Agenda Item	10.
Report No	PEO 31/17

HIGHLAND COUNCIL

Committee: **People Committee**

Date: **19 October 2017**

Report Title: **Children's Services - 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.

3 Positive Progress and Transformation

3.1 Immunisation team pilot

3.1.1 Following the approval by the Committee in June steps have been taken to establish a pilot team for the South and Mid areas to provide a dedicated immunisation service.

3.1.2 The schools-based Immunisation Team is now in place and ready to undertake the majority of vaccinations in schools across the Mid & South areas. There will still be a need for some school nurses to assist, particularly during the primary school flu vaccine programme, but all of the secondary school vaccines will be delivered by the team releasing valuable school nursing capacity. In tandem with this, the implementation of the recommendations from the National School Nursing review will also begin across Highland.

3.1.3 In addition there is a national Vaccine Transformation Programme occurring over the next 2 years, which will change how all vaccines are to be delivered in Scotland. For Highland this work is being led by NHS Highland but evaluation of the Highland Council Immunisation Team should provide useful information on a team-based delivery model.

4 Areas for Development – Allied Health Professionals (AHP) waiting times

4.1 Concern was raised at the last People committee about waiting times and the impact of vacancies on these. **Appendix 1** provides further detail of the actions being taken to address this.

5. Balanced Scorecard

5.1 The scorecard is attached at **Appendix 2.** NHS Highland has reported that there is a national technical issue which is affecting the provision of data for measures related to health checks for children at 6-8 weeks and 27-30 months. Work is ongoing to resolve this issue.

5.2 Performance measure 36 concerns the percentage of statutory health assessments that are completed for a child within 4 weeks of becoming Looked After. Progress continues to be made towards seeing children and young people for their initial health assessment within 4 weeks of notification despite an increase in the number of children becoming Looked After in the past 6 months. Although this has increased the pressure on practitioners in terms of completion times, it should be noted that any assessments not undertaken within the timescale have largely been as a result of personal choice. This is where a minimum of 3 attempts are made to engage with the young person and/or their family but they have declined.

5.3 Performance measure 37 relates to the percentage of health assessments for Looked after children who are accommodated that are available for the initial child's plan meeting at six weeks. Assessments of children placed directly out of Highland when they become Looked After are undertaken by the receiving NHS

Board. In addition, senior school nurses and nurse specialist for the youth action service are currently supporting this health assessment process. There has also been recent improvement in both assessment processes and quality assurance which have resulted in better alignment between the health assessments being completed and being available to the child and family to support decision making at the initial child's plan meeting.

6. Implications

6.1 Resources

No updated finance monitoring report is available for this Committee. There are no new resource implications.

6.2 Legal

There are no issues identified.

6.3 Community (Equality, Poverty and Rural)

No issues have been identified.

6.4 Climate Change / Carbon Clever

There are no new issues.

6.5 Risk

Risks are routinely reported to the NHS Highland Risk Governance Group. A full copy of the current risk register is attached at **Appendix 3** for information.

6.6 Gaelic

There are no issues identified.

Designation Director of Care and Learning

Author Sandra Campbell, Head of Children's Services

Date 3rd October 2017

Appendix 1

Allied Health Professionals Waiting times

Compliance with the target of 90% of clients receiving support within 18 weeks of a request for service being made has not been achieved consistently for all AHP teams. For all professions there is an increase in both the volume and complexity of requests for service. At the same time recruitment and retention of qualified staff is an ongoing difficulty. A national and local focus on early intervention, prevention and self-management, while welcome and predicted to have a long term effect of reducing requests, has put added pressures on teams, particularly Speech and Language Therapy. The development of NDAS (Neuro developmental assessment service) has also added to pressure on SLT and Occupational Therapy at present, as this once again encourages early identification of needs.

Data on numbers of requests for service and wait times, along with information on possible reasons for changes in these figures is now being collected and monitored by AHP leads and teams. We are collecting information on what service users want, their concerns and needs when a request is made, and the outcomes from first conversations. This helps us decide what we need to be working on and towards, and where we need to target support, training and further supervision. We aim to collect statistics on outcomes following AHP intervention, how support is given, use of self-management materials, training offered and attended, and amount of travel time for AHPs.

A plan has been put in place with the aim of reducing waiting times and increasing satisfaction for all clients. This is multi- faceted and will take some time to implement fully.

This plan includes:-

Recruitment- This is an issue nationally with at present around 70 AHP vacancies across NHS Highland area. NHSH/ HC Employment services along with Lead AHPs are working on raising the profile of AHP careers in schools; developing a microsite for recruitment; improving the candidate information pack; having a perpetual advert for AHPs; attending careers fairs; possibly developing apprenticeships; and UHI developing support practitioner training. Recruitment is likely to be an ongoing issue in the near future so looking at skill mix is essential.

Retention- Initiatives include providing flexible working; improving staff wellbeing through wellness training and illness management; mentorship, supervision and team working; and ensuring opportunities for staff development and innovation.

Staff Development- Training in ‘Effective Referral Conversations’, which will improve triage decisions and caseload management, will take place soon following a successful bid for Fellowship funding. A supervision policy and structure has been agreed, and training for supervisors is to be sought. Training in improvement, change and leadership is ongoing- and projects around this are linked to the CYP AHP Plan, formally supported and monitored.

Workforce planning- Mapping of current and future workforce needs is taking place, including succession planning, and looking at use of admin and support practitioners.

Increased use of technology- We presently mostly use phone conversations as a first point of contact following a request for service being made. Advice and onward referral can then be offered if necessary.

'Attend Anywhere' (a secure Skype like system) is about to be trialled in Skye and Lochalsh by SLT following agreement for national and NHS Highland support. Use will then be spread throughout Highland council area and will reduce travel time for staff and clients. It is presently used by NHS Highland Pharmacy and by some other NHS teams throughout Scotland.

SLT and Dietetics are trialling the use of 'Florence', which is a simple, interactive service which uses mobile phone text messages. Users may receive text messages which offer reminders, health tips, advice and support; ask questions related to health and wellbeing and respond to the answers given.

Self-management- Written self-help information has been and continues to be developed and is available on www.bumps2bairns.com and www.highlandliteracy.com. SLT have developed information on which websites and apps may be useful, and the other AHPs will be adding to this. SLT are about to trial giving universal access to online booking via the bumps2bairns site for training courses for professionals, parents, carers and young people. We are also trying drop in sessions and are aiming to have an advice line.

Services- We plan to agree core services with service users, and develop and update clinical pathways.

These measures when taken together should make a positive difference. Reductions in waiting times are predicted to take place in the next few months, with this continuing over the next year and beyond.

Kayrin Murray

Principal Officer AHPs, Care and Learning, Highland Council.

Appendix 2

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	70.6%	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%	52%		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	33.1%	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	70%	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	76.1%	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	77.8%	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	80%	Reported quarterly

Appendix 3

Commissioned Child Health (Integrated Services)

Risk Register – <u>September 2017</u>

The following matrix will be used for risk prioritisation, further information can be found in the Risk Management Policy.

LIKELIHOOD	CONSEQUENCES / IMPACT				
	Insignificant	Minor	Moderate	Major	Extreme
Almost Certain	MEDIUM	HIGH	HIGH	VERY HIGH	VERY HIGH
Likely	MEDIUM	MEDIUM	HIGH	HIGH	VERY HIGH
Possible	LOW	MEDIUM	MEDIUM	HIGH	HIGH
Unlikely	LOW	MEDIUM	MEDIUM	MEDIUM	HIGH
Rare	LOW	LOW	LOW	MEDIUM	MEDIUM

Date	Description Of Risk	Risk Owner(s)	RISK EXPOSURE			RISK CONTROL		RISK EXPOSURE		
			Likeli-hood (L)	Severity (S)	Risk rating	Existing Control Measures	Actions	Likeli-hood (L)	Severity (S)	Risk Rating
Revised Aug 17	Health visitor capacity increasing however vacancies largely filled with trainee posts leading to inexperienced teams & level of need increasing as new pathway is introduced. Risk of not fully providing the pathway for every family. Increasing stress levels for HVs.	PO Nursing & CSM	Almost certain	Moderate	High	Practice Leads (EYs) to ensure robust supervision.	Develop reporting & action planning template to capture the measure taken to prioritise the need. Increase levels of recruitment of qualified HVs Robust preceptorship arrangements in place.	Almost certain	Moderate	High
Aug17	School nursing service requiring clear direction to ensure equity and quality of service – risk of inequity of provision and variation in quality of service.	Lead Nurse for LAC & SYs/ CSM	Possible	Moderate	Med	PL (Schools) have management and Po Nursing has professional responsibility	Develop a Lead nurse for School Years post. Develop school nurse guidance Implementation of School Nursing review recommendations			Med
October 2015	Changing team bases can result in some school nurse	PO Nursing & CSM	Possible	Minor	Med	Robust records transport system to be put in	District manager to ensure that a robust records management system is created including transport from off-site storage	Possible	Minor	Med

	records being stored off site.					place.	top base within 2 days. Expectations of other agencies to be managed.			
Revised June 2016	Failure to provide adequate archive processes and facilities for inactive child health cases.	PO Nursing PO AHPs/ Deputy NHS Director of Nursing & Midwifery	Possible	Moderate	Med	Escalated to PO and short term systems in place through the Archive centre	Work with HC information management team to identify robust solutions for each area to include tracking; secure storage; retrieval system. Require agreement with NHSH re ownership of the records and ownership of this risk. NHSH now sited on this and discussions progressing.	Possible	Moderate	Med
Ref 7 Added April 2016	Senior Manager for Health vacancy leading to lack of focus on health issues	Head of Children's Services	Possible	Major	High	Agree JD and recruit	Work with NHSH to ensure agreement of JD & authority to recruit, Principal Officer roles providing some health focus however this is affecting their professional roles.	Possible	Major	Med
Ref 8 Added June 2016	Lack of robust cross agency transport system creates risk of health records and information being delayed or lost	PO Nursing PO AHPs/ Deputy NHS Director of Nursing & Midwifery	Possible	Major	High	Recommendation re using Royal Mail for health records unless previously agreed between sender and recipient.	Work with NHSH to create formal guidelines re transportation of health records.	Possible	Major	High
Updated Aug 2017	Lack of easy access to NHSH intranet for policies etc plus cost implications	PO's & IT	Likely	Moderate	High	Ordering VPN fobs as budget will allow Introducing VRFs to allow access to certain systems via HC network	VRFs being rolled out but no clear timetable Sept 2017 update : SBAR to be submitted to HC & NHSH	Possible	Moderate	High
Added Oct 2016	Lack of robust mechanism for the clinical/professional	PO Nursing	Possible	Moderate	Med	Discussions with Practice Leads (Early Years) to	Develop a Lead nurse for School Years post to develop clinical supervision arrangements.	Unlikely	Moderate	Low

	supervision of School Nurses					share supervision with PL (Schools)				
Added Aug 2017	Work force planning issues may lead to capacity in service to deliver	PO AHP/Nursing	Likely	Moderate	High	Teams submit an action plan identifying additional measures to mitigate risks	Regular management review of action plans and resources targeted to areas of highest risk	Possible	Moderate	Med
Added Aug 2017	School nurse records regularly not available due to problems in identifying when children transfer in or out of schools	PO Nursing	Likely	Minor	Med	School nurses continue to work with schools to obtain timely notifications	Regular monthly reports from SEEMiS to identify transfers Investigate use of GP registrations	Possible	Minor	Med