Agenda Item	9.
Report No	PEO 04/17

HIGHLAND COUNCIL

Committee: **People Committee**

Date: **21 June 2017**

Report Title: **NHS Highland Assurance Report**

Report By: **Director of Care and Learning**

1. Purpose/Executive Summary

1.1 The purpose of the 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.

2. Recommendations

2.1 Members are asked to:

i. Scrutinise the data and issues raised in this report. Comments will be incorporated into a report to NHS Highland as part of the revised governance arrangements.
ii. Support the testing of a Schools Based Immunisation Team during academic session 2017-18.

3 Positive Progress and Transformation

3.1 As previously reported, a new Health Visitor pathway was introduced across Scotland with routine contacts increasing from 5 to 11 in the first years of a child's life. The rationale is to promote a therapeutic relationship between the family and their Health Visitor, allow an environment where any additional needs are identified early, and promote strength-based interventions in a timely manner. The full document is available at http://www.gov.scot/Publications/2015/10/9697/0

3.2 Highland was one of the first areas to begin the incremental introduction of the pathway, and it was agreed that this should be for all babies born from the 1st May 2016. For local Family Teams, this will mean that the first babies to benefit from the pathway are currently reaching their first birthdays. The work of the implementation group has focussed on 3 main areas: workforce planning, care planning, and education and training.

3.3 Workforce planning has been agreed in line with the national caseload weighting tool, and the additional Scottish Government funding available for this and over the next 2 financial years, to provide an additional 13.75 FTE posts and take the Health Visitor capacity to 62.6 FTE posts. To date an additional 9.3 Health Visitor posts have been established with the final additional posts being established in the current financial year.

3.4 The workforce planning tool was re-run for Highland at the beginning of 2017, to monitor any changes in demographics and to ensure that the remaining additional posts are established to meet changing population requirements. It is intended that this caseload monitoring exercise be repeated at least every 2 years to ensure adequate team capacity.

3.5 The care planning work is well underway with the revised 13-15 month review process ready for introduction in June. Training in the use of the newly adopted national developmental assessment tool, Ages & Stages Questionnaires (ASQ), has been completed and introduced at the 8, 13-15 and 27-30 month reviews. These reviews will shortly be reported nationally and this will give, for the first time, a Scotland-wide picture of developmental progress. There is also testing work with one of the Family Teams around the sharing of the developmental outcomes at the 27-30 month review with the local preschool nursery. This will allow the nursery to focus on any identified developmental needs from the child's first attendance.

3.6 We have agreed with the Scottish Government that implementation of the pathway will require local teams to be flexible in their approach; for example with regard to the number of visits that are delivered in the home, or the number of contacts that can be undertaken by a qualified Health Visitor and those that can be safely delegated to a Community Early Years Practitioner. Where deviation from the prescribed pathway occurs, teams will provide an action plan to senior management explaining the agreed actions and the rationale behind this. A quarterly reporting system is being developed to monitor the level of pathway compliance. There is currently discussion about Health Visitor use of

telemedicine in rural and island areas which could ease capacity issues in many of these communities.

3.7 It is also recognised that in this interim period of implementation, Health Visitors are running two systems of care. The old pathway, with fewer visits, generates additional input requirements from nursery aged children whose developmental needs may not have been recognised before starting nursery. The new pathway, with the improved contacts and better relationships with families, is designed to pick up any needs early and be in the process of being addressed by the time the child reaches nursery.

3.8 Health visitors currently have to deal with both areas of demand, and this will continue until the birth cohort on the new pathway reach nursery age. It is hoped that in 2019, when Health Visitor numbers reach the agreed levels and the birth cohort on the new pathway reach nursery, the new pathway will be fully implemented as per the national guidance.

4 Introduction of new pathway to assess neurodevelopmental needs

4.1 Following a Rapid Performance Improvement Workshop, the referral route for assessment of children with neurodevelopmental difficulties has been amended so that there is one route into a multi-agency team comprising

- Community Paediatrician
- Speech and Language Therapist
- Clinical/Assistant Psychologist
- Occupational Therapist

4.2 The new pathway was launched on 8th May and introduces: a new assessment/ information form, a central point of entry, weekly triage meetings with service managers and clinical planning across Highland. It is intended to promote earlier identification of needs, and over time, a quicker response.

4.3 There have though been some complications in implementation, with multi-disciplinary partners questioning why additional information is being required from them. This will need to be followed up.

5 Areas for Development – immunisation service

5.1 The national school nurse review recommended that caseload holding school nurses direct their work to focus on substance misuse, transitions, complex health needs and improving health outcomes for vulnerable groups (e.g. Looked After Children and Child Protection). Immunisation is no longer expected to be delivered by school nurses but by staff nurses on a lower pay band. Many health boards are now looking to create immunisation teams whose role it would be to undertake immunisations to children, not currently undertaken by GPs. It is suggested that Highland Council test out a model of schools based immunisation delivery in academic session 2017-18.

5.2 School nurses are spending increasing amounts of time delivering schools based immunisation sessions to the detriment of other activities. The current

immunisation programme for school aged children involves a total of 22,000 immunisations per year in Highland schools.

5.3 National GP contract negotiations are currently underway, and may result in GPs no longer undertaking any childhood vaccines. This will result in a greater workload for other health staff making this proposal a useful test for future delivery.

5.4 It is estimated that the pilot team would require:

Role	**Banding**	**FTE (working annualised hours)**	**Annual cost**
1x Team Leader	Band 6	0.91 (equivalent to 1FTE term time)	£40995
4x Staff Nurses (0.6FTE)	Band 5	2.4	£72571
1x Admin Support	HC03	0.5	£10890
Total cost			**£136902 Including oncosts**

6. Balanced Scorecard

6.1 The Balanced Scorecard is attached as **Appendix 1.**

6.2 The Primary Mental Health Worker (PMHW) Service provides monthly data on waiting times for children and young people referred to this service. – **see Appendix 2.** The service aims to start treatment for each child or young person referred to the service within 18 weeks and is required to do this for 90% of patients, in line with the NHS HEAT target. Generally, referrals are seen well within the 18 week target, many seen within 6 weeks, as this is an early intervention service.

6.3 There have been several changes of staff over the past 9 months and this has affected the consistency of the service, although in only one month has the service failed to meet the referral to treatment target. These changes have been managed in a way that has kept disruption in service delivery to a minimum but at times patients have waited longer than would be ideal for an early intervention service

6.4 Indicator number 24 is not showing improvement (6-8 week health reviews) but there has been work with GPs to improve returns, and the Health Visitor data is showing that the returns are more complete than previously.

6.5 Indicators 31 and 32 (relating to dental registration and number of children aged 2 years who have seen a dentist) have been raised by NHS Highland with dental services and improvement work is planned across the Oral Health and Health Visitor teams, aimed at improving uptake.

7. Implications

7.1 Resources

7.1.1 The additional capacity required to deliver the health visitor pathway has been partly funded through Highland Council's preventative spend and partly from additional recurring resource from the Scottish Government. However after 2017/18, any additional training requirements will require to be met by Highland Council.

7.1.2 Locally, the Health Visitor training programme is being delivered by the University of Stirling, and 2 cohorts of trainees have completed and taken up posts as qualified Health Visitors. A further 6 trainees are currently undertaking the programme, due to complete in December 2017. It is expected that a further 5 trainees will enrol in January 2018, to achieve the agreed final establishment.

7.1.3 There is a budget of £58.2k for the immunisation service. The balance of £78.7k would be achieved from slippage on the overall quantum budget provided by the NHS. This would enable a 10 month pilot.

7.1.4 The outturn on the revenue budget for 2016/17 is included at **Appendix 3.** It should be noted that it is increasingly difficult to accurately reflect the respective contributions of Highland Council and NHS Highland to these budgets, given the further development of integrated services and continual improvement leading to structural changes.

7.2 Legal

7.2.1 There are no issues identified.

7.3 Community (Equality, Poverty and Rural)

7.3.1 In relation to the Health Visitor pathway, as this is an enhanced universal pathway, it provides an enhanced service to all families. By increasing the contact for all families where additional needs are identified, families will be offered additional support at an earlier opportunity. It is hoped that through working with other island and rural Boards, innovative use of telecare will enable an equally effective universal health visiting service.

7.3.2 The new neurodevelopmental pathway is designed to improve access and speed up delivery to children with additional needs.

7.4 Climate Change / Carbon Clever

7.4.1 Additional home visiting is leading to additional travelling requirements. Health Visitors will be asked to plan their visiting to keep travelling to a minimum.

7.5 Risk

7.5.1 No new risks have been identified.

7.5.2 The proposal to re-shape immunisation services is aimed at reducing risks by enhancing and re-shaping the delivery mechanism. Risks are routinely reported to the NHS Highland Risk Governance Group.

7.6 **Gaelic**

There are no issues identified.

Designation Director of Care and Learning

Author Sandra Campbell, Head of Children's Services

Date 8 June 2017

Appendix 1

Balanced Scorecard

Key
Performance improving
Performance declining
Performance is stable

HEALTHY Outcome 4. Children and young people experience healthy growth and development							
	Indicators	**Target**	**Baseline**	**Status**	**Improvement Group**	**Current performance**	**Comment**
20	% of children reaching their developmental milestones at their 27 – 30 month health review will increase	85%	75%		Early Years	79%	Reported annually
21	% of children will achieve their key developmental milestones by time they enter school will increase	85%	85%		Additional support Needs	87%	Reported annually
22	There will be a reduction in the percentage gap between the most and least deprived parts of Highland for low birth weight babies	Improve from baseline	2.7%		Early Years	4.2%	Reported annually
23	Improve the uptake of 27-30 month surveillance contact from the baseline of 52% to 95%	95%	82.5%		Early Years	87.6%	Reported quarterly
24	95% uptake of 6-8 week Child Health Surveillance contact	95%	85.1%		Early years	82%	Reported quarterly
25	6-8 week Child Health Surveillance contact showing no difference in uptake between the general population and those in areas of deprivation	No variance	-8.4%		Early years	-5.7%	Reported annually
26	Achieve 36% of new born babies exclusively breastfed at 6-8 week review	36%	30.3%		Maternal infant nutrition	31.3%	Reported quarterly
27	Reduce % gap between most & least affluent areas for children exclusively breastfed at 6-8 weeks	Improve from baseline	14.4% compared to 41.9%		Maternal infant nutrition	15.8% compared to 38.8%	Reported annually
28	Maintain 95% Allocation of Health Plan indicator at 6-8 week from birth (annual cumulative)	95%	97.3%		Maternal infant nutrition	100%	Reported quarterly

29	Maintain 95% uptake rate of MMR1 (% of 5 year olds)	95%	94.6%		Early Years	96.3%	Reported quarterly
30	Sustain the completion rate of P1 Child health assessment to 95%	95%	93.1%		Early Years	99.8%	Reported quarterly
31	The number of 2 year olds registered at 24 months with a dentist will increase year on year	Improve from baseline	73.9%		Public Health and Wellbeing	73.4%	Reported quarterly
32	The number of 2 years olds who have seen a dentist in the preceding 12 months will increase	Improve from baseline	67.3%		Public Health and Wellbeing	42.9%	Reported quarterly
33	Waiting times for AHP services to be within 18 weeks from referral to treatment	95%	85%		Additional support Needs	80%	Reported quarterly
34	95% of children will have their P1 Body Mass index measured every year	95%	91.1%		Early Years	94.5%	Reported annually
35	90% CAMHS referrals are seen within 18 weeks	90%	80%		Mental Health	93%	Reported quarterly
36	% of statutory health assessments completed within 4 weeks of becoming LAC will increase to 95%	95%	70%		Looked after children	85%	Reported quarterly
37	95% of health assessments for LAC who are accommodated are available for the initial child's plan meeting at six weeks	Improve from baseline	66.7%		Looked after children	67%	Reported quarterly
Outcome 5. Children and young people make well-informed choices about healthy and safe lifestyles							
38	The number of hits on pages relating to children and young people on the Substance Misuse Website increases	Improve from baseline	422		Public Health and Wellbeing	538	Reported annually
39	Self reported incidence of smoking will decrease (P7)	Improve from baseline	0.5%		Public Health and Wellbeing	1%	Data from 2015 Lifestyle Survey
40	Self reported incidence of smoking will decrease (S2)	Improve from baseline	5.5%		Public Health and Wellbeing	3%	Data from 2015 Lifestyle Survey
41	Self reported incidence of smoking will decrease (S4)	Improve from baseline	12.%		Public Health and Wellbeing	10%	Data from 2015 Lifestyle Survey

Appendix 2

PMHW waiting times

	Aug '16	Sept '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	April '17
Number of patients seen each month	39	40	40	14	42	9	40	41	13
% of patients seen within 18 weeks of referral	**97%**	**100%**	**100%**	**93%**	**100%**	**89%**	**100%**	**100%**	**100%**
% of patients seen within 6 weeks of referral	79%	90%	90%	21%	69%	30%	73%	73%	23%

Appendix 3

Integrated Finance Report

2016/2017 Integrated Health Monitoring Statement			
Activity	**Budget**	**Actual to Date**	**Variance**
Allied Health Professionals	3,073,568	2,751,014	-322,554
Service Support and Management	1,129,461	1,034,721	-94,740
Child Protection	446,408	338,557	-107,851
Health Development	596,335	533,013	-63,322
Family Teams	16,788,311	16,162,624	-625,687
The Orchard	1,186,056	1,189,564	3,508
Youth Action Services	1,456,911	1,250,736	-206,175
Primary Mental Health Workers	535,929	497,824	-38,105
Payments to Voluntary Organisations	953,774	983,906	30,132
Total	**26,166,753**	**24,741,959**	**-1,424,794**
Commissioned Children's Services income from NHSH	**-9,274,498**	**-9,274,498**	**0**