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 28 June 2023 with attendance as noted below.
- **Note** the Assurance Report and agreed actions resulting from the review of the specific topics detailed below.

Present:
Philip Macrae, Non-Executive, Committee Vice Chair (in the Chair)
Tim Allison, Director of Public Health (until 3pm)
Ann Clark, Board Non-Executive Director and Vice Chair of NHSH
Cllr, Muriel Cockburn, Board Non-Executive Director
Claire Copeland, Deputy Medical Director
Pam Cremin, Interim Chief Officer
Kate Dumigan, Staffside Representative
Cllr, David Fraser, Highland Council (until 3pm)
Cllr, Ron Gunn, Highland Council
Joanne McCoy, Board Non-Executive Director
Kara McNaught, Area Clinical Forum Representative
Gerry O'Brien
Kaye Oliver, Staffside Representative
Michelle Stevenson, Public/Patient Representative
Simon Steer, Director of Adult Social Care
Neil Wright, Lead Doctor (GP)

In Attendance:
James Bain, Transaction & Income Manager, Adult Social Care
Sarah Bower, Healthcare Improvement Scotland
Rhiannon Boydell, Head of Strategy and Transformation
Louise Bussell, Nurse Director
Sarah Compton Bishop, NHS Highland Board Chair
Stephen Chase, Committee Administrator
Fiona Duncan, Chief Social Worker, Highland Council
Gillian Grant, Head of Commissioning
Arlene Johnstone, Head of Service, Health and Social Care
Donellen Mackenzie, Depute Director Adult Social Care
Nathan Ware, Governance and Assurance Co-ordinator

Apologies:
Simon Steer, Catriona Sinclair, Cllr Chris Birt, Cllr David Fraser, Mhairi Wylie, Fiona Malcolm.

1 WELCOME AND DECLARATIONS OF INTEREST

The meeting began at the later time of 2pm and was introduced by the P Macrae who noted that he would chair the meeting at the request of G O'Brien, who would return in full to committee duties following the present meeting.

The meeting opened at 2pm, 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.

1.2 DECLARATIONS OF INTEREST

There were none.

1.3 Assurance Report from Meeting held on 26 April 2023

The draft minute from the meeting of the Committee held on 26 April 2023 was approved by the Committee as an accurate record pending the following amendment:

- K Oliver noted a correction regarding her recorded job role.
- Item 3.5: clarify the agreed level of assurance.

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

1.4 Matters Arising From Last Meeting

- M Stevenson read a letter from former member Michael Simpson to the Committee:
  The letter noted that a promised meeting to discuss the North Coast Redesign with the Chief Officer and colleagues had not taken place and expressed disappointment with the lack of engagement with him on this issue. He also noted that he had not received a promised official letter acknowledging these services.
  The Chair expressed regret that the meetings had not taken place and that this had been due to work pressures. It was clarified on the latter point that a letter from the regular Chair had been posted but had not been received.

- G O'Brien noted that he had met with the Chairs of the Clinical Governance Committee and the Audit Committee in relation to care, governance and that he and the Chief Officer would discuss this further to bring a proposal having determined the appropriate governance route, to the Board. A further update would come to the next meeting.

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

2 FINANCE

2.1 Year to Date Financial Position 2022/2023

The Chair gave apologies to the Committee that a report had not been available due to illness, noting that this was especially unfortunate as no update had been provided to the previous meeting.

- A Clark suggested that, though there may be extenuating circumstances, this was a significant matter which should be mentioned in the Committee's update to the Board at its next meeting.

3 PERFORMANCE AND SERVICE DELIVERY

3.1 Care At Home Assurance Report

This report set out the current issues in relation to the provision and delivery of care at home services across the Partnership area and described plans to co-create a care at home delivery vision and co-develop an accompanying and supporting commissioning approach. The report was provided to the Committee for awareness of the proposed areas of activity and with a proposed level of moderate assurance as to the steps being taken to address current and forecast challenges.

During discussion, the Committee considered the following areas,

- In terms of collaborative commissioning, this work had been driven in response to the Feeley Report to work more with Third Sector partners and assist with their sustainability through coproduction. This would enable contracts to be extended as opposed to repeatedly returning to market and would ensure better workforce experience through continuity.
- G Grant commented that there was a short life working group looking at collaborative commissioning which was considering the issues from the ground up, ways to encourage and promote collaboration, and the practical issues faced by workers on the road between clients.
- The need to support flexibility for staff was discussed and it was noted that the Reservists programme had been a good means to address the needs of staff who wish to work in alternative ways due to care and other responsibilities. It was also noted that some of the reservists have gone on to take permanent contracts due to the experience of having been afforded the opportunity of this experience of work. The response to the programme has been positive but there are infrastructure issues to address to support the larger than expected uptake.
- It was commented that the engagement work around the first objective outlined in the report around improving outcomes was integrated with the strategic plan. The engagement work had addressed areas of confusion around the Joint Strategy and the Together We Care programme and areas of engagement fatigue.
- It was suggested that the assurance level offered by the report maybe did not address the scale of the challenge faced from a workforce perspective and that previous measures mentioned in the paper had not had the intended impact. It was felt that the failures outlined were largely due to the larger than expected impact of external providers pulling out of care home provision due to sustainability issues.

The Chair noted the change from an initial assurance level of substantial to moderate. This was to acknowledge the challenges ahead but to note the robust procedures and work streams in place to mitigate against the challenges.

It was requested that an update on the immediate actions arising from the report be brought to the Committee in six months' time either as a standalone item or via the Chief Officer's report.

The Committee:

- **NOTED** the report, and
- **Agreed** to accept **moderate** assurance and that an update on the immediate actions would come to the Committee in six months.

3.2 Annual Report of Care Home Oversight Collaborative

The previous report provided to the Committee on 26 April 2023, gave an overview of independent sector care home provision, focusing on the recent sector turbulence experienced over 2022-23 and the mitigating actions in relation to the care home

closures which had been or were being managed. This further report provided an overview of wider sector oversight during 2022-2023 and sets out the move towards collaborative care home support arrangements and proposed a level of substantial assurance to the Committee.

- G Grant spoke to the paper and noted that the collaborative continued to oversee activity meeting fortnightly over 2022/23. It had addressed issues around black and red status care homes and provided oversight of large-scale investigations, any suspension of admissions, and bed vacancies.
- The second part of the report related to the shift in approach from Scottish Government and they requested partnerships to move away from oversight towards a collaborative support approach and with the intention of improving lives of people in care homes.
- Scottish Government had allocated the Highland Partnership £681,000 on the basis of putting in a submission detailing how that resource would be directed and targeted toward the collaborative working.
- Appendix 5 of the paper included information that submitted as part of the bid (appendix one of this appendix 5 outlined the NHS Highland element) and set out specific proposals for the use of the allocation.
- The collaborative Care Home support team will be invested in to broaden capacity and scope. This will include among other things, speech and language therapy as a drawdown resource when needed.
- The second element regards collaborative workforce solutions for work with the independent sector.
- The third element concerned bed availability and supporting beds to become available.

During discussion,

- It was clarified that Scottish Government were still to come back to the Collaborative with its responses to the plan.
- The shift from the Care Homes Strategic Group and the new Collaborative arrangement was noted as having been welcomed by partners and that partners had been keen not to have activity imposed and appreciated a more ‘draw down’ responsive resource approach.
- It was noted that NHS Highland is well placed to effect the new collaborative approach and that it had good engagement from partners but that work will need to be intensive as soon as the proposals from the Collaborative are agreed by Scottish Government.
- The Nurse Director noted her ongoing and continuing responsibility in the role for care homes and that this would not change with the new arrangement in ensuring quality controls for patients.
- It was noted that there is a separate Care Home Oversight Collaborative for Argyll and Bute with collaborative working with North Highland in the area of infection control via Public Health.
- It was noted that care home residents were at the centre of the initiatives and that service users and their families were helping to steer the direction.
- The risks around the new arrangements were discussed and it was clarified that the models developed in the response to Scottish Government were intended to reduce the risks around a collaborative way of working. It was added that the pandemic had seen the development of a more positive and trusting relationship with care homes and that this had led to productive working with earlier recognition shared of the issues.

The Committee:

- **AGREED** to accept **substantial** assurance from the report.

3.3 Dental Services position paper

The report noted the current situation and actions being taken to mitigate, current

reduced access to Primary Care Dental Services detailing a deterioration in access to Primary Care Dental Services, increasing concerns about the sustainability of Primary Care Dental Services, provided information about ongoing national reform of Primary Care Dental Services, and proposed a level of limited assurance to the Committee.

The Director of Dentistry noted that it was disappointing to be bringing little in the way of good news to the Committee and commented that the situation in Highland with regard to lack of access to primary care dental services was a national matter.

- It had been acknowledged that the system of administration for General Dental Services required reform, and that services were still recovering slowly from the impact of COVID where dental services were suspended in the main leading to significant backlogs of treatment and practises effectively looking at the future viability.
- He noted that it is often thought that health boards have a statutory obligation to provide General Dental Services but that this is not actually the case. Access to emergency dental services for unregistered patients is provided but in terms of General Dental Services, health boards are only required to maintain a list of dentists who provide or are contracted to provide the service.
- In terms of local pressures, there had been three recent practice closures across the region and ongoing deregistration of patients was sitting at about 1% of the total number of NHS deregistrations. However, many patients are being retained on a temporary lists awaiting recruitment of a dentist to their practice. In terms of private practices, Bupa had made a national corporate decision to withdraw many practises from the NHS.
- Around 16% of practices in the region were currently delivering less than 50% of the pre COVID level of activity.
- The dental helpline for the partnership area dealt in the last year with approximately 13,000 calls, and it was anticipated that this would increase.
- Workforce recruitment and retention was one of the main issues for patient access to services and a reason as to why practises may be deregistering patients.
- Current data showed that early career dentists were not committing to the NHS. The Director of Dentistry had spoken to some recently qualified dentists who had gone straight from training into private practice with no intention of working in the NHS.
- COVID had led to a delay in graduating dental students for a year, which was a temporary blip, but this had knock on effect for vocational training. In addition, the pandemic had led a number of dentists to change their work life balance reducing availability.
- More than 50% of practices in the region were now corporate dentists and these had also experienced significant issues around recruitment in spite of their greater buying power.
- It was felt that the key to progress was Scottish Government reform of Primary Care Dental Services. Final information was awaited from the government following a period of engagement with the main stakeholder, the British Dental Association, about what reform may look like but this review currently only covered payment reform with other areas to follow and progress had been slow.
- Provision of care for priority group patients is handled by the PDS (Public Dental Service) and the impact on the PDS was becoming significant due to the need to support emergency dental services and support services where GDP dentistry was not currently available.
- Recruitment to PDS has been very difficult with a general lack of suitable applicants for a number of roles.
- Scottish Government had made Scottish Dental Access initiative grants available to extend and establish dental practises. Two bids had recently been accepted in Alness and Inverness.
- Initiatives to improve recruitment and reduce barriers to recruitment of dental professionals are outwith the control of NHS Highland. They sit at national level and with the UK General Dental Council.
- Where it had not been possible to recruit dentists, there had been some successes with the recruitment of dental therapists recently. This was supported by the School of Dental

Therapy at UHI in Inverness with a new cohort of students due to graduate soon. The scope of practise of a dental therapist is less than a dentist and they are required to work to prescription, but approximately 60% of NHS work can be carried out by a dental therapist.

- But yet another barrier that sitting at at Scottish Government level at at this moment in terms of action, need to ensure that our help lines have the resilience to deal with increased calls that are public dental service look at or EDS and being able to meet demand for services and we utilise where there is any public dental service capacity bearing in mind that we're currently running at 25%.
- If planned reforms of dentistry are not accepted by practitioners general dental services could see further deterioration and risk overwhelming the health board's public dental service.
- There is evidence from oral health inspections of school children of deterioration and widening health inequalities.

During discussion,

- It was clarified that there is no waiting list maintained by Primary Care for patients looking to be newly registered in the region and that an idea of figures is gained via calls to the helpline for patients wanting to register as new or those who have been deregistered.
- The issue of public messaging was raised and it was confirmed that work is underway in partnership with other health boards to provide clear messaging about what NHS dentistry can offer in light of the stated aims of Scottish Government to eventually provide free dental treatment and to avoid issues around self-dentistry.
- The potential for the Board to 'buy-in' independent and private dentistry was discussed and it was noted that this sector is suffering similar issues around recruitment to NHS dentistry.
- It was noted that the difficulties in local recruitment were not especially affected by the remote and rural geography of the region and that it reflected a national picture. In addition, any impact on the specific circumstances of Highland from the reform process is currently unknown.
- The Director of Dentistry commented that there was a very effective oral health promotion team across Highland and Argyll and Bute in conjunction with a series of national programmes including the highly successful Child Smile programme. Colleagues liaise with care homes, schools and nurseries, and there was an active fluoride varnishing programme supported via NHS Highland.
- The pay reforms were discussed and it was noted that Scottish Government's current preference was for a blended model based on treatment allowances and capitation. That's probably not the professions preferred model and we'll wait to see how that plays out. I'm not party to those discussions. Those are between the stakeholders.
- Workforce planning had shown that that there would be a shortfall of new dentists by 2030. It was felt by the Director of Dentistry that dental complementary professionals such as dental therapists were underused and that Highland was in a very good position with the School of Dental Therapy in Inverness which graduates about 11 students per year. Changes to regulation would need to be ensured to support more dental therapists if the scope of their work is to widen.
- The PDS had been recruiting more dental therapists due to a shortfall in dentists and that this had worked well in dealing with priority groups but there would still need to be more brought in to the service.
- The Director of Dentistry noted that currently health boards had limited control over General Dental Services and only ensured the maintenance of a GDS list and provided emergency dental services. It was thought that this area would form the third part of the general reform process. Practices with NHS patients were required to offer the full range of NHS care.

The Committee:

- **AGREED** to accept **limited** assurance from the report.

The committee held a short break at 2.55pm and reconvened at 3.05pm.

3.4 Self-Directed Support: Personal Assistant rates for Direct payment, Option 1's

The report provided an update to the Committee of the significant progress towards establishing a co-produced reference hourly rate for Options 1's in partnership with the SDS Peer Support Group by establishing a fair, transparent, and mutually understood personal assistant hourly rate for Option 1s, and recommended implementation of the new proposed reference hourly rate(s) from Monday 3 July 2023, noting the additional cost commitment for this financial year of £0.750m based on the current service user profile.

J Bain provided an overview of the report for the Committee and noted that the SDS Highland Peer Support Group consisted of recipients of SDS and family members involved in organising Option 1's with a current membership of about 12 supported by a couple of officers from NHS Highland. The prosed figure was arrived at in part by recognising the difficulty of recruiting and retaining staff across health and social care and current rates of inflation. The growth in Option 1's highlighted an unavailability of other options but also showed a need for more independence and decision making ability from patients.

The Chair noted the significant cost attached to the proposals against the backdrop of current cost pressures and invited discussion.

- It was commented that the Joint Officer Group had found Option 1 to be the most cost-effective for many people. In house services and commissioned external services were found to be more expensive, and there had been a significant reduction over the last two years for external care home hours of provision.
- Rates for bespoke packages were discussed. The SDS Peer Support Group had recognised the complexity of this issue but that a base rate to set the framework for packages more widely and to address recruitment issues in making the work more attractive would be desirable.
- It was noted that the starting point for the pay model was the UK Home Care Association rate for care at home packages in conjunction with a consideration of the overheads for individuals with a premium for travel. It was added that robust standard operating procedures were in place to ensure that if packages were not delivered that the monies were recoverable. It was thought that reclaimable monies for the current year would be between £¾ million and £1 million.
- The Chair summarised from the discussion that there was a desire to support the proposals in principle but that there was a difficulty around recommending the proposals when it was not certain where the money would come from.
- It was noted that Option 1 is not the only available option to be rolled out for individuals but that Option 1 enabled access to other areas such as Day Care services.
- G O'Brien noted that the Committee would need to be mindful of adding to the cost burden of the Board and the Partnership and that it would need to be clarified if the Committee has the deciding vote in recommending the proposals.
- The Chief Officer noted that the proposals would go to the Senior Leadership Team when it next met.
- N Wright noted the difficulty of seeing purely financial benefits arising from the proposals but that the outcomes would be qualitative and impact on various areas of the service as shown through items such as the IPQR.
- The Chief Officer noted that a number of transformational and efficiency programmes were in process and would return soon to the Committee.
- The Committee accepted moderate assurance from the paper and supported the recommendations in principle but noted that it could not recommend the proposals in full without the Senior Leadership Team and Joint Officer Group having considered the proposals and without a consideration of the financial position of the Partnership.

The Committee:

- Accepted **moderate** assurance from the report, and
- **Noted** its support for the proposals in principle but added that
- The Committee it could not recommend the proposals in full without the Senior Leadership Team and Joint Officer Group having considered the proposals and without a consideration of the financial position of the Partnership.

3.5 IPQR Dashboard Report

The report set out performance indicators used to monitor progress and evidence the effectiveness of the services that North Highland provides aligned to the Annual Delivery Plan. An increase in Care At Home unmet need was shown and an increase in delayed discharges since the last report, with figures for care home occupied beds remaining static. Psychological therapies waiting times showed improvements with reduced waits.
Following a request at the last meeting detail of unmet need in terms of waiting times was added to the data presented.

During discussion, the following areas were raised:

- It was asked if it was possible to show the balance for Care At Home unmet need in in terms of getting waiting times down versus new assessments of need and how decisions are made around priorities. The Chief Officer noted the multifaceted nature of the issue but that this was an area that should be reflected upon in terms of data. D Mackenzie commented that multidisciplinary teams were involved in making daily decisions around facilitating patient flow and avoiding inappropriate admissions and that this had provided early insights into community needs.
- It was noted that of data documented by hand that this could include anything that was not reported directly to government which may include community mental health data and non-reportable specialties.
- J McCoy requested that the following information might be included in the next iteration of the IPQR:
  - To include total number of beds for each area in North Highland care homes or the percentage occupied;
  - To include numbers for each hospital in North Highland regarding delayed discharges so as to better see trends, and to add lines to the graph for each hospital to help give a clearer picture for assurance;
  - To include trend data for North Highland Community Hospital delayed discharges from the information collected so far;
  - To include more detail, trends and optimal wait times for ongoing waits for non-reportable specialities;
  - To show trend data around reasonable wait times for each service on Community wait lists.

The Committee:

- **NOTED** the report.

3.6 Chief Officer's Report

The Chief Officer's report provided project updates for North Skye Healthcare, the Lochaber redesign, and Caithness Redesign. The HSCP Annual Performance Plan was noted and answers regarding the plans for the Ross Memorial Hospital were outlined. News of NHS Highland colleagues who had received awards in the Kings Honours list were announced which included an MBE for Cathy Shaw, Lead Advanced Practitioner for the Remote and Rural Support Team (West) and the Hospital at Home Team Skye with NHS Highland, has been recognised and awarded an MBE for services to nursing in rural Scotland. Dr Miles Mack, a GP with Dingwall Medical Group, was recognised and awarded an
OBE for services to general practice

M Stevenson raised the following questions regarding the Ross Memorial Hospital:

- What steps or measures are being planned within the RMH to address and resolve the fire compliance issues that pose a significant organisational risk?
- Is there an organisational commitment to oversee the reconfiguration of existing services on the RMH site?
- Why is it that Estates, as a support service, are leading the NHS strategy instead of the clinical personnel who should be guiding the strategy while support services follow?
- And if this is not the case then my next question is….
- Given that Estates have not yet actively pursued the reconfiguration project; Funding has not been secured, and Layout plans have not been developed, what exactly are the intentions of Estates at this point of the project?
- Is there an intention to evaluate the entire RMH building and services rather than solely focusing on fire compliance works, including a potential decision to close the RMH?
- The district manager who has been overseeing the reconfiguration of works was unable to give assurances to stakeholders recently that work is progressing, so where should stakeholders be looking for assurances that the work is progressing within RMH?
- Which stakeholders as mentioned on Wednesday, other than patient groups, are involved in the reconfiguration of the RMH works?
- Has there been any consideration given to relocating the GW patients to Invergordon Hospital, which is a newer and more suitable building, and if not, why not?
- Previous Questions still awaiting answers, which I would like to bring up at this time.
- What is the name of the project manager appointed by Estates, that was mentioned at the HHSCC meeting on 26 April 2023?
- Despite assurances made during the HHSCC meeting on 11 January 2023 that the HRU would remain unaffected by any changes, it appears that the situation has changed. What guarantees can be provided to ensure the safety of the remaining 5 Inpatient rheumatology beds from closure?
- Where there is a need for works to relocate the GW beds to the HRU, how will the active Rheumatology services be able to continue without interruption?
- Where will the Rheumatology outpatients and Infusion services be temporarily relocated to in order to ensure uninterrupted continuity of the service as promised from the senior leadership team earlier this year?

The Acting Chair and the regular Chair noted the valid questions raised and commented that he did not believe there was any deliberate stonewalling around the information. He commented that there was an engagement group set up to deal with the Ross Memorial Hospital and that this was a better forum than the current Committee in which to receive assurances about the work in question.

- The Chief Officer clarified that the Estates Department do not make decisions around which projects to invest in and that they respond to requests. She noted that the Assistant Medical Director had visited the hospital the previous week and that the Chief Executive was due to visit with the Chief Officer and that they were completely engaged with the project.
- The Chair requested that the Chief Officer pick up the issues to ensure M Stevenson receives the necessary responses.
- M Stevenson noted that she felt that there had been some unnecessary delays in response to the issues.

The Committee:

- **NOTED** the report.

4 HEALTH IMPROVEMENT

District Reports

This item was postponed to the August meeting due to local system pressures.

- A Clark noted that it would be useful to consider how best to address this item in response to the recent Internal Audit on Community Planning and the context of system pressures.

5 COMMITTEE FUNCTION AND ADMINISTRATION

5.1 Committee Work Plan

The Chair introduced the Work Plan for approval by the Committee and noted that the June meeting was likely to be a busy one.

- In discussion it was suggested that a rethink was needed to address health improvement and Community Planning within the context of highly pressured agenda.
- The Chief Officer proposed a development session be held on community planning which would address both service redesign programmes and locality issues, and the recent Internal Audit report on community planning.
- G O'Brien noted that on his return to chairing duties he would consider future agendas and the work plan with the Chief Officer.
- It was suggested that the duration of the next meeting be extended to cover what would be a very full agenda.

The Committee

- **noted** the planned revisions and **agreed** the Work Plan for 2023-24 in its current form.

6 AOCB

A development session was scheduled for 19 July from 1pm to consider Transformational Change and Health and Social Care.

7 DATE OF NEXT MEETING

The next meeting of the Committee will take place on **Wednesday 30 August 2023** at **1pm** on a virtual basis.

The Meeting closed at 5.20pm