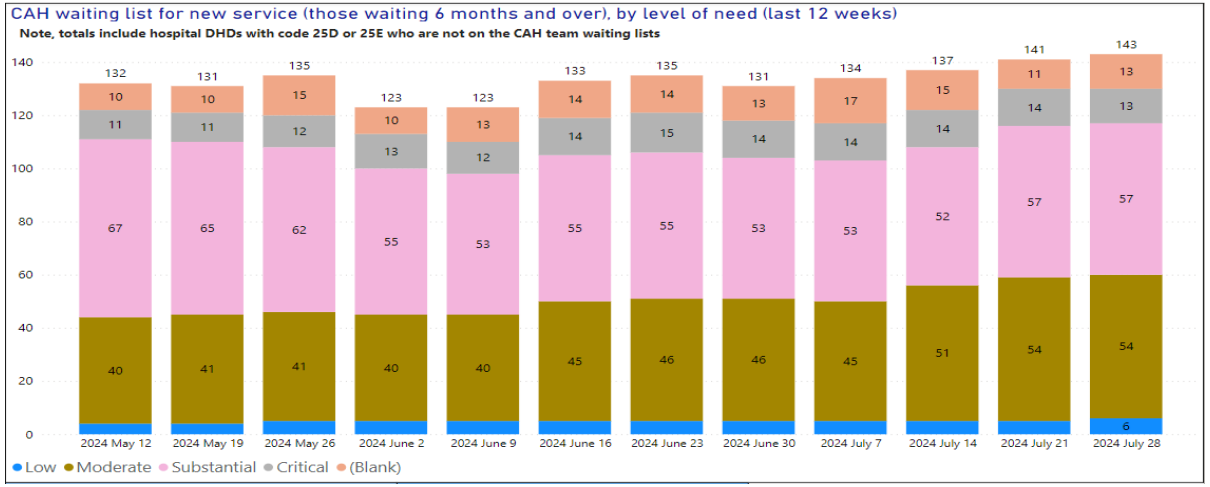
OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Care at Home

PERFORMANCE OVERVIEW	TARGET	To be agreed	NHS HIGHLAND	312 people waiting	TREND		BENCHMARK	Not available	POSITION	Not available

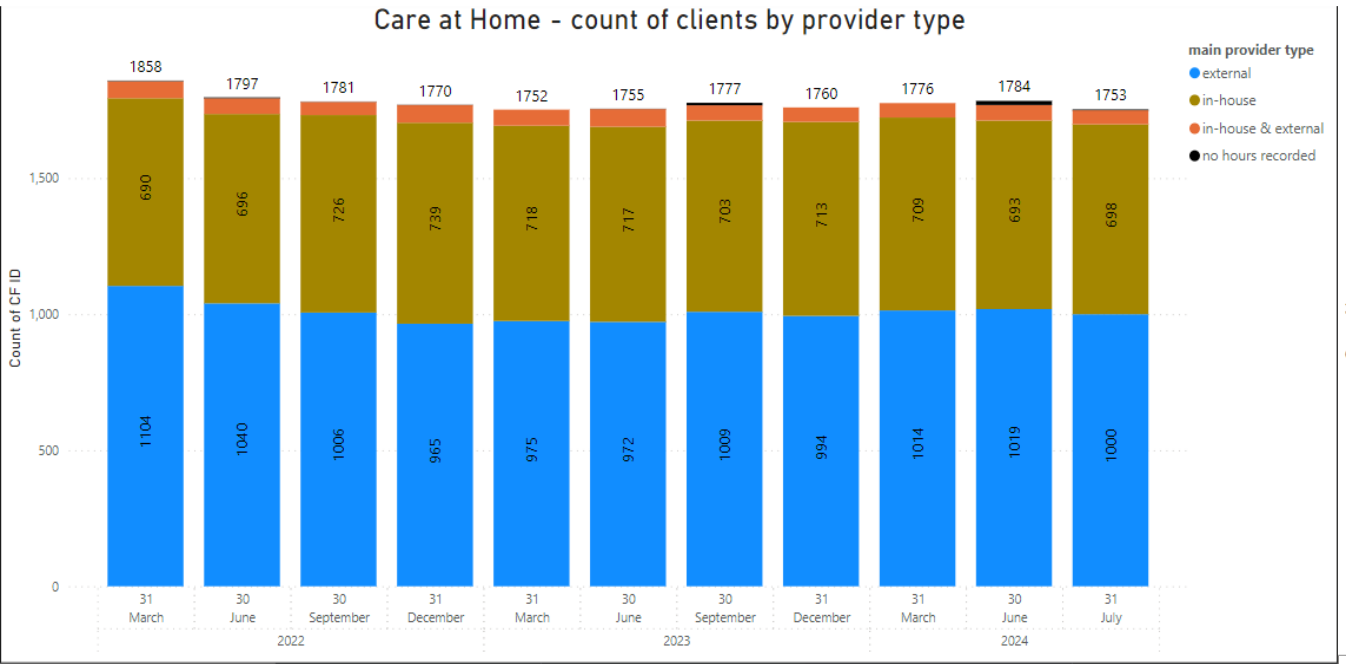


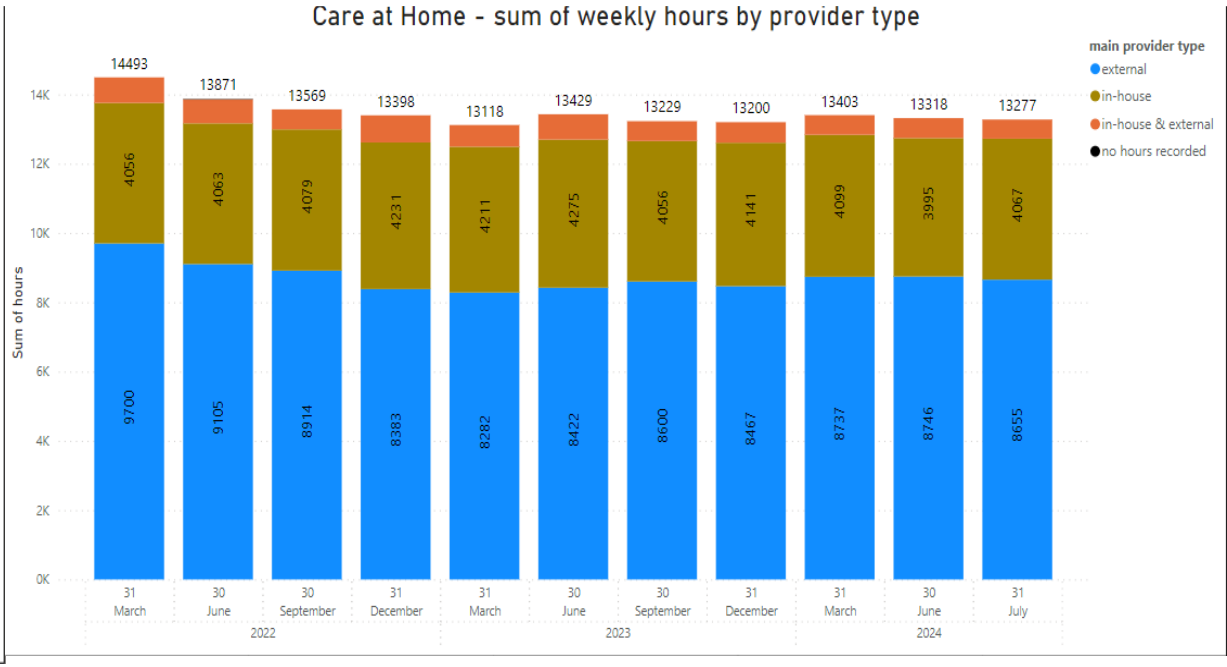


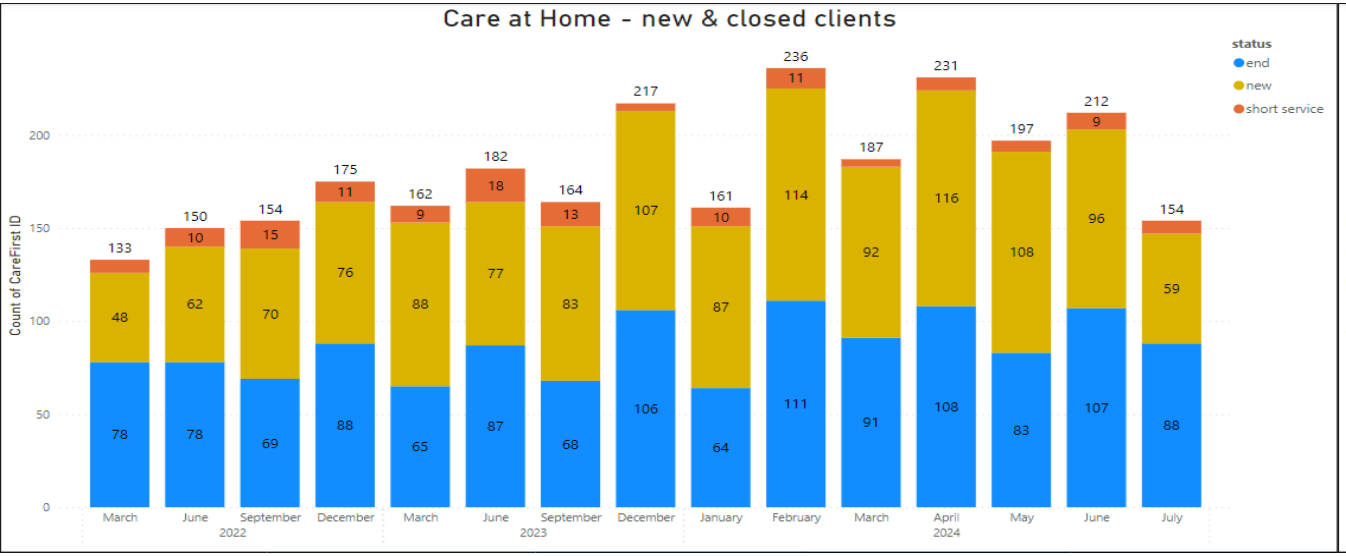


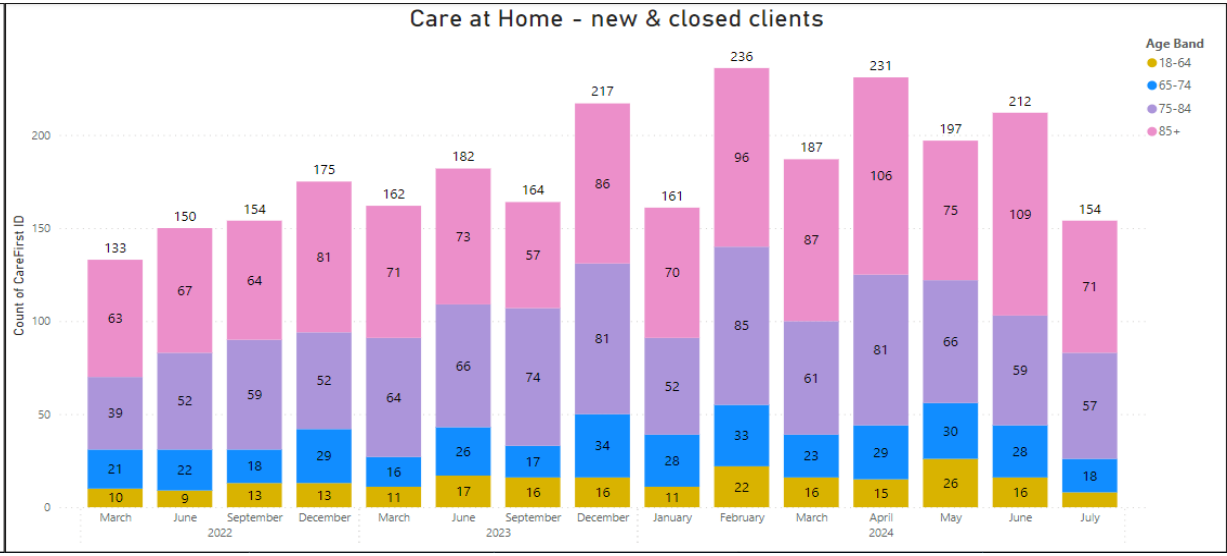


OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Care at Home







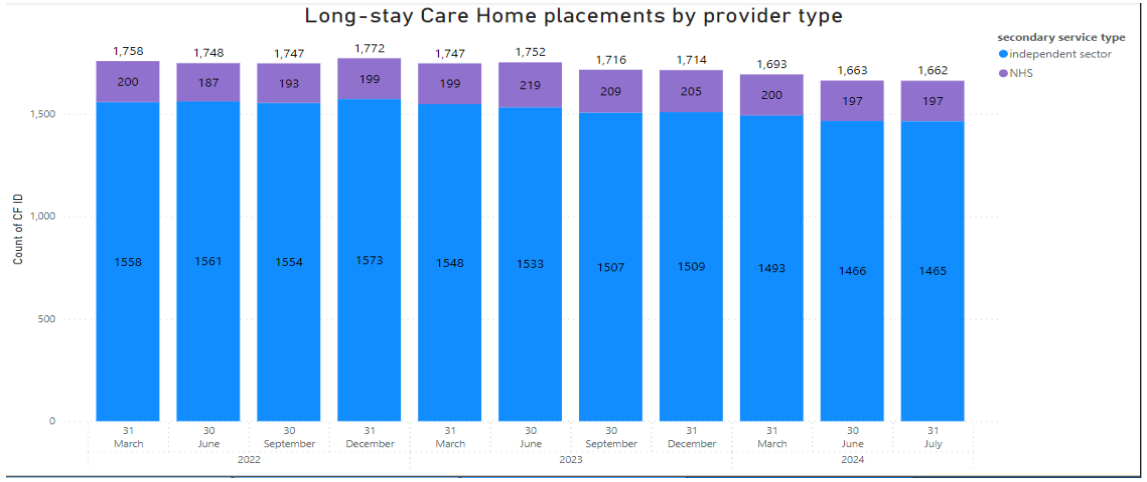


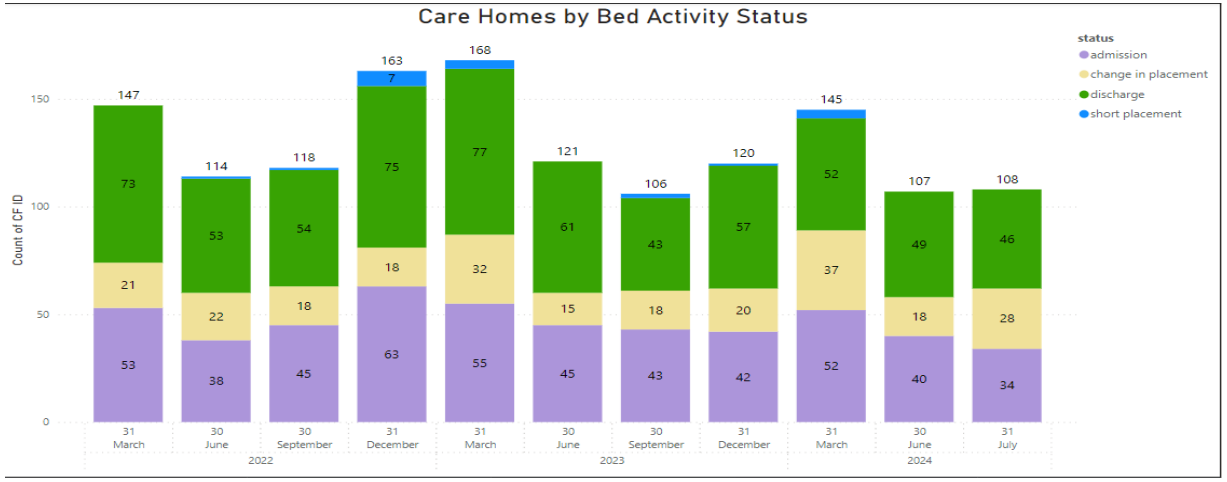
OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Care at Home

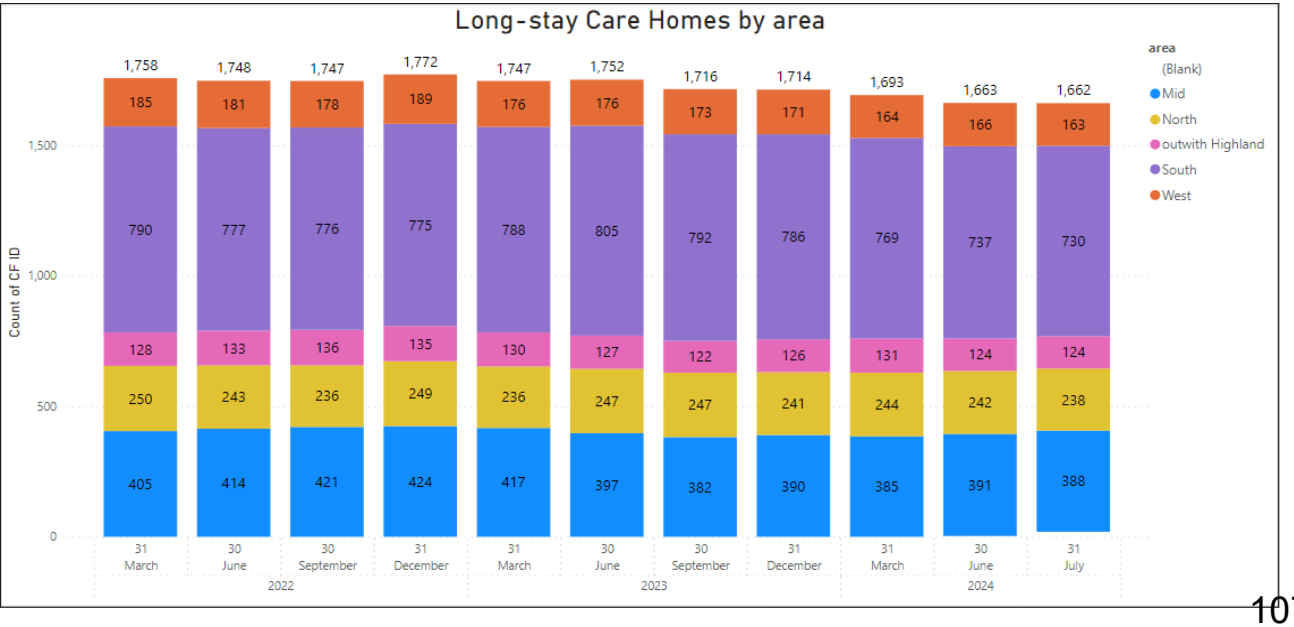
The Issue and Cause	Plan and Mitigation	Expected Impact
All HHSCP delayed hospital discharges (DHD's) are included which show those assessed as requiring CAH in either a hospital, or at home. • Community - 312 awaiting a care at home service, increase of 26 reported from last IPQR • DHDs – 30 awaiting a care at home service, reduction of 5 reported from last IPQR • Other DDs - No change from last reported last IPQR. This data is published by PHS and weekly returns from CAH officers are provided to allow for validation and analysis. We have seen some small signs of recent growth although service delivery is still down overall after a period of sustained reductions from the peak of March 2022. NHS Highland (NHSH) and care at home providers continue to operate in a pressured environment . We have not seen the expected growth in external care at home and low levels of recruitment and the loss of experienced care staff to NHSH continue to be the primary concern expressed by providers in our frequent and open discussions. The impact of lower levels of service provision on flow within the wider health and social care system is significant, and this needs to be recognised as part of the approach to, and solutions around, addressing care at home capacity.	Despite significant ongoing organisational and provider effort to improve flow, the overall unmet need for CAH is 2529 planned hours per week. Care at home is a specific action within the 90 Day Urgent and Unscheduled Care Improvement Plan. As previously highlighted and confirmed in committee reports, a short life working group (SLWG) has co created and co-developed proposals to try and address capacity and flow issues. The SLWG has co-produced **eight** commissioning proposals which are being prioritised with an implementation plan. A multi-disciplinary and sector implementation group was initiated in June 2024, to take forward proposals around the following focus areas: **Improving Access and Processes** • Clear pathway • Information quality • Zones/runs/flexibility • Outcome commissioning/interactive commissioning tool **Valuing Staff** • Tariff implementation • Joint training/locality shared staff • Collaboration event **Troubleshooting** A wider **care at home collaborative** has been established in August 2024 to consider and progress wider strategic and collaborative opportunities	• Expected impact and trajectories for improvement have been developed for overall delayed discharges. • Sustaining current service delivery levels for care are home. • Targets and any future realistic growth trajectories need developed for external care at home at a district level

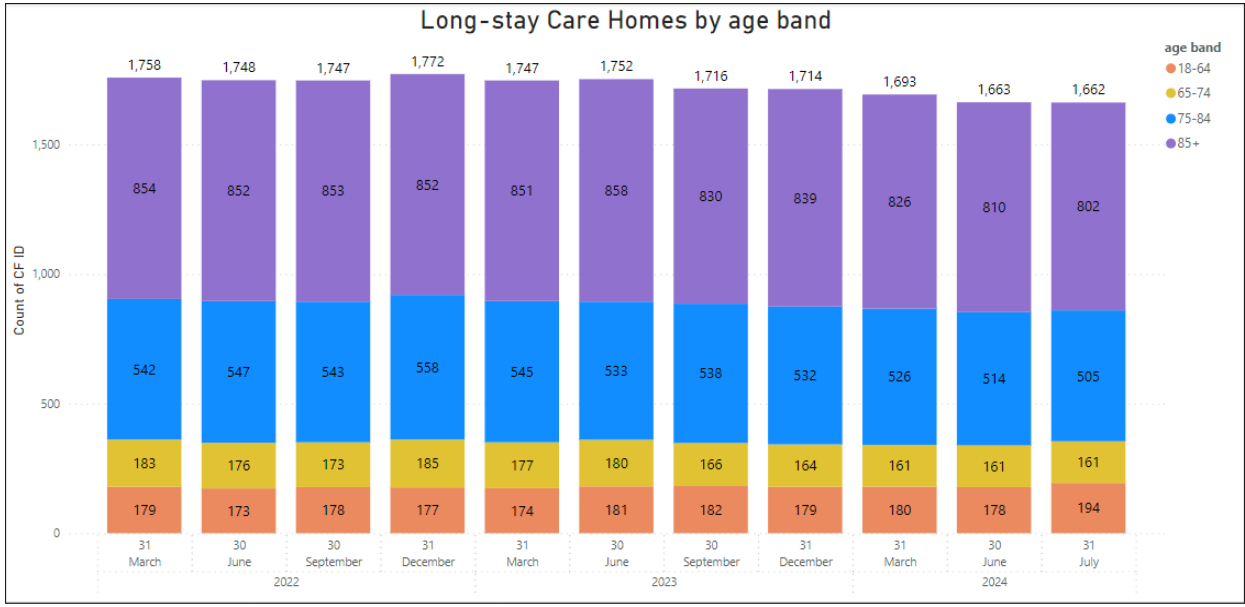
OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Care Homes

PERFORMANCE OVERVIEW	TARGET	To be agreed	NHS HIGHLAND	n/a	TREND		BENCHMARK	n/a	POSITION	n/a









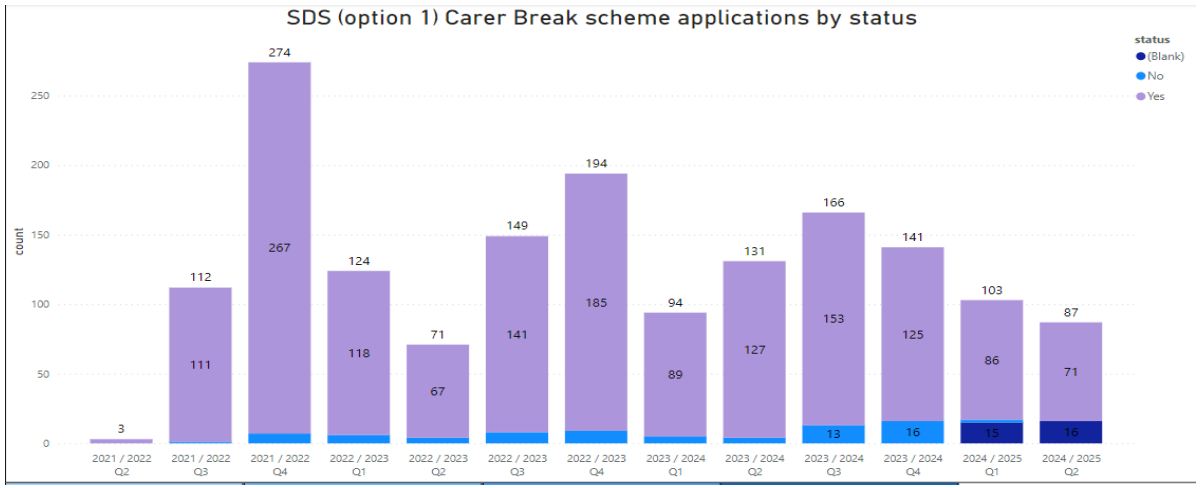
OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Care Homes

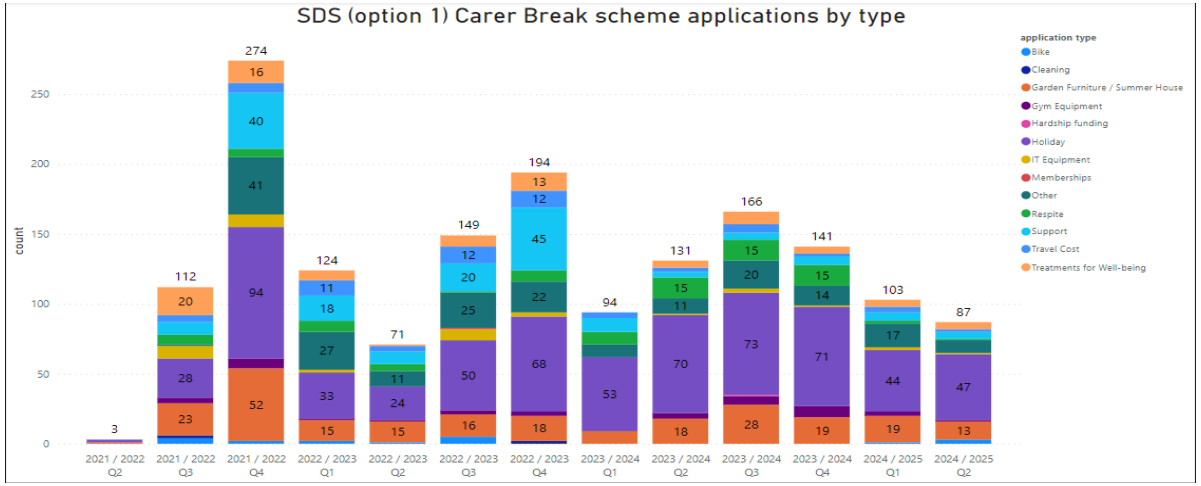
PERFORMANCE OVERVIEW	TARGET	To be agreed	NHS HIGHLAND	n/a	TREND		BENCHMARK	n/a	POSITION	n/a

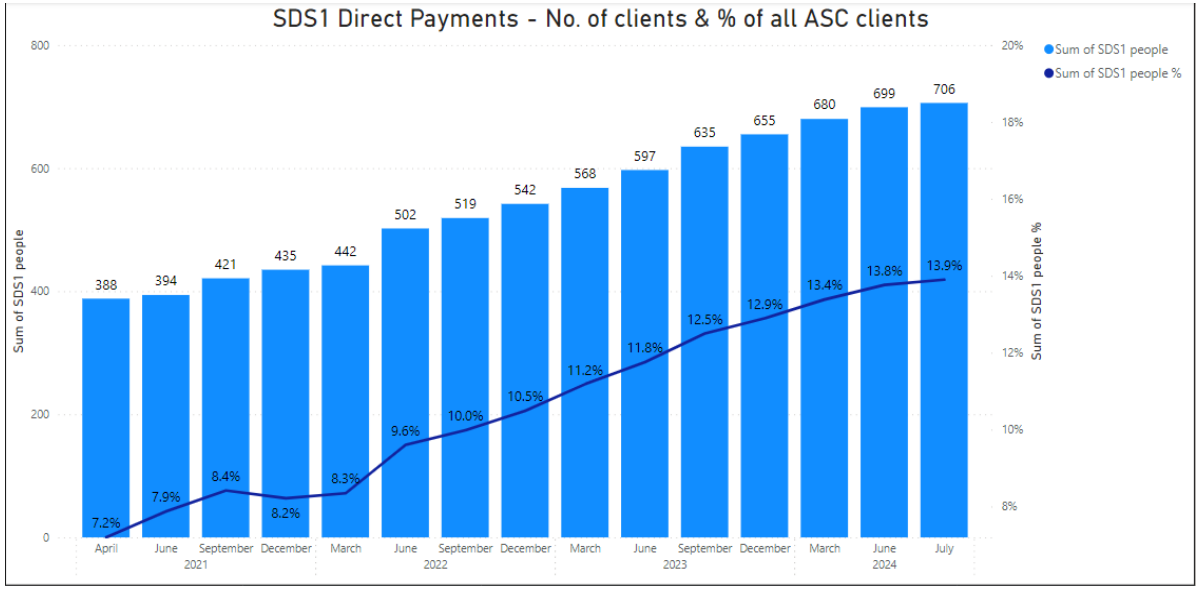
The Issue and Cause	Plan and Mitigation	Expected Impact
Since March 2022, there has been significant and sustained turbulence in the care home market related to operating on a smaller scale, and the challenges associated with rural operation - recruiting and retaining staff in these localities, securing and relying on agency use, and the lack of available accommodation which compounds the challenge. A further compounding factor of this turbulence relates to the current National Care Home Contract (NCHC) – this is insufficient to cover their costs and particularly disadvantages Highland as the NCHC rate is predicated on a fully occupied 50 bed care home – in Highland only 7 of the 46 independent sector care homes are over this size. In-house care homes and many care home providers are still experiencing staffing resource shortages. Since March 2022, 6 independent sector care homes have closed. During this period, the partnership also acquired a care home in administration to prevent the closure of this facility and a further loss of bed provision. Supplementary staff costs for care and nursing staff is significantly higher in the recently acquired NHSH care homes. 4 in house care homes have also closed, although three are closed on a temporary basis and the closures are all in small rural and remote communities with closure due to acute staffing shortages. This reduced bed availability (211 registered beds) is having an impact on the wider health and social care system and the ability to discharge patients timely from hospital.	There is a need for a Care Home commissioning and market facilitation plan to be developed in 2024-25. This plan will include both in-house and external care homes underpinned by quality and sustainable services in identified strategically important locations. This facilitation plan will be discussed at the Strategic Planning Group and will also form part of the agenda for a collaborative care home listening and learning event planned for August 24. High level commissioning intentions are agreed A Care Home overall risk status has been developed for all external commissioned care homes and is reviewed at the Care Programme Board A **Care Programme Board** has been established to oversee: • Acquisitions, closures and sustainability • Forward Planning and Strategy	• Sustainability of exiting care home provision • Future market intentions stated • To be developed

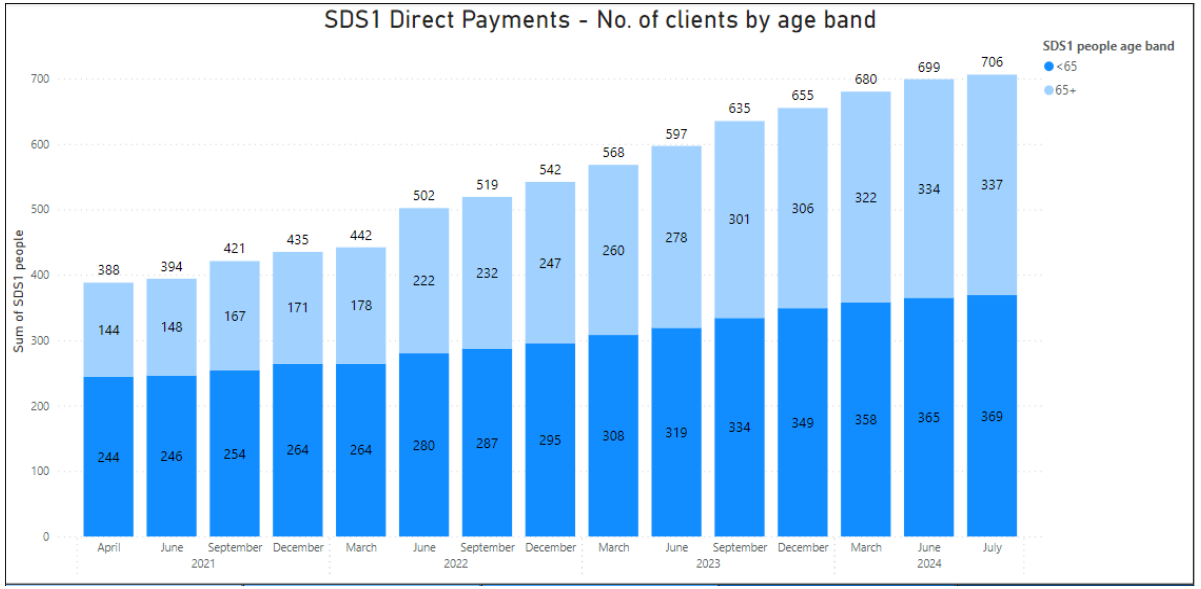
OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Adult Social Care: Self Directed Support

PERFORMANCE OVERVIEW	TARGET	To be agreed	NHS HIGHLAND	n/a	TREND		BENCHMARK	n/a	POSITION	n/a

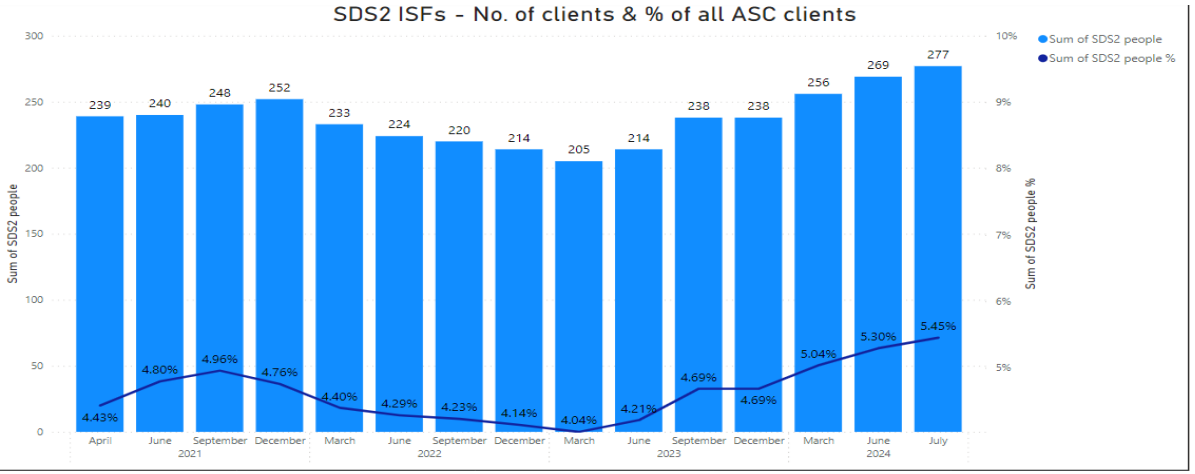


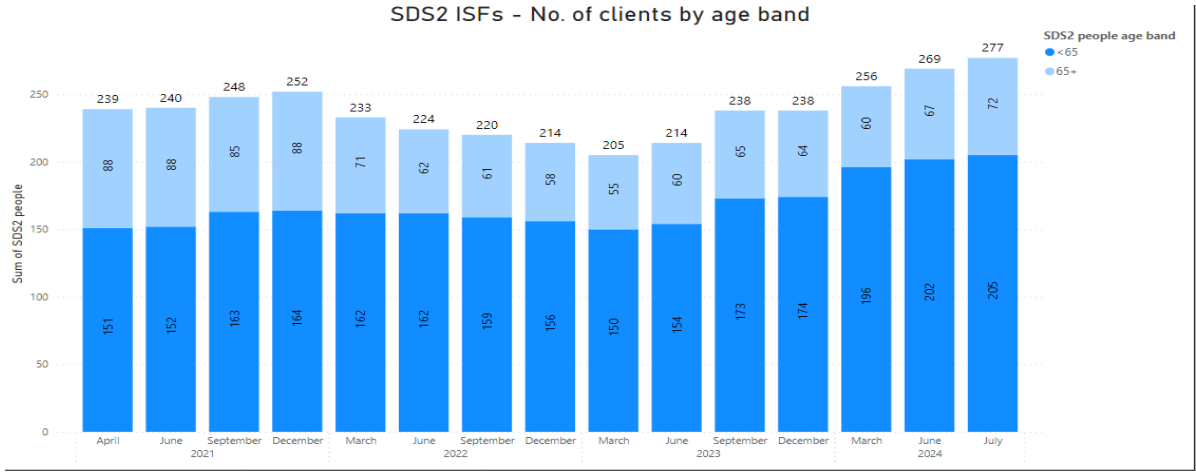






OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSPCP Adult Social Care: Self Directed Support – Option 2 (Individual Service Funds)
PERFORMANCE OVERVIEW	TARGET	To be agreed	NHS HIGHLAND	n/a	TREND	BENCHMARK	n/a	POSITION	n/a





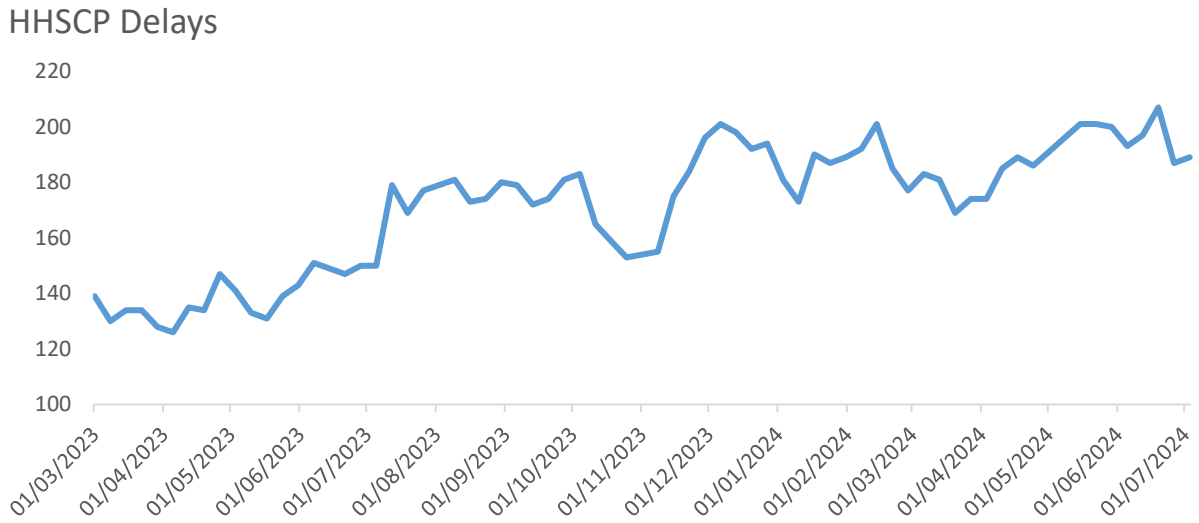
The Issue and Cause	Plan and Mitigation	Expected Impact
ISFs reduced during 2022 although we have seen a welcome and sustained increase in commissioned service provision during late 2023 continuing in 2024. Current numbers of ISFs are now exceeding pre pandemic levels of the 2021 peak. Our current number of active service users is 277 with a projected annual 2024-25 cost of £7.53m. Graph 2 - Overall number of ISFs split by age band, noting 74% of our current service provision is provided under this commissioning option to younger adults.	• After an inclusive inquiry into the operation of our Option 2 offer in Highland plans are now in place to increase the range and number of 'providers' who can offer an ISF within an overall programme for Promoting choice, flexibility and control.	• As per plan and mitigation • To sustain and grow Option 2s

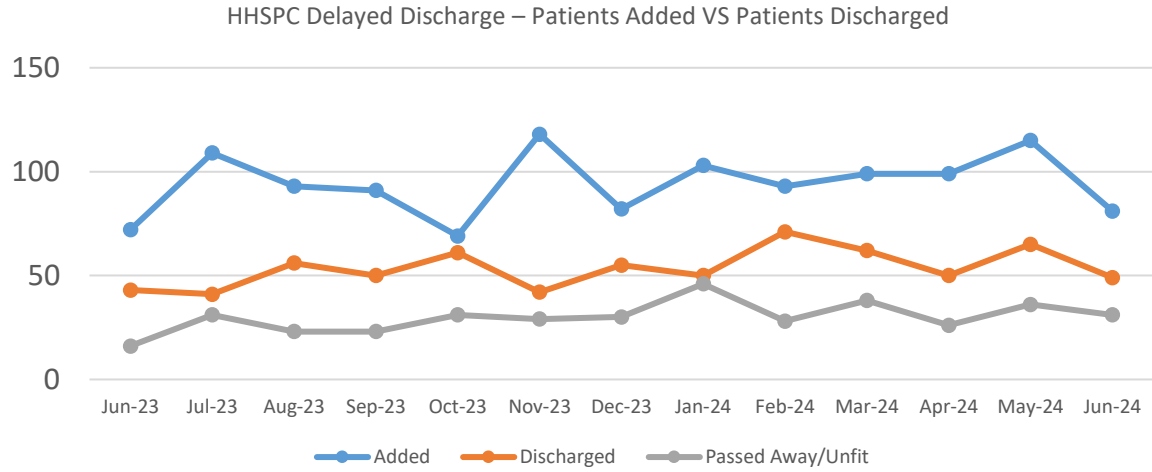
OBJECTIVE	In Partnership	OUTCOME	Care Well & Value Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Adult Social Care: Self Directed Support

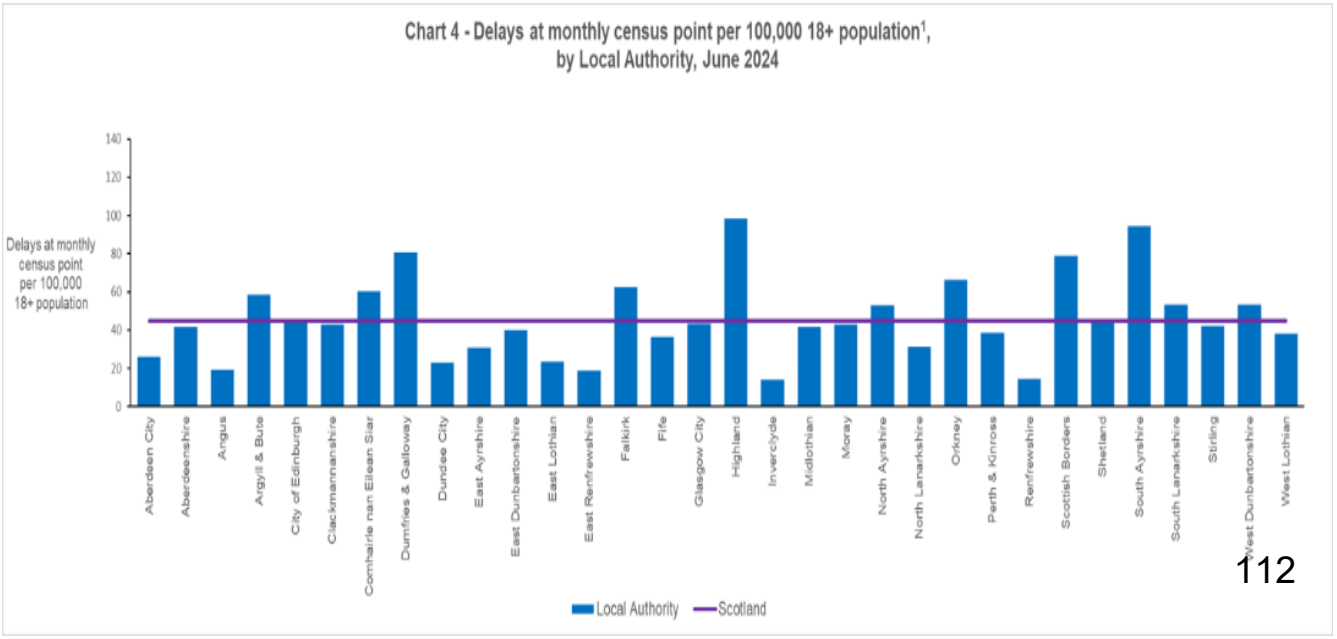
The Issue and Cause	Plan and Mitigation	Expected Impact
SDS Option 1 (Carer Well-being fund) We are continuing to use powers within the Carers Act to provide an Option 1 Well-being fund for unpaid carers. It seeks to make resources available to carers via a simple application process supported by a social worker or a carers link worker etc. The scheme is largely free from resource allocation decision-making processes and seeks to rely on professionals and carers coming together to identify the kind of help that would be right for them. Help is targeted to support unpaid carers to be willing and able to maintain their caring role.	• We have also been liaising with our unpaid carers reps to ensure the scheme reflects their priorities. Currently the scheme works to a finite budget of around £1m per annum (£0.25m made available in quarterly tranches). Their suggestion is that there are financial ceilings set for different types of purchases used for a short break, limits to contributions for holidays, summer houses and e-bikes etc. The fund reopened to new applicants in April 2024. • In addition to financial ceilings, those applying for the first time will receive priority status for funds, ensuring that as many carers as possible benefit from the scheme • A new Carers Services Development Officer is now in post and the officer is prioritising revisiting our arrangements with our range of unpaid carers services seeking to ensure we have a strong collaborative basis to build upon going forward.	• Improved access for SDS option 1 (wellbeing fund) in future aligned to what matters to people approach • Protection of adult carer funding for short breaks
SDS Option 1 (Direct Payments) We have seen sustained levels of growth for both younger and older adults in our urban, remote and rural areas with further growth expected to continue this financial year for SDS Direct These increases do however highlight the unavailability of other care options, and our increasing difficulties in our ability to commission a range of other care services, strongly suggest a market shift in Adult Social Care service provision. We are also aware of Option 1 recipients who struggle to retain and recruit personal assistants. This demonstrates the resource pressure affecting all aspects of care delivery. Work is underway locally to promote the opportunities that taking on Personal Assistant (PA) role can offer people.	• Option 1 recipients all received a substantial above inflationary increase due to the significant investment from NHSH to level up the previous low baseline hourly rate. • This uplift was required to ensure its sustainability and is still the most cost effective and efficient delivery models due to the absence of any other traditional delivery and more expensive care models. • 2024-25 rates for PA's has been updated and the allocated funding from SG passed on to service users.	• NHSH is committed to increasing the level of independent support across all service delivery options but due to the current financial constraints, officers are exploring any remaining funding available to procure independent sources of advice, information and support by reinvesting any unused funds to strengthen our independent support. • Work is progressing in this area and committee will be updated as plans progress.

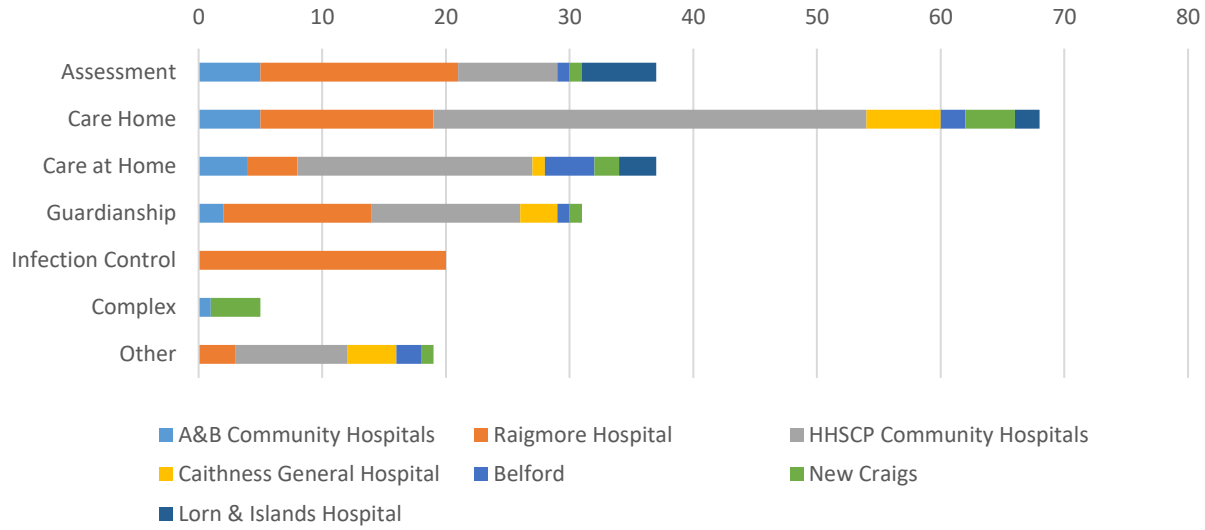
OBJECTIVE	**In Partnership**	**OUTCOME**	**Respond Well & Care Well**	**EXEC LEAD**	**Pam Cremin, Chief Officer, HHSCP**	**Service**	**HHSCP Community Hospital Delayed Discharges**

PERFORMANCE OVERVIEW	**TARGET**	**Reduction of 65%***	**NHS HIGHLAND**		**TREND**	↓	**BENCHMARK**	**n/a**	**POSITION**	**14 out of 14**









*Target reduction still to be confirmed which will be 30% or 65% then trajectories will be in next version

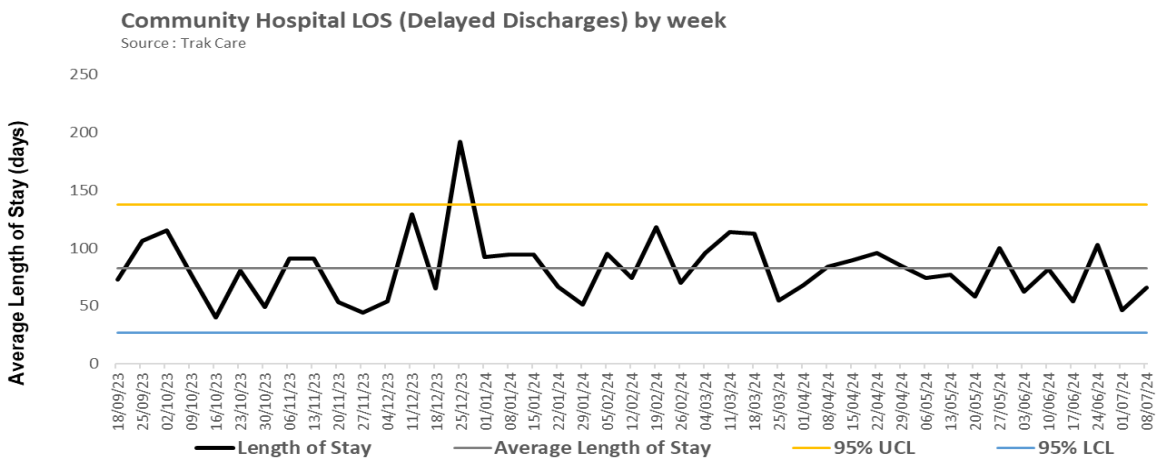
OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	HHSCP Community Hospital Delayed Discharges

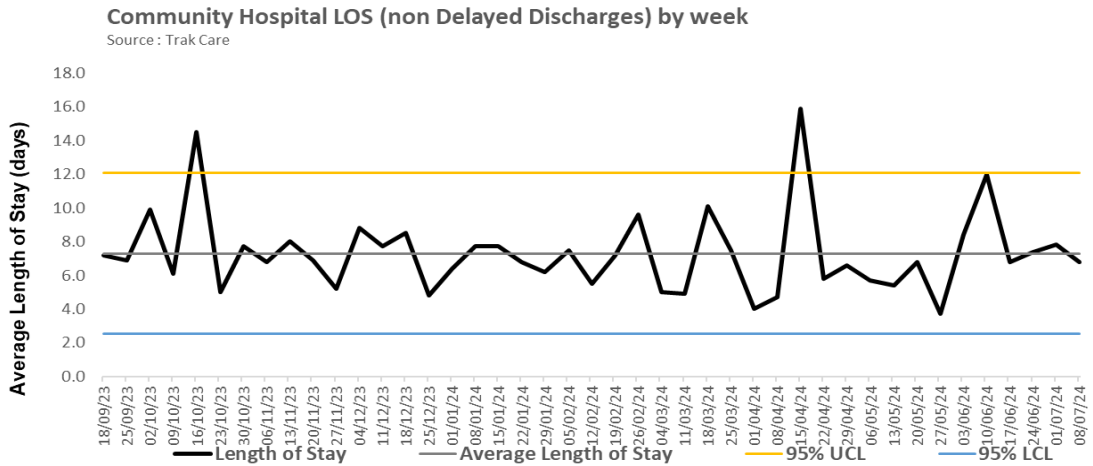
The Issue and Cause	Plan and Mitigation	Expected Impact
See previous slides on issue and cause with care at home and care homes which is the main cause for delayed discharges	We have an ambitious local target of reducing the number of people experiencing delay in discharge from hospital by 30% which has yet to be confirmed as SG currently are modelling on 65%. We aim to ensure we get our population cared for in the right place at the right time. The potential for increasing Care Home capacity is currently being explored. A weekly scrutiny group for delayed hospital discharges is being established to ensure that there is appropriate senior managerial and professional leadership to ensure we are responding to people in delay timeously and in line with best practice. A 90 day Improvement Plan has been agreed which will support the reduction of delayed discharges through a range of actions in the following areas and with the following outcomes referenced below.	• Targets and trajectories have been agreed and will be available in the next HHSCP IPQR

Area	What do we want to do?
Respond	Respond quickly to support our population across our system who are vulnerable or in crisis
Rapid	Facilitate rapid discharge and support to embed the “home is best” approach
Reduce	Reduce occupancy and avoidable admissions and identify at risk population by working collaboratively
Redirect	Redirect inappropriate attendance to suitable services so emergencies are seen quickly

OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSCP	Service	Community Hospitals

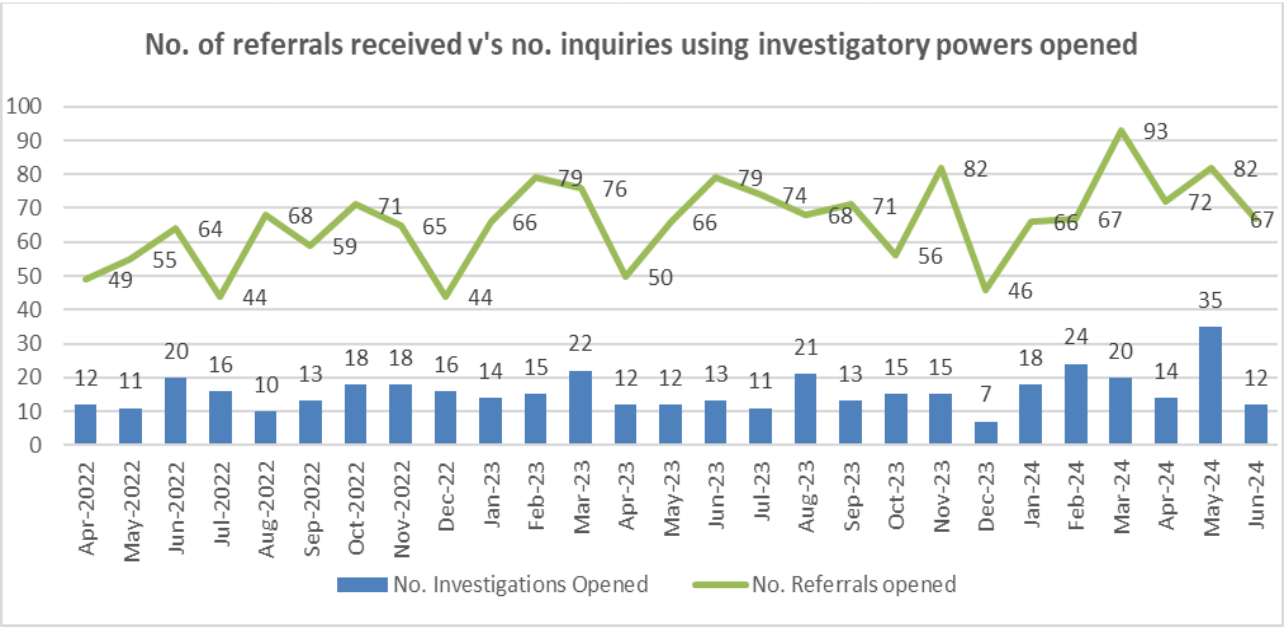
PERFORMANCE OVERVIEW	TARGET	No target agreed	NHS HIGHLAND		TREND		BENCHMARK	n/a	POSITION	

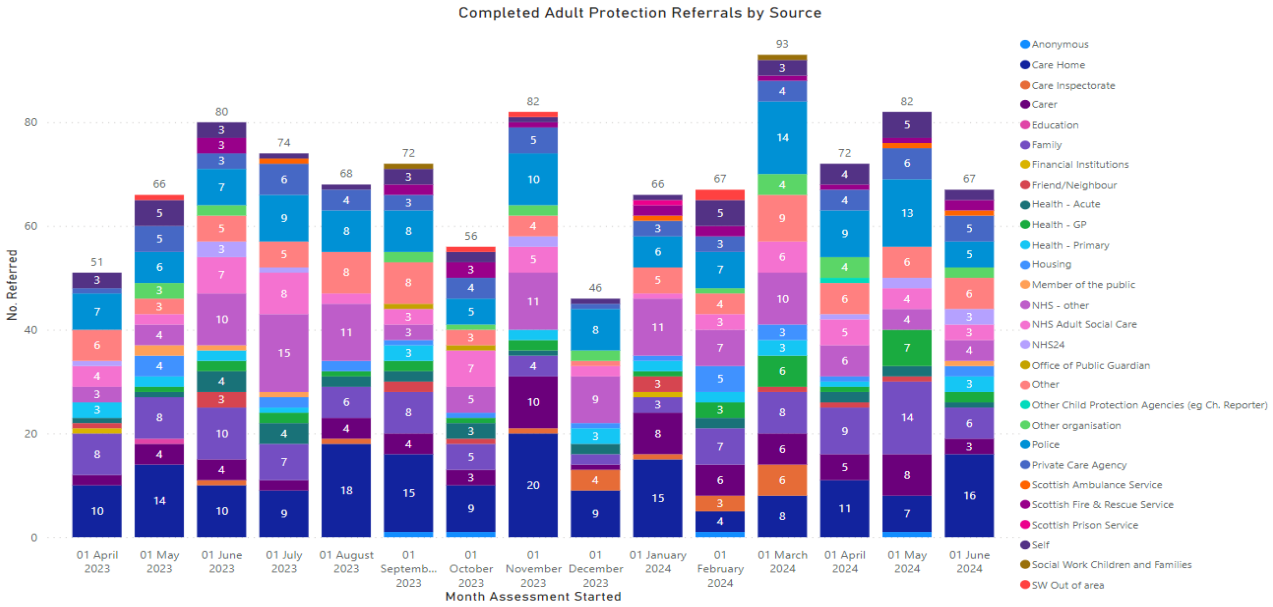




The Issue and Cause	Plan and Mitigation	Expected Impact
Community Hospital LOS this is compounded by the current capacity within care homes and C@H and the increase DHDs that we are experiencing some of the mitigation for these will also impact on the LOS of those not in delay.	Plans to mitigate are: daily huddles ensuring that there is input for AHPs, working with families and implementation of the choice guidance with a greater emphasis on home is best, ensuring that PDDs are updated and accurate. Long LOS are being experienced by those in delay, not those who are not in delay.	Reduced LOS for DHDs possibly slight reduction for the non DHDs

OBJECTIVE	In Partnership	OUTCOME	Care Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSPC	Service	HHSCP Adult Protection
PERFORMANCE OVERVIEW	TARGET	To be agreed	NHS HIGHLAND	n/a	TREND		BENCHMARK	n/a	POSITION	n/a

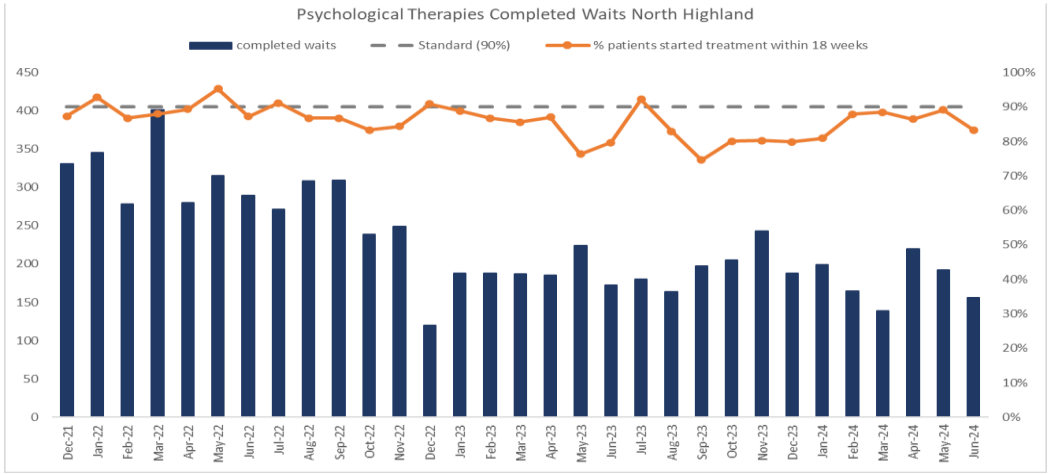


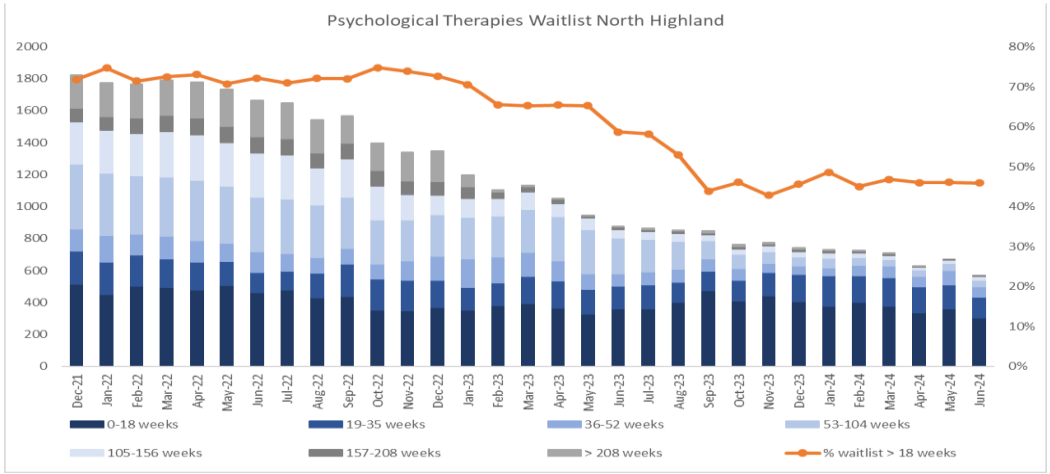


The Issue and Cause	Plan and Mitigation	Expected Impact
The definitions of Referrals, Inquiries (with or without the use of Investigatory powers), Case Conferences and Protection Plans have been consolidated and agreed across Scotland. Benchmarked data (across the 32 Local Authorities) is expected from Q2 or Q3 2024. The ability to greater analyse referrals in respect of type and location of harm is already being utilised to give a clear picture of harm in our communities. A peak of 93 referrals was recorded in March 2024. Ongoing and increasing demand on Adult Protection Services is shown in the adjacent chart.	• Highland's Adult Protection arrangements across Health, Social Work and Police were the subject of a recent Joint Inspection. • An update report on the inspection and associated improvement plan was considered at the last committee meeting.	• To implement the agreed action plan and improvement actions from the recent inspection as reported to committee.

OBJECTIVE	In Partnership	OUTCOME	Live Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSPC	Service	HHSCP Psychological Therapies Performance

PERFORMANCE OVERVIEW	TARGET	90% within 18wks	NHS HIGHLAND	83.3%	TREND		BENCHMARK		POSITION	2nd of mainland Boards

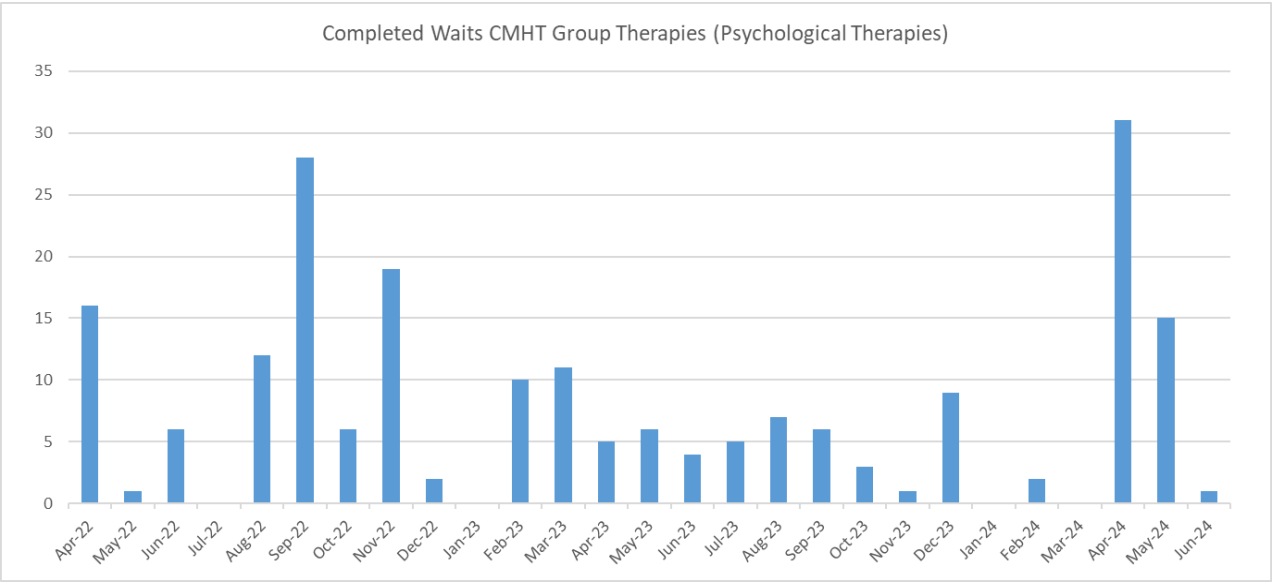


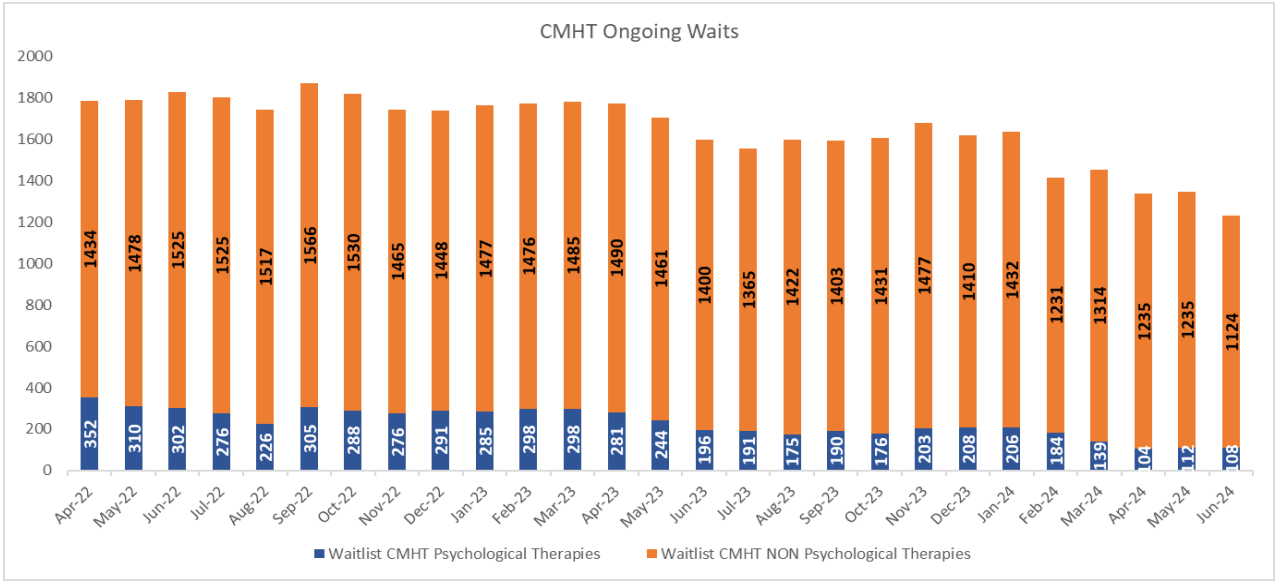


The Issue and Cause	Plan and Mitigation	Expected Impact
As at June 2024: • 564 of our population waiting to access PT services in North Highland. • 259 patients are waiting >18 weeks (45.9% breached), a significant reduction from 738 waiting >18 weeks in March 2023. Psychological therapies services have had longstanding challenges with significant waiting times. There are a number of factors that have led to this including a lack of any other route for psychological interventions at an earlier stage.	• The development of Primary Care Mental Health services will help to fill this gap in provision along with the targeted use of community resources and the development of CMHT colleagues to work with their Psychological Therapy colleagues. It has also been identified that there is a gap in the provision of Clinical Health Psychology. This is currently being addressed by the Board and Director of Psychology. • Recruitment and retention is difficult when national recruitment is taking place, however, there has been some success to date with the development of our Clinical Neuropsychology service which has proved effective in reducing a large number of our extended waits.	• There will always be a need for specialist services and the team are working to build a resilient model. The Director of Psychology is working closely with her team to reduce the current backlog and to build for the future. The data provided here is already showing improvement overall with clear trajectories agreed with SG as we progress with our implementation plan. • De-escalation is expected given improvement

OBJECTIVE	In Partnership	OUTCOME	Live Well	EXEC LEAD	Pam Cremin, Chief Officer, HHSPC	Service	HHSCP Community Mental Health Teams

PERFORMANCE OVERVIEW	TARGET	Not agreed	NHS HIGHLAND		TREND		BENCHMARK		POSITION	

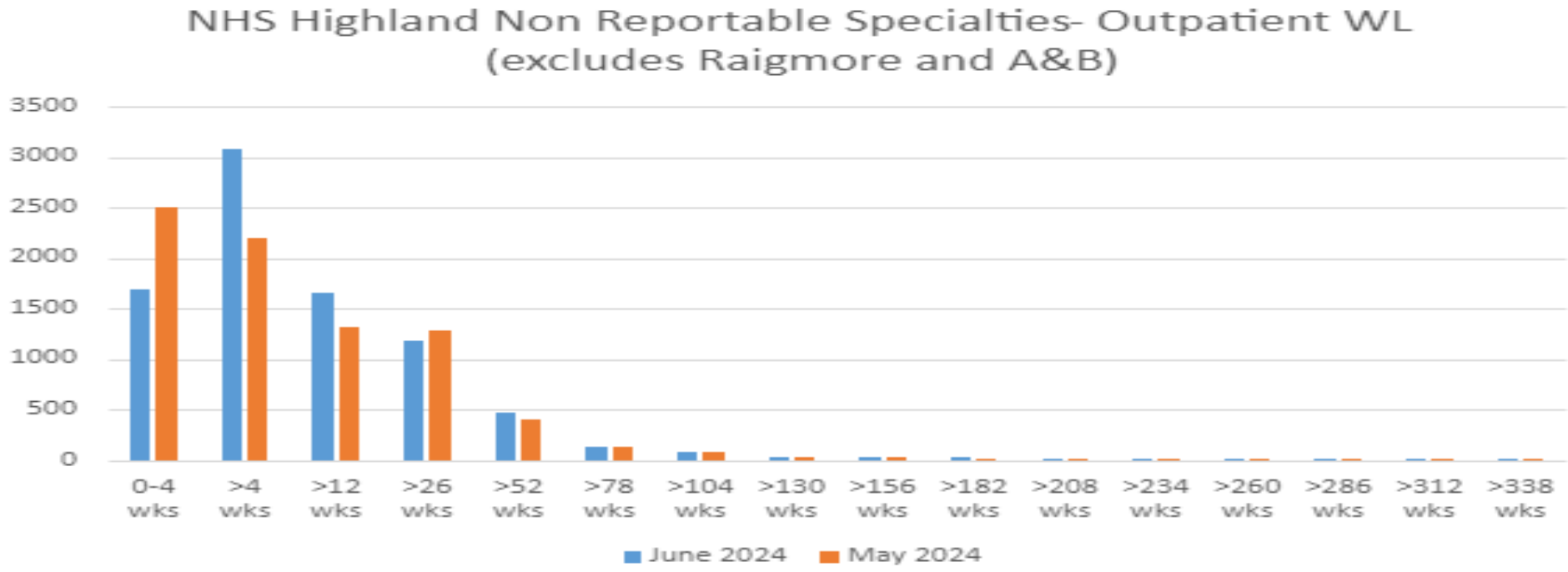




The Issue and Cause	Plan and Mitigation	Expected Impact
The ongoing waits for CMHTs are not currently reported unless they fit the criteria for psychological therapies such as group therapies (STEPPS/IPT/Mindfulness). The delivery of these group therapies was halted during COVID and the availability of an online method was slow to progress. This resulted in a significant backlog in this area, gradually reducing over the course of 2023/24.	• Validation work is ongoing around this waitlist as has happened within PT • There is a shortage in STEPPS trainers within the UK so we are therefore exploring a range of options for increasing NHS Highland STEPPS practitioner capacity.	• To be defined

OBJECTIVE	In Partnership	**OUTCOME**	Treat Well	**EXEC LEAD**	Pamela Cremin, HSCP Chief Officer	**Service**	Overview of Other HHSCP Waiting Lists – Up to 10th July 2024

PERFORMANCE OVERVIEW	**TARGET**	No target defined	**NHS HIGHLAND**	8443 on waiting list	**TREND**	↓	**BENCHMARK**	Not available	**POSITION**	Not applicable



MAIN SPECIALTY	0-4 wks	>4 wks	>12 wks	>26 wks	>52 wks	>78 wks	>104 wks	>130 wks	>156 wks	>182 wks	>208 wks	>234 wks	>260 wks	>286 wks	>312 wks	>338 wks	Total
Chiropody	516	607	223	17													1363
Dietetics	149	177	175	129	25	6	8	1	2	1		1		1	1		676
Obstetrics Antenatal	7	1		1													9
Occupational Therapy	17	31		1					1		1						51
Physiotherapy	625	783	647	441	172	5	3	2	5	2						1	2686
General Psychiatry	155	209	268	406	188	36	8	1	2								1273
Learning Disability	13	927	191	113	80	82	66	24	15	23	10	11	16	6	5		1582
Learning Disability Nursing	39	152															191
Psychiatry of Old Age	94	86	65	46	6	3											300
Psychotherapy				1	1		1										3
GP Acute	75	101	81	29	2		1										289
Investigations and Treatment Room	4	3		2	4	1	1							1			16
Social Work						1			1		2						4
Current Report	**1694**	**3077**	**1650**	**1186**	**478**	**134**	**88**	**28**	**26**	**26**	**13**	**12**	**16**	**8**	**6**	**1**	**8443**
Previous Report	**2505**	**2203**	**1321**	**1281**	**397**	**138**	**77**	**30**	**30**	**20**	**14**	**14**	**14**	**15**	**3**	**1**	**8063**

OBJECTIVE	In Partnership	OUTCOME	Treat Well	EXEC LEAD	Pamela Cremin, HSCP Chief Officer	Service	AHP Services in Community

PODIATRY - The Issue and Cause	Plan and Mitigation	Expected Impact
Vacancies main issue for longer waits, solutions for cover being exhausted. Vacancies, having biggest impact in Skye and Caithness/Sutherland.	• Working tightly to prioritisation framework within service spec to ensure highest risk patient seen first, rearranged clinics and geographic spread of staff for best cover as able within workforce policies	• Minimise effect on highest risk patients, however lower risk patients likely to experience impacted service,

DIETETICS - The Issue and Cause	Plan and Mitigation	Expected Impact
Community dietetics team working with 50% capacity due to vacancies and long term absence.	• All staffing working maximal hours to cover, no bank staff available Agency cover being sought. Recruitment challenges impacting on service delivery.	• Minimise risk to patients and impact on secondary care.

PHYSIO - The Issue and Cause	Plan and Mitigation	Expected Impact
vacancies/demand out strips capacity/challenges in leadership posts being vacant/increase in capacity in other areas impacting on physio outpatient capacity. Data quality work still on going.	• Physiotherapy: continued review of vacancies and use of Sup staffing to fill these, wider discussions about team lead roles (3/8 vacant) and how to best support - currently district managed services so movement of resource difficult. Standardisation work being undertaken within current models, however full MSK/Ortho pathway review required. SBAR on increase in NTC ortho surgery impact on physio outpatients to be developed - collect data on increased referrals and impact on capacity.	• Physiotherapy: support for teams in capacity/demand decisions and maximise use of all staffing available. Ensure equity across North highland physio outpatient clinics.

OT - The Issue and Cause	Plan and Mitigation	Expected Impact
Data being checked and verified		

OBJECTIVE	In Partnership	OUTCOME	Treat Well	EXEC LEAD	Pamela Cremin, HSCP Chief Officer	Service	Mental Health & GP Acute

GENERAL PSYCHIATRY - The Issue and Cause	Plan and Mitigation	Expected Impact
• Source data and recording does not reflect the current delivery of services therefore this heading consists of a number of different teams. Issue relates to waits for both psychological therapy group work, first OP appointment and CMHT waits.	• Work is ongoing to adjust TRAK to ensure accurate data recording and gathering.	• Accurate data gathering and reporting

LEARNING DISABILITIES - The Issue and Cause	Plan and Mitigation	Expected Impact
• The LD service have recently moved to the use of TRAK to record LD Health Checks and service activity. The waits are mostly in relation to LD Health Checks. The funding received will not enable all people to receive a HC and agreed prioritisation.	• LD Health Checks are underway and therefore the "waits" will reduce as individuals receive a HC.	• Reduction in waits

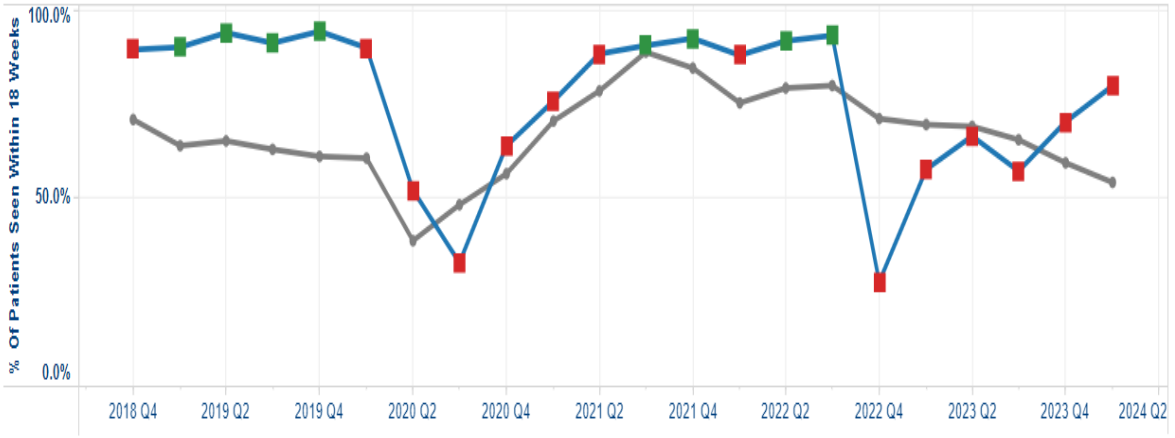
PSYCHIATRY OLD AGE - The Issue and Cause	Plan and Mitigation	Expected Impact
• Recruitment difficulties in relation to substantive medical Psychiatric staffing.	• Short term locum staff employed, substantive staff fulfilling additional sessions, exploration of ANP staff and alternative models	• Reduction in waits

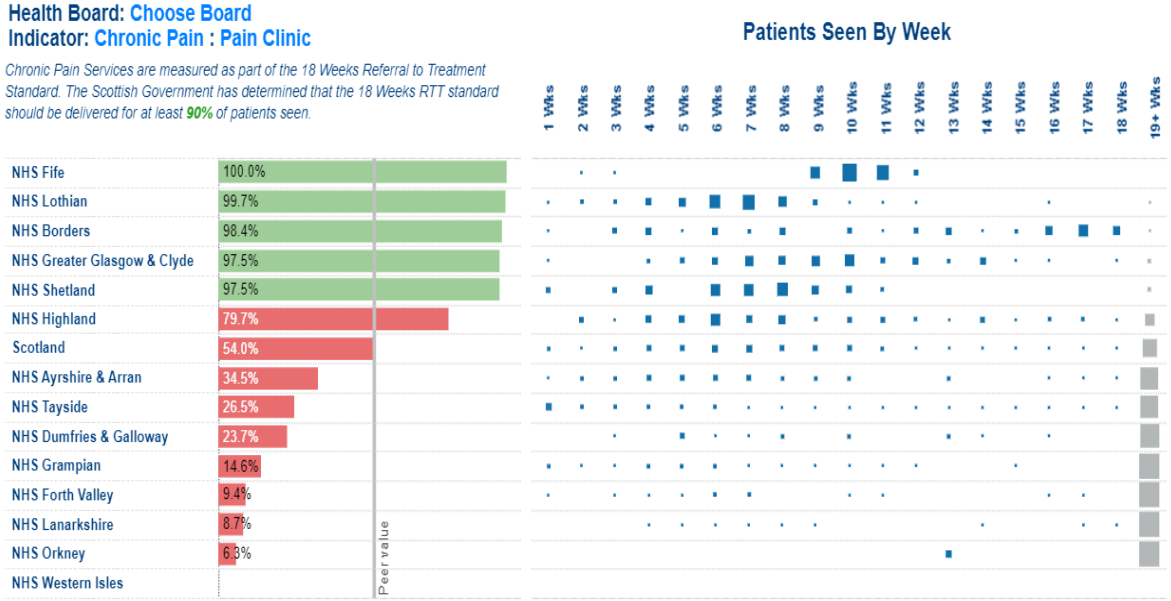
PSYCHOTHERAPY - The Issue and Cause	Plan and Mitigation	Expected Impact
• The data identifies that there are 3 people waiting for Psychotherapy interventions. As for General Psychiatry there is an issue in relation to the source data and the team the code refers to is unknown.	• Further deep dive into the source data to ensure re-alignment to services	Accurate data gathering and reporting

GP ACUTE - The Issue and Cause	Plan and Mitigation	Expected Impact

OBJECTIVE	In Partnership	OUTCOME	Treat Well	EXEC LEAD	Pamela Cremin, HSCP Chief Officer	Service	Chronic Pain

PERFORMANCE OVERVIEW	TARGET	90%	NHS HIGHLAND	72%	TREND		BENCHMARK	Not available	POSITION	n/a

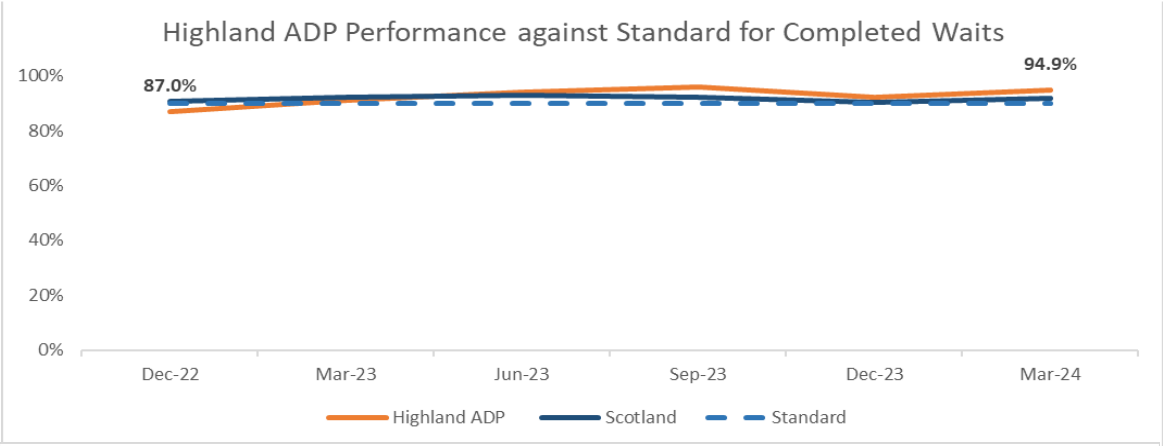


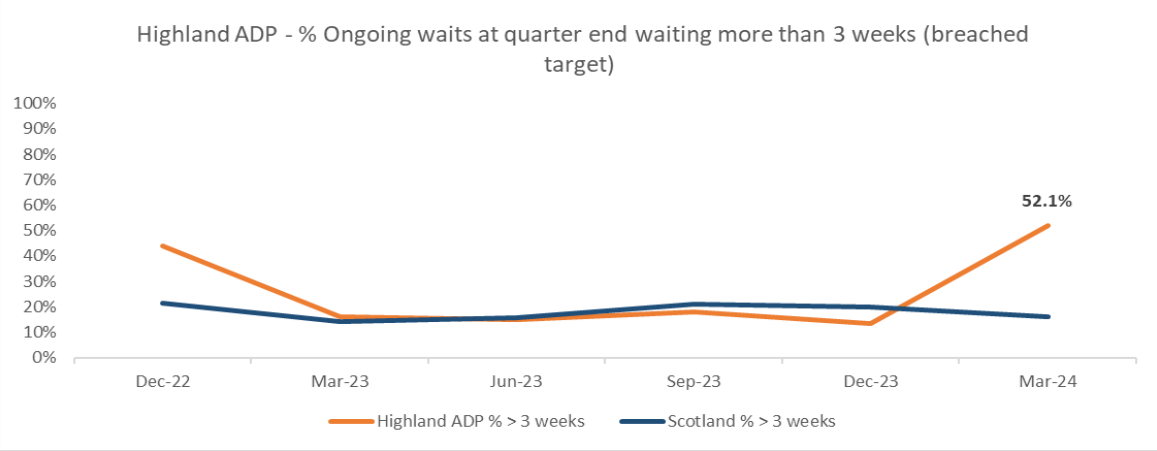


The Issue and Cause	Plan and Mitigation	Expected Impact
Patients are listed for an initial pain education session (same approach across Scotland), these are run fortnightly and most patients are then able to be seen within 18 weeks, however not all patients are suitable due to comorbidities or lack of technology as these are delivered remotely. Those that are not suitable are listed for a 1-2-1 appointment, the wait is significantly longer (figures correct as end of July 2024): Initial MDT assessment: 19/57 patients = 33% waiting longer than 18 weeks Initial nurse assessment: 7/14 patients = 50% waiting longer than 18 weeks initial physio assessment: > 300 patients waiting longer than 18 weeks - this is our main issue with capacity as we are 0.69 physiotherapist and no budget to recruit more.	•Increase in remote delivery by utilising NEARME and using booked spaces in hospitals and libraries as per NEARME expansion. •Currently piloting joint MDT assessment to reduce demand across service •September 2024: Meeting with physiotherapy leads and management to discuss alternative routes of funding to support rotational band 6 physio into service to increase capacity and allow for planned group work to commence. •September 2024: Meeting to discuss development within primary care of MDT, support and training from chronic pain service to improve earlier MDT access in primary care, reducing reliance on secondary care service which cannot meet demand.	•NEARME to reduce number of patients not attending education session due to lack of internet / IT at home. •Joint MDT aimed at increasing success of pathway throughout service and reduction in time taken to complete a full MDT assessment. •Physiotherapy rotational post, to increase physio capacity across the service, enable groups to run, upskilling of physio staff across Highland. •Primary care development: reduction on secondary care service, improved services in primary care, less reliance on GPs.

OBJECTIVE	Our Population	OUTCOME	Stay Well	EXEC LEAD	Dr Tim Allison, Director of Public Health	Service	HHSCP Drug & Alcohol Waiting Times Less than 3 Weeks from Referral to Treatment

PERFORMANCE OVERVIEW	TARGET	90%	NHS HIGHLAND	94.9%	TREND	⟷	BENCHMARK	Not available	POSITION	





HHSCP - Highland ADP only

No. of referrals to community based services completed in quarter end 31/03/2024	Highland ADP	
Alcohol	*172*	
Drug	*145*	
Co-dependency	*32*	
Total completed	349	
% of referrals to community based services completed within target in quarter end	**Highland ADP**	**Scotland**
% completed <= 3 weeks - Alcohol	91.2%	90.5%
% completed <= 3 weeks - Drug	98.4%	94.3%
% completed <= 3 weeks - Co-dependency	100.0%	91.2%
% completed <= 3 weeks - All	**94.9%**	**91.9%**
TARGET	**90%**	**90%**
> 3 weeks	5.1%	8.1%

Ongoing referrals to community based services at quarter end 31/03/2024	Highland ADP	
Alcohol	78	
Drug	22	
Co-dependency	21	
Total ongoing	121	
<= 3 weeks	58	
> 3 weeks	63	
% breached ongoing waits as at quarter end 31/03/2024	**Highland ADP**	**Scotland**
% ongoing > 3 weeks - Alcohol	53.8%	56.3%
% ongoing > 3 weeks - Drug	45.5%	58.3%
% ongoing > 3 weeks - Co-dependency	52.4%	58.1%
% ongoing > 3 weeks - All	52.1%	57.0%

The Issue and Cause

- Struggled to maintain previous performance due to increased demand coupled with reduced capacity.
- Recruitment delayed by limited access to finance support
- Financial instability has delayed tender for support to individuals misusing substances

Plan and Mitigation

- Exploration of shifting balance of NHSH DARS teams towards dependant substance use and tender to third sector for non-dependant use
- Finance support now available and time has been prioritised to confirming posts for recruitment

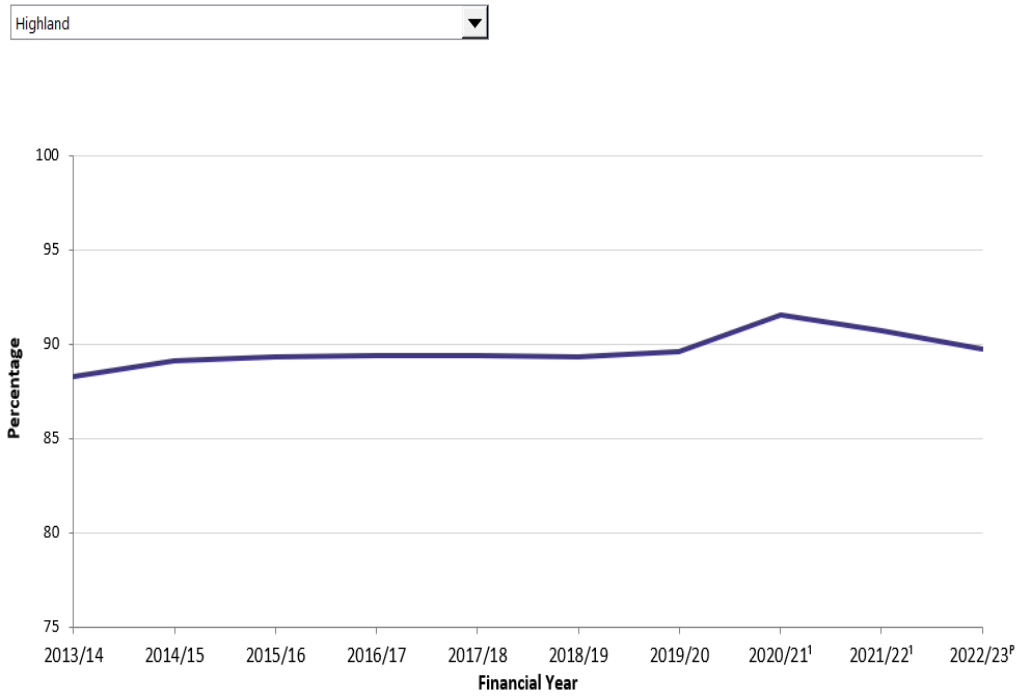
Expected Impact

- Waiting list targets met

OBJECTIVE	In Partnership	OUTCOME	End Well	EXEC LEAD	Pamela Cremin, HSCP Chief Officer	Service	Palliative and End of Life Care

PERFORMANCE OVERVIEW	TARGET	n/a	NHS HIGHLAND	89.8%	TREND	↓	BENCHMARK	89.1% (End 22/23)	POSITION	

Figure A1.1: Percentage of last six months of life spent at home or in a community setting by NHS Board of Residence; Highland



Health and Social Care Partnership	Number of Deaths	% time spent at home/in the community	Average number of days spent at home/in the community[4]
Aberdeen City	2,174	90.3	165
Aberdeenshire	2,539	90.7	165
Angus	1,479	92.2	168
Argyll and Bute	1,142	89.6	164
Clackmannanshire and Stirling	1,636	89.4	163
Dumfries and Galloway	2,074	88.4	161
Dundee City	1,722	90.0	164
East Ayrshire	1,555	89.1	163
East Dunbartonshire	1,238	88.1	161
East Lothian	1,199	88.1	161
East Renfrewshire	902	87.7	160
Edinburgh	4,714	88.2	161
Falkirk	1,887	88.1	161
Fife	4,453	91.2	166
Glasgow City	6,258	88.0	161
Highland	2,768	89.8	164
Inverclyde	1,109	87.8	160
Midlothian	992	87.3	159
Moray	1,166	90.5	165
North Ayrshire	1,873	88.1	161
North Lanarkshire	3,852	89.1	163
Orkney Islands	270	90.9	166
Perth and Kinross	1,846	88.9	162
Renfrewshire	2,127	88.8	162
Scottish Borders	1,469	87.7	160
Shetland Islands	248	93.5	171
South Ayrshire	1,639	88.0	161
South Lanarkshire	3,757	88.8	162
West Dunbartonshire	1,126	87.7	160
West Lothian	1,828	90.4	165
Western Isles	419	90.3	165
Scotland	**61,461**	**89.1**	**163**

The Issue and Cause	Plan and Mitigation	Expected Impact
Accounting for Value report complete, demonstrating where people die and associated financial information published Initial discussions taken place internally and externally to develop programme delivery structures	• Develop improvement plan • Develop delivery structure for improvement plan, including all internal governance structures • Review interface between service delivery and bereavement / spiritual support	• Increased proportion of people receive palliative care in a homely setting • People, carers and staff feel confident in supporting homely palliative services

Agenda Item 3.5

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**4 September 2024**
Title:	**Internal Audits:** **Adult Social Care Services – i) Multi-Disciplinary Planning For Discharge Across Community and Acute Services and ii) Care at Home Review & Systems and** **Younger Adults Complex Care Packages Governance Arrangements Actions Update**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer**
Report Author:	**Rhiannon Boydell, Head of Integration, Strategy and Transformation**

1 Purpose

Please select one item in each section ***and delete the others***.

This is presented to the Board for:

- Assurance

This report relates to a:

- Board Objectives: Internal Audit findings and requirements.

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

The Adult Social Care Services i) Multi-Disciplinary Planning For Discharge Across Community and Acute Services and ii) Care at Home Review & Systems and Younger Adults Complex Care Governance Arrangements audit reports were considered by the NHS Highland Audit Committee in May 2024. The contained recommendations and associated management actions due in October 2024. The improvement required and the actions to be undertake in response are attached.

2.2 Background

The Adult Social Care Audit Report states that the background to the audit is:

Adult social work and social care is about managing risk while meeting people's needs and outcomes. It supports people - as much as practicable - to live ordinary lives. To ensure NHS Highland (delegated services on behalf of the Highland Health and Social Care Partnership) can deliver such services it is fundamental that a consistent and integrated approach is taken across NHS Highland involving both the Community and Acute services. Further, it is fundamental NHS Highland has a sufficient understanding of what services are being delivered to individuals and that these remain the services required at a point in time. In accordance with the 2023/24 Internal Audit Plan, we reviewed two areas i) Multi-Disciplinary Planning for Discharge across Community and Acute Services and ii) Care at Home Packages."

The Younger Adults Complex Care Packages Governance Arrangements Audit Report states that the background to the audit is:

"There are currently 142 people within the NHS Highland area with care packages with a service provision cost of over £100k each, totalling approximately £21million in aggregate. As such it is important, that there are arrangements in place for developing, reviewing, and approving packages for younger adults which are over £100k in value. This review considered how these packages are reviewed and approved in the context of wider service delivery and the sustainability of the packages for the future."

2.3 Assessment

The conclusion of the Adult Social Care Audit Report states that:

"NHS Highland has implemented a new discharge planning model in response to best practice national guidance issued by the Scottish Government. This is led by the 'Home is Best' approach. This has involved fundamental changes to ways of working, including clients being 'pulled' out of hospital by Community Teams rather than 'pushed' out by Acute, and a number of new processes and tools being implemented. While this is intended to improve processes and reduce issues or delays in discharge planning, we have outlined a number of recommendations that would support more efficiency and effectiveness of this new model. The recommendations can be grouped into the following key themes:

- Leadership oversight and accountability
- Upfront project plans and design of new processes
- Resource allocation (personnel and funding)
- Communication and training plans
- Ongoing support to be fully embedded.

We also found issues with the governance of Care at Home package reviews. Implementing an effective process for monitoring and reporting on these reviews will ensure appropriate level of care is provided to service users and reduce unnecessary spend by the organisation."

The conclusion of the Younger Adult Complex Care Packages Governance Arrangements Audit Report states that:

"We confirmed there is a process in place for the development, review and approval of complex care packages within NHS Highland. For all care packages a personal outcome plan is developed for end users, detailing the social circumstances and when appropriate, medical history of the applicant, needs, personal outcome and required resources for the package to be delivered by NHS Highland. For packages over £100k in value these are reviewed by Pre-ACAAG (Adult Care Advisory and Allocation Group) before being presented to Highland Adult Care Advisory and Allocation Group (HACAAG) for approval. However, we have identified areas for improvement in the current processes in place. These include (i) the need to document the development and approval process for complex care packages, (ii) update the Terms of Reference for the Pre-ACAAG and HACAAG, (iii) developing a reporting framework for complex care packages in which the number and costs of packages are reported regularly within the NHS Highland governance structure, and (iv) ensuing reviews from Pre-ACAAG are clearly documented and provided to HACAAG."

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

The report is providing assurance that actions are being progressed. Actions are not yet complete but are on track.

3 Impact Analysis

3.1 Quality/ Patient Care

As described in the improvement required and action to be undertaken.

3.2 Workforce

It is expected that clear governance structures and operational processes will support staff in decision making.

3.3 Financial

It is expected that financial governance and decision making in the allocation of resources will be improved. As described in the reports.

3.4 Risk Assessment/Management

The audit report recommendations and management actions identify risk and aim to mitigate those risk.

3.5 Data Protection

No personally identifiable data is used in the Audit Reports

3.6 Equality and Diversity, including health inequalities

It is expected that improving governance arrangements and operational processes will ensure equitable allocation of resources.

3.7 Other impacts

3.8 Communication, involvement, engagement and consultation

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

The Audit Reports have been considered by the NHS Highland Audit Committee.

The Audit Report Adult Social Care Services **–** i) Multi-Disciplinary Planning For Discharge Across Community and Acute Services and ii) Care at Home Review & Systems has been shared with the HHSCP SLT and the integrated SLT (acute and community systems leaders); and management

actions are being taken forward by relevant key individuals in the SLTs and their teams.

The audit reports identify the key contacts involved in the audit process.

3.9 Route to the Meeting

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

- The reports have been shared with the HHSCP SLT and will be reported to Audit Committee in September 2024

4 Recommendation

- **Assurance**
- The committee is asked to accept moderate assurance that management actions are being progressed appropriately.

4.1 List of appendices

The following appendices are included with this report:

- Internal Audit Status Update August 2024

Internal Audit Report 2023/2024

Younger Adults Complex Care Packages – Governance Arrangements.

Status update for HSCC & Audit Committee.

21/08/2024

Control Objective 1:

There are clear policies and procedures in place for the development and approval of complex care packages which are being adhered to in practice.

Management Action:

1.Policies and procedures relating to the allocation of funding to be reviewed and ensure reflect SDS standards, including current recommendations around eligibility and consider the reality of resource availability.

2. Update ToR for HACAAG and to include process to monitor and check review and resource allocation.

3. Ensure clear roles and responsibilities for HACAAG members. Support this with a checklist to ensure consistent decision making and the support of all stakeholders.

Due date: Implement urgently with review October 2024

August status update:

- Adult Social Care now has a specific area on the NHS intranet, this will support with a consistent application to guidance and regulation as is located in a central location. Next Steps – to ensure all guidance in relation to funding and resourcing ASC packages is current and uploaded.
- Director of Finance has gathered ToR for all decision making fora in this area to promote consistency and compliance with governance requirements.
- Draft ToR completed. Final review and implementation pending. Roles and Responsibilities are documented in ToR.

Control Objective 2:

Package development includes an analysis of need and availability of resource and there is appropriate oversight of all packages to ensure they are considered in the context of the entire service model, priority and sustainability of service provision.

Management Action:

1.Management will ensure that requests for service based on individual outcomes are considered in relation to resource availability – or non availability in its entirety.

Decisions are requested based on individual circumstances but resource allocation for packages over 100k cannot continue to be made without a clear mechanism to document the availability and impact on other parts of the service if approved. Documentation to support HACAAG will assist with this to provide assurance that individuals have been empowered to consider choice and control. There also needs to be a clear statement of available resource.

2. Use of the Dynamic Support Register as a tool at HACAAG to monitor resource allocation, pending requests and unmet need.

3. HACAAG reporting to go via SLT on a monthly basis.

4.HACAAG to report into SLT as acting on behalf of the Health and Social Care Partnership. Therefore a process of escalation and decision to be considered for packages above a certain threshold if they are considered an exception. Guidance and SOP to be developed for this and to consider the interface with Fees Group.

5. A process of auditing to be established and embedded through the whole system

August 2024 Status Update

- Dynamic Support register is established, accurate and monitored.
- Monthly Reporting to SLT commenced, however further work planning required to establish better understanding of trajectories, and associated variance.
- Role and Remit of Fees group is being reviewed in conjunction with this work to ensure streamline processes. This links to the Governance review referenced above.

Control Objective 3:

There is ongoing monitoring and reporting on the packages in place to management and the governance structure with any issues being escalated in a timely manner.

Management Action:

1.In line with guidance and SOP actions to support HACAAG a document will be created to record and monitor resource allocation.

2. An exercise will be undertaken to establish compliance with SDS reviews in line with legislative principles and report via HACAAG.

3.HACAAG , acting on behalf of the Health and Social Care Partnership, to report into SLT. Therefore a process of escalation and decision to be considered for packages above a certain threshold if they are considered an exception. Guidance and SOP to be developed for this and to consider the interface with Fees Group.

4. A process of auditing to be established and embedded through the whole system.

August Status update:

- Districts have clear mechanisms to monitor financial spend and resource allocation as well as waits for resource allocation.
- Current systems do not enable automatic reporting of SDS reviews and remains a manual exercise until such time CareFirst is replaced.
- Further work required to establish relationship between Option 1&2 investment and associated Option 3 disinvestment

Summary and Conclusions

Improvement work in relation to the allocation of social care resource, across all service user groups (not exclusively younger adult complex care packages) is accepted as an area of priority.

This work is now being taken forward on behalf of the HSCP by the Interim Deputy Director of Adult Social Care and the Head of Mental Health, Learning Disabilities and Drug &Alcohol Recovery Services.

A programme approach has been adopted and this work is being amalgamated with other projects aimed at cost containment. It is recognised that the improvements and management actions published in the audit report are the foundations of ensuring service improvement and best allocation of resources. In addition it will act as a platform to accurately inform service gaps and commissioning requirements currently and in the future. This programme will formally commence on 30/08/24.

Internal Audit Report 2023/ 2024

Adult Social Care Services

1. **Multi Disciplinary Planning for Discharge across Community and Acute Services.**
2. **Care at Home Review and Systems.**

Control Objective 1:

There are clear processes in place within districts to ensure the MDTs are working alongside staff within Acute to ensure discharge planning is taking place in a joined-up way.

Management Action:

1.Create an escalation policy to enable a single route for decision making when required. This route to be accessible in a timely manner and to be led by an appropriately skilled professional who understands needs, risks, outcomes and resource availability in the community.

2. CM2000 Project to be supported to completion in September 2024 to create the foundations for the consistent use of the system which includes establishing procedures for governance and reporting as well as the accuracy and consistency of reviews. Oversight of action via Care Programme Board.

3. Review of the model that incorporates the DMT process that is supported by the Chief Officers, Professional and Clinical Leads. Review to include the governance route for reporting

4. Chief Officers (Acute and Community) supported by clinical and professional leads to ensure standardised processes for all discharge destinations. To ensure overarching guidance is in place to support the required SOP's and to have clear single place for access. To link with the Care at Home implementation plan and have governance via the Care Programme Board.

5. Management to develop, roll out and review training and practice development plan for all relevant staff including managers and clinical leaders.

6. Ensure existing national plans guiding the DWD group and associated local reports are presented and a level of assurance provided to appropriate governance committees, namely Care Programme Board.

August 2024 Status Update

- Decision Making Team structure reviewed and confirmed largely functional. Alternate “campus” approach being designed to better manage pressures of Inverness area.
- Areas of improvement in relation to communication identified and improvements being progressed.
- Escalation process for DHD definition and complex planning being progressed
- Resource availability data being reviewed with decision making hub being explored.
- CM2000 project largely due for completion, ongoing maintenance of system use required. Project Manager continuing in post for 6 months to ensure seamless transition.
- Discharge planning model reviewed (August 2024) with improvement areas identified.
- Revised SOP under construction for multi disciplinary roll out.
- Specific analysis of implementation of Discharge App being undertaken
- Full DHD data quality review undertaken.
- First stage of development complete through full review of data quality which has indicated improvement areas and areas of confusion.
- As per above, data based assurance now being established based on accurate DHD list.
- Training needs identified and plan in response under construction
- Leadership and reporting arrangements for Unscheduled Care and Delays in Discharge amended. Leadership now resting with Medical Directors and Chief Officers (Community and Acute) **See Appendix 1**

Control Objective 2:

There is an effective interface between Community MDTs and discharge support teams / discharge planning teams in Acute.

Management Action

(*There is a constant cycle of education in relation to the statutory role of social work and its interface with ASC meaning that a social worker is not always the best placed professional to take forward community discharge planning)*

1.To have assurance that the Care Portal is in place and can store key information from all relevant systems including CareFirst, Morse, Sci and Trak care.

2.The detailed Guidance relating to Discharge Without Delay is reinforced and implemented with appropriate clinical and management engagement, monitoring and review.

3. Practical application of “Choice” Guidance is reviewed

August 2024 Status Update

- Particular attention and analysis given to the SW Assessment definitions within DWD. This has informed reductions in totals and more accurate recording.

- Visible clinical and managerial leadership identified as above. **See Appendix 1.**
- Accurate coding is allowing a focused pursuit of compliance with “Choice” Guidance.

Control Objective 3:

There are clear escalation processes in place where differences of opinion arise over where patients should continue to receive treatment.

Management Action

Create an escalation policy to enable a single route for decision making when required, This route to be accessible in a timely manner and to be led by an appropriately skilled professional who understands needs, risks, outcomes and resource availability in the community.

August 2024 Status Update

- ASW&SC Directorate scoping the professional resource required to support this work.
- Chief Officer for Acute has instructed a delegated group to scrutinise DD and resource availability. ToR are being established
- Revised Leadership and Coordination arrangements in place (**See Appendix 1**)

Control Objective 4:

There are clear policies and procedures regarding the monitoring and review of Care at Home packages

Management Action

We acknowledge that there is a legacy of inconsistency from previous management structures. We will provide clarity on the responsibility and direction of the Care at Home Service. This will enable single route for consistent reporting. Variation should be accepted if the whole service is working to the same principles and ethos.

August 2024 Status Update

- Head of Service – Registered Services commenced in post in May 2024 and has been reviewing and creating standard work with professional leadership and operational teams. This includes the monitoring and review of individual care at home services
- Current community redesign to include a clear position of the management and leadership of Care at Home (in house)
- Recognising that there has been a lack of consistent coordination of Care @ Home interventions, the Joint Officer Group has vested oversight in the Head of Commissioning. Establishing this discipline is being taken forward.

Control Objective 5:

Care at Home packages are being reviewed in line with requirements and services adjusted as and when necessary

Management Response

Provide clarity and leadership on consistent principles based on the ASC Practice Model to support dynamic reviews. This will link with the established SDS strategy as per the ambition of national guidance.

August 2024 Status Update

- Purpose, frequency and quality of reviews are being audited via professional leadership.
- There is good work in areas where there is risk or actual provider service collapse in that communication goes to all service users and there is constant consideration in relation to rebalancing distribution of available care resource.

Control Objective 6:

There is regular reporting on the reviews taking place to management and the governance structure with data outputs and trend analysis

Management Response

1.CM2000 Project to be supported to completion in September 2024 to create the foundations for the consistent use of the system which includes establishing procedures for governance and reporting as well as the accuracy and consistency of reviews.

2.Building from the completion of the CM2000 project (end September 2024) have agreed centralised support for CM2000. Link with ehealth and strategy and transformation to describe the product that is needed and resource to cover summary level information, granular information, system support and training. A specification of scale is being developed and will be reported to SLT. Power BI will assist with this and improve effectiveness and oversight.

3. ASC planning and performance capacity has been redirected to other NHS priorities. The report requirements and resourcing will be reviewed within the context of a more general review of SW/ASC reporting requirements and resourcing. This action will be linked closely with the C@H sector in terms of broader reporting, link to the C@H implementation plan and report finally to the Care Programme Board.

August 2024 Status Update

- There has been some slippage in the CM2000 project due to issues with the provider that have had to take priority for resolution. This has been to ensure that technology is working to enable carers to know where to deliver service. However the project is largely due for completion and the system will accurately show where there is activity in relation to reviews.
- The system reporting will then support the existing audit process and target any areas of improvement.

Summary and Conclusions

Meeting the needs of people in our communities is becoming more complex as individuals are living with more co morbidities, frailty and risk than in previous years. NHS Highland must have a clear and consistent understanding of the complexity involved in delivering care at home compared to even 5-10 years ago.

The recent focus area of work in relation to Delayed Hospital Discharge data has enabled targeted monitoring of the role and function of the Decision Making Teams. In the main, it is clear that those working in Districts knew individuals very well, to enable sound assessment and decision making. This is more challenging in Inverness and does impact on communication therefore a campus style model is being considered.

The idea of building the discharge app while trialling is sound in principle, however, given the system pressures, there has been unforeseen complication and duplication onto systems. Consideration is being given to pause this initiative and ensure that the required foundation work is robust .

There is a programme of improvement work underway in relation to in-house care at home services and this does include the review process. The service has been historically fragmented has been differentially managed within Districts. A revised approach is being taken forward to ensure the continuation of integration but also to enable cohesive and consistent service delivery through a professionally directed approach.

Agenda Item 3.6

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**5th September 2024**
Title:	**Highland Health and Social Care Partnership Annual Performance Report 2023/24**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer**
Report Author:	**Rhiannon Boydell, Head of Integration, Strategy and Transformation, HHSCP**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

The Health, and Social Care Annual Performance Report (APR) for the year 2023 follows the requirement by the Public Bodies (Joint Working) Scotland Act, 2014. Submission on the Annual Performance Report as per deadlines of 30th September 2023 respectively.

The Health and Social Care Partnership (HSCP) is responsible in ensuring that our local communities are clear on how health and social care integration is performing. The HSCP has built upon previous years and demonstrates how services have improved and adapted to complement highland communities Primary, across Community, Mental Health, Acute Care, Children and Adult Social Care.

The Annual Performance Report (APR) assures the progress in meeting the priorities and actions and is required to be updated and submitted annually to the Scottish Government.

2.2 Background

The Highland Health and Social Care Partnership delivers health and social care services through a lead agency Partnership Agreement. This consists of The Highland Council act as lead agency for delegated functions relating to children and families and NHS Highland who undertake delegated functions related to adults.

The strategic framework for planning and delivery of health and social care services consists of 9 Health and Well Being Outcomes and a core suite of integration indicators.

At the time of writing, the key performance indicators for the Annual Performance Report, the National Integration indicators and Ministerial Strategic Indicators, for this period are yet to be published by Public Health Scotland and when available will be published as appendices to the report.

2.3 Assessment

The Annual Report provides an overview of performance at both Health and Social Care Partnership (HSCP) and Scotland level including:

- Assessment of performance in relation to the 9 National Health and Wellbeing Outcomes
- Assessment of performance in relation to integration delivery principles
- Comparison between the reporting year and pervious reporting years, up to a maximum of 5 years. (This does not apply in the first reporting year)
- Financial performance and Best Value

It also includes examples of key achievements during the year.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial	x	Moderate	
Limited		None	

Comment on the level of assurance

3 Impact Analysis

3.1 Quality/ Patient Care

Included in the Annual Performance Report

3.2 Workforce

Included within the Annual Performance Report

3.3 Financial

Included within the Annual performance Report

3.4 Risk Assessment/Management

The work described within the report is risk assessed and managed.

3.5 Data Protection

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

3.6 Equality and Diversity, including health inequalities

Work described with the report includes impact assessment.

3.7 Other impacts

3.8 Communication, involvement, engagement and consultation

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

This has been compiled through with intention leads and senior responsible officers.

3.9 Route to the Meeting

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

- Highland HSCP Senior Leadership Team
- Highland HSCP Joint Officer Group.

4 Recommendation

- **The report is presented as draft ahead of approval being sought from the Joint Monitoring Committee and publication at the end of September for awareness and discussion.**

4.1 List of appendices

The following appendices are included with this report:

Appendix 1

Highland HSCP Annual Performance Report.

The Highland Council
Comhairle na Gàidhealtachd

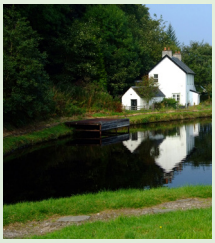
NHS Highland
na Gàidhealtachd

Annual Performance Report

2023 - 2024

Table of Contents



Foreword

Welcome to the Annual Performance Report (APR) by Highland Health and Social Care Partnership on the performance of integrated health and social care provision. The report highlights key successes for our health and social care services, as well as areas of challenge.

2024 sees the launch of the 3 year joint Strategic Plan and this report will inform the implementation of the plan, enabling us to build on our achievements and tackle our challenges. We have committed to implementing the joint Strategic Plan through engagement and collaboration with our Highland communities, and work has begun in District Planning Groups across Highland with community members, carers, care providers, partners and staff, working together to improve the health and wellbeing of the Highland population.

We look forward to continuing to work in collaboration with our stakeholders and partners to shape the future of health and social care in Highland. The delivery of health and social care services continues to be challenging and we would like to thank all those involved for their contributions and ongoing commitment. We would also like to take this opportunity to recognise the dedication, professionalism and resilience of all colleagues working in health and social care, partner agencies, unpaid carers and community volunteers in shaping and delivering person-centred health and social care to the population of Highland.

Introduction

The Health and Social Care Partnership aims to improve the health and wellbeing of the population of Highland, working in collaboration with communities and stakeholders. We aim to provide excellent services in Primary, Community, Mental Health and Learning Disability, Acute, Children's and Adult Social Care.

This Annual Performance Review (APR) outlines the key achievements and challenges NHS Highland faces in delivering health and social care services. It features many examples of positive performance for sharing, maintaining and developing further, and also highlights the areas of complexity and challenge which we will be working with our communities and stakeholders with into the future.

Strategic Context and Overview

Highland Health and Social Care Partnership delivers health and social care services through a lead agency Partnership Agreement. The Highland Council acts as the lead agency for delegated functions relating to children and families, while NHS Highland undertakes delegated functions related to adults.

Both partners report through joint arrangements, with the partnership's governance overseen and managed by the Joint Monitoring Committee. This ensures transparency, accountability, and effective management of the partnership's operations.

The Partnership covers the Highland Council area and is divided into nine districts centred on local Community Planning Partnerships.

The Partnership has fostered a collaborative environment, producing a joint strategic plan for adults. Developed through a multistakeholder Strategic Planning Group, and following a public engagement process, this three-year plan covers the period 2024 – 2027. Ongoing engagement in implementation of the plan is occurring in similarly multi stakeholder District Planning Groups.

The Integrated Children's Services Planning Board (ICSPB) is developing the next iteration of the integrated children's service plan on behalf of Highland Community Planning Partnership.

The ICSPB has undertaken a joint strategic needs assessment to develop this plan. The data gathered from this activity will support an evaluation of the current plan's performance management framework. The strategic needs assessment takes a life course approach, which will be reflected in the structure of the 2023 – 2026 plan.

Performance Management and Governance

The strategic framework for the planning and delivery of health and social care services consists of 9 Health and Well-Being Outcomes and a core suite of integration indicators.

The NHS Highland strategy, Together We Care (TWC), is a board-wide strategy that clearly communicates the strategic vision, mission, and objectives we need to achieve over a five year period. Progress towards achieving its aim is set out and monitored in our Annual Delivery Plans. These plans are fully cognisant of the role and responsibilities of the lead agency Integration Authority (IA)in Highland and the Integration Joint Board (IJB) in Argyll & Bute.

In terms of delivery of adult services by NHS Highland, the IPQR has been redesigned. This report gives the board a bi-monthly overview of performance and quality across NHS Highland. It is compiled from data considered at our governance committees and comments, risks and mitigations from our executive leads. A subsection of the IPQR has been agreed by the Highland Health and Social Care Committee, which receives the report and assurance on performance against it at each meeting. The IPQR also informs the Adult Services Update report for the Partnership Joint Monitoring Committee.

The integrated children's services partnership recognises that children's services planning is an ongoing process. Central to good planning is ensuring a robust connection between national and local strategic planning. Our performance management framework connects partnership strategic planning within a single framework. This framework provides tools for planning, self-evaluation, reporting, performance management, and assurance.

The Integrated Children's Service Planning Board monitors progress towards achieving the outcomes outlined within the Integrated Children's Services Plan. It utilises a fully developed Performance Framework to achieve this.

Within our planning processes, lead officers from partner organisations have been identified for each themed group, along with a lead officer for each improvement priority. Partners work together and take responsibility for coordinating performance reporting regularly. In addition, our performance is measured by listening to the voices of children, young people, and their families, learning from self-evaluation, analysing intelligence, and scrutinising an agreed set of qualitative and quantitative improvement measures.

Performance Overview

Key Performance Overview

The key performance overview demonstrates the financial year (April 2023 – March 2024). This ensures data continuity linking previous and new reporting using full-year data. The Latest performance against the National Integration indicators and ministerial indicators is detailed in the appendix.

Benchmarking

The benchmark for the National Integration Indicators, comparing it with the Scottish average, has been incorporated into the appendix. This allows a performance comparison as there are no national standards or targets in place. The table below explains the percentage comparison.

- Better than average
- Average +/- 5%
- Worse than average

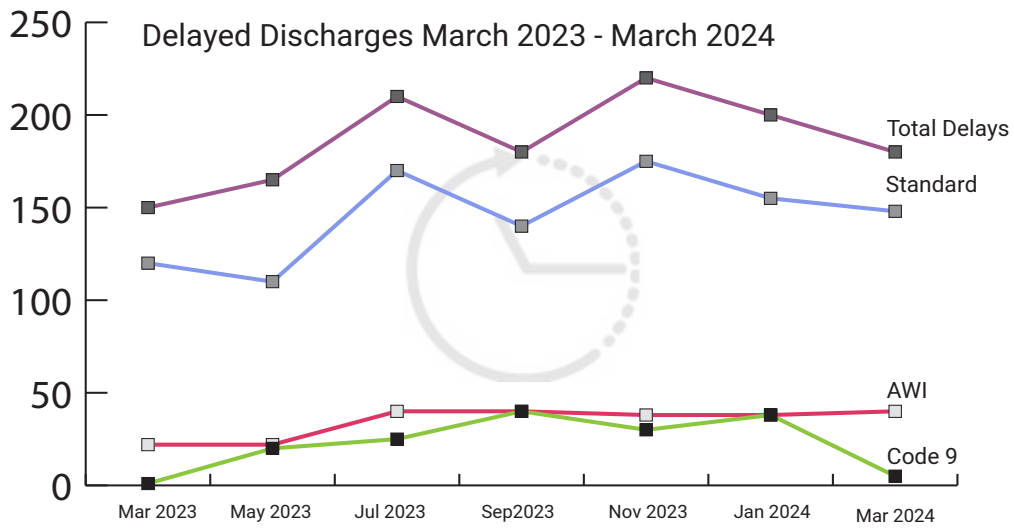
Integrated Performance and Quality Report (IPQR)

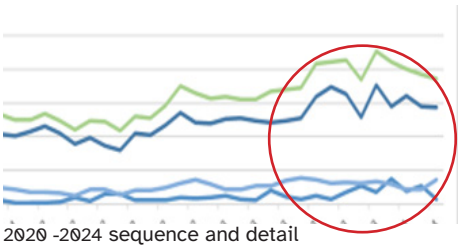
The Highland Health and Social Care Partnership IPQR is a set of performance indicators used to monitor progress and evidence the effectiveness of North Highland's services aligned with the Annual Delivery Plan. Data from the report is included in this Annual Performance Report in addition to the required performance against the National and Ministerial Integration Indicators.

Whole System Flow

Delayed Discharges

Figure 1 demonstrates the total number of people whose discharge from hospital has been delayed once they no longer require the level of treatment provided in a hospital (delayed discharge) across Highland over the year.



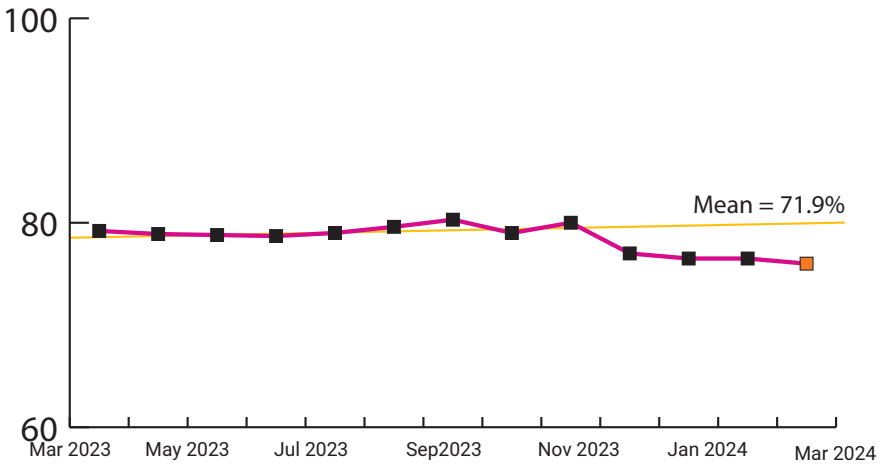

2020 -2024 sequence and detail

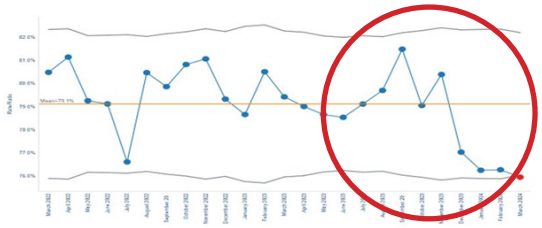
The graph identifies the number of standard delays as opposed to those related to complex situations (Code 9 and AWI) and it is the pathways for these people that are the focus of the work to improve system flow.

Ensuring people's journeys through the health and social care system are without delay at any point remains a challenge for the Health and Social Care Partnership. System flow is a complex area with many factors with the potential to cause delay, it requires collaboration from all parts of the health and social care system and the Partnership have been working closely with colleagues in the acute sector and in partner organisations to reduce delays and ensure people receive treatment and care in the right place at the right time.

Work has focussed on reducing the demand on Accident and Emergency, providing alternatives to admission to an acute hospital, improving systems and processes within hospitals, improving pathways to community services and building capacity in community services through redesign and commissioning approaches.

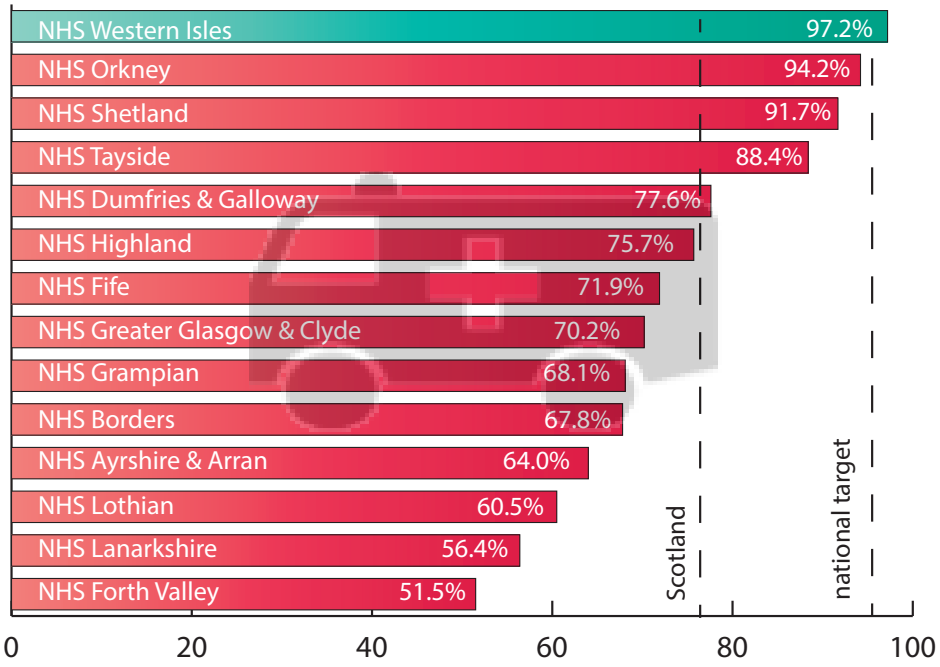
The following charts demonstrate NHS Highland's performance in achieving nationally set 4-hour Emergency Access Standard (that new and unplanned return attendance at A and E should be seen and then admitted, transferred or discharged within 4 hours) and the NHS Highland position benchmarked with other Boards nationally.





2020 -2024 sequence and detail

4 Hr. A&E performance by Health Board March 2024



Integrated Children's Services

Since the Integrated Children's service plan was launched in August 2023, the Integrated Children's Service Board and delivery groups have made significant headway in progressing the priorities and change ideas detailed within the Highland Children's Service plan 2023-26. here

The priorities articulated within the plan were underpinned by the findings or the Joint Strategic Needs Assessment undertaken during 2023. here

Our Commitment

Keeping the promise

We will ensure that all Highland's children and young people are safe, healthy, achieving, nurtured, loved respected and included

We will support Highland's families with respect, care and compassion, ensuring that their voices are integral to all we do

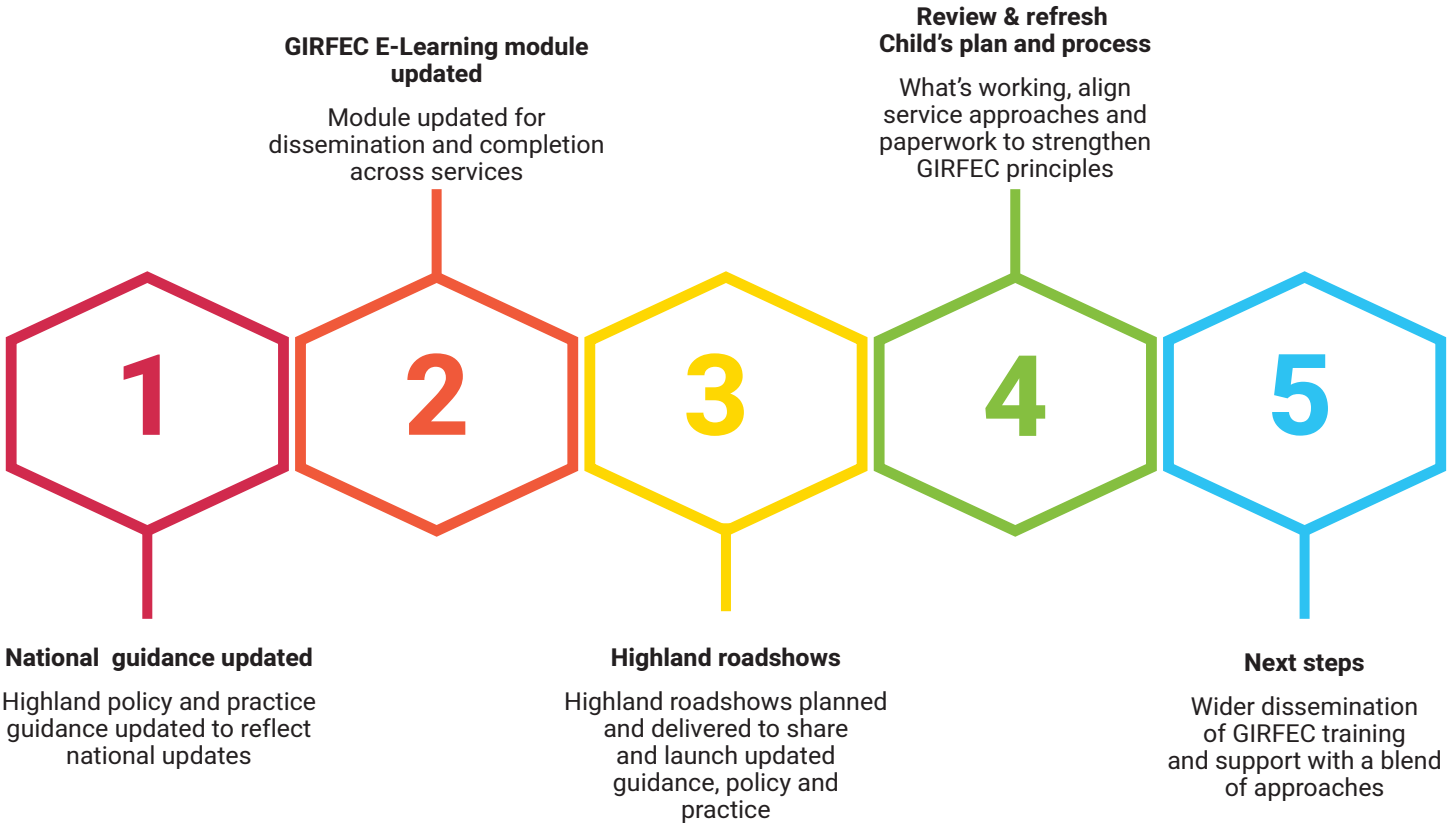
We will enable and empower families to thrive and stay together wherever possible

We will tackle poverty and inequalities and will support and enable families to live and thrive together in their communities

GIRFEC Getting It Right for Every Child

In reviewing the latest National GIRFEC and Child Protection procedures and practice guidance, we have completed the alignment of local procedures and guidance. From April 2024 the ICSP board will deliver a series of local workshop sessions to launch the updated guidance and begin the process of engaging with partners across Highland.

GIRFEC
Implementation Flowchart



Whole family wellbeing approach

Following the recruitment process and setting up of the Whole Family Wellbeing Programme Team between May 2023 and September 2023, the Programme entered the Evaluation Phase on 30th September 2023. This phase is designed to ensure that the framework of the Programme remains within the above four Programme Pillars, and that it remains evidence-based and needs-led, at a locality level. To ensure this, the following approach has been developed.

Data Gathering

Recognising that no single source of data will be sufficient to provide robust evidence of need, a mix of evidence from a range of sources is being gathered, namely;

- Performance Data in the form of the Integrated Children's Services Planning Board Performance Management Framework and the Highland Joint Strategic Needs Assessment.

Stakeholder Views

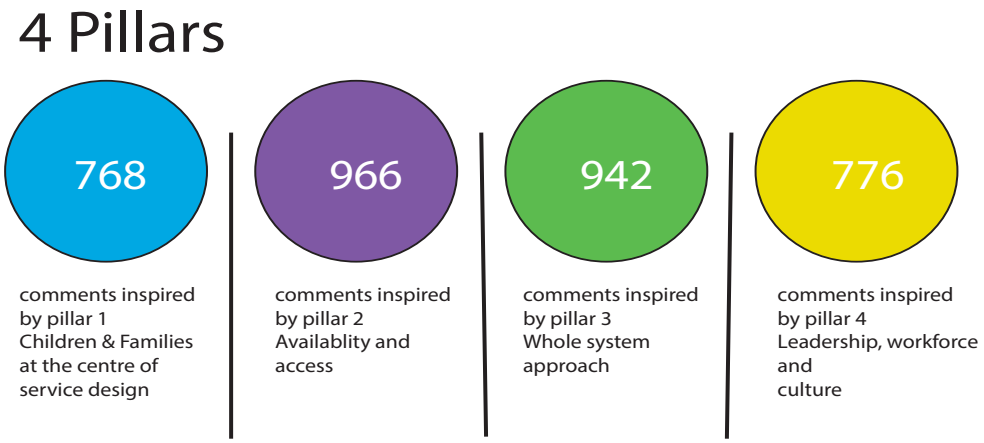
- Practitioner Participation Sessions, providing the voice of practitioners within Statutory and Third

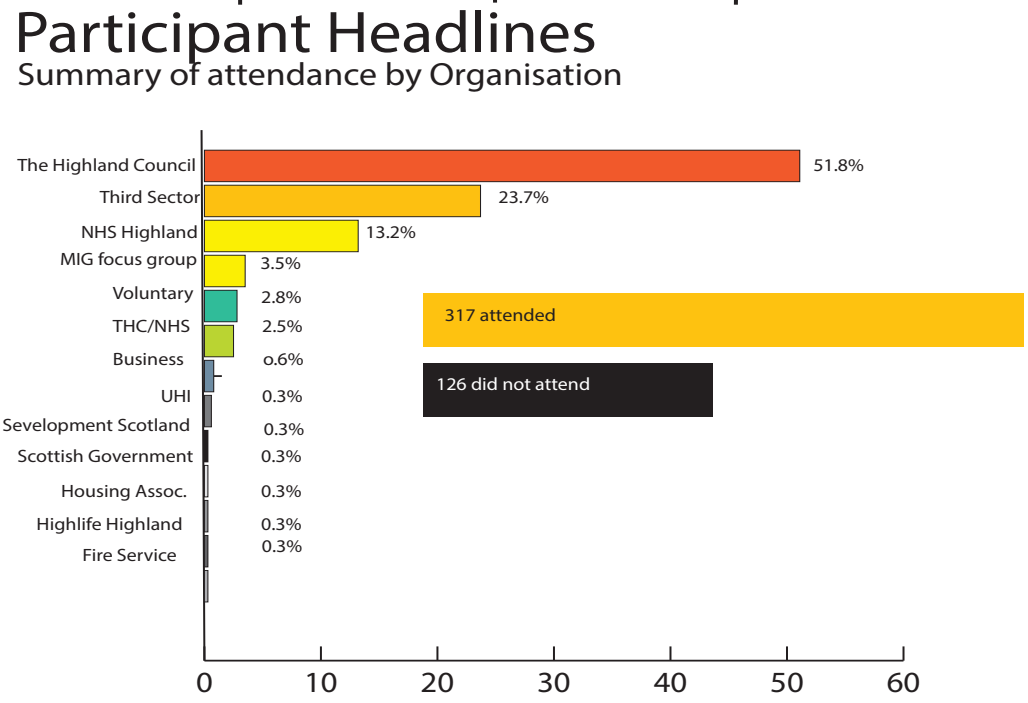
Sector organisations in Highland, who deliver support services to families. Gathered between October 2023 -January 2024. A summary of which can be seen here:

Children and Families Participation
Providing the voice of families from across Highland about support provision and access to support – utilising the Integrated Children's Service Board Participation Strategy and gathering wider community-based consultation data. This will be commencing in March 2024.

Whole Family Wellbeing Funding
National Self-Assessment Toolkit to be undertaken by Statutory and Third Sector organisations in Highland, who deliver support services to families. This will commence in March 2024.

Service Provision Scope/Mapping
which will be incorporated into the Whole Family Wellbeing Funding - National Self-Assessment Toolkit process. Commencing February 2024 to March 2024. The gathering and analysis of this data set will ascertain predicated need around each of the nine Community Partnership localities and will further allow for the process of funding applications to commence.





ICSB PARTICIPATION STRATEGY

1000 children and young people will actively have taken part in the process. The strategy can also be informed by the views of over **700** professionals in Highland on the topic of children and young people's participation

63 Promise cafe attendees

150 staff engaged in promise awareness sessions

18 Promise ambassadors recruited in the last year

Projects	Details
The Promise CPC language guide	the production of a "language guide" in the form of an online microbite which was developed through engagement with children and young people with experience of care and professionals
CPC The Bairns Hoose	£63 000 funding secured from the national Bairns Hoose fund to improve premises used for interviewing and supporting children and young people
ADP Planet Youth prevention model	progress through the 10 steps. second round of bi-annual surveys completed by S4s in 5 pilot schools with data being processed via Planet Youth in Iceland

WHOLE FAMILY WELLBEING PROGRAMME

317 participation session attendees

"whole family wellbeing, the promise and families first work in harmony"

3000 comments from practitioners

"there was lots of exchange of realistic, positive and creative thinking from the participants. I really hope the spirit of that and the realisation will continue"

37 different sectors engagement

"Really supportive session. I have high hopes that our input is being listened to and used"

INTEGRATED PLANNING - OUR THEMES

- Poverty
- Rights & Participation
- Child Protection
- Health & Wellbeing
- Corporate Parenting
- Drugs & Alcohol

Poverty

Poverty

The Poverty Reduction Delivery Group has undertaken a mapping exercise to identify areas for action going forward. The mapping took the form of two strands; considering what is happening and being delivered and alongside this, where the gaps and opportunities are for shared partnership action. A survey of third sector groups supported this exercise, followed by a review and reflection session.

Information and Awareness Raising

- Supporting Practitioner Learning - developing the approach to poverty related practice. Building on existing learning packages to create a suite of materials to support practitioner learning.
- Shared partnership resources targeted to support people experiencing poverty. Resources to support individuals access the advice and services required. Developing routes for sharing and referral routes (building on learning from health visitor pathway)
- Addressing Stigma – building an approach into practitioner learning and shared resources

Community Based Approaches

Collective practitioner support - providing support and advice where individuals are coming together e.g. parent and toddler groups/community growing spaces/community cafes/tenants
Lived experience - developing our approach to understanding lived experience and using this to identify areas for development

Specific Strands of Work

- Developing the approach to period poverty in schools
- Roll out of cost of the school day toolkit
- Developing flexible models of childcare in rural areas

Child Protection

Following feedback from Highland's inspection for children at risk of harm, and a review of current priorities, the Child Protection Committee have been progressing key issues to deliver change ideas to support children, young people and families. Highlights include:

- GIRFEC and Child Protection Procedures reviewed and updated in line with national guidance with accompanying e-learning resources
- Implementation of the Scottish Child Interview Model (SCIM) in September 2023
- Highland invited to be an affiliate in the National Bairns' Hoose programme
- £63000 funding secured from national Bairns' Hoose fund to improve premises used for interviewing and supporting children and young people in Caithness and Inverness initially
- Work with Children and Young Peoples Centre for Justice and Action for Children in relation to re-imagining youth justice underway
- Exploitation Partnership Steering Group established to oversee CORRA project and development of RISE service and the Anchor project.
- £200,000 funding secured from The Promise CORRA fund to support young people affected by criminal and sexual exploitation
- Highland evaluation completed by the National Missing People project and recommendations to improve responses to missing young people now being progressed
- Increased focus on Quality Assurance of child protection processes including roll out of Interagency Referral Discussion audit work and implementation and analysis of the new National Minimum Dataset
- Development of language guide in partnership with The Promise Highland team

Corporate Parenting

People

- 'develop relationships' Promotion and engagement of The Promise continues across Highland. To date 9 sessions to over 150 staff, and 4 Promise Café have been held with 63 attendees. There have been 4 Keeping the Promise newsletters produced and circulated across the partnership. Data from pre & post measures indicate an increase in staff knowledge, they feel more informed and have more ideas about how to #Keepthepromise.
- 'Promise Ambassadors' 18 Promise Ambassadors have been recruited, across Health, Social Care and Education. The ambassadors have met 4 times over the last year. This initiative is expanding with opportunity to extend beyond The Council.

Family 'Empower families through Family Group Decision Making'

- Empowering families to build safety for children and young people is central to the Promise and Highland's commitment to delivering the Promise. Family Group Decision Making (FGDM) is currently being rolled out as a pilot across 3 family teams in the Inverness areas.
- 78 Children identified for possible FDGM. Focus in 2024-25 will be on tracking outcomes and learning from the pilot

Voice

- The production of a 'Language Guide', in the form of an online 'microbite' developed through engagement with children and young people with experience of care will be launched early 2024. Training from Each & Every Child on their framing recommendations (evidence based framing recommendations to change the public perception of care experience) was delivered to Highland's Child Protection Committee and Promise Board.
- Care Experienced young people of Highland produced a video for Corporate Parents on what they wanted from Board members, which was shared as part of training sessions to The Promise Board.
- The Better Meetings Practitioner Guides were launched in 2022. These guides emphasised good practice before, during and after meetings and hearings to ensure that the voice and views of young people are at the heart of everything we do. They are currently being evaluated, with the views of children and young people central to the findings.

Care

- Your Voice Matters gathered the views of young people who experienced residential care in Highland from Jan 2020 – July 22. A striking finding was the significance of relationships. Improvements are underway with early data being collated. 2023 inspections in residential care homes have begun to evidence improvement and progress (inspections: good, very good and excellent)

Rights & Participation

United Nations Convention on the Rights of the Child

The 16th July marked the commencement of the UNCRC (Incorporation) Act in Scotland. This determines that decision makers and other duty bearers must uphold children and young people's rights as they protected in Scots law. Impact Assessment training has been rolled across the Highland Council ensuring that any changes in policy and practice require to have an Integrated Impact Assessment completed. These assessments include UNCRC considerations.

The Rights and Participation delivery group launched the Rights and Participation Website. This includes a wealth of information, resource videos and links. There is also space to provide opportunities for children and young people to have their voice heard. The website can be found at: https://www.childrensrightshighland.co.uk/ In addition, a training module for Children's Rights and UNCRC incorporation is available to access on The Highland Council Traineasy platform.

Children and Young People Participation Strategy

A draft of The Children and Young people participation strategy was approved by the Integrated Children Service Board inJune 2024. Strategy development ensuredthe meaningful and equitable participation of children and young people at the heart of the process. With input gathered from almost 1000 children and young people from across Highland, the strategy will be launched at the annual Integrated Children's Service Event - Vision 26 in August. An implementation plan is in development to support the partnership take the first collective steps towards the ultimate goal of making Article 12 of the UNCRC (I have the right to be listened to and taken seriously) an everyday reality in Highland.

GIRFEC (Getting it Right for Every Child) refresh and reset

Following a National update of GIRFEC and Child Protection procedures and practice guidance, the Highland partnership has completed the alignment of our own guidance to reflect this. This GIRFEC refresh reflects the current national drivers including The Promise and United Nation Convention of the Rights of the Child (UNCRC)

The Integrated Children's Service board are leading on the delivery of the GIRFEC Refresh and Reset across Highland. This started with face-to-face multi agency sessions across Highland earlier in the summer. Participants had to undertake the new eLearning module prior to attending the sessions. Valuable feedback has been received across the partnership highlighting the GIRFEC and child protection continuum.

Drugs & Alcohol

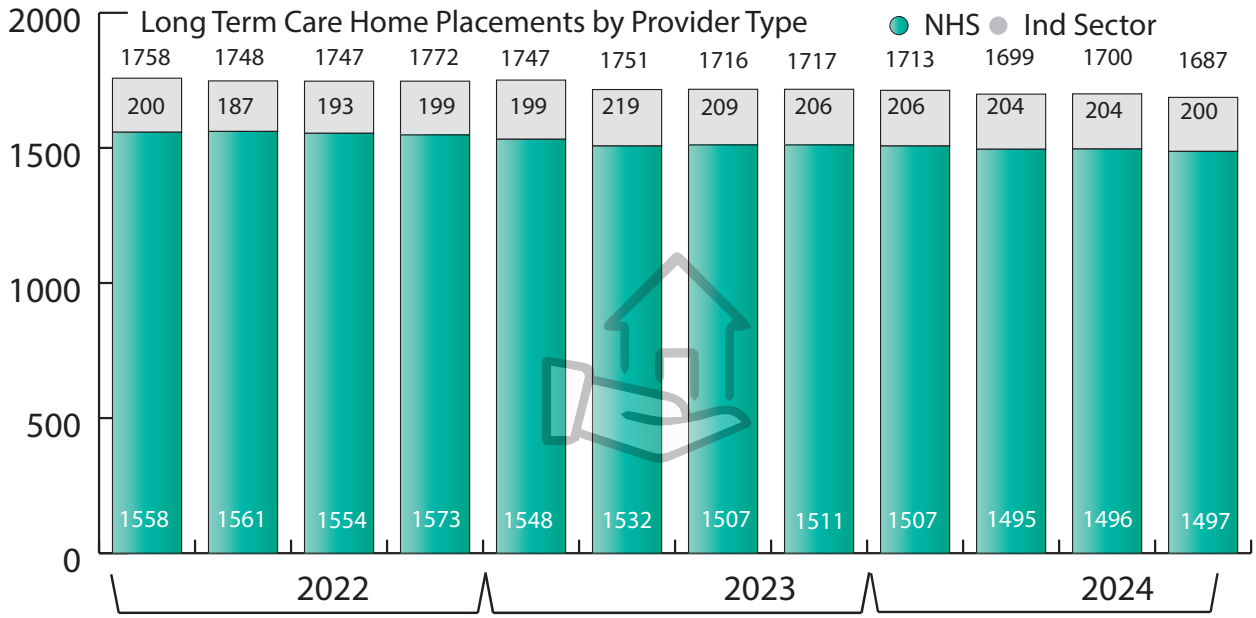
- Foetal Alcohol Spectrum Disorder Awareness Training is underway.
- "Pregnancy Alcohol and Drugs Advice and Support Sessions" for midwives supporting women and families who are affected by continued drugs or alcohol use during pregnancy.
- Pre-conception Information Support Preparation and adaptation of Alcohol Brief Interventions learning package for community midwives. Resources have been developed for midwives.
- Support for Antenatal Care Networking with Third Sector to support improved signposting by midwives, Improved liaison and collaboration with Drug and Alcohol Recovery Service (DARS).
- Planet Youth – Prevention Model Continue to progress through the ten steps. Second round of bi-annual surveys completed in 5 pilot schools with data being processed via Planet Youth in Iceland. Data will be further analysed and collated into a Highland report . Planet youth Strategic Group now providing leadership for the programme
- Culture Change/Whole Family Activities Collaboration with Highlife Highland partners to increase positive activities in targeted areas. This includes, supervised family gym blocks which are free of charge and aim to embed family involvement in sport and physical activity.
- Discussing Drugs and Alcohol with Young People resource including Pre-course eLearning via TURAS in development.
- Highland Substance Awareness Toolkit (H-SAT) Whole school early intervention approach to embedding H-SAT as a test of change underway. Regular review of content via google analytic with promotion through community events
- Advanced Nurse Practitioner Specialist alcohol and drugs role being developed for schools to strengthen knowledge, skills and confidence of school nurses to deliver substance related priorities.
- Treatment and Support Planning underway to respond to UK Clinical Guidelines for Alcohol Treatment Consultation young people sections, Participation via Health improvement partners in development of national prevention strategy Planning for second Scottish Government self-assessment exercise on the Whole Family Framework - Drugs and Alcohol to be followed by a local improvement plan.
- Assertive outreach teams active in Inverness (to extend to Mid and East Ross) and Caithness providing support to those at higher risk of harm and death from 16 and over that are not currently in school Inverness team includes a social worker post. Harm prevention police officer post collaborating with assertive outreach teams.

Adult Social Care

Care Homes

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

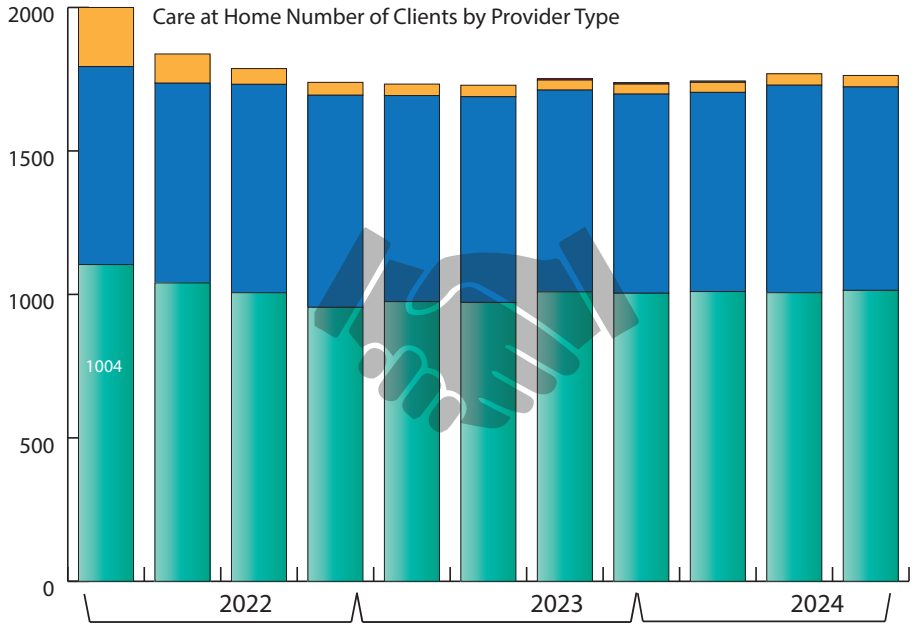
Over the last 12 months, there have been continued concerns regarding independent sector viability, mainly around the ongoing operational and financial sector pressures relating to small-scale, remote, and rural provision, the challenges associated with attracting and retaining staff, and the financial impact of high agency use. The sector continues to raise these issues, which are not decreasing.



NHSH has sought to build on existing supportive and collaborative arrangements to support the best delivery of care home services and improve the lives of those living in care homes.
There are 62 care homes across North Highland (April 2024), 46 of which are operated by independent sector care home providers and 16 of which are in-house care homes operated by NHS Highland.

There are currently around 1,850 care home beds commissioned or delivered, with around 86% commissioned from independent providers.

Regarding the size of care homes, within Highland, 15% (7) of independent sector care homes have 50 beds or more, with 3 of these being over 80 beds. However, 85% (39 care homes) are under 50 beds, with 48% (22 care homes) operating with 30 beds or less.



Market and Service Changes

There have been six independent sector care home closures since March 2022, these being as noted below:

- Shoremill in Cromarty (13 beds) — March 2022
- Grandview in Grantown (45 beds) — May 2022
- Budhmor in Portree (27 beds) — August 2022
- Mo Dhachaidh in Ullapool (19 beds) — March 2023
- Castle Gardens, Invergordon, (37 beds) — June 2023
- Cradlehall Care Home, Inverness (50 beds) — April 2024

NHS Highland / The Highland Council also acquired a care home
Main's House (Newtonmore) in April 2023. This was a care home in administration, along with Grandview (Grantown), which subsequently closed. The partnership secured Main's House to avoid the loss of both care homes at the same time in this locality. It is also relevant to note that many in-house care home closures have occurred. These have arisen due to acute staff shortages and the inability to be safely and sustainably staffed. The status of these care homes is as noted:

- Dail Mhor, Strontian (6 beds) — December 2022 (temporarily closed)
- Caladh Sona, Talmine (6 beds) — May 2023 (closed)
- Mackintosh Centre, Mallaig (6 beds) — August 2023 (temporarily closed)

The total impact of the nine care home closures since March 2022 has been the loss of 211 beds. The common theme across all closure situations is staff recruitment and retention, the cost of securing agency cover, and financial viability.

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

- Additional capacity is expected in the next 12 months – the newly built 56-bed care home at Milton of Leys in Inverness, scheduled for completion in spring 2024.
- Planning applications are intended for two care homes with additional ten-bed wings, creating 20 beds. The timescales around this are subject to the planning process.

Key Messages

There is a higher proportion of smaller operator sizes and a larger provision scale within North Highland. This minor scale provision reflects Highland's geography and population. However, it presents increased financial sustainability and vulnerability risks, particularly given that the National Care Home Contract rate is calculated based on a 50-bed care home operating at 100% occupancy.

Care home quality across Highland is generally good, although there has been a recent experience of a short-notice care home closure arising from quality issues.

Independent providers (and NHSH care homes) continue to experience difficulties recruiting and retaining staff, representing a very high risk across the sector. The most significant challenge is recruiting nurses to work in care homes.

Staffing difficulties are further exacerbated in homes in rural locations away from the larger population centres but are not limited to rural locations.

Investment in a Scottish Care hosted Independent Sector Care Home Career and Attraction Lead.

Investment in a Scottish-hosted Independent Sector Care Home Lead.

Creating a multi-disciplinary team for the Collaborative Care Home Support Team (Nursing, Public Health, speech and language therapy, physiotherapy, dietetics) operating to a work plan jointly developed with the care home sector.

From the available Scottish Government funding, £0.241m was directed from unfilled posts for a resident wellbeing fund; 96% of Highland residents could benefit from the fund directly.

Care at Home

NHS Highland (NHSH) and commissioned care providers operate in a pressured environment.A consequence of an insufficient supply of care-at-home services is that a significant number of people are delayed in hospital awaiting discharge, who are medically fit to be discharged and should be in the safer and more comfortable environment of their own homes.

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

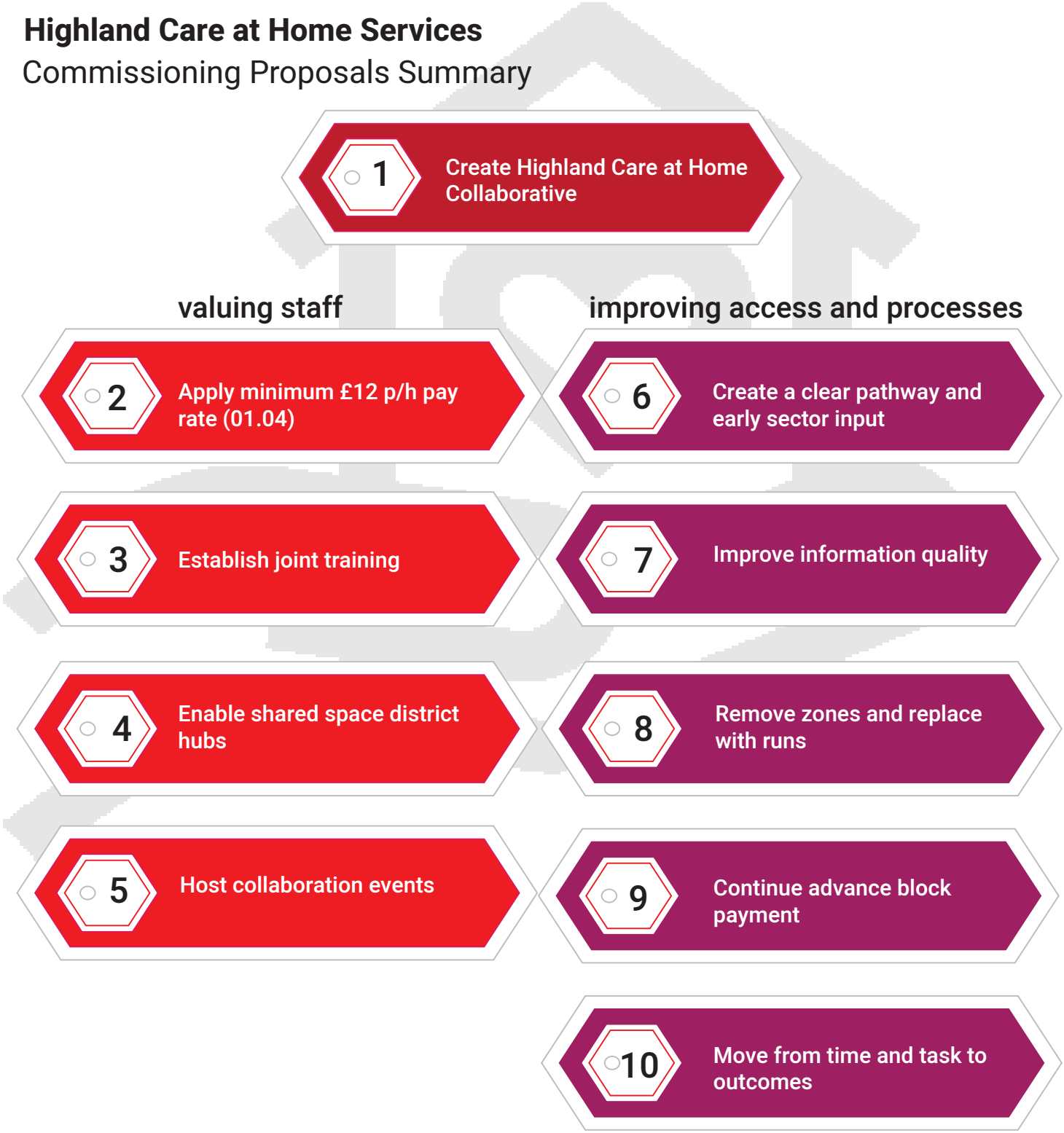
All employment sectors are experiencing significant recruitment challenges. NHSH is well aware of its own staffing challenges, and these are being similarly, and arguably, more acutely, experienced by independent sector providers, whose terms and conditions are generally lower than those offered by NHSH.

In Highland, the unemployment rate (November 2023) is 2.7%, which is significantly lower than the Scottish average of 3.2% (June 2023) and the UK average of 3.8% (June 2023) - meaning there is a comparatively lower pool of potential employees within the marketplace in Highland from which to recruit. Highland has further particularly challenged areas around tourism and seasonal economies, increasing difficulty in recruiting and retaining staff.

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

A short-life working group (SLWG) has co-created and co-developed proposals to address capacity and flow issues.

The SLWG has co-produced and agreed on commissioning proposals, which are being prioritised with an implementation plan for 2024-2025.



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

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

Key Messages

The consequence of the attrition and recruitment challenges has been reduced capacity available to NHSH. Currently, commissioned activity is around 8,900 hours per week – a reduction of 2,500 hours compared to the peak of service delivery in March 2021. Care at home unmet need is currently quantified at 2,600 hours per week.

Care at home capacity has been reducing over recent years, and the lack of a sufficient level of care at home capacity is causing people to be delayed in hospital, causing poor outcomes for them, increased risk, and financial implications for NHSH. More care-at-home capacity needs to be generated to alleviate this issue.

SLWG identified two key theme areas: valuing staff and improving access and processes.

SLWG has co-produced and agreed on ten commissioning proposals, prioritised with an implementation plan from April 2024.

Investment in a Scottish-hosted Independent Sector Care at Home Lead.

redesign of care at home	improved staff well-being	workforce planning and development	collaboration and engagement	contribution to strategic planning
Independent Sector Providers will be included in any planning & redesign Maximisation of resources to support better access to services leading to better choices and person centred options for people accessing services in line with HSCP strategic priorities Better use of resources to support preventative work and support progress towards Hospital discharge targets	The needs of Independent Sector Staff will be considered and opportunities for engagement with Staff well-being provisions within the HSCP will be supported Independent Sector Staff will be aware of opprtunities for improved well-being and how to engage with these Improved Staff resilience and well-being in line with HSCP strategic priorities better retention of staff and lessening of recruitment challenges	Independent Sector will continue to contribute to and be considered in development and implementation of work force planning Consideration of challenges facing the Sector alongside t improved access to opportunities fror staff development to support growth of the workforce	Engagement with existing opportunities for collaboration and engagement will be supported Barriers to collaboration identified (i.e methods of commissioning, percieved competition) and addressed	The insight and experiences of the Independent Sector will help shape strategic planning in Highland Providers will be engaged with and have opportunities to contribute to planning for a National Care Service

NHSH review of the tariff, the hourly rate we pay providers in urban, rural and remote areas of North Highland. The agreed proposals have not yet been fully implemented as they are subject to a business case with additional funding required.

A review of commissioning and fee condition arrangements concerning independent sector care at home provision and co-produced proposals for the Partnership's consideration.

Promoting choice, flexibility and control – SDS Strategy Implementation

NHS Highland, The Highland Council, and a range of partners conducted a significant consultation exercise that gathered the views of people who need support—and those involved in its provision—about how we should deliver Self-directed support in the future. Responses were received (via online surveys and 13 targeted focus groups) from around 200 individuals.

SDS is the mainstream approach to delivering social care in Scotland. Its aim is to enable people to live their lives to the full as equal, confident, and valued citizens.

Adopting the ethos of SDS is intended to promote the development of a healthier population living within more vibrant communities and can contribute to achieving a fairer Highland. We are seeking to put the principles of independent living into practice to enable people to be active citizens in their communities.

Consistent with our approach, we have set up a number of initiatives, highlighted below, to bring people together to address the implementation issues and progress the required changes. This is consistent with our aim to work in partnership with people who need support and partners to ensure they have a greater role in decision-making about SDS at all levels.

Self-Evaluation and Improvement

NHSH and THC evaluated the quality of practice in Highland concerning our delivery of SDS. We used high-quality professional facilitation from In Control Scotland to run a set of "Appreciative Inquiry" sessions with 40 participating professional staff across three sites, with the intention of developing a set of tangible improvement actions.

This exploration flagged up some of the characteristics – and tensions - within the current system.

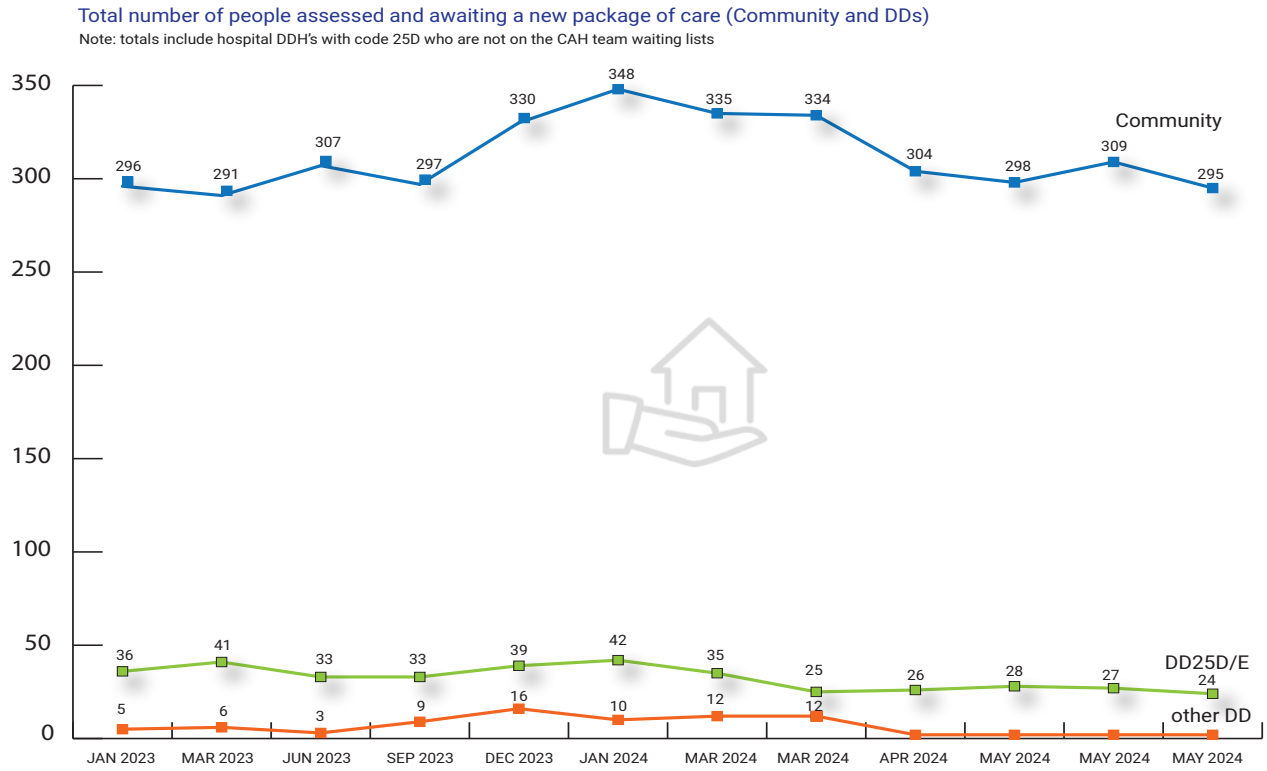
A small set of focused improvement actions (experiments) have emerged from these themes. These ideas were co-designed by participants based on their shared understanding of the system they worked within. The areas identified for piloting by identified Teams are:

1. Trialling Team and Worker Autonomy, delegated budgets and collegiate decision-making
2. Trialling a different model of "Eligibility": considering the role of Teams should be to provide appropriate advice, guidance and assistance within their communities
3. Exploring new approaches to place-based commissioning to meet local needs across a defined geography

Growing intelligence and hearing the issues

We have heard clearly from recipients as a result of our local consultations with a wide range of service users and their families of Option 1 that recruiting personal assistance is becoming increasingly difficult

In our localities, several Personal Assistant (PA) support events are being scheduled. "Becoming a PA in Social Care in Highland" and "Promoting PA Employment Opportunities Locally" were initially run in Lochaber. The turnout for these events was good, with a high percentage of attendees looking to become PAs. Feedback was positive, with attendees leaving feeling informed and supported. Our plan is now to initiate a rolling programme of events around Highland.



Independent Support

NHS Highland is fortunate to benefit from the independent support services offered by Community Contacts. Funded centrally via the Support in the Right Direction (SIRD) initiative, service users, carers, and statutory services all benefit from their advice and assistance in exploring the SDS options available in any given circumstances. However, we also know that financial balances accrue for those individuals awarded Option 1 who cannot find appropriate assistance or support. Work is beginning to develop a scheme to recycle some of these balances. The idea is to use some of those resources in specific geographical areas where assistance is complicated to find to purchase additional independent support and to use as a catalyst for developing other community-based services or supports. The specification for such a model of independent support should encourage as much flexibility as possible, ensuring it can not only accompany people along their journey to getting the help they need (including practical help in identifying, recruiting and managing personal assistance) but that it should also encompass developing peer support, increasing support for personal assistants

Option 2's – Individual Service Funds

Good Option 2 arrangements can deliver outcome-focused, personalised and effective care and support, and the use of brokerage and sub-contracting by Option 2 providers can increase this capacity.

NHSH are exploring organisationally whether the outline of work below will help us broaden the opportunities our Option 2 offer provides:

- Our current tri-partite agreement should be reshaped to align to good practice models (e.g. CCPS Tripartite Agreement) that promote personalised and outcome-focused arrangements
- We should develop "boilerplate" contracts (utilising standardised clauses) to underpin Option 2 arrangements across a much wider variety of services and supports
- We should develop a specification with an appropriate contract and terms and conditions for organisations other than those providing care and support to hold Option2s for people – thereby also developing a brokerage model.

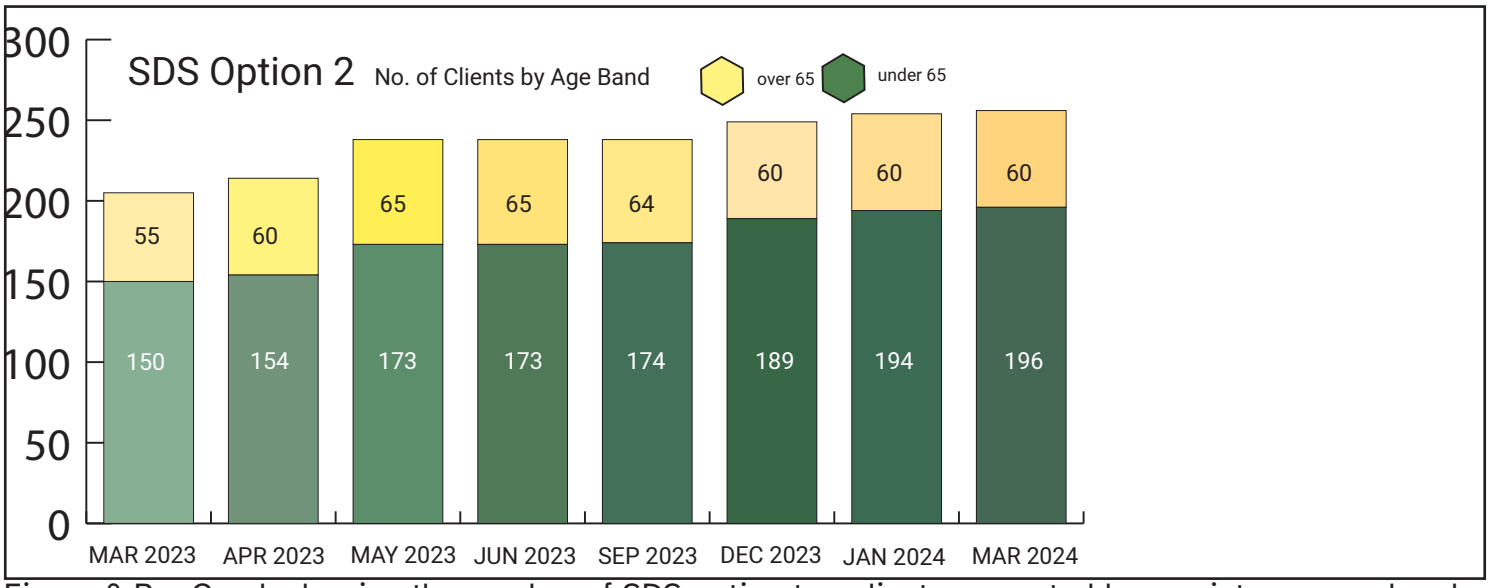


Figure 8 Bar Graph showing the number of SDS option two clients separated by age into over and under 65s, for specific months in 2021 to 2024

Costing care and identifying budgets transparently

A group of people interested in managing Option 1 (Direct Payment) has been working with officers in NHSH to see if they could describe a fair, equitable, and sustainable co-produced framework for calculating Individual Budgets together. The aim is to support the exercise of choice by ensuring that recruiting and retaining Personal Assistants (PAs) is a realistic and sustainable option in our communities.

This work of the SDS "Highland Peer support group" and NHSH created an agreed and mutually understood model which recognises the direct staff costs of employing a PA in our urban, rural and remote geographies with an agreed "business overhead" rate in place. After many good conversations, a co-produced model was implemented on 02/10/23. The individual's postcode determines the new hourly rate payable to each recipient of Option 1 by using the Scottish Government's urban, rural and remote classification and application of the agreed model.

Given the above, Option 1 service users all received a substantial above-inflationary increase during 2023-24 due to NHSH's significant investment in leveling up the previous low baseline hourly rate.

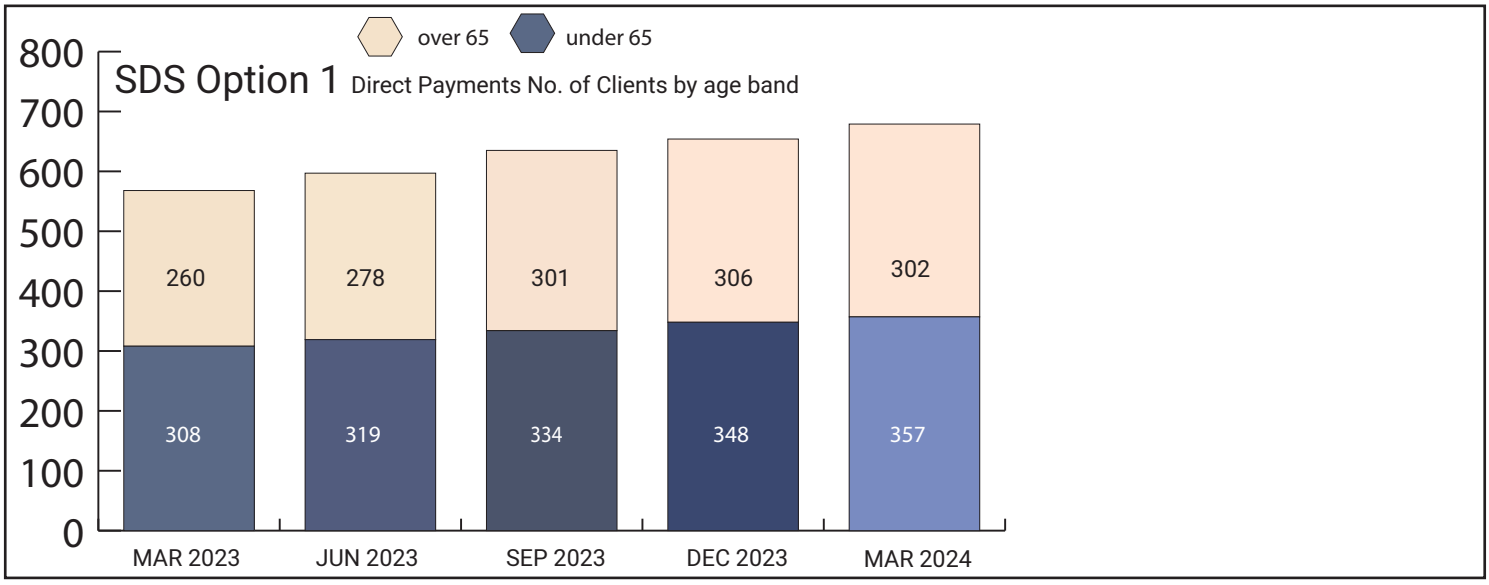


Figure 9 Bar Graph showing SDS option1 payments separated into over and under 65s for specific months in 2021 to 2024

Community Led Support
Community Led Support (CLS) seeks to situate early and preventative help and signposting into the heart of our communities. Linking the skills and knowledge of a range of professionals across the health and social care system to work closely with existing community groups and using platforms like ALISS for signposting, this approach has provided valuable guidance and support to the communities we serve.

The success of CLS initiatives in Highland can be attributed to a unique approach to community engagement. By partnering with existing groups such as lunch clubs, mother and toddler groups, etc., community-led approaches have been able to integrate seamlessly into the community fabric.

Place-Based Commissioning – West Lochaber
We have seen significant systemic challenges in the West Lochaber area (as in many other Highland Communities) in delivering traditional care services sustainably. The NHS-owned Care Home has been unable to maintain safe staffing levels, and the system of Care at Home is stretched.

A small project team was formed by bringing statutory partners together with Urram (a local community organisation) and In Control Scotland. The aim was to explore what local people thought about social care and – importantly - what options might exist to do things differently

One of the most vital themes throughout our conversations is that these are close communities that know their members well and that they have a strong perspective on their challenges and potential solutions.

Currently, there appear to be various components of our health and social care system which work in isolation or non-complementary ways. Our team thought that there is learning from models such as Burtzorg and Community Led Support that could be applied to develop a new way of arranging and coordinating care on West Lochaber. A well-coordinated, local, multidisciplinary team comprising statutory, voluntary, and community services over a tightly drawn local geography is an idea we are actively exploring.

This is an ambitious idea, but one which feels entirely achievable given the small size of the communities. Given this, our small team plans to co-produce such a model in one village as a test of change. This will involve co-producing an experiment of what this locally coordinated team could look like, describing the enablers and barriers to this and how these could be maximised or overcome, and exploring how it will work in practice. This must be led locally, and given Urram's solid reputation, the team hopes to take the lead on co-producing this project with our support.

Taking a Programme Approach
With the breadth of the challenge of addressing the culture and practice of SDS in Highland, improvement efforts have necessarily been wide-ranging, identifying several key opportunities for and barriers to change. Realising these opportunities – and, where relevant, overcoming cultural and organisational blockers – requires input, identified capacity and coordination across the Social Care system.

Given this, a coordinated Programme approach is being taken to ensure progress in the work outlined above is monitored at an appropriate level and, where necessary, supported by identified Scottish Government Transformational funding.

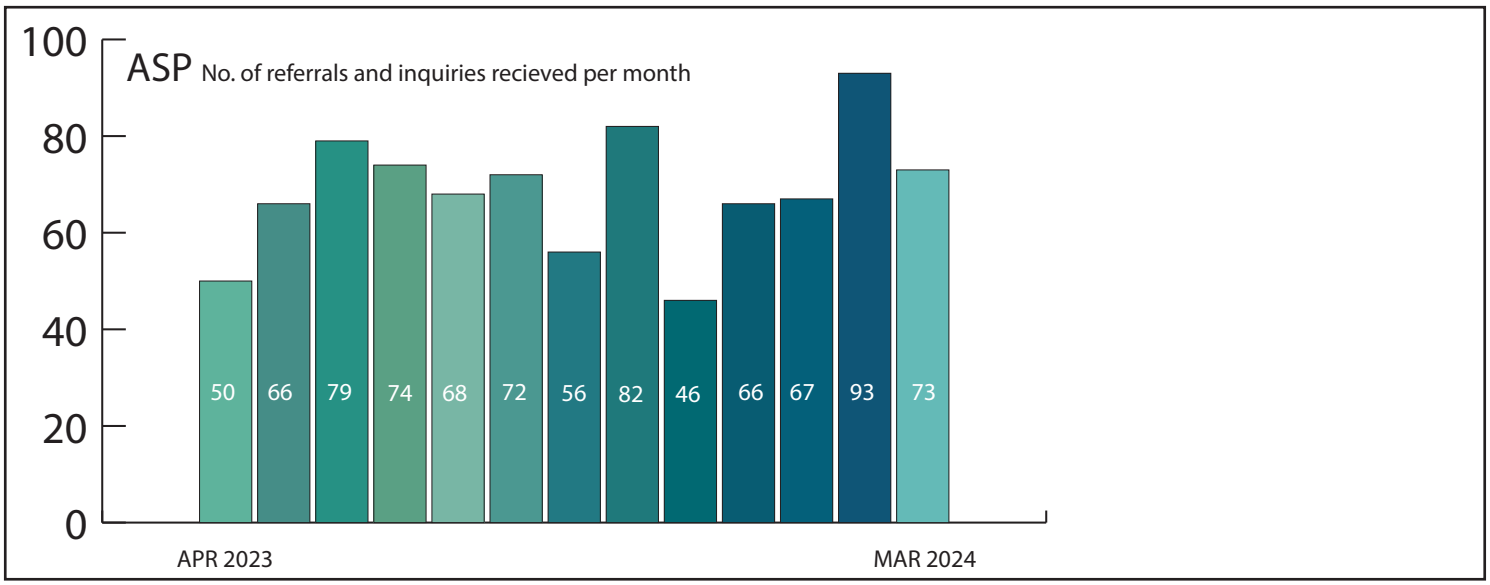
Highland Partnership Adult Support and Protection Report

The Care Inspectorate and its partners have recently published its Inspection Report of Adult Support and Protection within the Highland Partnership.

Joint Inspections aim to provide national assurance about individual local partnership areas' effective operations of key processes and leadership for adult support and protection.

Garry Coutts, Independent Chair of the Highland Adult Protection Committee, said" *We are pleased that the inspection report has concluded that there are adequate adult support and protection practices across the Highland Partnership"*.

The report highlights that our practice was person-centred, and there have been clear improvements from the previous inspection. We are aware of the improvement areas identified in the report and are working to develop a plan to address these.



Technology Enabled Care (TEC)

What has happened to us?

We have been experiencing some supply issues that have caused delays in completing TEC installations. Transitioning to digital TEC has been slow due to the lengthy process of securing funding and ongoing contractual negotiations with Care and Repair, who install the equipment.

NearMe

- The service continues to maintain provision across all specialities post-pandemic.
- Use of phone rather than video consultations has continued despite facilities being in place for Near Me video consultations

Connect Me

- Remote Health Monitoring has changed the national strategy and capacity available to develop the system because of changes in the national Digital Health & Care team structure.
- Locally, the retiral of a critical team member has resulted in Connect Me being incorporated into the Near Me team

What have we aimed to achieve in 23/24

Technology Enabled Care (TEC)

- Increase the number of people using Technology Enabled Care (TEC)
- Begin transitioning clients to digitally enabled units
- Transfer Highland Council Grouped Schemes to NHSH TEC
- Test and deploy new technologies that support individuals and their carers, like Carephone
- Increase the use of technology available on the high street to help people lead healthier and happier lives
- Continue raising awareness about Technology Enabled Care and high street technology among NHSH staff

Near Me

- Increase the number of specialties using Near Me video consultations
- Increase the number of patients able to benefit from using Near Me
- Increase the total travel miles saved through the use of Near Me consultations

Connect Me

- Continue to promote and deliver remote health monitoring pathways to support long-term conditions
- Increase the number of patients using Blood Pressure pathways
- Commence and recruit patients to the Chronic Pain Pathway
- Transition Asthma patients from Florence to Inhealthcare Asthma pathway

Technology Enabled Care in numbers

2,944 clients

↑ 5% increase in total clients on previous year

123 staff attended training

6 Highland Council grouped schemes transferred to NHSH telecare

80 average new referrals per month

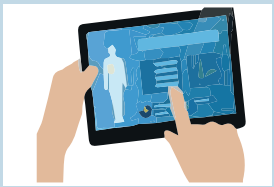
13% of telecare clients now have a digitally enabled unit

880 new clients

46 community events and groups attended

what have we done?

introduced our new digitally enabled units



developed a guide to simple video calling devices & high street tech

hosted the spring tech event in Inverness

deployed new technology like Alcove Video Carephone

Near Me
Travel Miles saved 2023/24: 1.9 million
Total Remote appointments: 101674, of which 24580 (24%) were Near Me appointments. 5% of all appointments were conducted using Near Me in 2023/24.
Top providers of Near Me appointments in 2023/24 were:

- Clinical Genetics
- Psychological Services
- Endocrinology
- Sleep Apnoea

Most travel miles saved were for patients in Caithness and Skye & Lochalsh.
West Sutherland was the area with the highest percentage of outpatient appointments by Near Me.
Patient surveys consistently report a 95% satisfaction rate with Near Me.

Connect Me
We are piloting remote monitoring pathways for multiple long-term conditions and lymphoedema reviews. Recruitment of patients to the Blood Pressure pathway continues, with between 40 and 50 new patients enrolled every month.

Primary Care

This section outlines the recent activities and developments concerning Board-managed GP Practices under NHS Highland. The focus is on practice mergers, recruitment challenges, success stories, quality improvement projects, and various workstreams aimed at enhancing service delivery.
It highlights the progress made through the local development of the national Primary Care Improvement Program (PCIP). This is a collection of investment and improvement programmes supported by the national Healthcare Improvement Scotland organisation.

Practice Mergers and Sustainability
- Three Harbours Medical Practice: Merged Riverview Wick, Riverbank Thurso, and Lybster to support sustainability.
- West Highland Medical Practice: Combined Acharacle and Lochaline for improved resilience.

Recruitment and Success Stories
- Recruitment Challenges: Persistent vacancies in remote and rural areas, often covered by locums.
- Alness & Invergordon Medical Practice: Progress has been made with regard to GP recruitment at Alness & Invergordon; with an enthusiastic new team helping to progress positive change. Working collaboratively with local partners to improve health & well being, in a patient centred way; and to develop an ‘education ethos’ within the team for future teaching roles.

Quality Improvement Projects
- Asthma Care Project: Progressing towards implementation in Mallaig and then Alness & Invergordon, aiming to optimise

GMS Lease Assignation
- Lease Assignations: Several practices have shown interest, with one near completion and two progressing. Dedicated resources support this work.

Practice List Closures
- Culloden Medical Practice and Culloden Surgery: Applied to close patient lists due to space constraints, with efforts ongoing to find alternative facilities.

Local Enhanced Services
- Service Specifications: Revised specifications under negotiation, with five already agreed and the rest

due by end of July 2024.

Primary Care Improvement Plan (PCIP)

- PCIP 7 Tracker: Submitted to the Scottish Government, including workforce information, service delivery, financial data, achievements, and barriers.

Premises and Finance

- Primary Care Manager (Premises): New post focusing on GP premises leases and requirements for specific locations.
- PCIF Allocation: Awaiting notification for the year 2024/25, with indications of a single tranche payment.

Pharmacotherapy and First Contact Physiotherapy (FCP) Workstreams

- Pharmacotherapy: 16 GP practices supported by Inverness-based Pharmacy Hub. Positive recruitment and live dashboard development for resource allocation.
- FCP Service: Achieved full staffing with ongoing training. PHIO Access trial shows promising patient engagement and outcomes.

Community Link Workers

- Service Extension: Contract retendering complete, extending service to all GP Practices from August 2024. High referral rates for mental health, loneliness, and social isolation.

Primary Care Mental Health (PCMH)

- Service Specification: Finalised and shared with all GP Practices. Successful recruitment to key vacancies. Live dashboard development for resource allocation.

Vaccination Transformation Programme (VTP)

- Childhood Vaccinations: Tracking below national average due to operational constraints. Peer review conducted, with an action plan in development.

Community Treatment and Care (CTAC)

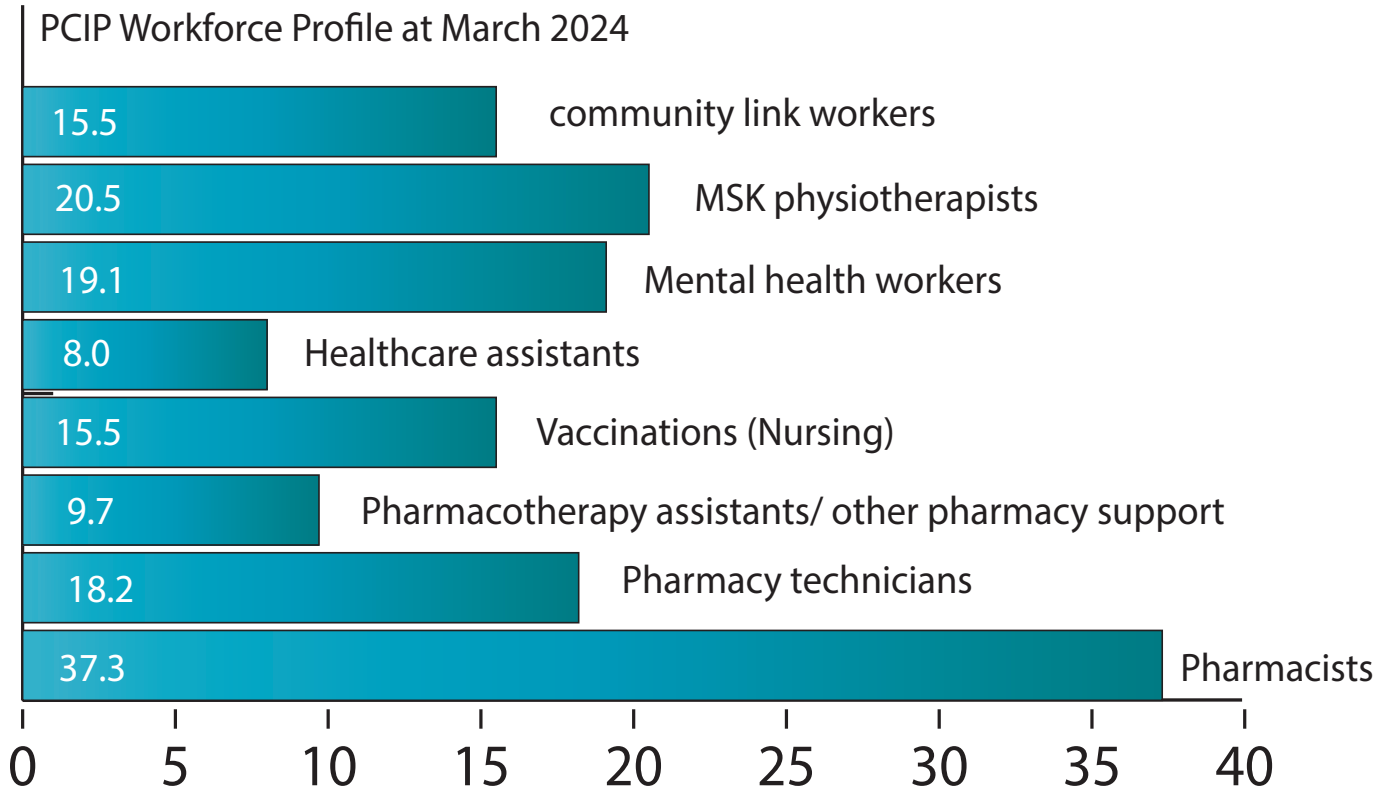
- Rural Options Appraisal: Submitted to Scottish Government, with feedback to be discussed. Transitional payment arrangements continue during 2024/25.

Additional Board Managed Positives

- Rediscover the Joy

This summary highlights the strategic initiatives and operational challenges faced by all NHS Highland's North GP Practices. The focus is on improving sustainability, enhancing service quality, and addressing recruitment and resource allocation issues to provide high-quality primary care services. clinical & non-clinical leadership - recruitment of full cohort of CDs and DMLs has been challenging, but positively successful recruitment to PCM role.

Seeking to improve interfaces - primary/secondary care, GP/mental health, and GP/community nursing/ health visiting.



Community Dental Services

Recruitment and retention of dentists remains challenging, especially in rural areas, for both Public Dental Services and Independent Dental Practices.

The Independent Dental Practice in Gairloch closed siting recruitment and retention difficulties as the critical factor.

Scottish Dental Access Initiative Grants continue to offer an opportunity to improve access to General Dental Services.

Fyrish Dental Practice, Alness received grant assistance to extend by one surgery. As a result, the practice accepts new patients to achieve 1,500 new patient registrations.

An award of grant assistance was approved to help set up a new NHS dental practice with three surgeries in Inverness. The practice will open in June 2024. The Scottish Government has confirmed that Scottish Dental Initiative Grants will be available for the Highland area in 2024.

In response to the closure of the GDP Dental Practice, the Ullapool PDS Dental Clinic opened in November 2023. The clinic operates on a part-time basis and provides routine and emergency treatment. A total of 121 patients are currently registered at the clinic, with children being prioritised in the initial stages.

The pilot of a weekday evening out-of-hours service was run in Inverness. Following evaluation, the pilot has been placed on hold due to low patient uptake, and a review is planned for October 2024.

The Minor Oral Surgery Service at the Inverness Dental Centre continues to contribute to the Oral surgery pathway, ensuring that referrals are managed in the primary care setting where appropriate.

The National Dental Inspection Programme's October 2023 report showed an increase in the number of

caries-free children within the area, which was consistent with the national trend. It also identified a significant increase in unrestored teeth, which was directly related to the delayed recovery of primary care dental services post-COVID.

Oral Health Team update
Childsmile Programme: Following the redesign of services due to recruitment challenges, the Childsmile programme has restarted in the Lochaber and Skye & Lochalsh areas.

Childsmile – Sustainability programme - Recycle & Smile - staff continue to collect used toothbrushes and toothpaste tubes from nurseries and schools, which TradeBe then recycles. Recycled to fire engine parts, plant pots or children's climbing and play frames

Caring for Smiles - online oral health raising awareness training successfully delivered to NHS and health care partner staff, including Modern Apprenticeships, NHS Reserves, Care@Home teams and Adult Social Care Fundamental Skills at induction.

Community Optometry

Community Glaucoma Service
The Scottish Government Community Eyecare Team, NHS Education for Scotland Digital, and National Services Scotland are supporting the development of the Enhanced Service for Community Glaucoma Service (CGS) across NHS Highland to ensure safe patient care.

Within NHS Highland, including Argyll & Bute, 6 Accredited Clinicians have achieved the NES Glaucoma Award Training (NESGAT) qualification and 5 Accredited Providers (Community Optometry Practices). A further cohort of NESGAT training is due to commence early in 2025.

Work is ongoing with colleagues in e-health to develop the roll-out of Openeyes as the preferred Electronic Patient Record, which is fundamental for the service's operation and roll-out.
When developed and operational, the Community Glaucoma Service will provide patients with a safer service closer to home in areas with Accredited Providers.

Mental Health and Learning Disability Services

Introduction

The "Together Stronger" strategy is NHS Highland's five year plan (2023-2028) to deliver Mental Health and Learning Disability services. The plan aims to create compassionate, consistent and collaborative care and support services that meets the needs of the Highland community.

To create the strategy we engaged with over 108 community partners, workforce members, and individuals with lived experiences through sessions, workshops, and hosting conversation cafes. With this collaboration, we focused on creating meaningful relationships and ensuring every voice was heard and valued, and we will continue to make this a priority moving forward.

We are guided and in alignment with national strategies including Scotland's Mental Health and Wellbeing Strategy and the Core Mental Health Quality Standards to make sure that the right support is always available, in the right place, at the right time, whenever anyone asks for help.

Locally, one of the strategic objectives of the NHS Highland Board wide strategy 'Together We Care' is making sure there is an emphasis on reducing stigma, improving access, and ensuring quality care. Our

We are guided and in alignment with national strategies including Scotland's Mental Health and Wellbeing Strategy and the Core Mental Health Quality Standards to make sure that the right support is always available, in the right place, at the right time, whenever anyone asks for help.

Locally, one of the strategic objectives of the NHS Highland Board wide strategy 'Together We Care' is making sure there is an emphasis on reducing stigma, improving access, and ensuring quality care. Our "Together Stronger" strategy agreed five service commitments that we will action in all service improvements or redesign work:

Strategic Commitments

Commitment 1
Our Services will be easy to find and contact

PRINCIPLES	ACTIONS
Our services should be able to be found by people with no prior knowledge of the system and people should be directed to the service they need by the first person they come into contact with. This is also known as the "no wrong door" principle.	We will provide clear information, enable digital access, and streamline referral processes.

Commitment 2
Our Services will be clear about what you can expect from us and we will be clear about what we expect from you

PRINCIPLES	ACTIONS
The purpose of our services will be made clear from the beginning to all who meet with us. We will explain what the service does, why it exists, how it works and who it is for. We will design our services to support you when you are at risk, and we will do this in a way that encourages positive risk taking and protects both you and our staff at times of crisis.	We will provide clear information, enable digital access, and streamline referral processes.

Strategic Commitments

Commitment 3
Our Services will work together with you

PRINCIPLES	ACTIONS
We will work with individuals to deliver person centred care. We will respect the preferences, values and goals of each individual. We will work with people, using health and social care services, as equal partners in planning, developing and monitoring their care We will work within the principles of Realistic Medicine (in both health and socialcare settings) to ensure you feel empowered to make decisions about you care.	Our health and social care staff will work alongside you to advise and agree the most appropriate therapy or support to meet your needs and support your mental health recovery. We will listen to hear your goals and desires and work together with your networks to create opportunities to achieve your dreams with the support that you need.

Commitment 4
Our Services will enable our Staff to provide safe, high quality care and support

PRINCIPLES	ACTIONS
We will support our colleagues to provide the care and support that individuals need, when they need it, in a way that works for them. We will ensure that our staff can progress a meaningful, enjoyable, and rewarding career.	We will provide specialist training, protected learning and development time, and support career progression for our staff. We will create a Workforce Development plan to support service plans and map our future staffing needs.

Strategic Commitments

Commitment 5
Our Services will evolve in response to changing need and we will explain why decisions are made

PRINCIPLES	ACTIONS
We will respond to changes in strategy, circumstance, and service delivery quickly as our resources allow. This will mean that we need to design and lead services that can transform quickly and efficiently. We will also respond to changes in individuals needs quickly and ensure that any changes are organised and delivered timely and efficiently	Our service will respond to Scotland's Mental Health and Wellbeing Strategy and the Core Mental Health Quality Standards. Following the Coming Home report, we will work in partnership with housing and support providers to ensure that people's needs are met in appropriate environments. We will continue to redesign and evolve our services to meet the Medication Assisted Therapy (MAT) Standards and work alongside partner agencies to ensure that people are able to access the support they require.

We regularly review and evaluate the services we provide by seeking continuous feedback from service users, carers, and partners to help inform service improvements and have established a Strategic Partnership Working Group with all interested stakeholders to ensure continued influence on Mental Health and Learning Disability Service Design.

To meet the strategic intentions of the Scottish Government, NHS Highland and the Health & Social Care Partnership we have designed new services and improved existing pathways.

The model of care for delivery of Annual Health Checks to people with a Learning Disability has been agreed and the service became live mid 2024. People with a Learning Disability and complex healthcare need will be prioritised, and the Health Check will be completed by an Advanced Nurse Practitioner in the Learning Disability Service.

The Dynamic Support Register for individuals with a Learning Disability who are at risk of placement breakdown or of being unable to return from an out of area placement is fully operational. The support from the Community Living Change Fund has enabled one individual, who had been in an out-of-Scotland hospital placement for more than 15 years to return to Highland into his own home with support from a community provider.

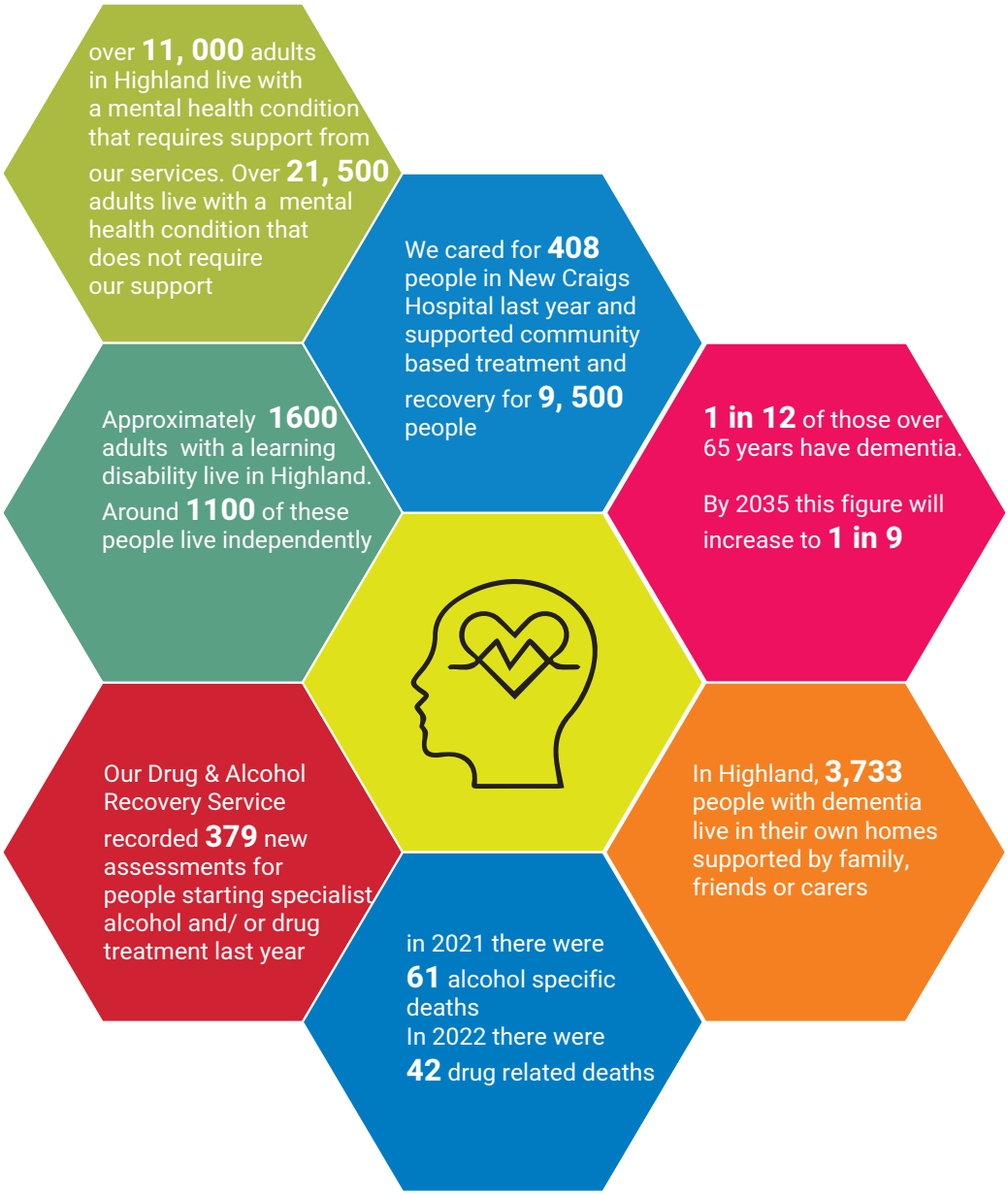
A full review of the Highland Psychiatric Emergency Plan was completed in 2023. This plan is a comprehensive guide designed to manage psychiatric emergencies within the Highland Health and Social Care Partnership. The plan emphasises a collaborative, multi-agency approach to ensure a structured and compassionate approach to ensure high quality care for individuals experiencing mental health crisis. It highlights the importance of collaboration, clear communication and adherence to legal and ethical standards in delivering mental health services.

The Police Custody Healthcare Team identified that 52% of patients in police custody at risk of drug reduced death were not referred to health for support. The Medication Assisted Treatment Pilot at Custody Toolkit (MATPACT) was created as an

innovative approach to proactively identify those at risk and offer health intervention. This innovation has recently won Quality Improvement awards and been recognised by HIS, more information can be found on the HIS website: NHS Highland MATPACT Case Study - NHS Highland MATPACT Case Study (ihub.scot).

We continue to experience capacity and demand pressures within in-patient services in New Craigs. The Mental Health Assessment Unit, in partnership with SAS, now has a Paramedic based within the team enabling joint working and a fast response to Mental Health crisis in community settings. Patients with complex support needs continue to experience a delay in availability of social care support or secure hospital care within Scotland.

NHS Highland Drug and Alcohol Recovery Service (DARS) works in partnership with the Alcohol and Drugs Partnership to meet the Medication Assisted Treatment (MAT) Standards. Treatment Waiting Times shows that Highland continues to perform above the Standard at 94.9% of people seen with three weeks for first treatment. This is the fifth quarter in succession that Highland have remained above the standard of 90% and have exceeded Scotland's overall position for the past four quarters.



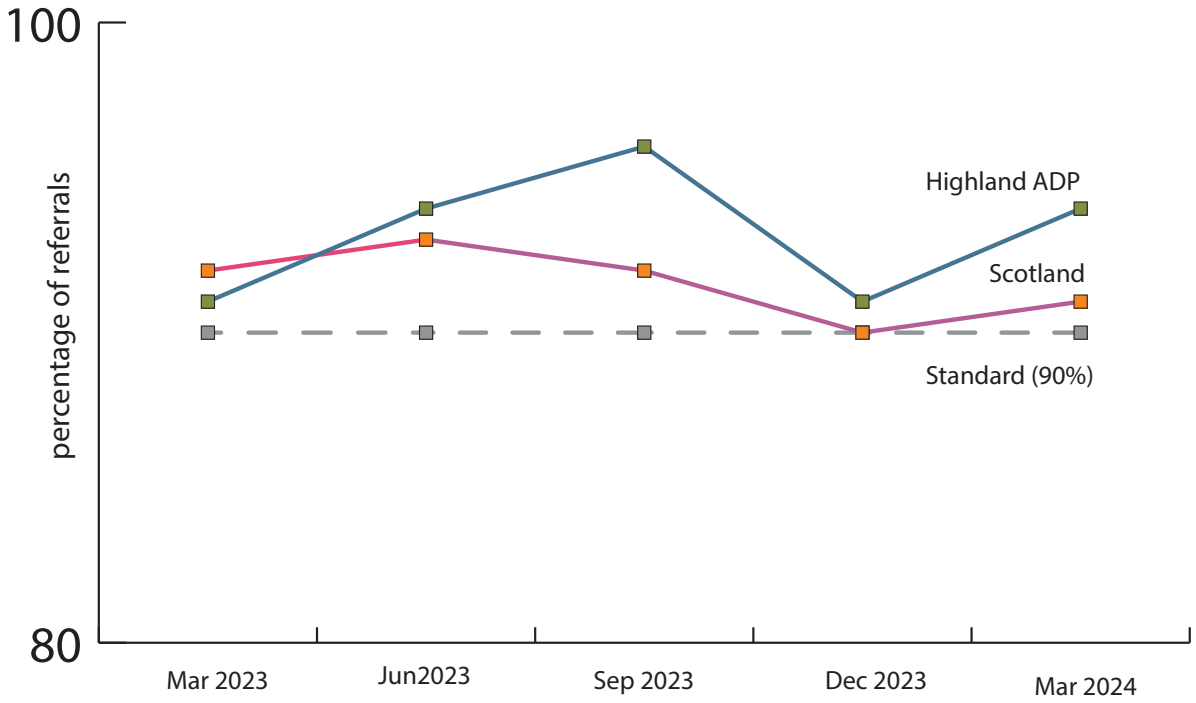


Table 1A Completed waits all Services types from referral to first treatment

Quarter ending	number of waits	% waiting 3 weeks or less	NHS Highland	Scotland	Standard	Scotland
March 2023	230	91.3%	91.0%	92.0%	90%	92.2%
June 2023	218	94.0%	94.0%	93.0%		93.0%
September 2023	234	96.1%	96.0%	92.0%		92.2%
December 2023	204	91.1%	91.0%	90.0%		90.5%
March 2024	138	94.9%	94.0%	91.0%		91.9%

Fig. 1A Completed waits all Services types from referral to first treatment

1. This information relates to community-based services.
2. Information about waiting times for drug and alcohol treatment is provided by the treatment services. Alcohol and Drug Partnerships (ADPs) have the responsibility of ensuring services are submitting accurate and up-to-datep information.
3. These data were extracted from the new Drug and Alcohol InformationSystem (DAISy) and its predecessor the Drug and Alcohol Treatment Waiting Times (DATWT) database. DAISy replaces the previous systems: the DATWT database and the Scottish Drug Misuse Database (SDMD), and holds data in relation to drug and alcohol treatments and waiting times from services throughout Scotland delivering tier 3 and 4 interventions. Tier 3 interventionsinclude provision of community-based specialised drug assessment and coordinated care-planned treatment and drug specialist liaison, while Tier 4interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.
4. For completed waits, the length of wait is calculated from the date the referral was received to the date the first treatment started. For ongoing waits, the length of wait is calculated from the date the referral was received to the
date of the last day of the quarter. In both cases, the length of wait is adjustedfor periods of unavailability.
5. DATWT and DAISy are dynamic databases. This means that data forprevious quarters are updated and so may not be the same as found inprevious publications for the same time period.

Infrastructure & Partnership

Infrastructure Needs

Finance	Achieve financial sustainability and maximize resource use.
Health Inequalities	Focus on reducing health inequalities across communities.
Governance	Refine organizational governance.
Quality Improvement	Foster a culture of continuous improvement.
Climate Change	Work sustainably to meet carbon commitments.
Digital Integration	Implement electronic systems for seamless interaction.
Research & Development	Partner for research opportunities.
Workforce	Motivate and inspire teams to achieve strategic goals.

Partnerships

Collaboration	Work with a wide range of stakeholders, including GP's, third-sector organizations, independent sector providers, and families.
Strategic Partnership Forum	Bring together organizations to develop relationships and practices.

Conclusion

The "Together Stronger" strategy is a comprehensive plan to enhance mental health and learning disability services across Highland. It focuses on compassionate, consistent, and collaborative care, ensuring services are accessible, person-centred, and adaptive to changing needs. Continuous engagement with communities and stakeholders is pivotal in achieving these commitments. For more detailed strategies and guidance, visit the NHS Highland Mental Wellbeing website.

Medication-Assisted Treatment (MAT) Standards Implementation

MAT Standard 1: Same-Day Access
- Actions/Deliverables: Increasing Non-Medical Prescribers (NMPs) within the service.
- Progress: Some Band 6 vacancies filled, with new prescribers expected to complete training by January 2025.
- Risks/Barriers: Persistent vacancies affecting service capacity.
- Remedial Action: Ongoing recruitment and training efforts.
- Timescale: Full implementation by January 31, 2025.

Assessment: **Provisional Green.**

MAT Standard 2: Informed Choice
- Actions/Deliverables: Standardized information leaflets to support informed decision-making.
- Progress: Liaising with specialists to make leaflets available online.
- Risks/Barriers: Outdated resources and limited staff time.
- Remedial Action: Online portal development.
- Timescale: August 31, 2024.

Assessment: **Green**.

MAT Standard 3: Identifying High-Risk Individuals
- Actions/Deliverables: Implementation of a trigger checklist.
- Progress: Strategic lead conducting in-house learning and roll-out work.
- Risks/Barriers: Need for a unified outreach model.
- Remedial Action: Converting social work posts to support outreach.
- Timescale: September 23, 2024.

Assessment: Green.

MAT Standard 4: Evidence-Based Harm Reduction
- Actions/Deliverables: Rollout of harm identification and intervention tools.
- Progress: Forms being shared across different systems.
- Risks/Barriers: Information sharing challenges.
- Remedial Action: Converting forms to a shareable format.
- Timescale: July 5, 2024.

Assessment: Green.

MAT Standard 5: Support to Remain in Treatment
- Actions/Deliverables: Increase third-sector provision.
- Progress: Financial implications raised with oversight groups.
- Risks/Barriers: Funding constraints.
- Remedial Action: Discussions within anticipatory care planning.
- Timescale: August 31, 2024.

Assessment: Green.

MAT Standard 6: Psychologically Informed System
- Actions/Deliverables: Increase capacity for Tier 2 interventions.
- Progress: Transfer of psychological services to NHS Highland psychology.
- Risks/Barriers: Vacancy and tender progress issues.
- Remedial Action: Collaboration with psychology services.
- Timescale: September 30, 2024.

Assessment: Amber.

MAT Standard 7: MAT Shared with Primary Care
- Actions/Deliverables: Specialist GP and homeless team clinic setup.
- Progress: Data gathering on service progress.
- Risks/Barriers: Financial constraints.
- Remedial Action: Specialist pharmacist-led exploration of prescribing models.
- Timescale: July 14, 2024.

Assessment: Amber.

MAT Standard 8: Access to Independent Advocacy
- Actions/Deliverables: Meeting with third-sector agencies.
- Progress: Scheduled meetings to discuss pathways.
- Risks/Barriers: None specified.
- Remedial Action: Continued collaboration.
- Timescale: July 30, 2024.

Assessment: Amber.

MAT Standard 9: Co-occurring Drug Use and Mental Health Care
- Actions/Deliverables: Joint working process with CMHT and DARS.
- Progress: Policy complete; testing ongoing.
- Risks/Barriers: Team size and patient fit issues.
- Remedial Action: Testing and refining policies.
- Timescale: August 28, 2024.

Assessment: Amber.

MAT Standard 10: Trauma-Informed Care
- Actions/Deliverables: Monthly meetings and in-house training rollout.
- Progress: Steering group and supervision models in place.
- Risks/Barriers: Staff training and supervision challenges.
- Remedial Action: Promotion of attendance at training sessions.
- Timescale: July 31, 2024.

Assessment: Amber.

Learning Disability Services

Health Checks

Progress	Advanced Nurse Practitioner employed, prioritizing known individuals.
Risks/Barriers	Insufficient resources to meet demand.
Remedial Action	Prioritization of services.
Assessment	Moderate assurance due to resource limitations.

Support Provision

Progress	Good relationships with support providers; ongoing improvements through meetings.
Risks/Barriers	Recruitment and retention challenges in certain areas.
Remedial Action	Collaborative forums and new models of support.
Assessment	Moderate assurance due to recruitment difficulties.

Complex Needs

Progress	Implementation of the Dynamic Support Register.
Risks/Barriers	Staffing issues in cluster housing developments.
Remedial Action	Monthly meetings and exploring new housing developments.
Assessment	Moderate assurance, with ongoing efforts to address issues.

Overall Service Delivery

Strengths

- Consistent progress in implementing MAT standards.
- Strong collaboration and communication with third-sector agencies.
- Positive relationships between staff and service users.

Challenges

- Recruitment and retention of staff, particularly in rural areas.
- Financial constraints impacting service delivery and development.
- Need for more consistent implementation of psychosocial interventions.

Recommendations

1. Enhance Recruitment Efforts: Address staffing shortages by developing targeted recruitment campaigns and offering competitive incentives.
2. Increase Funding: Secure additional funding to support the expansion of third-sector services and address financial barriers.
3. Strengthen Collaboration: Improve partnerships between primary care, mental health services, and MAT providers to ensure integrated care.
4. Expand Training Programs: Enhance training for staff to deliver psychosocial interventions and trauma-informed care effectively.

Highland Psychiatric Emergency Plan 2023

Introduction

The Highland Psychiatry Emergency Plan (PEP) 2023 is a comprehensive guide designed to manage psychiatric emergencies within the Highland Health and Social Care Partnership (HHSCP). The plan emphasizes a collaborative, multi-agency approach to ensure high-quality care for individuals experiencing mental health crises.

Key Components of the Plan

1. Initial Contact and Response
- First Responders: Standardized contact points for members of the public (NHS 24) and professional partners (Mental Health Assessment Unit - MHAU).
- Self-Referral: Patients can self-refer via NHS 24 with direct access support services available.
- Triage and Support: Stages of triage are performed by NHS 24 and MHAU to address non-diagnosable mental health issues and minimize police intervention.

2. Crisis Care Planning
- Crisis Care Plans: Templates and anticipatory care planning mechanisms like the Care Programme Approach (CPA) are used to identify and respond to crisis situations.
- Legal Powers and Warrants: Clear procedures for obtaining and executing warrants (Sections 35, 292, 293) for patient assessment and removal, emphasizing minimum necessary force.

3. Places of Safety
- Specified Locations: Hospitals (New Craigs, Raigmore, Broadford, Belford, and Caithness General) and emergency departments are designated places of safety.
- Guidelines for Use: Detailed criteria for appropriate use of places of safety and protocols for transferring patients from police custody.

4. Management of Alcohol and Substance Misuse
- Intoxicated Patients: Guidelines for handling patients too intoxicated for assessment and considering underlying distress or mental health issues.

5. Transport Arrangements
- Modes of Transport: Guidelines for choosing appropriate transport modes, reducing stigma, and ensuring patient privacy and comfort during transport.
- Professional Roles: Clear roles and responsibilities for professionals involved in patient transport, including use of force when necessary.

6. Assessment Procedures
- Responsibility for Assessment: Clear pathways and responsibilities for medical practitioners carrying out assessments at places of safety.
- Trauma-Informed Services: Emphasis on trauma-informed care, gender-specific considerations, and services for patients with personality disorders.

7. Dispute Resolution
- Professional Disagreements: Procedures for resolving disagreements between professionals, such as Mental Health Officers (MHO) and Approved Medical Practitioners (AMP), regarding patient detention.

8. Information Sharing
- GDPR Compliance: Pathways for sharing information in compliance with GDPR, emphasizing the duty to share information when necessary for patient safety.
- Advance Statements and Named Persons: Systems to ensure advance statements and named persons are consulted during mental health assessments.

9. Services for Young People
- Age-Appropriate Services: Coordination between adult mental health and CAMHS to provide services for young people up to 18 years.
- Inpatient and Community Services: Regional inpatient facilities and community mental health services for young people, including care for care-experienced young people.

10. Support for Carers
- Duties to Dependents: Responsibilities for ensuring the care of dependents, including children and vulnerable persons, when a patient is detained.
- Carer Support: Provision of support plans and information for carers, ensuring they are not pressured into caring for patients.

11. Management of Missing Patients
- Missing Persons Protocol: Procedures for handling patients who abscond from assessment or are at risk in the community, including use of warrants.

12. Homelessness
- Referral and Aftercare: Pathways for referring homeless patients to mental health services and ensuring appropriate aftercare, including access to GPs and community support.

13. Learning Disability and Autism
- Specialized Support: Consideration for individuals with learning disabilities and autism, ensuring access to emergency services and appropriate assessments.

14. Aftercare
- Follow-Up Arrangements: Guidance on follow-up and alternative pathways for managing distress when immediate treatment is not required.
- Recording Outcomes: Documentation of crisis presentations and outcomes to ensure continuity of care.

15. Use and Review of the PEP
- Values and Review Process: The PEP is grounded in patient-centered values and is reviewed annually, with provisions for earlier reviews if necessary.
- Accessibility and Dissemination: The plan will be made accessible to all relevant parties, including public and partner agencies, with named managers responsible for publication and review.
- Debrief and Incident Review: Procedures for debriefing and reviewing incidents to support frontline staff and improve future responses.

Conclusion

The Highland Psychiatry Emergency Plan 2023 provides a structured and compassionate approach to managing psychiatric emergencies, ensuring safety, dignity, and high-quality care for patients and their

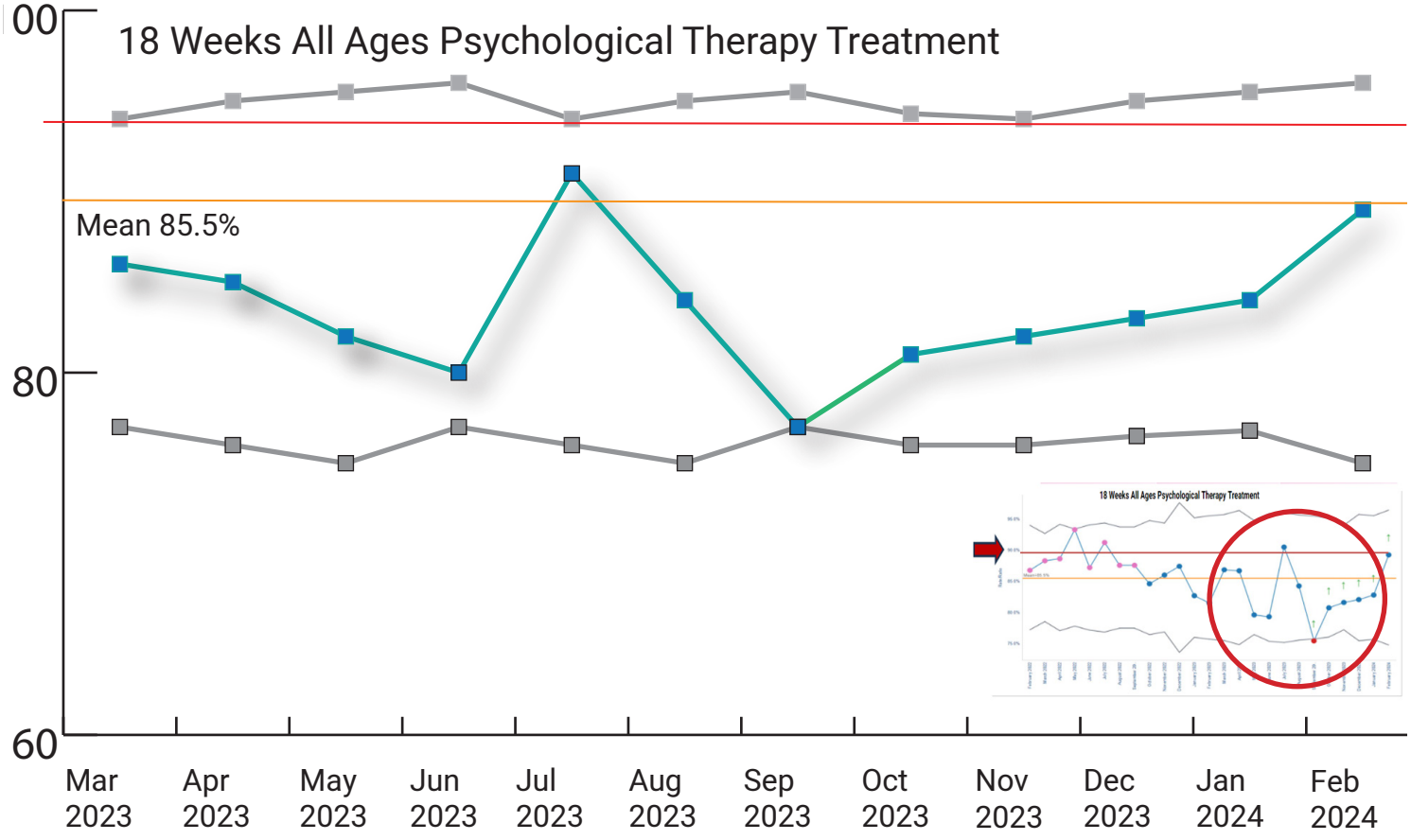
carers. The plan highlights the importance of collaboration, clear communication, and adherence to legal and ethical standards in delivering mental health services.

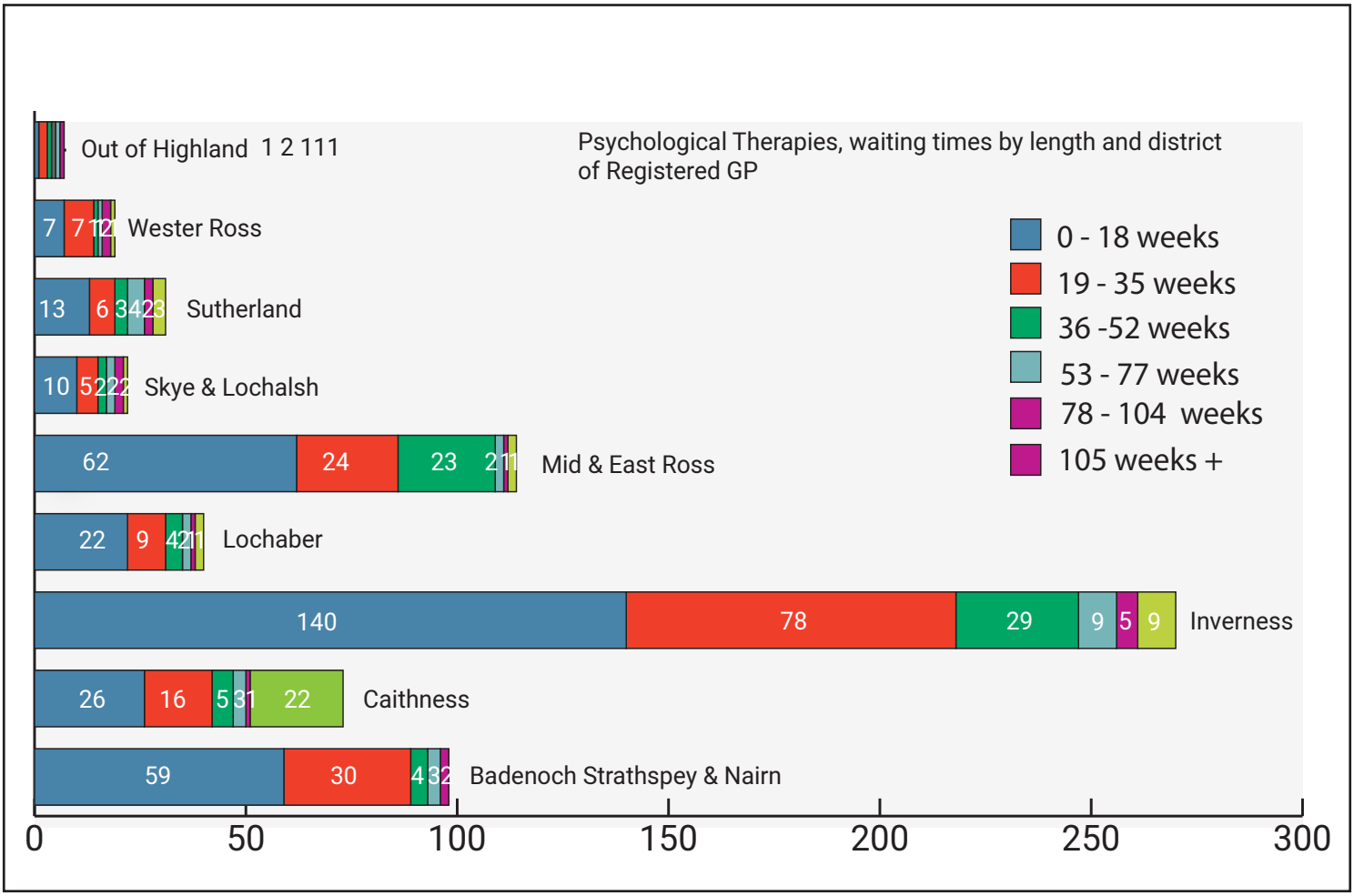
Psychological Therapies

In Scotland, all NHS boards have national Psychological Therapies targets to meet, and NHS Highland is no exception. Although the department has been largely successful in achieving these targets and improvements, the significant challenge has been to do this against a backdrop of unprecedented financial pressure on NHS Highland, attraction, recruitment and retention of specialist staff to the area, and an imperative for the department to utilise resources in a very controlled and measured way.

The first of the targets mentioned above is that 90% of referrals to Psychological Therapies referrals will commence psychological therapy-based treatment within 18 weeks of referral. Psychological therapy services have experienced longstanding challenges with significant waiting times; several factors have led to this (including a lack of any other route for psychological interventions at an earlier stage, as well as recruitment and retention of clinical and non-clinical staff).

However, as can be seen from the diagram below, Psychological Therapies has achieved enormous success in making significant reductions in wait times across Adult Mental Health Psychology, Older Adult Psychology, Neuropsychology, and Adult Learning Disability Psychology. This success is mainly due to utilising the limited resources available to re-align psychology services to offer our patients more timely, improved, and appropriate access to psychological care. Further development of primary care mental health services, targeted use of community resources, and the further collaborative work between Community Mental Health Team colleagues and their Psychological Therapies colleagues have also played a big part in this.



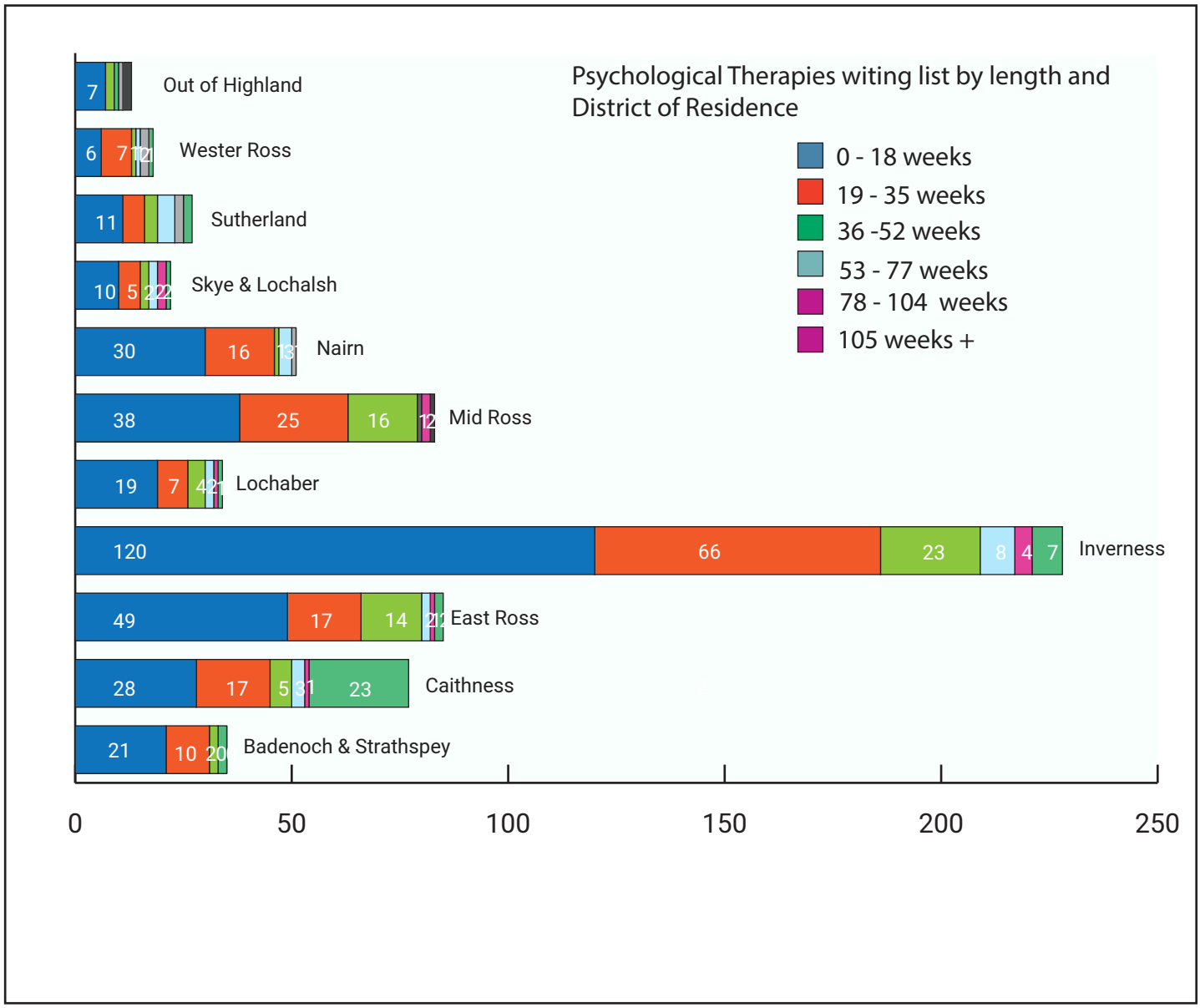


A second new target introduced in late 2023 concerns improvements in the range and depth of data that NHS boards in Scotland supply to the Scottish Government about Psychological Therapies and is called CAPTND (Child, Adolescent, and Psychological Therapies, National Dataset). This involves collecting and disseminating specific (non-clinical) information fields by boards to help the Scottish Government understand more about service trends, patient journeys and outcomes so that good practice can be highlighted and areas for further improvement identified. The target is for all NHS Boards, including NHS Highland, to comply with supplying all the required monthly data to the Scottish Government. During Phase 1 of this project, NHS Highland successfully embraced this data provision and fully complied with the mandatory data requirement. Phase 2 of this national programme's target is to expand the number and range of data fields collected monthly from 2024 onward.

In other work, it was previously identified that there is a service provision gap in Clinical Health Psychology. Work is underway to develop this service to fill this gap, improving patient access and meeting patient needs across NHS Highland. Equally, there has been ongoing success in neuropsychology since its launch, and the service has gone from strength to strength in helping patients in this specialist area. Neuropsychology had formed the majority of Psychological Therapies extended waits, but with a priority focus on wait time reduction, this is now significantly reducing.

Psychological Therapies has, where funding and opportunity have allowed, continued to invest in staff attraction, recruitment, and retention. However, this remains a particular challenge in terms of service provision to meet patient demand. Access to funding for specialist staff recruitment and retention remains scarce, as it does across all of Psychological Therapies.

The data provided in Figure 1 above shows overall improvement, with clear trajectories agreed with the Scottish Government as we progress with our implementation plan.


Psychological Therapies witing list by length and District of Residence
0 - 18 weeks
19 - 35 weeks
36 -52 weeks
53 - 77 weeks
78 - 104 weeks
105 weeks +
Out of Highland
Wester Ross
Sutherland
Skye & Lochalsh
Nairn
Mid Ross
Lochaber
Inverness
East Ross
Caithness
Badenoch & Strathspey
0
50
100
150
200
250

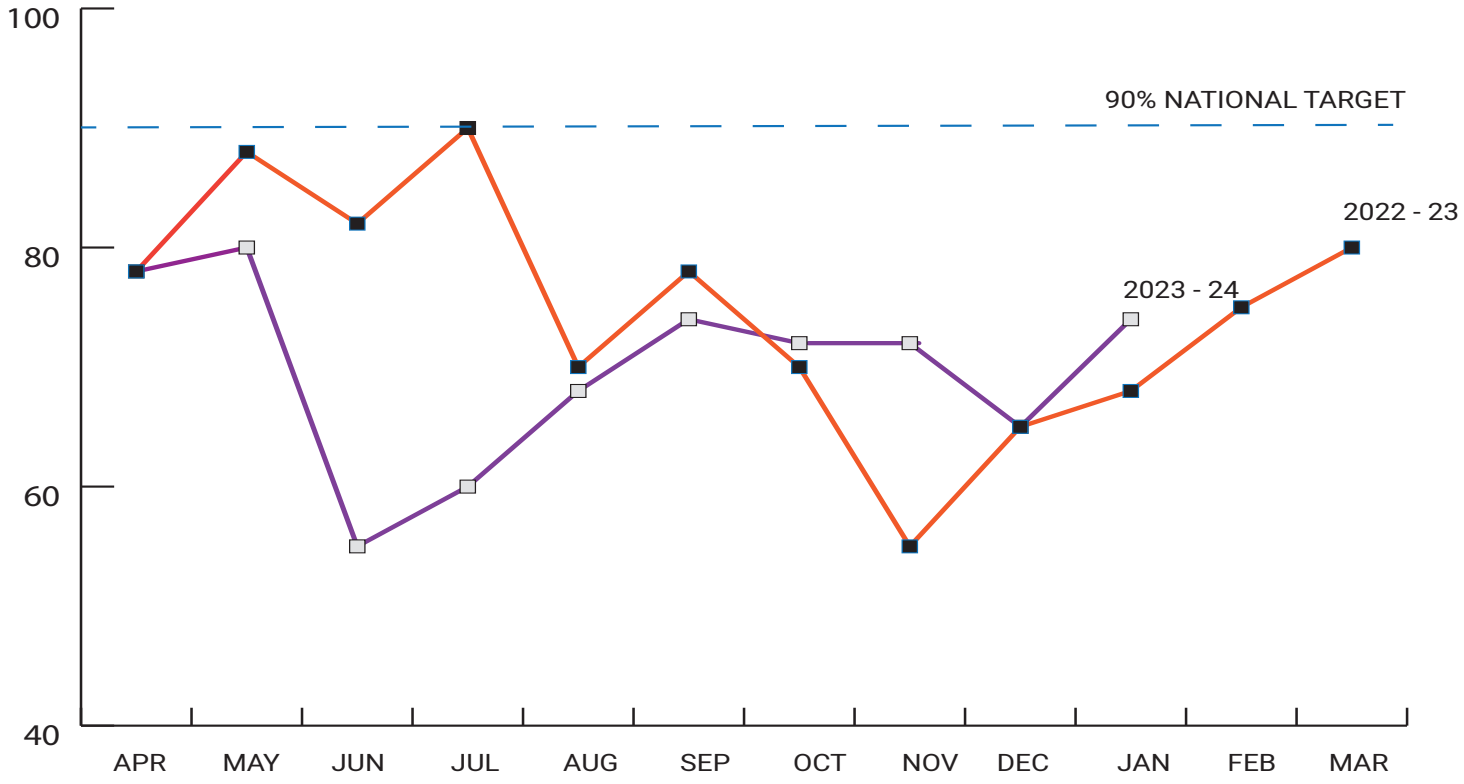
Child & Adolescent Mental Health Services (CAMHS)

The national target for Child and Adolescent Mental Health Services (CAMHS) is that 90% of young people to commence specialist CAMHS services within 18 wks of referral. NHS Highland performance is around 70%

NHS Highland performance in 2023/24 remains extremely challenging in terms of meeting the 18 week target from referral to access to CAMHS services. A service improvement plan is underway to develop a sustainable operating model that will embed a trajectory towards NHS Highland meeting this target. This includes assessment of the workforce model required to deliver these services across the vast geographical area.

We are aware that NHS Highland performance is below the national target and waits to access the Paediatric Neurodevelopmental service (NDAS) have followed a similar trajectory.

A joint improvement plan is required to enable different models of care that support an improvement in performance. This is a key area of focus for 2024/25.



Finance

Highland Health & Social Care Partnership Finance Report to 31st March 2024

Final position to March 2024

For the 12 months to March, HHSCP have overspent against budget by £10.634m, components of this overspend can be viewed in Table 1 below.

		Position to date		
Annual Plan £000	detail	**plan to date £ 000**	**actual to date £ 000**	**variance to date £ 000**
254, 114	NH Communities	254, 114	262, 988	(8, 874)
51, 864	Mental Health Services	51, 864	58, 163	(6, 299)
155, 000	Primary Care	155, 000	156, 926	(1, 926)
(773)	Adult Social Care Central	(773)	(7, 238)	6, 465
460, 205	**Total HHSCP**	**460, 205**	**470, 839**	**(10, 634)**
281, 717	Health	281, 717	292, 540	(10, 823)
178, 488	Social Work	178, 488	178, 299	188
460, 205	**Total HHSCP**	**460, 205**	**470, 839**	**(10, 634)**

Within the NH Communities year end out-turn of £8.874m, there are several main areas driving this position; £0.615m of unfunded pressures in Chronic Pain and the ECS services and supplementary staffing in OOH and community hospitals reflecting the recruitment issues rural areas are experiencing. Adult Social Care for 2023/2024 saw an increase in Independent Sector Care costs, with Learning Disability younger adult packages being the main attribute.

Mental Health Services ended the year with a £6.299m overspend; with locum and agency usage the main outliers along with out of area patient costs. National recruitment difficulties within the Psychiatry service meant a greater reliance on the use of medical locums with £2.468m agency expenditure in the financial year. Increase in clinical observations in both the Dementia and LD units have resulted in nursing agency costs of £3.001m. However, ongoing vacancies across both inpatient and community services have mitigated this pressure.

Primary Care's year end out-turn showed an overspend of £1.926m. A key driver being locum spend associated with Board Managed Practices mainly in the rural areas and prescribing where short supply and inflation increased costs nationally with the HHSCP overspending by £3.041m in 2023/2024. Mitigating this position, Dental reported an underspend of £1.274m which reflects the ongoing recruitment difficulties within the service.

ASC Central are reporting a £6.465m underspend. This position allows ASC to balance overall across the HHSCP and can be viewed on appendix 1.

Cost Improvement Plan
NHS Highland identified a Cost Improvement Plan of £29.500m to deliver a balanced position at the start of the year, of which £11.011m was allocated to the HHSCP. Whilst there was delivery of savings and cost reductions of £3.836m from the Division, additional support from the SG at the end of the year was required to deliver a breakeven position for the Board overall.

Conclusion
HHSCP financial position completed the year end with an overspend of £10.634m. This position reflects the challenge of the service pressures and slippage on 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 deliverance 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.

NHS Highland
Appendix 2
Adult Social Care Financial Statement at Month 12 2023 - 2024

services cagtegory	annual budget £ 000's	YTD budget £ 000's	TYD actual £000's	YTD variance £ 000's	Outturn £ 000's	YE variance £ 000's
Older people Residential/ Non-Residential Care						
older people Care Homes (in-house)	20, 047	20, 047	18, 783	1, 264	18, 763	1, 264
older people Care Homes (ISC/SDS)	35, 447	35, 447	35, 629	(182)	35, 629	(182)
Other non-residential care (in house)	1, 419	1, 419	1, 506	(87)	1, 506	(87)
Other non-residential care (ISC)	1, 445	1, 445	1, 457	(12)	1, 457	(12)
Total older people Residential/ Non-Residential	**58, 359**	**58, 359**	**57, 375**	**984**	**57, 375**	**984**
Older people Care at Home						
older people Care at Home (in-house)	17, 907	17, 907	16, 488	1,419	16, 488	1, 418
older people Care at Home (ISC/SDS)	16, 767	16, 767	20, 354	(3, 587)	20, 354	(3, 587)
Total older people Care at Home	**34, 674**	**34, 674**	**36, 843**	**(2, 168)**	**36, 843**	**(2, 169)**
People with a Learning Disability						
People with a Learning Disability (in-house)	5, 087	5, 087	4, 116	962	4, 116	962
People with a Learning Disability (ISC/SDS)	36, 699	36, 699	41, 330	(4, 631)	41, 330	(4, 631)
Total People with a Learning Disability	**41, 778**	**41, 778**	**45, 446**	**(3,668)**	**45, 446**	**(3, 668)**
People with a mental illness						
People with a mental illness (in-house)	575	575	461	115	461	115
People with a mental illness (ISC/SDS))	7, 701	7,701	7, 913	(212)	7, 913	(212)
Total People with a mental illness	**8, 276**	**8, 276**	**8, 373**	**(97)**	**8, 373**	**(97)**
People with a Physical Disability						
People with a Physical Disability (in-house)	1, 036	1, 036	822	214	822	214
People with a Physical Disability (ISC/SDS)	7, 298	7, 298	7, 827	(529)	7, 827	(529)
Total people with a Physical Disability	**8, 334**	**8, 334**	**8, 650**	**(316)**	**8, 650**	**(316)**

services cagtegory	annual budget £ 000's	YTD budget £ 000's	TYD actual £000's	YTD variance £ 000's	Outturn £ 000's	YE variance £ 000's
Other Community Care						
Community Care Teams	9, 882	9, 882	9, 544	338	9, 544	338
People misusing drugs & alcohol	0	0	0	0	0	0
People misusing drugs & alcohol (ISC)	105	105	140	(35)	140	(35)
Housing Support	5, 839	5, 839	6, 087	(248)	6, 087	(248)
Technology Enabled Care	987	987	1, 012	(25)	1, 012	(25)
Carer's Support	1, 628	1, 628	1, 465	163	1, 465	163
Total other Community Care	**18, 441**	**18, 441**	**18, 247**	**194**	**18, 247**	**194**
Support Services						
Business Support	2, 095	2, 095	1,799	296	1, 799	296
Management & Planning	7, 055	7, 055	2, 934	4, 121	2, 934	4, 121
Total Support Services	**9, 150**	**9, 150**	**4, 733**	**4, 417**	**4, 733**	**4, 417**
Care Home Support/ Sustainability payments	**0**	**0**	**(655)**	**655**	**(655)**	**655**
Total Adult Social Care Services	**179, 011**	**179, 011**	**179, 011**	**0**	**179, 011**	**(0)**
check	**0**	**0**	**0**	**0**	**0**	**(0)**
ASC Services now integrated within Health codes	**4, 193**	**4, 193**	**4, 193**	**0**	**4, 193**	**0**
Total Integrated Adult Social Care Services	**183, 204**	**183, 204**	**183, 203**	**0**	**183, 204**	**(0)**
Total ASC less Estates	**178, 488**	**178, 488**	**178, 299**	**189**	**178, 299**	**188**

Document Information

This document is produced on behalf of NHS Highland and The Highland Council by Strategy & Transformation, NHS Highland.

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FINAL DRAFT 21.08.2024

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**04 September 2024**
Title:	**Chief Officer Assurance Report**
Responsible Executive/Non-Executive:	**Pamela Cremin, Chief Officer**
Report Author:	**Pamela Cremin, Chief Officer**

1. Purpose

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

2. Service Redesign

A meeting of the Sir Lewis Ritchie Steering Group took place on 28th August to articulate progress against the 15 Recommendations and agree future communication and engagement and co production of service redesign and delivery. The meeting was attended by members of Skye SOS, NHS 24, Scottish Ambulance Service and Local Councillors. The next meeting will focus on the Joint Strategic Plan and its implementation and engagement with Skye Localsh and West Ross citizens via the District Planning Group Process – the second meeting of the District Planning Group will take place on 12 September. The urgent care model has been further developed and put in place and commenced on 16th August which is endorsed by Sir Lewis Ritchie and the Scottish Government. Good outcomes were reported about the co produced workforce recruitment and sustainability solutions.

3. National Focus on Discharge Without Delay

Weekly engagement and oversight by the national Collaborative Response and Assurance Group (CRAG) continues at pace, chaired by the Cabinet Secretary for NHS Recovery, Health and Social Care to take forward intensive, focussed activity with the aim to achieve material and sustained reduction in people in delay to discharge.

Each integration authority is required to reduce people in delay to at least 34.6 delays per 100,000 population ahead of the winter period and anticipated winter pressures. This will be challenging for Highland to achieve with a steady position of 100 delays per 100,000 population over the summer months.

A refocussed structure for the delivery of urgent and unscheduled care across health and social care services has been developed and articulated in a 90 Day improvement plan. This

plan articulates action required to reduce people in delay in hospital by 30% by the end of October 2024, ahead of the winter period.

As part of CRAG there is national learning, shared improvement work and bespoke support to integration authorities to support improvement and reduce delay.
The Permanent Secretary for Scottish Government visited Highland on 17th July and met with NSH Highland and The Highland Council representatives to hear directly how we are approaching our improvement plan to reduce people in delay.

In addition the Minister for Social Care, Mental Wellbeing and Sport continues to meet with Highland monthly to seek assurance of action plans to achieve sustained improvement. The most recent meeting was held on Monday 26th August 2024.

There is also the ongoing NHS Highland Performance and Improvement Bi-monthly Call led by Scottish Government which undertakes review of progress against Urgent and Unscheduled Work Streams and Centre for Sustainable Delivery Priorities.

The 90 Day Improvement Plan is summarised on one page, as shown below.

FINAL – 90 Day Plan on a Page - Urgent & Unscheduled Care (August – October 2024)

AMBITION – IN PARTNERSHIP

Create value by working collaboratively to transform the way we deliver health and care

STRATEGIC OUTCOMES

Care Well	Respond Well
Work together with health and social care partners by delivering care and support that puts our population, families and carers experience at its heart	Ensure that our services are responsive to our populations needs by adopting a "home is best" approach

PLANNING FOR SUCCESS - STRATEGIC TARGETS

Reduce standard DDs by 30% by end October 2024	Increase A&E attendances complete within 4 hours by 5% by end October 2024	Reduce A&E attendances lasting more than 12 hours by 5% by end October 2024	Reduce the time spent in A&E for people admitted to hospital - day time and overnight by 5% by end October 2024	Reduce LOS for delayed and non-delayed people by 5% by end October 2024	Increase the amount of people discharged on their PDD date	Reduce Social Care waiting lists and C@H unmet needs hours	Decrease numbers of times OPEL status is at levels 4/5	Reduce inappropriate occupancy fo our population

Area	What do we want to do?	What priority 1 actions will we take?	How will we know we have achieved?
Respond	Respond quickly to support our population across our system who are vulnerable or in crisis	•Implement sector agreed proposals to stabilise provision and increase C@H capacity •Ensure consistent application of standard work for AWI •Develop community urgent response to crisis from ED •Maximise capacity of In reach social work team to Raigmore •Risk overview of all care homes and business continuity plan including closed beds and opportunities for cost benefit analysi s	1.Reduced delayed discharges 2.Equitable access to hours of care at home 3.Increased flow of assessment 4.Reduction in <1 day admissions
Rapid	Facilitate rapid discharge and support to embed the "home is best" approach	•Implement PDD improvement and compliance plan •Review length of stay for all non delayed discharges. Targeted conditions •Whole system OPEL •Community hospital specification and agreed pathways •TEC solutions to enable social care assessment at home •Pre-noon discharge plan	1.PDD compliant discharges 2.Reduction in length of stay to peers 3.Increased flow through community hospitals 4.Reduced black status
Reduce	Reduce occupancy and avoidable admissions and identify at risk population by working collaboratively	•Hospital at Home Framework •Implement frailty standards and pathway •Root cause analysis of ED performance •Review all MIU pathways •Review higher volume medical admission pathways	1.Hospital at Home Framework 2.Reduced admissions in >65 years 3.Increased ED performance 4.Increased hospital at home activity
Redirect	Redirect inappropriate attendance to suitable services so emergencies are seen quickly	•Scope opportunity to develop our Community Urgent Care Response •Choice guidance utilisation monitoring •Research current impact and causes of inappropriate attendances at A&E and develop a campaign to reduce them. •Pilot a campaign to increase use of Pharmacy First	1.FNC utilisation 2.Call before you convey 3.Choice guidance applications

The Cabinet Secretary for NHS Recovery, Health and Social Care met with Highland again on Tuesday 27th August 2024 to seek assurance against the improvement plan and to seek areas where bespoke support solutions could assist.

4. Winter Plan 2024/25

Through iterations of winter plans and the development of the UUSC 90 Day Improvement Plan, workstreams to address winter pressures will be stood up in line with the 4 areas an prioritised for action accordingly.

5. Joint Monitoring Committee

A development session for the Joint Monitoring Committee was held on Thursday 22nd August to focus on further progress of the 11 outcomes from the previous development session, agenda planning and development session dates and topics.

The next meeting of the Joint Monitoring Committee will be held on 25th September 2024.

6. Enhanced Services

9 new contracts for Enhanced Services have been developed and agreed by NHS Highland and Highland LMC. These are currently in a position of offer with a date next week for response after which a procurement process will be undertaken.

7. Care Homes - Making a Difference Listening and Learning Collaboration Event

This event was held on Friday 23 August 2024 in person and provided a valued opportunity to for NHS Highland, The Highland Council and the care home sector to come together and collaborate on current service delivery and challenges and outline future focus on capacity, strategic direction and our collective desire to improve and develop our relationship and sector collaboration going forward.

A report from the event is being pulled together to look at the immediate and next steps to be agreed and taken forward and to build on the outputs from the event.

8. National Care Service

On 24th June 2024, the Minister for Social Care provided further information on the Bill, which is currently at Stage 2 of its journey through the Scottish Parliament.

The Minister sent draft Stage 2 amendments and other related documents as an update for Stage 2 of the Bill. Full details in relation to those documents which provide significant levels of detail can be found in this link - the Scottish Parliament website.

There is a consultation in relation to those Stage 2 amendments and the consultation was first intended to close on 30 August 2024 but that time scale has now been extended until 20 September 2024. Both the NHS Highland and The Highland Council have provided a response that ensures that the consultation takes into account the unique Lead Agency arrangements currently in place in Highland. CoSLA and other relevant national bodies including Social Work Scotland are also engaging with the Scottish Government in terms of implementation plans.

NHS Highland Board held a development session about the National Care Service and its implementation on Tuesday 27th August.

A National Care Service Fact Sheet is attached to this report.

The Health and Social Care Committee may wish to consider a more detailed paper or hold a development session on the proposed arrangements for the NCS amendments and any implications for health and social care delivery going forward.

Scottish Government
Riaghaltas na h-Alba

National Care Service

Factsheet

July 2024

Contents

Contents

About the NCS

Information included in the factsheet is correct at the time of publishing.

The Scottish Government is working with people and organisations across the country. Our aim is to improve community health, social work and social care support in Scotland.

We want everyone to have access to consistent, high-quality services wherever they live, and whenever they need them.

That's why we are introducing the National Care Service (NCS). We are shaping the NCS with organisations and people who have experience of accessing and delivering these services.

NCS principles

The NCS will be founded on a set of core principles.

These are to:

- embed human rights in social care and social work support
- increase equality and enable people and communities to thrive
- ensure that the NCS is an exemplar of Fair Work practices
- co-design services with people with experience of accessing and delivering them
- make sure that we recognise and value the care workforce and unpaid carers

What is the NCS?

NCS principles cont.

- improve outcomes through prevention and early intervention
- continuously improve services to promote equality, non-discrimination and individual dignity
- provide financially sustainable care, giving security and stability to people and their carers
- make sure that the NCS communicates with people in an inclusive way

NCS services

The NCS will make collaboration and information sharing between these services easier:

- social work services provided by local authorities
- social care services provided by local authorities, the NHS, and private and third sector organisations who receive public funding through contracts or grants
- support, including breaks, for unpaid carers
- community health services

About the NCS

Digital, data and information sharing

The NCS, NHS, Scottish Government and Local Government will continue to improve public and workforce access to information. They will be an authoritative source for:

- information, advice and guidance about available community health, social work and social care support services
- collation, analysis and publication of data about social care provision
- public sector data about people, their needs, and their care
- guidance on good planning and delivery of care

Governance, oversight and standards

The NCS will strengthen governance, provision and quality of service across Scotland. It will do this by providing a consistent approach to:

- national and local management and governance arrangements – involving people with experience of accessing and delivering community health, social work and social care support
- oversight and delivery of national outcomes and standards
- national change and improvement programmes to improve aspects of social care
- a national support and improvement framework to make sure local areas meet standards

About the NCS

Rights, complaints and advocacy

The NCS will aim to make sure everyone accessing community health, social work and social care support services in Scotland knows their rights. It will also aim to make them aware that there are clear routes to upholding these rights when they are not met.

People with experience of accessing and delivering community health, social work and social care support are co-designing relevant areas. These include:

- the NCS Charter to help people understand and claim their rights
- an NCS complaints service to help people access complaints processes if their rights are not met
- enhancing independent advocacy provision for those who need help to access the support they are eligible for

About the NCS

Accessing the NCS

Access to the NCS will depend on how someone first realises they need support.

That might include:

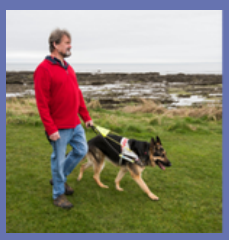
- an accident, illness, disability or health condition
- preparing to leave hospital and needing help to return home
- contacting the local authority to seek help
- moving into residential care
- referral from a GP or other medical professional
- experiencing risk that requires support to reduce or avoid harm
- moving from children's services into adult services
- engaging with children and young people's services
- engaging with the prison systems
- moving between local authority areas
- starting to receive a disability or carer's benefit

Why we need an NCS

People with experience of accessing or delivering community health, social work and social care support have told us the system must change. We have heard that we must tackle the unwarranted variation of care across the country and drive up quality.

The creation of the NCS offers opportunities to focus on the population's health and wellbeing. The goal is to have a positive impact on life expectancy and on quality of life.

To achieve this, our health, social work and social care systems must work together. They must support everyone to live as independently as possible, whatever their needs and wherever they live.







Why we need an NCS

Current challenges

The data shows us that the relationships between health and social care issues are often very complex. Many people need to access and transition between services from across the health and social care spectrum. This can often include several services at the same time.

This highlights the need for people to be able to access services when and where they need them.

Demographics

The latest data on people receiving social care and social work support tells us that in 2021 to 2022:

- around 238,000 people received social care support in Scotland – 4% of the population
- around 58,000 (26% of records submitted) were under the age of 65
- around 75,000 people receiving social care or social work support had a physical or sensory disability
- around 22,000 had a learning disability
- around 16,000 people were receiving social care support due to mental health issues
- people can be receiving support for several reasons – for example, substance misuse, neurological conditions, dementia, palliative care or other reasons

Why we need an NCS

Care at home and residential care

The latest data on people receiving care at home shows that 89,620 people in Scotland received care at home in 2022 to 2023.

Based on the latest care home census, 34,365 people (aged 18+) were residing in a care home. People residing in a care home tend to be older, with around 90% of residents aged 65+ and nearly 50% aged 85+.

Unpaid care

There are around 839,000 people (19%) aged 18 and over providing unpaid care support across Scotland. This figure comes from the 2020 Scottish Health Survey telephone survey results. The 2022 update to the Scotland's Carers report also estimated there are around 30,000 unpaid young carers aged 4 to 17 in the country.

What is new and different about the NCS

Each year, thousands of people access and deliver community health, social work and social care support services. The NCS will aim to provide greater consistency across different services and locations in Scotland.

Greater consistency across the country

The NCS will ensure there is flexibility to address local needs and circumstances. But it will also aim to ensure the same high quality of service is available wherever people live by:

- creating a NCS Board to oversee the planning and delivery of services, in line with national standards and guidance
- aligning the national standards and guidance that apply to community health, social work and social care support

What is new and different about the NCS

Improved information sharing and integration

The NCS will aim to smooth transitions between services and geographical locations. It will empower people by giving them easier access to information.

To do this it will:

- enhance the local arrangements for planning and delivering services between different bodies – for example local authorities, the NHS and the third sector
- develop an Integrated Health and Social Care Record to make people's information more accessible to them and to staff who support them

A voice for people who access and deliver care

The NCS will give people with experience of accessing and delivering community health, social work and social care support more control by:

- involving people with experience of services at every level of planning
- helping people to access complaints pathways and remedies if their rights are not met
- providing coherent information and guidance
- enhancing independent advocacy provision

What is new and different about the NCS

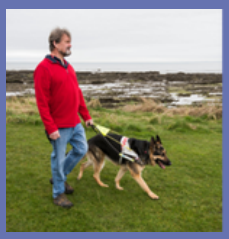
A new National Social Work Agency

We will create a new National Social Work Agency (NSWA) as part of the NCS.

NSWA will be a single national body created through partnership working. It will work with agencies and social workers to lead the social work profession. It will aim to ensure a skilled, supported and sustainable workforce across Scotland.

NSWA will provide national leadership and oversight of:

- social work education
- improvement and implementation support for local areas
- workforce planning
- social work training and development







How the NCS will be organised

Two structures will be very important in the NCS.

One will be the NCS Board, which will operate at a national level. The other will be NCS Local Boards, with responsibility at local level.

NCS Board

The NCS Board will:

- provide national oversight and governance of community health, social work and social care support services
- ensure these services are consistent, fair, and rights-based
- support communities to maximise the benefits of reformed local delivery of services

The Board will have oversight of standards, guidance, and performance metrics. These will include an agreed support and improvement framework. If services do not meet standards, the framework will support NCS Local Boards to improve.

The Board will include representatives of the Scottish Government, local government and the NHS. It will also include people with experience of accessing services, unpaid carers and the workforce. Further detail relating to the membership will be co-designed. This will include exploring topics such as the support board members would need to make sure they can all take part on equal terms.

How the NCS will be organised

NCS Local Boards

Current local organisations, known as integration authorities, will continue to plan and commission community health, social work and social care support services. These organisations will be renamed to NCS Local Boards and will be reformed to improve how they function.

Local government, NHS and other local providers will continue to deliver services. However, the way they operate will be directed by the NCS Local Board and guided nationally by the NCS Board. This will ensure all services follow a consistent human rights-based approach.

NCS Local Boards will continue to work with all organisations providing services in the area. Simpler governance processes will help people understand decisions about local services.

Right now, local integration authorities receive funding through local government and the NHS. We will keep this funding route in place. But we are also exploring giving Scottish Ministers the ability to directly fund NCS Local Boards for specific reasons.

How the NCS will be organised

Co-design and NCS Local Boards

NCS Local Boards will plan services with the people who receive and deliver them. People with experience of accessing or delivering services will sit on NCS Local Boards. They will have voting rights and receive support and training for their roles.

Engagement within local areas will be strengthened and communities will have the opportunity to say how services should be designed.

NCS Local Boards will continue to carry out long-term planning. They will identify the best use of resources to meet future needs within their area. People with experience of accessing or delivering community health, social work and social care support services will be given a more prominent role in co-designing this vision.

This planning will be overseen and supported by the NCS Board. This will ensure plans are consistent with the NCS principles. We want everyone in Scotland to receive the same standard of care, wherever they live.

What the NCS will cost

The most recent financial year that we have full figures for spending on social care in Scotland is 2022 to 2023. In that year, £5.75 billion was spent on social care. This figure includes money spent on providing social care to support older people and disabled people to live well in their communities. It also includes money spent on services for children and families to access essential care and support.

There will be some costs in future years to make the NCS a reality. We expect these to come to around £345 million over the 10 years from 2022 to 2032. This money will provide for a National Board, National Social Work Agency and the NCS Local Boards. This will ensure we deliver a National Care Service that improves quality, fairness and consistency of social care provision across the country.

Benefits of investing in the NCS

We must improve the experience of people who receive care. Improving national standards and ensuring access to complaints processes is key to this. Supporting unpaid carers to protect their health and wellbeing is also important. This includes young carers.

The NCS will help drive improvements in these areas. The NCS has the potential to lead to large benefits for people who access or deliver community health, social work or social care support. This includes unpaid carers.

How the NCS will affect the workforce

According to the Scottish Social Service Sector: Report on 2022 Workforce Data, over 200,000 people work in the social service sector. They work for a wide range of organisations and carry out a wide range of jobs.

The NCS will improve conditions by:

- ensuring that the work all those people do across Scotland is planned and delivered consistently to meet people's needs
- drawing on the experience of the workforce in its design
- including workforce representation on the NCS Board
- exploring developing a Workforce Charter which supports a workforce who feel engaged, supported and valued

How the NCS will reflect people's experience

We will co-design national parts of the NCS with people who access and deliver community health, social work and social care support.

This will include a Charter explaining people's rights. It will also include accessible pathways to complaints and remedies if rights are not met. It will also include an electronic integrated social care and health record.

During the co-design of the NCS we will speak to people from across Scotland. Over the last year alone we have already engaged over 1,000 people in co-design activities. This work will continue.

Co-design brings people with different life experiences and views together. It promotes understanding and can help people reach a consensus.

Our co-design work includes people such as:

- people who access services that will fall under the NCS
- their family and support network
- unpaid carers
- the workforce
- organisations and people who deliver services that will fall under the NCS
- people who have accessed or delivered these services in the past
- third sector organisations

How the NCS will reflect people's experience

How we will use the findings from co-design

Co-design brings people who are affected by decisions into the decision-making process. Our co-design work is already having an influence on the way we're designing the NCS. Our Workforce Charter is one example of how this works in practice.

Co-designing the Workforce Charter

The Scottish Government ran a series of co-design sessions over November and December 2023 to help develop a Workforce Charter. These sessions included Scottish Government staff, professional advisors and members of the workforce. To recruit for these sessions we used our Lived Experience Experts Panel (LEEP). We also selected organisations directly.

The goal of the sessions was to understand the need and purpose of a Workforce Charter and to gain feedback on a draft. We are now developing a Workforce Charter draft and sense checking it against the findings from these sessions.

What's next for the NCS

The NCS Bill Stage 1 debate took place on Thursday 29 February 2024. The Parliament voted for the Bill to pass Stage 1.

Changes to the Bill at Stage 2

The Scottish Government will continue to work with stakeholders to develop proposals for the NCS. These stakeholders include people with experience of accessing and delivering social care support. We will also consider any changes that may be needed to the Bill at Stage 2.

We set up an Expert Legislative Advisory Group with stakeholders who had a strong interest in the NCS Bill which ran from April to June 2024. The purpose of the group was to discuss the Bill and its draft amendments before the draft amendments were shared with the Health, Social Care and Sport Committee in June 2024. The group added to, rather than replaced, our current stakeholder engagement structure.

We are committed to continuing our work to reach consensus with stakeholders following their feedback on the Bill. This will keep those who receive and deliver social care, social work and community health support at the forefront of our work. This will ensure that the NCS creates greater transparency in the delivery of community health and social care, improves standards, strengthens the role of the workforce and provides better support for unpaid carers.

Contact

If you require any further information please contact NationalCareService@gov.scot

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
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Edinburgh
EH1 3DG

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