Appendix

1

Shetland Islands Council

Executive Committee **5 May 2014**
Shetland Islands Council **14 May 2014**

Chair's Report – Environment and Transport Committee 23 April 2014 – Provision of Refuse Sacks to Householders
Report No. Exec–0505-ISD08

1.0 Summary

1.1 The purpose of this report is to consider the recommendations from the Chair of the Environment and Transport Committee in relation to a report requiring a decision of the Executive Committee.

2.0 Decision Required

2.1 That the Executive Committee RECOMMENDS to Council that it approve the recommendation of the Environment and Transport Committee that the charge for a box of refuse sacks be reduced from £11 to £3.50.

3.0 Report

3.1 The Environment and Transport Committee, at its meeting on 23 April 2014 (Min. Ref. 16/14) made the decision to no longer provide householders with an annual supply of refuse sacks free of charge for the collection of household waste, and recommends to Executive Committee that it recommend to the Council that the charge for a box of refuse sacks be reduced from £11 to £3.50.

3.2 A roll of 50 refuse sacks from the supermarkets in Shetland costs between £1.20-£6.00 depending on the quality of the bags purchased. The Council charge for a box of 52 is currently £11 and it is proposed that the charge be reduced to £3.50 as this would cover the purchase, shipping, storage and administration costs.

3.3 As Environmental Services will continue to order refuse bags for its own use, it is proposed that refuse bags will continue to be made available for purchase at various Council locations. It is also proposed that these refuse sacks could be purchases in bulk by rural and small Lerwick shops to stock and sell at the same price. This would ensure that everyone can purchase these refuse sacks at convenient locations across Shetland.

3.4 Copies of the report have been previously circulated, or can be accessed via the Council's website at the link shown, or by contacting Committee Services.

3.5 The Chair will present information to the Council as to any debate or issues that the Committee considered.

4.0 Implications

4.1 Detailed information concerning the proposals was contained within the report already circulated to Members, including the strategic and resources implications for the Council.

4.2 There are no additional implications to be considered by the Committee, other than those set out in the report.

For further information please contact:

Mr A Wishart, Chair of Environment and Transport Committee
28 April 2014

List of Appendices
None

Background documents:
Environment and Transport Committee – 23 April 2014
http://www.shetland.gov.uk/coins/allBodyMeetings.asp?bodyid=396&bodytitle=Environment+and+Transport+Committee&MeetingYear=2014

END

Appendix

2

Shetland Islands Council

Executive Committee **5 May 2014**

Chair's Report – Environment and Transport Committee 23 April 2014 – Non-Aviation Use of Council Owned Aerodromes
Report No. Exec–0505-ISD09

1.0 Summary

1.1 The purpose of this report is to consider the recommendations from the Chair of the Environment and Transport Committee in relation to a report requiring a decision of the Executive Committee.

2.0 Decision Required

2.1 That the Executive Committee approves the recommendations from the Environment and Transport Committee, not to make the Tingwall Airport available for use as a location for motor sports in order to provide the ongoing 24/7 provision of air ambulance.

3.0 Report

3.1 Members of the Environment and Transport Committee were advised that previous reports on the use of Tingwall Airport for non-aviation events did not consider the need to close the airport to all air traffic during the event.

3.2 For any event to occur at Tingwall Airport the Duty FISO would need to issue a NOTAM (Notice to Airmen) to indicate that the airport is closed and unavailable for use for the period of the event, including air ambulance.

3.3 Members were advised that the Air Ambulance Services pays the Council to provide 4 men to ensure the Tingwall aerodrome is available on a 24/7 basis, which was a risk identified in the risk assessment provided with the report. The Risk Assessment also highlighted the deterioration of the runway surface and the close proximity of a store of aviation fuel.

3.4 The report presented to Environment and Transport Committee on 23 April 2014 (Min. Ref. 15/14) sought a decision to no longer make the Tingwall Airport available for non-aviation use, to ensure it's 24/7 availability to the Air Ambulance Service in a medical emergency. This is therefore the recommendation of the Environment and Transport Committee.

3.5 Copies of the report have been previously circulated, or can be accessed via the Council's website at the link shown, or by contacting Committee Services.

3.6 The Chair will present information to the Council as to any debate or issues that the Committee considered.

4.0 Implications

4.1 Detailed information concerning the proposals was contained within the report already circulated to Members, including the strategic and resources implications for the Council.

4.2 There are no additional implications to be considered by the Committee, other than those set out in the report.

For further information please contact:

Mr A Wishart, Chair of Environment and Transport Committee
28 April 2014

List of Appendices
None

Background documents:
Environment and Transport Committee – 23 April 2014
http://www.shetland.gov.uk/coins/allBodyMeetings.asp?bodyid=396&bodytitle=Environment+and+Transport+Committee&MeetingYear=2014

END

Agenda Item

3

Shetland Islands Council

Social Services Committee **Date 1 May 2014**
Executive Committee **4 May 2014**
Shetland Islands Council **14 May 2014**

Mental Health Strategy	
CC-12-14	
Director of Community Health & Social Care	**Community Care Services**

1.0 Summary

1.1 The Shetland Mental Health Strategy for Shetland is written to reflect Shetland's needs and priorities on mental health, to give a vision for mental health and wellbeing and the development of mental health services in Shetland over the next 10 years.

2.0 Decision Required

2.1 That the Social Services Committee and the Executive Committee RECOMMENDS that the Council:

1. Adopts the Shetland Mental Health Strategy; and
2. Agrees to its inclusion within the Council's Strategic Policy Framework.

3.0 Detail

Introduction

3.1 This report presents the Shetland Mental Health Strategy to the Committee / Council for approval.

3.2 It builds on the previous local Mental Health Strategy published in 2007, and has been written by the Shetland Mental Health Partnership following extensive engagement with partner organisations (statutory and third sector), service users and carers.

3.3 The report makes reference to the National Mental Health Strategy for Scotland published in 2012, and the range of relevant national policy including Public Bodies (Joint Working) (Scotland) Bill, Delivering for Mental Health (2006), Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 and the Scottish Government's National Performance Framework.

3.4 The report includes information under the following headings:

- Tackling stigma and discrimination
- Self management, self help and social prescribing
- Employability
- Crisis prevention
- Access to psychological therapies
- Mental health of older people
- Mental health of children and adolescents
- Mental health and alcohol & drugs
- Carers
- Mental health and offending
- Suicide prevention
- Presents information on local needs, priorities and potential action under each of these headings.

4.0 Proposals – priorities for implementation

- Ensuring people can access information to maintain their own mental health
- Promoting resilience and mental health promotion to prevent mental illness and distress.
- Early recognition & treatment of mental illness & disorder
- Providing person centred care which can only be achieved through well integrated services focussing on an individual's needs including their carers(s) and families.
- Ensuring service users are at the centre of care and treatment
- Effective engagement of families and carers to support care and treatment
- Embedding recovery approaches within services
- Redesign of the mental health service in line with the service review.

5.0 Implications

Strategic

5.1 **Delivery on corporate priorities**

Shetland's CHP Agreement has provided the framework for the delivery of a range of mental health services, but assessment of local need and review of current services has identified the need for development and service redesign. This will support delivery on the longer term Single Outcome Agreement priorities of:

- Reducing key risk factors for poor health outcomes

- Tackling health inequalities by ensuring the needs of the most vulnerable and hard to reach groups are identified and met, and that services are targeted at those most in need.

- Achieving financial sustainability and balance within each partner; and a better balance between a dynamic private sector, a strong third sector and efficient and responsive public services.

5.2 **Community and Stakeholder Issues**

The Shetland Mental Health Strategy has been developed through the work of the Mental Health Partnership and the Mental Health Forum which have representation from the range of public and third sector services working with people with mental health issues, and from users and carers. Engagement with users and carers has been a key strand of strategy development, and their views are represented throughout the document. The draft was also widely consulted on to ensure that all relevant stakeholders have been involved in the final strategy.

5.3 **Policy and Delegated Authority**

Mental Health Services are managed by the Director of Community Health and Social Care within the portfolio of jointly managed services, commissioned through the Community Health and Care Partnership (CHCP) Agreement, and therefore this Shetland Mental Health Strategy has been presented to and agreed by Shetland NHS Board Strategy & Redesign Committee.

For Shetland Islands Council, the Social Services Committee has delegated authority to take decisions in relation to those functions within its remit, including community care and community health and wellbeing. However, the Council's Executive Committee has responsibility for advising the Council in the development of its strategic objectives, policies and priorities, but determination of new policy or strategy, to be included within the Council's Strategy Framework Documents, is reserved to the Council [SIC Scheme of Administration and Delegations 2.1.3 and 2.2.1].

5.4 **Risk Management**

Risks relating to community health and care services are set out in the CHCP Risk Register, which is included in the CHCP Agreement. Risks specific to the strategy relate to the sustainability of quality mental health services in Shetland, to the promotion of mental health and well being and the development of positive outcomes for people living with mental illness.

5.5 **Equalities, Health and Human Rights**

The proposals in this report support the responsibilities of the Council and NHS Shetland with regard to equalities, health and human rights.

5.6 **Environmental Issues**

None.

Resources

5.7 **Financial**

There are no financial implications arising directly from this report. Work to date on the development and redesign of mental health services has been undertaken within existing resources. The Shetland Mental Health Strategy recognises the financial challenges facing the Council, NHS Shetland and third sector partners, and identifies the need for further work to implement the strategy within available resources. In particular, the pressures on staffing and the need for redesign in some elements of statutory service provision need to be taken into account in implementation of the strategy.

5.8 **Legal**

The Shetland Mental Health Strategy is written in the context of current mental health legislation. Appropriate service development will support compliance with the relevant legislation.

5.9 **Human Resources**

The Shetland Mental Health Strategy highlights the staffing and workforce issues that have been identified as relevant to service development and redesign. The response to the mental health service review provides more detail and a process for taking forward these issues within NHS Shetland and Shetland Islands Council.

Shetland Islands Council have a number of HR policies that may apply in the implementation of the Strategy such as the Policy for Organisational Restructure. Consultation with affected staff and the Trades Unions will take place in line with those policies and procedures.

5.10 **Assets and Property**

There are no implications for assets and property arising directly from this report.

6.0 Conclusions

6.1 The Shetland Mental Health Strategy provides direction in the way forward for mental health services in Shetland. It provides a vehicle for developing Shetland as a place that is free from stigma and disadvantage in relation to mental health issues; that promotes positive mental health and increases our resilience as individuals, families and communities to live positively and free from mental illness wherever possible; to deal sensitively and effectively with mental illness when it does occur, working with people living with mental illness towards recovery.

For further information please contact:

Simon Bokor-Ingram, Director of Community Health and Social Care simon.bokor-ingram@nhs.net
Dr Sarah Taylor, Director of Public Health sarahtaylor1@nhs.net

Date: 9 April 2014

Appendices
Appendix 1
Shetland Mental Health Strategy 2014

Background Documents
National Mental Health Strategy for Scotland 2012,
Public Bodies (Joint Working) (Scotland) Bill,
Delivering for Mental Health (2006),
Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011
Scottish Government National Performance Framework

NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET*

Name of document	Mental Health Strategy for Shetland 2013	
Registration Reference Number	PHSTR004	**New** ☐ **Review** ☐
Author	Elizabeth Robinson, Health Improvement Manager	
Executive Lead	Dr Sarah Taylor, Director of Public Health	

Proposed groups to present document to:	
Shetland Mental Health Forum	Done
Shetland Mental Health Partnership	Done
PFPI	TBA
Area Clinical Forum	TBA

Date	**Version**	**Group**	**Reason**	**Outcome**
5.12.13	1	SMHP	PI, C/S	SC
13.01.14	2.2	Community Health and Care Partnership Committee	PO, C/S	
	2.2	Social Services Committee	PO, C/S	
	2.2	Area Clinical Forum	PO, C/S	
	2.2	CHCP Operational and Strategic Groups	PO, C/S	MR
27.02.14	3	SMHP	PI, PO, C/S	MR

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
Professional input required re: content (PI)	Significant changes to content required – refer to Executive Lead for guidance (SC)
Professional opinion on content (PO)	To amend content & re-submit to group (AC&R)
General comments/suggestions (C/S)	For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
For information only (FIO)	Recommend proceeding to next stage (PRO)

*To be attached to the document under development/review and presented to the group
Please record details of any changes made to the document on the back of this form

DATE	CHANGES MADE TO DOCUMENT
10.12.13	Significant editing, reordering. Further background information on each element within the strategy, updated data.
20.02.14	Further details of outcome and recommendations of Mental Health Review, minor revisions to factual information, format, layout
28.02.14	Final editing and production of an Executive Summary.

Shetland Mental Health Strategy

2014 - 2024

Date: March 2014

Version number: 3

Author: Elizabeth Robinson/Sarah Taylor

Review Date: March 2017

If you would like this document in an alternative language or format, please contact Corporate Services on 01595 743069.

SHETLAND MENTAL HEALTH STRATEGY

2014 – 2024

Executive Summary

The Strategy aims:

- to provide direction in the way forward for mental health services in Shetland;
- to provide a vehicle for developing Shetland as a place that is free from stigma and disadvantage in relation to mental health issues;
- that promotes positive mental health and increases our resilience as individuals, families and communities to live positively and free from mental illness wherever possible;
- to deal sensitively and effectively with mental illness when it does occur, working with people living with mental illness towards recovery.

It refreshes the previous Shetland Mental Health Strategy and takes account of current national policy including the Mental Health Strategy for Scotland, 'Delivering for Mental Health' and 'Towards a Mentally Flourishing Scotland'. It is built on the national quality ambitions of person-centred, safe and effective, and will help to deliver Shetland's Single Outcome Agreement priorities of:

- Reducing key risk factors for poor health outcomes
- Tackling health inequalities and
- Having financial sustainability and balance.

The strategy was developed with extensive engagement through the Mental Health Forum involving services providers, service users and carers, and drawing on local survey work as well as national guidance.

The local priorities detailed within the strategy are:

- Ensuring people can access information to maintain their own mental health
- Promoting resilience and mental health promotion to prevent mental illness and distress.
- Early recognition and treatment of mental illness and disorder
- Providing person centred care which can only be achieved through well integrated services focussing on an individual's needs including their carer(s) and families.
- Ensuring service users are at the centre of care and treatment
- Effective engagement of families and carers to support care and treatment
- Embedding recovery approaches within services
- Redesign of the mental health service in line with the service review.

The Strategy gives more detail and action plan priorities on the following themes:

Tackling Stigma and Discrimination

Our vision is: for people in Shetland with experience of mental illness or distress to live free from stigma and discrimination, in a community that is understanding and accepting, which actively supports recovery.

Our priorities for action are:

- To continue what is already in place
- To target hotspots for suicide e.g. men's workplaces, certain areas of Shetland
- To continue to work with children and young people to promote resilience and remove the stigma of mental ill health
- To highlight examples of good practice

Self management, self help and social prescribing

Our vision is: for individuals to be able to support themselves and find support within local communities to promote better mental health and increase their sense of 'well-being, to be resilient and to live in recovery.

Our priorities for action are:

- To continue to deliver the wealth of activity that promotes positive mental health and supports those who are most vulnerable
- To continue to target workplaces with Keep Well checks, with particular emphasis on men of working age and those who are least likely to access help and support.
- To offer workplaces support in developing awareness of mental health issues and how to support people with mental health problems

Employability

Our vision is: for people in Shetland of working age to be in the right work, to remain in work or be able to return to work as part of recovery, knowing that this is good for a person's health and improves their quality of life and wellbeing.

Our priorities for action are:

- To continue to work alongside the Employability Pipeline to ensure that people with mental health problems receive the support they need to remain in work/get back into employment.
- To understand the effectiveness of the NHS/SIC Employee Assistance Programme in supporting people with mental health problems
- Continue to deliver training to support workplaces in promoting positive mental health and supporting people with mental health problems.

Crisis Prevention, Support and Treatment

Our vision is: to have a safe and effective crisis prevention, support and management service that includes place(s) of safety and local capacity for emergency treatment, in and out of hours.

Our priorities for action arising from the recent Review of Mental Health Services are:

To promote strong leadership for Mental Health through the Director of Community Health and Social Care, with appropriate support from the Chief Executives

Recruit a second psychiatrist at staff/consultant grade

Integrate the Community Mental Health Team and Annsbrae teams into one Community Mental Health Service

Increase numbers of Community Psychiatric Nurses as a priority

Create a crisis response service from the above and establish a pool of Control and Restraint trained staff

Explore options for accommodation for crisis support

Exploring best use of resources.

Access to Psychological Therapies

Our vision is: to build on local strengths in the use of psychological therapies, to have in place an inter-agency, tiered model of support, which meets the needs of people in Shetland in terms of the speed at which people are seen and in the quality of the interventions provided.

Our priorities for action are:

the introduction of a stepped care model for psychological therapies

developing the psychological therapy skills base in all clinical areas so that more clinical staff are able to offer low intensity therapeutic interventions

to identify other ways of delivering very specialist psychological therapy at Tier 3

to establish a visiting psychology service

developing local information on how to access psychological therapies and about alternatives to psychological therapies, including web- and telephone based services such as Living Life.

Mental Health of Older People

Our vision is: to prevent mental ill health and to promote positive mental health and well being in older people, maintaining independence and support in the community where at all possible, and treating appropriately where necessary. For Shetland to be

a dementia friendly community, with safe and effective support and services in place for people with dementia.

Our priorities for action are:

- to develop our understanding of the wider mental health of old people in Shetland through the development of the Older Peoples Strategy
- to develop a Dementia Strategy for Shetland.

Mental Health of Children and Young People

Our vision is: a Better Brighter future for all children and young people in Shetland, where children are safe, nurtured, happy, healthy and resilient, with opportunities to reach their potential.

Our priorities for action are:

Support to those on the Autism Spectrum where this group experiences a varied service provision

- To be clear about pathways for young people 16 to 18 years, including links to regional and national specialist in-patient services
- To review Tier 1 support to young people including within schools, access to advice and/or counselling, and developing resilience, with links to work within the Children's Services Plan.
- Internet safety which links to issues of bullying, and the vulnerability of children and young people in relation to risks of exploitation and abuse, linking to work through the Child Protection Committee.
- To develop a protocol for responding to a young person at risk of self-harm/suicide.

Mental Health and Alcohol & Drugs

Our vision is: to provide safe and effective services to support people with substance misuse and mental health problems, to promote mental well being amongst people with problems relating to substance misuse, and to reduce the suicide rate in Shetland.

We want a resilient community in Shetland and to support people with mental health issues to find positive alternatives to substance misuse in coping with their problems.

Our priorities for action are:

- Publicising the links between alcohol, poor mental health and suicide
- Community awareness raising on what individuals can do to promote and protect mental health, with a specific focus on bar staff, taxi drivers, people selling alcohol in shops
- Broadening understanding of mental health among all health and care professionals working in substance misuse services

- To ensure that the current redesign of substance misuse services takes account of the needs of people with dual diagnosis
- To have mental health and drug & alcohol services working together in a coordinated way to provide the best experience and access for service users

Carers

Our vision is: that those who are caring for people with mental illness are supported to fulfil their caring role, are involved in the cared-for person's care-planning, and consulted and engaged in decision making about the person they are caring for.

Our priorities for action are:

- Increasing use of self help and access to support information
- Boosting use of carers groups
- Involving carers in learning events
- Encouraging carers through local media to seek support and assistance
- A culture shift in involving carers from the beginning of engagement
- Making sure that confidentiality is not used as a barrier to supporting carers.

Mental health & offending

Our vision is: that mental health and Criminal Justice services work closely together to provide appropriate services liaison and referral for people in the criminal justice system, including risk management and links to the regional secure unit.

Our priorities for action are:

- To maintain appropriate professional relationships with outside organisations such as Advocacy, Moving On, and Citizens Advice Bureau
- To maintain local services with the national move to NHS provision of healthcare for people in prison and custody, and in any national redesign of criminal and community justice services across Scotland.

Suicide Prevention

Our vision is: that Shetland should be a community that is aware of suicide and suicidal behaviour, where there are appropriate responses to suicidal behaviour, and 24 hour access to support when someone is feeling suicidal.

Our priorities for action are:

- To develop community resilience and awareness raising including in schools.
- Responding to people in distress including developing arrangements for support following suicide attempts and completed suicides
- Continue to audit all local suicides to understand and act on preventative factors
- Target ASIST/SafeTALK training towards workplaces (in particular Coastguard, Northern Constabulary, HIFRS, NFU, farming and fishing industries).

An action plan will be developed to take forward the priorities, to show how we will measure improvements in outcomes, and how we will know when we have achieved our aims.

Contents

1. Introduction

A Mental Health Strategy for Scotland was published in 2012, and the Shetland Mental Health Partnership has committed to refreshing our local Strategy to reflect Shetland needs and priorities.

2. The Challenge

The challenge is enormous. We know that mental illness and ill health is one of the top public health challenges in Europe. We know that Shetland has a high suicide rate. Along with other places, Shetland is experiencing a period of great change, with reductions in public service funding against an aging population and increasing demand for services. We also recognise that day to day practicalities such as having enough money to live on, dealing with debts, housing issues, and employment problems can have a negative impact on a person's mental health and can delay their recovery.

3. Background

Both Shetland Islands Council and NHS Shetland aspire to providing the very best mental health services within the resources available. However, in recent years there has been a growing amount of dissatisfaction with mental health provision in Shetland, including issues of recruitment and retention of staff, and a perception that more people are being moved off island because of the limitations of the local service. Shetland has currently the highest rate of suicides in Scotland, which has compounded the concern about local services, though sudden death case audits have not highlighted specific concerns about the quality of service in relation to these individuals.

There is a work programme in place to address some of the recognised gaps in service, but planned service redesign has not progressed at the pace that we would have liked.

A review of the service in its entirety was commissioned to understand what elements of local service are fit for purpose, or where there are gaps and/or risks, and how we might mitigate those risks, with options to take forward on service development / redesign.

The Review Report has now been considered by SIC and NHS Shetland and will result in a local action plan to take forward service development and redesign.

The report makes recommendations on "the essential ingredients for the development of a more robust and resilient Mental Health service" which have been included as part of this Strategy.

4. Policy Context

The Scottish Government has developed a National Performance Framework which is designed to focus their work and ambition. One of the Government's strategic objectives is: 'helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare'.

The Government has also set some National Outcomes which help to direct the Mental Health Strategy:

- We live longer, healthier lives
- We have tackled the significant inequalities in Scottish society
- We have improved life chances for children, young people and families at risk
- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it
- Our public services are high quality, continually improving, efficient and responsive to local people's needs

The Shetland Community Planning Partnership (CPP) has agreed to make sure that we prioritise working with the most disadvantaged and vulnerable people in the Shetland community. In its Single Outcome Agreement (SOA), it describes a vision where the public, private and third sectors work in harmony to deliver services, jobs and economic growth. In the short term this means that Community Planning is directed towards encouraging a dynamic private sector and strong third sector to help mitigate some of the potential impacts of reduced public spending. The CPP recognises that designing efficient and responsive public services is a key component of striking a balance in this area which can be achieved through involving communities in service planning and design. We should bear this in mind as we look to develop mental health in Shetland.

Within the Single Outcome Agreement, the Shetland Community Planning Partnership has agreed the following outcomes relevant to the Mental Health Strategy:

- Reduce key risk factors for poor health outcomes
- Tackle health inequalities by ensuring the needs of the most vulnerable and hard to reach groups are identified and met, and that services are targeted at those most in need.
- We have financial sustainability and balance within each partner; and a better balance between a dynamic private sector, a strong third sector and efficient and responsive public services.

4.1 Integration Agenda

The Scottish Government is in the process of developing a Public Bodies (Joint Working) (Scotland) Bill. The idea of this is to join up Health & Social Care services to address people's needs holistically and to ensure that resources follow patients' and service users' needs. In particular this applies to people who access many services over prolonged periods, such as people with long term conditions, older people, and people with complex needs. The idea is for:

- Consistency of outcomes across Scotland, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within, while allowing for appropriate local approaches to delivery;
- A statutory underpinning to assure public confidence;
- An integrated budget to deliver community health and social care services and also appropriate aspects of acute health activity;

- Clear accountability for delivering agreed national outcomes;
- Professional leadership by clinicians and social workers;
- It should simplify rather than complicate existing bodies and structures.

This Bill will build on many years of joint working in Health and Community Care in Shetland and Mental Health is already included as one of our joint areas of working. Progress in Shetland has been achieved through the establishment of the Project Board in 2011, reporting to the SIC Social Services Committee and the Community Health and Care Partnership (CHCP) Committee. Work is also progressing through the Joint Staff Partnership Forum, the Local Partnership Finance Team and the Joint Human Resources group.

The Shetland Mental Health Partnership is the vehicle through which partners debate and agree mental health direction, strategy and spend in Shetland. The membership and terms of reference for both these groups can be found at Appendix 2.

4.2 Delivering for Mental Health and Towards a Mentally Flourishing Scotland

"Delivering for Mental Health" was the mental health delivery plan for Scotland, developed in 2006, which set out targets and commitments for the development of mental health services. This plan focused on the key elements of services that needed to be in place at each point in a journey of care with the idea that clinicians, service users and carers could be clear about what was needing to be delivered.

Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 was the government document designed to outline the roles and responsibilities of government, local public agencies and third partner agencies in promoting positive mental health See Appendix 1 for more details.

4.3 A Health Promoting and Preventative Approach

The government, in its Mental Health Strategy for Scotland, proposes a healthcare system which integrates health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, the expectation is that day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

In 2011 The Scottish Association for Mental Health (SAMH) produced a report showing the economic cost of mental health in Scotland[i] . It reported that for the year 2009/10 mental health problems had cost the Scottish economy £10.7 billion. This is broken down as follows:

Human costs	**£5, 576m 52%**	Human costs are calculated by looking at the adverse affect on quality of life.
Output losses	£3,228m 30.1%	Output losses focus on the impact of mental health problems on employment

		and work.
Health and social care	£1, 920m 17.9%	Health and social care costs includes the cost of care services for people with mental health problems.
Total costs:	**£10, 724m 100%**	

The following table shows incidence of depression and anxiety across the lifespan as based on a British study[ii]:

	Percentage
1. No symptoms in childhood or adulthood	44.8
2. Adult onset, moderate	11.3
3. Adult onset, severe	2.9
4. Repeated moderate symptoms over the life course	33.6
5. Repeated severe symptoms over the life course	1.7
6. Childhood onset with good adult outcome	5.8
Total	100.0

The study illustrated that mental health problems often start in the early years, and that these tend to persist and recur over the lifespan. Research also shows that half of diagnosable mental illnesses start by the age of 14[iii]. This emphasises the need for placing efforts for prevention in the early years and children.

Although the cost benefits of mental wellbeing promotion are less clear than prevention of mental illness , research conducted in Wales estimated savings of £1 billion, by promoting mental health wellbeing across the country in one year group of children[iv]. Mental health promotion has an important role to play in public health by reducing sickness and premature death, reducing use of health care and improving mental and social functioning, which in turn, could be argued are all cost savings.

The focus on "prevention, anticipation and supported self management" is central to taking forward mental health policy in Scotland and Shetland. Services in Scotland have already reduced the number of mental health hospital readmissions by around 25%. The national strategy asks for:

- Early intervention for conduct disorder in children through evidence based parenting programmes;
- Treating depression in those with long term conditions such as diabetes;
- Early diagnosis and treatment of depression; and
- Early detection and treatment of psychosis.

There is a strong focus throughout this strategy on actions that people can take for themselves and with their communities to maintain and improve their own health. There is a good

evidence base for such approaches, in particular for the role of physical activity in maintaining positive mental health and in helping recovery.

4.4 Quality Ambitions

This Mental Health Strategy fully supports and adopts the **3 Quality Ambitions** for Scotland that health and care must be:

Person centred - which is;

Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe - which is;

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.

Effective - which is;

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.

4.5 Inequalities

We know that mental wellbeing is influenced by biological, psychological, social and environmental factors, which interact in complex ways. Environmental factors include inequalities in life circumstances; good living environments, housing, transport, education and a supportive political structure. Community also affects mental wellbeing, such as a sense of belonging, social support, a sense of citizenship and participation in society.

Populations at most risk from social exclusion are more at risk of developing mental health problems, including those with limited opportunities for employment; women; racial and ethnic minority groups; refugees; sex workers; people living with disabilities, addictions or chronic illnesses; homeless people; and older people living on reduced income.

Scotland's Mental Health: Adults 2012 (ScotPHO)[v] highlighted clear inequalities in mental health within the Scottish population, by socioeconomic status, age and gender. Specifically, greater socioeconomic disadvantage is associated with a poorer state of mental health. The study highlighted three area indicators where there is solid evidence of worsening over the last decade or so: psychoactive substance related deaths, alcohol dependency and manager support at work. The trends for deaths from mental and behavioural disorders due to psychoactive substance use and alcohol dependency were noted as being of particular concern.

5. Process of developing the strategy

The main information gathering for the development of this strategy has been through the Mental Health Forum, a group of individuals with an interest in promoting positive mental health and reducing mental ill health in Shetland. A number of recent pieces of work carried out by partner agencies such as Mind Your Head and Advocacy Shetland have been extremely useful in understanding perceptions of mental health across Shetland and the challenges that face people with mental health problems and their carers. The

epidemiological information has been gathered from local and national sources; in particular the performance management system used by NHS Shetland and Shetland Islands Council, and ISD (Information Statistics Division) Scotland. The priorities for action at the end of each section are identified through local survey work, engagement with services, users and carers and what the epidemiology tells us.

6. Needs Assessment

In order to develop a strategy we need to know where we are starting from and where we want to get to. In developing this strategy, we have focused on the following three elements:

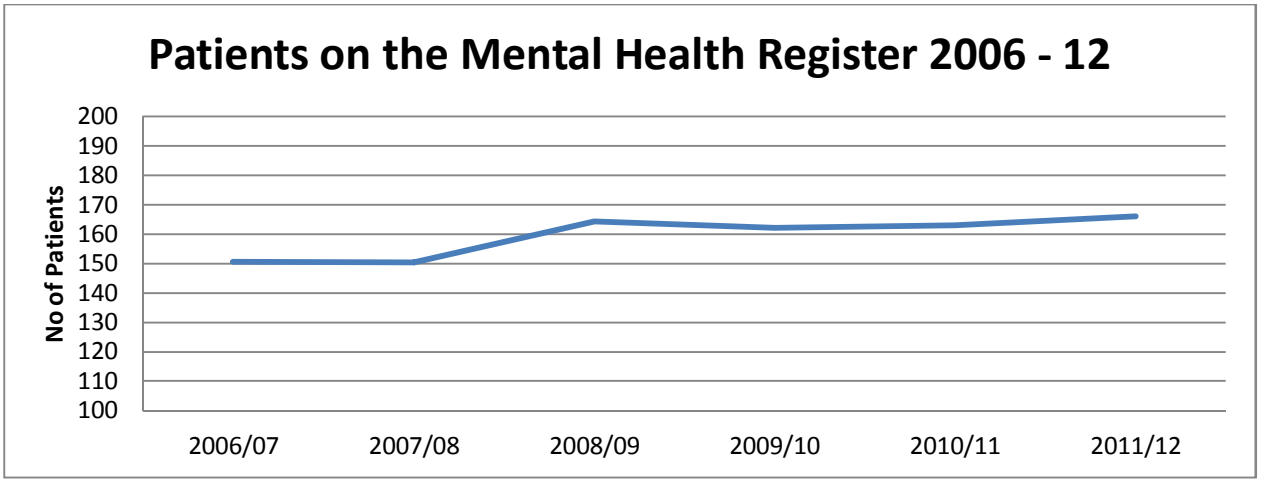
a. Epidemiological approach – using data obtained from research, surveys and studies on rates of illness and specific disorders, applied from national work to estimate numbers within the local population, and predicting likely service usage. It can take account of local demographic information about the population to record or predict specific factors that might affect local communities (such as age, other issues that might inter-act with mental health like health problems, alcohol misuse, economic or social factors).
b. Corporate needs assessment: Information from services and those working in the field of mental health – description of current services, routinely collected information on use of services, activity within services, and the views of professionals working within services, comparison with services in other areas, identifying gaps or weaknesses in local services.
c. Information from users, carers and the community (participatory / consultative needs assessment) – qualitative information – feed-back on current services by those with direct experience of them, the experience of living with mental illness or distress, and the needs and aspirations of those affected by mental illness for future improvements and developments.

6.1 Epidemiology of Mental Health Problems in Shetland

As with most small areas, there is little good data on the actual prevalence and incidence of mental health problems and mental illness in Shetland, though GP practices hold registers of patients with serious mental illness, defined as schizophrenia, bipolar effective disorder or other psychoses. These indicate that between 140-150 patients are identified with these diagnoses for the period 2012/13. Practices also hold information on people diagnosed with depression, both those newly diagnosed, and those with a long term illness (Coronary Heart Disease or diabetes) also assessed as having depression.

The following chart refers to MH001 in the EMIS QOF register, meaning that the contractor establishes and maintains a register of people with schizophrenia, bipolar disorder and other psychoses and other patients on lithium therapy.

The rise in numbers between 2006/07 and 2008/09 is probably the time it took for some practices to fully populate the register, and does not appear to be a real rise in the numbers of people with severe mental illness in Shetland.



It is also possible to estimate the level of mental illness in the community by applying national rates, or the results of epidemiological studies carried out elsewhere to the population of Shetland; by understanding the nature and prevalence of underlying risk factors and by looking at use of mental health services.

The Scottish Mental Health Strategy uses European figures to demonstrate the prevalence of mental health problems in the population. Mental illness is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. Applying that to the Shetland population, it means that out of 15,000 adults aged 15-65, at least 5,000 will experience some form of mental ill health or distress each year. About 1-2% of the population have psychotic disorders (approximately 150-300 adults in Shetland, which fits with the prevalence from GP data).

The ageing population is leading to an increase in the number of people with dementia, 5% of people over 65 (approximately 200 in Shetland) and 20% of those over 80 years of age.

In all countries, most mental disorders are more prevalent among those who are most deprived. The prevalence of mental disorders does not appear to be changing significantly over time, though more people are accessing treatment and support as understanding grows and the stigma of mental illness is reducing.

Demography

The prevalence of both mental health problems in general and specific illnesses varies with a variety of demographic characteristics including age, gender, ethnicity and socio-economic status. For example, there tend to be high levels of depression and anxiety in disadvantaged populations, suicide is more common amongst young men and the unemployed and dementia usually (but not always) affects elderly people. These factors also affect the level and nature of services required, people with less social support in the community are likely to need increased input from services.

Age and gender profile

The population of Shetland has increased by 5.5% since 2001 to 23,200. 18% of the population are under 15 (approximately 4000), 64% aged 15-64 (approximately 15,000) and 18% aged over 64 approximately 4000).[vi] Although Shetland has a relatively 'young' population compared to the rest of Scotland, it will not remain static. There is a falling birth rate, which, combined with certain patterns of migration and a falling death rate, is leading to an increase in the older age groups; in particular a marked increase is anticipated in the over 75 age group. This will have a significant impact on the levels of mental health problems that tend to affect the elderly in the population, especially dementia.

Ethnic mix

Approximately 1% of the total population is from a minority ethnic group (230 individuals) which is relatively low and much lower than other parts of Scotland. Despite low numbers, Shetland has seen an increase in both the number of minority ethnic people and the diversity of races and there are an increasing number of immigrants described as European or 'Other White'. The minority ethnic population tends to be widely spatially distributed in Shetland. People from black and ethnic minority groups may have an increased likelihood of experiencing isolation, lack of social support and discrimination which can contribute to mental ill health.

There is some information on the experiences of people from minority ethnic groups from a survey carried by NHS Shetland in 2009 the Council's Your Voice citizen's panel, as highlighted in the SIC Equality and Diversity Framework for 2011 (http://www.shetland.gov.uk/communityplanning/documents/EqualitiesFramework2011.pdf) .

These include feelings of isolation and lack of support networks or integration into the community. However, many of the issues faced by black and ethnic minority populations are not unique to this group, but affect the wider community as a whole. These are housing, transport, childcare, provision of health and social care services.

The specific mental health needs of ethnic minority groups in Shetland have not been fully assessed. Though all services are required by law to understand the impact of diversity characteristics (race, gender, age, disability, sexual orientation) on access to services, data on this is not collected in a systematic way that can be used to inform an assessment of need.

Socioeconomic status

Whilst Shetland is not considered as a socioeconomically deprived area overall, there are individuals and families within Shetland who are living in poverty or are otherwise disadvantaged. Remoteness and can also be a significant risk factor for mental health problems, through isolation, lack of social support and difficulty in accessing services.

According to the most recent (2010) community health profile for Shetland (http://www.scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000037.pdf), Shetland compares favourably to Scotland for education and economy indicators. For example, among the working age population, only 10.4% have low or no educational qualifications (Scotland 14.8%); and only 1.7% claim Jobseeker's Allowance (Scotland 4.4%). Income deprivation is significantly better than the Scotland average. However, an estimated 11.1% of households are experiencing extreme fuel poverty (Scotland 7.5%) and being a largely rural island area,

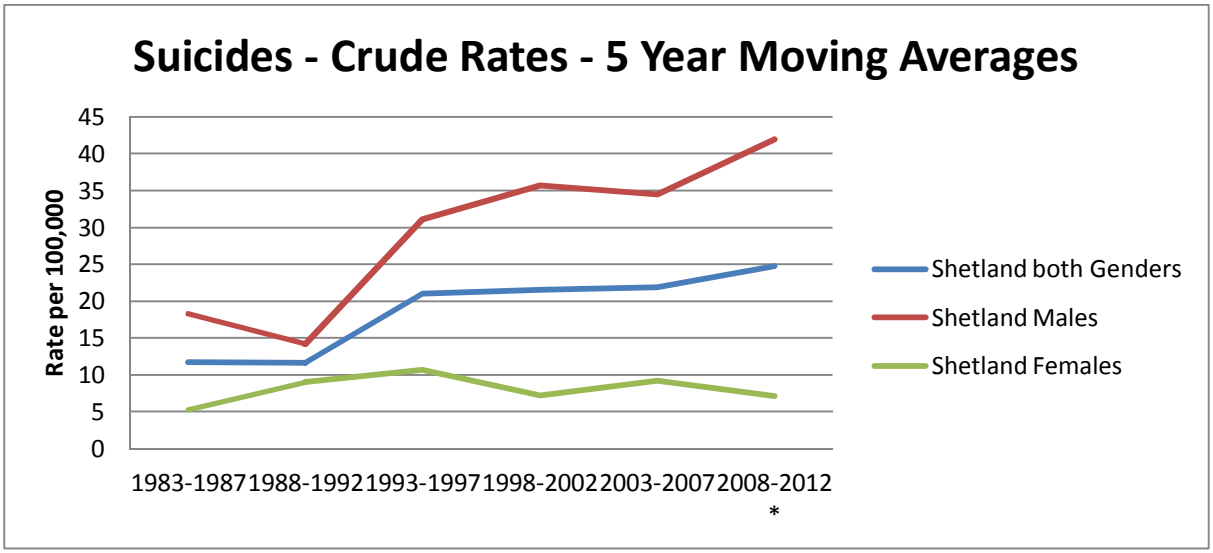
three-quarters of the population (75.2%) live in the 15% 'most access deprived' areas in Scotland.

Estimates of incidence and prevalence of mental health problems and distress in Shetland

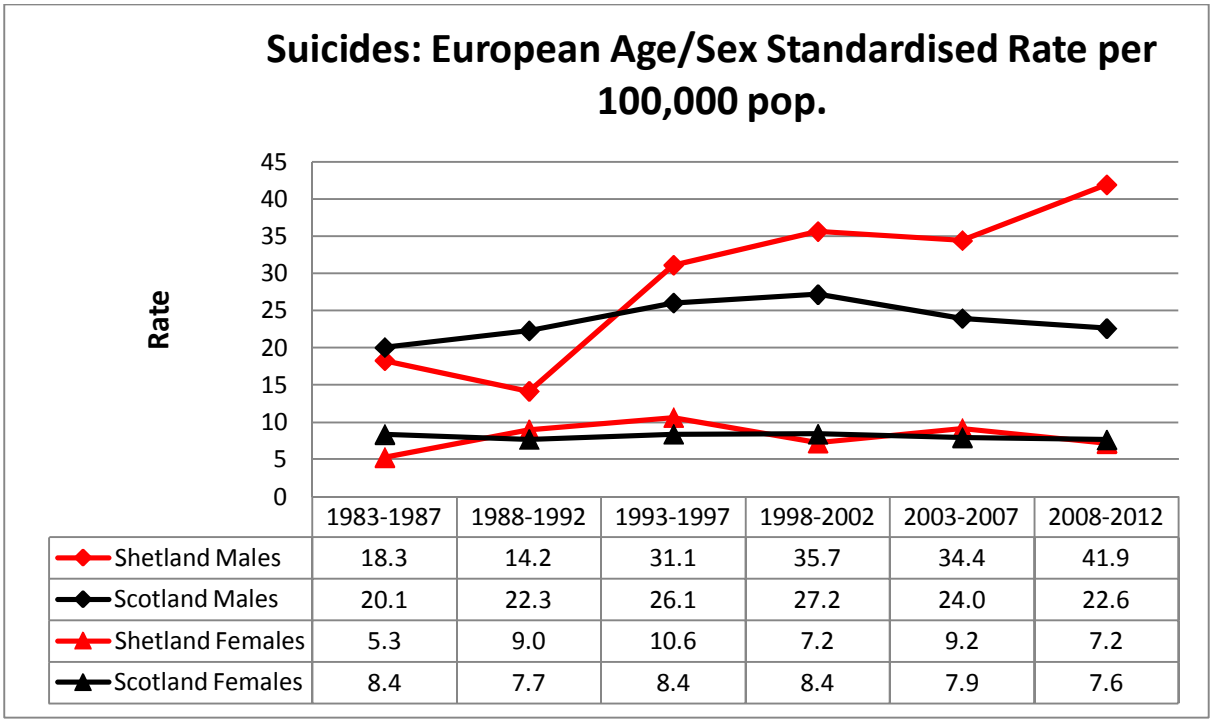
Suicide

Suicide is a relatively rare event, and is often, but not always, associated with mental illness. However, it is considered as a reasonable proxy measure for the level of psychological distress in the community, and in the absence of any consistent and reliable methods for collecting morbidity data is commonly used as a measure of mental illness in a population. Furthermore, suicide rates are used to evaluate the outcomes of strategies to reduce mental illness and improve mental health services. People with mental health problems are more likely to complete suicide than the general population. 10-15% of people diagnosed with schizophrenia will die through suicide and 15% of those with major depression.

Deaths caused by intentional self harm and events of undetermined intent, registered in Scotland, by NHS Board and 5-year time period, both genders and total



* 2008-12 analysis uses old coding rules for each year to allow consistent comparisons over time



	1983-1987	1988-1992	1993-1997	1998-2002	2003-2007	2008-2012
Shetland Males	18.3	14.2	31.1	35.7	34.4	41.9
Scotland Males	20.1	22.3	26.1	27.2	24.0	22.6
Shetland Females	5.3	9.0	10.6	7.2	9.2	7.2
Scotland Females	8.4	7.7	8.4	8.4	7.9	7.6

* 2008-12 analysis uses old coding rules for each year to allow consistent comparisons over time

Hospital admissions

Admission to psychiatric hospital only occurs for a very small percentage of all the people in Shetland with mental health problems, usually those with the most severe mental illnesses, and this data is published by ISD, but at present is not reliable in its published form. The nature of many severe mental illnesses is that they follow a relapsing and remitting course, sometimes necessitating a number of admissions to hospital over time. The length of admission can vary greatly, from a few days up to many months.

Mental health and wellbeing

The Scottish Health Survey includes a number of measures that indicate mental 'wellness'. The survey only involves a relatively small number of people in Shetland each year, but the most recent figures combine the results from 2008-11 to give a bigger sample and allow more meaningful interpretation.

Mental Wellbeing

Mental wellbeing is measured using WEMWBS (Warwick Edinburgh Mental Wellbeing Score), where a higher score indicates more positive wellbeing. The mean score for Scotland for all adults was 49.9, and was slightly higher for men than women (50.1 and 49.7). The figure for Shetland was higher, at 50.8, which is the highest in Scotland along with the Borders.

GHQ-12

15% of adults in Scotland scored 4 or more on the General Health Questionnaire (GHQ12), indicative of a potential psychiatric disorder. Nationally, there were significantly more women (17%) than men (12%) with high GHQ scores. The average score for Shetland was 10%, which was significantly lower, with Orkney having an average score of 9%.

Life Satisfaction

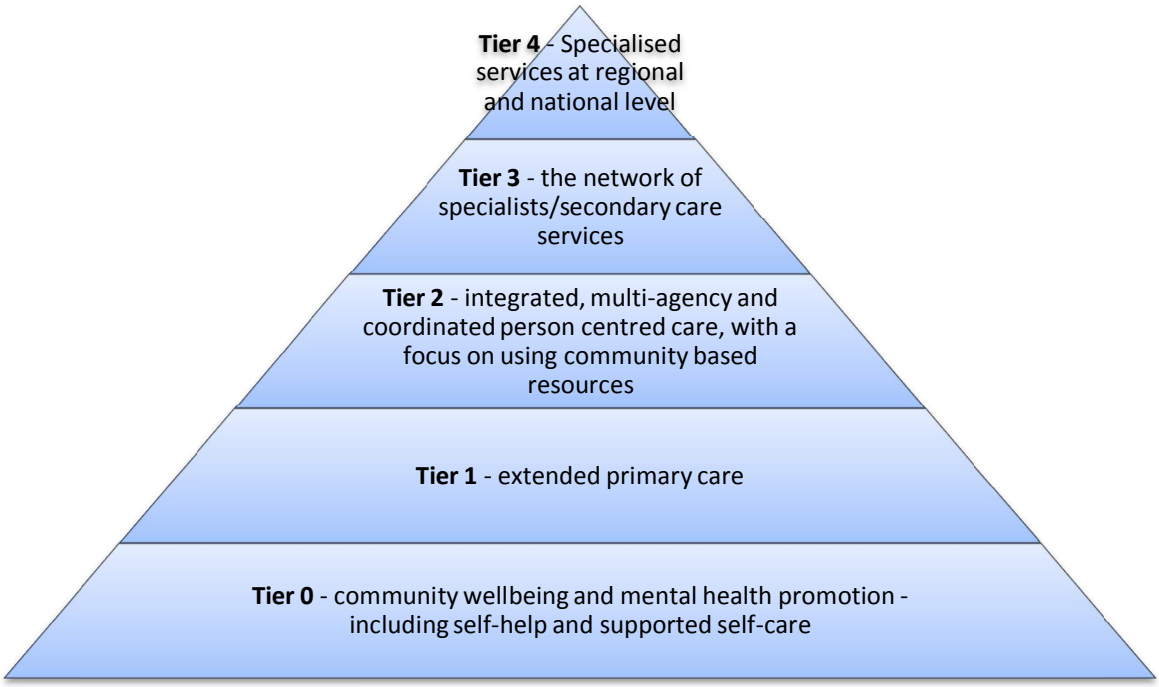
Life satisfaction was measured on a scale of 0 - 10 where higher scores signified greater life satisfaction. The average score among all adults in Scotland was 7.6 with no difference between men and women. The highest life satisfaction score was recorded in Shetland (8.0), with Borders, Grampian, Highland, and Western Isles also having a significantly higher score than the national average (7.8). The lowest life satisfaction score was recorded in Greater Glasgow & Clyde (7.4).

7. Key elements that the strategy covers

7.1. Tackling Stigma & discrimination
7.2. Self management, self help and social prescribing
7.3. Employability
7.4. Crisis Prevention
7.5. Crisis services
7.6. Access to Psychological Therapies
7.7. Mental Health of Older People
7.8. Mental Health of Children and Adolescents
7.9. Alcohol, Drugs and Mental Health
7.10. Carers
7.11. Mental Health and Offending
7.12. Suicide Prevention
7.13. Recovery

Under each of these headings is some background information, relevant statistics where available, information about what already exists, perceived gaps and priorities for action. **Note**: the Well Scotland site http://www.wellscotland.info/priorities gives a comprehensive guide to each of the priorities identified in the MH Strategy, offers rationale for each priority and evidence of effective interventions.

One helpful way of describing mental health services is to use the Tiered Approach described in the National Framework on Mental Health[vii], reproduced here:



This tiered model helps us to understand the principle of dealing with mental health issues and problems at the lowest possible level. There is a strong evidence base for the prevention of mental ill health and a general acceptance from policy makers, service deliverers and

stakeholders that we should be doing all we can to prevent mental ill health and distress wherever possible. There is also a strong recognition now that we should focus on recovery from mental health illness or mental health problems. Nationally the Mental Health Improvement Outcomes Framework has been developed, to help enable services to capture outcomes that are personal and social as well as clinical; the idea being that services should look beyond purely clinical outcomes to see the whole person and their social and personal outcomes as equally valid.

> Recovery is often defined as a process of curing or managing the symptoms that are associated with psychiatric diagnoses. It has been argued that medical definitions of recovery overlook the creation of new debilitating conditions as a result of long-term medication, dependency on mental health services, and social exclusion. Some people who have experienced mental distress argue that recovery is a process of moving forward from symptoms, side effects, negative attitudes, devaluing and disempowering services, prejudice in society and social exclusion. Others talk about recovery as a process rather than a goal or end point and that people need to have the chance to talk about their lives - the bad as well as the good aspects - and to reflect on their life journey.
> Recovery and Resilience - African, African-Caribbean and South Asian women's narratives of recovering from mental distress

Tier 0

7.1 Tackling Stigma and Discrimination

The stigma of mental ill-health has been called 'one of the last great taboos'. People with mental health problems often tell us that the reactions of family, friends, neighbours, work colleagues and employers is harder to deal with than the illness itself.

Stigma can range from being ignored and excluded to verbal and physical harassment and abuse. 81% of people with lived experience of mental ill-health told 'see me' (a national agency which aims to tackle stigma) that they had experienced stigma. And many people keep quiet about their experiences due to uncertainty about how people would react - 59% of people don't talk much about themselves because they don't want to burden others with their mental health problem.

The threat of discrimination means that people are far less likely to talk about their mental health problems or be open about them. Those diagnoses most likely to attract stigma are personality disorder, eating disorder, self-harm, schizophrenia and obsessive-compulsive disorder (OCD)[viii]

The most common situations where people with lived-experience have had to face stigma and discrimination are: by friends and family; in employment/at work; within the local community; within mental health or other health services.[ix] These are also the situations where people are most likely to have disclosed their mental health problems.

Recovery from mental ill-health is helped by support from family members and friends.[x] Although this research is from 6 or 7 years ago, it is backed up by local research carried out by Mind Your Head more recently:

The Mind Your Head Community Survey from 2011 reported that many people commented on the island rural nature of our community along with 'word of mouth' and feelings of being

'talked about'. Respondents also communicated their strong desire to see MYH continue in tackling stigma within the community as well as raising awareness of mental ill health.

- 59% of respondents felt stigma was an issue.
- 60% felt the community were more accepting of mental health than it was 5 years ago.
- Attitude and stigma were felt to be the most challenging aspects of coping with mental ill health in Shetland.
- The top 3 priority areas were selected as awareness raising (specifically with teenagers), stigma reducing campaigns and increasing access to self help.
- In feedback there was a feeling that people understand what stigma is in theory but then don't practice being non judgemental in reality and there is a level of ignorance regarding mental health.[xi]

There are a range of organisations and initiatives in Shetland which help to tackle stigma and discrimination. These include

Locally:

- Mind Your Head a local charity which was formed to raise awareness of mental ill-health. Its aim is for Shetland to be a place where
    - Mental health is supported positively within the community
    - Information and knowledge of support services is easily accessible
    - People do not feel isolated because of mental illness
    - Negative attitudes are replaced with understanding and acceptance
- A range of training is available and well attended: ASIST / Scottish Mental Health First Aid / Self-harm Awareness / Stress Less training events which give people confidence to speak about how they feel or ask others and also to answer the myths that surround mental health
- Advocacy Shetland – an independent organisation which offers support to vulnerable people who feel they are not being listened to, including people with mental health problems.
- Moving On Employment Project – supports people in overcoming barriers to employment and helps them to re-integrate into workplaces
- Family Mediation Shetland works with families experiencing separation and/or divorce or general interpersonal conflict. Using trained mediators, family group work can be undertaken involving parents, children and young people, step parents, grandparents and any other significant family members. Ongoing interfamilial conflict can cause stress leading to depression and other forms of mental ill health and this service can help to reduce the likelihood of this.
- Community Mediation Shetland uses a third party to help resolve disputes within communities. Sometimes someone with Mental Health issues can behave in ways which other people find frightening or hard to understand, and being helped to understand this behaviour can help to break down stigma and discrimination.
- Women of Worth is a group for women who have experienced emotional difficulties or problems with mental health & well being. It is run by women for women. The group offers mutual confidentiality, acceptance and respect for others.
- Shetland Link Up – a voluntary sector agency which provides somewhere safe, friendly and accepting where people with mental health problems can feel supported as they work through things.

- Shetland Women's Aid – works to end violence against women. Clearly domestic abuse can have an impact on mental distress, and, in addition to counselling and therapeutic support, Women's Aid work to challenge domestic abuse, the stigma and the secrecy surrounding it.
- Sexual Abuse Survivors Support Group – A Shetland based support group that supports people recovering from sexual abuse and who may have long term mental health issues related to the sexual abuse.
- There is often overlap between substance misuse issues and mental health. Community Alcohol and Drug Services Shetland (CADSS) provide support in developing self esteem and managing anxiety for people with drug and/or alcohol problems.
- Annsbrae House offers 7 supported accommodation tenancies together with a Skills centre. There is a short break flat available and social care workers provide an outreach service from Annsbrae House. The Outreach Service provides support to people with mental health conditions in their own home, whether they live at Annsbrae itself or in the community. Outreach services are tailored to individual need and are intended to support a person to live as independently as possible. Support may be provided with a variety of life and social skills such as cooking, budgeting, shopping, anxiety management, hygiene etc.

Nationally

- SAMH is the Scottish Association for Mental Health which has a number of roles including campaigning against stigma and bullying, suicide prevention, promoting the physical activity to improve mental health, and providing some community based support programmes in areas of Scotland.
- See Me – Scotland's national campaign to end the stigma and discrimination of mental ill health. The Scottish Government together with Comic Relief are investing £4.5 million in a three year anti-stigma and discrimination national programme. Building on the legacy of the See Me campaign, SAMH (Scottish Association for Mental Health) and Mental Health Foundation (MHF) is planning to deliver an innovative programme of awareness raising and local and national activities that challenge the discrimination associated with mental ill-health.

Our priorities for action are:

- To continue to deliver the wealth of activity that promotes positive mental health and supports those who are most vulnerable
- To continue to target workplaces with Keep Well checks, with particular emphasis on men of working age and those who are least likely to access help and support.
- To offer workplaces support in developing awareness of mental health issues and how to support people with mental health problems

7.2 Self management, self help and social prescribing

Many local initiatives are helping support local communities and individuals to promote 'better mental health' and increase a sense of 'well-being'. There are a number of information events scheduled each year, including those organised by Mind Your Head, Shetland Arts, Moving On, Shetland Link Up, Alzheimer Scotland, CADSS and many other localised support groups and networks. In addition many training events have been arranged that continue to add to local knowledge and expertise so that information is being facilitated and cascaded to those who require it the most.

Resilience is a key factor in protecting and promoting good mental health. It is the quality of being able to deal with the ups and downs of life, and is based on self esteem. Resilience is a skill that can be learnt, and there are a number of sources of training being developed in Shetland at present.

NHS Shetland Health Improvement continues to deliver Mental Health for Managers training and all courses to date have been over-subscribed. In order to achieve the Healthy Working Lives Award, businesses need to demonstrate that they are delivering a mental health promoting activity or awareness raising programme to their staff. In addition the team has delivered a number of 'Stress-less-sessions' across Shetland. A range of training is delivered, including ASIST, self- harm awareness, mental health first aid, and safe talk.

Mind Your Head have recently been involved in a number of 'promise signing' events. Similar to the See Me pledge this is a local initiative whereby local agencies/organisations sign a promise that they will encourage and support positive mental health in their workplace/organisation. Part of the promise includes agreeing to undertake mental health awareness training.

The Health Improvement team deliver workplace based health checks to specific priority groups, in particular men who are involved in more manual types of work, as these are a key target group identified through the audit of suicides and sudden deaths that we undertake in Shetland. The health check includes questions about mental health, and the men who have been involved have been extremely grateful to have the chance to talk about the issues that affect them. The aim with this type of normalising conversations about mental health and mental distress is to see an impact on numbers of people coming forward for help and eventually on positive outcomes such as reducing suicide numbers.

Priorities for action are to continue the wealth of activity in this area to promote positive mental health and support those who are most vulnerable, including:

- Continue to deliver the wealth of activity that promotes positive mental health and supports those who are most vulnerable.
- Continue to target workplaces with Keep Well checks, with particular emphasis on men of working age and those who are least likely to access help and support.
- Offer workplaces support in developing awareness of mental health issues and how to support people with mental health problems.

7.3 Employability

Employability is one of the strands of the Mental Health Strategy for Scotland. We know that being in the right work is good for a person's health and improves their quality of life and wellbeing. We also know that remaining in work or being able to return to work quickly helps them to recover from mental ill health. Over the last couple of years, the local authority and partners have been working to find ways of supporting people to remain in work where possible, or to move back into work as quickly as possible. This is known as employability. Employability encompasses all the things that enable people to increase their chances of getting a job, staying in and progressing further in work. For each individual there will be different reasons why they are not achieving what they would like in employment - perhaps their confidence and motivation, their skill, their health or where they live compared to where jobs are available.

The employability pipeline is the stages a person has to achieve in order to gain employment. Some clients will move from start to finish of the pipeline, where as others may start later in the process and miss steps out. One of the main functions of the assessment is to develop a plan for the client that includes the most appropriate service to them at the right time. The starting point is to bring clients into the employability pipeline. This will involve a number of new processes including referrals from organisations whose main business is not employability as well as active outreach activity by employability organisations.

We recognise the major impact that changes like Welfare Reform will have on people with mental health problems. A range of local activities are being developed through the Fairer Shetland initiative to respond to the problems created by Welfare Reform including publicity about Welfare Reform, ways of managing a budget and where to access support and help.

Priorities for action:

- To continue to work alongside the Employability Pipeline to ensure that people with mental health problems receive the support they need to remain in work/get back into employment.
- To understand the effectiveness of the NHS/SIC Employee Assistance Programme in supporting people with mental health problems
- Continue to deliver training to support workplaces in promoting positive mental health and supporting people with mental health problems.

7.4 Crisis Prevention, Support and Treatment

Some mental health problems can be episodic in nature, with people experiencing stable periods with few symptoms, and periods of crisis with intense symptoms. Sometimes crises arise when a person's life circumstances change, or when there is a change to medication that helps to stabilise a condition. The response to this type of crisis is probably the area of service which has received most criticism over recent years in Shetland. In general stakeholders felt that there was a lack of anticipation of crises and that there were a number of things which might help to prevent crises happening in the first place. The national strategy recommends the following components of crisis prevention services:

- Routine use of lapse and crisis contingency planning for individuals who have experienced more than one acute episode;
- Integrated (cross health and social care) and person-centred care planning;
- Effective involvement of families, friends and carers; and
- Timely responses by specialist services when an individual or their carers highlight the occurrence of early warning signs.

The current Mental health Service in Shetland has grown from a single adult Community Psychiatric Nurse (CPN) in 1986 to the current Community Mental Health Service with a range of responsibilities and services, all of which can be accessed via a GP using an Electronic Single Point of Referral as part of the wider With You For You process.

The core philosophy is to ensure that people are seen by the most appropriate clinician as quickly as possible.

Services are managed within the Community Health and Social Care Directorate, with support from; NHS Mental Health Department Manager; Dementia Services Development Manager; SIC Annsbrae Team Leader and Mental Health Officer Senior Social Worker.

Community Psychiatric Service

<u>General Adult Psychiatry, Old Age Psychiatry (excluding dementia), Emergency/Liaison Psychiatry.</u>

Referrals for "General Adult" (16/18-65 years old), "Old Age" (65+) and Emergency/Liaison" categories are received from GPs, Hospital Consultants, and Social Work. The duties of the service are:

- To provide a clinical service in community psychiatry for adults and older people including; out-patient consultations; assessment and treatment of patients in the community and a range of care settings, emergency assessment and treatment.
- To provide assessments and advice on patients in the care of medical and surgical colleagues and those attending accident and emergency with mental health problems.
- To assess patients in police custody on request of a police surgeon (Consultant Psychiatrist).

- Fulfil the duties associated with the Mental Health (Care and Treatment) (Scotland) Act, 2003.
- To contribute to the teaching and training of students, trainees and multidisciplinary staff groups as appropriate.

The service does not provide specialist “in person” care in the areas of Eating Disorder, Forensic Psychiatry, Old Age Psychiatry or Perinatal Psychiatry. Advice and treatment in these areas is available from NHS Grampian

Additionally, an NHS National Service for Treatment Resistant Depression & Obsessive-Compulsive Disorder can be accessed, for patients who meet the criteria for these services.

Specialist psychotherapy services are occasionally accessed through NHS Grampian as a “tertiary” level service.

The Community Psychiatric Service provides a comprehensive service to adults (18+) in both office based and home settings, with out-patient clinics being held in health centres throughout Shetland. Services are provided by

- Consultant Psychiatrist
- Community Psychaitric Nurses
- Specialist social Worker /MHO

The review of Mental Health Services in Shetland makes a number of recommendations to strengthen this area of service:

- The report notes that demand for psychiatric services is very variable and an on island psychiatric ward would not be cost effective
- Some patients will always require admission to more specialist inpatient services off island
- There is a gap in the provision of out of hours/crisis service, development of this would avoid some unnecessary off island transfers
- Better care management would focus on early intervention and prevent crisis escalation
- Shetland requires an on island clinical psychiatric presence; the current arrangement of one stand alone psychiatrist does not provide an effective service
- Community Psychiatric Nurse (CPN) staffing levels have been historically reduced and increasing demand and reduction in staff have reduced effectiveness of the Community Mental Health Team service
- further integration of CPN and Social work services would help to make the service more robust and reduce delays

The aim should be to develop an Out of Hours/Crisis service including place(s) of safety and capacity for emergency treatment. Over the last five years, an average of 25 people per year have been admitted to Royal Cornhill Hospital Aberdeen from Shetland with 10 of these patients discharged within two weeks. Providing a service where two 2 staff, (trained in control and restraint) can be available for up to 72 hours, (the duration of an Emergency Detention Certificate) in an agreed place of safety, with appropriate clinical governance for e.g. rapid sedation, would give local services an opportunity to stabilise the situation, and provide a more

thorough assessment, reduce the number of admissions to RCH, and provide a more effective service.

Priorities for action

- To promote strong leadership for Mental Health through the Director of Community Health and Social Care, with appropriate support from the Chief Executives
- Recruit a second psychiatrist at staff/consultant grade
- Integrate the CMHT and Annsbrae teams into one Community Mental Health Service
- Increase numbers of Community Psychiatric Nurses as a priority
- Create a crisis response service from the above and establish a pool of Control and Restraint trained staff
- Explore options for accommodation for crisis support
- Explore best use of resources

7.5 Access to Psychological Therapies

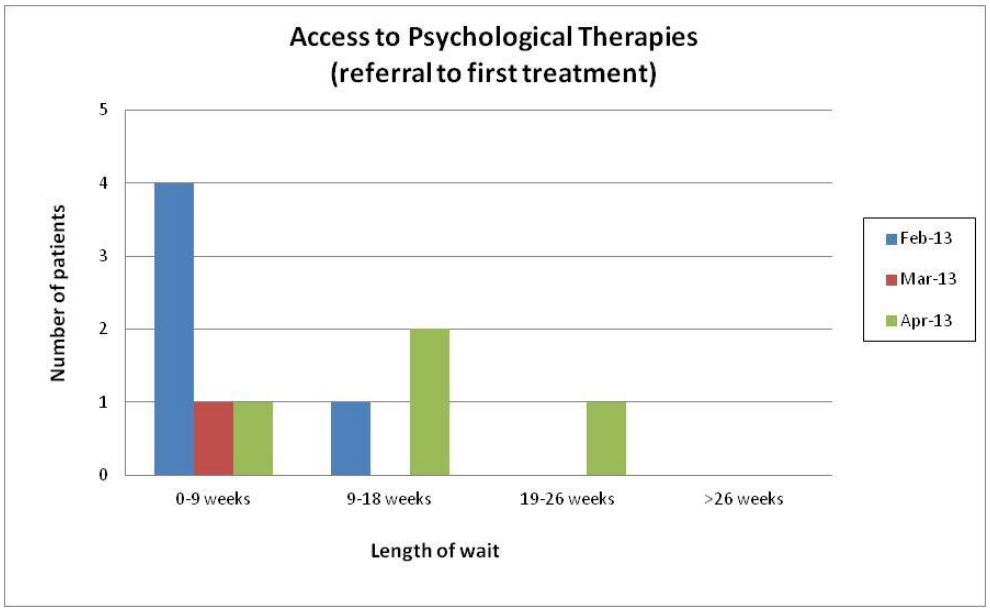
The Matrix (2011) outlines the training that is required for the management of adult mental health problems by different NHS staff groups to deliver evidence-based psychological therapies. It amalgamates the recommendations from both SIGN and NICE guidance.

Research shows that GPs are most often the first point of call for people experiencing mental health issues, but may not have the skills or confidence to deal with these individuals. It is estimated that 90 per cent of mental health problems are dealt with in primary care, therefore having the skills to help patients is not only important for GPs but for practice and community nurses also. Allied health professionals, Dental staff, Social care workers and Housing outreach workers are in prime positions to recognise and refer on people with mental health issues. Health improvement staff have a role in prevention and promotion of mental health issues as do a range third sector providers.

The recent review of mental health services in Shetland found that talking therapies are well used but there are significant access and delivery problems. This has been a concern for some time, and work has been ongoing to tackle this issue. In particular, a Psychological Therapies Steering Group was established to help support the provision of psychological therapies in Shetland. The aim is to have in place an inter-agency, tiered model of support, which meets the needs of people in Shetland in terms of the speed at which people are seen and in the quality of the interventions provided. This includes identifying gaps in provision and developing an increased psychological therapy skills base in all clinical areas so that more clinical staff are able to offer low intensity therapeutic interventions.

The Psychological Therapies Service currently in place within NHS Shetland provides access to non-pharmacological interventions in accordance with the guidance provided in the Scottish Government publication "The Matrix" for people with mental health needs. It is a secondary care service, with the majority of provision being at level 3-4 of the Tiered model. Where appropriate, psychological therapies are used to complement more traditional psychiatric interventions.

The government-set target for accessing psychological therapies is within 18 weeks from referral to treatment by December 2014.



Lowering the threshold for referral to the service (December 2012) increased the number of referrals which may impede the ability of the service to achieve the target by December 2014. A number of other services in Shetland also deliver psychological therapies. These include

- CADSS for substance use and mental health for client group and families,
- Shetland Bereavement Support Service provided one-to-one counselling for people affected by bereavement and loss in Shetland, but is now closed due to lack of ongoing funding.
- Shetland Women's Aid provides counselling and cognitive behavioural therapy style approaches to women who have experienced domestic abuse and to children who may have witnessed abuse.
- Family Mediation Shetland provides mediation where families are separating or divorcing and where there are parenting issues as a result.

Priorities for action:

- the introduction of a stepped care model for psychological therapies
- developing the psychological therapy skills base in all clinical areas so that more clinical staff are able to offer low intensity therapeutic interventions
- to identify other ways of delivering very specialist psychological therapy at Tier 3
- to establish a visiting psychology service
- developing local information on how to access psychological therapies and about alternatives to psychological therapies, including web- and telephone based services such as Living Life.

7.6 Mental Health of Older People

We often think about dementia in relation to mental health and older people, but it is only one of the strands that affect older people. In order to give dementia a separate but complementary focus and create the environment to meet the aspirations for Shetland to be a dementia friendly community, a separate Dementia Strategy for Shetland will be developed early in 2014. The headline challenges from the National Dementia Strategy are:

- To dispel the fear of dementia so that people do not delay in coming forward for diagnosis and help
- That people with dementia and their carers should get the information and support after diagnosis that they need
- That general healthcare services should always understand how to respond well to people with dementia and their carers, leading to better outcomes
- That people with dementia and their carers should always be treated with dignity and respect
- That family members and people who support and care for people with dementia should receive the help they need to protect their own welfare and to enable them to go on caring safely and effectively

The Mental Health Strategy for Shetland needs to consider the range of issues that affect mental health in older age. The determinants of mental health and well-being in old age are the same as for other adults: physical health, psychological resources such as self-esteem and coping skills, financial resources, life-style, life experiences, quality of relationships with family and friends or having a meaningful activity and role in the community.

Consequently we should be focusing on prevention of mental ill health and early intervention in older adults, in maintaining support in the community where at all possible, and treating appropriately where necessary. As people become older and less able, there may be additional issues in terms of maintaining independence, maintaining positive interaction with friends and networks and managing medication.

Some of the preventative work in this area will be best managed through locality based working and through the community capacity building work that the CHCP is engaged in.

Through the development of the Older People's Strategy we can do further work to understand the prevalence of depression in older people in Shetland and the links to chronic disease, dealing with dying and end of life. We also need to support general awareness about mental health issues amongst staff working with the elderly.

Priorities for action:

- to develop our understanding of the wider mental health of old people in Shetland through the development of the Older Peoples Strategy
- to develop a Dementia Strategy for Shetland.

7.7 Mental Health of Children and Adolescents

The majority of children in Shetland are, on the whole, healthy and happy, and never need specialist children's mental health services. We recognise the need to maintain this situation, and universal services such as maternity, health visiting, nurseries and schools work hard to promote positive mental health and wellbeing in young people in Shetland.

Barnados describes the many different factors affecting resilience in children as being:

- secure early attachments
- confidence of being loved and valued by one's family and friends
- clear sense of self-identity (personal, cultural and spiritual)
- sense of self-efficacy (being able to make decisions and act independently)
- confidence to set goals and attempt to achieve them.

The Shetland Children's Plan is the process through which prevention and early intervention activities are developed.

NHS Shetland Children and Adolescent Mental Health Service (CAMHS) consists of three permanent members of staff (2.7 whole time equivalent) on island (the psychiatric nurse for children and adolescents, the clinical associate in applied psychology and the primary mental health worker). We have visiting consultants in psychiatry and psychology.

The model for allocation of referrals in NHS Shetland CAMHS is a multi-agency team discussion occurring once weekly. Referrals which are accepted are then allocated and triaged into the appropriate assessment slots, which may be with one of the visiting consultants. If necessary, the staff on Isle will complete a preliminary assessment before an appointment in one of the visiting consultant's clinics; this is not always necessary when it is apparent that the first appointment will need to be with one of the visiting consultants. In the majority of cases though, young folk and their families are seen by the on Isle staff.

This triage system ensures that the children and young people of Shetland are kept waiting for the minimum amount of time before getting their first appointment with CAMHS. It also ensures that those who are not taken on are sign-posted to the most appropriate resource to meet their need, which includes self-help materials.

This triage system also ensures that NHS Shetland CAMHS continues to keep well within the current HEAT target for wait times. The model of monthly visits by specialist consultants ensures that our youngsters access more specialist support in a safe, effective and timely manner.

The Primary Mental Health Worker carries a case load which is focussed on early intervention, working with children and young people in the school setting as well as in clinic. The consultant psychiatrist is routinely involved in the assessment and further enquiry of those patients presenting with attention difficulties, mood disorders and neuro-developmental disorders and is vital to the assessment of eating disorders with rapid weight loss, sudden behavioural change suggestive of emerging psychosis and treatment refractive depression as well as those complex cases where the inter-generational dynamics and familial background necessitate the experience and knowledge of a consultant psychiatrist.

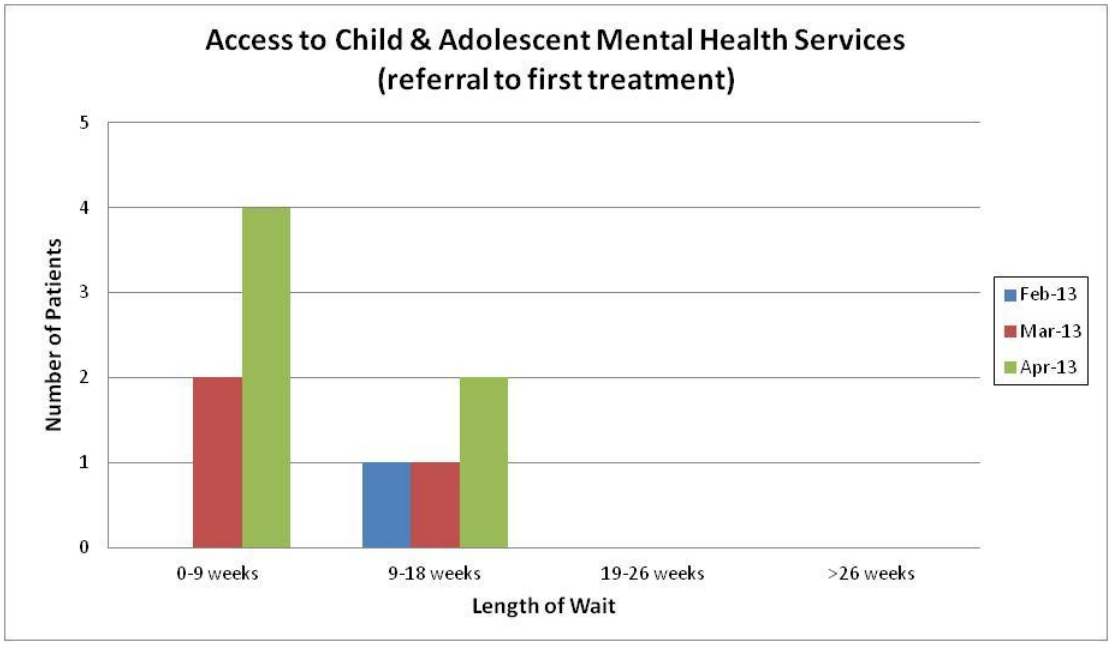
The consultant psychologist directly assesses young people where obsessive compulsive disorder may be present, concerns regarding eating disorders, complex trauma or attachment

difficulties, complex developmental difficulties and neuro-developmental disorders. The consultant psychologist will see a case for assessment first hand when the whole team agree that the benefit of that specialist experience is warranted.

In the case of a young person being admitted to Ward 3 of the Gilbert Bain Hospital having deliberately self harmed with suicidal intent, practice is for a member of the team to see them before they are discharged home. In the twelve months from August 2012 to August 2013 there were five such patients; four were seen by the psychiatric nurse and one by both the consultant psychiatrist and the primary mental health worker together.

Target: Faster access to Child and Adolescent Mental Health Services

18 weeks from referral to treatment by December 2014



Stakeholders felt that the current service they receive from CAMHS is very good, there was concern that 26 weeks (the previous government waiting times target) is a long time to wait if you are a child or young person in distress, or if you care for a child or young person in distress. However, the data shows that no young people in Shetland have to wait this long: the service already complies with the new target to reduce waiting times to 18 weeks by December 2014.

There was feedback that Parenting Programmes, Triple P & Parent Link are helpful in supporting positive parenting and thereby promoting positive mental health.

Priorities for action:

- Support to those on the Autism Spectrum where this group experiences a varied service provision
- To be clear about pathways for young people 16 to 18 years, including links to regional and national specialist in-patient services

- To review Tier 1 support to young people including within schools, access to advice and/or counselling, and developing resilience, with links to work within the Children's Services Plan.
- Internet safety which links to issues of bullying, and the vulnerability of children and young people in relation to risks of exploitation and abuse, linking to work through the Child Protection Committee.
- To develop a protocol for responding to a young person at risk of self-harm/suicide.

7.8 Mental Health and Alcohol & Drugs

There is a distinct overlap between mental health and substance use/misuse. The ongoing audits of suicide and sudden deaths in Shetland show that alcohol is almost always a factor – either a significant quantity has been used immediately prior to death, or there has been a history of unhealthy drinking patterns. Almost 1 in 10 cases in Accident and Emergency (A&E) are alcohol related, and of these a third have Mental Health issues.

In the Mental Health Strategy for Scotland, the government describes the delivery of Alcohol Brief Interventions as being one of the key methods of tackling unhealthy levels of drinking. They recommend clearly aligning the work in place to diagnose and respond to depression with the delivery of alcohol brief interventions to reduce people's alcohol consumption. In Shetland, A&E staff, the sexual health clinic and substance misuse service routinely screen for alcohol misuse; Primary care services, however, continue to show reluctance to engage with this tool.

A redesign of the substance misuse service is currently taking place, and within this the role of Dual Diagnosis staff will be considered.

Priorities for action:

- Publicising the links between alcohol, poor mental health and suicide
- Community awareness raising on what individuals can do to promote and protect mental health, with a specific focus on bar staff, taxi drivers, people selling alcohol in shops
- Broadening understanding of mental health among all health and care professionals working in substance misuse services
- To ensure that the current redesign of substance misuse services takes account of the needs of people with dual diagnosis
- To have mental health and drug & alcohol services working together in a coordinated way to provide the best experience and access for service users

7.9 Carers

Research conducted during 2013 by Advocacy Shetland found that carers of people with mental health problems wanted to be involved in the cared-for person's care-planning, wanted to be consulted and engaged in decision making about the person they were caring for. They felt this would make a significant difference to their ability to fulfil their roles and work with and reassure the person that they were caring for.

A community survey recently undertaken by Mind Your Head found the following:

Carers felt that better understanding was required both generally within the community and also for carers themselves. A means by which to easily learn and understand, know what action to take, etc was often highlighted as being important.

"There is not even enough service support for those with mental health problems let alone their families and carers"

"There is a point where patient confidentiality is not in the best interests of the patient and family"

"There are some excellent support services available, but people need to be made more aware of them"

"Seems to be little help for those caring for older patients recently diagnosed with the likes of Alzheimer's or Depression related illness"

"The carer can become isolated because of the ill person"

"Not enough information given to help public understand and be able to help people who suffer from mental health problems"

Shetland services are attempting to work more effectively with families and carers and are utilising the following initiatives; some of these initiatives are in a more advanced stage of implementation than others e.g.

- With You For You
- Carers Assessments
- Care Programme Approach
- Voluntary sector support
- Advocacy

and some are requiring review or development to ensure that they remain fit for purpose and achieve maximum benefit for those in greatest need:

- Increasing use of self help and access to support information
- Boosting use of carers groups
- Involving carers in learning events
- Encouraging carers through local media to seek support and assistance
- Culture shift in involving carers from the beginning of engagement
- Making sure that confidentiality is not used as a barrier to supporting carers.

7.10 Mental health & offending

Shetland has only a small number of offenders, though that does not prevent local services being extremely responsive. There are good links with the regional secure unit and risk management advice and training has been provided. The Scottish Government is currently considering the redesign of criminal and community justice services across Scotland (options being to have a single structure across Scotland, or local authority run service, or enhanced Community Justice Authorities). The outcome may impact on Shetland services and will be monitored as required.

The criminal justice liaison group is the forum for offender related discussions and a courts protocol for obtaining psychiatric advice was agreed shortly before the previous Sheriff's departure. The Criminal Justice executive lead manager is located with the Community Care structure and ensures that criminal justice matters linked to mental health receive attention.

Where substance misuse issues are important for prisoners returning to the community the local services involved liaise directly.

Multi-agency Public Protection Arrangements (MAPPA) intervention for the risk management of sex and violent offenders is deployed appropriately and agencies are involved according to specific case need.

People within these arrangements suffering from mental ill-health are protected through appropriate referral and liaison with specialist services. These arrangements are often strengthened, and the support given to clients is more effective, where there are strong, appropriate professional relationships with outside organisations such as Advocacy, Moving On Employment Project, and Citizens Advice Bureau.

The recent national changes to NHS provided healthcare for people in prison and custody have not made a significant difference to local services, though planning is in place to ensure sustainability and compliance with national standards of care.

Priorities for action:

- To maintain appropriate professional relationships with outside organisations such as Advocacy, Moving On Employment project, and Citizens Advice Bureau
- To maintain local services with the national move to NHS provision of healthcare for people in prison and custody, and in any national redesign of criminal and community justice services across Scotland.

7.11 Suicide Prevention

The Suicide rate is now the sole measure used by government for suicide reduction across Scotland. Small numbers locally mean large fluctuations as can be seen from the graph. A rise from 5 suicides in 2010 to 7 in 2011 put us behind our trajectory rate and we now have the highest suicide rate in Scotland. Training continues with a wide range of service staff and the community, and the Sudden Death Audit Group examines all local cases with a view to identifying any issues/trends.

Deaths caused by intentional self harm and events of undetermined intent, registered in Scotland, by NHS Board and 5-year time period: Persons

NHS Board	**Crude Rates per 100,000 population**					
	1983-1987	**1988-1992**	**1993-1997**	**1998-2002**	**2003-2007**	**2008-2012 ***
Ayrshire & Arran	12.3	12.6	14.9	18.6	14.2	12.0
Borders	12.4	15.5	15.0	16.9	14.8	16.3
Dumfries & Galloway	15.8	14.6	16.2	19.3	16.8	15.8
Fife	13.6	13.5	14.9	15.8	13.3	13.3
Forth Valley	12.6	12.0	15.8	15.5	12.3	11.3
Grampian	14.9	13.0	16.5	16.0	14.4	13.7
Greater Glasgow & Clyde	15.3	17.0	19.0	19.7	18.3	16.9
Highland	19.5	19.1	22.4	20.8	19.1	17.4
Lanarkshire	10.2	12.3	13.1	14.9	15.4	15.4
Lothian	12.9	14.0	15.7	15.9	13.2	15.3
Orkney	10.4	16.5	28.3	14.5	15.3	14.6
Shetland	11.6	11.6	21.0	21.6	21.9	24.8
Tayside	14.7	15.4	18.1	17.1	17.1	12.7
Western Isles	16.1	22.9	21.6	22.4	21.3	14.2
Scotland	***14.0***	***14.7***	***16.9***	***17.4***	***15.7***	***14.9***

* 2008-12 analysis uses old coding rules for each year to allow consistent comparisons over time

A national Suicide Prevention Strategy has recently been published. We are in the process of reviewing this against our local strategy, and it is likely that our priorities will be based on the following chart:

Theme from strategy	Actions in current action plan	Current activities	Possible future actions *(This will include further actions identified from the recent multiagency workshop in this column once info is collated)*
Responding to people in distress	Review arrangements for post suicide attempts support Develop arrangements for support following completed suicides Target ASIST/SafeTALK training towards workplaces (in particular Coastguard, Northern Constabulary, HIFRS, NFU, farming and fishing industries)	ASIST training delivered 4 times a year to service providers. CMHT visit patients admitted to GBH or in A&E who are distressed/ suicidal. Will undertake a risk assessment and offer follow up if necessary.	Out of hours crisis service – as per recommendations in service review report Develop a multi-agency protocol (similar to child protection procedures) Single point of access.
Talking about suicide	In partnership with MYH develop a programme of awareness raising activities for throughout the year to establish a continued reminder of what support/training is available	In partnership with MYH provide varied activities during Suicide Prevention Week	Community resilience work – (helping people to respond better to each other's "I'm fine")
Developing the evidence base	Review numbers of PHQ-9 depression tests undertaken in Primary Care	Continue to audit all potential suicides	Root cause analysis training?
Supporting change and improvement	Develop a consistent, clear framework regarding prevention/awareness raising in school in relation to suicide and		Through the Children's Plan.

Theme from strategy	Actions in current action plan	Current activities	Possible future actions *(This will include further actions identified from the recent multiagency workshop in this column once info is collated)*
	self harm		

The recent Suicide Prevention Planning Event identified the following outcomes: -

- That Shetland as a community should become more aware of suicide and suicidal behaviour;
- That 24 hour support should be available when someone is feeling suicidal;
- That all Services in Shetland respond appropriately to suicidal behaviour;
- That Suicide is no longer a cultural norm;
- Reduction in substance misuse;
- That professionals in Shetland have a better understanding of suicide and suicidal behaviour;
- Reduced access to Lethal Means.

An action plan to deliver on these priorities is currently being written. **Our priorities are**:

- To develop community resilience and awareness raising including in schools.
- Responding to people in distress including developing arrangements for support following suicide attempts and completed suicides
- Continue to audit all local suicides to understand and act on preventative factors
- Target ASIST/SafeTALK training towards workplaces (in particular Coastguard, Northern Constabulary, HIFRS, NFU, farming and fishing industries).

8. Strategic Priorities

- Ensuring people can access information to maintain their own mental health
- Promoting resilience and mental health promotion to prevent mental illness and distress.
- Early recognition & treatment of mental illness & disorder
- Providing person centred care which can only be achieved through well integrated services focussing on an individual's needs including their carers(s) and families.
- Ensuring service users are at the centre of care and treatment
- Effective engagement of families and carers to support care and treatment
- Embedding recovery approaches within services
- Redesign of the mental health service in line with the service review.

9. Resources and Workforce

As part of the implementation of the strategy, the Shetland Mental Health Partnership will think about how best to use the people and resources we have available to deliver the strategy. It is unlikely that new money will be available, so we need to think about how we use existing services, staff and resources differently. Some of the difficult questions for services include: Is there anything that we could stop doing? How do we free up time and capacity to develop and move forwards?

10. Outcomes and Indicators including timescales and leads

The development of an action plan will address the challenge of how we measure improvements, and how we will know when we have achieved our aims.

The aims of the Strategy can be summarised as:

- to provide direction in the way forward for mental health services in Shetland;
- to provide a vehicle for developing Shetland as a place that is free from stigma and disadvantage in relation to mental health issues;
- that promotes positive mental health and increases our resilience as individuals, families and communities to live positively and free from mental illness wherever possible;
- to deal sensitively and effectively with mental illness when it does occur, working with people living with mental illness towards recovery.

Appendix 1: Towards a Mentally Flourishing Scotland – roles and responsibilities

In the area of mental health improvement the key roles of the **Scottish Government** are to:

- give national leadership to the mental health improvement agenda and foster a culture which encourages mental health improvement;
- set, in partnership with others, the strategic framework for action and national priorities;
- support delivery organisations to develop and implement interventions and approaches;
- take forward wider policies that will contribute towards mental health improvement goals.

Most council services, including education, community care, employment and social inclusion,are directly relevant to mental health improvement. The key roles of **local government** in this area are to:

- give local leadership to the mental health improvement agenda;
- develop, with Community Planning Partners and Community Health Partnerships, local plans for delivery;
- develop and implement local interventions and approaches;
- embed mental health improvement approaches into other services, building on the learning from implementing the *Mental Health (Care and Treatment) (Scotland) Act 2003* and the guidance in *With Inclusion in Mind.*

NHSScotland has a lead role in health improvement as 'every healthcare contact is a health improvement opportunity'. The key roles of the NHS mental health improvement are:

- through **NHS Health Scotland** to provide national support and leadership for the delivery of mental health improvement;
- through local **NHS Boards** to support and deliver local plans for delivering mental health improvement in conjunction with Community Planning Partnerships and Community Health Partnerships;
- to embed mental health improvement into **all NHS activity**, but in particular in respect of those who are at risk of developing mental health problems as a result of substance misuse or other lifestyle issue, and those experiencing mental illness.

All public sector employers should demonstrate a commitment to mental health improvement and leadership in the way that they discharge their role as employers.

The **Third Sector** makes a significant contribution to the mental health improvement agenda both nationally and locally. Its key roles are to:

- deliver services which directly or indirectly promote mental health improvement;
- innovate in the development of new service approaches and interventions;
- act as a catalyst in promoting active citizenship and social capital to develop community capacity;
- advocate change and improvement for service users and the general population.

The actions of **individuals** and **communities** are also central to this agenda. We know that 'intentional' activities (activities over which we have control) are important drivers of mental wellbeing. Improvement may be achieved through interventions that change our behaviour, for example, taking regular exercise; our cognitions, for example, interpreting events in a positive light; and our motivations, for example, focusing on goals that reflect deeply held values rather than external rewards, as a method of improving mental wellbeing.

Such an approach acknowledges human agency. However, individuals do not make choices in isolation from the broader social and physical environment of which they are part and there is a clear role for Government in creating the social and environmental context in which individuals and communities are able to act on their own behalf. Advocating for individual responsibility and self-help in mental health improvement is therefore *set within* a framework with equal attention to the creation of mentally-healthy environments within which individuals and communities are empowered.

There is no single solution to achieving outcomes in mental health improvement and no single sector, agency or programme can deliver this agenda on its own. **Partnership working** through Community Planning Partnerships, Community Health Partnerships and other organisational structures will be key to delivering mental health improvement at local and national level.

Appendix 2: Roles & Remits of Mental Health Partnership and Forum

THE SHETLAND MENTAL HEALTH PARTNERSHIP (SMHP)

REMIT

The SMHP will take an over view of all mental health services in Shetland. In addition the SMHP will produce a new mental health strategy. This new strategy will be for the next three years and include the full range of mental health services. In the longer term, it will be used by the 2020 vision project.

The partnership will have a multi agency approach and include representatives from the Health Board, Council services and the Voluntary Sector, assisted by service users and carers.

The partnership will have an annual work plan, which will include overseeing initiatives such as Choose Life, the Suicide Prevention Action Plan and the Joint Local Implementation Plan (JLIP).

Responsibility for the strategy will rest with the SMHP. The SMHP will work with its partners to implement the strategy. When preparing the strategy consideration will be given to:

- Relevant national policies;
- Guidance for adults and children;
- The national framework for Mental Health services;
- The findings of national monitoring;
- The findings of recent needs assessment;
- Development of services including a local resource centre;
- Capacity within the Mental Health service;
- Making links to specialists services at a regional and national level;
- Agreeing joint spending plans;
- The variety of funding sources.

The Mental Health Operational Management Team (MHOMT) and the Mental Health Forum (MHF) will provide support to the partnership. In return the partnership will feed back its results to the Management Team and the Mental Health Forum.

The partnership will promote good communication between all agencies working on mental health issues.

Agreed at the Shetland Mental Health Partnership meeting on 14th July 2005.

Membership (March 2014)

Ann Thomson	Welfare Rights Adviser (CAB)
Hughina Leslie	Service Manager Community Care and Chief Social Work Officer (SIC)
Simon Bokor-Ingram	Director of Clinical Services (NHS)
Sergey Boyadjiev	Locum Consultant Psychiatrist (NHS)
Hazel Anderson	Advocacy Shetland

Camille Brizell	Lead Officer for Scottish Health Council
Kathleen Carolan	Director of Nursing, Midwifery and Allied Health Professionals (NHS)
Drew Ratter	Elected Member
Ellen Hughson	Shetland Bereavement Support Service
Gwilym Gibbons	Shetland Arts
Jillian Hood	Health Improvement Practitioner
Janette Scantlebury	Shetland Link Up
Kellie Naulls	Moving On
Julie Kidson	Community Psychiatric Nurse (NHS)
Barbara Leslie	A&E Representative
David Morgan	Mental Health Services Manager (NHS)
Alan Murdoch	Community Mental Health Team (NHS)
Muriel Forbes	Annsbrae Unit Manager
Elizabeth Robinson	Health Improvement Manager (NHS)
Shona Manson	Mind Your Head
Karen Smith	Alcohol & Drug Development Officer (NHS/SIC)
Sarah Taylor	Director of Public Health (NHS)
Helen Ward	GP with Special Interest
Rhiannon Jehu	Lay Representative
Jim Shepherd	Relationship Counselling
Allan Wishart	Mind Your Head

Role and remit of Mental Health Forum, including membership

The Shetland Mental Health Forum exists to support and inform the work of SMHP, by ascertaining, co-ordinating and expressing the views of service providers, service users and those in need of services. To this end the Forum is required to be broadly based, representing the interests of those who provide services in the field of Mental Health, families, carers and partners of those people who experience mental health issues and the wider community.

1: Forum Objectives

The objectives of the Forum are to:

1. To participate in the promotion of events and projects which promote a mentally healthy lifestyle and an awareness of mental health issues; This includes sharing project ideas and plans with members and working proactively to promote such.

2. To provide support for mental health awareness projects in the community

3. Make Shetland Mental Health Forum approachable by, and of benefit to, the Shetland community by promoting the partnership and openly inviting views from the community

4. To provide operational expertise that contributes to the wider debate and planning of the development of local strategies, for the promotion of positive mental health and access to services throughout Shetland. In particular through assisting in the development of SMHP strategy.

5. To assess the provision of mental health services in Shetland. Then promote, through the SMHP, the implementation of local strategies, and recommend the provision of the necessary resources for agencies to tackle identified problems at a local level. This includes using the Forum's seat(s) on SMHP to this advantage whenever possible.

6. To promote multi-agency working and co-ordination between statutory and voluntary agencies at a local level, which the availability for services to provide information and updates at Forum meetings

7. To contribute to the debate on best practice and value for money and to share information and experience with others

8. To participate in, contribute to, influence and inform through the SMHP the formulation of policy at a national level

2: Duration of the Agreement

This Partnership Agreement will take effect on the date on which it is signed by all partners and will remain in force for a period of 24 months.

3: Forum Partners

Forum partners are the organisations and services that are responsible for carrying out specific Forum activities, where required, and who are responsible for representing the interests of said organisations at the Forum. At present, partners include:

Carers, Advocacy Shetland, Voluntary Action Shetland, NHS Shetland, Shetland Bereavement Service, Mind Your Head, Alzheimer's Scotland, Moving on Employment Project, Shetland Islands Council, Community Alcohol and Drugs Service Shetland, Women's Aid, Couple Counselling Shetland, Shetland Link up, Shetland Health and Wellbeing Forum

4: Organisational Structure of the Forum

The Forum is presently chaired by Elizabeth Robinson, and supported by Allan Wishart as Vice-Chair. The Forum and its Chairs are further supported by officers from the Health

Improvement team. The Forum Constitution should be referred to for a more detailed summary of roles and responsibilities.

The Forum will have the ability to delegate specific tasks or responsibilities to sub committees where appropriate. These tasks may include specific pieces of research, individual projects and/or events as identified by the Forum.

5: Monitoring, Evaluation & Reporting

SMHP will monitor the Forum and regular reports and updates will be disseminated to the SMHP via the Forum representation by the Chair and Vice-Chair.

In some instances the SMHP may require the Forum to undertake a specific piece of work, for which Forum partners will have a joint responsibility to complete.

6: Confidentiality

The Forum partners agree that any information/documents shared and exchanged are kept confidential, provided that one partner or the Forum itself explicitly requests such.

8: Modifications, withdrawals & disputes

Any modification to the present Partnership Agreement must be made in writing to the Forum Chair, to be given approval by the Forum partners.

Forum partners agree not to withdraw representation unless there are unavoidable reasons for it. Should one representative be unable to attend the organisation should endeavour to send another representative.

In case of any disputes amongst Forum partners, the obligation will be to work towards and amicable settlement. Disputes will be referred to the Forum, but where these cannot be resolved, the SMHP will have overall responsibility of settling disputes.

Appendix 3: Service Data and Activity

Referrals accepted into NHS Shetland CAMHS

Seventy nine referrals were accepted into NHS Shetland CAMHS between August 2012-August 13. The breakdown of who sees these referrals for assessment is in the following table:

Clinician(s)	Number of Assessments
CPN & PMHW	11
PMHW & CAAP	10
PMHW	10
Consultant Psychiatrist & CPN	20
Consultant Clinical Psychologist & CAAP	6
Consultant clinical psychologist and PMHW	5
Consultant clinical psychologist	8
CPN	2
CPN and CAAP	3
CAAP	1
CPN and Children and Families social worker	1
PMHW and Bridges support worker	1
Whole CAMHS team	1

Fig. 3 Referrals from Ward 3 GBH August 2012 to August 2013.

Month	Number of Referrals from Ward 3
October 2012	1
December 2012	1
March 2013	1
May 2013	1
June 2013	1

Glossary of terms and abbreviations

ASIST	Applied Suicide Intervention Skills Training
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
CPN	Community Psychiatric Nurse
CPP	Community Planning Partnership
HIFRS	Highlands and Islands Fire and Rescue Service
MYH	Mind Your Head
NFU	National Farmers' Union
PHQ-9	Patient Health Questionnaire, used as a screening and diagnostic tool for mental health disorders of depression, and anxiety
PMHW	Primary Mental Health Worker
SMHFA	Scotland's Mental Health First Aid
SOA	Single Outcome Agreement

<table>
<tr><td colspan="2">Which groups of the population do you think will be affected by this proposal?

• minority ethnic people (incl. gypsy/travellers, refugees & asylum seekers)
• women and men
• people in religious/faith groups
• disabled people
• older people, children and young people
• lesbian, gay, bisexual and transgender people
• PEOPLE OF LOW INCOME
• people with mental health problems
• homeless people
• people involved in criminal justice system
• staff

Other groups:

Partner organisations working in the field of mental health.

The Shetland community.</td></tr>
<tr><td rowspan="2">N.B. The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed.</td><td>What positive and negative impacts do you think there may be?</td></tr>
<tr><td>Which groups will be affected by these impacts?</td></tr>
<tr><td>What impact will the proposal have on lifestyles? For example, will the changes affect:

• Diet and nutrition?
• Exercise and physical activity?
• Substance use: tobacco, alcohol or drugs?
• Risk taking behaviour?
• Education and learning, or skills?</td><td>Intended to positively improve lifestyle in terms of mental health and risk factors to mental wellbeing. Links to substance misuse, specifically alcohol and drug misuse.

Includes priorities on community awareness raising and public education, work in schools and with staff working in the field of mental health.</td></tr>
<tr><td>Will the proposal have any impact on the social environment? Things that might be affected include

• Social status
• Employment (paid or unpaid)
• Social/family support
• Stress
• Income</td><td>Links to employability and supported employment should improve health at work and employment opportunities for people living with mental illness.

The strategy also has implications for communities supporting people living with mental illness, and for families and carers.

The strategy is intended to reduce the impact that stress and other life factors have on mental health and well being, and to improve the resilience of individuals, families and communities.</td></tr>
<tr><td>Will the proposal have any impact on
• Discrimination?
• Equality of opportunity?</td><td></td></tr>
</table>

• Relations between groups?	The strategy has a priority of reducing stigma and discrimination around mental illness.
Will the proposal have an impact on the physical environment? For example, will there be impacts on: • Living conditions? • Working conditions? • Pollution or climate change? • Accidental injuries or public safety? • Transmission of infectious disease?	No impact.
Will the proposal affect access to and experience of services? For example, • Health care • Transport • Social services • Housing services • Education	The strategy includes priorities around mental health service redesign and aims to improve the experience of service users in terms of access, clearer pathways into and between services, and best use of available resources.

RAPID IMPACT CHECKLIST: SUMMARY SHEET	
POSITIVE IMPACTS (NOTE THE GROUPS AFFECTED) Positive impacts on users of mental health services, and on people caring for people with mental illness. Positive impacts on staff working in mental health services and partner organisations working in the field of mental health. Positive impacts on communities in raising awareness of positive mental health and reducing stigma.	**NEGATIVE IMPACTS (NOTE THE GROUPS AFFECTED)** No negative impacts, recognising that change will have to be managed within existing resources.
ADDITIONAL INFORMATION AND EVIDENCE REQUIRED Additional information is available within the body of the Strategy. No additional evidence is required.	
Recommendations It is recommended that the Strategy is approved.	

FROM THE OUTCOME OF THE RIC, HAVE NEGATIVE IMPACTS BEEN IDENTIFIED FOR RACE OR OTHER EQUALITY GROUPS? HAS A FULL EQIA PROCESS BEEN RECOMMENDED? IF NOT, WHY NOT?

No negative impacts identified for equality groups. A full EQIA process has not been recommended because sufficient attention has been paid to equality impacts within the Strategy.

Manager's Signature: **Date: 3rd March 2014**

References:

[i] SAMH, 2011, What's it worth now? The social and economic costs of mental health problems in Scotland

[ii] Colman I, Ploubidis G, Wadsworth M, Jones P and Croudace T (2007) A longitudinal typology of symptoms of depression and anxiety over the life course. *Biological Psychiatry*, 62, 1265–1271

[iii] Kessler RC, Amminger GP, Aguilar-Gaxiola S, *et al* (2007) Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry*, **20**, 359–364.

[iv] (Friedli L, Parsonage M, Promoting mental health and preventing mental illness: the economic case for investment in Wales. All Wales Mental Health Promotion Network. 2009).

[v] Scotland's Public Health Observatory: http://www.scotpho.org.uk/publications/reports-and-papers/887-scotlands-mental-health-adults-2012

[vi] 2011 Census release, National Records of Scotland 2013

[vii] Scottish Executive Health Department: Framework for Mental Health Services in Scotland (1997) http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm

[viii] A Fairer Future? 'see me' report into experiences of people with lived experience (2006) p24

[ix] A Fairer Future? 'see me' report into experiences of people with lived experience (2006) p25

[x] Well? What Do You Think? (2006) Scottish Government Social Research (pub 2007) p.63

[xi] Mind Your Head Community Survey 2011

Agenda Item

4

Shetland Islands Council

Executive Committee **5 May 2014**

Procurement Strategy Action Plan and Procurement Capability Assessment	
CPS-06-14-F	
Executive Manager – Capital Programme	**Capital Programme Service**

1.0 Summary

1.1 This report contributes to the fulfilment of the role that Executive Committee has to monitor performance against the Council's approved Procurement Strategy, in terms of the Planning and Performance Management Framework. It provides an update on the Council's Procurement Strategy Action Plan as requested by Executive Committee on 3 February 2013, including a review of the Council's 2013 Procurement Capability Assessment (PCA) and options to be considered for further improvement.

2.0 Decision Required

2.1 That the Executive Committee;

2.1.1 Notes the progress made by the Procurement team in implementing the Council's Procurement Strategy as detailed in the Action Plan at Appendix D to this report; and,

2.1.2 Notes the options to improve the Council's PCA set out in Appendix A to this report and comments on the aspects of procurement activity to be prioritised moving forward as set out at paragraph 3.11 in this report.

3.0 Detail

3.1 Members were provided with a procurement update report that included the Procurement Strategy Action Plan update at Executive Committee on 3 February 2013 (Min. Ref 05/14).

3.2 The outcome of the Council's 2013 PCA was also reported then along with a comparison of the scores achieved by the other four regional Councils (Orkney, Western Isles, Highland and Moray). Members agreed that this

was an area that the Committee focus attention on as part of its performance monitoring remit. It should be noted that Scotland Excel have recently adopted a new business structure and this Council now forms part of a larger "North Region" of ten Councils.

3.3 The annual PCA is carried out by Scotland Excel on behalf of the Scottish Government and is generally carried out in October and November. It is an evaluation of the Council's procurement capability as a whole, i.e. not the Procurement section within Capital Programme Service. This is an important point, as any actions agreed to improve the PCA will apply to, and have the support of, all Directorates.

3.4 The PCA is a generic exercise, i.e. it does not differentiate on the basis of local authority location, type of goods, works and services required, structure, resources and related policies of the Council concerned.

3.5 The PCA comprises eight sections and a total of 55 questions, 52 of which apply to Councils. Each question has a score ranging from zero to three. The exercise itself is evidence based and usually takes a day to complete with four staff (two from Scotland Excel and two from Procurement). Prior to the assessment, a significant amount of suitable information needs to be provided to, and collated by, the Procurement Section. Information provided is not always readily available and/ or is in a format that does not meet the higher scoring criteria applying.

3.6 The PCA categorises each section and the overall summary as: Non-conformance; Conformance; Improved Performance and Superior Performance. The 2013 PCA for Shetland Islands Council is in the Conformance category as shown in Appendix C to this report.

3.7 In 2013 the highest PCA score was attributed to Renfrewshire Council at 80% and the lowest to Orkney Islands Council at 31%. Shetland Islands Council scored 35% and the average score is 56% (see Appendix B).

3.8 A detailed follow up review of the 2013 PCA has been carried out, on a question by question basis and is attached as Appendix A to this report.

3.9 Feedback has been sought from Comhairle nan Eilean Siar (Western Isles Council) on the approach undertaken to improve its PCA score and the following main points can be noted:

- Graduate Placement appointed to carry out category and supplier surveys. The Head of Exchequer Services specifically reviewed and continues to review the PCA and identifies / targets areas for improvement;
- Developed more detailed process, compliance procedures and documents with a view to targeting savings opportunities in future;
- Advertise all contracts on the web portal Public Contracts Scotland and in the local press where appropriate;
- Head of Exchequer Services has responsibility for Procurement and Accounts Payable functions;
- Head of Exchequer Services appointed as chair of the Scottish Local Government Procurement Forum (SLGPF);

3.10 It should be noted that the PCA is an assessment of process, procedures and supporting documentation. It does not consider the monetary value of any savings derived from the resulting investment in time and resources.

Summary PCA Improvement Options

3.11 A summary of the main sections of the PCA, including options, resources and decisions required is attached as Appendix A to this report. In considering the options for improvement, Members should note that given the limited resources available to progress matters coupled with Council restructuring and staff changes, it is likely that it would be of benefit to target specific elements of the PCA (detailed below for ease of reference) as opposed to targeting improvement in all sections.

- Procurement Leadership and Governance
- Procurement Strategy and Objectives
- Defining the Supply Need
- Commodities/ Project Strategies and Collaborative Procurement
- Contract and Supplier Management
- Key Purchasing Processes and Systems
- People
- Performance Measurement

4.0 Implications

Strategic

4.1 Delivery On Corporate Priorities – The Corporate Plan 2013-17 states that we will renegotiate contracts with our biggest suppliers to achieve savings, work with public sector partners to buy things cheaper together and train relevant staff to use online buying systems and other forms of electronic ordering. Full implementation of the Action Plan set out in the current 2012 – 2015 Procurement Strategy and attached as Appendix D to this report would contribute to an improved PCA score.

4.2 Community/ Stakeholder Issues – Greater involvement of contractors and suppliers coupled with contract and supplier development would contribute to an improved PCA score.

4.3 Policy and/ or Delegated Authority – Securing the co-ordination, control and proper management of the financial affairs of the Council is delegated to Executive Committee. The Executive Committee has functional responsibility for corporate procurement and, through the Council's Scheme of Administration and Delegations, is required to monitor and review achievement of its key outcomes in that area, in accordance with the Planning and Performance Management Framework.

4.4 Risk Management – There are significant financial and reputation risks associated with failure to maintain and implement the Council's Procurement Strategy. In addition, there are legal risks associated with failure to comply with Procurement legislation, with the costs and programming implications of a challenge to any tendering exercise.

4.5 Equalities, Health And Human Rights – None

4.6 Environmental – None

Resources

4.7 Financial –Subject to the decision of Committee, there may be financial implications depending on where additional resources are deemed necessary. Procurement exercises planned for 2014/15 and other general activity are expected to yield savings of approximately £300,000.

4.8 Legal – The work of the Procurement team, particularly with regard to advising on the Council's Contract Standing Orders and procurement legislation supports Governance and Law in ensuring that the Council is safeguarded against potential legal challenge or prosecution.

4.9 Human Resources – The procurement section comprises 3.5 FTE staff that carry out both a contract compliance and procurement function. Many of the measures described in the appendices to this report would require additional staff resources, either within the Procurement team or across other Council services, to implement.

4.10 Assets and Property – None

5.0 Conclusions

5.1 This report provides an update on the progress that has been made by the Procurement team and a more detailed review of the 2013 PCA along with options for improvement. It provides an opportunity for Executive Committee to comment on the PCA and to highlight potential areas for improvement.

For further information please contact:
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List of Appendices:

Appendix A – PCA detailed options by question
Appendix B – PCA scores for all 32 Scottish local authorities
Appendix C – SIC 2013 PCA Bar Chart
Appendix D – Procurement Strategy Action Plan Update

Background documents:

Procurement Strategy

END

Section 1	Procurement Leadership and Governance	LEVEL 0	LEVEL 1	LEVEL 2	LEVEL 3	NOTES	OPTIONS TO BE CONSIDERED FOR HIGHER SCORE	RESOURCE / COST IMPLICATION	ACTION BY
1.1	Does the organisation provide clear leadership of the procurement activity?		2013			Same as 2012	LEVEL 2 Consider amended Standing Orders and regular CMT reporting. For LEVEL 3 we would need to be part of procurement peer groups, consider procurement board and full leadership in wider public sector networks.	Time and additional Travel/Subsistence costs	Would require to be considered by Director of Corporate Services and Chief Executive.
1.2	Is the procurement function responsible for the effectiveness and quality of sourcing activity across the organisation?		SAME SCORE				New Standing Orders now implemented so LEVEL 2 or LEVEL 3 to be sought 2014. Procurement to be involved with all Directors/Executive Managers/Accountancy to ascertain High Value/High Risk procurement	Time spent on closer working relationships with Executive Managers and Accountancy to have a Forward Action Plan for each Service	Procurement / Executive Managers
1.3	Does the procurement function effectively manage relationships with internal stakeholders?		SAME SCORE				Extension of 1.2 above. To get a LEVEL 3, Procurement needs to be a Key Player at the development stage of business case and strategy.	Time (as above)	Executive Manager - Capital Programme or Director of Corporate Services
1.4	How clear is the process of delegation and authority for procurement?		2013			Same as 2012	LEVEL 2 Head of Procurement is responsible and accountable for ensuring all staff comply with the scheme of delegation. LEVEL 3 The separation of duties and authority levels are embedded into computer systems to ensure compliance and appropriate authority for transactions.	LEVEL 2 - Amended required for Scheme of Delegation/Standing Orders. LEVEL 3 - Financial Systems upgrade / No Manual Order Books being used / Corporate Credit Cards/ Purchasing Cards	Executive Manager - Capital Programme / Executive Manager - Finance / Director of Corporate Services / Chief Executive
1.5	Does internal audit provide assurance that the organisation's internal control systems for procurement are adequate and effective?			2013		Same as 2012	LEVEL 3 - Regular Internal Audit Statements demonstrating no significant risks in the past 3 years. Reducing the number of potential breaches of Contract Standing Orders or EU Regulations. Provision of Audit evidence to be available to Scotland Excel.	Time resource for roll out of Contract Standing Orders and EU Procurement Training	All Executive Managers / Procurement / Internal Audit

Section 2	***Procurement Strategy and Objectives***	LEVEL 0	LEVEL 1	LEVEL 2	LEVEL 3	NOTES	OPTIONS TO BE CONSIDERED FOR HIGHER SCORE	RESOURCE / COST IMPLICATION	ACTION BY
2.1	How developed is the organisation's procurement strategy?			2013		Same as 2012	LEVEL 3 - Cross reference Scottish Procurement Policy Notes and keep evidence of same. Develop a PCA Action Plan and cross reference to SIC Procurement Strategy.	Time resource - Procurement Section	Procurement Section
2.2	Is there a clear process for procurement involvement in strategic reviews of service provision? These reviews would normally consider options such as outsourcing, insourcing, shared services, etc		2013			Same as 2012	LEVEL 2 - Evidence of Procurement being involved at an early strategic stage. LEVEL 3 - Procurement initiates research on market opportunities for strategic innovations to current service delivery and subsequently makes the case for change at a senior level.	Formal / regular communication from Performance & Improvement	Chief Executive / Director of Corporate Services
2.3	How well is the procurement strategy supported by Senior Management within the organisation?		2013			SAME SCORE AGREED	LEVEL 2 - Most senior managers provide full support for the strategy trhough communications and provision of resource to support implementation of procurement objectives, including change projects. LEVEL 3 - All senior managers provide full support for the implementation of the strategy.	Intial contact with WIC to be followed up for futher implementation advice	Procurement Section
2.4	Has the procurement function developed, and acted on, an improvement plan for the organisation?		2013			SAME SCORE AGREED	LEVEL 2 - Create Procurement Board (consider e-mail / intranet communication) or equivalent (CMT?) which is jointly resourced across departments. The plan is on schedule and delivering results. LEVEL 3 - The improvement plan has been delivered and the organisation has adopted a continuous improvement to its procurement performance. Procurement performance is owned by the Procurement Board. Regular reports identify savings and benefits from further improvements.	Staff time - Procurement Contacts and Section	Executive Manager - Capital Programme / Director of Corporate Services

2.5	What level of external collaboration exists to identify and adopt good procurement practice?		2013			SAME SCORE AGREED	LEVEL 2 - Collaboration to develop best practice with peer organisations. Collaborating with Centres or Expertise on Scottish Procurement & Commercial Directorate on best practice. LEVEL 3 - Recognised as a lead organisation in procurement best practice areas, including development of strategy and policy encompassing wider public sector.	Maintain evidence of collaborative best practice. Follow up for further advice from WIC / OIC	Procurement Section

Section 3	***Defining the Supply Need***	LEVEL 0	LEVEL 1	LEVEL 2	LEVEL 3	NOTES	OPTIONS TO BE CONSIDERED FOR HIGHER SCORE	RESOURCE / COST IMPLICATION	ACTION BY
3.1	Are specifications for the procurement of goods and services designed to maximise value for the organisation and its customers? (e.g. output specs, technology, roadmaps, legislation, whole life costing)?		2013			SAME SCORE AGREED	LEVEL 2 - Key contracts are based on output specifications which have been developed based on market research and in line with Procurement Journey Routes 2 and 3. LEVEL 3 - Market engagement is undertaken prior to issuing the Invitation to Tender through supplier awareness days / open meetings etc and the market intelligence obtained is used to develop specifications.	Time and costs involved arranging Supplier Awareness Days etc	Procurement & All Executive Managers
3.2	How early and to what extent is the procurement function involved with internal customer teams in the design and development of their business plans and strategies?		2013			SAME SCORE AGREED	LEVEL 2 - Procurement function is engaged by some internal customers in the development of business plans and strategies. LEVEL 3 - Procurement function is engaged in all levels with all internal customer teams on their business plans and strategies.	Time engaging with All Executive Managers to develop Action Plans for each service area.	Executive Manager - Capital Programme / Director of Corporate Services. Procurement & Executive Manager - Finance and All Executive Managers / All Team Leaders
3.3	To what extent are the development and management of commodity strategies and the rationalisation of goods, works and services based on reliable and robust internal information?		2013			SAME SCORE AGREED	LEVEL 2 - Regular work done to identify opportunities to rationalise goods, services and works. LEVEL 3 - Detailed management information, including line item detail and forecast data, informs all relevant procurement decisions.	Closer working relationship with Accountancy. Better data available from Integra. CMT to endorse change control for rationalising goods, services and/or works.	Procurement / Executive Manager - Finance / Director of Corporate Services / Chief Executive

3.4	Is there effective demand management early in the procurement process?		2013			SAME SCORE AGREED	LEVEL 2 - Review and regular challenge of demand as part of sourcing process, including some benefits. LEVEL 3 - Significant improvements and benefits can be demonstrated. Demand management fully integrated in procurement processes.	Financial management and other sourcing systems need to be developed to provide detailed information on demand and consumption of commodities.	Executive Manager - Capital Programme / Director of Corporate Services in consultation with Executive Manager - Finance / Executive Manager - ICT
3.5	To what extent, and how, is detailed and rigorous supply market analysis used to drive strategy development? E.g. understanding whole life cost, benchmarking price, quality etc		2013			SAME SCORE AGREED	LEVEL 2 - Research conducted frequently across the market when developing new strategies. LEVEL 3 - Most commodity / project strategies are based on comprehensive research of the supply markets, including the supply chain.	Financial management and other sourcing systems need to be developed to provide detailed information on demand and consumption of commodities.	Executive Manager - Capital Programme / Director of Corporate Services in consultation with Executive Manager - Finance / Executive Manager - ICT
3.6	Are mechanisms in place to encourage new suppliers and ensure openness and transparency?		2013			Same as 2012	LEVEL 2 - Quick Quote and PCS embedded in organisation's procedures and being used across the organisation, with the majority of contracts being advertised and award notices published. LEVEL 3 - All Contracts are advertised and Award Notices are published on Public Contracts Scotland portal.	Massive time resource for Procurement / Departmental Staff due to the likelihood that there would be a high level of interest in all advertised contracts.	Director of Corporate Services / Chief Executive and the relevant committee/ Full Council

Section 4	***Commodity/Project Strategies and Collaborative Procurement***	**LEVEL 0**	**LEVEL 1**	**LEVEL 2**	**LEVEL 3**	**NOTES**	**OPTIONS TO BE CONSIDERED FOR HIGHER SCORE**	**RESOURCE / COST IMPLICATION**	**ACTION BY**
4.1	Are commodity strategies and business cases for Cat C contracts and Cat A & B mini-comp's developed in line with good practice in the Procurement Journey?	2013				Same as 2012	LEVEL 1 - The procurement team develops commodity strategies or business cases based on the appropriate route of the Procurement Journey. LEVEL 2 - There is an organisation-wide sourcing approach using the Procurement Journey. LEVEL 3 - Examples of commodity strategies (for Routes 2 & 3) or business cases (for Route 1) have been developed using the Procurement Journey and are shared as best practice across the sector	Procurement Team - familarisation with the Procurement Journey - to consider rolling this out to Executive Managers & Team Leaders. Consider using the Procurement Journey as best practice and then roll out to other organisations.	Procurement Team

4.2	To what extent is the (Cat C or mini-comp's on Cat A or B) requirement developed as part of a cross functional team (e.g. a UIG type activity) when demand crosses departmental boundaries?			2013		Same as 2012	LEVEL 3 - The requirements are developed including key cross functional input for more than 80% of eligible contracts.	We need to maintain a note against Contract Awards highlighting inter-departmental or cross-functional examples.	Procurement Team
4.3	How much of the overall spend (CAT A, B & C) is covered by signed-off commodity/project strategies? All strategies should include forecast savings and/or benefits.	2013				Same as 2012	LEVEL 1 - Between 50% - 70% of influenceable spend covered with commodity / project strategies. LEVEL 2 - Over 70% of influenceable spend covered by commodity / project strategies.	Time - We need to review the spend data and identify the % which is covered by a Commodity Strategy. We need to liaise with Payments and/or Accountancy to reconcile data on Integra and Spikes Cavell.	Procurement Team
4.4	How does the organisation take account of sustainability in its procurement activity? N.B. This includes Community Benefit Clauses (CBS's) and capacity building for SME's (including Third Sector).		2013			Same as 2012	LEVEL 2 - The organisation can demonstrate that procurement exercises have successful sustainability outcomes and are meeting the sustainability targets from the procurement strategy.	Much more feedback and support from departments on ongoing and completed projects which have sustainability targets. To achieve a LEVEL 3 we need to raise the level of awareness across all Procurement Practitioners to consider sustainability at all stages of the procurement process.	Check with Environmental Health and get information from all Executive Managers / All Team Leaders
4.5	How does the organisation monitor its progress towards demonstrating sustainable procurement practices and processes?		2013			Same as 2012	LEVEL 2 - The organisation has assessed itself at Level 3 in all 5 areas of the Framework and can evidence the outcomes of their achievement.	Review the Flexible Framework again and be realistic. NOTE: No other local authority has achieved a LEVEL 2	Procurement Team & (Mary Lisk)
4.6	How does the organisation manage and mitigate risk during the sourcing process?		2013			Same as 2012	LEVEL 2 - Risk reporting, including sustainability and reputational, is regular and proactive with mitigation plans in place.	Consider whether we need to have more involvement with the Risk Register. Consider having Training on Supplier Selection.	Accountancy / Safety & Risk / Audit (Regular reports about Fraud)

4.7	How are suppliers selected within the organisation?		2013			Same as 2012	LEVEL 2 - The supplier selection process should be well communicated throughout the organisation. LEVEL 3 - The organisation takes action to reduce the burden of the selection process for suppliers and to improve the process as a whole.	Consider cross referencing with PCST to see if template available. Consider updating / refreshing our intranet page. Procurement to consider updating the "Feedback" section on internet (SME Feedback). Remind Executive Managers / Team Leaders about the Selection Process.	Procurement Team
4.8	Do post procurement reviews take place to identify lessons to be learned from the process and to determine whether planned benefits and VFM was achieved?	2013				Same as 2012	LEVEL 1 - Post procurement reviews are conducted for contracts considered by the organisation as high risk. Lessons learned for these are sometimes circulated, but not consistently or systematically. LEVEL 2 - Post Procurement reviews are conducted for high and medium risk contracts based on segmentation . Lessons learned are always circulated for these cases. LEVEL 3 - There is a clear and systematic process for circulating lessons learnt.	Consider developing a Post Review Process / Procedure. For LEVEL 1 carry out reviews for 2013/2014 High Risk Contracts. For LEVEL 3 - We would systematically circulate this to updated / refreshed Procurement Network. Request that Internal Audit formally advises Procurement of any post-project Reviews being carried out (E.g, Shetland College)	Procurement Team with support from the service delivery departments involved.
4.9	How is the organisation increasing its C1 local collaborative procurement with other public bodies?		2013			Same as 2012	LEVEL 2 - The organisation can demonstrate participation in several collaborative C1 contracts with the past 12 months.	Do an analysis of our spend to identify potential C1 collaborative opportunities.	Procurement Team along with the other four Regional Councils (Highland, Moray, WIC, OIC) UPDATE:-Now part of North Region which comprises 10 Councils.
4.10	Is the organisation working with Centres of Expertise on collaborative procurement?			2013		Same as 2012	LEVEL 3 - Greater than 90% participation in collaborative contracts.	Increase awareness of collaborative contracts.	Procurement Team, Executive Manager - CPS, All Directors. May need to advise Executive Committee/SIC.

4.11	Which evaluation criteria are used during local procurement exercises?		SAME SCORE				Apply "Whole-life Costs" as appropriate and lessons learned.	Raise awareness and incorporate lessons learned by systematic feedback.	Procurement Team and All Services.
4.12	Does the organisation place business with supported businesses through Cat A, B or C contracts?	2013				Decreased from Level 2 in 2012	LEVEL 3 - Award more than one contract to Supported Business.	Raise awareness with local supported businesses to Register on portal.	Procurement Team and All Services.

Section 5	***Contract and Supplier Management***	LEVEL 0	LEVEL 1	LEVEL 2	LEVEL 3	NOTES	OPTIONS TO BE CONSIDERED FOR HIGHER SCORE	RESOURCE / COST IMPLICATION	ACTION BY
5.1	How does the organisation ensure that Cat A, B and C contracts are being used?		2013			Same as 2012	Needs to raise awareness through Standing Orders roll-out, coupled with spend analysis and reporting.	Largely staffing implication but also systems upgrade analysis.	Procurement Team, Accountancy and All Services.
5.2	Does the organisation have a clear understanding of its contract coverage?		2013			SAME SCORE AGREED	Develop a comprehensive Contract Register linked to Spend Information.	Staffing and system upgrade/analysis.	Procurement Team, Executive Managers - Finance & ICT and Director of Corporate Services.
5.3	How are contracts and suppliers managed across the organisation?	2013				Same as 2012	Raise awareness of "The Procurement Journey" and Contract & Supplier Management, coupled with Case Studies.	Staffing and a pro-forma document for online completion.	Procurement Team / All Services.
5.4	During the life of the contract, how proactive is the organisation's approach to the review of specification of current products and services to deliver benefits?		2013			Same as 2012	LEVEL 3 - Identify all "Key Purchases" delivering benefits and set up a systematic review of these.	Carry out a review and agree approach with Exec Manager and Team Leaders.	Procurement Team, Executive Manager - CPS and Director of Corporate Services.
5.5	Does the organisation manage supply risk during the life of the contract?		2013			Same as 2012	Review the Risk Register and cross-reference to the key suppliers and business continuity plan.	Staffing and time - better use of the Risk Register.	Procurement Team / All Services and Safety & Risk
5.6	Do suppliers have an opportunity to provide structured feedback to the organisation during the life of the contract?		2013			Increased from Level 0 in 2012	Create a formal online / documented feed-back process and raise awareness. Cross-reference feed-back to other contracts.	Staffing and time.	Procurement Team and Services to use the feed-back.

5.7	How are supplier and organisational processes developed during the life of the contract to deliver benefits to the organisation?		2013			Same as 2012	Maintain "Register" of supplier reviews to be passed to Procurement for action as part of Supplier Development Programme.	Staffing / Supplier Events. Services to keep Procurement up-to-date.	Procurement Team, All Services and possible Economic Development Unit (e.g. Business Gateway)

Section 6	***Key Purchasing Processes and Systems***	LEVEL 0	LEVEL 1	LEVEL 2	LEVEL 3	NOTES	OPTIONS TO BE CONSIDERED FOR HIGHER SCORE	RESOURCE / COST IMPLICATION	ACTION BY
6.1	How effective is the process for receiving and authorising payment for goods, services and works?	2013				Same as 2012	LEVEL 1 - Options to be considered 50 - 75% LEVEL 2 - 75 - 90% LEVEL 3 - 90% +	Staffing / Systems Analysis INTEGRA, SERVITOR, MAST & CAFM	Executive Manager - Finance and Director of Corporate Services.
6.2	What is the organisation's performance in terms of payments to suppliers?		2013			Same as 2012	LEVEL 2 - 90% and LEVEL 3 - Good payment terms are promoted in the supply chain	Staffing / Systems awareness / less Manual Orders	Executive Manager - Finance and Director of Corporate Services.
6.3	How established is quality assurance in the procurement process for goods and services?					N/A			
6.4	Are suitable technology-based tools in place and used?		2013			SAME SCORE AGREED	LEVEL 2 - systematic use of e-procurement via PCS along with Contract Database.	Systems review/ upgrade including staffing.	Executive Managers - Finance/CPS & ICT and agreed by Director of Corporate Services. Possibly Exec Committee.
6.5	How does the organisation ensure that products and services are correctly and consistently coded, that prices are correct and updated in a timely manner and that this information is available in the general ledger/finance system?		2013			Increased from Level 0 in 2012	LEVEL 2 - better use of CCM / item subjective codes. Full E-procurement review analysis. Procurement to be responsible for corporate coding.	Staffing / systems upgrade / review analysis.	Procurement Team, Executive Manager - Finance, Director of Corporate Services and possibly Exec Committee.
6.6	Has the organisation assessed its procurement process automation and information requirements and implemented an ICT strategy to meet them?		2013			SAME SCORE AGREED	LEVEL 2 - develop a Procurement ICT Strategy (separate from Procurement Strategy)	Staffing / systems review upgrade. Possibly a Project Board	Executive Managers - CPS/ICT/ Finance and Director of Corporate Services. Possibly Exec Committee.

6.7	To what extent is the supplier delivery framework tailored to meet specific product needs?					N/A			
6.8	How developed are the processes for stock management and is inventory managed efficiently?					N/A			

Section 7	***People***	LEVEL 0	LEVEL 1	LEVEL 2	LEVEL 3	NOTES	OPTIONS TO BE CONSIDERED FOR HIGHER SCORE	RESOURCE / COST IMPLICATION	ACTION BY
7.1	How proactive is the Procurement department in terms of planning future resources?		2013			Same as 2012	LEVEL 2 - identify appropriate training for none-procurement staff. LEVEL 3 - Training have procurement authority. Assess competancy levels as part of an overall Performance Review endorsed at Management level.	Formal issue the Brightwaves Training. Identify training requirements.	Procurement Team, All Executive Managers with support and advice from HR.
7.2	Do Procurement Professionals contribute to initiatives to improve procurement efficiency and effectiveness? E.g improving efficiency in procurement processes, removing duplication etc			2013		Increased from Level 1 in 2012	Continue to contribute to new initiatives. LEVEL 3 - instigate and lead procurement efficiency and effective initiatives.	Staffing/time mainly. Report regularly to CMT on potential procurement initiatives.	Procurement Team, Executive Manager - CPS, Director of Corporate Services and CMT.
7.3	Do Procurement Professionals and Officers have their competency levels assessed using the Scottish Procurement Competency Framework or a similar competency framework?		2013			SAME SCORE AGREED	LEVEL 2 - Use the Procurement Competancy Framework annually and link to your Employee Reviews. LEVEL 3 - similar approach to wider procurement staff / network.	Staffing/time. Use the Procurement Competancy Framework systematically across all services.	Procurement Team, HR & Training. Director of Corporate Services decision for Corporate Procurement Training.

7.4	How well established are the training and development support structures for Procurement Professionals and Officers? Is there a designated budget for procurement training which is equivalent to the training budget allowed for other specialist areas?		2013			SAME SCORE AGREED	LEVEL 2 - need to have a strategic approach to Training for Procurement Staff and others. Follow up review after training to demonstrate effectiveness. LEVEL 3 - align to SIC's Organisation Strategy. Consider mentoring and secondments for development.	Staff time. Consult with HR / Training / Performance & Improvement.	Procurement Manager, Executive Manager - CPS, Director of Corporate Services and HR / Training and Performance & Improvement.
7.5	Is there a process in place for ensuring that non-procurement staff who have authority to procure have the appropriate competency levels?		2013			Same as 2012	LEVEL 2 - identify non-procurement staff and their training requirements. LEVEL 3 - develop appropriate training prior to authority being given to procure. Linked to Employee Review	Staff time / systematic roll-out of Brightwave Training. Need "Skills Gap Analysis" training with support from HR / Training and Finance.	Procurement Manager, Executive Managers - CPS and Finance, Director of Corporate Services (HR / Training).
7.6	How proficient with EU Procurement Legislation are the Procurement Professionals and Officers within the organisation (including those with delegated purchasing authority)?		2013			Decreased from Level 2 in 2012	LEVEL 2 - run EU Procurement Training annually / and/or communicate accordingly. LEVEL 3 - EU knowledge including Training Plans for all Procurement Staff including those outwith the Procurement Team.	Staff / Training cost. Run EU Training annual by VC. Maintain EU Guidenace Update Page or Link on Council's intranet page	Procurement Team, Director of Corporate Services / HR Training.

Section 8	***Performance Measurement***	LEVEL 0	LEVEL 1	LEVEL 2	LEVEL 3	NOTES	OPTIONS TO BE CONSIDERED FOR HIGHER SCORE	RESOURCE / COST IMPLICATION	ACTION BY
8.1	How well defined are the procurement performance measures?		2013			SAME SCORE AGREED	LEVEL 2 - systematic Contract Supplier Management being reported regularly to Senior Management. LEVEL 3 - review benefits and report at board level.	Staffing and creation of board. Consider Senior Management Procurement Board reporting structure.	Procurement Manager, Executive Manager - CPS, Director of Corporate Services and Chief Executive.
8.2	Do Procurement Officers and relevant managers get appropriate, timely and accurate procurement spend information?		2013			SAME SCORE AGREED	LEVEL 2 - spend analysis variances require to be reported to Procurement. LEVEL 3 - financial reporting to define and measure performance targets.	Staffing / Systems Review resource requirement. Need to create systematic review reporting on Goods, Works & Services.	Procurement Team, Executive Managers - CPS / Finance, Director of Corporate Services and CMT.
8.3	Do all appropriate stakeholders receive, and act on, relevant procurement reports?			2013		Increased from Level 1 in 2012	LEVEL 2 - Regular reports highlighting opportunities, risks and trends in departments. LEVEL 3 - reports to all procurement customers.	Staffing / Systems - create Report and reporting structure.	Procurement Team, Executive Manager - CPS, All Directors.

8.4	Is procurement spending monitored to ensure that it realises its anticipated benefits and savings against targets?		2013			Same as 2012	LEVEL 2 - Monitor savings and quality benefits. Set targets. LEVEL 3 - define savings and quality benefits at Project and Business Level.	Staff / systems clearly identified on a case by case basis. Could Covalent be used?	Procurement Team, Executive Manager - CPS, All Directors.
8.5	How does procurement use customer feedback to improve its performance?		2013			Same as 2012	LEVEL 2 - annual two-way customer feedback process (Suppliers/Staff) LEVEL 3 - Action Plan which is evidence-based and clearly shows any improvements.	Staffing / Systems - set up a streamlined feedback and action plan process.	Procurement Team, agreed by Executive Manager - CPS and All Directors.
8.6	Does the organisation contribute to analysis of trends in Scottish procurement by supplying relevant information?			2013		Increased from Level 1 in 2012	To maintain a LEVEL 2, BPI's need to be updated regularly. LEVEL 3 - we would have to participate in National Working Groups to shape Management Information. Creat and publish a Sustainable Procurement Action Plan.	Staff / Systems / Cost (Travel / Subsistence) - create Sustainable Procurement Action Plan	Procurement Manager, agreed with Executive Manager - CPS, Director of Corporate Services and Chief Executive.

2013 Question	Aberdeen City	Aberdeen shire	Angus	Argyll & Bute	City of Edinburgh	Clackmannanshire	CNES	Dumfries &	Dundee	East Ayrshire	East Dunbarton	East Lothian	East Renfrews	Falkirk	Fife	Glasgow	Highland	Inverclyde	Midlothian	Moray	North Ayrshire	North Lanarkshir	Orkney	Perth & Kinross	Renfrewshire	Scottish Borders	Shetland	South Ayrshire	South Lanarkshir	Stirling	West Dunbarton	West Lothian	AVERAGE
PCA Score	70%	67%	51%	63%	59%	37%	57%	50%	51%	59%	44%	55%	62%	60%	52%	67%	51%	54%	60%	55%	61%	56%	31%	59%	80%	58%	35%	65%	62%	55%	58%	62%	56%
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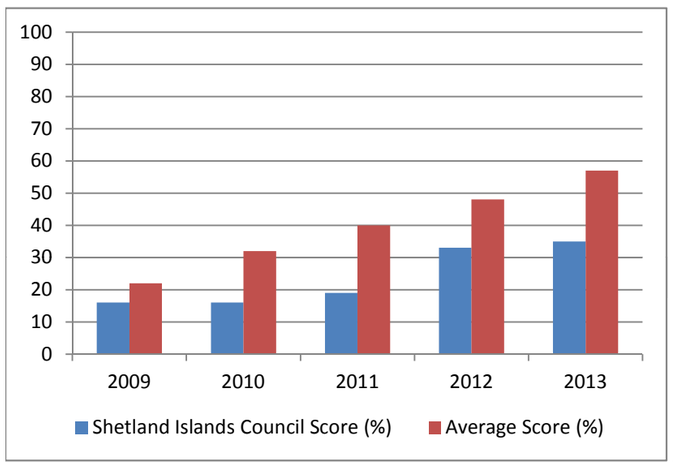
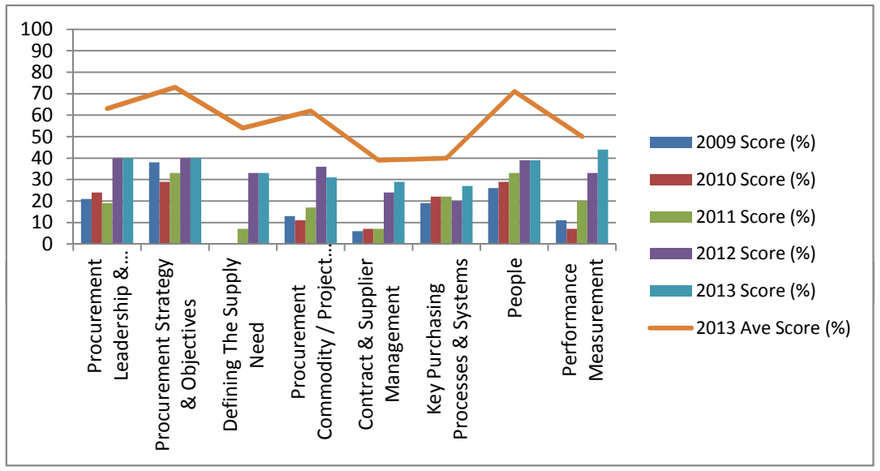
Shetland Islands Council

SECTIONS

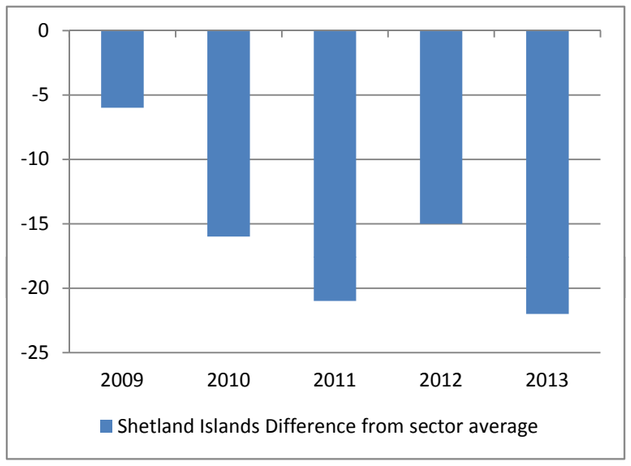
Sections		Assessed Status			
		Developing	Conformance	Improved Performance	Superior Performance
Procurement Leadership and Governance	40%				
Procurement Strategy and Objectives	40%				
Defining The Supply Need	33%				
Procurement Commodity / Project Strategies & Collaborative Procurement	31%				
Contract and Supplier Management	33%				
Key Purchasing Processes and Systems	27%				
People	39%				
Performance Measurement	44%				
Overall Procurement Status for the Organisation	35%				
		Developing	Conformance	Improved Performance	Superior Performance



Shetland Islands Council's score compared to the sector average



Shetland Islands Council's 2009 - 2013 scores by section with the 2013 sector average tracked above



Shetland Islands Council's performance against the sector average for each year

Summary of Strategic Objectives and Action Plan

Strategic Objective	Rationale	Who	Action	When	Update
2.1 Create and manage a procurement service that addresses the aims of the Council's Improvement Plan, and meets the guidelines and recommendations of the Scottish Government.	• Implement strategy with high level support • Raise visibility and importance of procurement • Improve internal communication and collaboration • Create a strategic centre for information and advice • Ensure suitability of policies and procedures	• CMT via an executive sponsor • Executive Manager Capital Programme Service • Procurement Section • Procurement Network • Executive Manager Governance and Law	▪ Align implementation of the Council's Action Plan under this Strategy, with national initiatives for procurement activity.	Ongoing	Ongoing 2013/14 - Provided Procurement Reform Bill Briefing Notes for Council Leader and Chief Executive (COSLA). Spring 2013 participated in Federation of Small Business survey. Report published July.
			▪ Review and revise Councils Standing Orders Relating to Tenders and Contracts	May 2012	Approved August 2013. Roll out workshops to be held Spring 2014

Strategic Objective	Rationale	Who	Action	When	Update
2.2 Having established a central procurement function, develop a communication plan and provide the means to network. This should disseminate best practice, information and advice to all levels of the Council and its stakeholders, as well as providing a framework for reviewing, learning and sharing of knowledge	• Raise awareness and importance of procurement • Improve internal communication and collaboration • Improve external Collaboration and communication	• Executive Manager Capital Programme Service • Procurement Manager • Procurement Network	• The Executive Manager Capital Programming will represent the procurement service at senior management level. • A strategic team will co-ordinate procurement activities. • Web sites, both internal and external, will be developed to provide easy access to procurement activities. • Collaboration will be considered and acted upon objectively in all procurement activities.	Implemented December 2010 Ongoing Ongoing Ongoing	December 2010 Mid 2012 / ongoing *(Follow on from 2010/11) Mid 2012 / ongoing *(Follow on from 2010/11) Ongoing – incorporated in new Contract Standing Orders "Spotlight on Procurement" published on the Internet Oct 2013

Strategic Objective	Rationale	Who	Action	When	Update
2.3 Embed good procurement practice across the Council underpinned by good communication and collaboration.	• To eliminate maverick spend • Obtain value for money • Ensure compliance with council policy and procedures and legislative framework • Ensure transparency in all transactions and processes	• Executive Manager Capital Programme Service • Procurement Section • Procurement Network • Executive Manager Finance • Payments Manager	• In order to address these issues the Procurement Network will be further developed, covering all services. This will ensure consistency and improved practice across the council.	Ongoing	Mid 2012 / ongoing. This requires further review in 2014. Restructuring and staff leaving has hindered progress. Procurement contact Roles & Responsibilities established.

Strategic Objective	Rationale	Who	Action	When	Update
2.4 Review all Procurement processes and functions to develop procurement capacity, ensure compatibility with other Council systems, provide Business Information, improve procurement controls including integration with suppliers and partners, where appropriate.	• To automate the Procure to Pay process • Reduce costs and introduce greater efficiency in the procurement process	• ICT Unit Manager • Payments Manager • e-Procurement Project Group • Executive Manager EDU • Procurement Section • Internal Customers • Technology Partners • External Stakeholders – suppliers, service providers	• Present review proposals for procurement system(s) in operation across the Council to CMT. • Prepare a detailed Business Case to support the proposals. • Prepare a detailed implementation plan where a new approach to e-procurement is recommended.	April 2012 – April 2014 April 2012 – April 2014 April 2012 – April 2014	Partial progress – Reconsider as a stand alone Procurement ICT Strategy. Integra Catalogue Expert (ICE) approved as "spend-to-save" 2012/13. ICE rollout ongoing. implemented August 2013. Cross ref. to CCM implementation during 2014.

Strategic Objective	Rationale	Who	Action	When	Update
2.5 Establish a collaborative culture within the Council. Promote collaboration as the first factor to be considered, whether internally or externally for all procurement activities.	• To challenge the inefficiencies associated with disparate procurement. • To address recommendations of the McClelland Report now being followed by Scottish Government • To ensure compliance where aggregation rules apply • To obtain Best Value • To address audit recommendations regarding corporate tendering.	• Executive Manager Capital Programme • Procurement Manager • Procurement Network • Procurement Partners – Scotland Excel, Scottish Procurement and Commercial Directorate, NHS Shetland, Scottish Water, Trusts, OIC, Buying Solutions, other public sector bodies	• Identify existing and further internal procurement opportunities and progress options for corporate collaborative solutions. • Actively engage in collaborative opportunities with external partners, such as Scotland Excel, Procurement Scotland, NHS Shetland, Trusts and other public sector bodies, where appropriate. • Make use of existing knowledge base regarding collaboration, i.e. established frameworks and pilot procurement projects. • Identify commonly purchased commodities and progress centralised procurement as appropriate.	Ongoing Implemented and ongoing Ongoing Implemented and ongoing	Ongoing Office Supplies centralised Dec 2011. (Cat A) SXL Workshop June 2012 NHS meeting Sept 2013 Aids for Daily Living with WIC Oct 2012 (Cat C1) Weather Forecasting Ports and Roads (June 2013) -Cat C Marine Gas Oil - June 2013 - Cat C Other Liquid Fuels Oct 2013 – Cat A Collaborative opportunities with NHS Shetland under review 2014/15.

Strategic Objective	Rationale	Who	Action	When	Update
2.6 The provision of a monitoring system that accurately identifies and values all benefits accruing from revised procurement activities, that can be measured against recognised standards and can be utilised for regular monitoring and management reporting purposes.	• To accurately monitor and report benefits accrued. • To adopt a model which allows easy comparison both internally and with other public bodies. • Introduce consistency of approach to savings monitoring • Create the basis for a benchmarking network	• Executive Manager Finance • ICT Unit Manager • Procurement Section • Procurement Network	• Review internal reporting tools to identify "Monitoring System", consult with the Scottish Government and other public sector organisations, where necessary, to trial and adopt an appropriate monitoring tool.	March 2012	No specific monitoring tool identified. Developed internal savings reports early 2013
			• Engage internally via the Procurement Network to implement and maintain this monitoring tool.	June 2012	Review required – see 2.3
			• Develop a reporting hierarchy for the benefits identified.	June 2012	Reconsider options for reporting 2014/15.

Strategic Objective	Rationale	Who	Action	When	Update
2.7 Establish a Procurement culture that recognises accessibility and sustainability as the norm and promotes the Councils objectives for business and the community.	• To embed the Council's sustainability policy in the procurement process • To reflect the Councils commitment to the environment. • To fulfil legislative obligations	• Procurement Manager • Procurement Network • Others as required e.g. WRAP • Executive Manger Waste and Energy	• Provide portals for procurement accessibility via the intranet and the external Internet website.	April 2014	Intranet 2 and Internet web portal updated 2011/12.
			• Liaise with the Economic Development Unit and other parties, to promote and simplify business accessibility.	Ongoing	Suppliers event planned for Feb 2012 postponed. Presentation to Shetland Business Network March 2013 Procurement Seminar - held Sept 2013
			• Promote consideration of a green procurement guide/toolkit	Ongoing	Guidance and toolkit on intranet under review Spring 2014. Flexible Framework to be reviewed/updated.
			• Ensure that the Council's procurement exercises reflect our targets on sustainability and recycling wherever possible.	Ongoing	Ongoing (e.g.Shetland College, Haulage, Walls Pier, Special Waste Disposal)

Strategic Objective	Rationale	Who	Action	When	Update
2.8 Develop Procurement Staff with skills and competences to the necessary professional level.	• To meet the recommendation of the McClelland Report (as now being progressed by the Scottish Government) • To apply improvement to the delivery of procurement services • To identify and address skills gap • Participate in national initiative to raise procurement standards • Motivate and empower staff • Reinforce the Council commitment to Personal Development	• Train Shetland • Procurement Manager & Procurement Officer • Procurement Network • Procurement Partners, Scotland Excel OIC, Trusts, Shetland Enterprise, Scottish Government	• Identify competences via a skills audit and collate training requirements. • Actively engage in collaboration with internal partners, Scotland Excel, Scottish Government and other organisations, to implement a recognised training programme. • Implement training programmes for staff, which support Personal Development with professional qualifications, where appropriate. • Encourage staff development internally.	By June 2012 Ongoing September 2012 – December 2014 Ongoing	Survey Monkey Nov 2012. Requires update /re-issue following restructuring /staffing reductions Consider more strategic approach for procurement training in 2014. Spring 2013 Procurement Manager joined SXL Learning & Development Board Procurement Manager gained MCIPS March 2013. Asst. Contract Compliance Officer SVQ Level 4 March 2013. Procurement Officer enrolled for CIPS Diploma in Procurement & Supply - April 2013

Strategic Objective	Rationale	Who	Action	When	Update
2.9 "The provision of a Procurement function that can combine technology and best procurement practice with effective review and learning to facilitate effective business outcomes."	• Deliver measurable procurement performance • Enhance relationships with suppliers and procurement partners • Deliver identifiable savings	• Executive Manager Capital Programme Service • Procurement Section • Procurement Network • Customers and suppliers	• The Procurement Manager will give direction to the implementation of the Procurement Strategy via the network of Procurement contacts to assist Executive Managers. This group will meet regularly to drive implementation and act as a forum for procurement activities generally.	Ongoing	Ongoing. Not fully implemented as anticipated (See 2.3)
			• CMT guided by recommendations from the Executive Manager Capital Programming will approve a list of products/services that will be subject to procurement review.	Ongoing	Centralised office supplies. Others ongoing e.g. foodstuffs, cleaning products & flooring.
			• The Network will monitor implementation of the strategy and procurement reviews and report to the Procurement Manager The Action Plan will be in the form of a Traffic Light update report.	Ongoing	Ongoing. Requires reconsideration and review as detailed for reasons stated in 2.3 above.