Agenda Item	5
Report No	JMC/16/22

THE HIGHLAND COUNCIL/NHS HIGHLAND

Committee: **Joint Monitoring Committee**

Date: **5 October 2022**

Report Title: **Chief Officer Report**

Report By: **Louise Bussell, Chief Officer**
Fiona Duncan, Executive Chief Officer, Health and Social Care

Purpose/Executive Summary

1. The purpose of this report is to inform the Joint Monitoring Committee of the activities that support delivery on the Highland Health and Social Care Partnership's strategic priorities.

The report acknowledges the previous request from the Committee to shift the content to an integrated focus and invites views on a proposed refreshed template and future content for inclusion.

2. Recommendations

2.1 Members are asked to:

i. **Note** the update;
ii. **Consider** and provide direction on the proposed refreshed template and future content.

3. Implications

3.1 Resource

There are specific resource issues arising out of the delivery of Adult Social Care (ASC) by NHS Highland, which is governed by the Integration Scheme currently in place, as signed off by the Council and Board in March 2021 and which received Ministerial sign off in February 2022.

Detailed resource issues and implications are provided within the financial report elsewhere on the agenda.

3.2 Legal

The legal arrangements covering the delivery of integrated service, are provided for within the above referenced Integration Scheme.

There are no further or additional arising legal issues to be brought to the attention of the JMC, which are not as noted within this report.

3.3 Community (Equality, Poverty, Rural and Island)

No arising issues.

3.4 Climate Change / Carbon Clever

No arising issues.

3.5 Risk

NHS Highland and The Highland Council continue to work collaboratively to address the risks represented in terms of the funding available for the provision of Adult Social Care.

3.6 Gaelic

No arising issues.

4.0 Preamble

4.1 It is acknowledged that the Joint Monitoring Committee (JMC) has requested to receive reports which cover and focus on integrated services and which report on the activity relating to the Strategic Plans.

4.2 Although there is a well established strategic plan for services for children and young people, the JMC will be aware through previous reports to the Committee, that the Strategic Plan in respect of adult services is however not yet in place and of the intent to develop this plan over the course of this current financial year.

4.3 This Strategic Plan is therefore not yet in place to enable reporting against this plan and against the performance framework and measures to be set out within the said plan, however we have a clear understanding of the key areas that will form the plan and require our attention.

4.4 This report therefore seeks to take a progressive step towards the preferred content of the committee.

4.5 In moving towards a more comprehensive report, a high level review of Chief Officer reporting to IJBs has been undertaken, in order to inform the development of a consolidated template to incorporate the considered best practice examples identified.

4.6 A draft template has been prepared and is provided at **Appendix 1,** with the intended flow of reporting on children's services, transition, then adult services.

4.7 The views of the Joint Monitoring Committee are invited as to:

a) proposed report template; and
b) areas for routine inclusion going forward.

PART 1: Integrated Children's Services

Section eight of The Children and Young People (Scotland) Act 2014 (Part 3), requires every local authority and its relevant health board to jointly prepare a Children's Services Plan for the area of the local authority, in respect of each three-year period.

The current plan outlines our priorities for improving outcomes for Highland's Children. It articulates where partnership working improves outcomes for children, young people and their families acknowledging that individual services have their own plans.

Within the plan, partnership priorities for improvement are set around the following themes:

- Health and wellbeing including mental health
- Child poverty
- Children's rights and participation
- Child protection
- Corporate parenting
- Alcohol and drugs

Governance

The children's services planning partnerships Board provides oversight to the on-going work of the plan. This group has broad membership, including lead officers from The Highland Council, NHS Highland, Police Scotland, Scottish Fire and Rescue Service and a number of Third Sector organisations. The Board reports to the Community Planning Partnership Board with additional reporting to Highland Council, NHS Highland Board and the Joint Monitoring Committee.

Progress with the plan

The planning framework within the Integrated Children's Services Plan outlines that it is the responsibility of each planning group to develop the priorities and actions within their plans, based on the agreed outcomes and needs assessment. Plans are monitored and evaluated and updated on a regular basis and formally reviewed annually. The thematic plans are dynamic and regularly reviewed and updated. For the purpose of this report key priorities and developments have been highlighted to provide members with oversight of the progress being made to deliver on the plan since the last report to this committee.

Highland Alcohol and Drug Partnership

Progress has been made in driving forward a Whole Family approach to drugs and alcohol. The Children and Young People Drug and Alcohol Sub Committee, provides oversight to this strategic planning and improvement work taking forward priorities including workforce development and a number of key improvement projects including the Icelandic Model / Caithness Cares project, the Caithness Schools Survey, the expansion of the substance awareness toolkit and the evaluation of a whole family pilot approach to drugs and alcohol within a primary school.

The strategic approach taken within integrated children's services with respect to drugs and alcohol is predicated on the recognition that children live in families and as part of their community and collaboration across the whole system is essential to ensure services, support, intervention and treatment reaches whole families when they need it most.

There is ongoing work, modelled on the successful Housing 1st MDT to drugs and alcohol project, involving the creation of a multi disciplinary immediate response team within health and social care (criminal justice). The team will provide assertive outreach to those in need or at risk of overdose or significant episodes and will work alongside the proposed early years prevention and intervention drug and alcohol support team.

The work of the partnership in developing a whole system approach to family support was showcased recently at a Highland conference in collaboration with The Scottish Government.

Mental Health and Wellbeing

Distress Brief Interventions development.
Distress Brief Interventions (DBIs) provides quick, connected and compassionate support to people experiencing distress in the community. The need to improve the response to people presenting in distress has been strongly advocated by people who have experience of distress and by front line service providers. This identified need resulted in Scotland's DBI pilot. The initial pilot focussed on adult support however has also been extended to 16 and 17-year-olds across the four pilot areas (Aberdeen, Inverness, Scottish Borders and Lanarkshire)

There will now be a further pilot in Inverness City to includes S3 – S6 secondary students. The Inverness City pilot aims to implement a CAMHS DBI pathway by November 2022 with the implementation of a schools DBI pathway by Nov 2023. The Scottish Govt DBI Team will work with the Highland Health and Social Care Partnership, The Young Peoples Advisory Group and with "Support in Mind Scotland" who have been commissioned to deliver the Inverness DBI interventions. It is recognised that in order to achieve this there will need to be systems, process and infrastructure set up, including service user information, awareness raising, team and wider staff training as well as the identification of the Inverness schools for the pilot area. Governance of the pilot will come through NHS Highland, The Highland Council and the national DBI Team.

Care Experienced Children and Young People improvement Group

To support improving outcomes for Care Experienced Children and Young People, between 2010 and 2020, a multi-agency Improvement Group led improvements across the partnership.

There have been a number of key challenges since 2020 which have impacted on the partnerships ability to work collaboratively to improve outcomes for Care Experienced Young People including whole system pressure due to the Covid pandemonic.

In recent months this group has become re-established with a focus on ensuring the outcomes from the corporate Parenting Board plan are met through streamlining working groups to ensure more effective and efficient approach.

Neurodevelopmental assessment Service (NDAS)

The aim for NDAS is to reduce waiting times as quickly as possible and improve communication and support throughout the assessment process. Currently the length of the longest wait and the average wait time is reducing. Wait times are still around 3 years and the numbers waiting to start assessment are around 650 with around 180 part way through the process. A new NDAS team is being recruited to, with staff starting now and in the next few months. The use of commercial companies for private assessment is being trialled. A Scottish Government funded Test of change team has started work on trialling ways of improving support and communication. Processes, procedures and pathways are being developed to improve consistency and increase efficiency. It is expected that in early 2023 the new team and ways of working will be in place and that wait times and numbers of complaints will reduce over 2023 and further in 2024.

Joint Inspection of Services for Children at Risk of Harm in Highland 2022

The Care Inspectorate (CI) announced on the 25th of April 2022 a joint inspection of services for children and young people at risk of harm. This is a Partnership Inspection involving statutory agencies and the Third Sector

The scope of the inspection is on:

- Children and young people who have been subject to a child protection investigation and this has not led to registration on the child protection register.
- Children and young people whose names have been placed on the child protection register
- Children and young people involved in care and risk management processes

The focus of the inspection and their final report will be determined against 4 inspection statements:

1. Children and young people are safer because risks have been identified early and responded to effectively.

2. Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.

3. Children, young people and families are meaningfully and appropriately involved in decisions about their lives. They influence service planning, delivery and improvement.

4. Collaborative strategic leadership, planning and operational management ensure high standards of service delivery.

The Partnership has recently completed phase 2 of the inspection which involved the submission of a joint position statement and supporting evidence and an engagement week in August where the inspection team met with children, young people, parents/carers, frontline staff, managers and senior leaders.

A report will be finalised this month and published at the end of October 2022.

PART 2: Transitions Service

This part of the report is focussed on Transitions which relates to those young people in receipt of a service from children's services – which may be a universal service such as education – and will then be entitled to a social care service from adult care services delivered by NHS Highland.

It is thus a key interface in terms of the relationship between The Highland Council and NHS Highland and is also a key area for young people as they move on from a children's social work and/or education service to an adult care service.

It is a challenging area as the nature of the service is likely to change at the same time as the agency providing that service also changes and in recognition of that challenge this Committee will recall that the programme board had identified it as a project within the programme of work identified which related to younger adults with complex needs. Notwithstanding the fact that the programme itself is no longer extant the work identified in relation to this area has continued.

This section of the report is intended to provide information in relation to progress as part of that workstream for younger adults with complex needs which was part of the transformation programme.

The work envisaged related principally to the remit of the transitions team and the financial arrangements in place and associated lack of guidance governing the interface between the transition of service from children's services -the Council – and Adult Services – NHSH.

In recognition of those concerns a project team comprising officers from both organisations was established with 2 principle aims being:-

1. Preparation of guidance in terms of the interface between the 2 organisations;

2. The remit of the transitions team established in the Inner Moray Firth Area in terms of its operation and how that interfaces with delivery of transitions in the rest of the Highland area.

Preparation of Guidance

In terms of the first ask, for some time there had been concerns about how effectively transitions are managed and questions arose on a fairly regular basis about the timing of that transition and at what point a young person became the responsibility of Adult care services recognising that not all young people who receive a service from children's services will be eligible for an adult care service. This report relates only to those young people who are eligible for such a service.

It is recognised too that all cases are different and in particular there are differences in relation to the legal framework which is in place in terms of the Council's ongoing responsibility in terms of continuing care for care experienced young people. Put short, care experienced young people are entitled to choose to remain in the residential placement they were accommodated in at the time they ceased to be looked after subject to certain exceptions. Such a young person can be contrasted with a young person who is not looked after but has been open to disability services within children's services and is considered to be an adult at 16 albeit may remain open to education services.

It is also relevant to consider that some young people are likely to lack capacity at 16/18 and that too has an impact on what choices they might make. Put short, the legal framework surrounding transitions is complex.

In recognition of that complex picture, previous managers agreed that regardless of the legal position, responsibility should transfer from Children's Services to Adult Services at 18. Whilst having the advantage of simplicity, it is widely agreed that this is not workable and has caused issues about management of cases and does not reflect the legal – or actual -position of Highland's young people. It was also recognised that whilst seeking to reflect that position more appropriately it would be helpful to update the guidance for the case management of transitioning cases.

In terms of that challenge two documents have been prepared and are attached as **Appendix 2** and **Appendix 3** to this report. They reflect an agreed position between both organisations and have been in place since April 2022. It is intended that they be reviewed after one year in terms of any issues which have arisen. They are:-

1. Guidance for staff managing transitions. This document has been shared with the Transitions Team and those staff in the areas managing transitions and it is considered that it is helpful and reflects a procedure which would assist case management. It is also thought that it will provide clarity for families so that they understand how the transition of their child from children's services to adult care services will operate.

2. A financial flow chart. This is intended to reflect a more realistic proposal in terms of where responsibility should sit bearing in mind the legal framework and the case management guidance which has been agreed.

Remit of the Transitions Team

In terms of the second of those points referenced above, work is ongoing in relation to that.

By way of background, at present transitions are managed in Highland by a Transitions Team for Inverness and the Inner Moray Firth and by the local teams outwith those areas.

The Transitions Team is comprised of 2 separate teams of staff (1 Council and 1 NHSH) working together on a co located basis from an office in Inverness to provide a service to young people.

Whilst this colocation is considered positive it should be noted that this is not something which operates outwith the Inner Moray Firth area and as such there is ongoing work in terms of determining if a pan Highland approach is required and if so how that ought be delivered.

There are queries about the remit of that team in terms of its client base and how it operates. At the present times work is ongoing in terms of carrying out an options appraisal to consider how transitions ought be delivered pan Highland going forward. The outcome of that options appraisal will be reported to a subsequent Committee.

PART 3: Adult Services

Introduction

As noted in the preamble of this report, there is an intention to revise the future format and content of the Chief Officer report.

In the meantime, the Committee is reminded of those areas most recently reported to the Joint Monitoring Committee, are as highlighted below:

- Strengthening of Social Work Teams
- Commissioned Care at Home Services
- Commissioned/NHS Highland Care Homes
- Carers
- Staff Wellbeing and Support
- Response to Winter pressures/activity
- Mutual Aid Deployment
- Self-Directed Support Strategy
- Adult Support and Protection in Highland/Large Scale Investigations
- Care Response Team
- National Care Service
- Review of Covid-19 Key Issues and Risks

Whilst views are sought on preferred content going forward, this update focuses on wider key areas of activity as noted below:

Integrated Community Health and Social Care Teams

The NHS Highland Annual Delivery Plan has identified integrated community health and social care services as a priority over the next four years.

Ambition 9, Care Well includes the intention: "*we will develop front line community health and social care teams which offer fully integrated services*" (Intention 9.3)

Work has begun on identifying a definition and core function of integrated community health and social care teams which can be agreed and understood by all elements of the health and social care system.

Work will then progress to ensure teams have the environment to work in a fully integrated manner and be able to evidence their impact. This will involve workstreams related to facilities, IT and planning performance, workforce and integrated team processes and systems development.

In addition to community health and social care teams, the Community Directorate includes a number of hosted services including chronic pain, long covid, sexual health, Out of Hours and vaccinations.

Updates on these services have not been included in this first integrated community health and social care teams report (with the exception of vaccinations, as noted below), nor on the current redesigns (Caithness, Lochaber, Skye).

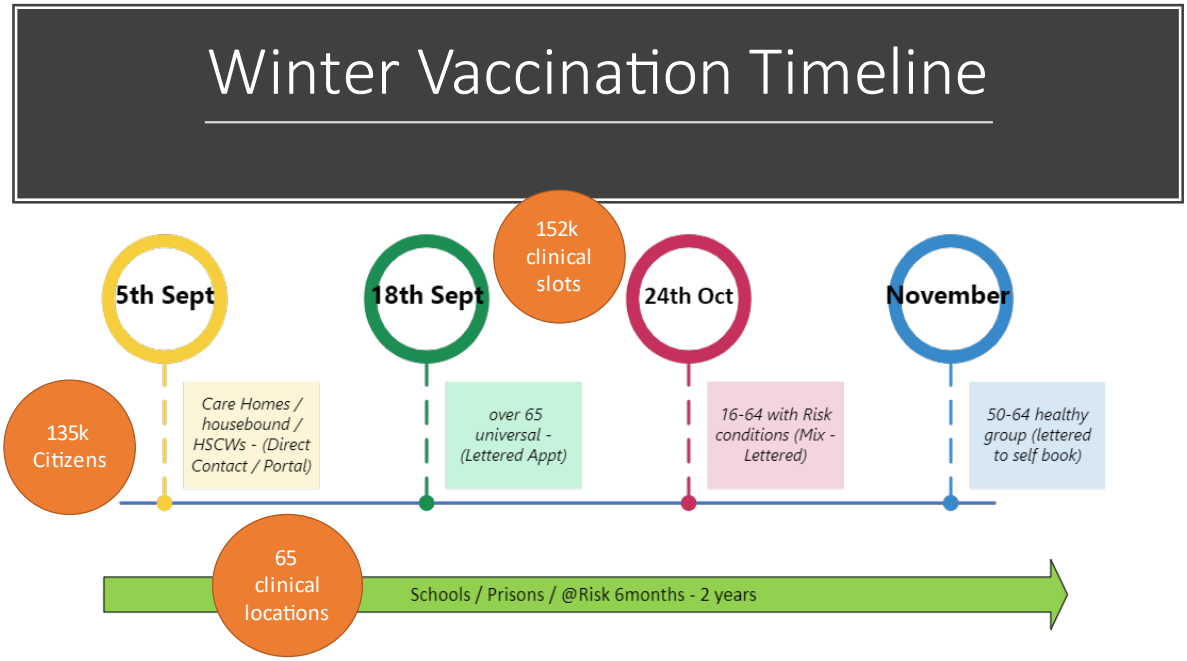
An initial **Integrated Performance and Quality Report** has been developed to be inclusive of the wider Partnership requirements and to further develop indicators in agreement with the Health and Social Care Committee and the Community Services Directorate. A development session was held with the Health and Social Committee on 29th September 2022 to review the performance and quality report as a first baseline. Thereafter the Committee will receive trend data with analysis on a quarterly basis. It is envisaged that the Partnership data set will enable the Joint Monitoring Committee to receive data on key issues to provide assurance and describe delivery on the Health and Social Care Partnership's strategic priorities which underpin successful integration.

- National Integration Indicators
- Self Directed Support – all Options
- Adult Protection
- Care Homes and Care-at-Home
- Flow/Pressure and Delayed Discharge from Hospital
- Capacity and Resource Utilisation
- Compliance - (AWI, ASP, Complaints, Absence Management, FOI, Data Protection etc)
- Experience/Quality/Carers Agenda
- Care Homes and Care-at-Home Programme

A full data set will be provided to inform the next Joint Monitoring Committee in this regard.

Vaccination Programme

The autumn / winter flu and covid vaccination campaign timeline is as noted below:



Flu and Covid vaccinations are now completely delivered by the Health Board with participating community pharmacies and Scottish Ambulance Service support in remote locations.

Travel vaccinations will be delivered by community pharmacies and this arrangement is currently being implemented.

The remaining adult vaccinations, pre school and school vaccinations will transfer to the Health Board delivery by April 2023.

Winter Planning

Planning is underway to consider and implement key actions in order to

- Avoid, minimise or redirect demand across all services (NHSH and external partners)
- Stabilise the services we commission or deliver
- Enable the services we commission or deliver to be prioritised and used to best effect

A key component of this plan is about communication and a draft communication strategy and campaign have been prepared to seek to raise awareness among service users, relatives and the wider community of the current pressures on our health and social care system.

We aim to help the wider community to understand what these pressures mean and how they can help NHS Highland and our partner agencies to reduce these pressures but most importantly, help to support themselves and also those living in their local communities to continue to live safely and with fulfilment in their own homes, with what might be just a little extra support.

We also want to help our service users and relatives understand why flexibility and contingency planning is important in relation to the care provided.

Our desired outcomes include:

- Increased awareness of adult social care services within the wider community, across all age groups
- Greater understanding and awareness of the role of the independent sector across internal NHS Highland areas referred to, or directly or indirectly with commissioned care services
- Improved understanding by service users and their relatives of the pressures on, and appreciation of, the work of our care staff across independent and in-house sectors
- Increased willingness for service users and relatives to be more flexible in how their care is delivered
- Increased number of people attracted to work in the adult social care sector and decreased staff turnover
- Additional capacity created within the social care system
- Maximised informal and community supports
- Improved resilience of care packages

Our messaging must be clear, simple and consistent. It may be that people are not aware of current workforce pressures; therefore explaining these pressures may be helpful. We can also explain the direct consequences these pressures have on service users, residents and staff.

The messages to be conveyed will therefore require to be different for different audiences as follows:

- Current service users and relatives – messaging to be flexibility, promotion of contingency planning
- Future service users and relatives – messaging to be awareness, managing expectations and utilising wider supports
- In-house staff – messaging to be awareness and understanding of pivotal role in wider system and the consequence of interactions
- Staff working across independent sector services – messaging to be that they are equally valued, and that actions are being taken to reduce the pressure
- Wider community in Highland – messaging to be we all have a role to play, they can help in really simple ways that can make a huge difference

This work is being progressed with multi-representation across NHS Highland and with a lead role from the Communication and Engagement team.

The key priority of this area of work is to initiate actions to within the next few weeks to get people talking and preparing to have a healthy and safe winter and to think about "what's my plan?".

In addition to seeking to manage demand through the above actions, a number of other areas are in progress to both maximise commissioned service capacity and also organisational capacity to respond to anticipated increased demand.

Mental Health and Wellbeing in Primary Care Services

The Scottish Government announced funding in February 2022, to support the formation and implementation of the Mental Health and Wellbeing in Primary Care (MHWBPC) Services Model.

MHWBPC services are required to be established within an area served by a group of GP practices (locality or cluster area). The service should include a multi-agency team providing assessment, advice, support and some levels of treatment for people who have mental health, distress or wellbeing needs. The guidance states that every MHWPC service should ensure that it provides access to a link worker to support wellbeing, with every GP practice having access to a community link worker who, through their role, will support mental wellbeing.

The guidance also covers how individuals should be able to access the service, digital and self-help approaches, and pathways for people who require urgent care. The services are expected to be developed incrementally by Spring 2026, and funding has been confirmed to support its delivery, building on the funding already in place to support mental health in primary care through Action 15 of the Mental Health Strategy and Primary Care Improvement Funding.

Highland has recently developed a Mental Health Primary Care service supported by funding from Action 15 monies and the Primary Care Improvement Fund. A separate service of Community Link Workers. delivered by Support in Mind, has been commissioned through Public Health. To progress the next phase of work Highland will bring together the different strands into one workstream and intend to host a workshop in the forthcoming months to discuss future models of service delivery.

The indicative funding allocations shows £501,014.32 allocated to Highland in 2022-23 rising to £1,000,621.55 in 2024-25. There has been a delay in the allocation of this funding and therefore plans have not yet progressed. Further details on the plan can be brought to the Joint Monitoring Committee if required.

Coming Home Report in relation to people with a Learning Disability

"Coming Home Implementation: A report from the working group on complex care and delayed discharge" was published by the Scottish Government on 21 February 2022.

The report made 4 key recommendations:

- a dynamic support register should be developed into a tool for national use,
- a national support panel should be established in order to provide support and oversight of the dynamic support register,
- a national peer support network should be established to facilitate people coming together to learn and share best practice and
- further work should be undertaken to explore the issues in relation to people with enduring mental health conditions who are subject to delayed discharge from hospital.

A Coming Home Change Fund was also established, and Highland was allocated funding of £814.627 over 3 years. This funding has been used to support the development of new cluster housing in Muir of Ord for individuals with learning disabilities and behaviours that challenge services. The fund will also support all attempts to prevent individuals needing to move to placements out of Highland. Further details on the plan can be brought to the Joint Monitoring Committee if required.

Medication Assisted Treatment (MAT) Standards implementation

The MAT standards were published in May 2021 with the intention of contributing to the successful delivery of the National Mission to save and improve lives in response to Scotland's drug deaths crisis. The standards enshrine a rights-based approach to immediate, person-centred treatment for problem drug use, linked to primary care, mental health and other support services.

There has been a delay in Highland's ability to implement all of the standards fully, although much work has progressed, and Highland is now receiving additional support from the Scottish Government to implement the standards.

An action plan is currently being worked upon by the team, with support from the Highland Alcohol and Drug Partnership (HADP) and is due to be submitted to the Scottish Government by the end of September. Further details on the standards or the plan can be brought to the Joint Monitoring Committee if required.

Carers

Work has been ongoing in Highland during 2022-23 to continue to implement a balanced "carers programme" aimed at meeting our duties under the Carers Act.

This has included:

- Supporting a number of local projects to increase carers' access to practical and creative help in the short term to mitigate the impact of Covid-19.

- Maintaining our Option 1 Short Breaks scheme to increase the access of carers to flexible, personalised ways to give them a break; and

- Supporting our core carers services to ensure we can meet our duties to provide: advice and information and Adult Carer Support Plans (ACSPs) etc.- at a time of increasing demand and inflation.

Taken together, just under 500 Adult Carer Support Plans were in place via our Carers' Centre, and over 190 individual carers have benefitted from an SDS Option 1 Short Break in the last 2 Quarters (totalling over £0.5m in funding).

We are also co-producing a new Carers Strategy for Highland so that the available resources are used to meet our statutory duties in a way which reflects the needs and priorities of our unpaid carers.

We want the work of our strategy to promote:

- the voice of carers, so that it shapes policy and practice and the culture of decision-making across Highland
- the open sharing of information
- the rights of carers
- access to timely support, help and advice for carers - which helps them cope.
- the choice and control of carers in shaping the support they need
- positive attitudes towards unpaid carers within statutory bodies, employers and wider society - and that the role of carers is properly valued

There will be a co- production of this strategy, this is in line with an evolving, relationship-based and systems thinking approach. The aim will be to have the strategy outlined by mid-2023.

Self-directed Support (SDS) Strategy

We do not think there is a simple, technical fix to the complex set of implementation issues in respect of Self-directed support. Rather, we believe we need to bring people 'around the table' to explore how we can make the changes together.

NHS Highland's SDS Strategy is therefore about forming relationships, building trust, sharing intelligence and co-producing the new ideas and solutions necessary to truly refresh our approach to implementing Self-directed support in Highland.

Subsequent to a significant consultation effort, a number of local co-production groups are now working to improve our delivery of SDS, including by:

- Improving local information about how budgets can be used flexibly
- Exploring how SDS can be used to complement Community-Led approaches to act preventatively
- Agreeing a realistic budget that those managing an Option 1 and 2 can translate into good quality care
- Agreeing how we can best engage people in realistic and creative conversations about the choice and control that SDS can offer them, and
- Seeking to bring together statutory and community partners to explore realistic "place-based" commissioning in some of our most rural communities

We anticipate the growth trend in Option 1s to continue over time – and we are keen, therefore, to increase the availability of independent support to help those choosing this option.

This strategy development is also progressing along an approach similar to the above Carers strategy.

Adult Protection

The proposed structure of the Adult Protection Committee (APC) Sub-Groups under the Continuous Improvement Framework is now in place with all groups meeting quarterly and with agreed terms of reference, clear work plans and progress being demonstrated via action trackers.

A Learning Review Sub-Group has also been set up with delegated authorisation from the APC to make decisions around new learning review referrals and oversee reviews that are being undertaken.

A self-audit was completed in December 2021 of 5% of 2020-2021 referrals to social work (32 cases).

Findings of the audit - in general terms – were that the “duty to inquire” is discharged appropriately and the “three-point test” is properly applied in the great majority of cases.

The quality of risk assessments and protection plans was rated as good; and the timescale for work being done seems to be in keeping with the needs/risks of individuals. There is also evidence of good outcomes in most cases. Nevertheless one or two cases caused concerns at different parts of the protection process, and an improvement plan is being effected.

A review of learning and development within Adult Protection in Highland has been completed and was supported by the Learning and Development Sub-Group of the APC.

A survey of those who work with people at risk of harm (and adults with incapacity) across the system has informed this, and an updated Adult Protection training programme is now in development.

Commissioned Care at Home Services

A detailed update on commissioned care at home services was provided to the JMC at its previous meeting on 3 August 2022.

The current priority around this area remains on working with the sector to address service reduction, ensure service stability and build capacity. NHSH is working closely with care at home providers both individually and collectively as a sector to identify and address any issues and to co-produce solutions.

A key component of this area relates to maximising available capacity within care at home scheduling, which is a complex area and which needs to take account of multiple factors such as visit locations, durations, staff inputs (eg if double up), timings (eg if time sensitive) and proximity of the preceding and next calls.

In ensuring all available capacity is fully utilised, we are encouraging flexibility with service users and their families for whom timed visits such as medication dispensing, is not critical. Communications around this area are being finalised for release, alongside the wider communication plan referred to above.

Commissioned Care Home Services

The JMC is aware of current fragility issues, as reported to the JMC previously and as elsewhere on this agenda.

Recommendation

i. **Note** the update;

ii. **Consider** and provide direction on the proposed refreshed template and future content.

Designation: Chief Officer, North Highland Health and Social Care Partnership

Date: 27 September 2022

Report Contributors:

- Head of Integrated Childrens Services
- Head of Integration, Adult Social Care
- Head of Community
- Head of Mental Health, Learning Disabilities and Drug & Alcohol Recovery Services
- Adult Social Care Leadership Team
- Deputy Chief Officer HH&SCP

Appendix 1
Proposed reporting template

JMC Chief Officer Report DRAFT TEMPL.

Appendix 2
Guidance for staff managing transitions

Appendix 2 - Chief Officer Report - Draft

Appendix 3
Financial Flow Chart

Appendix 3 - Chief Officer Report Transit

APPENDIX 1

Agenda Item	
Report No	

THE HIGHLAND COUNCIL/NHS HIGHLAND

Committee: **Joint Monitoring Committee**

Date: **XX**

Report Title: **Chief Officer Report**

Report By: **Louise Bussell, Chief Officer**
Fiona Duncan, Executive Chief Officer, Health and Social Care

Purpose/Executive Summary

1. The purpose of this report is to inform the Joint Monitoring Committee of the activities that support delivery on the Highland Health and Social Care Partnership's strategic priorities.

2. Recommendations

2.1 Members are asked to:

i. **Note** the update; and
ii. **Consider** the recommendations as noted within the report.

3. Implications

3.1 Resource

3.2 Legal

3.3 Community (Equality, Poverty, Rural and Island)

3.4 Climate Change / Carbon Clever

3.5 Risk

3.6 Gaelic

PART 1: Children's Health Services

PART 2: Transitions Service

PART 3: Adult Services

This update is to inform the Joint Monitoring Committee of the Chief Officer's activities that support delivery on the Highland Health and Social Care Partnership's **strategic priorities** and its delivery of the **9 Health and Wellbeing outcomes**.

Introduction / H&SCP Updates
Eg
Ministerial Visits
Visit to services
Awareness weeks

Strategic Plan and Strategic Planning Group – Status and Update
Eg
Status of Strategic Plan, action plan, themes and issues from Strategic Planning Group

Workforce - Staff, Structure, Wellbeing
Eg
Changes to key posts within the H&SCP
Periodic provision of staffing structure
Actions and initiatives to support in house and commissioned services staff wellbeing

Service Updates
Eg Vaccination programme, outpatient appointments

Community

Primary Care

Mental Health, Learning Disabilities and Drug & Alcohol Recovery Services

Commissioned Services

Service Redesigns

Operational Challenges
Eg
Recruitment and retention
Care homes
Care at home
GP Services

Regional Updates
If appropriate

National Updates
Eg
Winter vaccinations
Face masks
Smoking ban
Retiring NHS staff helped to return to workplace
Cyber security
National Care Service
Social Care digital landscape review
Current state of pressure

Audits and Inspections
Eg
Care Inspectorate
Internal / external audits

Risks and Risk Management
Eg
Risk register, risk mitigations and management

Good News
Eg
Staffing qualifications, awards, commissioned services accolades

Designation: Chief Officer, North Highland Health and Social Care Partnership

Date: XX

Authors / Report Contributors:

APPENDIX 2

Transitions Planning Guidance for Young People (note post 18 comment applies to care experienced young people only

Important Note_- Ages given are indicative only. Please ensure that you also look back at the previous columns to ensure the tasks are completed (particularly in relation to need for AWI legislative interventions). The Service Lead is indicative, it is recognised that some young people may have a different pathway.

From Age 14: Children Services Lead	**By Age 15: Children Services Lead**	**At Age 16:**	**At Age 17:**	**At Age 18:**	**At Age 19:**	**At Age 21:**	**At Age 25: Adult Services Lead**
Children's Services Lead Professional advises NHSH District Health and Social Care Service that input may be required . Agreement sought between children's and adults services in terms of whether a young person is likely to require an adult care service Part A of the POP used to alert Adult H&SC Care Team either on Care First or hard copy. Adult service acknowledges receipt **within 1month** Young People with complex needs who will require housing and support into adulthood should be added to the complex case list.	Child's Plan with transitions' focus agreed. Impact of Benefit changes considered and factored in. Capacity issues actioned as appropriate Advocacy Issues actioned as appropriate. Carers needs actioned as appropriate POP considered. Adult Social Care professional allocated and POP commenced as appropriate to indicate intended outcomes and independent living options if these are likely to be required. **Future living options**	Child's Plan with transitions' focus agreed. Impact of Benefit changes considered and where appropriate accessed. Potential for further education, training, work or volunteering explored. Positive Pathway Agreement actioned where appropriate Carers needs considered and need for ongoing support for carers considered	Work on POP continues and any necessary accommodation option agreed and identified by young person and their supporter and/or legal proxy. ***Post 18 S-DS reassessed*** . ***Potential for further education, training, work or volunteering explored.***	P.O.P. ***completed*** capturing intended outcomes and plans for independent living/ accommodation options together with education/training/work/volunteering actions to be agreed and identified by young person and their supporter or legal proxy. Information required in terms of care experienced young person remaining in accommodation on a continuing care basis Carer's Support Plan completed where appropriate Benefits accessed. 'Aftercare Support' continues to be delivered up to age 26 (to an eligible young person and should be managed by that young person or their proxy Consider ordinary residence guidance if young person is expressing a wish to stay in or move to an out of area placement.	Ongoing review and monitoring of P.O.P. with young person and their supporter/legal proxy to include all outcomes referred to previously Carers Support Plan updated	Ongoing review and monitoring of P.O.P. with young person and their supporter/legal proxy to include all outcomes referred to previously . Review of Aftercare Support up to age 26 by children's services	Ongoing review and monitoring of P.O.P. with young person and their supporter/legal proxy to include all outcomes referred to previously . Review of Aftercare Support up to age 26 by children's services

Post school outcomes discussed including Housing. Capacity & Advocacy Issues considered. .	**and planning for accommodation Post 'Care Placement'** P**lanning <u>completed at least</u>** 12 months before the confirmed leaving date Ongoing need for liaison with the young person and any advocate						

Glossary of Terms

Care Experienced - A young person who has previously been looked after by the local authority whether by way of a supervision order or a Permanence Order or as a result of an arrangement pursuant to s25 Children (Scotland) Act 1995 (with consent of parents or if no person with parental rights and responsibilities who is able to provide accommodation)

***P.O.P.* -** (Personal Outcome Plan) is the tool that is used by staff to undertake an outcomes-focussed assessment in partnership with an individual. It sets out what the individual is seeking to achieve and details agreed outcomes, to which resources may be awarded.

Complex Case list – A young person is in a purchased residential placement in our out of Highland and/or it is anticipated that the young person will require housing and support option before 25yrs and/or the package is in excess of £30k and/or there are potentially high levels of risk (agreed at Complex Case Forum meetings)

Post Care Placement - place where the young person resides when they are no longer looked after.

Continuing Care - Duty upon the local authority (children's services) to provide young people whose final placement is in foster, kinship or residential (non secure) care with the same accommodation which was provided at the time the young person ceases to be looked after unless such a placement is not wanted by the young person or if the local authority takes the view that continuing to provide such accommodation would have an adverse effect on that young person's welfare. Note too that continuing care and its provision by children's services is in relation to those services provided by children's services in terms of accommodation – costs costs (if any) will be met by adult care services as required.

Aftercare – Duty upon the local authority (children's services) to provide advice, guidance and assistance to eligible care leavers if those needs cannot be met through existing universal services

Carer's Support Plan- People who have an unpaid caring role may need support to sustain what is often a very demanding role. 'Connecting Carers' is a Highland-wide, third sector carers centre service that can undertake an assessment and agree an outcomes-focussed Carers Support Plan with the Carer.

NOTES:

1. This chart is for people aged between 16 and 21. Under 16 funding is THC responsibility. Over 21 is NHS responsibility

2. This chart is for Social Care Costs only.

3. If young person lacks capacity, decisions should be made by a legally appointed proxy. If the young person (or proxy) does not want to remain in continuing care but no alternative has been identified then adult services are responsible for the cost of that continuing placement whilst an alternative is identified.