The Highland Council

Agenda Item	8.
Report No	ECAS 21/16

Education, Children and Adult Services Committee
17 March 2016

Assurance Report – Children's Services

Report by Director of Care and Learning

Summary

The purpose of this report is to provide assurance to NHS Highland in relation to services commissioned and delivered through Highland Council. The content of each assurance report is informed by the Highland Health and Social Care Committee and discussion with the Child Health Commissioner.

1 Locally Agreed Targets and Outcomes

1.1 Within *For Highland's Children 4,* there are 14 high level outcome measures with a number of performance measures relating to each. The performance measures for the commissioned service sit within Outcome 4: 'Children and young people experience healthy growth and development'. **Appendix 2** is an extract from the performance framework. Many of these indicators are only updated on an annual basis.

1.2 Allied Health Professionals

1.2.1 An updated exception report regarding AHP waiting times is attached as **Appendix 1** to this report.

1.3 Uptake of the 27-30 month surveillance contact

1.3.1 The current agreement is that data will be provided by the NHS Child Health Surveillance team on a quarterly basis for children who are recorded as not having had a 27-30 month review. The first report will cover children born between 01.01.2013 and 30.06.2013, and the information is being received by Highland Council during the compilation of this Committee report - therefore it is not possible to provide a detailed Delivery Plan and trajectories at this stage. This process will enable a greater understanding of why any reviews have not been undertaken, and appropriate actions to be considered. Indicative data for December is included in the table in Appendix 2, but timescales have precluded verification and analysis of the data.

1.3.2 Early analysis indicates that there is continuous improvement in the uptake of the 27-30 month review. In the main, where no review has been undertaken, two attempts have been made to engage with the families in line with NHS Highland and national policy. Subsequent attempts to engage with families are only made if the health visitor considers there is some concern. These reports are extremely useful in helping to identify children who have not had a review, enabling Health Visitors to focus on those children who are eligible for a review and have not yet been offered an appointment. In the meantime, the available data will be used to continue to monitor and improve performance.

1.4 **Looked after Children Health Assessments**

1.4.1 There are 2 performance measures relating to Looked after Children health assessments. The first of these is that the percentage of statutory health assessments completed within 4 weeks of a child becoming looked after, will increase to 95%. In the last reported quarter (October - December 2015), there were two key issues which significantly affected performance. Five young people refused contact with the school nurses undertaking the assessment, despite them making multiple attempts to engage with the young people, and there were three children where parental consent was refused. The initial health assessment for LAC is a targeted health assessment and needs explicit parental consent for those children who are unable to consent for themselves. This is generally for children aged up to 13. Both of these issues are unusual, but the impact on the performance measure was significant.

1.4.2 The second performance measure relates to 95% of health assessments for LAC who are accommodated being available for the initial child's plan meeting at 6 weeks. This was also affected by the 8 children who either refused contact or had no parental consent.

1.4.3 Other issues that impact on achieving the desired timescales include late notification of children becoming looked after, and staff shortages in the school nursing teams.

1.4.4 Agreement has been reached that additional support will be put into LAC health team to support the initial health assessments for school aged children, who make up the biggest proportion of LAC. The impact of this will be monitored through the LAC Improvement Group.

1.5 **Health Visitor vacancies**

1.5.1 The current Health Visitor workforce situation is detailed below. There are currently 3.4fte vacancies across the authority, and teams are able to access bank Health Visitors through the NHS Highland Integrated Staff Bank to cover some of these gaps.

1.5.2 Since the January report, there has been some movement of staff between teams, which has created additional vacancy in the Mid Ross team. This is currently being recruited to. We have also successfully recruited a 0.6fte post from outwith the area, to increase capacity in Inverness West.

1.5.3 We have 8fte trainees undertaking the Health Visitor programme this year, and another 3fte currently working as staff nurses within the Early Years workforce who are waiting to commence the programme in January 2017. We are waiting confirmation of the 2016/17 additional Health Visitor funding to determine how many additional posts can be established in the next financial year, with the remainder being established in 2018, to take the total to 62.6.

Health Visitors in Family Teams 01/03/2016

Caithness	5.8	3.8	2	0	8
Sutherland	2.7	1.7	1	0	2.7
East Ross	6	5.8	0	0.2	7.6
Mid Ross	5.4	3.8	0	1.6	5.4

Skye, Lochalsh, West Ross & Assynt	4.2	3.9	0	0.3	4.6
Lochaber	5	4.7	0	0.3	5.5
Inverness West	8.4	6	2	0.4	9.5
Inverness Central, B & S	10.8	7.4	3	0.6	10.8
Inverness East & Nairnshire	8.5	5.5	3	0	8.5
Totals	**56.8**	**42.6**	**11**	**3.4**	**62.6**

2. National Priorities, Targets and Standards

2.1 Ready to Act: A transformational plan for children and young people, their parents, carers and families who require support from allied health professionals

2.1.1 Ready to Act was launched on 21 January 2016, and outlines the five key ambitions for AHP services for children and young people:

Issue	Ambition
Participation and engagement	Children and young people's views will be asked for, listened to and acted upon to improve individual and environmental well-being outcomes and AHP services.
Early intervention and prevention	Every child will have the best possible start in life with AHP services using an asset-based approach to aid prevention through universal services and supportive nurturing environments at home, nursery and school.
Partnership and integration	Children and young people, their parents, carers and families will have their well-being outcomes met at the most appropriate level through the creation of mutually beneficial, collaborative and supportive partnerships among and within organisations and communities.
Access	All children and young people in Scotland will access AHP services as and when they need them at the appropriate level to meet their well-being needs, with services supporting self-resilience through consistent decision making.
Leadership for quality improvement	Children and young people, their parents, carers and families will experience services that are led by AHPs who are committed to a leadership and quality improvement approach that drives innovation and the delivery of high quality, responsive, child-centred care.

2.1.2 The plan builds on the ambitions of the National Delivery Plan and will be incorporated into the life-course framework of the Active and Independent Living Improvement Programme. Whilst acknowledging that some children with complex disabilities will still require more traditional models of AHP service delivery, the plan outlines the continuing shift towards prevention; self-management; and capacity building of individuals and communities to deliver better outcomes for children and young people.

2.1.3 In order to improve consistency across Scotland, national implementation

workstreams are to be established:

- developing a national approach to requests for assistance – consistent decision making
- establishing a national information/learning hub
- developing a national foundation AHP resource (a national repository for first line self-management materials)
- undertaking community mapping to support partnership working
- Reviewing and updating the existing guidance on Partnership Working Between Allied Health Professions and Education

2.1.4 Local implementation plans will be developed in collaboration with stakeholders; alongside a clear national reporting and evaluation framework to be developed by the national AHP Children and Young People's Forum. Precise goals and targets for each ambition are expected to emerge from the national and local planning structure. The AHP Associate Director will be accountable for implementation and reporting against improvement activity in relation to the five ambitions, answering the following questions:

- How are we doing?
- How do we know?
- What can we do differently to speed up implementation?

2.1.5 In Highland, there has been a range of improvement activity undertaken in AHP services that will support delivery of the ambitions e.g. Before Words, developmental overviews (pre-school), developmental continuums (P1), building capacity in pre-school environments, introduction of an initial telephone consultation response to requests for assistance.

2.1.6 The full plan can be accessed via the electronic link below:
http://www.gov.scot/Publications/2016/01/1324

3 Child and Adolescent Mental Health Social Worker posts

3.1 The 2016/17 budget included the deletion of two Child & Adolescent Mental Health Service (CAMHS) Social Worker posts. These posts had evolved so that they were no longer providing a statutory Social Work function, and were not providing an effective liaison between CAMHS and the Family Teams. In terms of risk management, the posts did not deal with cases that would be deemed to be high risk within the Family Teams and they did not act as Lead Professionals.

3.2 While the deletion of the posts reduces the overall capacity of the CAMHS service, this has to be seen as part of the necessary overall reduction in capacity across Children's Services, because of the budget challenge. Senior managers are meeting to establish closer working relationships with the CAMHS service in future.

4. Governance / Risk Management Issues

4.1 The Head of Health and two Principal Officers (Nursing & AHPs) have held discussions with the NHSH Executive Board Nurse Director regarding formalising the clinical governance arrangements within the commissioned child health services. A Governance Framework is being developed and the Principal Officer (Nursing) and Principal Officer (AHPs) now attend the NHS Highland Clinical Governance Committee.

4.2 Further discussions are underway to assure NHS Highland of the appropriate

access to clinical supervision for health staff employed in Highland Council, supplementary to line management supervision.

4.3 Future assurance reports will adopt the new format, developed by both organisations, to better inform the commissioning and service delivery agency, for both children's and adult services.

5. Revenue

5.1 The funding for Child Health from NHS Highland is £8.8m. As previously indicated, Highland Council has committed additional funding to child health services. The January monitoring statement is attached as **Appendix 3**.

6. Implications

6.1 There are no **resource, legal, equalities, climate change/carbon clever, risk, Gaelic** or **rural** implications from this report.

7 Recommendation

7.1 Members are asked to consider and scrutinise the issues raised in this report.

Designation: Director of Care and Learning

Date: 4 March 2016

Author: Sandra Campbell, Head of Children's Services

Appendix 1

Allied Health Professions (AHP) Waiting Times Report

Target: 90% AHP referral to treatment to be within 18 weeks by December 2014

1 CURRENT POSITION

The target of 90% of children referred to services seen within 18 weeks was introduced in the strategic document: AHPs as Agents of Change in Health and Social Care, the National Delivery Plan for Allied Health Professions (AHP) in Scotland, 2012- 2015 (The Scottish Government 2012). This document is updated by Ready to Act: A transformational plan for children and young people, their parents, carers and families who require support from allied health professionals, which was launched in January 2016. There will be a continued focus on access to services.

NHS Highland service planning department has now been able to provide regular reports against compliance with the target for each AHP service employed within Highland Council: Occupational Therapy, Speech and Language Therapy, Physiotherapy and Dietetics.

Service pressures continue to exist within Occupational Therapy and Speech and Language Therapy and neither service has achieved compliance with this target to date. However, improvement has been seen across the quarterly data reports: from 78% in September 2015 to 86% at the end of February 2016.

Currently the waiting times are measured from the date of receipt of the request for assistance to the date of first face to face contact. This complied with previous definitions of waiting times; however as AHP services in general have increased the focus on supporting people to self-manage conditions through telephone consultation this way of calculating waiting times now needs to be updated.

Whilst the table below details the waiting times as at the end of February 2016 from receipt of request for assistance to the first face to face contact, many of the children reported as waiting will be receiving intervention through access to active self-management advice and support; and parents/other professionals will be having regular follow up telephone calls with the relevant AHP to give further guidance and support.

CALCS AHP Services - Ongoing Waits & 18 Week RTT Compliance As At 29/02/2016

Profession	Total Num	Number <18 wks	% <18 wks
Dietetics	91	89	98%
Occupational Therapy	107	90	84%
Physiotherapy	19	18	95%
Speech and Language Therapy	344	283	82%
Total	**561**	**480**	**86%**

It should be noted that:

Occupational Therapy

a) The data above is inclusive of all activity across the integrated OT service, including equipment and adaptations. Nationally this aspect of service provision is not included in the 18 week RTT target.

Speech and Language Therapy

a) The data excludes adult caseload for North and West – adult service data will be available from April 2016 following completion of the caseload redesign within the activity and waiting times system.

2 ACTION PLANS TO ADDRESS

Throughout 2015, telephone triage in Occupational Therapy has been developed in order to enable any person (including parents) to contact the service to discuss a potential request for assistance. These conversations have led to the creation of a range of self-management advice sheets around common areas of concern and have proven successful in enabling other professionals and parents to be empowered in supporting children. Often the self-management sheets are used as an initial intervention so that when the child is seen face to face by the therapist improvements can already be seen/therapy intervention can be more targeted.

This method of providing fast access to advice and support through telephone consultation is becoming commonplace within AHP services and the model we have evolved now meets the criteria as a waiting times “clock” stop in accordance with National ISD data definitions. Telephone consultation is currently being rolled out across speech and language therapy, supported by the development and use of simple self-management advice sheets.

Work is now being undertaken to develop standard procedures to be applied across all services that ensure there is consistency in decision making around what telephone consultations are to be identified as the end of the “wait” period.

3 EXPECTED IMPACT OF ACTIONS

It is anticipated that the application of telephone consultation as a “clock” stop in line with National ISD data definitions will achieve compliance with the target.

Claire Wood, Principal Officer AHPs
March 2016

FHC4		12/13	13/14	14/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Target / comment	Imp Group
Healthy																
4. Children and young people experience healthy growth and development																
26	% of children reaching their developmental milestones at their 27 – 30 month health review will increase			75.1%			78%			78.7%			79.1%		EYC Stretch aim – 85% by December 2016	Early Years
27	% of children will achieve their key developmental milestones by time they enter school will increase		85%	87%											Target - 85% Reported annually	Additional support Needs
30	Improve the uptake of 27-30 month surveillance contact from the baseline of 52% to 95% by March 2016		82.5%	78.9%			80.2 % (Indicative measures)			75.6% (Indicative measures)			45% (Indicative measures)		ISD data for 2014/15 is 81.9%	Early Years
31	95% uptake of 6-8 week Child Health Surveillance contact		85.1%	81.7%			79%								Target - 95%	Early years

32	6-8 week Child Health Surveillance contact showing no difference in uptake between the general population and those in areas of deprivation		2.9% variation	5.4% variation											No variance Reported annually	Early years
34	Achieve 36% of new born babies exclusively breastfed at 6-8 week review March-17	32.4%	31.2%	30.3%			34.6%								Revised performance measure and trajectory to be agreed at NHS H improvement committee	Maternal infant nutrition
35	Reduce % gap between most & least affluent areas for children exclusively breastfed at 6-8 weeks		14.8% compared to 40.5%	15.8% compared to 36.2%											Reduction – reported annually by NHSH	Maternal infant nutrition
36	Maintain 95% Allocation of Health Plan indicator at 6-8 week from birth (annual cumulative)	97.3%	99.5%	99.7%	99.5%		99.8%								Target - 95%	Maternal infant nutrition
37	Maintain 95% uptake rate of MMR1 (% of 5 year olds)	94.6%	96.7% Q4	96.2%	97.1%		96.1%								Target - 95%	Early Years

38	Sustain the completion rate of P1 Child health assessment to 95%	93.1%	99.5% Q4	99.0% Q3											Target - 95% Reported annually	Early Years
39	95 % of children with significant ASN will have their learning planned for through a child's plan	65.0%	70.0%	94%						97%					Target - 95%	Additional support Needs
40	The number of 2 year olds registered at 24 months with a dentist will increase year on year		76.8%	73.9%	72%		67.4%			76%			73.7%		Increase from 76.8% baseline	Public Health and Wellbeing
41	The number of 2 years olds who have seen a dentist in the preceding 12 months will increase		67.3%	64.4%	63.9%								82.6%		Increase from 67% baseline	Public Health and Wellbeing
42	The percentage of 5 year olds will have no obvious dental decay will increase to 80%		70.1%	70.1%											Target - 80%	Public Health and Wellbeing
45	90% CAMHS referrals are seen within 18 weeks (Primary Mental Health Workers)	80.0%		95.3%	92.9%	90%	100%	98%	82%	82%	100%	92%			Target - 90%	Mental Health

46	% of statutory health assessments completed within 4 weeks of becoming LAC will increase to 95%	70.0%	66.7%	66.7%			66.7%			67.6%			57.4%			Target - 95% Amber status represents improvement post integration.	Looked after Children
47	95% of health assessments for LAC who are accommodated are available for the initial child's plan meeting at six weeks						68%			82.4%			59.4%			Looking for improvement from the 68% baseline.	Looked after Children
48	Waiting times for AHP services to be within 18 weeks from referral to treatment									78%			85%			Target - 95%	Additional support Needs
49	95% of children will have their P1 Body Mass index measured every year	93.1%	90.2%	99.6%												Target - 90% Reported annually	Public Health and Wellbeing
53	Number of staff trained to deliver approved input on sexual health, relationships and parenting increases		16	45												Target - 25 Reported annually	Public Health and Wellbeing

5. Children and young people make well-informed choices about healthy and safe lifestyles																
54	The number of hits on pages relating to children and young people on the Substance Misuse Website increases			422											Improve from 422 baseline	Health and Wellbeing
58	Self reported incidence of smoking will decrease (P7)		0.5%			1.0%									Target - 0% Data from 2015 Lifestyle Survey	Public Health and Wellbeing
59	Self reported incidence of smoking will decrease (S2)		5.50%			3.0%									Target - 5% Data from 2015 Lifestyle Survey	Public Health and Wellbeing
60	Self reported incidence of smoking will decrease (S4)		12.0%			10.0%									Target - 11% Data from 2015 Lifestyle Survey	Public Health and Wellbeing

January 2015 Integrated Health Monitoring Statement

Activity	Budget	Actual to Date	Projection	Variance
Allied Health Professionals	2,925,927	2,305,803	2,767,334	-158,593
Service Support and Management	890,536	716,582	871,297	-19,239
Child Protection	479,534	303,439	404,906	-74,628
Health Development	342,810	216,885	327,390	-15,420
Family Teams	16,807,053	12,812,597	15,703,528	-1,103,525
The Orchard	1,292,211	956,774	1,292,211	0
Youth Action Services	1,471,117	1,047,712	1,185,110	-286,007
Primary Mental Health Workers	521,388	391,669	474,787	-46,601
Payments to Voluntary Organisations	1,240,678	1,219,192	1,240,678	0
Total	**25,971,254**	**19,970,653**	**24,267,242**	**-1,704,013**
Commissioned Children's Services income from NHSH	**-8,944,593**	**-4,450,339**	**-8,944,593**	**0**