Agenda Item	10.
Report No	PEO 46/17

HIGHLAND COUNCIL

Committee: **People Committee**

Date: **6 December 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 Access to Child and Adolescent Mental Health and Primary Mental Health Services

3.1.1 Improvement advisors from Health Scotland are working on improved data on CAMHS waiting times for consultation, treatment and interventions, as per national data definitions. This is expected to enable better understanding of the demand and capacity at Tier 2 (Primary Mental Health Workers) and Tier 3 levels (specialist CAMHS), and further information will follow in future reports.

3.1.2 The Primary Mental Health Worker Service is an early intervention service, provided by Highland Council. The team members therefore aim to see children and young people quickly where possible. The Scottish Government target that the Service is asked to adhere to is that 90% of referrals for direct intervention are seen within 18 weeks of referral. Generally interventions are provided well within the target set, with on average 97.3% of children and young people waiting less than 18 weeks for a service.

3.1.3 More positively, 70% of children and young people are being seen within 6 weeks of a service being requested during the session. This compares favourably with national figures for CAMHS, of 84.2% of patients being seen within 18 weeks and 50% starting their treatment within eight weeks (NHS Scotland 2016). For further information, members can access the Standards and Quality report for 2016/17 at the following link.
https://www.highland.gov.uk/downloads/file/18504/primary_mental_health_worker_service_standards_and_quality_report_2017

3.2 Health Visitors

3.2.1 The Health Visitor funded establishment has now reached the agreed 62.7 full-time equivalent posts. Although there are 62.7 posts in the establishment, many of these are filled by trainees. Other posts have become or are due to become vacant due to resignations and retirals.

3.2.2 Currently there are a total of 7 FTE posts vacant across Highland Council. This challenge to reach full Health Visitor capacity despite the increased trainee numbers is being experienced by all Health Board areas. Highland Council currently has 4 trainees due to qualify in January 2018, with a further 8 trainees due to start training in January 2018.

3.2.3 The one year programme has proved to be a very intensive route to the health visiting qualification, and many of the trainees report high levels of stress as they tackle both the academic study and develop new clinical skills. Having discussed this with the University, it is planned to test a 2 year route with three of next year's trainees. Government funding for Health Visitor training is due to finish with the 2018 cohort, and Highland Council will then need to consider how course fees are funded in future years

3.3 **Family Nurse Partnership**

3.3.1 The Family Nurse Partnership programme is now fully funded by the Scottish Government, which remains committed to the programme and to ensuring every first time mother under the age of 20 years has access to the programme. In Highland Council the programme operates in the Mid & South areas and has recently appointed a 5th Family Nurse to enable the programme to be available on a continuous rolling basis within the current geography rather than on the original 3 yearly cohorts. There are ongoing discussions with the Scottish Government as to how the programme becomes available in other parts of Highland. It is intended that a full report is brought to a subsequent Committee.

3.4 **School Nursing Review**

3.4.1 NHS Boards are now being encouraged to implement the recommendations from the Scottish School Nursing review, which was previously reported to Committee. These include moving to a specialist and targeted school nursing service with a remit to address health inequalities and vulnerabilities in school aged children and young people. Highland Council has now set up a School Nursing Implementation Group which is being chaired by the Lead Nurse for Looked after Children, who has expanded her remit to include School Years in order to lead this work.

3.4.2 There continue to be recruitment challenges within School Nursing. Trainees are being recruited, but there is no Scottish Government funding for training. Accordingly, training budgets are being stretched, and the number of nurses able to undertake the programme each year is limited. This year, we have 2 school nurse trainees enrolled on the revised 2 year school nurse programme.

3.4.3 One consequence of this reduced capacity is that the remaining nurses are being asked to focus on those children who have additional health and wellbeing needs, resulting in some of the universal input being reduced. This has become apparent in the percentage of children in Primary 1 who received a health assessment screening. This is a performance measure with a target of 95% which has reached 99.8% previously. This year it is expected to drop to around 88%. Further investigation is being undertaken to identify specific schools where health assessments have been missed. Mitigation for reduced health checks include a verbal handover of each child from the health visitor to the school nurse, which is undertaken during August of each year, and a health screening questionnaire completed by parents on enrolment to P1.

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

4.1 At the previous People Committee, Members requested further details of AHP waiting times. This is included in **Appendix 1.**

5. Balanced Scorecard

5.1 The scorecard is attached at **Appendix 2.** In October 2017, NHS Highland reported that there was a national technical issue which affected the provision of

data for measures related to health assessments for children at 6-8 weeks and 27-30 months, and that work was ongoing to resolve this issue. In addition, NHS Highland has agreed that they will provide data on a quarterly basis and, as a consequence, there is no new data for this report.

5.2 Members commented, at the previous Committee, on decreasing performance against Performance measure 32: “the number of 2 years olds who have seen a dentist in the preceding 12 months will increase.” This was brought to the attention of the Child Health Commissioner, who has raised it with the Dental Director of NHS Highland, and it will be reviewed in January with the Dental team.

6. Implications

6.1 Resources

The September 2017 monitoring report is attached at **Appendix 3.** There are no new resource implications, however it should be noted that the key variances are due to staff turnover.

6.2 Risk

Risks are routinely reported to the NHS Highland Risk Governance Group. A full copy of the current risk register is attached at **Appendix 4** for information.

6.3 Legal, Community (Equality, Poverty and Rural), Climate Change / Carbon Clever and Gaelic

No issues have been identified.

Designation Director of Care and Learning

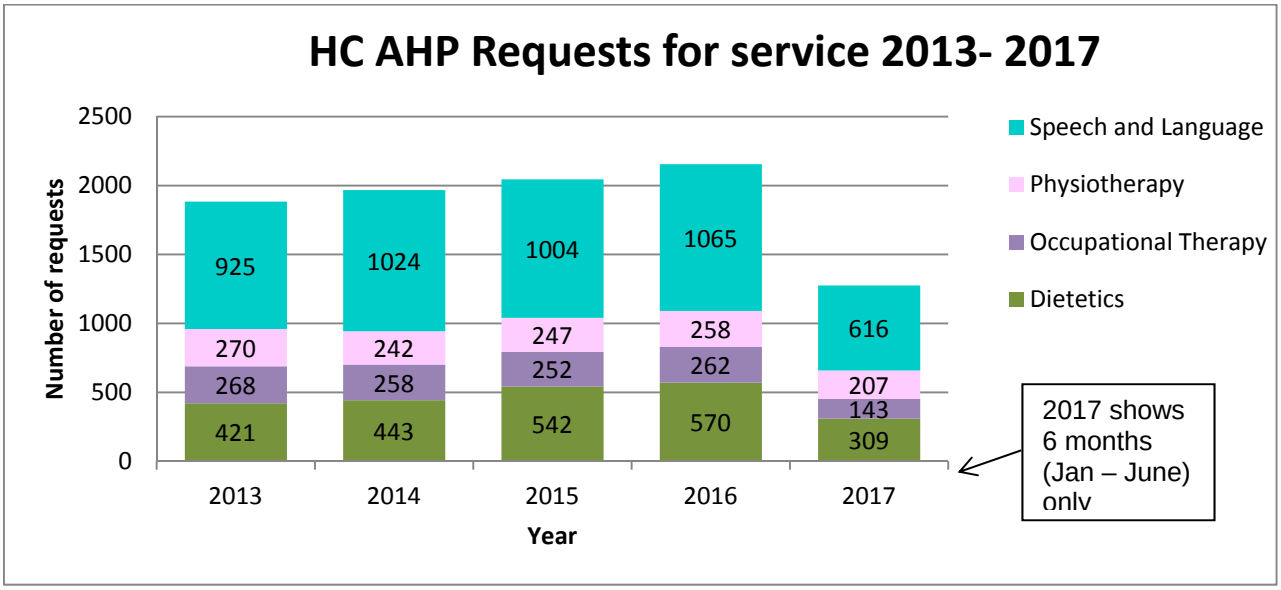
Author Sandra Campbell, Head of Children’s Services

Date 15 November 2017

Appendix 1

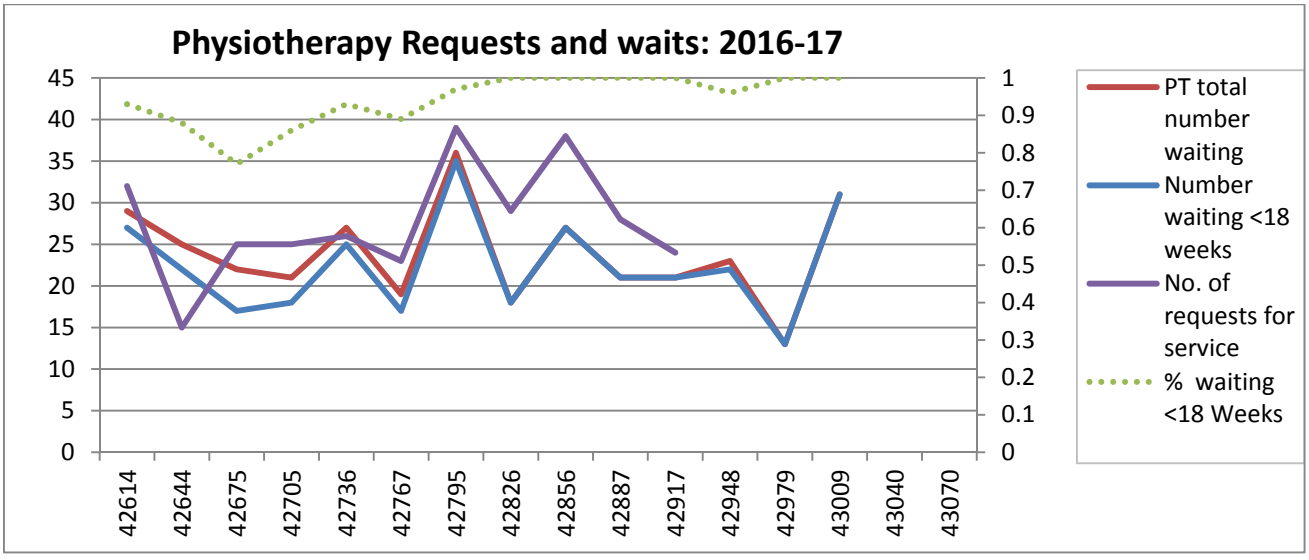
Allied Health Professionals: Waiting times

Compliance with the target of 90% of clients receiving support within 18 weeks of a request for service being made has not been achieved across all AHP teams. For all professions, the number of requests for service and levels of complexity continue to increase.



Physiotherapy

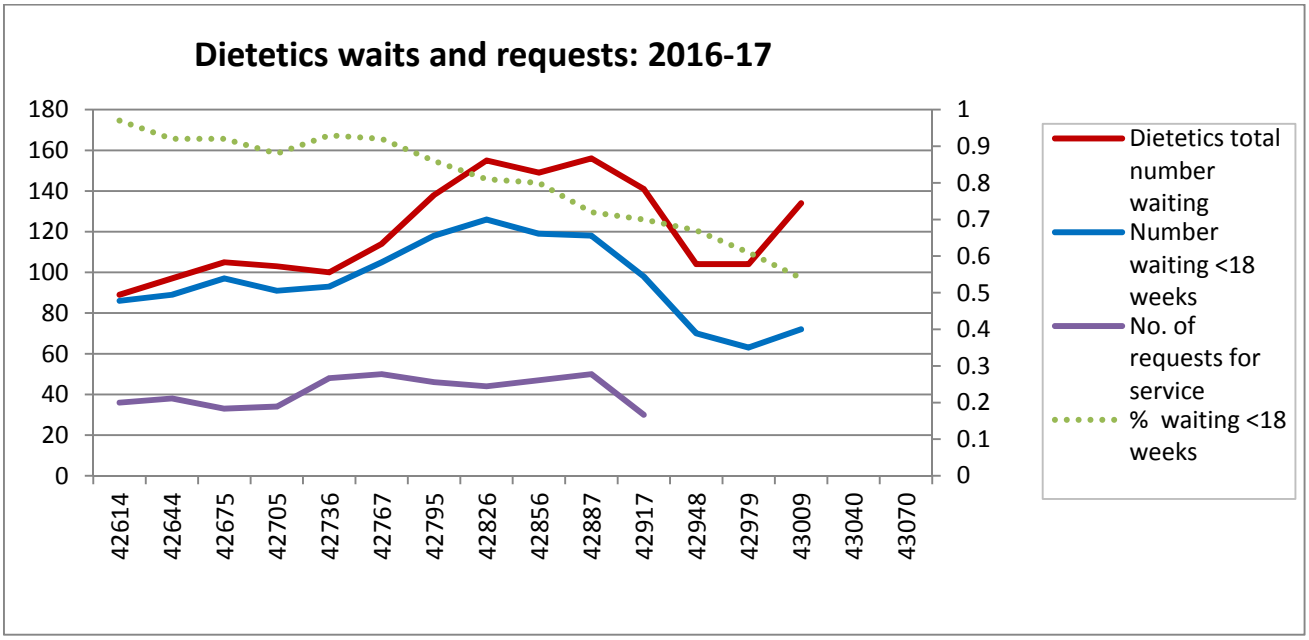
Physiotherapy has mostly been compliant with the target. Numbers waiting and numbers waiting <18 weeks often track each other . Previous difficulties have been due to the time taken to recruit replacement staff and demand. The team is small with 7.7WTE Physiotherapists.



(N.B. NHS Highland provide the figures, and have been unable to provide the number of requests for service recently due to changes in staffing in that Department. Numbers of requests tend to follow the school year, with less during holiday periods.)

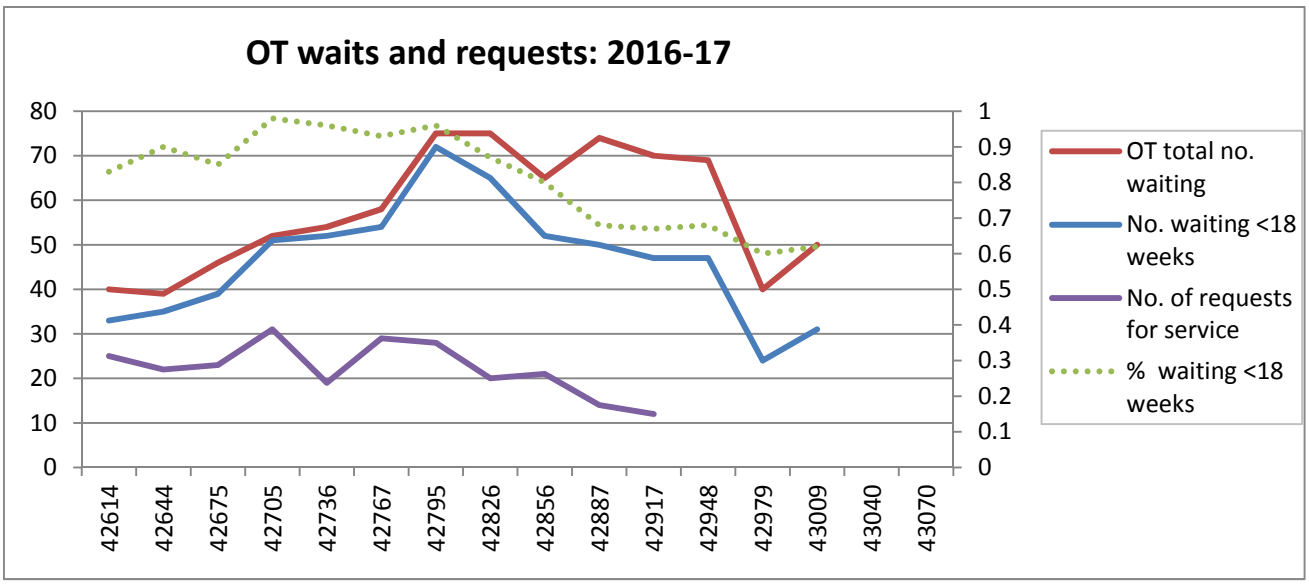
Dietetics

Dietetics has some children and young people who require weekly and sometimes even daily review because of the complex nature of their medical condition and at times acute illness. Some children are seen urgently on the day the request is made. This is a small service of 3.45 WTE Dieticians, and 0.5 WTE support practitioner (SP), so any changes to demand or reduction in staff have a significant effect. The increase in numbers waiting in spring 2017 was mainly due to leave. At present there is a 0.6WTE temporary vacancy. This is partly being covered by other team members working extra hours as we were unable to recruit to this. The numbers waiting fell when this started, but have shown recent increases partly due to annual leave but also demand.



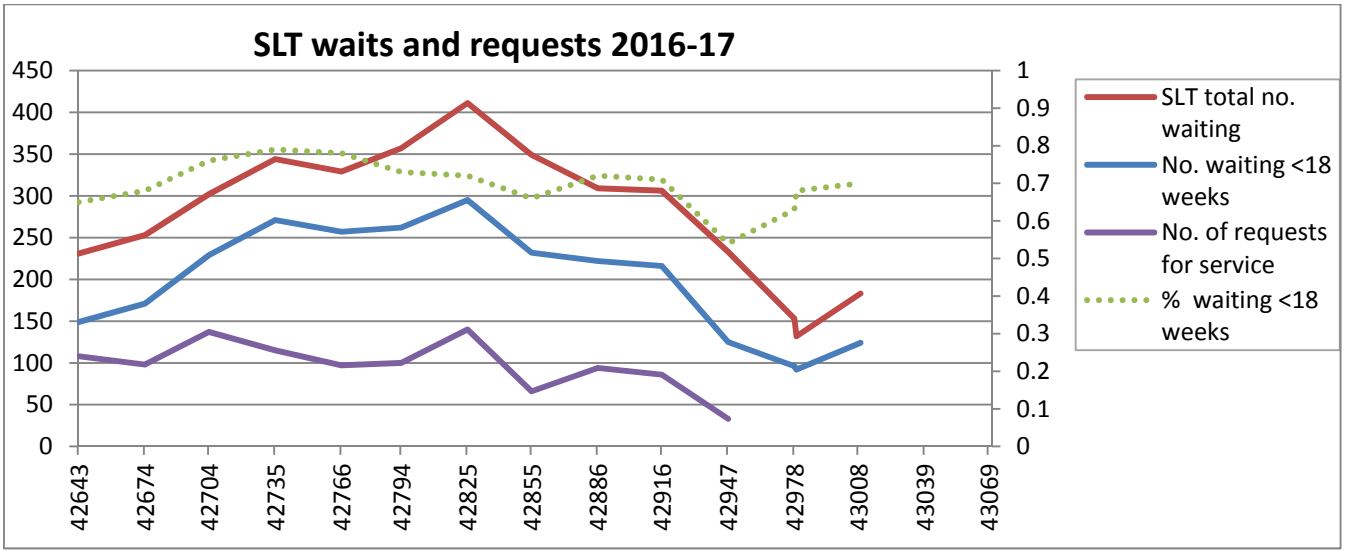
Occupational Therapy

Increased waits within Occupational Therapy have mainly related to staffing difficulties with increased waits following vacancies, some of which have been difficult to fill. Recent reductions to numbers waiting are due to some children being moved to the Neuro developmental assessment service (NDAS). The team has 11.5WTE OTs and 0.8 WTE Support Practitioner (SP).



Speech and Language Therapy

The numbers of children waiting for SLT has decreased in recent months. This is partly due to some children being moved to the Neuro developmental assessment service (NDAS). Staffing is an issue with constant vacancies which we have sometimes been unable to fill. Generally new graduate and Support practitioner posts have been filled, but recruitment of experienced staff is an issue. We have been unable to recruit staff, including agency staff, to cover short term or part time posts. SAC and PEF qaulified SLT posts are presently also unfilled. All staff who are able and willing to do extra hours are doing this. The team, if fully staffed, would have 30.35 WTE SLTs and 8.4 WTE Support Practitioners (SP). SAC posts are an additional 0.2 WTE SLT and 2.6 WTE SP; and PEF posts approximately 0.3 WTE SLT and 0.1 WTE SP at present.



Neurodevelomental Assessment Service

Figures from NDAS for AHP services are now collected with October . This is a multidisciplinary assessment team so waits are not just for AHP services. They do show further pressures to the AHP teams.

	Total no. waiting	No. waiting <18 weeks	No. of requests for service	% waiting <18 weeks
OT	12	5	0	42
SLT	145	64	7	44

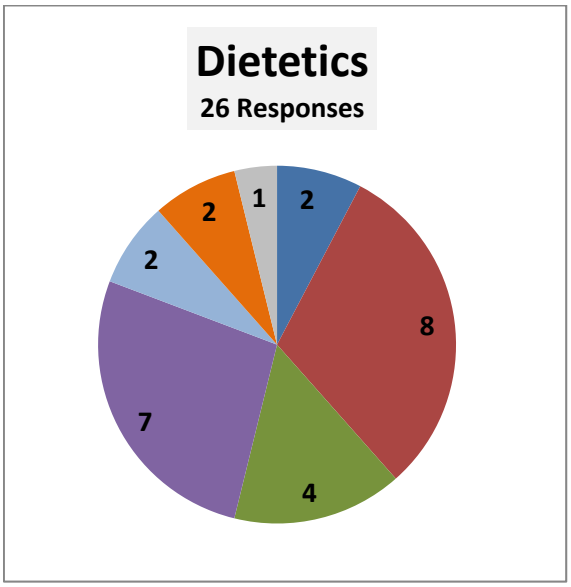
Statistics

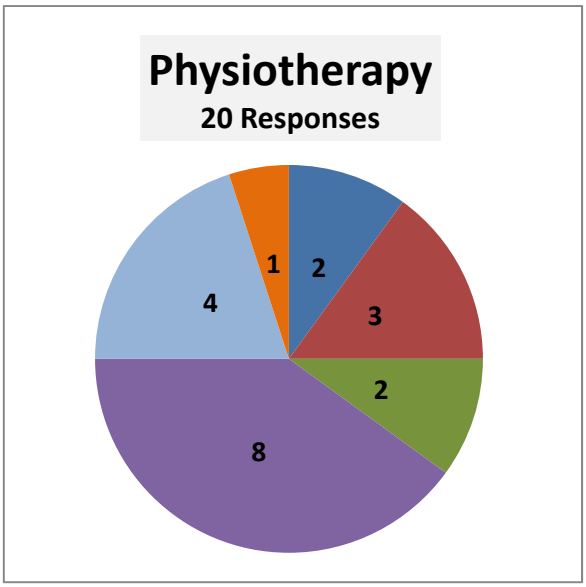
The data above is being monitored by AHP leads and teams. We also have started, or are about to start, collecting statistics on staffing levels, AHP decision making, how and what type of support is given, use of self- management materials, training offered and attended, amount of travel time for AHPs, and outcomes following AHP intervention.

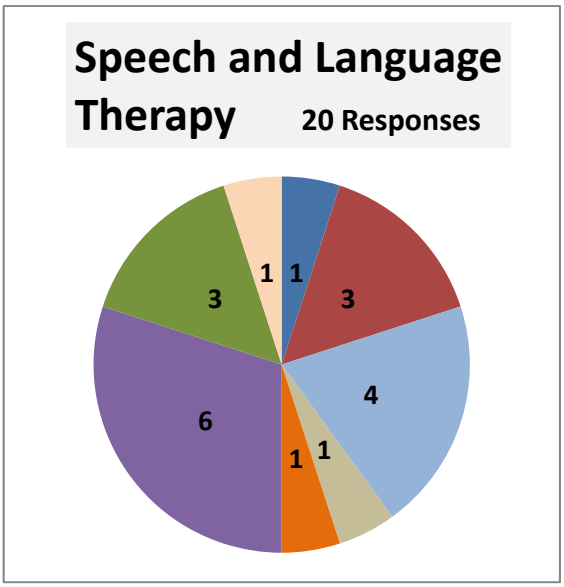
Service user views

We continue to collect 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. Results from a recent survey show high satisfaction with services. The top response to the question 'What worked well for you?' for OT, PT and SLT was 'everything', and for Dietetics was 'good strategies' and 'helpful'.

What worked well for you?







Regular appointments
Personality of AHP
Good Strategies/Helpful
Good Communication
Onward Referral
Promptly seen
Everything
Flexibility
Where seen

Comments included-*'A therapist who treated me like an equal', 'Everyone has been brilliant', 'Being able to contact via email', 'Supportive, understanding and helpful', 'Lovely staff', 'Very professional, approachable, honest, and helpful with suggestions/ recommendations'.*

Initiatives to reduce waiting times

Various initiatives have aimed to improve the waiting times, reduce demand on the service while maintaining satisfaction for all clients. These include those common to all AHPs and those specific to each service (e.g. Dietetics have group appointments for milk free weaning and milk ladder). This plan is multi- faceted and will take some time to implement fully.

This plan includes:-

Universal and targeted work- This is a focus nationally and locally as the importance of CYP experience in early stages in particular is acknowledged to affect later life outcomes. Work is ongoing, particularly in SLT with 'Words up', around developing training, materials, and support- and evaluating the usefulness of these. SLT and OT are involved with Highland literacy and Northen Alliance work. Dietetics is inolved in Healthy weight and health gain programmes (e.g. 'High 5' and 'Eat well') which contribute to the health and wellbeing of children and youing people. It is expected that all these initiatives will reduce the need for specialist AHP services in future.

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.

Recruitment- This is an issue nationally with at present around 70 AHP vacancies across NHS Highland area. 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 SLT. 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; andUHI developing support practitioner training. The recruitment process is often slow, particularly when it is necessary to make changes to hours or grading in order to fill posts, and can contribute to lengthy vacancies. It has been suggested to the improvement team that this may be a suitable RPIW (rapid process improvement workshop).

Workforce planning- Mapping of current and future workforce needs is taking place, including succession planning, and looking at use of admin and support practitioners. Recruitment is likely to be an ongoing issue in the future so looking at skill mix is essential. We have now had agreement for a generic AHP Support Practitioner job description. We will now be able to recruit to this post which will give greater flexibilty in following demand and will potentially allow one SP to support individual children around all AHP recommendations and therapy, particularly in rural areas.

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 AHP 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 FHC4 AHP Plan, formally supported and monitored.

Caseload management- Regular supervision is beginning to be monitored and caseload management tools are used to ensure appropriate case mangement abd timely discharge. Difficulties in getting accurate figures is being addressed by admin staff being trained in monitoring this and getting up to date information from staff.

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.

Services- We plan to agree core services with service users, and develop and update clinical pathways. The development of NDAS (Neuro developmental assessment service) has been complex but is likely to settle into a better way of working in the next few months.

These measures when taken together should make a positive difference. They are tracked through the FHC4 AHP service plan which links with national and local guidance and requirements. 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.
071117

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	72.9%	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	70%	Reported quarterly

Appendix 3

September 2017 Integrated Health Monitoring Statement				
Activity	**Budget**	**Actual to Date**	**Projection**	**Variance**
Allied Health Professionals	3,144,187	1,399,040	2,923,341	-220,846
Service Support and Management	1,134,225	559,698	1,065,471	-68,754
Child Protection	447,948	187,377	416,496	-31,452
Health and Health Improvement	483,063	279,677	462,097	-20,966
Family Teams	16,633,066	7,907,321	16,110,582	-522,484
The Orchard	1,194,384	550,274	1,194,384	0
Youth Action Services	1,505,690	590,769	1,395,599	-110,091
Primary Mental Health Workers	542,467	266,428	519,230	-23,237
Payments to Voluntary Organisations	953,774	519,597	953,774	0
Total	**26,038,804**	**12,260,181**	**25,040,974**	**-997,830**
Commissioned Children's Services income from NHSH	**-9,562,153**	**-2,479,105**	**-9,562,153**	**0**

Appendix 4

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